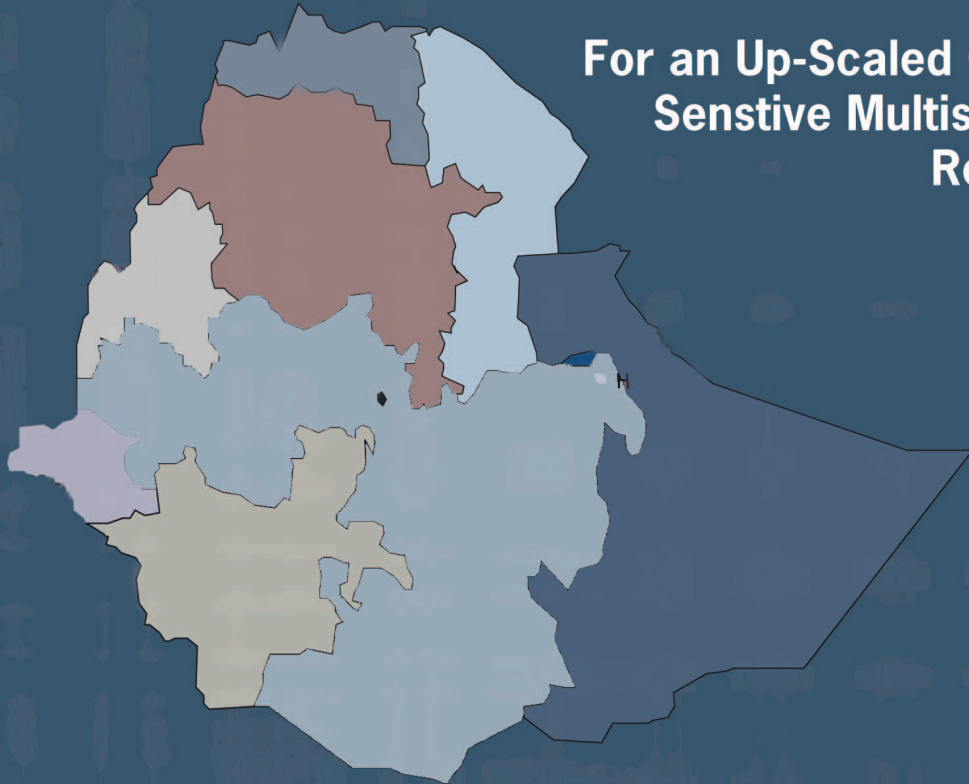# A HANDBOOK FOR HIV AND AIDS
MAINSTREAMING

For an Up-Scaled Gender Senstive Multisectoral Response

Joinlty prepared by the HIV/AIDS Prevention and Control Office (HAPCO) and the UNDP Ethiopia Country Office

PREFACE

The 2001 UNGASS Declaration of Commitment on HIV and AIDS required countries to integrate their AIDS response into their national development plans. To achieve this, "mainstreaming" HIV/AIDS and gender into the sector policies and programs has become a crucial step in the management of the epidemic.

Many sectors and institutions however, continue to request clarity on mainstreaming at both a conceptual and operational level. Although there are many definitions of mainstreaming currently in practice, UNDP suggests that mainstreaming should respond to the following sets of questions:

(i)   What is the impact of AIDS and gender on development, and what policies, strategies and actions do we need to put in place to minimize these impacts?
(ii) What are the "positive" impacts associated with the implementation of development policies and strategies on HIV/AIDS and gender issues in the community? And what policies, strategies and actions should be put in place enhance these positive impacts?
(iii) Lastly, what are the potential "negative" impacts associated with the implementation of development policies and strategies on HIV/AIDS and gender issues in the community? And what policies, strategies and actions should be put in place to minimize these negative impacts?

To answer the above questions, HAPCO and UNDP have developed this handbook which outlines seven tools to provide planners and program managers with the technical ability to apply mainstreaming as part of standard program management within all sectors. Given the centrality of the issue of gender, this handbook is also inclusive of a gender analysis tool that continues to address gender in synergy with HIV/AIDS. The content of this document has also benefited from the mainstreaming work of our various partners including, GTZ, OXFAM, HERD, ILO, and UNAIDS.

This handbook is part of a holistic Leadership for Results (L4R) package offered by the UNDP to operationalize, in conjunction with HAPCO, up-scaling of the Government of Ethiopia's multisectoral HIV/AIDS Strategy. This includes: (i) The Leadership for Development program which emphasizes the importance of individuals and their commitment to take action in reversing and stopping the spread of HIV. (ii) Community Conversations, a transformational methodology which unleashes the social capital for taking action at the community level. (iii) The Mainstreaming initiative which underpins individual and community actions, through HIV/AIDS and gender sensitive changes, in policy and programs in the formal sector; and (iv) The Media and Arts component, which focuses on changing the discourse of HIV and AIDS to one that is positive, and to up-scaling of the

L4R program through advocacy, documentation and dissemination of best practices and role models.

The Mainstreaming handbook builds on the key frameworks and training materials developed by the UNDP Regional Program based in South Africa, and has been further embellished and indigenized through intensive field testing and trainings within Ethiopia; in particular, in the Southern Nations, Nationalities and Peoples Regional State (SNNPRS). This national process has resulted in over 500 people being trained and a national by-in of the mainstreaming methodology. A very special thanks therefore, to H.E. Mr. HaileMariam Desalegne, President of SNNPR, and his government colleagues, for their foresight and initiative in pre-testing these tools. Furthermore, we extend our appreciation to Ms. Roman Tesfaye, First Lady of SNNPRS, Bureau of Finance and Economic Development, and Dr. Erssido Lendebo, SNNPR HAPCO, for actively pioneering the trainings throughout the Southern Region.

We would like to thank Dr. Roland Msiska and his UNDP South Africa team, whose innovative conceptual package of frameworks and tools, gave new meaning to the concept of mainstreaming. We also extend our gratitude to this team for including Ethiopia as one of the initial six countries trained on these tools and for their continued support and technical assistance.

The outstanding dedication and hard work of the Ethiopian Core Technical Team -- Mr. Kemal Ali, M & E Team Leader, HAPCO, Dr. Erssido Lendebo, Head of SNNPR HAPCO, Dr. Geira Baruda, HIV/AIDS Programme Officer, UNDP, and Ms. Kadia Petricca, Junior Professional

We are pleased to make this handbook available to all partners in Ethiopia. This is a 'living handbook' and through its use and adoption across Ethiopia, it is expected to contribute to the development of a series of sector specific mainstreaming guidelines. HAPCO and UNDP invite all partners to join in opertaionalizing and up-scaling this national multi-sectoral endeavor, including through the use of this handbook within the formal sector.

Modibo Toure, Resident Representative
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United Nations Development Programme
HIV/AIDS Prevention and Control Office

EXECUTIVE SUMMARY

1) As one of the factors limiting the realization of the Millennium Development Goals (MDGs), HIV/AIDS, particularly in Ethiopia, continues to hamper any hope of alleviating poverty and hunger, achieving universal education, promoting gender equality due to the feminization of the virus, and reducing child mortality as a result of parent to child transmission. HIV and AIDS have become as much a development concern as they have been a health concern. Through an increase in mortality and morbidity rates due to HIV/AIDS, the epidemic is in turn, altering the structure and function of the sectors by straining and limiting the output of services, while simultaneously increasing the complexity and quantity of services required. Consequently, these social alterations result in a disruption in sectoral income and expenditure which will ultimately hamper national development.

2) In this line of thought, it is critical to begin thinking of what strategies and measures will be effective in mitigating these rates. In order to address all the dilemmas surrounding this global and national epidemic, sectors must begin forecasting and planning for the future trends and impacts of the disease. It is becoming increasingly important to up-scale the AIDS response, and mainstreaming HIV/AIDS with a gender sensitive mindframe is intended for that purpose. The existence of gender inequality has a great influence on a differential spread of HIV/AIDS, where issues of inequality place women disproportionately at a greater risk for infection. . In gender mainstreaming, all gender biases are removed and strategies are planned and implemented with the concerns of women, men, boys and girls in mind and how the intended intervention affects them differently. To mainstream HIV and AIDS adequately, it is imperative that issues surrounding gender imbalance within sectors and institutions be considered.

3) The government of Ethiopia's five year Strategic Multi-sectoral Plan for HIV/AIDS is complementary to the tools and frameworks discussed herein. These handbooks ties closely with the UNDPs and HAPCOs goal to assist in the implementation and up-scaling of this strategy, and are prepared to take this initiative to scale through the provision of technical support. In recognizing the importance of inter-sectoral collaboration, the UNDP and HAPCO welcome all partners and sectors to implement these tools and mainstream HIV and AIDS into their core policies and strategies.

In his World AIDS Day address, Mr. Mark Malloch Brown, UNDP Administrator, stressed the importance of partnerships in up-scaling the HIV/AIDS response, *"There have been initial successes in those countries which have adopted policies and implemented programmes that promote multisectoral approaches; which encourage partnerships and alliances between government and civil society, which minimize discrimination and address factors that intensify vulnerability; which support the creation of an "enabling" political and social environment to respond to the health and well-being of their citizens. Inclusive policies and programmes can help to ensure that those affected by HIV and AIDS will not be marginalized or trapped in an endless cycle of poverty. . .Strong leadership, bold action, compassion and solidarity are required if effective strategies against HIV/AIDS are to be implemented.. These challenges can be met if strategic decisions are made to re-examine national and international policies and strategies now."*

4) The Concept of Mainstreaming: The goal of mainstreaming HIV and AIDS into development and humanitarian work at a sectoral, institutional and community level is to ensure that the impacts of HIV/AIDS are addressed as well as ensuring that program policies and strategies have put preventative efforts in place. Mainstreaming HIV and AIDS intends to assist individuals in going beyond the "business as usual" mentality, and thus, address the epidemic in a strategic way in all sectors, both inside their own organizations and extending to the communities they serve.

5) For the purpose of this handbook, the following definition of mainstreaming given by the UNDP regional HIV/AIDS team has been adopted as this definition best relates to the different tools discussed in Module III of this handbook. *"Mainstreaming at a conceptual level is defined as bringing HIV and AIDS to the center of the development agenda."* This essential feature of the mainstreaming paradigm aims to address, in an operational way, the following basic questions:

(I)   What is the impact of AIDS and gender on development and what policies, strategies and actions do we need to put in place to minimize these impacts?

(II) What are the "positive" impacts associated with the implementation of development policies and strategies on HIV/AIDS and gender issues in the community? And what policies, strategies and actions should be put

in place to enhance these positive impacts?

(III) What are the potential "negative" impacts associated with the implementation of development policies and strategies on HIV/AIDS and gender issues in the community? And what policies, strategies and actions should be put in place to minimize these negative impacts?

As defined by the Core Technical Working Group, the following definition represents characteristics of what the Mainstreaming Taskforce believes mainstreaming should encompass:

> "Mainstreaming HIV/AIDS is a systematic and dynamic process of change in policies, strategies, values, norms, power and economic relations surrounding HIV and AIDS within sectors, organizations, communities and households. As a result, mainstreaming proactively responds to the bidirectional impacts of HIV/AIDS by reducing vulnerability to infection, while simultaneously creating an "AIDS-competent society" in order to mitigate its future impacts."

6) Highlights of the different Tools used for Mainstreaming: The following tools have been adapted the from various works of Dr. Roland Msiska and his UNDP South Africa Regional Team, Peter Senge's Systems Thinking, and John Kotter's Framework for Change.   These tools have been consolidated, adapted and enriched to facilitate with mainstreaming HIV and AIDS into the Ethiopian context. To compliment this handbook and assist the user in scaling up their response, PowerPoint training materials have been attached for use by trainers. These should serve as a guide on how to train stakeholders on mainstreaming, but they may be altered to serve their local needs.

Systems Thinking – will enable us to view the complexity of the problem caused by HIV/AIDS and what solutions to propose much beyond what appear to be simple. Systems' thinking is a tool that helps to manage mainstreaming in relation to other responses. HIV/AIDS and it is also a concept that helps ones way of thinking in the midst of a complex reality. This tool can be applied at all stages of mainstreaming at all levels of intervention.

Rapid Assessment for Measuring AIDS Impacts – the rapid impact assessment tool is a useful tool to measure to what extent a sector or an institution is affected by HIV/AIDS and will be affected in the future unless some serious measures are taken. This tool is best utilized at early stage of main-

streaming at any level of a hierarchy.

Cross-Impact Analysis – Shows us how the different sectors impact on one another. The use of this tool requires good understanding of the mandates and structures of the different sectors, and the functional relationship and interdependence of the different sectors and institutions in a given location. Some sectors affect the functions of many sectors and are called strategic sectors; while others are easily affected by the changes in many sectors and are called vulnerable sectors. Cross-Impact Analysis helps in focusing our resources and efforts to the most strategic and most vulnerable sectors. This tool could be best applied at the community level to identify those who influence whom and who is worst affected in a community and at the household level. Hence, allowing interventions to focus on individuals that have leverage in our interventions. This tool is however applicable across all the stages of mainstreaming.

The Demand and Supply Model – this is a tool that shows how the change in the quantity and pattern of demand by the community changes the delivery/supply capacity of a sector/an institution and/or how the change/disturbance in the capacity of an institution or a sector will in tern disturb the quantity and pattern of services by the demanders. Though there is a place for this tool in all the stages and level, it is best applied at stages III and IV, and best used by planners at any level.

Basic HIV and AIDS Epidemiology and its relevance to Mainstreaming – helps professionals outside of public health to understand basic facts on HIV/AIDS risk, transmission and pathway of the disease from infection to death. This is also an important tool that helps each stage of HIV and AIDS be applied to Public health and development interventions. The period before infection could be useful for risk surveillance; the window period could be used for incidence surveillance; the long asymptomatic period helps for prevalence surveillance; the illness or AIDS phase for AIDS surveillance; and the phase beyond could be used to assess impacts and plan interventions accordingly.

The low probability of infection per the different mode of contact as opposed to the high prevalence in the community helps one to understand other contributing factors that fuel the epidemic such as early sexual initiation, number of partners, the rate of acquisition of new partner, partner diversity, and the use of preventive technology, etc.

SWOT and PEST Analysis – *SWOT analysis* is a tool for assessing an organization and its environment. It is a very

effective way of identifying Strengths and Weaknesses, and of examining the Opportunities and Threats a sector or institution faces in mainstreaming of HIV/AIDS. Carrying out an analysis using the SWOT framework helps to focus on implementing agency or individual's activities into areas where it is strong and where the greatest opportunities lie. SWOT helps to gather, analyze, and evaluate information and identify strategic options facing a community, organization, or individual, engaged in HIV/AIDS activities, at a given time. It is useful in all stages of mainstreaming starting from initial planning to reflect on experiences in the process and evaluate results in mainstreaming. There is no limitation to the level that this tool could be applied. *PEST analysis* is a strategic tool that is used to scan the external macro-environment in which an HIV/AIDS coordinating or implementing entity operates.   PEST factors are usually beyond the control of organizations and must normally be considered as either threats or opportunities. Though it is hard to change PEST factors to meet organizations needs, understanding of the environment helps organizations to utilize their internal strengths and existing opportunities to plan for success in a rough PEST environment.

Gender Analysis as a tool for HIV and AIDS Mainstreaming – highlights the differential risks for women and men to HIV exposure and vulnerability to its impacts. Gender imbalance and inequality in many contexts continue to be a determining factor of vulnerability for women. Thus, understanding this vulnerability and developing strategies to overcome it can be assisted through this tool.

As this document is not specifically addressing the foundations of mainstreaming gender per se, we still feel that to address HIV and AIDS, one must address issues surrounding gender at a policy level. Gender must be taken into account during each step of the program cycle including defining the problems/issues; formulating a strategy; identifying the target group; establishing/strengthening the institutional framework; specifying objectives and indicators for success; defining inputs, outputs, and activities and specifying monitoring and evaluation procedures.

Framework for Change - To ultimately address the epidemic, a change in the current mindset and framework are required. The way we are currently leading our lives, our behaviours and practices, in conjunction with policies, strategies and actions in development thus far have not made the sustainable impacts in mitigating the epidemic or in transforming behaviours that are needed to address the epidemic. To be viable in this era of HIV/AIDS, we need to be HIV/AIDS competent, and to be competent we need to change and

view this problem more systematically. The philosophy behind this tool focuses on individuals and sectors looking inward to assess how to become a learning organization for AIDS competence.

The Internal Mainstreaming/ Workplace Intervention -
Internal mainstreaming or workplace intervention refers to the first and second stages of mainstreaming under the UNDP classification. Workplace intervention involves measuring and predicting the impacts of HIV/AIDS, undertaking HIV/AIDS activities to reduce vulnerabilities and risks to HIV infection, and caring and support of affected people as well as minimizing the impacts of AIDS on the functioning of people within the organization, sector, program, project, etc.

The following justify the need for internal mainstreaming:

- HIV/AIDS highly impacts on the world of work – reducing the supply of labor and available skills, increasing labor costs, reducing productivity, threatening the livelihood of workers and employers, and undermining human rights.
- Workplaces are communities where people come together and they discuss, debate, and learn from each other. This provides an opportunity for awareness raising, education programs, and protection of rights.
- Employers and trade unions take crucial leadership in their labor and professional communities to fight against HIV/AIDS.

The challenge of HIV/AIDS could be addressed in the workplaces by consciously formulating workplace policies and guidelines that inform day-to-day practice, thus contributing to the protection of the workforce and the deepening of an organization's understanding of the multidimensional impact of the epidemic.

MODULE 1

Overview of the HIV/AIDS Situation

A Rationale for Mainstreaming HIV/AIDS

Overview of HIV/AIDS Situation

1.1. Global Background

In 2003 alone, AIDS killed a total of 3 million people globally, of which half a million were children. According to the UNAIDS 2004 Global Report on the AIDS epidemic, a total of approximately 38 million people were living with HIV/AIDS by the end of 2003; adults consisting of 36 million (women 17 million), and 2.1 million children less than 15 years. In that same year, around 5 million people were newly infected with HIV globally, of which 4.1 million were adults and 630,000 children under 15 years of age.

During the initial stages and leading to the discovery of HIV and AIDS, responses and research was initially heavily focused on the biomedical realm of the virus. Scientists in the field of microbiology, virology, immunology and others related were the major actors in this response, and their efforts were directed at the behavior of the virus and the immune response of the human body. As HIV virus spread at such an alarming pace however, it was soon realized that its behaviour had just a minor role in the potency of the problem. Further research became focused on socio-economic and cultural aspects that were influencing behaviours and placing individuals in high risk scenarios for infection.

In order to address the innate complexities that are propagating the spread of the virus, political commitment has grown stronger, grass-roots mobilization is becoming more dynamic, funding is increasing, treatment programmes are shifting into gear, and prevention efforts are being expanded. All of these responses demand joint efforts by the different disciplines, nations, agencies, sectors, cultures and groups for their survival. These joint responses are the basis for the global and national multisectoral response, which in turn created a further advanced response strategy, named HIV/AIDS Mainstreaming, dealing predominantly with institutional behavioral change or 'AIDS Competence" --a process whereby institutions, sectors and organizations are able to assess and respond openly to the factors that may be putting their workforce and communities at risk of HIV, and systematically respond to groups infected and affected both internally and externally. Consequently, an environment is created to ensure that an institution and /or sector will be able to persevere and survive in this era of HIV/AIDS and fulfill its primary mandates.

1.2. African Background

The Sub-Saharan region continues to persist as the worst affected by the HIV/AIDS epidemic. HIV prevalence has remained relatively steady at high levels, whereby the increases in the number of those living with HIV/AIDS is proportional to the growth in the adult population. By mid-2004, an estimated 25 million people in this region are living with HIV/AIDS, sharing over two-thirds of the global burden. Approximately 3 million individuals were newly infected, and AIDS killed roughly 2.3 million, 77% of the global deaths.

This continental generalization however does conceal regional variations such as those rates which are increasing in some nations while decreasing in others. For instance, HIV prevalence varies considerably across the continent, ranging from less than 1% in Mauritania to almost 40% in Botswana and Swaziland. This is of course is a result of a complexity of issues, cultures and practices that are context specific for various areas.

Since the beginning of the spread in Africa, the virus has beared a female face. In the sub-region, 57% of infected adults are women who are at least 1.2 times at a greater risk for infection in relation to men. This ratio is highest among young people aged 15–24 years where 75% of those infected are girls and are found to be two-and-a-half times as likely to be HIV infected.

This disproportionately of infection has been attributed to several factors, both biological and social in nature. At a biological level, HIV is generally more easily transmitted from men to women (than vice versa). In addition, the gender imbalance typically persistent in many African countries as well as income inequality has forced many women to adopt sexual behaviours that place them highly vulnerable to infection.

Furthermore, sexual activity tends to commence at earlier stages for young women who often take on much older partners more likely to be infected with the virus. More than one in five pregnant women are HIV-infected in most countries in Southern Africa, while elsewhere in sub-Saharan Africa median HIV prevalence in antenatal clinics

exceeded 10% in a few countries. It is readily apparent that to target HIV infection, gender disparity should be given much attention.

To continue fighting against the virus, Heads of states and governments from the Maputo and Abuja Summits have committed to assess the situation and mitigating the impacts that are directly resulting.

1.3. The Ethiopian Response to HIV / AIDS

In 1984, the first evidence of HIV in Ethiopia was discovered, and two years following, the first case of AIDS was reported. Since then, the spread of the disease accelerated at an alarming rate due to such factors as socio-economic vulnerabilities, cultural practices and gender disparity.

Presently in Ethiopia, an estimated 2.2 million out of nearly 70 million, mainly of the age group 15–49 years are living with HIV (Ministry of Health, 2002). Such staggering rates have made Ethiopia the third most highly affected country worldwide in terms of absolute numbers. Consequently, sectors and communities are now forced to cope with over one million orphans who have been left behind due to the epidemics effects.

As a response to the epidemic, Ethiopia first established a National Task Force on HIV in 1985 and Two Medium Term prevention and control plans were designed and implemented between 1987 and 1996. Activities related to Information, Education, Communication (IEC), Behaviour Change and Communication (BCC), condom promotion, HIV surveillance, patient care and expansion of HIV screening laboratories in different health institutions, were carried out. This response however, was not strong enough as compared to the gravity of the problem. The initial involvement of the public at the community level was quite minimal, and coordination and integration across sectors were not adequately established.

As a result of the continued high rates of infection, the government approved a comprehensive HIV/AIDS policy in August 1998 to provide an enabling environment for a multi-sectoral response for the prevention and control of the epidemic.

Furthermore, cognizant of the threat of the epidemic, the Government prompted itself to take a series of measures to meet the challenges and reduce spread of the disease. The

National AIDS Prevention and Control Council was then established in April 2000, headed by the president of the Federal Democratic Republic of Ethiopia. This Council consists of members drawn from: Sector Ministries, Regional States, NGO's, religious bodies and representation from civil society and people living with HIV/AIDS. The Council oversees the implementation of the federal and regional HIV/AIDS plans, examines and approves annual plans and budgets, and monitors plan performance and impact. A National HIV/AIDS Prevention and Control Secretariat was also established under the Prime Minister's Office to coordinate and facilitate the multi-sectoral response to HIV/AIDS. Later, the National HIV/AIDS Council Secretariat was upgraded to National HIV/AIDS Prevention and Control Office (HAPCO) by proclamation in June 2002 and has now become autonomous body.

Moreover, a five year National Strategic Framework (2001-2005) was drawn by the Government of Ethiopia consisting of the following targets – IEC, BCC, Condom Promotion and distribution, VCT, Management of STIs, Blood safety measures, Universal Precaution, Prevention of MTCT, Care & Support. To implement and make the framework operational, the Government of Ethiopia in partnership with and support from international donors formulated the Ethiopia Multi-Sectoral HIV/AIDS Control Project (EMSAP), which is in its third year of implementation. To date, many of the intervention areas described in the Strategic Framework have been implemented and a number of accomplishments have been recorded including expanding VCT sites, increasing numbers of people getting tested, as well as increases in condom use. Proper evaluation of these successes is still in progress.

In Ethiopia, government bodies, institutions, non-government organizations (NGOs), religious bodies and local communities must fully understand the harsh strain and hindering effect that this epidemic is placing on advancements in development. Such a developmental crisis, as in Ethiopia, requires a multisectoral response, whereby all sectors and institutions are involved to fight AIDS in their daily efforts to alleviate future devastating impacts. In August 2003, the publication of the Mainstreaming guideline sponsored by HAPCO introduced new ways of approaching the epidemic via a multi-sectoral response. The document promoted sectors to assess the impacts of AIDS on their respective sectors, and tried to assist in mitigating these impacts.

In realizing the effects of HIV/AIDS on advances in development, and the challenges associated with the concepts and the

**Box 1 - A Statistical Overview of Ethiopia
(Human Development Report, 2004, AIDS in Ethiopia, 2002)**

Human Development Index ranks Ethiopia   170

Total Population   67,800,000

Life Expectancy at birth   Men   45.5 yrs
                           Women   45.5 yrs

Population below the UN poverty line   1$US/day   26.5%
                                         2$US/day   80.7%

% of undernourished children <5 yrs   47%

Estimated number of people living with HIV/AIDS   2.2 million   Adult HIV Prevalence
        6.6%

Estimated number of children living with HIV/AIDS   200,000

Number of estimated Orphans   1.2 million

"how to" of mainstreaming, both HAPCO and the UNDP – HIV/AIDS Unit (whose work has largely been centered on targeting HIV/AIDS in a development mind frame) united to produce a set of tangible tools that will provide sectors with the capacity to achieve "AIDS competence."

1.4. The Rationale for a Multisectoral Response and HIV/AIDS Mainstreaming

Historically, HIV and AIDS have been considered solely as health related issues, requiring only health related interventions.   For too long, the effects of the virus on the development sectors capacity to deliver had gone unrecognized. However, for all intents and purposes of this document, and even when understanding the various facets of the epidemic, it is essential to view HIV/AIDS as a development issue. The reason to consider a multisectoral response to approach the epidemic is because it is causing multisectoral negative effects.   HIV/AIDS is having a huge impact on societies, economies, cultures, and demographic and thus, sectors, institutions and communities are now forced to respond to this predicament in a holistic manner.

Despite all the above effort, the burden of the problem has reached a stage beyond that which the health sector can solely manage. The already overstretched health system in most

instances has reached its threshold of service delivery -- due to the change in the demand for and supply of health services through increase in the pattern of disease presentations, increase in number of complicated cases, very high consumption of health resources by HIV/AIDS cases, etc. The world now has realized the need for multisectoral response to this seemingly never ending challenge by the establishment of HAPCO, a national authority with a broad based multisectoral mandate.   The establishment of this authority is not to override the health sector's mandate, nor is it to work on behalf of the other sectors, but it is to coordinate and support all sectors and allies in their efforts to ensure the viability of the generation, the economy and their own survival as sectors and agencies in the midst of this epidemic.

Sectors and institutions involved in multisectoral mandates must realize that their involvement or future involvement to mainstream HIV/AIDS will benefit their sectors capacity to cope. And not solely support the works of the health sector or a unit person assigned to coordinate health or HIV/AIDS within the sector/institution.

FIGURE 1: How AIDS brings erosion of capacity to deliver of a Sector/Institution
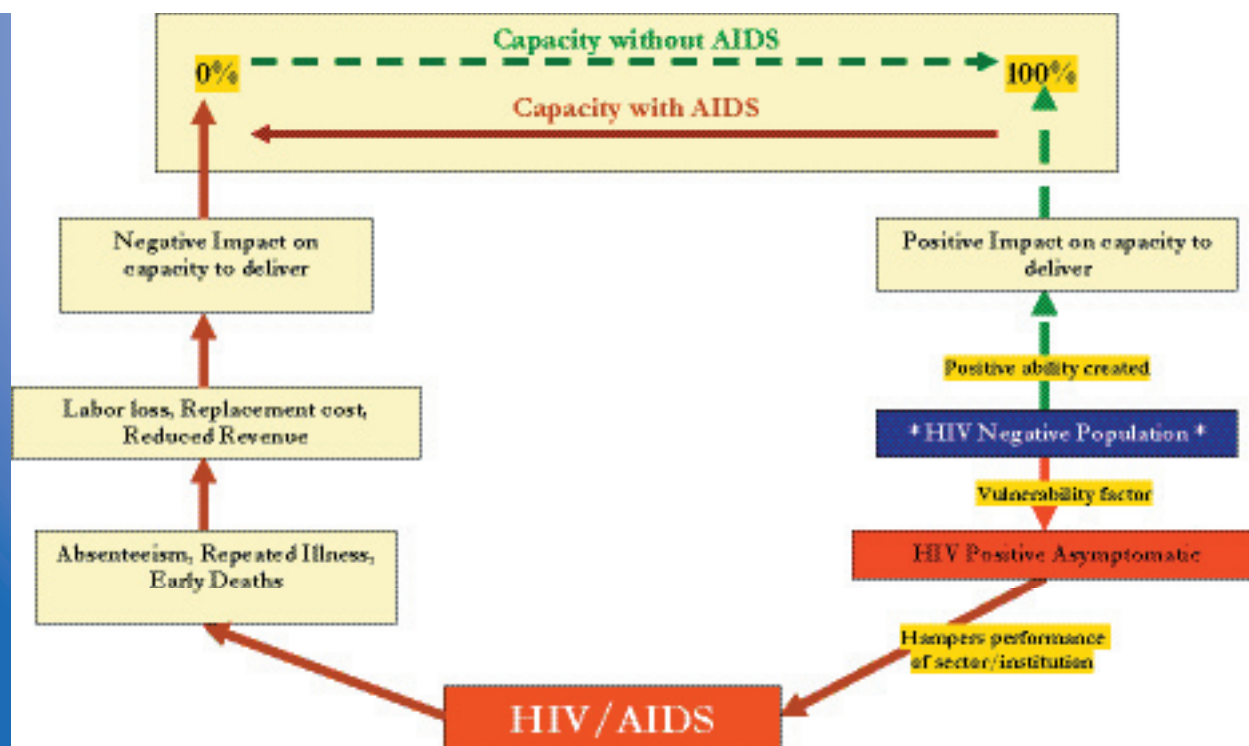
Mainstreaming HIV/AIDS and gender into development efforts involves change in:

- The way actors think.
- The way key development policies, strategies and actions are planned, implemented, monitored and evaluated.
- The context within which development takes place.

The analysis process and method of HIV/AIDS Mainstreaming will change depending on the context be implemented in. Mainstreaming will in turn change the networks and partnerships within sectors as a result of implementing more AIDS conscious policies and practices. It will change the content of key sectors, policies, programs and plans involved in delivering key development mandates.

1.4.1. How HIV/AIDS Erodes a Sectors / Institutions Capacity to Deliver

HIV/AIDS primarily affects sectors by increasing mortality and morbidity rates of its most productive contributors and workers. These rates in turn, negatively alter the structure and function of the given sectors by straining and limiting the output of services (supply), while simultaneously increasing the complexity and quantity of services required (demand). Ultimately, this results in changing the output and expenditure of the respective sectors or institutions leading to a less effectively functioning society.

Figure 1 Illustrates the impact of HIV/AIDS on the capacity to deliver within the economy. The green arrows indicate the contribution of a population towards development without the negative social and economic impacts of HIV/AIDS. The red arrows depict some of the avenues in which AIDS erodes an individuals and/or a community's capacity to deliver.

1.4.2. The HIV/AIDS – Gender - Poverty – Culture Interaction:

When aiming to mitigate such negative effects due to AIDS, it is crucial to understand how the complex relationship between poverty, gender and HIV/AIDS reinforce each other. Figure 2 outlines the complex dynamics and causalities of the HIV/AIDS epidemic that affects the social capital of a given society. When addressing aspects of the epidemic, whether through policy or strategies, it is essential to analyze the bi-causal relationship between poverty and HIV/AIDS and gender at the centre of this relationship. In Africa, the HIV/AIDS epidemic has been and

Box 2 – Examples of How AIDS has induced or deepe

- In a study in Thailand, one-third of rural families affected by AIDS experienced a halving of their agricultural outputs, which threatened their security. Another 15% had to take their children out of school, and over half of the elderly people were left to take care of themselves. Families spent on average US$ 1000 for medical care during the last year of an AIDS patient's life – the equivalent of an average annual income.
- In urban areas in Cote d'Ivoire, the outlay in school education was halved, food consumption went down, by 41% per capita and expenditure on health more than quadrupled. When family members in urban areas fall ill, they often return to their villages to be cared for by their families, thus adding to the pressure scarce resources and increasing the probability that the spouse or others in the rural community will be affected.
- As the number of orphans grows and the number of potential caregivers shrinks, traditional coping mechanisms are stretched to breaking point. Households headed by orphans are becoming common, in high prevalent countries. Studies in Uganda have shown that following the death of one both parents, the chance of orphans going to school is halved and those who do go to schools spent less time there than they did formerly. Other work from Uganda suggested that orphans face an increased risk of stunting and malnutrition.
- AIDS threatens the educational system and so undermines the social capital of the country. In high prevalence countries like Central African Republic, Cote d'Ivoire and Zambia, it is eroding the supply of teachers and thus increasing class sizes, which is likely to reduce the quality of education.
- The effect on agricultural production can be serious. In West Africa many cases have been reported of reduced cultivation of cash crops or food products. These include market gardening in the provinces of Burkina Faso and cotton, coffee and cocoa plantation in parts of Cot d'Ivoire.
- Some companies in Africa have already experienced the impact of HIV/AIDS on their balance sheets. Managers at one sugar in Kenya have noted increased absenteeism (8000 days of work lost due to sickness between 1995 and 1997), lower productivity (a 50% drop in the ratio of processed sugar recovered from raw cane between 1994 and 1997) and higher overtime cost for workers obliged to work longer hours to fill in for sick colleagues. Costs of social benefit related to HIV infection have risen sharply in the same company, due to funeral and health care costs.
- A recent stuffy estimated that Africa's income growth per capita is being reduced by about 0.7% per year because of HIV/AIDS. Had the HIV prevalence not reached 8.6% in 1999, Africa's income per capita would have grown 1.1% per year – or nearly three times the growth rate of 0.4% per year achieved in 1990-1997 (World Bank, 2000b). a country specific economic model of the south African economy suggests that overall GDP will be 17% lower by 2010 than it would have been without AIDS and that average per capita will be 7-10% lower because of AIDS (Lewis and Arndit, 2000)

continues to be deeply rooted in issues concerning poverty, gender, cultural practices and issues of gender. A true analysis of these relationships is important to consider when upscaling the response to HIV/AIDS within the various sectors and institutions.   What is unfortunate, yet important to understand is that the conditions that are fuelling the rapid spread of the disease are also those which are making it difficult for societies to respond. The transmission factors and impact of the epidemic are not separate entities – Poverty, Gender,
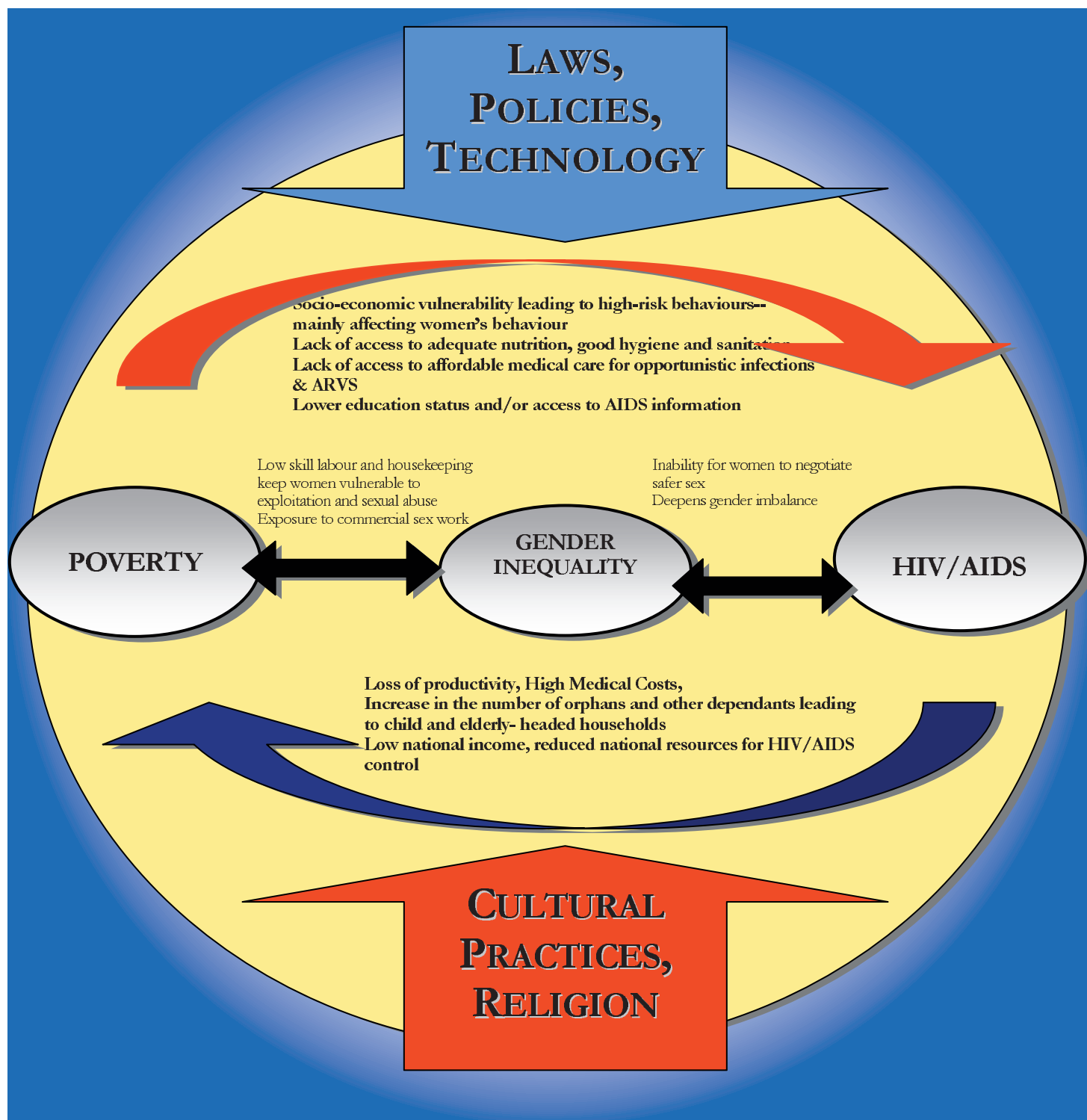
HIV/AIDS are intimately linked and the intensity of their interaction is dependant on background factors such as traditions, culture, existing laws, policies, strategies, and technology.
At the heart of this poverty-HIV/AIDS cycle are issues of gender inequality, tradition, power imbalances, economic own-

ership which are central in many African contexts. Thus, to challenge HIV infection rates, one must challenge the gender roles that are pervasive within their own cultures and provide women with avenues for empowerment and autonomy.

1.5. Gender and Vulnerability to HIV/AIDS

In Ethiopia, as in most African countries, HIV infections, are largely transmitted through heterosexual intercourse, and because of this, most effective methods of HIV prevention are partner dependent – abstinence, faithfulness and condom use. The extent to which sexual partners are free to negotiate safer sex and to protect themselves and their partners is greatly influenced by the gendered aspects of sexual behavior. Sexual behavior in turn is greatly influenced by a person's

FIGURE 2: Poverty, Gender and HIV/AIDS Cycle in the context of policy and culture

LAWS, POLICIES, TECHNOLOGY

Socio-economic vulnerability leading to high-risk behaviours--
mainly affecting women's behaviour
Lack of access to adequate nutrition, good hygiene and sanitation
Lack of access to affordable medical care for opportunistic infections
& ARVS
Lower education status and/or access to AIDS information

Low skill labour and housekeeping
keep women vulnerable to
exploitation and sexual abuse
Exposure to commercial sex work

Inability for women to negotiate
safer sex
Deepens gender imbalance

POVERTY   **GENDER INEQUALITY**   **HIV/AIDS**

Loss of productivity, High Medical Costs,
Increase in the number of orphans and other dependants leading
to child and elderly- headed households
Low national income, reduced national resources for HIV/AIDS
control

CULTURAL PRACTICES, RELIGION

understanding of sexuality, broadly understood as the social construction of a biological drive. Whom one has sex with, in what ways, why, under what circumstances, with what outcomes defines ones sexuality.

In addition, a person's sexuality is defined by gender, age, economic status, ethnicity, etc. Therefore, gender and sexuality are at the heart of any understanding of the dynamics of HIV transmission, and significant factors that determine the spread of HIV. The interconnection between gender and HIV/AIDS cannot be understood without understanding these key concepts of gender and sexuality.

Gender and HIV/AIDS Mainstreaming seeks to address the differential impacts of HIV/AIDS on women, men, boys and girls. Gender mainstreaming also seeks to promote social justice by reducing gender inequality. It uses gender analysis as the framework to describe the current power relationships between women and men and their differential authority to decide on people's access to and control over the use of resources (i.e. condoms).

Gender analysis identifies the multiple ways in which HIV/AIDS related policies and programs differentially affect men and women at all levels, and especially at the household level. Gender mainstreaming ensures that gender inequalities are addressed in the design, planning, implementation, monitoring and evaluation of HIV/AIDS programs, and ensures that the beneficial outcomes are shared equitably by all – women, men, boys and girls. In gender mainstreaming, all gender biases are removed and strategies are planned and implemented with the concerns of women, men, boys and girls in mind and how the intended intervention affects them differently. The existence of gender inequality has a great influence on a differential spread of HIV/AIDS, where the inequality factors, in many ways, place women disproportionately at a greater risk for infection. Thus, to mainstream HIV/AIDS adequately, issues surrounding gender must be heavily considered.

The following categories are factors which are wide reaching and commonly recognized as determinants of gender vulnerability in many contexts:

- Social Factors: Social construction of gender and the socialization process of men and women; myths regarding masculinity and femininity and unquestioned sexual roles and sexual behaviors; peer pressure to engage in sexual activity is higher among men than in women; lack of positive role models; lack of gender sensitivity in social institutions, including families; lack of education for girls results in low exposure to HIV/AIDS education messages due to low literacy rates; age differentials in who has sex with who - older men having sex with younger women.
- Cultural & Religious Factors: Female subordination; age of marriage and assumptions of maturity/adulthood an cultural expectations for men and women; circumcision and purification; wife inheritance; unquestioned assumptions about female and male sexuality; gender

Box 3: Key Concepts – Gender and Sexuality

Gender is defined as the set of characteristics, roles and behavior patterns that distinguish women from men socially and culturally. Gender is a social and culture–specific construct that differentiates women from men and defines the ways in which women and men interact. Gender is learned, and therefore can be unlearned. Unlike gender, sex is biologically determined; it is received, universal, and cannot be changed. The concept of gender refers not only to the roles and characteristics of women and men but also to the power relations between them. Typically, men are responsible for the productive activities outside the home while the domain of women are the reproductive and productive activities within the home. In most societies women have limited access to income, land, credit and education, and have limited control over these resources.

Power determines whose pleasure is given priority and when, where, how, and with who sex takes place. There is an unequal power balance in gender relations that favors men. This translates into an unequal balance of power in heterosexual interactions. Male pleasure has priority over female pleasure, and men have greater control than women over when and how sex takes place. An understanding of male and female sexual behavior requires an awareness of how gender is constructed by a complex interplay of social, cultural, and economic forces that affects the distribution of power. These concepts are important in discussion and in formulating effective program responses to HIV/AIDS.

bias regarding issues of sexual violence and rape; weak laws against sexual violence; religious perspective of condom use; different perspective and interpretation of male and female sexual behavior; stigma on sex as sinful and lack of integration of religious values.

- Economic Factors: Lack of education for girls results in poverty and economic dependence on men; few opportunities for girls/women to access job/career opportunities create negative effect on control of resources vis-à-vis men and women; low economic status and low representation of women in decision-making at all levels leading to women engaging in commercial sex work and other risky environments.

1.6. How HIV/AIDS is Impacting the Millennium Development Goals

On top of being a challenge in its own right, HIV/AIDS is imposing a huge cross-cutting negative impact across all the Millennium Development Goals (MDGs) as set out by the UNDP throughout the world and especially in Sub-Saharan Africa. The table below highlights how HIV/AIDS is challenging the progress and realization of the MDGs.

Addressing linkages between HIV/AIDS and the MDGs is one of the many critical roles of the Resident Coordinator System. UNDP has a Corporate Strategy on HIV/AIDS that gave the UN Coordinator System the mandate to identify how National Development and Poverty Reduction Strategies can be accelerated and strengthened to address the impact of HIV and AIDS on household incomes, livelihoods, access to education and health services, and food security.

Millennium Development Goal	MDG Target	Impact of HIV/AIDS on the Goal
1. Eradicate extreme poverty and hunger	1. Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day. 2. Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Reduced productivity by affected families. Increases consumption needs and depletes household assets; and slow or reverse progress towards the goal at household, community and national levels. (The proportion of people living in poverty in Burkina Faso is projected to increase from 45% to nearly 60% by 2010 in Thailand food consumption in affected household fell from 15% to 30%.
2. Achieve universal primary education	3. Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	Coverage and quality of education reduced due to the impact of HIV/AIDS on the supply (less teaching time due to death, illness and absenteeism by teachers) and the demand (students dropout, due to parents illness, death and poverty in the family). These impacts are demanding different patterns of education service. In the Central African Republic and Swaziland, school enrolment is reported to have fallen by 20% to 36% due to AIDS and orphan hood. This impact is more serious on girls.
3. Promote gender equality and empower women	4. Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015	In affected families, girls are the first to dropout and even if they continue they are less likely to succeed. In some of the worst affected countries nearly 50% of children who lose their parents to HIV/AIDS drop out of school; the majority of them are girls.
4. Reduce child mortality	5. Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Infant and child mortality will continue to increase for the next decade and longer due to the impact of HIV/AIDS on HH food security and hence child nutrition, mother-to-child HIV infection and the more general poverty creating effects of the epidemic. In some countries there will be deterioration over the period set for the target. Under-five mortality in South Africa will increase to 160 per 1000 live births by 2010, instead of falling to 44/1000.

5. Improve Maternal Health	6. Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	The already poor health status of mothers in poor countries is getting more complicated due to HIV/AIDS causing more maternal deaths. Teenage girls and young women are five to six time more likely to be infected. New infections are disproportionately concentrated among poor and illiterate adolescent women. The epidemic has overstretched the health services reducing the
6. Combat HIV/ AIDS, malaria and other diseases	7. Have halted, by 2015, and begun to reverse the spread of HIV/AIDS 8. Have halted, by 2015, and begun to reverse, the incidence of malaria & other major diseases	The increasing pressure on the health and other related sectors and actors due to HIV/AIDS is affecting their capacity to deal with malaria and other major diseases. The very high morbidity and mortality related to HIV/ AID is absorbing the resources, overcrowding the health services; increasing demand for care and support negatively affect efforts on prevention.
7. Ensure Environmental sustainability	9. Integrate the principles of sustainable development in to country policies and programmes and reverse the loss of environmental resources. 10. Halve, by 2015, the proportion people without sustainable access to safe drinking water. 11. By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers.	Loss of labour in the family forces children and women to be engaged in relatively less time taking livelihood activities firewood selling causing deforestation; illness, increased labour demands for caring, and lost labour reduce time for collecting water, especially for women. Human resource losses and costs in water supply services affect delivery and increase the cost of services to households. AIDS reduces ability to afford even the most basic housing by the poor. In Zambia, urban households affected by HIV/AIDS lost 80% of their income.
8. Develop a Global Partnership for Development	12. Develop rule-based, predictable, non-discriminatory trading and financial system. 13. Address the special needs of the LDCs. 14. Address the special needs of land-locked countries & small island developing states. 15. Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term. 16. In cooperation with developing countries, develop and implement strategies for decent and productive work for youth. 17. In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries. 18. In cooperation with the private sector, make available the benefit of new technologies, especially Information and Communications.	The very high funding needs for tackling the epidemics is affecting the aid pattern of donors on other development initiatives. The very high budget expenditure for prevention, care and support compounded with reducing productivity due to HIV/AIDS is compromising the debt repayment capacity of the LDCs and hence negatively impacts the opportunity of getting loans. HIV screening made a condition by some nations to enter their country is restricting the freedom of movement and education.

1.7   HIV/AIDS, Poverty Reduction Strategy Papers (PRSPs) and Debt Relief

For many, Poverty has historically been seen as a lack of income, which could be measured by the number of people living below the absolute or relative poverty line. Such a narrow view of the term limits the political and socio-economic influences that are impacting poverty within a context.

Nowadays, it is recognized that poverty is multidimensional, referring to the various interrelated aspects of well-being that influence a person's quality of life and standard of living, which can be material (food, income, housing, etc) and non-material (participation in decision making and social support networks).

> The World Summit for Social Development in Copenhagen, 1995, defined poverty as:
> A lack of income and productive resources sufficient to assure sustainable livelihoods; hunger and malnutrition; ill health; limited or lack of access to education and basic services; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environment; and social discriminations and exclusion. It is also characterized by a lack of participation in decision making and in civil, social and cultural life (Article 19).

Sustainable Development and Poverty Reduction Program (SDPRPs) are strategies that are intended to specify the issues and approaches to poverty reduction in developing countries, most urgently in the countries receiving debt relief under the enhanced HIPC (an initiative to bring a country's debt burden to sustainable levels). An effective poverty reduction strategy would be expected to: (i) be prepared by the country; (ii) focus on faster and broad-based economic growth; (iii) reflect a comprehensive understanding of poverty and its determinants; (iv) assist in choosing public actions that have the highest poverty impact; and (v) establish outcome indicators that are set and monitored using participatory process. Under HIPC initiatives, debt sustainability is defined as 150% of the level of export at the net present value.

Some of the major benefits of such HIPCs and SDPRPs are the opportunity to address HIV/AIDS into major development instruments such as mobilizing additional resources, integrating AIDS into a multisectoral approach and upscaling interventions. In realizing the inherent link between poverty and AIDS, such plans for poverty reduction, as made through the Poverty Reduction Strategy Papers (PRSPs) should include avenues for mainstreaming HIV/AIDS and the mobilization of resources as items on the development agenda.

It is therefore, essential that countries responsible for SDPRPs and HIPCs in each country focus on HIV/AIDS and prepare a set of materials that fit in to the main sections of the poverty and debt relief documents. These materials would cover at least the following essential aspects:

*   AIDS as a cause of poverty, and possibly a discussion of poverty and income inequalities as contributors to conditions that make persons vulnerable to HIV infection and less able to cope with the consequences of being infected;
*   The main strategies in the national AIDS plan as a central part of the overall national poverty reduction programme, justified and costed;
*   Medium-term goals and poverty monitoring indicators derived from the national AIDS plan; and
*   Short-run actions for the successful implementation of the national AIDS plan, which could form agreements for debt relief.

1.7.1.SDPRPs and HIV/AIDS in Ethiopia

In realizing the impacts of HIV/AIDS on advancements in development, the Ethiopian government has approved and adopted a comprehensive HIV/AIDS policy (in 1998) and Strategic Framework for the National Response to HIV/AIDS (in 2001-2005).   As taken from the SDPRP document produced by MOFED and the FDRE (2002), the main components outlined for this strategic framework for the national HIV/AIDS policy are the following:

*   Intensify efforts on risk reduction interventions such as IEC/BCC, condom promotion and distribution, STI control and management, blood safety and universal precautions, and VCT;
*   Intensify care and support infected/ affected individuals, families and communities focusing on the most vulnerable population;
*   Prevention of Mother to Child Transmission
*   Legislation and Human Rights
*   Gender sensitivity in all interventions;
*   Enhancing the mainstreaming of HIV/AIDS into all

forms of interventions by government, non-government and private actors;

- Establishment of functional institutional framework from the federal to the community level;
- Enhancing community level responses;
- Emphasis on monitoring and evaluation, surveillance and information handling.

"Mainstreaming HIV-related priorities in a development framework helps create an 'enabling policy and resource environment' for an effective response to the epidemic, thus achieving synergy between diverse interventions across many sectors, and ensuring adequate financing for HIV/AIDS," Dr. Sukehiro Hasegawa, Special Representative of the Secretary General for Timor-Leste, UN Resident Coordinator and UNDP Resident Representative."

MODULE II

What is Mainstreaming?
Concepts and Definitions

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Concepts of Mainstreaming

"Multi-sectoral mainstreaming means looking beyond prevention to the whole epidemic. This includes treatment, policies and programmes to mitigate the impacts of AIDS, and policies that will change the societal factors that influence long-run susceptibility and vulnerability to HIV/AIDS. In government, each ministry has to ask, what HIV means for its core businesses and what it should be doing differently. Multisectoral response recognizes the role of social and contextual factors conditioning individual decisions (Barnett and Whiteside, 2003)."

2.1. Mainstreaming HIV/AIDS into Development

Surfacing in the late sixties to seventies, the term *mainstreaming* arose within the education sector to describe classrooms whereby all boys and girls received the same education regardless of mental or physical capacity. The goal of these mainstreamed classrooms was to ultimately provide the same education in various ways to suit these different needs and abilities, ensuring that all have equal access. Through mainstreaming, the education sector has undergone many modifications to its practices from the creation of policies to support students, and administrative practices, to the methods of training for teachers (UNAIDS, 2002).

The concept later arose within the sphere of environmental challenges, gender imbalance, and business where mainstreaming was and still is seen as a way of modifying operational practices to address these concerns.

In recognizing the devastating impacts of the HIV/AIDS epidemic and the need for up-scaling and expanding the response to the epidemic worldwide, HIV/AIDS mainstreaming within the various sectors is becoming a fundamental component in many contexts. The goal of mainstreaming HIV/AIDS into development and humanitarian work at sectoral and community levels is to ensure that the impacts of HIV/AIDS are addressed and reduced within communities and organizations, in all sectors. Many sectors,

institutions, and development and humanitarian organizations want to mainstream HIV/AIDS in their policies and strategies and actions, but have little understanding of how to operationalize mainstreaming, where to start, and what basic activities to undertake. The current

The purpose of mainstreaming HIV/AIDS is to help people get beyond the "business as usual" mentality, and to address the epidemic holistically in all sectors, both inside their own organizations and in the communities they serve. Mainstreaming constitutes a range of practice and strategies for up-scaling responses and addressing the developmental impacts of HIV and AIDS at different levels.

To date, the terms integration and mainstreaming have often been used synonymously, but indeed have distinct operational principles and applications. *Box 1* outlines the following discrepancies between the two terms. Essentially, HIV/AIDS mainstreaming aligns and influences the core

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**BOX 1: Integration vs. Mainstreaming
(UNAIDS, 2002)**

"**Integration** occurs when HIV/AIDS related issues and interventions are introduced into a project, programme or policy context as a component or a content area, without much interference within the specific core business of the institution or the main purpose of the policy instrument. Consistent HIV/AIDS activities may be executed, but they are being maintained as a separate area rather than incorporated in, and interfere with already existing ones."

"**Mainstreaming then starts from the analysis of the mandate or purpose and the routine functions of an institution or purpose and the routine functions of an institution, sector or instrument, and moves beyond integration by:**

1) **Identifying the specific areas of responsibility related to HIV/AIDS relevant to the institution;**
2) **Outlining context-specific actions underpinned by adequate financial commitments addressing each of these areas in its relationship with the core mandate and activities of the institution."**

business of an institution or sector when addressing the epidemic, rather than merely including it as an "add-on" to ones mandate.

Conceptually, the issue of HIV/AIDS is considered as fully addressed after it is streamlined and has become part and parcel of the program of a particular agency or institution that has mainstreamed it.

As an example, extensive work has been undertaken in assessing the potential impacts of mainstreaming on the education sector. The Association for Development of Education in Africa (ADEA) and the UNDP have examined the concepts of mainstreaming HIV/AIDS within the education sectors across Africa. In this investigation, what surfaced was the need for a better understanding of the bi-directional impact between the HIV/AIDS epidemic and the educational system.

The central point that emerged from the ADEA/UNDP experience in the education sector was the true need to focus on the core mandates and policies stemming from the construction of schools to the functioning within. Mainstreaming HIV/AIDS within the education sector could act as a positive vehicle for social change than merely a forum for awareness building, and thus, could definitely enrich the national response.

In Ethiopia, the findings elicited from a recent report (HAP-CO, 2003) on the status of mainstreaming within the government sectors and bureaus suggests that within the education sector the transition from "integration" of HIV/AIDS to "mainstreaming" has yet to be made.

Early successes of countries throughout Africa fighting the battle against AIDS could be attributed to the adoption of a 'multisectoral response.' At the end of the 1990s, this became an international buzzword, although it meant different things to different people. What seems to have worked is commitment across a society, from political leaders at all levels through to religious leaders, NGOs, the private sector and traditional leaders. Ministries of Health had to relinquish ownership of the disease. This is seen in the location of AIDS leadership outside the health sector – in the Prime Ministers Office in Thailand and Uganda. In countries where health has jealously guarded its interests, success has either been slower or non-existent. "Multi-sectoral means looking beyond prevention to the whole epidemic. This includes treatment, policies and programmes to mitigate the

impacts of AIDS, and policies that will change the societal factors that influence long-run susceptibility and vulnerability to HIV/AIDS. In government each ministry has to ask, *what HIV means for its core businesses and what it should be doing differently. Multisectoral response recognizes the role of social and contextual factors conditioning individual decisions (Barnett and Whiteside, 2003)."*

> ### Box 2 – What Mainstreaming is NOT ABOUT
>
> By way of providing a comparative reference, the Working Group included warning notes on what mainstreaming HIV/AIDS does not entail:
>
> - It is NOT (about) simply providing support for a Health Ministry's programme.
> - It is NOT (about) trying to take over specialist health-related functions.
> - It is NOT (about) changing core functions and responsibilities (instead, it is viewing them from a different perspective and refocusing them).
> - It is NOT (about) business as usual – some things must change.

2.2   Definitions of Mainstreaming

Different agencies have defined Mainstreaming in different ways but all definitions are mutually reinforcing than exclusive. The term mainstreaming is often used interchangeably with terms such as 'the multi-sectoral response' or 'integrating HIV/AIDS' (Holden, 2003).

The evolvement of the concept of mainstreaming has witnessed only a short life span, since it is still under dynamic development. Twenty years after the epidemic first began the meaning of mainstreaming within the context of HIV/AIDS is still being debated. Several conferences and international workshops have been carried out to filter-up the concept and application of mainstreaming.

In order to bring some clarity to the term, it is worth displaying different definitions and ideas surrounding mainstreaming. All the definitions below revolve around mainstreaming being seen as a dynamic process leading to change in

attitudes, structures and different systems through proactive interventions that result in organizational (families, communities, institutions, and businesses) 'AIDS competence.'

Accordingly, the following definitions are examples of how different agencies have defined mainstreaming:

~ Definition developed by a Working Group at a workshop in Liverpool School of Tropical Medicine (December 2002) ~

Mainstreaming HIV/AIDS can be defined as the process of analyzing how HIV and AIDS impact on all sectors now and in the future, both internally and externally, to determine how each sector should respond based on its comparative advantage.

The specific organizational response may include: Putting in place policies and practice that protect staff from vulnerability to infection and support staff who are living with HIV/AIDS and its impacts, whilst also ensuring that training and recruitment takes into consideration future staff depletion rates, and future planning takes into consideration the disruption caused by increased morbidity and mortality, refocusing the work of the organization to ensure those infected and affected by the pandemic are included and able to benefit from their activities, ensuring that the sector activities do not increase the vulnerability of the communities with whom they work to prevent HIV/STIs, or undermine their options for coping with the affects of the pandemic.

~ UNDP Definition ~

The UNDP African Regional HIV/AIDS team defined mainstreaming operationally and conceptually as follows:
Mainstreaming at conceptual level is defined as bringing HIV and AIDS to the center of the development agenda.

When the conceptual definition is translated to operational meaning is basically responding to the flowing basic questions: (i) What are the impacts of AIDS on development? What policies, strategies and actions do we need to put in place to minimize this impact? (ii) What are the positive impacts of the implementation of development policies and strategies on the spread of HIV, prevention, care & support; prevention and mitigation of its impacts in the community and what policies, strategies and actions should be put in place to enhance these positive impacts, (iii) and What are negative impacts of the implementation of development policies and strategies on HIV/AIDS in the community? What policies, strategies and actions should be put in place to minimize these negative impacts?

For the purpose of this handbook the definition given by the UNDP Regional HIV/AIDS team has been adapted as this definition best relates to the different tools discussed in Module III of the handbook.

~ Oxfam's Definition ~

Mainstreaming is "about change and it starts at the individual level where it must be internalized by the people in the institution. The process of change is from a vertical to a horizontal process, from a lack of action towards a push, demand and request for support, to integration, based on increasing ownership. It is about a growing organizational consciousness and culture towards integrating HIV/AIDS".

> **Box 3: Definition of Mainstreaming adopted by the Core Technical Working Team and Consultative group for refining this handbook:**
>
> Mainstreaming HIV/AIDS is a systematic and dynamic process of change in policies, strategies, values, norms, power and economic relations surrounding HIV/AIDS within sectors, organizations, communities and households. As a result, mainstreaming proactively responds to the bidirectional impacts of HIV/AIDS by reducing vulnerability to infection, while simultaneously creating an "AIDS-competent society" in order to mitigate its future impacts.

2.3. The Different Classification Systems of Mainstreaming HIV/AIDS

Mainstreaming is typically classified into two major categories: Stage of Implementation and Level of Implementation. Classifying mainstreaming based on its stages of implementation helps sectors and institutions establish a baseline status for planning, plan mainstreaming works, and create landmarks to monitor the progress of anti-HIV/AIDS implementation within sectors/institutions and regions. Therefore preparation of tools/checklists for monitoring and evaluation of mainstreaming activities need to consider the mainstreaming classification based on stages. Works directed to the organizations internal human resource is commonly classified as internal (supply) and works related to the delivery of the organization is external (demand).

2.3.1. Classification based on Stages of Implementation

All of the Stages in the below UNDP Classification are part of a continuum of analyses and implementation of interventions. Stages I and II in the classification refer to Internal Mainstreaming/Workplace Intervention (see Module IV for further detail). Stages III and IV commonly address demand requirements of a society.

2.3.2 Classification based on Levels of Mainstreaming

Another way of classifying mainstreaming is based on its level of application -- International, Regional/Sub-Regional, National, community, and household levels. This hierarchy of classifications is indicative of a broad myriad of mainstreaming commitments by donor agencies, government bodies, the civil society and communities.

International - the UNGASS declaration,[1] the PRSP, HIPC & debt relief initiatives are some of the examples of HIV/AIDS mainstreaming at global level.

Regionally/Sub-Regionally: includes the commission on HIV/AIDS and Governance in Africa (CHGA), the Abuja declaration, etc.

National – The way to systematically mainstream at the national level should include mainstreaming HIV/AIDS into polices (capacity building, food security, etc.), programs, plans (strategies and budgets) and individuals. In the Ethiopian context, this includes EMSAP, the sectoral initiatives by the government ministries, and the current attempts by FBOs (Catholic, Protestant, Orthodox and Muslim) to mainstream HIV/AIDS in their spiritual teachings and programs. \
Community: Programs and projects by, CBOs, NGOs, and Other purposefully organized interest groups to join and contribute to the prevention, care and support activities of agencies. PLHAs organized their own support groups in the fight against the epidemic. The levels of implementing mainstreaming could go down to community and households as discussed in the other sections.

2.4. HIV/AIDS Mainstreaming at Household and Community Level

The ultimate goal of development efforts by sectors is to change the quality of life in communities and households. However, most of these efforts underestimate the role of mainstreaming HIV/AIDS at such levels since, to date, the concept of mainstreaming has been misunderstood as a strategy that works only from government sectors.

HIV/AIDS mainstreaming is commonly misunderstood as only applicable to a decision-making level, and consequently most agencies restrict their efforts towards influencing

FIGURE 1: UNDP Classification based on its Stages of Implementation

Stage 0 – No Sector HIV and AIDS interventions

Stage I –Sector HIV and AIDS plan with the following elements:

- Sector workers AIDS Risk analysis.
- Evidence based communications for behavior change.
- Condom promotion.
- Focal point person designated.
- Financial resources made available

Stage II - Components in stage I +:

- AIDS Sector Impact analysis conducted
- Policies, strategies and actions developed
- Actions to mitigate impact implemented.

Stage III - Components in stage II +:

- Analysis of Sector policies, strategies and actions and reflection on such policies, and interventions to decipher their negative or positive influence on the spread of HIV in the communities they serve.
- Implemented for ensuring positive actions are maintained.
- Implemented change in negative actions.
- A monitoring and evaluation framework developed and being implemented.

Stage IV - Components in stage III +:

- Evidence of incorporating lessons learnt in sector policies, strategies and actions.

policy, strategy and actions at sector ministries. It is understandable that changes in policies, strategies and actions at sectoral and higher hierarchy influence change at the community level, but mainstreaming efforts do not only assume a top to bottom approach.

Therefore, the concepts and definitions of HIV/AIDS mainstreaming as noted above can as well be applied not only to sectors, but also to community and household levels. The interaction between HIV/AIDS and Household/Community (HH/C) is as strongly bi-directional as it is within the sectors.

One could easily apply the above meanings of mainstreaming in to community's structural, traditional, cultural, spiritual and social relations, values, customary laws and norms in relation the spread of HIV in the community and consider modifying changing or banning them. Similarly, this could also be applied to household/family lifestyles, norms, and family relations with emphasis to gender and roles members in the day-to-day life of a family. To   understand mainstreaming at this level, one has to visualize households and communities as institutions.
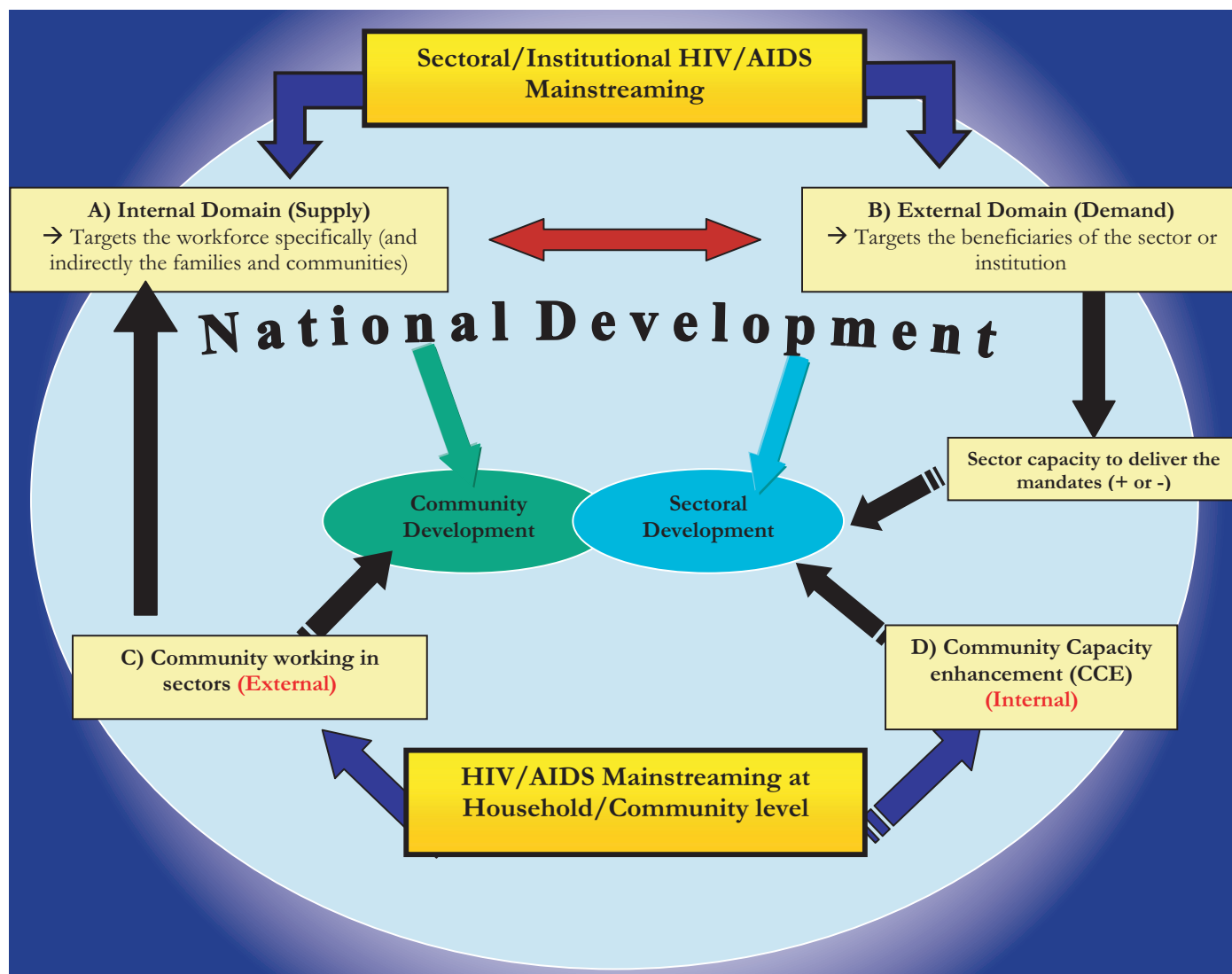
FIGURE 2 – Framework for Sector / Community Mainstreaming Interactions

Sectoral/Institutional HIV/AIDS Mainstreaming

A) Internal Domain (Supply)
→ Targets the workforce specifically (and indirectly the families and communities)

B) External Domain (Demand)
→ Targets the beneficiaries of the sector or institution

National Development

Community Development

Sectoral Development

Sector capacity to deliver the mandates (+ or -)

C) Community working in sectors (External)

D) Community Capacity enhancement (CCE) (Internal)

HIV/AIDS Mainstreaming at Household/Community level

Figure 2 highlights the impact of mainstreaming at the national, community and household levels and how mainstreaming would ultimately lead to national development via both community and sectoral development. The blue arrows are representative of the direct impact of mainstreaming on a sectoral/institutional level, and at a community level. From the top, HIV/AIDS mainstreaming has the potential to positively impact both the supply (A) and demand (B) of an economy. Mainstreaming at the internal domain (effecting supply) is comprised of a society's workforce, and can directly impact community development and sectoral development by hampering the capacity of a sector/institution. At the external domain (effecting demand), HIV/AIDS will impact the ability of a sector/institution to deliver its mandates. Through mainstreaming HIV/AIDS, sectors can forecast the harsh effects AIDS will pose on its own structure and functioning and on those who are reliant on its services.
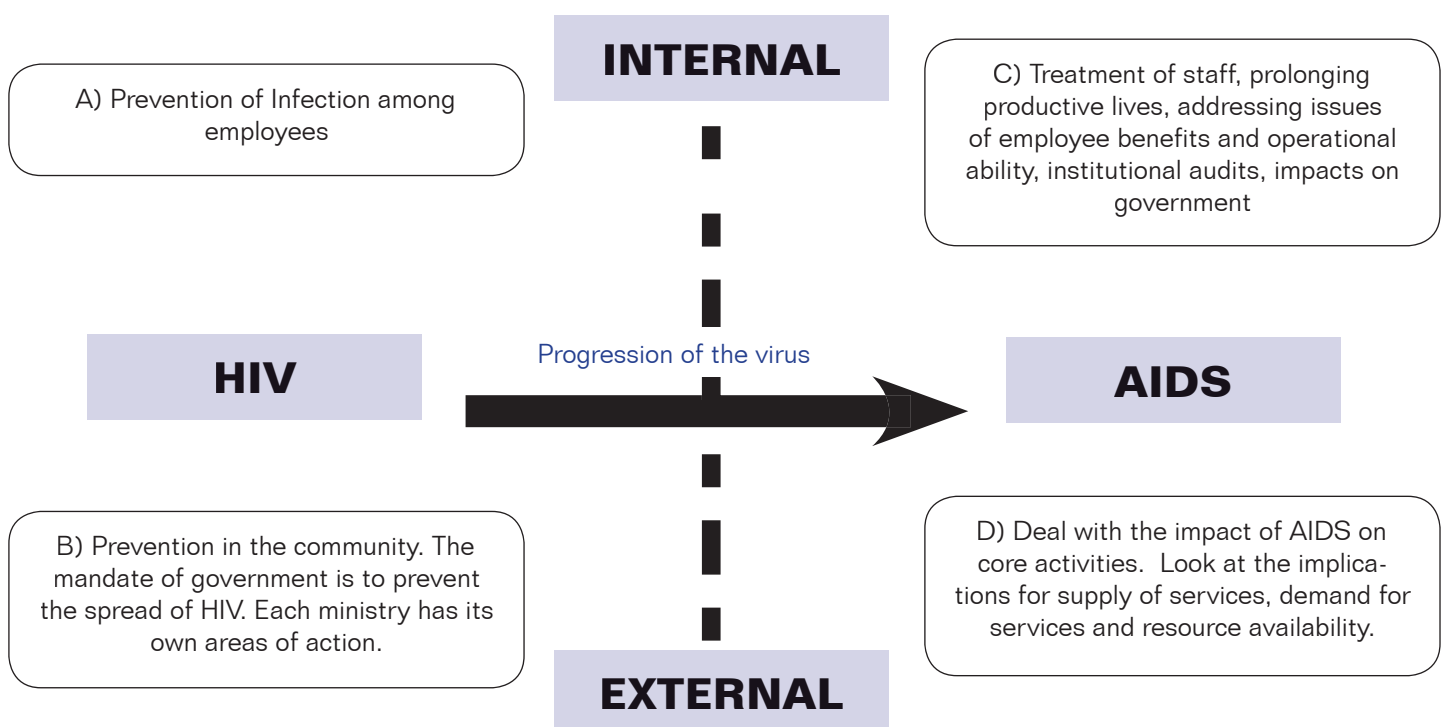
The principles, concepts and rationale of sectoral/organizational mainstreaming equally applies to the community and household level. Internally, communities and household need to put HIV/AIDS at the center of their social, economic and gender relations. To operationalize this, communities need to openly discuss dialogue on how HIV/AIDS is creating negative impacts on their members and what social, economic and cultural practices are fuelling the spread of the epidemic. With this understanding, communities need to start seriously considering adjustment in their lifestyles and lifestyles and relationships in an HIV/AIDS sensitive way to ensure their survival as a society.

An example of such a methodology that has worked to inspire such action, is the Community Capacity Enhancement Program spearheaded by the UNDP and HAPCO. This methodology had been piloted in Alaba and Yabello and aimed to foster community participation in addressing the cultural and social issues that are propagating the spread of the virus Please refer to the Community Capacity Enhancement Training Handbook on the rationale and concepts for this methodology (CCE Training Manual, 2002).

Externally, sectors and communities are not mutually exclusive. Those within communities are directly contributing to the functioning of their respective societies since they comprise the workforce and labour of the sectors working towards national development.

Figure 3: The impact of HIV/AIDS on government (Barnett and Whiteside, 2002)

INTERNAL

A) Prevention of Infection among employees

C) Treatment of staff, prolonging productive lives, addressing issues of employee benefits and operational ability, institutional audits, impacts on government

HIV

Progression of the virus

AIDS

B) Prevention in the community. The mandate of government is to prevent the spread of HIV. Each ministry has its own areas of action.

D) Deal with the impact of AIDS on core activities. Look at the implications for supply of services, demand for services and resource availability.

EXTERNAL

In line with the previous figure, governments, sectors and institutions are facing many challenges and negative impacts as a result of HIV/AIDS. These negative impacts are placing large limitations on both the financial resources and personnel capacity of these respective institutions. Thus, when analyzing the effects of AIDS internally and externally (vertical axis), governments and sectors need to assess the impacts throughout the entire progression from HIV infection to AIDS illness and death (horizontal axis).

Barnett and Whiteside (2002) in *Figure 3* outline this interaction between the progression HIV and AIDS (which involves the dynamic between individuals and the epidemic) and the Internal and External components of a sector/government. Box A relates to the interactions between HIV and a sectors internal priorities and functions (i.e. issues surrounding supply). From a mainstreaming perspective, Internal/Workplace Mainstreaming would be incorporated at this point and would mainly concentrate on preventing infections among the workforce (i.e. education, condoms, etc.). Please see Module IV for further understanding of the Workplace Intervention. Box B is concerned with how HIV is affecting the beneficiaries of a sector/institution. This involves looking inward at how their own sector/institution activities, and analyzing how they may function differently to circumvent the impacts from AIDS. A useful example cited by Barnett et. al (2002) stresses that although overnight delays at border crossings can place migrant workers vulnerable to infection through the increased potential for high risk behaviour via sexual contacts, prevention and policy activities can be modified to lesson this vulnerability. Prevention activities can be established by the organizations coordinating such travels (i.e. providing condoms and education), and also, those departments in charge of such customs procedures should work to quicken such logistical processes.

Furthermore, Box C examines how AIDS illness and death will impact a sector/institutions capacity to fulfill its mandates internally including -- extended absenteeism, and AIDS associated deaths affecting the workforce. Please refer to the Cross-Impact Analysis tool in Module III for further clarity. Lastly, Box D looks into the effects AIDS illness and death within a sector/institution will have on beneficiaries of these services. For instance, how will less individuals working on a portfolio because of AIDS related sicknesses and deaths impact other institutions working towards similar goals.

The above framework highlights how both HIV and AIDS at different stages can impact and infringe upon a sectors/

institutions ability to achieve its core functions and impact its beneficiaries. Module II highlighted the reality that all sectors and institutions are inherently linked to each other in some facet, whether directly or indirectly, and each are reliant on the other adequately fulfilling their mandate(s) to survive themselves. Sectors now need to begin shifting their thinking beyond solely focusing on prevention (i.e. IEC, and BCC activities) and ask themselves A) How is AIDS impacting our capacity to achieve our intended goals and B) How are we impacting other sectors if we are limited by the effects of AIDS.

Module III will provide a set of tools and mental frameworks that have been consolidated to assist sectors and institutions to shift into this holistic mentality and carry out such impact analyses.

(Endnotes)
[1] United Nations General Assembly Special Session on HIV/AIDS. (25 – 27 June 2001). *Declaration of Commitment on HIV/AIDS.*

3) 4)   ▪   ▪   ▪   ▪   ▪
        ▪   ▪   ▪   ▪   ▪   ▪
        ▪   ▪   11.   12.   13.   14.
        15.   16.   17.   18.   19.   20.
        ●   ●   ●   ●

Box 4 - Principles and Critical Elements of HIV/AIDS and Gender Mainstreaming

The principles of mainstreaming provide a comprehensive framework to analyze where and when to introduce and implement HIV/AIDS mainstreaming. The characteristics of the principles of mainstreaming are highlighted as follows:

1. Understanding the multi-sectoral nature of comprehensive response.
2. The entry points for mainstreaming HIV/AIDS should be clearly defined. The importance of Gender in HIV/AIDS mainstreaming should not be undermined.
3. Mainstreaming efforts should be located within the existing institutional structures in the frame of reference of the national policies and strategic framework, because the already available management and coordination of the existing structures can be used for HIV/AIDS control program.
4. It is necessary to build the implementation capacity of those involved in mainstreaming HIV/AIDS and Gender at all levels of the response.
5. Establish partnerships based on comparative advantage, cost effectiveness, and collaboration.
6. Mainstreaming should have a clear plan with realistic time frame
7. Ensure HIV/AIDS issues are addressed in all phases of sectoral planning cycles including analysis, development, appraisal, implementation, monitoring and evaluation.
8. It must address both internal (work place) and external aspects related to the organization's specific mandates and functions, with special emphasis to Gender.
9. Develop a clear line of accountability based organizational mandates and responsibilities to the HIV/AIDS responses.
10. The need for advocating to ensure strong political will and commitment to be emphasized.

Tools for Mainstreaming

MODULE III

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Tools for Mainstreaming

3.1. General Overview of the Tools used for Mainstreaming HIV/AIDS

This segment of this handbook is dedicated to a set of mental frameworks, and tools of mainstreaming that will assist users on the "how to" aspects of Mainstreaming HIV/AIDS into development plans and actions. One should get highly familiarized with all aspects and intricacies of the tools. There are no restrictions on the use of the various tools to their levels of application, user category, and stage of mainstreaming or type of organization/ institution.

However, the authors of this handbook make suggestions on how each specific tool could be best applied to certain conditions, stages and hierarchy.

In this handbook, you will find eight tools that will allow you to -- understand the complexity of the virus and epidemic, be able to assess its impact on your sector or institution, and ultimately aid you in addressing these impacts through holistic and cross-sectoral interventions.

The following tools are listed in no particular order and can be carried out in any desired step that is fitting to your sector /institution.

Box 1: Mainstreaming Tools included in this handbook:

Tool 1 - Basic Epidemiology & significance for Mainstreaming

Tool 2 - Systems Thinking

Tool 3 - Rapid Assessment

Tool 4 - Cross-Impact Analysis

Tool 5 - Demand and Supply

Tool 6 - SWOT and PEST

Tool 7 - Gender Analysis

Tool 8 - Framework for Change Management

TOOL 1 - Basic Epidemiology & Significance for Mainstreaming

Epidemiology has been defined as "the study of the distribution and determinants of health-related conditions and events in populations, and the application of this study to the control of health problems (Last, 1988)."

3.2.   Concepts of Epidemiology

Although Epidemiology is an important discipline in its own right, for the purpose of this handbook, it is used as important tool to operationalize HIV/AIDS Mainstreaming. *This tool can help professionals outside of public health field better understand basic facts on HIV/AIDS risk, transmission and social pathways of the disease from infection to death, and beyond.* Epidemiology analyzes data in order to assess the socio-economic, geographical and demographic patterns and dynamics of a disease.

The HIV/AIDS epidemic in many countries however, is quite complex to understand, and thus requires a multi-dimensional understanding. Barnett and Whiteside (2003) outline some of the challenges associated with understanding the complexity of HIV/AIDS data as an inability to distinguish the difference between HIV versus AIDS; the variability and quality of the data; the inclusion of biases within data and exclusion of important confounding variables. Such misinterpretations are important to keep in mind when analyzing the trajectory of the HIV/AIDS epidemic within a sector/institution.

This tool will aid in applying each stage of the HIV virus to public health and development interventions. For instance,
the period before infection could be useful for risk surveillance; the window period could be used to analyze incidence surveillance; the long asymptomatic period can be used to analyze prevalence surveillance; the illness or AIDS phase for AIDS surveillance; and the phase beyond could be used to assess impacts on household and community levels and plan interventions accordingly.

Within the spectrum of epidemiology, two concepts that are essential to grasp are the differences between incidence versus prevalence. Incidence is seen as the number of new cases arising in a given period in a specified population. On the other hand, prevalence is determined by assessing the number of cases in a defined population at a specified point in time. One can think of prevalence as a photograph taken of epidemics in a population at a specific moment in time. Other terms that should be kept in mind are described in Box 6.

> For individuals and families affected, the risks and harms are 100%

Figure 1 displays a generalized diagram of the pattern of HIV/AIDS within a community. Stemming from the general population are a set of risks, both high and low. Many factors can contribute to an individual's higher risk for infection including –gender, given that HIV has a female face, poverty, cultural practices, demographic, etc. New infections arising increase the incidence of HIV/AIDS prevalent in a community. As you will see below, these new infections then join the numbers of those already infected. It is this pool of newly infected and those already infected that increases the prevalence of HIV and AIDS within a society.
Individuals who succumb to the virus contribute to the incidence of AIDS deaths.   These statistics are important in assessing what impact the epidemic is having on mortality rates and in turn, demographic impact. Death rates as well as morbidity due to infection consequently lead to a myriad of negative impacts on the society and its capacity. Survivors including spouses and children are left to cope with household expenses and the psychological impacts of the death. In addition, societal capacity is also affected with the deaths of its productive workers. This entire process leaves emotional scars on the people infected and affected, and negative impacting wounds on a society's capacity to function.

FIGURE 1: A Simplified Illustration of HIV/AIDS Epidemiology (adapted from generic PowerPoint material prepared by Dr Roland Msiska)
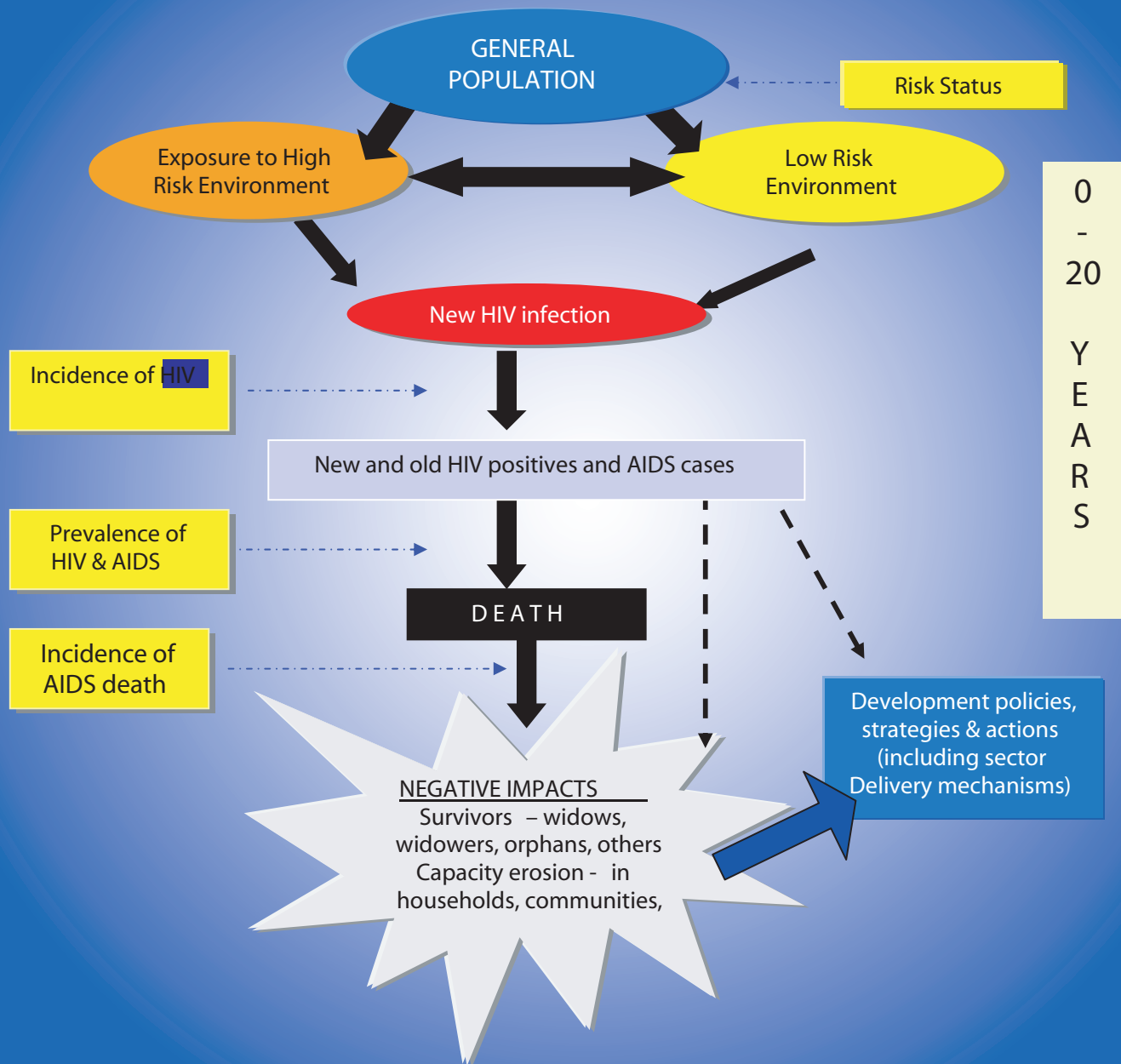
Table 1 - Probability of HIV-1 infection per Exposure (Source: World Bank 1997)

Mode of transmission	Infections per 100 exposure
• Male to female unprotected vaginal sex.	0.1 -0.2
• Female to Male, unprotected vaginal sex.	0.033-0.1
• Male to male, anal sex	0.5-3.0
• Needle stick	0.3
• Mother to Child transmission.	13-48
• Exposure to contaminated blood products	90-100

Epidemiology provides us with the methodology to obtain the statistics/data to give us a broader understanding of mode of transmissions and associated risks. In Table 5, care should be taken in interpreting data -- not to transmit an unintended message. Heterosexual contact is known to contribute to 90% of the cause of HIV transmission in many African countries. At first glance, this data can be very misleading and one may feel compelled to think that male to female unprotected sex would only lead to an approximate 0.1% risk for infection upon exposure. However, the seemingly paradoxical relationship between low risks of infection per sexual contact between men and women versus, the high proportions of heterosexual individuals infected presently could be explained by many factors.

The length of time a person remains infectious in a society, the presence of Sexually Transmitted Infections (STIs), the mode of sexual contact, the rate of acquisition of new sexual partners, the diversity of sexual partner (age, profession, risk status, etc.) and the use of preventive technology such as condoms—are all cumulative factors which increase a person's susceptibility to infection and increase in prevalence that are not readily apparent in this table.

An infected person remains infectious as long as he or she survives, and is sexually active. The HIV viral load in a newly infected person is at its peak in the first few weeks (window period), at which time a blood test will be negative but is very highly infective (see Figure 2); viral load will decline during asymptomatic period depicting the immune response attempting to check on viral replication only to grow back at AIDS phase. Though viral load rises again at AIDS stage, the person will be less sexually active due to physical weakness.

Anal sex has higher risk of transmission per contact, but it is less important as it is less frequently known to be practiced in Ethiopian context.

If a person acquires new sexual partner at higher frequency and the partners are from diverse groups (CSW, student, married woman, widow), the probability of spreading the virus from an infected person to non infected will be much higher than if the sexual partners are from uniform background but with similar acquisition rate. Apart from passing on the infection to other, he or she also acquires new sub-variety of HIV to recombine with existing sub-variety complicating the situation during ART. All the risks of transmission depend on whether the sexual acts are supported by preventive technology such as condoms.

The bi-directional impacts of poverty and HIV/AIDS are also best explained in relation to the different stages of HIV and AIDS at different levels. The stages of HIV/AIDS are: None infected but potentially vulnerable to infection; Infected with HIV but asymptomatic; Infected and symptomatic; AIDS related death.

These different stages impact on poverty at individual, household and community levels. Both household and community level economic conditions are highly linked and determine the status of the national economy. A poor economy that is already unable to effectively allocate funds into social services for all citizens, which is then exacerbated by AIDS leads to a further lack of access to basic necessities. These are factors that are also making many individuals in these contexts increasingly vulnerable to the epidemic.

BOX 2: WHO/UNAIDS Disease Staging / versus Classification of the HIV/AIDS Epidemic on Epidemiological Staging

- Low level - HIV prevalence has consistently not exceeded five percent in any defined population sub group.
- Concentrated – HIV prevalence has consistently exceeded five percent in at least one defined population sub group.
- Generalized - HIV prevalence consistently over 1% in pregnant women nationwide.

FIGURE 2– Lifecycle of HIV in Humans – From Infection to Death and Beyond (remove y-axis)
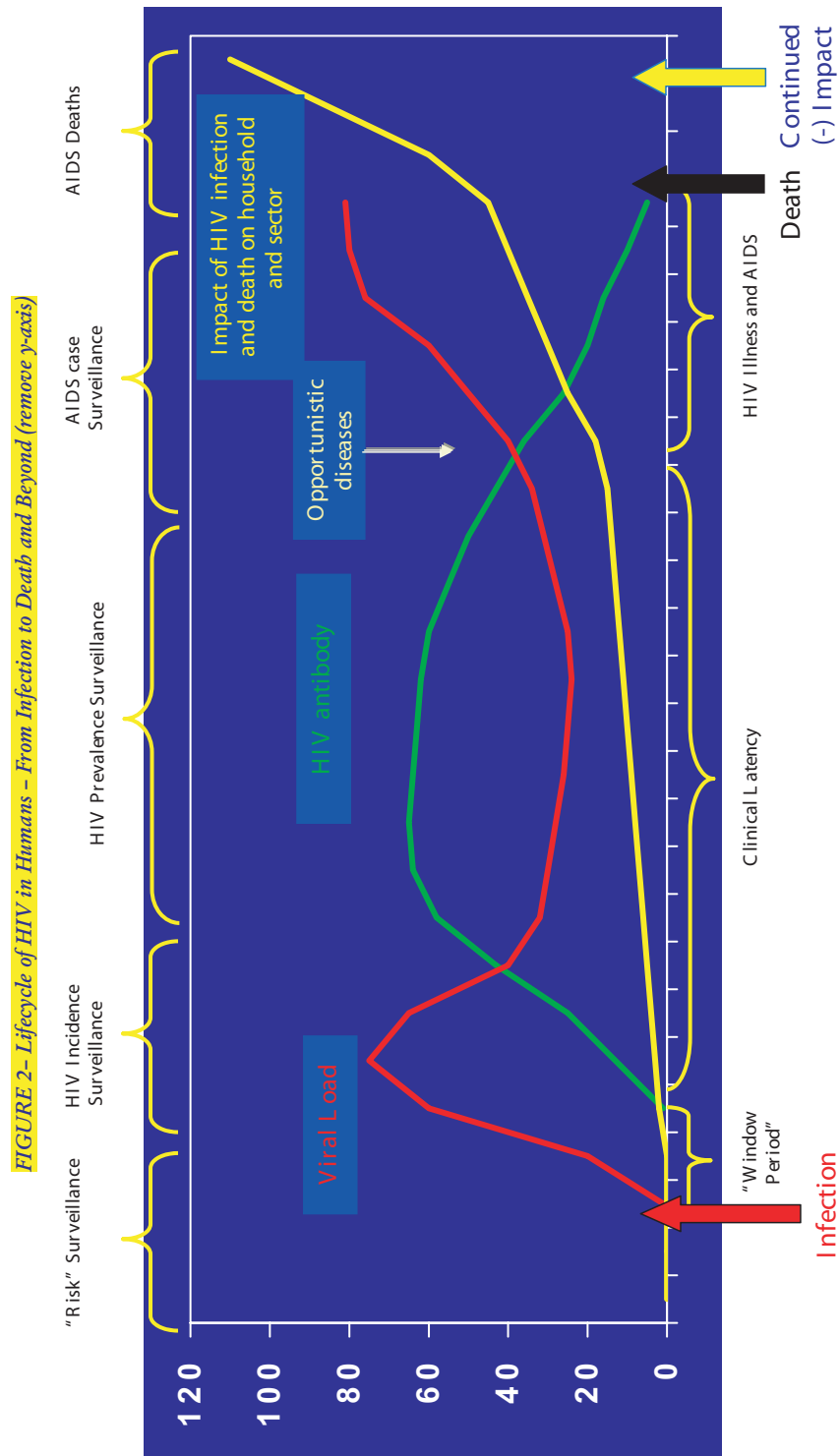
3.2. 1 Lifecycle of HIV in Human – From Infection to Death & Beyond

Figure 2 (adapted from Barnett and Whiteside, 2002) outlines the lifecycle of HIV in humans from onset of infection to death and the resulting negative effects beyond death. The duration of clinical latency (the duration of infection to illness) remains a crucial period for policy, development and sector planning for the epidemic's economic and social impacts. What should be considered is the fact that clinical latency and illness to death is highly influenced by one's environment, availability to adequate health care, access to proper nutrition, availability of Antiretroviral treatment, etc. Inevitably, this relationship of infection → illness → death is shortened in poorer developing countries and as a result, more attention should be focusing on proper planning and preparation to alleviate the socio-economic impacts.

Stage of Infection Window period:

As noted in *Figure 2*, the window period is the stage at which the virus is introduced within the body, and could be followed by an acute disease stage. This stage may pass unnoticed, as symptoms are non-specific. About 70% of infected individuals develop a self-limited illness similar to influenza: high fever, sore throats, headaches, and swollen lymph nodes. Some may develop rash, vomiting, diarrhea and thrush. This stage develops in 2-8 weeks and is referred to as **acute retroviral syndrome**. A person, who is in this stage, as is indicated by the red line in *Figure 2*, experiences a peak in viral load and consequently more likely to pass on the infection to the partner if unprotected sex occurs. Any individual who engages in unprotected sex with a non-regular partner, should consider the possibility of being infected, and should abstain from sex with a spouse or another partner for an extended period to minimize the risk of infecting him or her.

If one wants to undergo HIV test, it is recommended that he/she wait from three to six months after contact and potential exposure. Typically after the window period has passed, an individual could experience symptoms of illness synonymous with that of the flu, which may not been seen as a marker for HIV. This window period is then followed by an extended incubation period which is heavily influenced by the strength of a person's immune system.

Clinical Latency or Asymptomatic HIV disease stage:

Following acute illness, an infected adult can remain free of symptoms from 6 months to a median time of 11 years. An asymptomatic individual appears to be healthy and performs normal activities of daily living. During this stage, HIV in the blood drops to a lower level but it continues to replicate and destroy T4 cells in the system. This stage heavily compromises an individual's immune system, and thus, paves the way for opportunistic infections to override.

Symptomatic HIV Disease Stage:

This phase can last for months or years before a diagnosis of AIDS occurs. As the number of immune system cells (T4) decline, the person develops a variety of symptoms such as fever, weight loss, malaise, pain, fatigue, loss of appetite, abdominal discomfort, diarrhea, night sweat, headaches, and swollen lymph glands.

The destruction of lymph node structures occurring in the final stages of HIV limits and eventually ceases the immune response against HIV and other pathogens. Individuals at this stage often develop thrush, oral lesions, and other fungal, bacterial and/or other viral infections. The duration of these symptoms varies, but it is common for HIV-infected individuals to have them for months at a time. About 30% of persons in this stage who are not on ART can develop AIDS-associated infections within 5 years.

AIDS, Advanced HIV Disease Stage:

The diagnosis of AIDS is a marker, not an end in itself. Currently, most people recover from their first, second, and third AIDS-defining illnesses or encounter with an opportunistic disease. People with AIDS are very heterogeneous – some feel well and continue working for several years, others are chronically ill, and may die rather quickly depending on many biological factors including—nutritional status, environment, etc.. During this stage, the virus largely depletes the cells of the immune system causing serious immunodeficiency that leads to HIV diversity exceeding a threshold beyond which the immune system is unable to control the viral replication.

Impact of HIV Infection and Death on Households and Sectors:

Alongside the progression from HIV infection to AIDS death, one can assess qualitatively the degree of impact that this progression has both on a household and sectoral level. From the initial stages of infection to early stages of clinical

FIGURE 3 – Stages of the Epidemic in a Community or A Nation???
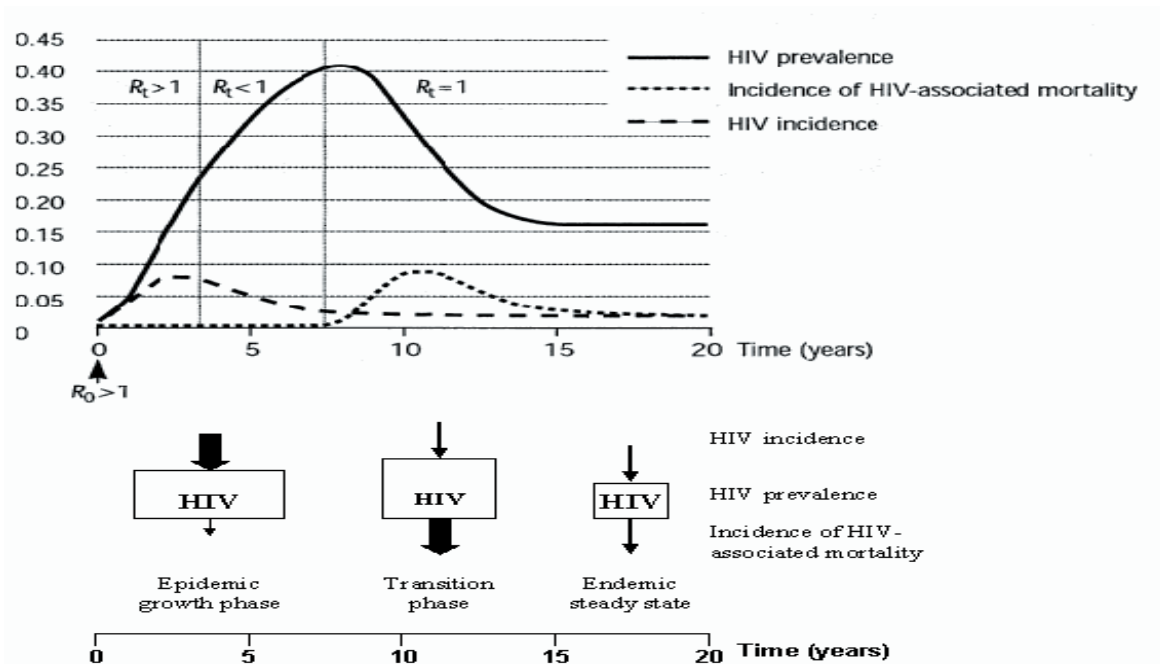
Courtesy of Dr. Thomas Rehle, Family Health International

latency, the impacts of an individual's infection are minimal on their family and workplace since their immune system is still viable.   However, as an individual's immune system becomes compromised by an increased viral load -- potentially leading to the onset of opportunistic infections – the burden of illness becomes more impacting on a household. Family members may have to take time off work, or school and care for the sick individual; children may become orphaned, etc. All of these factors negatively impact a households economic input and consequently lead to further effects on family members via decreased levels of mental and physical health.

In addition, a person who becomes increasingly sick and is unable to meet the requirements at work will also affect their workplace environment (others taking on more work), and in the long term, infringe upon the efficiency of output services for the institution employing them.

Figure 2 above outlines the progression of HIV within an individual and the after effects that will escalate upon an individual's death to AIDS or AIDS related illnesses. It is equally important to understand the progress of HIV within a community and/or society. *Figure 3* displays the pattern of the HIV epidemic within a specific community. HIV incidence initially increases with the onset of newly infected individuals. The decrease in the incidence rate could be attributed to the positive effects of HIV interventions. The

growth of the HIV epidemic phase begins at this point. As the cumulative numbers of people living with the virus (prevalence) increases, as the number of individuals newly infected levels off, the transition phase of the epidemic sets in. Prevalence peaks when the incidence levels begin to level off and the number of AIDS deaths begins to arise. When preventative efforts are geared towards reducing new infections and the number of AIDS deaths levels off, the prevalence rates plateau and an epidemic reaches a steady state as well. The transition phase is a stage whereby number of new infections decline, those infected about 10 years ago start to die bring about a decline in the prevalence and leading to an endemic state. At this stage, the rate of new infection (incidence), prevalence, and death are all in equilibrium.

The introduction of anti-retroviral drugs into this framework could have dual positive effects. Firstly, it could decrease the viral load transmitted and consequently decrease the likelihood of new infection arising from a sexual act. Secondly, it would prolong the lives of those already infected, which would have positive sustaining impacts on sectors, communities and households capacity to cope with the illness. As ARVs prolong the lives of infected individuals and hence the length of time they remain infective, their introduction should be accompanied with strong prevention activities.

FIGURE 4 – How development efforts influence the spread of HIV in a community

MACRO INFLUENCES

Socio-Cultural Factors

Development Policies, Strategies and Actions

Wealth/ Poverty Influence

| Budget for Interventions | Taxation & Subsidy | Legislation | Macro-economic Polices | Sector Polices | Provision of information |

All influence sectoral behaviour and response to the epidemic leading to direct/ indirect influences on sexual interaction, access to and use of prevention technology for males and females, access to resources and health care.

MICRO INFLUENCES

Resulting Effects on Types of Sexual Interactions: Forced Sex (Rape & abuse), Sex as a Commodity for exchange, Sex for ritual purposes, etc.

G E N D E R

Factors influencing vulnerability to infection:
- The amount of time a person remains infectious.
- The risk of transmission per sexual contact.
- The rate of acquisition of new partners
- Partner mix.

D Y N A M I C S

Confounded by the level of differential risk among male/female populations

NEW HIV INFECTIONS IN THE COMMUNITY

Figure 4 displays how the policies, strategies and the style we implement them can positively or negatively affect the spread of the infection; through our efforts to control the virus and mitigate its impacts. As shown from macro influences, the amount of budget we allocate into various development interventions, policies we have for taxation, our policies for sectors, the laws we have and our cultural practices directly or indirectly determine where, when, why and how we interact sexually.

Allocating adequate budgeting for small-scale micro-finance schemes for improving household income of poor households could improve the livelihood, which in turn reduces the possibility of using sex as a commodity for exchange. The interactions between socio-cultural and economic situations in a society are strongly influencing how these policies, strategies and their implementation are influencing sexual networks. In addition, the myriad of reasons surrounding why people engage in sexual relations, as noted in figure 4, and the factors (i.e. gender dynamics) that are contributing to and exacerbating the increased risk of infection determine the magnitude of new infections in the community.

Although it appears that there is one epidemic at play here, at the community and national level, there are in fact four discrete epidemics that emerge (Whiteside and Barnett, 2003). *Table 2* provides a brief description of the four emerging epidemics that occur throughout the progression of the virus to disease. We are well aware of the HIV and AIDS epidemics that have being impacting our societies through morbidity and mortality rates over the last two decades. In line with these epidemics is an impact epidemic that many countries are currently experiencing. Some of the largest indicators showcasing the effects of this sub-epidemic are the decreased life expectancies and the orphan epidemic that are emerging in many African countries.

Along with each epidemic lies both stigma and discrimination that continue to propagate elements of fear and denial limiting the effectiveness of interventions. To address the HIV and AIDS epidemics, a sector should begin by conducting an impact analysis and assess how it has been impacted and how it can improve its work strategies to function amidst HIV and AIDS.

TABLE 2: Description of the Four Emerging Epidemics

TIME	EPIDEMIC	WHEN	VISIBILITY TO COMMUNITY	CHARACTEIRZED BY AND MEANS OF VERIFICATION
1ST	HIV	Beginning	- Invisible to lay community or policy makers	- new cases of infection arising by asymptomatic / healthy appearing individuals - monitoring trends and serosurveillancc via epidemiology, VCT
2ND	AIDS	5-10 years after HIV epidemic	- Visible as a result of physical manifestation of illnesses and number of deaths in the community	- Increase in illness and in the number of deaths -rise in the mortality and morbidity data
3RD	IMPACT	In line with HIV and AIDS epidemic	- Impacts seen through the high % of orphans, poverty deepening, capacity depleting at household, community and national level	- Impact Assessment, Basic Statistics (eg. Structure and demography_ - decrease in life expectancy
Lingering and cross-cutting within each of the above epidemics	STIGMA & DISCRIMINATION	Along with HIV/AIDS impact epidemic	- fear towards PLWAs, denial of infection, refusal for testing, rejection and segregation of PLWAs	-Impact assessment socio-cultural analysis

Responding to the epidemic demands understanding beyond just epidemiology according to Barnett and Whiteside (2002). They classify the determinants of the epidemics, as previously discussed, in the *Table 3* below.

The distal determinants (in line with Figure 4) determine the susceptibility of infection, whereby the Macro and Micro Environments is influencing the atmosphere that affects the behaviour of the individual. The Proximal determinants (i.e. one's physiology) lead to the susceptibility of an individual to acquire the infection. For instance, a lower nutritional status can increase an individual's likelihood or susceptibility to infection.

Understanding all of the determinants and factors influencing both infection and illness are essential when aiming to employ strategies that will work to mitigate the impacts of HIV and AIDS. Although these tools are not presented in an order that sectors and institutions must strictly follow, we felt that an initial understanding of the epidemiology of the virus is imperative to comprehend the subsequent tools, and stages and levels that policies and programs should address. Many individuals at decision-making levels still fail to fully understand what and how factors such as development policies and strategies (as outlined in Figure 4) have impacts on infection rates. Epidemiology in this instance has allowed you to gage in understanding what influences infection rates, how the infection manifests itself biologically, socially and economically, and has intended to prepare you for implementing the next set of tools on assessment, impact analyses, and holistic thinking.

TABLE 3: Distal and Proximal Determinants of HIV Infection
(Whiteside and Barnett, 2002)

Determinants	Distal Determinants	⟶		Proximal determinants
	Macro Environment	Micro environment	Behavior	Biology
	Wealth	Mobility	Rate of partner change	Virus Sub-types
	Income Distribution	Urbanization	Prevalence of concurrent partners	Stage of infection
	Culture	Access to health care	Sexual mixing patterns	Presence of other STDSs
	Religion	Levels of Violence	Sexual practices and condom use	Gender
	Governance	Women's Rights and Status	Breast feeding	Circumcision
Interventions	Social Policy-Redistribution	Social Policy	Behaviour change communication	STD treatment
	Legal Reform	Economic Policy	Condom promotion and marketing	Blood Safety
	Human Rights	Legal reform	Voluntary Counselling and testing	Anti-retroviral therapy during pregnancy
	Taxation	Employment Legislation	IVDU harm reduction	Vaccines and Microbicides (when developed)
	Debt Relief			
	Terms of Trade			

TOOL 2 –
SYSTEMS THINKING

"A cloud masses, the sky darkens, leaves twist upward, and we know that it will rain. We also know that after the storm, the runoff will feed into groundwater miles away, and the sky will grow clear by tomorrow. All these events are distant in time and space, and yet are interconnected within the same pattern. Each has an influence on the rest. You can only understand the system of a rainstorm by contemplating the whole, not any individual part of the pattern (Senge, 1990)."

3.3. Concepts of Systems Thinking

Like the above interconnected ecosystem, organizations, sectors, communities and individuals are also part of an intricate network of interrelated actions. And like the above ecosystem, these interconnections within our human system are influenced by time and space, whereby the effects of the interactions take years before they become apparent. Typically, we tend to view a system in isolated parts, as an individual entity not impacted by or impacting on any other part. The key now is to shift this way of thinking to one that is more inclusive to the complexity of interactions within a system.

Systems thinking is a conceptual tool used to make patterns of interactions between and within systems more clear and allow us to understand and modify these interactions more effectively. Systems thinking is in turn, becoming a fast and powerful tool for decision-making and organizational change by taking into account this larger complexity of interactions. As Aronson (1996-8) describes, systems thinking is an effective tool for describing the most difficult types of problems to solve: those involving complex issues, those that depend a great deal dependence on the past or on the actions of others, and those stemming from effective coordination among those involved. This tool has proven useful in many complex scenarios including – situations that require helping policy makers, technicians and workers to see the "entire picture" and not just their own sector/institution; situations where an action affects (or is affected by) the environment surrounding an issue; and problems whose solutions are not obvious and require more holistic analyses.

With respect to the HIV/AIDS epidemic, this tool enables us to view the complexity of the problem caused by HIV/AIDS holistically, and what solutions to propose much beyond what appears to be simple. The reality is that the virus is not simply affecting isolated parts of our system (comprised of organizations, sectors, communities and households), but rather each of these compartments being altered by the virus are resulting in changes that are affecting the system as a whole. This tool provides a platform for different actors to act together and gives a deeper insight into the underlying causes and consequences of the virus ultimately leading to better response actions.

In relation to mainstreaming, Systems' thinking as a tool helps to manage the complexity of many HIV/AIDS responses that should be viewed synergistically. In order to mitigate this epidemic, sectors and institutions must change their way of viewing the impacts that HIV/AIDS is bearing on the supply and demand components of their given sectors/institution. The problem is that we don't experience the consequences of our actions, since cause and effect are far apart in time in space. Thus, an environment of learning and reflection from these actions should be created to foster awareness and sensitivity to the consequences of one's actions and decisions. Systems Thinking creates a better learning environment for changing the way HIV/AIDS is viewed and issues surrounding it are handled. As one will notice, this tool or frame of thinking can be applied at all stages of mainstreaming, and at all levels of intervention.

3.3.1 What is a System?

To begin understanding what Systems Thinking as a tool encompasses one must first understand what a system is. A system is a body of entities (or a whole) working together towards common end. The interactions that occur between these entities highly impact how the system functions. For the purpose of this handbook, we may view a system as a society comprised of many entities including sectors, institutions, organizations, and communities, all interacting with each other.

These interactions are a by-product of many influences such as business relationships, laws, policies, religion, culture, personal relationships, etc. The products of these interactions are typically classified as events. The problem lies however, in the fact that such events may not describe the specific entities or their pattern of interaction and as being an effect may not be related in place and time.

The diagram below displays a society as the system and the many interactions between the various entities resulting in events that determine how the society will function.

In relation to the pesticide problem, one could see the relationship as follows:
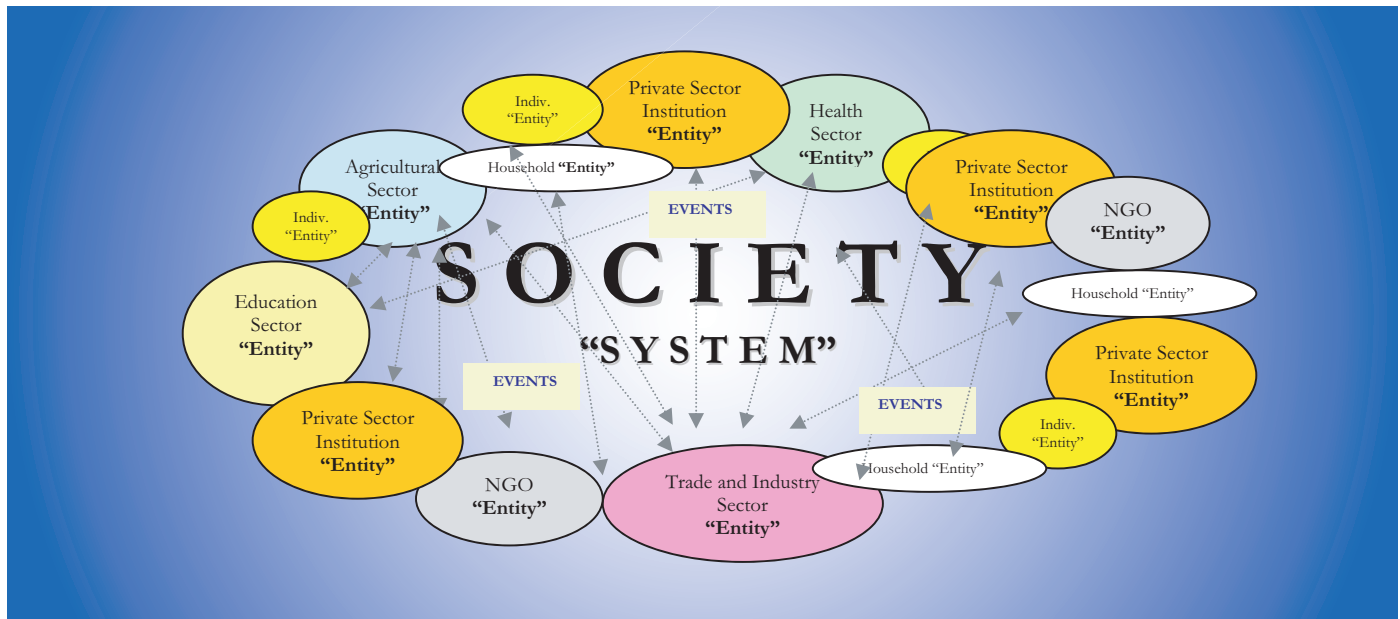
3.3.2 The Theory behind Systems Thinking

To analyze the root of the systems thinking approach one may consider a fairly rampant example within the field. Aronson (1996-8) outlines through the use of pesticides how one decision stemming from within an organization can yield unfavourable conditions on its strategy to function and outcomes on the functioning on the entire system.

If an agricultural firm was asked by a farmer to find a solution for an increase in pests (damaging his crops) which may have shown resistance to many previous pesticides, the firm may approach this predicament by creating a newer potent pesticide to circumvent this situation.

Typically, organizations view their actions in the below direction of causality with "o" representing how one makes the other change in the opposite direction. Simply, as you increase the action in element X, the outcome in element Y is decreased.

$$X \xrightarrow[\text{Method of Change}]{\quad \textbf{O} \quad} Y$$

$$\text{Pesticide Application} \xrightarrow{\quad \textbf{O} \quad} \text{Insect Damaging Crops}$$
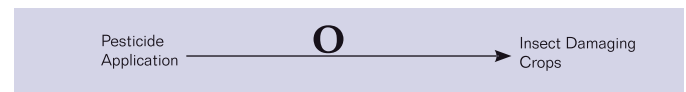
An increase in the amount of pesticide applied has a direct opposite affect on the number of insects damaging crops in that their number decreases. The problem that may arise however is the fact that researchers addressing this problem may view this above relationship blindly and hence, base their actions on a faulty understanding of the system in action. Consequently, the department's success at producing a stronger pesticide may not translate into lasting benefits for the company or the system. This decision and in turn action, will be incomplete since it is not inclusive of inherent *feedback relationships* that are involved.

It is evident that by increasing the application of a stronger pesticide, in the short term, the target insects and thus, the negative effects on the crops would be mitigated. However, as seen in the cycle below, other confounding variables may ultimately affect the long term targets and functioning of the system.   The "s" is indicative of a change in the same direction. What one will notice is an on-going cycle of increasing the application of pesticide to target insects → de-

creasing the number of target insects damaging the crops. Yet at the same time, an increase in potent pesticide use will also decrease the number of other insects which are controlling the target insect population. As a result, these insects are no longer exerting the control on the target insects as they once would.
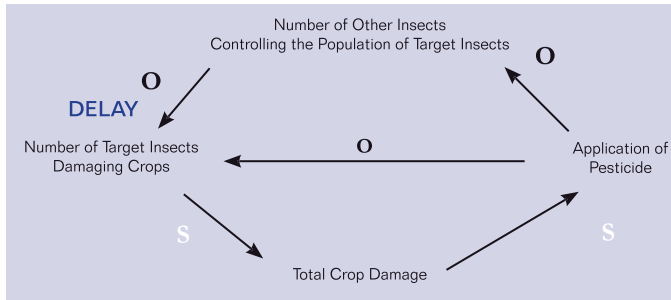
There is a delay in place here -- once the pesticide is no longer being used and the target insects recover from its effects, the control that the other insects once had over this insect population is no longer in place.   Hence, the farmer will get an explosion of the target insects, the one's he initially tried to get rid of years ago, and thus, as these numbers increase, the damage to his crops will continue leading to greater crop damage than previously. This will most likely cause the agricultural firm to continue applying the pesticide even though this will be resulting in resistance of the insects towards the pesticide.

The short term gains arising from the original problem are now overshadowed by a new sustaining problem arising from the original solution. As is noted in the previous example, a true understanding of the initial problem who have most likely produced more sustainable and favourable outcomes. An in-depth understanding and consideration to the complexity of interactions in place would have forecasted some of these predicaments that later arose. In this case, recognizing the symbiotic interaction between the insects, the development of more resistant strains, and even an analysis of the interactions that produced the later side effects – would have indicated to both the agricultural firm and farmer that the plan to use the potent pesticide would backfire.

The key to systems thinking is to always plan with the entire system in mind. How will the actions of your sector or institution impact other members within the system? Systems thinking allows people to focus on the *feedback relationships* that may impact the favorability of their decisions.

3.3.3. Systems Thinking, and HIV/AIDS – The Complex Reality

The reality of HIV/AIDS is one that is complex in its detail as a result of the myriad and multitude of factors interacting simultaneously to influence an individual's susceptibility and vulnerability to infection. Today, the high rates of HIV/AIDS related deaths and illnesses and continued high infection rates are a by-product of a factors including – types and level of sexual networks, the nature of the virus, various age vulernabilities, poverty vulnerabilities, current policies and interventions (or lack thereof), and cultural influences –to name a few major actors.

In addition, the HIV/AIDS reality is complex in its dynamic; as cause and effect may not be close in place and time. The major realities that individuals facing the virus must realize are:

1) *HIV infection and the illness that follows, AIDS, are far apart in place and time. People sick and dying today may have been infected at least five to ten years previously. The relation between cause and effect is not a simple linear interaction as A causes B, rather it is like:*
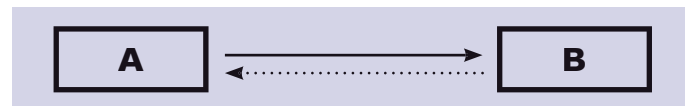
2) Today's result is the causation of yesterday's response, and the fruit of today's efforts are only visible after some years from now.

3) Understanding the complexity of the sexual network that is propagating the virus is very imperative. In the epidemiology of HIV, the risk of getting infected is a function of *the nature of the virus (risk per contact), sexual frequency, number of sexual partners, the nature of one's sexual partner, the presence of STIs, condom use, etc.*

Figure 5 depicts a possible scenario of a teacher who has sex with a commercial sex worker, his spouse, a colleague teacher, another married woman and his student(s). According to this scenario, not only the teacher, but also any community member of different age, sex, occupation, and social status can be at risk of encountering the infection. It is not only the individual behaviour but the socio-sexual context within the community that is placing people at increased levels of risk.

If the red circles represent people who are infected with HIV, this diagram in turn displays how the virus can have a tremendous potential to spread to exponential levels.   Someone who has a single sexual partner may have got the infection if his/her partner is infected and even the reverse may be true. This is the by-product of an inherent cascading sexual connection that people experience with others they don't know.

HIV/AIDS has no boundary and crosses inter-country boundaries, interregional boundaries and crosses intercultural and interethnic borders within a country. Ethiopia is a multiethnic country each ethnic group characterized by its own language, tradition and culture, which in turn have influences on their sexual relations and networks. Gender inequity, population dynamics, poverty, STI and poor condom use are major internal factors fueling the epidemic. Therefore, it is obvious how difficult it is to respond to this complex reality of HIV/AIDS.

FIGURE 5 – Complex Web of Sexual Interactions stemming from the school environment in a small community
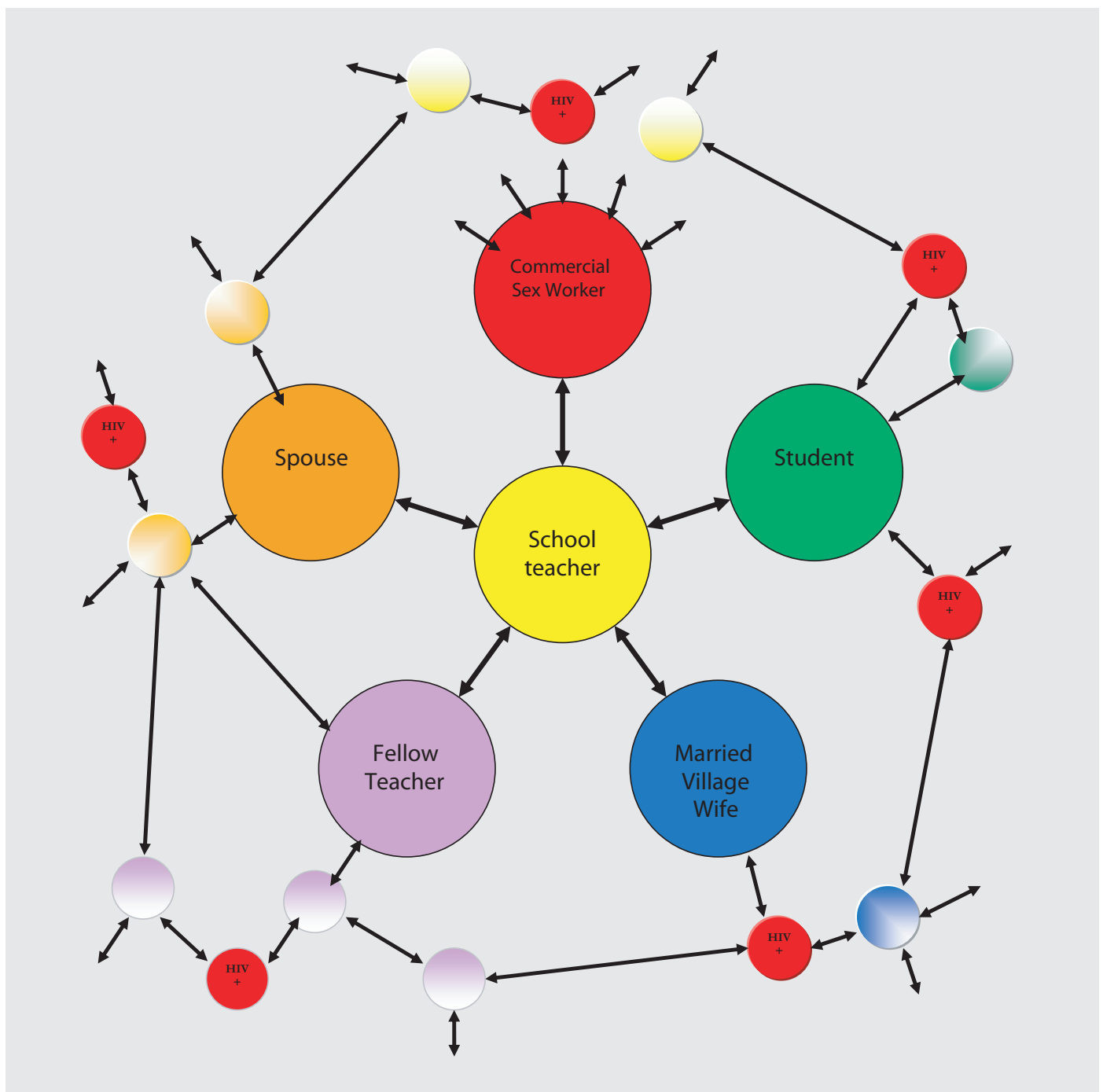
FIGURE 6: Diagram showing complex dynamics of (HIV/AIDS) sex network in Kokosa district with additional risk factors fueling the HIV/AIDS epidemic (SNNPR Study)
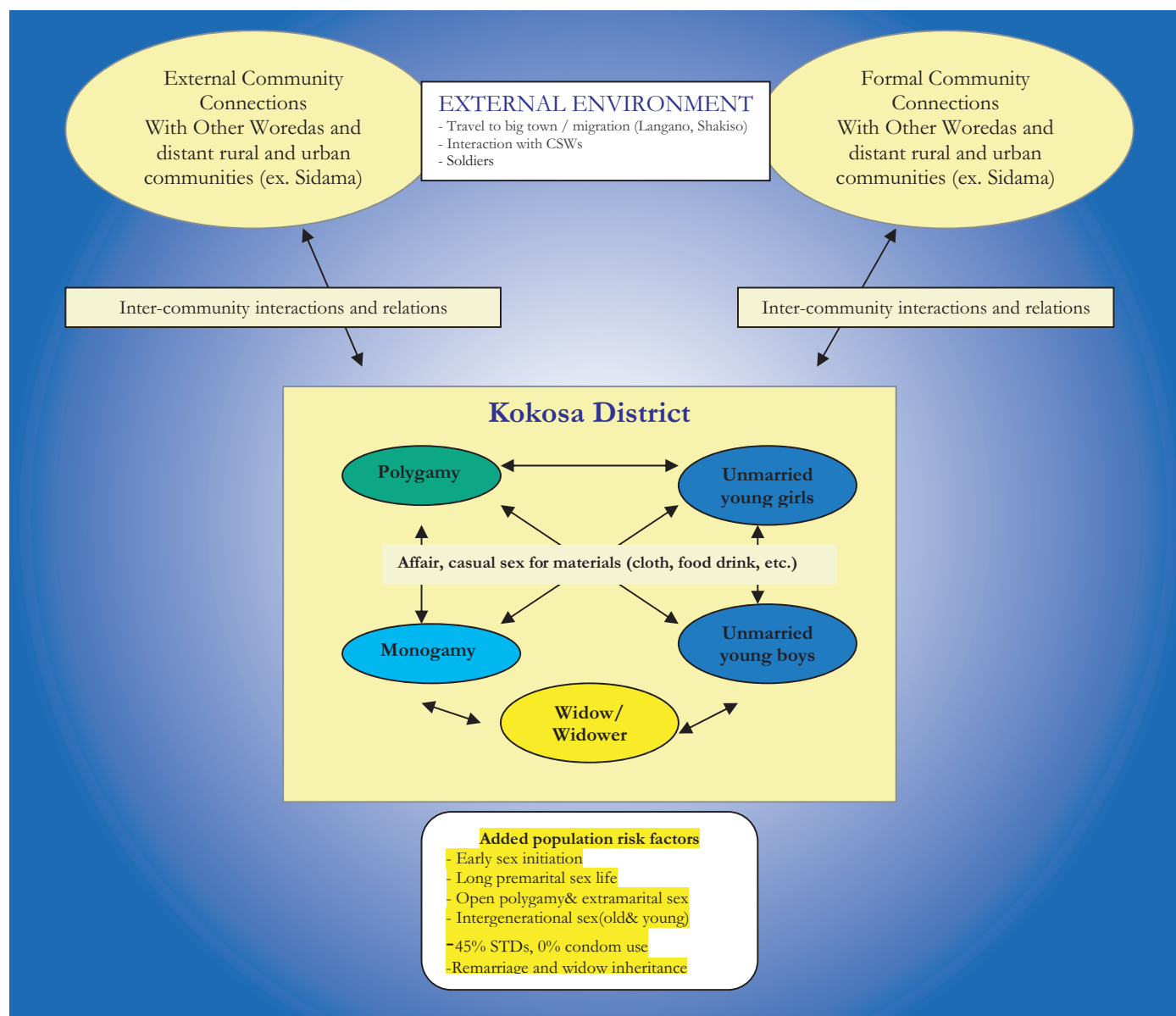
On a larger scale there exist interactions or sexual networks, which connect regions to other regions and the whole nation to neighbouring countries. The HIV/AIDS epidemic has been impacting the country for the past two decades. The complex socioeconomic, political, cultural, climatic and other dynamic issues that were occurring in the last two decades and lingering past historic issues have shaped the present Ethiopia. Below is an inter-regional and cross-national sexual map/sketch showing how for instance, SNNPR is sexually linked with the other neighboring regions, and bordering eastern African countries such as Kenya and Sudan.

The reality is hundreds of thousands of people from densely populated SNNPR district areas to Middle Awash to work on plantations, to all Ethiopian towns to Gurage and Siltea area as small scale traders and to areas in western zones to work on coffee and tea farms and to Shakiso area in Oromiya as gold miners. At the same time the region is affected by the Ethio-Kenyan Major road, which intersects with Moyale and people from Burji area are highly connected to the township of Nairobi. The Western zones (Bench-Maji, Kefa, and Sheka) interact with the Gambella region and are

impacted by Southern Sudan migration and a gold mine in Dima which attracts labourers from almost all parts of Ethiopia. Historically there has been two major events (the first being the down fall of Derg regime and the second being the post Ethio-Eritrean War) of demobilizing a considerable amount of soldiers which connects the region with the Northern War afflicted areas of Ethiopia. See Map below.

Figure 7 above outlines the sheer complexity of the HIV/AIDS epidemic within a society. This systems model displays the various interactions between sectors, institutions, communities and individuals or 'the whole story' of the HIV dynamic. This diagram outlines the cascade affects

and effects that may potentially stem from a sector actions. For instance, if one follows the potential impacts stemming from the education sector, one may visualize how the interactions between sectors can have a myriad of beneficial or negative outcomes. The education sector could positively provide a more skilled workforce which could translate into increasing the capacity of the economy indirectly by increasing productivity of the workers. Also, education has many impacts on diet and nutrition, individual behaviours as well as customs and traditions. All of these interactions have lasting impacts on HIV transmission and the manifestation of AIDS within an individual's body.

Anatomy of HIV in Complex Societies - A systems model
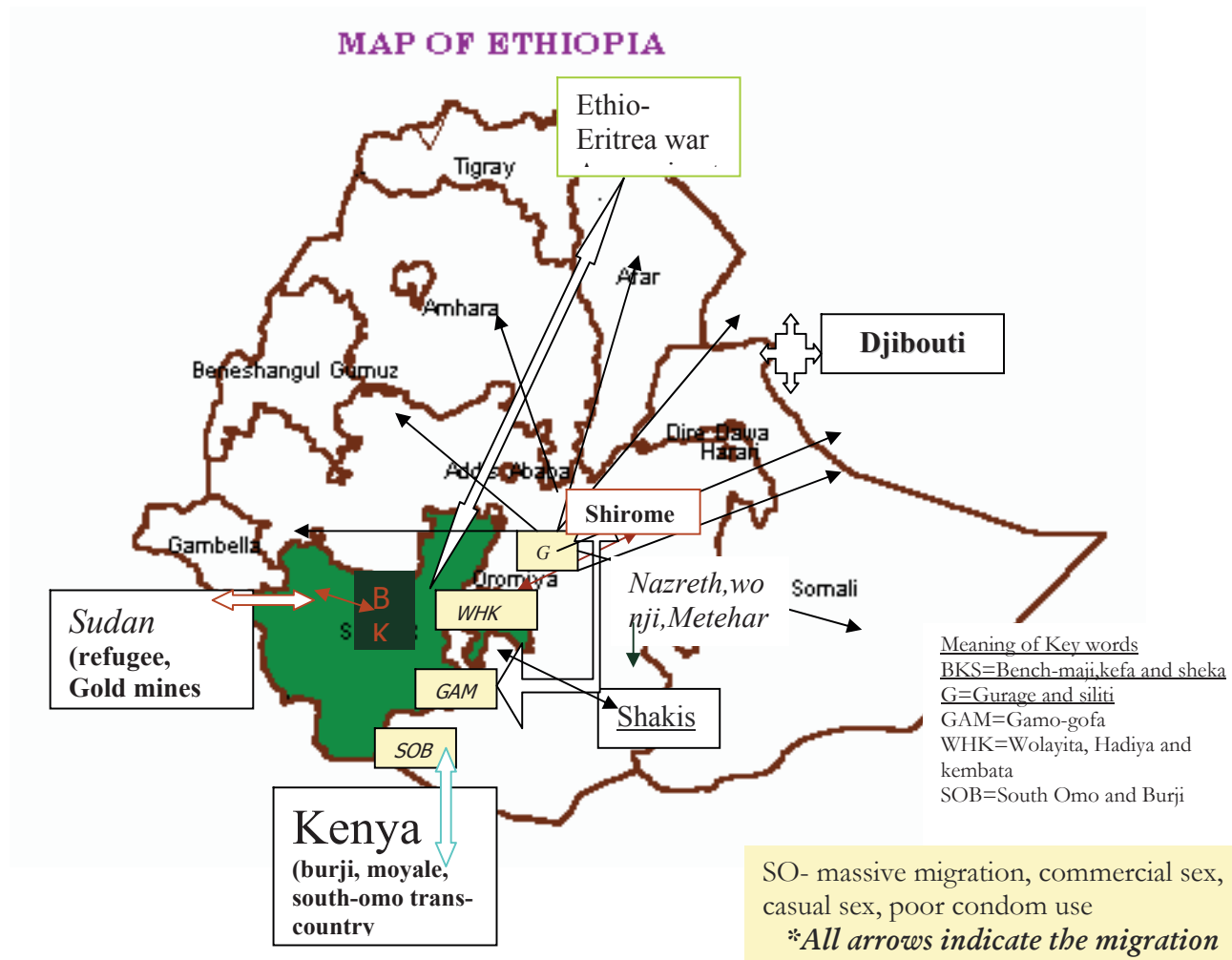
Figure 7 - Anatomy of HIV in Complex Societies - A systems model (Alan Whiteside)
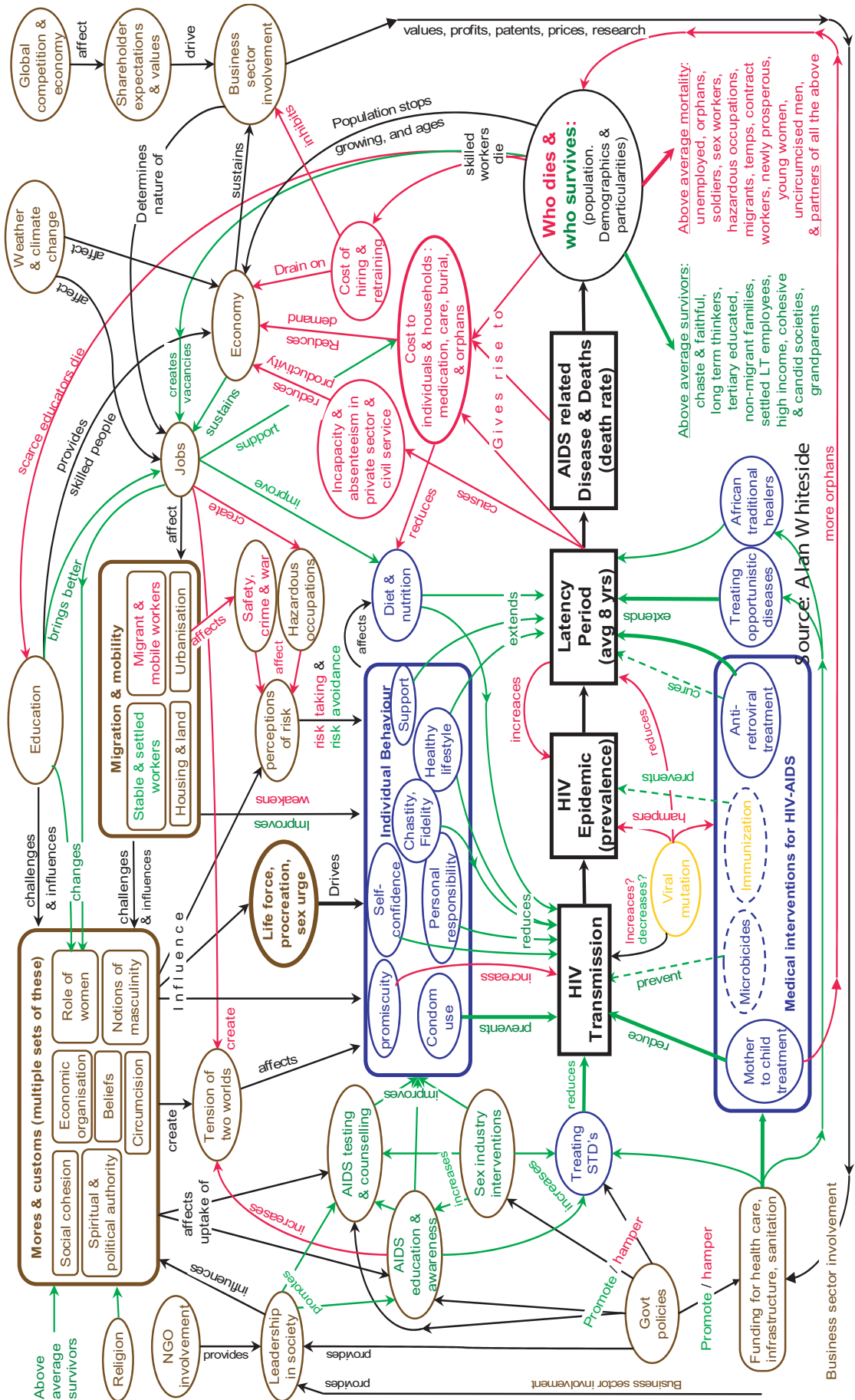
3.1.3. Issues to be considered in addressing such a complex nature of the HIV/AIDS problem

- What type of intervention can address this complex reality?
- Why we did not succeed in stopping the spread? Could it be because the responses in the past were not in line with the problem or did not have a complete understanding of the complex reality?
- Who should address it? Can a single actor/sector address it?
- If not, how could many sectors in different places with different mandates, expertise and understandings act together? How they share a common vision?
- What type of thinking can provide a common platform for all to play their role without changing their mandates?
- Could we afford, as citizens of a poor nation like Ethiopia to believe that a simple solution exists for this complex problem?

As can be deduced, the main reason we need to shift our thinking when coping with HIV/AIDS is because we now need new solutions, mental frameworks and tools for these old problems. It is not to undergo

different strategies or implement different interventions, but rather to address them in a different fashion; how will these efforts not only impact you and your sector immediately, but in addition, how will they impact others in society (directly and indirectly). Shifting our sectoral and institutional thinking and behaviour will be working towards the same goals as listed below:

1. Stopping new infection
2. Giving care, support and treatment
3. Reduce vulnerability
4. Mitigate the impact on individuals, families, communities and the nation at large.

The framework of systems thinking has therefore fostered the understanding of how various entities within a complex system are impacting each other on a continual basis. A change in one entity inherently results in modifications within another. On a sector/institution level, impacts of HIV and AIDS on one sector can have infringing impacts on sectors that are directly and in many cases indirectly working together. Trough comprehending such interactions, individuals can begin to shift their thinking in a manner that views our society much like the interrelated ecosystem previously alluded to – a system whereby a series of cascading affects result from one event. It is now time that we not only shift, but implement holistic thinking.

TOOL 3 – RAPID ASSESSMENT FOR MEASURING AIDS IMPACTS

Estimating the impact of the epidemic involves assessing retrospectively to what extent AIDS related morbidities and mortalities exist in a sector; and forecasting to what extent AIDS will cause morbidity and mortality in the future with certain assumptions.

3.4.   Concepts of Rapid Assessments

In recognition of the extent at which AIDS has impacted all sectors, and forecasting how seriously future impacts could be, one of the first steps that should be highly considered when commencing mainstreaming is an assessment analysis. The Rapid Assessment tool is best utilized at early stage of mainstreaming at any level of a sector or an institution. However, it could also be used at any stage to monitor progress and assess impacts. The intensity and strategy of response to the effects of HIV/AIDS on sectors depends on the degree and pattern at which HIV/AIDS is affecting the sectors capacity to deliver its mandates. AIDS primarily affects a sector through morbidity and mortality among its staff and indirectly through staff family, beneficiaries and other clients of the sector.

Rapid Assessment can be utilized as both an advocacy and planning tool for mainstreaming. The importance of this tool is to lead to the empowerment of the sector and subsequently understand their reality within the context of HIV/AIDS. This section will discuss different techniques for assessing the impacts of HIV/AIDS and will convey possible scenarios for forecasting how to prepare for future impacts.

Type 1: Direct Approach for estimating impact of HIV

3.4.1 Approaches to Estimating magnitude of HIV and AIDS in a sector

* In a situation where the HIV prevalence in the sector is known over three points in time (i.e. 3,6, 9 yrs.) the HIV prevalence obtained in this way can then be used to estimate the number of AIDS cases in the sector (Using short run models such as spectrum and epimodel).
* Once the number of AIDS cases has been projected, assumptions are made regarding how many days such individuals will be absent.
* Calculations are then made regarding the number of AIDS related absenteeism.
* Then this is applied to the production of a sector/ institution.

Type 2: Indirect Approach - extrapolation of antenatal HIV survey information

* In the absence of Sector specific HIV prevalence, the researchers use antenatal data and extrapolate the data to the sector.
* Then the number of HIV infected is estimated for example if the antenatal HIV prevalence is 5%, and the total workforce is 1,000. Applying the percentage to the sector one gets 50.
* Using a short run model such as spectrum or epimodel, one can estimate the number of AIDS cases that will emerge over time in the work place.
* Once the number of AIDS cases is known, an estimate of how many days one will absent can be determined.
* This is then applied to the production center.

Type 3: Clinical Approach to estimating impact of AIDS on sectors

* Use a epidemiological information to give clinical criteria to define:
* Major signs for clinical diagnosis of HIV/AIDS
* Minor signs for clinical diagnosis
* Use globally accepted standard criteria for identifying potential AIDS related criteria.
* Measure absenteeism and death in those identified as clinical AIDS compare with non-AIDS.
* This information can then be used retrospectively or prospectively.

3.4.2. Approach to measure impact of absenteeism on sectors

and Weiner quoted in Brian W. Hogwood and Lewis A. Gunn 1984)."

Box 2: Sampling Approach to impact of Absenteeism on Agriculture Sector

Step 1: To establish trends one has to start the year the first AIDS case was diagnosed in the country--- 1986.

Step 2: Choose a month in malaria season (MS) ---calculate the human days lost for that month for that location, repeat this for each year until the current year. Subtract from the denominator and numerator human days lost by accidents, pregnancy. For each year adjust for population of staff.

Step 3: Choose a month in non-malaria season (NMS) --- calculate the human days lost for that month for that location, repeat this for each year until current year. Subtract from the denominator and numerator human days lost by accidents, pregnancy. For each year adjust for population of staff.

Step 4: Calculate yearly difference for all the years= MS-NMS divide by Total expected human hours-Leave days for MS and NMS multiply 100

Step 5: Plot on graph from 1986 to current year

Step 6: Perform A Trend analysis

Box 3: Regular Approach to impact of mortality on sector's capacity to deliver

Step 1: To establish trends one has to start the year the first AIDS case was diagnosed in the country--- 1986

Step 2: For each year, estimate the number of staff who have died in the project until the current year; and subtract from the denominator and numerator deaths by accidents, pregnancy. For each year adjust for population of staff.

Step 3: plot on graph from 1986 to current year

Step 4: perform trend analysis

3.2.3 Developing Scenarios for Mainstreaming HIV/AIDS into Sectors

Scenarios are "hypothetical sequences of events constructed for the purpose of focusing attention on causal process and decisions points. They answer two kinds of question:

(a). Precisely how might some hypothetical situation come about, step by step? and

(b) What alternatives exist, for each actor, at each step, for preventing, averting or facilitating the processes (Kahn

Scenario planning is a method for developing, and exploring alternative futures in uncertain environments and evaluating the robustness of the organization to withstand the impacts of these Events on the sector (HIV and Agriculture Sector) (adapted from James L. Ritchie 2001).

Building Scenarios for Absenteeism
- Best-case scenario - the absenteeism has reached its maximum and is on the decline.
- Medium-case scenario - the absenteeism has reached it maximum but is on the plateau.

- Worst-case scenario - absenteeism still on increase.

Building Scenarios for Mortality

- Best-case scenario - the death has reached its maximum and is on the decline.
- Medium-case scenario - the death has reached it maximum but is on the plateau.
- Worst-case scenario - the death is still on increase.

The impact of mortality on Sector's capacity could be estimated:

- Using the best-case scenario.
- Using the medium-case scenario.
- Using the worst-case scenario. And therefore what measures should we put in place to ensure the sector's capacity to deliver on its objective.

Limitations of Scenario Planning

Scenario planning depends on the experience of individuals regarding the issue at hand, in this case their knowledge of HIV, and how it relates to their respective sector.

3.4.8. Linking Absenteeism and deaths to reduced productivity

- Define productivity measures for the sector or institution. Productivity in education could be viewed as the function of quality of teaching, coverage of the given curricula and finally could be measured by the percentage of students successfully qualifying to the next stage according to the teaching institution's standard.
- Estimate the annual productivity in terms of human hours with normal attendance. The institution's produc-

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Box 4: Steps for Scenario Planning

Step 1: Identify the focal issue - What is the core mandate of the sector?
- What sector policies and strategies define the core mandate?
- What delivery mechanism does the sector use to achieve it current mandate?

Step 2: Identify key forces in the environment- what in the sector's immediate world can affect the delivery of the core mandate?
1. What are the political, economical, social and technological factors that are going to influence the sectors capacity to deliver on its mandate?
2. How are these factors' going to influence the sector capacity to respond to HIV and AIDS over time?
3. How is the impact of AIDS going to influence the sector capacity to deliver its mandate over time?

Step 3: Identify driving forces - what are the structural and sector forces at play that will facilitate or inhibit the delivery of the core mandate?
- What is driving the political processes?
- What is driving the economical processes?
- What is driving the social processes?
- What is driving the technological processes?
- For each of the above responses
- Describe how it is going to facilitate sector capacity to deliver on its mandate?
- Describe how it is going to inhibit sector capacity to deliver on its mandate?

Step 4: Rank by importance and uncertainty
For each scenario developed in step 3 rank:
- Uncertainty: Which of the defined scenarios has the greatest possibility of happening?
- Importance: This will be in terms of the scenario's influence on sector capacity to deliver its mandate.

Step 5: Select scenario logics---what are the key linkages between sector performance and these impacts?
- What is the impact of the scenario on the capacity of sector to deliver its mandate?
- What is the impact of the scenario on the sector's capacity to reduce the spread of HIV in the community?
- What is the impact of the scenario on sector capacity to respond to AIDS impact on the sector?

tivity could be estimated based on the regular attendance of educators for the number of teaching credit hours according to a set quality standard of the institution.

- Estimate the annual productivity in terms of human hours lost. If absenteeism by educators is recorded regularly and the number of credit hours lost for the given course is calculated, the loss in productivity of the teaching institution could be estimated with reasonable certainty. This example could be fairly applied to a production center, as production rate per hour of a production center is better known than a teaching institution.

Rapid Assessment therefore allows a sector/institution to forecast for the future impacts of the epidemic by analyzing introspectively the impacts the epidemic has already had. Through conducting such an analysis, it is possible to foresee various components of a sector that may be impacted the most in the short and in the long term. After conducting such an analysis, one can begin assessing how their sector may be potentially impacting other sectors ("entities") within society.

TOOL 4 – CROSS-IMPACT ANALYSIS

The Cross-Impact Analysis/Matrix is a technique/tool that concentrates on the actual and potential relationships between the forecast events.

3.5. Concepts of Cross-Impact Analysis

The negative impacts of AIDS on a sectors' capacity to deliver their mandates are not always limited within that sector. Development is a complex function that involves interactions between and across sectors. The strength and weakness in one sector can positively or negatively influence the delivery capacity of one or more other sectors and on the reverse, the sector can also be positively or negatively be influenced by one or more sectors.

The ways in which various sectors influence each other can be as many as their complex visible and invisible relationships. These could range from, supply of skilled human resources, supply of appropriated raw materials, supply of spare parts, consumption of semi-processed and finished goods, transport, etc. In addition to the direct cross impact of sectors as a result of their give-and-take relationships, sectors also indirectly influence one another through their individual contributions to the national economic and social development. Each sector has a mandate to contribute to national development in some facet and if one sector fails to contribute economically, then the resulting limitations on the functioning of other sectors could be paramount.

The influence a sector imposes on the other and the capacity of the sector to absorb the shock caused by the influencing sector could be different from sector to sector depending on the inherent nature of the sector -- its management integrity, the kind of service the sector provides, the technology capacity of the sector, and other related factors.

This type of interaction as mentioned above between the sectors is expected to exist under normal situations. In the era of HIV/AIDS however, these interactions and intersectoral influence on their respective delivery capacity becomes more intensified and gets more complicated.

The use of this tool requires good understanding of the mandates and structure of the different sectors, and the functional

relationship and interdependence of the different sectors and institutions in a given location. This tool could also be best applied at community and household levels to identify who influences whom and who is worst affected in a community and at household level so that interventions will focus on individuals that have leverage in our interventions. This tool could be applied across all the stages of mainstreaming.

3.5.1   Cross-matrix and mainstreaming of AIDS in sector

As would be expected, very little is known about the potential and actual interaction of sectors in the context of AIDS. Cross-Impact Matrix is a system's tool that will enable us to explore how sectors interact in the context of increasing AIDS related mortality and morbidity, and how this influences the entire system capacity to deliver on its mandate. This tool will enable us to identify which sectors are more vulnerable than others at the same time assist in identifying sectors that one should focus on to change the situation.

It should be noted that the use of the cross-impact analysis tool is not strictly limited to analyzing the intersectoral impact. This tool can be used to analyze influence in family members to identify primary target in the family for behavioral change; it could also be used to cross-analyze interdepartmental influences within a single sector or organization.

3.5.2.   Key variables that influence cross-matrix analysis

- The structure of the system.
- The stage of the epidemic.
- Predominance of an economic system.

Figure 9 shows that sector to sector interactions are not a linear process, and is comprised of indirect impacts and cascading effects. For instance, Sector C directly impacts Sector B, but could have an indirect impact on Sector G in the long run as well. It is critical to keep these indirect impacts in mind when analyzing how the HIV/AIDS epidemic has effects on various sectors and ultimately national development.   The key is to understand these interactions among the sectors and analyze the relationships persisting within this network. T-the circle in the middle is indicative of a multi-dimensional interaction.

Box 5: Steps for Cross-Matrix Analysis

Step 1: Define the national political, economical system
Step 2: Draw a cross-matrix showing the sectors in the country.
Step 3: Use scale to measure force of impact.
Step 4: Sum up the impacts---Horizontally to define vulnerable sectors.
Step 5: Sum up vertically to define potential strategic sector for focus of intervention

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FIGURE 9: System's Perspective of Sector Interaction
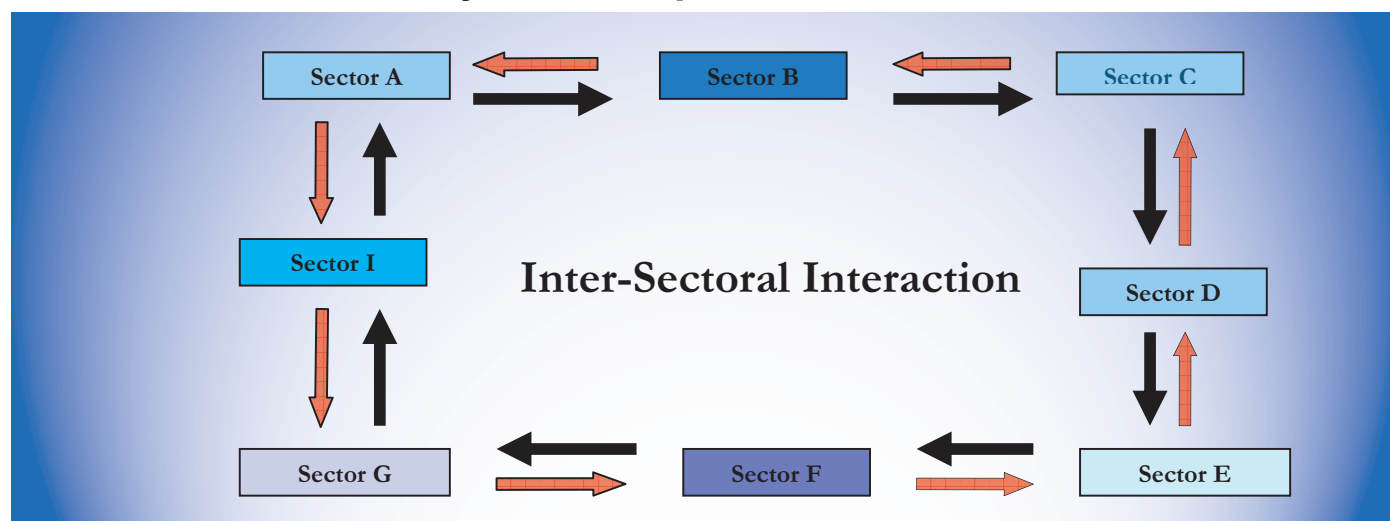
3.5.3 Defining the National System - Components and Areas (Economy, Social and Political Levels)

Before analyzing the cross-impact analyses of a system, it is essential that one defines the sectors within their communities (those strategic and vulnerable) and what the role each can play in the context of HIV/AIDS.

FIGURE 10 – Step 1: Define the National System – Components and Areas (Economy, Social and Political Levels)
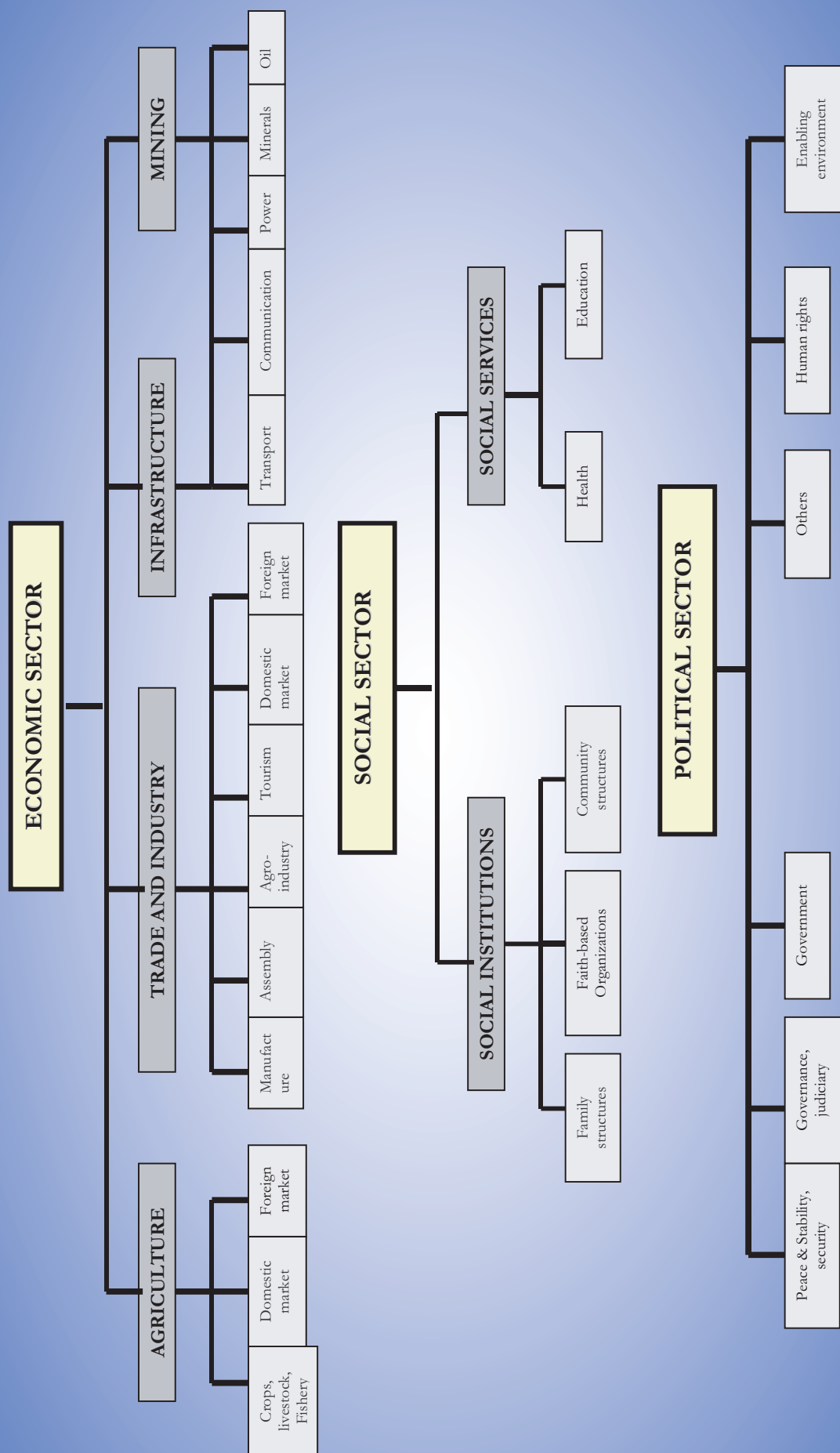
FIGURE 11 – Step 2 : Draw a Cross – Matrix showing the different Sectors

	Sector A	Sector B	Sector C	Sector D	Sector E	Sector F
Sector A						
Sector B						
Sector C						
Sector D						
Sector E						
Sector F						
Impact on A (From other sectors)						**Impact of A** (on other sectors)

FIGURE 12 – Step 3 :Define the impacts and add vertically to identofy Strategic Sectors

FIGURE 12 – Step 3 :Define the impacts and add vertically to identofy Strategic Sectors

	Sector A	Sector B	Sector C	Sector D	Sector E	Sector F
Sector A						
Sector B						
Sector C						
Sector D						
Sector E						
Sector F						
SUM OF IMPACT on	A	B	C	D	E	F

The direction of the heavy dark arrows indicates the impact of the sectors written in black on the sectors written in red. **Sectors A, B, C, D, E & F** impose their impacts on **Sectors A, B, C, D, E & F**. If we assign scores corresponding to the degree of impacts Sector A, imposes on the sectors written in red and add them up vertically, the total score will tell us the degree at which Sector A impacts on all other sectors. As we repeat the same calculation to all the sectors in black, we will finally get a value to help us know the sectors that are most impacting – the strategic sectors. Interventions invested on **the strategic sectors** also reflect on the other sectors.

The direction of the heavy red arrows indicates how the sectors written in red impacted by the sectors written in of black. **Sectors A, B, C, D, E & F** are impacted by the **sectors A, B, C, D, E & F**. If we assign scores corresponding to the degree of impacts imposed up on Sector A, by the sectors written in black and add them up horizontally, the total score will tell us the degree at which Sector A is impacted by all other sectors. As we repeat the same calculation to all the sectors in red, we will finally get a value to help us know the sectors most impacted – the vulnerable sectors.

FIGURE 13 – Step 4: Add figures horizontally to identify Vulnerable Sectors

FIGURE 14 – Illustration of Cross-Impact Analysis to identify Strategic and Vulnerable Sectors

		ECONOMY			POLITICAL		SOCIAL		TOTAL
		Agric.	Indust.	Finance	Water Works	Legal	Education	Health	
ECONOMY	Agriculture	0	1	2	1	3	2	1	10
	Industry	1	0	3	1	2	1	2	10
POLITICAL	Finance	1	3	0	1	3	4	3	15
	Water Works	2	1	1	0	2	1	2	9
SOCIAL	Legal	3	2	1	2	0	1	2	11
	Education	3	2	1	2	3	0	5	16
	Health	1	4	5	2	1	5	0	18
TOTAL		11	14	13	9	14	14	15	

Conventionally chosen scores of 0 – 5 are given to the degree at which a sector impacts another sector and to what extent one sector is impacted by the other sector. Although this system of scoring can be quite arbitrary, one could couple this scoring process with the direct level of involvement they specifically have with another sector. For instance, the Health sector would be highly impacted by the Education sector in that the training of physicians and health professionals could potentially lessen.

Based on *Figure 14*, the **Health, Education and Transport** sectors are identified as the most vulnerable of all the sectors in descending order. On the opposite end, the **Health, Legal and Education sectors** are identified as the most *strategic* sectors influencing other sectors and need priority interventions.

In the illustration, the **Health** and **Education** sectors appear as both strategic and vulnerable sectors indicating that the two sectors **are key for priority intervention areas** to bring about changes in the rest of the sectors.

By conducting a cross-impact analysis, sectors are going beyond assessing how HIV and AIDS is impacting themselves, and extending how they may potentially affect other sectors reliant on their services. This tool is of utmost importance in fostering capacity building to societies and economies disrupted by the epidemic.

TOOL 5 – THE DEMAND AND SUPPLY MODEL

This is a tool that shows how the change in the quantity and pattern of demand by the community as a result of HIV/AIDS changes the delivery/supply capacity of a sector/an institution, and how the change/disturbance in the capacity of an institution or a sector will in turn disturb the quantity and pattern of services by the demanders. Though there is a place for this tool in all the stages and level, it is best applied at stages III and IV, and best used by planners at any level.

3.6.   Concepts of Demand and Supply

*Understanding of a **"model"** concept is important step for understanding this tool.*

A *model* is the explicit interpretation of ones understanding of a situation or merely one's ideas about the situation. It can be expressed in mathematics, symbols or words, but is essentially a description of entities, processes or attributes and the relationship between them. It may be prescriptive or illustrative, but above all it must be useful (Wilson, 1992). Models are useful in communicating ideas; simplifying reality and showing the critical relationships between the various parts; simulating and forecasting what would happen

if certain policy measures were put in place; and problem identification and deriving solutions.

Mathematical or statistical models are used to simplify estimations of infection, morbidity, mortality and other impacts of HIV/AIDS nation-wide or within community. All models are only as good as the assumptions made. For example, modeling the behavior of the HIV virus within a community, sexual behavior patterns, labor market behavior,

system's behavior and/or the quality of data that has been used to carry out the simulations or forecasting will ultimately affect the planning that goes into such efforts.

Thus, in order to accurately forecast how HIV and AIDS will alter the demand and supply of an economy or society, one should understand the two main indicators impacting sectors -- mortality and morbidity rates. These rates in turn affect:

* **Demand** by increasing the complexity and quantity of services required of the given sector, and
* **Supply** by reducing the number and quality of service providers, and therefore changing the quality, coverage and effectiveness of the services provided by the respective sector.

The Demand and Supply model has been adapted from the field of economics for the purpose of simplifying the complex interaction between sectors' capacities to deliver their given mandates, inclusive of the changes in pattern, quality and quantity of demand of services by communities as a result of the increasing HIV/AIDS impact.

Box 6 outlines five steps that can be undertaken by sectors to construct a demand and supply model to assist in determining the supply and demand needs of their sector and/or given community. Some of the critical elements of this tool include defining the entire scope of the system (i.e. inputs and outputs, supply and demand respectively). Upon completion of this analysis, the next crucial step involves conducting an assessment of how HIV and AIDS have been impacting these two components. For instance, asking such questions as: What impacts are HIV and AIDS directly and indirectly having on the supply of services to your sector, and what impacts are the virus and the disease posing on your services? Table 4 below is an example what a construction of Box 6 would appear (Ask Geira)

Box 6: Steps for constructing a demand and supply model:

Step 1: Define the entire system to which the sector belongs.

Step 2: Define the inputs required for the sector to provide the services—this will be called the supply side of the model.

Step 3: Define the services that clients expect of this sector—this will be called the demand side.

Step 4: Using impact studies for the given sector—define the impact of AIDS on the supply and the demand side.

Step 5: Develop recommendations to respond to issues identified in step 4.

Table 4 - The Supply and Impact Model for Classifying the Impact of AIDS on Sectors

<table>
<tr><td colspan="2"></td><td colspan="3" align="center">SUPPLY (Inputs)</td></tr>
<tr>
<td colspan="2"></td>
<td>Quality of Service (a factor of experience)</td>
<td>Coverage (A factor of availability of staff and equipment, technology)</td>
<td>Productivity (A factor of quality of service, coverage and effectiveness of defined interventions)</td>
</tr>
<tr>
<td rowspan="2">D E M A N D</td>
<td>Pattern</td>
<td>Decrease Quality of service and increase in complexity of service required</td>
<td>Decrease in coverage as complexity of pattern of service increases</td>
<td>Decrease in productivity as complexity of service increased</td>
</tr>
<tr>
<td>Size</td>
<td>Decrease quality of service and increase in size of the problem</td>
<td>Decrease in coverage as size of the problem increases</td>
<td>Decrease in productivity as size of the problem increases</td>
</tr>
<tr>
<td colspan="5">An increase in the cost of maintaining the performance of the sector (This will be in form of training staff and need for special services).</td>
</tr>
</table>

3.6.1 Illustration of the Health Sector:

FIGURE 14 – Step 1 – Health Care system in Ethiopia
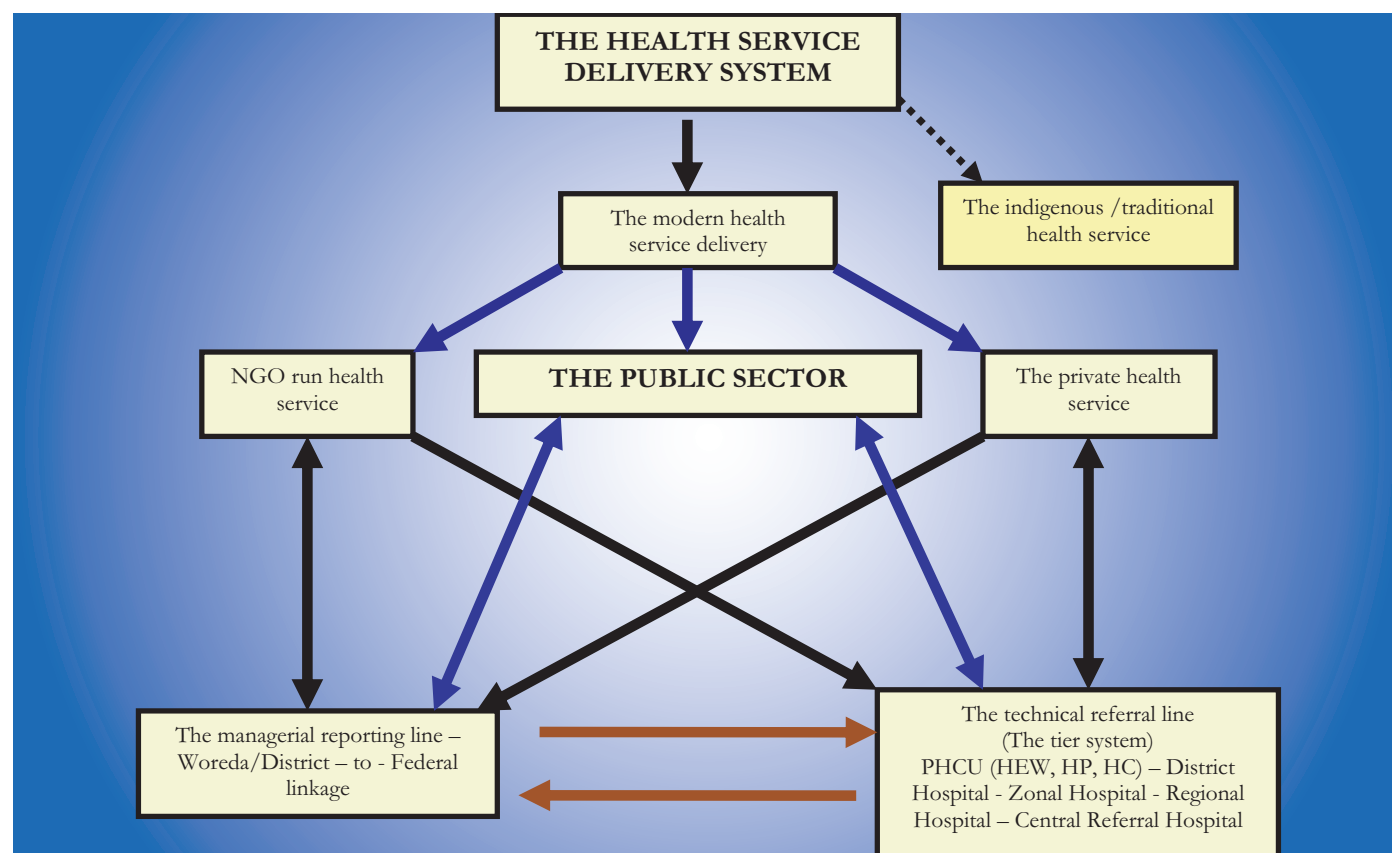
As an example, *Figure 14* illustrates a simplified version of the health system in Ethiopia. The system is structured in a technical referral tier system that consists of the Primary Health Care Unit (a health Centre with its satellite Health Posts and Health Extension Workers), District Hospital, regional Hospital and specialized hospitals. A parallel structure that handles the management of the health system within the country consists of the Woreda Health Office, Zonal Health Desk (not in all the regions), Regional Health Bureau and the Federal Ministry of Health. The managerial reporting structure is also responsible to manage the technical referral network.

In addition, health services are also classified based on their ownership status as public, private for profit and NGOs. Though the above classification refers to the modern health care delivery, a significant proportion of the population also utilizes traditional/ indigenous health services.

Using this example of the Health Sector, Table 5 has been constructed using steps 2, 3 and 4 from Box 6, to construct a demand and supply model showing the impacts of HIV and AIDS.

Through this analysis, a sector will be able to gage the potential impacts of the pattern and size of the disease on the service and productivity of the given sector.

1. Pattern of disease vs. Quality of service

As a result of increasing HIV and AIDS rates within the workforce of a given sector, the patterns of various opportunistic infections have significantly changed in their complexity, distribution and treatment requirements. These changes and susceptibilities indeed require more sophisticated diagnostic technology, new modalities and products of treatment, and more attention in altering the pattern of nutrition, etc. Furthermore, the availability of qualified and experienced health personnel decreases due to overwork due to HIV/AIDS related and other illnesses, absenteeism due to illness and death in family and friends, absenteeism due to the health personnel themselves affected by HIV/AIDS and the loss of qualified and experienced workers (i.e. institutional memory) due to HIV/AIDS.

Table 5 - Step 2, 3 & 4: the Demand and Supply Model – example from the Health Sector

		SUPPLY (Inputs)		
		Quality of Service (Availability of experienced staff	Coverage (Availability of staff, **drugs, reagents, technology)**	Productivity
D E M A N D	Pattern of disease	Increase in complexity of presentation of diseases such as TB (260% increase in ETB) as the quality of service goes down	The coverage may go down or remain the same but the quality of service is certainly a factor of time available to serve the client.	Productivity is a combination of quality service, coverage and effectiveness. With AIDS all these parameters are going down hence reducing the productivity in the health sector.
	Size of the disease	Increase in number of TB and other opportunistic infections without parallel increase in the resources required compromises quality	Coverage is bound to go up due to increase in HF visits bed occupancy, but the quality of service will go down.	An increasing disease burden, an increasing coverage reducing quality and increase in % of deaths as a ratio of discharges.
	Occupancy and average length of stay	Increase in Occupancy and declining average length of stay.	Coverage will go up but the potential of crowding out other equally important conditions has to be monitored.	This is likely to affect outcomes of other conditions as hospital begins to get crowded out.
	Home Based Care	Increased in Demand for HBC as number of staff drops.	Coverage will go up until resource constraints appear in form of finances,	Difficult to monitor
Increase in costs secondary to increased demand for drugs an d reagents, new services such as HBC, replacement costs of staff and this likely to be passed on to consumers in form of increased insurance cover.				

2.   Pattern of disease vs. Coverage

Health service coverage is a factor of the number of staff available, size of the population eligible for the service, availability of drugs, technology, reagents, logistics, etc. As the resources allocated to the health sector are depleted due to changing patterns of diseases and infections, the time loss by the staff of high number of staff significantly reduces health service coverage (What do you mean?).

3.   Pattern of Disease vs. Productivity and Effectiveness

Productivity and effectiveness in health service could be interpreted as the number clients given health service with reasonable quality and quantity by a given health facility and health personnel. Productivity is a function of quality service, coverage and effectiveness. With increasing HIV and AIDS rates, all of these parameters are decreasing and hence, reducing the productivity of the health sector.

4.   Burden/Size of disease vs. Quality of Service

Ultimately, increases in the prevalence of HIV leads to increases in the prevalence of AIDS. This in turn, leads to increases in the variety of opportunistic infections. With the limited availability of qualified and experienced health human resources in Ethiopia (?????), the existing very low per capita drug budget allocation, and the old and slow technology available to diagnose the highly increasing number of variety of cases are some of the many factors that negatively affect the quality of health care.

5.   Burden/Size of disease Vs Coverage

The burden and/or size of the disease and service coverage are directly related to number of health facilities, number of health workers and availability of drugs and medical supplies, and other resources. Coverage may increase at an early stage as the number of clients visiting healthcare facilities increases, but when the number of clients getting the necessary services and the quality of services they get will definitely go down?????.

In light of the strain being placed on the provision of healthcare, an alternative health service modality is needed. Home Based Care (HBC) for instance, has become a desired method of care to ultimately share the burden of the health services. HBC can be provided by qualified nurses, and/or community/household members trained on basic care provision skills. Despite its advantages in distributing the burden of care provision and improving the proximity of service to patients, HBC does also include a gender bias that imposes an extra burden to women and girls who may be frequently absent from work and school.

6.   Burden/Size of Disease vs. Productivity/ Effectiveness

Overall, an increase in the disease burden resulting from HIV and AIDS will increase pressure on the service delivery in an attempt to covering the eligible will reduce the quality and increase the percentage of deaths. ?????

3.6.3   Defining the Education Sector

Another example of conducting such an analysis could involve the education system. In the   Ethiopian context, components of the education sector to consider in such analysis include:

- **Traditional knowledge transfer systems**: Include traditional ways of transferring knowledge within and between generations. Knowledge and skills are transferred through apprenticeship from parent to the subsequent generation via the daily routines in the family and neighborhoods. Another method of transferring traditional skills and knowledge within Ethiopia can be through religious affiliation (i.e. through clergies, monasteries and Quran teaching systems).
- **The modern education system**: Also commonly named as the western education system, and is categorized as the public and private education sector.

In relation to HIV/AIDS, both education systems are equally vulnerable to the effects of the epidemic, as well as important avenues for transferring knowledge and behavioral messages. HIV and AIDS do negatively impact the demand and supply components of the education system through the deaths and illness of instructors, and thus, a decrease in efficient education provided. It could be likely that the traditional system may experience a more delayed impact, but once the impact manifests itself in the form of increased deaths of elders, etc, transferring of documentation and the storage of indigenous knowledge to the subsequent generations will be negatively affected.   *Table 6* outlines the supply and demand concerns for the Education sector including – the quality of service in terms of experience and availability of staff and effectiveness in delivery, as well as the pattern and size of the student body.

Table 6 -Step 2, 3, & 4: The Supply and Demand Model for AIDS impact on the Education sector

		SUPPLY (Number of teachers reducing, in form of teaching hours)		
		Quality of Service (factor of experience)	Coverage (Availability of Staff)	Productivity (Quality of service, effectiveness of interventions and coverage)
D E M A N D	Pattern of learners	Complicating type of teaching to accommodate children in distress & orphans (esp.child headed	Coverage may reduce or remain the same depending on the class size the authorities are prepared to allow.	As the number of children in special needs increase and teachers reduce the quality of learners finishing school is likely to go down.
	Size of learners	Learners may reduce as number of orphans increases who are not able to afford school	In the long run this could easily reflect the learner to teacher ratio at the same level.	Depending on policy towards orphans, the problem may remain the same.
	Curriculum Content	To include HIV/AIDS in current curriculum (Requiring new skills for teachers)	The reduction of teachers may reduce the capacity to deal with new curriculum.	New curriculum, inexperienced teachers and learners affected from AIDS are likely to lower productivity in the sector.
	Increase in cost for replacing teachers and introducin g new programs & curriculums in primary, secondary schools, training college and university.			

3.6.4 The Demand and Supply interfaces on Education impacts:

Pattern of Learners vs. Quality of Service – An impact on Demand

Within an HIV/AIDS impacted environment not only is there a change in the pattern of learners present, but also is there a change in the learning pattern itself. This alteration in the demand for learning pattern can be the result of many factors including:

- Children while still in school may be heavily under psychosocial stress due to the HIV/AIDS related illness and/or death of family and friends. Such psychological stress may also be exacerbated in girls who often carry the brunt of care within a family unit.
- Children may dropout from schools when the demand for care by the sick family member increases, and poverty in the family due to AIDS deepens when death occurs.
- Stigma and discrimination can also hamper the school environment making it non-conducive to actively learning. Teachers should be well attuned to these situations

and stop such occurrences.

To meet the above concerns, the following strategies should be considered:

- Providing informal education outside of the formal education setting.
- Different timing arrangements to meet the needs of students affected and under psychological stress.
- Mobile schools to reach students out of schools are becoming more prominent, etc.

It must be noted however, that all of the strategies included above are not without an extra cost to the education sector. The hiring of more experienced personnel, and materials adapted for such situations will require an increase in budget.

In addition, as a result of the changes in demand in the pattern of education, the effect of HIV/AIDS on teachers complicates the situation further by widening the gap between the demand and supply interactions. Such predicaments that are arising include -- time lost by educators due to illness and death in the teachers' families and communities,

absenteeism by teachers due to illness, and the loss of qualified and experienced teachers due to AIDS.   Consequently, the quality of education will significantly lower as a result of the above complex interaction between the change in the demand pattern for education and the loss of time and life in teachers.

Pattern of Learners vs. coverage of Service – An Impact on Supply

Within the education system, HIV and AIDS also challenges the supply and coverage of services. The term coverage could be understood in two dimensions at macro and micro levels. At macro level, education coverage could be defined as the percentage of school-age children enrolled to school in a walking distance. At a micro level,

For the purpose of explaining this model, coverage is interpreted as topics to be covered by a given teacher to a class in a specified time period based on the curriculum of the teaching institution. As stated above, the changing pattern on the demand for education requires more number of educators and more time per each educator compounded with the decline in the working hours due to absenteeism for various reasons, and number of teachers declining due to loss from AIDS are the major causes for poor coverage of subjects according to the given curriculum.

3.6.4.3. Pattern of Learners Vs productivity

A school's productivity could be measured in terms of the proportion of students successfully completing the class with reasonable grade based on the school's standard. As the number of children under stress increases and in turn, require special assistance and teaching arrangements and teachers reduce in their availability due to absenteeism and death, the quality of learner finishing school is likely to go down, reducing the productivity of the school.

3.6.4.4 Size of Learners Vs Quality of Service

The increase or decrease in the size of learners is dependent on the burden of the epidemic and the location (urban, semi-urban or rural). If the location is rural and the burden of illness in the community is in its early stage, teachers are more affected the community and the students due to their urban connection. With this scenario, there are more learners in schools than the teachers can manage. The second scenario could be: in the process of increasing the burden of the problem in the community and the teacher community having better access for preventive technology and information, there will be a reduction in the increased morbidity and mortality of teachers. In this scenario, there could be little imbalance in the teacher-student ration. This scenario does not imply that HIV/AIDS is not affecting the quality and productivity of education. The third scenario is the most commonly observed situation in most African counties, including Ethiopia. In this scenario, both are equally affected and are not easy to predict whether there could be more students than the teachers manage or more teachers than the students need. This is the reflection that the impact of AIDS on the demand and supply side of sectors is not as simple as one could calculate using simple arithmetic model.

3.6.4.5   Size of Learners Vs Coverage of Service

As a result of the HIV/AIDS impact on teachers and the efforts by the system to cope with the new demand pattern by learners, curriculum coverage will decline despite the increase or increase in the size of students in classes. In the complex impact pattern of HIV/AIDS size of teachers and students, we should not be mistaken by observing the same level of teacher-student ratio, as this does not guarantee adequate coverage of the curriculum.

3.6.4.6.   Size of Learners Vs productivity

In a situation where there is high number of students per class, poor curriculum coverage at the end of the academic year, the proportion of students meeting the school criteria to make it to the next class will decline.

3.6.4.7. Curriculum Content Vs Quality of Education

The rapid increase in the infection rate, the complexity of the impacts and the growing demand for care and support requires mainstreaming HIV/AIDS in the school curricula. The need for revising the school curricula requires skilled personnel to revise and develop HIV/AIDS friendly curricula. There is also additional requirement for developing the skills of teachers in the revised curricula. The impact of HIV/AIDS on the educators reduces the availability of teachers the skill development, negatively affects the quality of HIV/AIDS mainstreamed education.

3.6.4.8. Curriculum Content Vs Coverage of Education

The introduction a newly modified curriculum requires additional time by the teaches and may also pull teachers out of the teaching environment for orientation and training to familiarize them with the methods and content of the mainstreamed curriculum. The already poor coverage of curriculum as a result of the impact of HIV/AIDS on the supply side will further worsen due to the introduction of a new teaching curriculum unless innovative proactive measures are taken.

3.6.4.9. Curriculum Content Vs Productivity of Education

With the introduction of new curriculum there will be new concepts for the students to spend more time to study, with less experienced teachers on the subject matter compounded with stressed students due to AIDS in the family are likely to lower the academic success in the sector.

3.6.5 Recommendations based on the Demand and Supply Analysis:

1. **Human Resources Management Issues (Supply Issues)**

- Data on staff deaths, medical terminations and resignations should be registered within the operational level and reported routinely and timely to the next higher level of the sector, and the corresponding level of the Civil Service Commission for monitoring the situation and planning for replacements.
- Mechanisms for monitoring absenteeism in all sectors should be developed by the Civil Service Reform with a view of ensuring that current government regulations are adhered to and where there is need for change that is done immediately. There would also be great significance if an orientation package/program would be issued upon recruitment.
- Develop mechanisms for monitoring and evaluating productivity in all sectors by the Civil Service Reform. Develop mechanisms for monitoring and evaluating HIV and the workplace programs in all sectors.
- Monitor the payments of benefits in close collaboration with the employer organizations and the insurance industry HMIS

2. **Recommendation For the Health Sector:** Incorporate changes in the Health Management Information System. And make sure that the local decision makers use the modified HMIS.

- The changing disease patterns will require a change in care packages at various levels of the health system. This would include periodically reviewing the essential drug list
- for the different levels of the health service delivery to ensure that the increasing opportunistic infections are catered for. For example the increasing fungal infections would mean that health centers and health stations or health posts should start stocking antifungal agents in large quantities as compared to the pre-HIV era.
- The Ministry of Health at federal and regional level should review their current vertical programs and see how they can be synchronized. For example the National Tuberculosis Program, ARV program, the Community Based Reproductive Health program and the Home Based Care should work together as they're likely to be focusing on the same patients.
- The health sector, in collaboration with the local government and other partners, should review the current operations of Home Based Care and orphan care programs, with the view of bringing the resources of these programs together in single unit at district level to ensure that potential orphans are identified before their parents die. The health sector should ensure that all the training colleges for health workers include an HIV and AIDS component.
- In collaboration with the Civil Service Commission and higher institutions, the health sector may have to consider shortening of the training period of the health workers as a way of offsetting the serious shortages that are likely to occur as the impacts begin to manifest themselves in the years to come.
- Develop counseling services for health workers that are infected. Health workers are likely to find it difficult to get services in institutions, which they are serving in
- The health sector should support all health facilities to practice Universal Precaution.

3. **Recommendations for the education sector:** Ensure the private sector schools are using the same HIV/AIDS mainstreamed curriculum.

- In collaboration with Local Government and other partners, the education sector should work out approaches to deal with children in distress and orphans. Better communication between community organizations, local leadership and the schools could result in quicker identification of children in distress and orphans.

- The training of teachers should now seriously include counseling and guidance skills for HIV/AIDS.
- In collaboration with the Civil Service Commission develop an integrated HIV/AIDS Workplace Program based on clear understanding on the factors that are putting the learner and teacher at risk of infection. And consideration for putting teachers on ARV to reduce morbidity and mortality. Prolonging the lives of infected teachers is more cost effective than training for replacement. Training costs are much higher than the cost of ARV, experiences will be lost through replacement, and the impact on the family members supported by the affected teachers will be minimized through ARV.
- In collaboration with the Civil Service Commission and tertiary teaching institutions, review current human resource planning, with a view of considering less labor intensive approaches to instruction or reduce the number of years that teachers spend in the training college without compromising the quality of the service and the teachers training.
- In collaboration with the Civil Service Commission, review the current human resource management policies especially regarding absenteeism and deaths in the various education institutions.
- All colleges where teachers are trained should have a very aggressive HIV/AIDS program, based on clear understanding on what is putting the students and teachers at risk.
- Develop/modify Education Management Information System (EMIS) to track the impact of AIDS on the education system.
- Provide support for supplementary special behavioral researches to measure impact of various interventions. The researches may also consider innovative ways of reducing the labor intensity of the current way of instructing and assessing the students.

XXXXXX

TOOL 6 – SWOT & PEST ANALYSIS

3.7. SWOT Analysis for HIV/AIDS planning and Response

SWOT stands for Strengths, Weaknesses, Opportunities, and Threats. Strengths are positive aspects internal to the entity, and, Weaknesses are negative aspects also internal to the entity. Opportunities are positive aspects external to the entity, and Threats are negative aspects also external to the entity.

SWOT analysis is a tool for assessing an organization and its environment. It is a very effective way of identifying Strengths and Weaknesses, and of examining the Opportunities and Threats an entity faces in mainstreaming HIV and AIDS into development. Carrying out an analysis using the SWOT framework helps a sector or individual to focus their activities into areas where they are strong, and where the greatest opportunities lie. SWOT helps to gather, analyze, and evaluate information and identify strategic options facing a community, organization, or individual engaged in HIV/AIDS activities, at a given point.

SWOT can be used in the first stage of (strategic) planning, and for analyzing responses and in helping to implement agencies at all levels and categories to focus on key HIV/AIDS issues. SWOT is very important, particularly, when dealing with complex situations in a limited amount of time, and when trying to address all the issues involved often does not pay off. SWOT analysis provides a framework for identifying these critical issues. First, the focus should be on the concerned entity: an organization, a region, a city, a community, a building, and a person. Then, analyses are limited to the significant strengths, weaknesses, opportunities, and strengths that characterize the situation.

To carry out a SWOT analysis, the steps presented hereunder are recommended:

Table 6 - Checklist for SWOT Analysis on Care and Support interventions at a community level

Box 7: How to use the tool

Step 1: Write down / define the Subject of SWOT analysis.

Step 2: Prepare an agreed checklist identifying strengths, weaknesses, opportunities and treats.

Step 3: Draw a matrix containing strengths and weaknesses at the top row, and the opportunities and threats in the first column.

Step 4:   Fill the issues categorized in their respective rows and columns of the matrix.

Step 5: Analyze each category and the corresponding interface.

Step 6: Finally make conclusions and recommendations based on the analysis.

Table 6 - Checklist for SWOT Analysis on Care and Support interventions at a community level

Strength	Weakness
- Existence of shared vision and sense of urgency - Commitment and willingness of staff to carryout care and support - Creation of good interactions with the community	- Poor leadership style - Lack of knowledge and experience in psycho-social support for HIV/AIDS patients among the staff - Lengthy and bureaucratic processes and procedures - Unavailability of staff development programs based on merits
Opportunities	**Threats**
- Existence of active NGOs and faith based organizations operating at a community level - The prevailing extended community and family systems - Increase in financial pledges from different sources - The current conducive policies and political environment on care and support	- Stigma and discrimination towards AIDS patients - Growth in the number of patients - Poverty - Lack of devotion in the political leadership at some levels - Overstrain of families ensuing inability to provide care

Table 7 - Sample Matrix for SWOT Analysis

	STRENGTH	WEAKNESS
OPPORUNITIES	S - O	W – O
THREATS	T - S	W – T

Elucidation: The items indicated in the above sample matrix embrace all categories including their interface and could be explained as follows:

Strengths: show the positive characteristics and advantages of the issue, situation, or technique employed.

Weaknesses: show the negative characteristics and disadvantages of the issues, situations or techniques employed.

Opportunities: are factors, situations that can benefit, enhance or improve the issues, situation or techniques employed.

Threats: are factors, situations that can hinder the issues, situation or technique employed.

S – O: Shows how strengths can be employed to take advantage of the prevailing opportunities out there.

S – T: Shows how can strengths be used to counteract threats that tend to hinder achievements of objectives and pursuit.

W – O: Shows how weaknesses can be overcome to take advantage of opportunities.

W – T: Show how weaknesses can be overcome to counteract threats that tend to hinder achievement of objectives and pursuit of opportunities.

3.7.1   SWOT and PEST Analysis - **Assessing the Internal and External Factors of the Environment for HIV/AIDS Mainstreaming**

3.7.1.1 Defining the Environment

It is very imperative that an HIV/AIDS mainstreaming organizations/entities consider their internal as well as external milieu before proceeding further in the implementation process of HIV/AIDS responses. In fact, an "environmental" analysis should be continuous and feed all aspects of planning and implementation.

The organization's working environment is made up of the following surroundings:

Internal Environment

There are a number of settings, which could be listed as part of the internal environment for scanning. The following are some of the aspects that are presented as an example.

Governance: the governance of an organization is one of the areas, which is taken into account at the time of analysis. It includes the leadership style, either it is participatory or dictatorial or bureaucratic, which delays decisions without justifications. It looks also the stability of the leadership and its vision in leading and coordinating the organization

Management: The other factor, which is reckoned during scanning, is the management of the agency under consideration. It is evaluated with respect to its proposed organizational structure on the paper against its expected mandates. The management is also scrutinized taking into account the existing strategy to accomplish its duties and responsibilities. Furthermore, Processes, systems & procedures that the management follows will be examined against the urgency required in the implementation of the HIV/AIDS responses.

Human Resource: also is the other aspect examined at the time of scanning and considers the suitability of the skills of the expertise in the organization for the job to be accomplished. Moreover, the working culture within the organization and the values and attitudes of staff towards different

assignments, the staff development arrangements, salary & benefits and the personnel management are also reckoned. By and large the overall working environment will be deemed in the process.

Financial Resources: The availability and utilization of the financial resources are the other aspect surmised as one of the internal environment. Here, the adequacy of the available financial resource for use, the financial controlling and budgeting characteristic and   appropriate auditing and supervision mechanism are scrutinized.

Physical Facility: Physical facilities play a crucial role in easing the implementation of HIV/AIDS activities in any setting. The availability of favorable office space with the essential furniture and equipment are vital for staff to carry out their task. Moreover, transportation and communication machineries are indispensable elements of internal environment when inspected for evaluation.

External /Macro – Environment

The external or the macro-environment is mostly known as PEST and looks at the external surroundings. PEST stands for Political, Economic, Socio-cultural and

Technological factors and is useful to examine the impact of each of these factors (and their interplay with each other) on the HIV/AIDS responses. The results can then be used to take advantage of opportunities and to make contingency plans for threats.

Political factors: When examining political factors, it is vital to look at any political change/decision that could affect the activities of organization in relation to HIV/AIDS responses. The laws being drafted; the global changes that are occurring (The Millennium Development Goals, The

UNGASS Declaration of Commitment; The Abuja Declaration; the different initiatives such as The Bush initiative, the three by five initiative, etc) should be considered. Moreover, Government policies, Laws &Directives, Civil service reform, Rationalization, Decentralization, Donor Policies etc are factors, which make up the political environment. .

Economic Factors: Often the political factors spill over into economic factors. For example, tax is usually decided by politicians, based on a mixture of political and economic factors, in this case, the political decision made by the Ethiopian Government to exempt HIV/AIDS related imports from tax could be an ex-

ample. Interest rates, in many countries are decided by a central bank, but political factors may still be important. Other economic factors include exchange rates, inflation levels, income growth, debt & saving levels (which impact available money) and level of poverty and unemployment, Free market economy, Drought, Global economy, Pricing Policies.

Social Factors: Both the political and the social conditions are influenced by social factors - the elements that build society. Social factors influence people's behaviors and include the beliefs, values and attitudes of society. So understanding the social setting will be crucial. Comprehension of - the role of women in Society - attitudes to HIV/AIDS issues - attitudes to age (children, the elderly, etc.), the population/demographic structure & changes, Beliefs, values, attitudes & culture, opinions, lifestyles, Expectation of HIV/AIDS service users from the agency are critical elements to be regarded.

Technological Factors: Advances in technology can have a major impact on the prevention, care and support. And impact mitigation success. Technological change impacts on the speed of program implementations, people's expectations and socio-cultural attitudes. For example the coming out of ART has changed dramatically peoples aspirations and desires and the meaning of life after being tested positive. Furthermore, since HIV/AIDS is prone to new technologies there lots of new emerging technologies which have to be assumed during external scanning.

3.7.2. PEST Analysis for HIV/AIDS planning and Response

PEST analysis is a strategic tool that is used to scan the external macro-environment in which an HIV/AIDS coordinating or implementing entity operates. As pointed out above, PEST is an acronym for the Political, Economic, Social, and Technological factors. PEST factors play an important role in the value creation opportunities of a strategy. However they are usually beyond the control of organizations and must normally be considered as either threats or opportunities. It is also important to note that macro-economical factors can differ per country and region, so normally a PEST analysis should

be performed per in perspective. In order to undertake a PEST detailed scrutiny should be made on the following factors.

As regards to the PEST factors consideration should be on issues such as:

*   How stable is the political environment?
*   Will government policy influence laws that regulate tax on HIV/AIDS goods and services?
*   What is the government's position on multisectoral response to HIV/AIDS?
*   What is the government's policy on ARV?
*   Does the government appreciate the roles played by each stakeholder?
*   What is the global atmosphere with respect to technical and financial support for HIV/AIDS?
*   What is the level of unemployment and poverty in the country?
*   What is the role of religion in the fight against HIV?
*   What are attitudes of people towards new products and services?
*   Does technology allow for products and services to be made more affordable and accessible and to a better standard of quality?

3.7.3 SWOT and PEST analysis for HIV/AIDS planning and Response

SWOT and PEST analysis could be carried out together, by scanning the SWOT aspect against PEST factors. As pointed out above, in prescriptive planning approaches the SWOT analysis is carried out separate from PEST analysis – with the SW focusing in internal capabilities of the organizations whereas OT focuses on factors outside the organization.

PEST analysis is used in the general trends in the overall environment. Using an open system concept the factors in the general environment have immediate effect on the organization capability to respond to HIV and AIDS mainstreaming, and hence the link. Having carried out SWOT and PEST analysis separately, it is possible to mingle both analyses together to undertake a combined SWOT and PEST analysis.

Table 8 - Scanning the Environment Using the PEST and SWOT Analysis

	Internal		External	
	Strengths	Weaknesses	Opportunities	Threats
Political	P - S	P -W	P - O	P -T
Economic	E - S	E - W	E - O	E – T
Social	S - S	S - W	S - O	S – T
Technological	T - S	T - W	T - O	T – T

In undertaking the joint examination, sometimes, similar factors would be harmonized that appeared in each case.

It should be noted that both PEST and OT, which are shown in bold in columns 4 and 5, are external to the organization; however, their interaction could still have a positive and negative impact on the internal strength or weakness of organizations.

The steps to commence the analysis are similar to that followed by SWOT assessment. The SWOT and PEST analysis would help answer the following strategic questions.

3.7.4. Potential Questions and Answers

SWOT

What are the strengths in the current political, economic, social environment and the technology procedures and equipment to facilitate the integration of HIV/AIDS into sector?
• What do we do with strengths?
Develop a strategy or strategies to ensure that they are continued. And encourage the actors or organizations that have been carrying out these activities to continue.

SWOT

What are the weaknesses in the political, economic, social environment and the technology procedures and equipment regarding the integration of HIV/AIDS into sector?
• What does one do with weaknesses?
These areas that are desirable but need to be strengthened depending on the nature of the weakness so defined to ensure implementation.

SWOT

What are the opportunities (futuristic) in the political, economic, social environment and the technology procedures and equipment that would facilitate the integration of HIV/AIDS into sector?
• What does one do with opportunities?
Opportunities are to be exploited and strategies should be adjusted on the basis of the situation.

SWOT

What are the threats in the political, economic, social environment and the technology procedures and equipment for integration of HIV/AIDS into sector?
• What does one do with threats?
Threats are there to be removed or else the project or strategy will not be implemented.

TOOL 7 – GENDER ANALYSIS

3.8. Gender Analysis in HIV/AIDS Mainstreaming

This section of the Mainstreaming Tools module covers "Gender Analysis" as a specific tool for delineating gender based socio-cultural differences and for determining the implications of the delineations on vulnerabilities of women, young girls to HIV and AIDS. Gender Analysis is often used by Development planners, Gender Experts in a community setting to generate gender disaggregated data and to get an insight on the living conditions and positions of women (see box below for an example of data generated through Gender Analysis reflecting gender differences, even within the category of women. Gender Analysis is also used for participatory planning of specific interventions that can reduce women's socio-economic vulnerabilities, with the involvement of both men and women (reference Wanjiku Mukabi Kabira & Miriam Gachago, Nairobi, Kenya, 1993, "Gender and Development;a Femnet Manual for trainees – African women development and communication network". Canadian council for international cooperation, MATCH international center, Association Quebecoise des organesmes de cooperation internationale. Ottawa, 1991 "Tow halves make a whole; balancing gender relations in development").

In addition to Gender Analysis, there are other tools that can be used within an organization to analyze gender areas in assessing institutional responses and human resource issues e.g. The Gender Analysis Matrix, Gender Auditing. For the purpose of understanding Gender and HIV Mainstreaming, only Gender Analysis has been discussed in this chapter.

"The women in Gidan Woreda give an impression of tired bodies and invariably infected eyes. It is not uncommon to find mothers with children sucking at their sagging breasts, past their weaning age. Unless old or feeble, men with infected eyes are seldom seen. Probably, this is owed to constant exposure of women to smoke and perhaps, to the fact that the women do little to decorate their appearance……"

"Women perform burdensome tasks continuously without rest. The status of women in the society is subordinate, with limited knowledge of heir social environment and limited access to the outside world. Further, more control is held by men over important resources like large amount of grain, land and large amount of income earned. Women also have limited control over their life and bodies. All these factors contribute to the subordinate status they hold in society. Poor women depend a lot on firewood selling for their family's subsistence. Majority of female-headed households belong to the poor and very poor category. Besides leading a life in deplorable living condition, they hold stigmatized status in society". Gender Issues in Gidan, North Wello, Ethiopia, SNV-Netherlands Development Organization, Helen Amdemikael, October 1995.

Gender Analysis in HIV/AIDS Mainstreaming

As explained above, Gender analysis is a tool that helps to analyze disparities between men and women, as pre-determined by cultural status, roles in society. In the area of HIV/AIDS, it delineates how socio-cultural factors affect women's and men's susceptibility to infections, the access of both genders to prevention, treatment and care. It probes norms, values, attitudes and makes explicit the underlying factors that delineate the vulnerabilities between the two genders. The key areas that are explored in a Gender Analysis include:

Key Areas for conducting a Gender Analysis

- Division of labour on gender lines
- Access and control over resources and benefits based on gender
- Self-image and social-image and self-confidence of women vis-à-vis men's
- Women's influence over their own life and bodies vis-à-vis men's
- Role of women in the community vi-a-vis men
- Problems and needs of women vis-a-vis men (often used for addressing broader poverty issues)
- Social capital/institutions of women to address problems identified by women
- Assessment of stakeholders and their potential to address problems identified (and the gender sensitivity of the organizations)
- Recommend interventions that can address the practical/livelihood needs of women and their strategic/long term needs (but can be used in the HIV context as well).

Figure 15 reflects the key areas that are considered when conducting Gender Analysis in a given community. Each of the areas i.e. Division of Labour, Control over resources, Socio-cultural areas build on establishing the risks that women, young girls are pre-disposed to, as compared to men, young boys. In the Ethiopian setting despite huge variations in the living conditions and positions of women and young girls, generally, women experience lower socio-economic status and suffer the consequences of harmful traditional practices, thereby increasing their risks to HIV and AIDS.

3.8.1   The Differential risk of Men and Women for HIV/AIDS

A variety of factors increase the vulnerability of women and girls to HIV including their limited access to economic and educational opportunities and the multiple household and community roles they are responsible for. Compounding women's vulnerability are social norms that deny women sexual health knowledge and practices that prevent them from controlling their bodies. There is growing evidence that a large share of new cases of HIV infection is due to gender-based violence in homes, schools, the workplace and other social spheres. Unwilling sex with an infected partner carries a higher risk of infection, especially for girls. Since force is used, abrasions and cuts are more likely and the virus can more easily find its way into the bloodstream. What's more, condom use is unlikely in such situations.

In many countries, men are more likely than women to be admitted to health facilities. Family resources are more likely to be devoted to buying medication and arranging care for ill males than females. Men, and especially young boys, are vulnerable too. Social norms reinforce their lack of understanding of sexual health issues and at the same time celebrate promiscuity. This vulnerability is further increased by the likelihood of engaging in substance abuse (such as alcohol and other drugs) and of opting for types of work that can entail mobility and family disruption (such as migrant labor or the military) Statistics prove that both the spread and impact of HIV and AIDS is not random. It disproportionately affects women and adolescent girls who are socially, culturally, biologically and economically more vulnerable at the same time. As the country loses young productive people, the effects have an influence on all sectors. Households fall into deeper poverty, economies stumble and women are invariably left bearing even bigger burdens-as workers, educators, mothers and, ultimately as caregivers, as the burden of caring for ill family members is made to rest with women and girls. Girls are often removed from school, not to specifically care for the sick and dying, but to take up

FIGURE 15 – Summary of Factors contributing for the high differential risk for HIV/AIDS
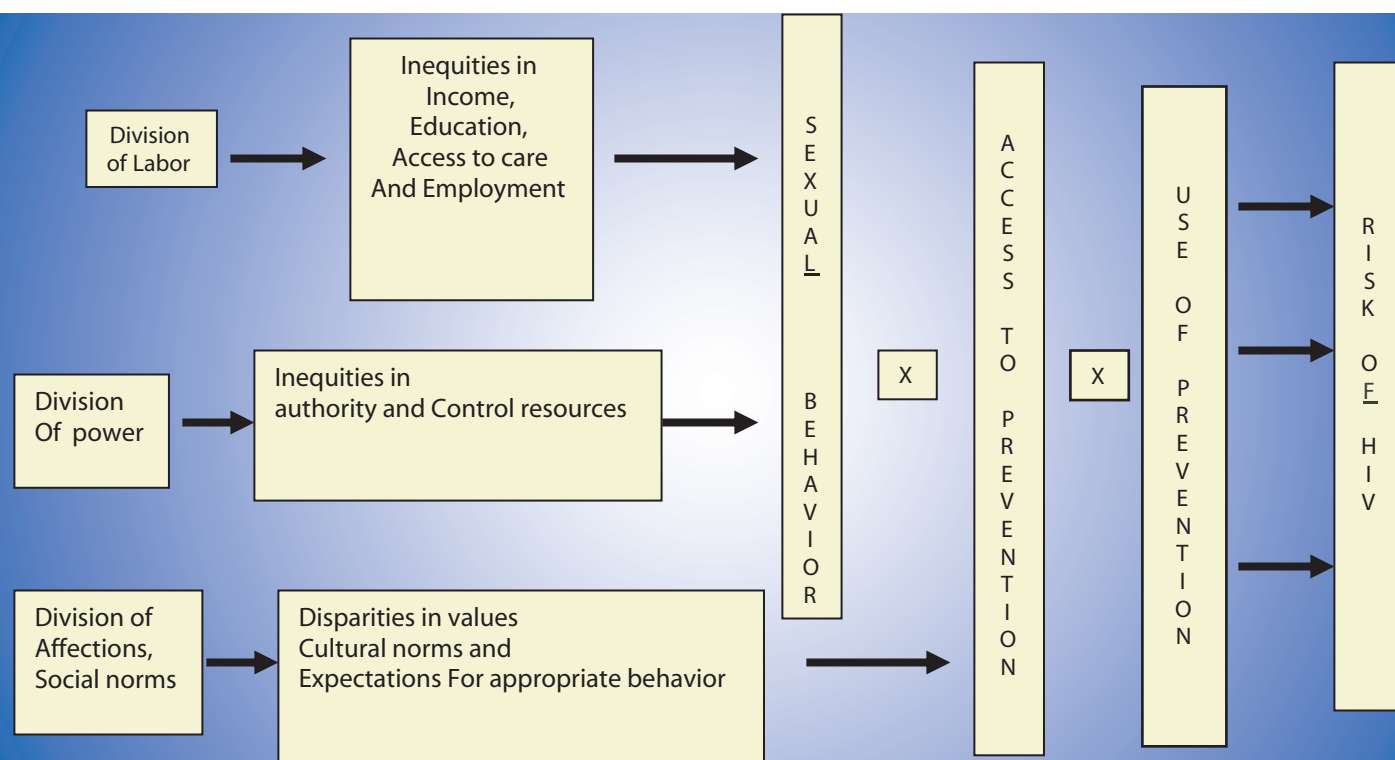

Table 9 - Differential risks for HIV/AIDS using Gender Analysis

Men	Women
• Sexual prowess, multiple partners and control over sexual interactions define masculinity. • Taking the lead in sexual activity is part of the gender-construction of being male. • Men normally take the initiative and decide where, when and how sexual relations take place. • Men tend to have more sexual partners than women and are prone to take risks by having unprotected sex. • Masculine norms make it difficult for men to admit any lack of knowledge in the sexual arena. • Access to and control of resources is profoundly gender-related in both the private and public domain. • Alcohol use and drunkenness is socially sanctioned for men and is common and widespread. • Bars, clubs and drinking establishments abound and are closely associated with reduced inhibition and casual sex.	• Women are objects of reproduction. • Childbearing and sexually satisfying her husband are the key expectations for a wife. • Women are not expected to discuss, make decisions about, or enjoy sex. • Unmarried women are generally expected to be abstinent. • Ignorance about sex is viewed as a sign of purity; too much knowledge is considered a sign of immorality. • Women may be pressured into having sex as a proof of love and obedience. • Women can not negotiate condom use; insistence on condom use invites violence and the suspicion of infidelity. • It is socially acceptable for men to have multiple partners. • Men may seek younger partners to avoid infection; sex with a female virgin is believed

"home duties" that release older women in the family for "care duties".

It is projected that between 2000 and 2020, 55 million Africans will die earlier than they would have in the absence of AIDS. (These projections are based on the assumption that prevention, treatment and care programs will have a modest effect on the growth and impact of the epidemic in the next two decades.

Generally, in most   humanity, men and women encounter diverse vulnerabilities and have different competence because of their gendered function. At times these roles are very different and unyielding; sometimes they are intersect and fluid. In both case, the failure to identify gender roles and to formulate HIV/AIDS policies, plans and programs with them consciously in mind can result in the inequitable delivery of assistance, and inadequate attention to the potential long-term outcomes of short-term interventions. In preparing HIV/AIDS and related policies and strategies that reduce the vulnerability and risk of both men and women, boys and girls to HIV/AIDS infection, and provide comprehensive treatment, care and support programs to all people infected and affected, the tool of gender analysis is a powerful one for accurately diagnosing opportunities and constraints in any situation.

Gender must be taken into account during each step of the program cycle including defining the problems/issues; formulating a strategy; identifying the target group; establishing/strengthening the institutional framework; specifying objectives and indicators for success; defining outputs, activities and inputs and specifying monitoring and evaluation procedures. How does gender analysis help us understand vulnerability? Gender is not the only determining factor of vulnerability. However, an understanding of vulnerability and the development of strategies for overcoming it can be advanced through gender analysis. There are several designs options for planning within a gendered context including women-specific projects, women's component in a general project and a general project with gender mainstreamed into it.

CREATING A FRAMEWORK FOR CHANGE
A SUMMARY TOOL

The picture of change is required from all types of sectors, organizations, households, and ultimately nations in order to survive, thrive and still development in the era of HV/AIDS is an issue of AIDS competence.

3.9.   Concepts of Framework for Change

The concept of Mainstreaming HIV and AIDS into sectoral development initiatives has become a very important strategy when addressing the future impacts of the virus and disease on long-term national development. Essentially, the concept and tools of mainstreaming have become the next step towards organizational or sectoral behavioral change in the era of this pandemic.

As previously alluded to in Module II, mainstreaming HIV and AIDS into development efforts should take into account the bi-directional influence of HIV/AIDS on development as well as impacts of development efforts on HIV/AIDS. This relationship inclusive of issues surrounding gender as well should always be considered when deciding to employ strategies for mainstreaming as it is difficult to mainstream without such perspectives.

To mitigate the impacts resulting from the epidemic, a change in the current mindset and frameworks in place are required. The concept of "**change**" requires considerations such as -- who should lead the change, who should be changed, the need for a change, what is to be changed, how could we bring about a change, when do we need to change, and where should change happen.

The way we are currently leading our lives, our behaviours and practices, in conjunction with policies, strategies and actions in development thus far have not made the sustainable impacts in mitigating the epidemic or in transforming behaviours that are needed to address the epidemic. To be viable in this era of HIV/AIDS, both institutionally and individually, we need to be "**HIV and AIDS competent.**" To be competent, we need to change and view this problem more systematically. The most appropriate ways to respond to issues related to change and to begin mainstreaming are outlined in the table below:

TABLE 10 – Issues Relating to Change and Initial Steps for Mainstreaming

Who should lead the change?	All of us should be our own leaders
Who should be changed?	Individuals, leaders, managers, families, communities, organizations, nations, etc.
Why do we need to change?	Our efforts so far did not stop the crises
What should be changed?	The way we live, the style we love, the way we implement our policies, strategies, actions, beliefs, …
How could we bring about a change?	Remains a question to all
When do we need to change?	Now and everyday
Where should change happen?	Everywhere: at home, workplace, policy level, at faith, at social life, etc

Ultimately, to change and foster AIDS competence, individuals, sectors and institutions must be continuously engaged in learning.

Learning Organizations and Individuals for AIDS Competence

Societies are comprised of many learning organizations -- families, communities, institutions. formal and informal sectors, businesses, and individuals. At all levels, building AIDS competence demands a lot of communication for social change, which is quite different than traditional communication prominent.

> **A Learning Organization is an AIDS-Competent Organization!**
>
> *Are our organizations AIDS-Competent? If not, then transformation is needed to recognize the importance of preparing for the effects of HIV/AIDS*

"The traditional understanding of the role of communication in development is one that seeks mainly to change individual behaviors. This behavior-change communication can be broadly defined as a process of understanding people's situations and influences, developing messages that respond to the concerns within those situations, and using communication processes and media to persuade people to increase their knowledge and change the behaviors and practices that place them at risk. Communication for social change, on the other hand, is defined as a process of public and private dialogue through which people define who they are, what they want and how they can get it. Social change is defined as a change in people's lives as they themselves define such change. This work seeks particularly to improve the lives of the politically and economically marginalized, and is informed by principles of tolerance, self-determination, equity, social justice and active participation for all (Citation).

All levels of a society should devise and adopt more open-ended approaches to dialogue so that conversations may flow more freely and lead to effective change. Conversations should be held in and between all the groups in the community; the role of external facilitators can be especially important in beginning this process and in supporting its long-term sustainability.

In facilitating discussion within a group, sector or institution, it will be useful to cover issues involving:

- Inclusivity - who should participate?
- Key issues and priorities - what do community members think are important factors to address?
- Visions – long-term goals for the organization or group.
- Causality - why are things as they are? (I.e. levels of absenteeism, lack of worker support)
- Identification of intra-institutional focal points who can lead such works and change and what systematic approach should be undertaken (i.e. starting with a certain department, or taskforce already established, etc.)
- Implications for and possible benefits of government, agency, district and community partnerships.
- Consideration towards issues of monitoring and evaluation.

It will not be easy to orient agencies and governments towards communication from a learning perspective. However, the urgency of the HIV/AIDS situation requires an immediate response, whereby action needs to stem from within the organization and the steps outlined above should be employed immediately. Change comes from within an individual and acts as a cascading affect to spark initiative

within an organization and community.

Essentially, it is change in strategy of planning, implementation and evaluation when addressing HIV/AIDS and development within a sector. For this to be possible, change must occur in institutional policies, regulations, methods and tools for the planning, implementation and evaluation. This change is about having personal and shared visions leading to individual and collective learning towards a paradigm shift which transforms us to AIDS competence institutionally.

> We all are not and can't be AIDS competent unless we all start to build a learning organizations.

What is needed to build AIDS-Competent Organizations?

The first step towards such change towards AIDS competence is recognizing what is basically needed to achieve it. The answer posed from the above question essentially is motivated PEOPLE who are leaders themselves. Yet, in many cases the larger question lies in why enough people are not assuming such roles. What is inhibiting all of us from becoming leaders to foster a learning environment and AIDS-Competence?

The way we think, individually and collectively. The way we see, interpret and act on reality depends on the way we see the past, present and future. We all are products of our own past and experiences as well as our current realities. This is what we call our mental model or mind-set. The equivalent of the mental model for a society or community or group is called a paradigm –the frame of thought or reality that one filters their actions through. This is constructed over a long period of time and has myriad of influencing factors -- genetic, historical, cultural, socio-economic, linguistic and spiritual. It is also subjective, in that there is no wrong or right (Citation?).

How can CHANGE occur for an individual to assume more leadership?

By changing one's mental model (or personal filter through which they perceive their reality), one may be more easily capable of breaking through the pre-existing paradigm. This requires a true reflection on how, who, and what comprises our daily existence, and how we can impact and redefines

how our organizations (sectors, communities, families, etc.) will cope today and in the future.

Finally, we must understand the positive and negative contributions of these interactions towards HIV and AIDS prevention care and impact mitigation to create a true strategy.

> **Why CHANGE in organizations fail?**
> Kotter (YEAR) has analyzed more than 500 change initiatives and identified eight key factors for failure of change in organizations.
>
> - Failing to create a sufficiency powerful guiding coalition.
> - Allowing too much complacency.
> - Underestimating the power of vision.
> - Under-communicating the vision.
> - Permitting Obstacles to block the new vision.
> - Failing to create short-term wins.
> - Declaring Victory too soon.
> - Neglecting to anchor changes firmly in the organization culture.

In order to frame the whole process of mainstreaming as a process of change, the UNDP regional project of HIV and development came up with a framework for change management of mainstreaming. is this true?

Learning Framework for Change

The only way of sustainable change is the one that involves a continual process of learning.

In this case learning for change and capacity building is about learning how to learn. It should happen both at individual and collective level. This five step learning framework for change as seen below is about how to create an AIDS/Poverty competent organization/Society. The ultimate goal of mainstreaming is AIDS competence at all levels in all prevention efforts to impact mitigation. It combines CCE, Kotters framework and Organizational learning concept of Peter Senge. These concepts are extensively used for leadership development programs for AIDS both globally and in Ethiopia.

a) Kotter's model of change
b) Since mainstreaming is a transformation of creating AIDS competent sector (organization or community) it has to be a loop.

c)   In the process all the tools are used in one of the steps
d)   Central to the process of generating sector transformation is commitment to participatory learning in action.
e)   This framework for mainstreaming will be a beneficial tool best used for analyzing and forecasting impacts of HIV/AIDS.

Keep in mind that Reflection and Review or Monitoring and Evaluation should ideally be done in all stages as a means to sustain short term wins and guide coalitions towards a re-generation of their goals!

In this, he has also proposed eight steps for the change process. These key steps are outlined in *Box 8* below:

Box 8: What are the key steps required for change using Kotter's model?

Step 1: Establishing a sense of urgency

- Evidence Based Advocacy
- Rapid Sector Impact Assessment (Use of impact studies in sub-Saharan Africa)
- Demand and supply model.
- Scenario building
- Gender analysis, Cross-impact analysis

Step 2: Creating guiding Coalitions

- Identify key stakeholders that would assist in the AIDS and gender mainstreaming in the sector. Use of stakeholder mapping will be helpful.
- Provide platforms for these partnerships to flourish.
- Important principles to achieve a wide guiding coalition are:
- Position power– enough key players from sector.
- Expertise---the right expertise from the sector.
- Credibility--- do the team leading the process of mainstreaming have a good reputation with others in the sector.
- Leadership: does the group include the proven leaders to lead the change process.
- Create trust and develop a common strategy.
- Potential methods and tools: Adult learning (Kolb Learning cycle) and System's thinking with a focus on mental models.

Step 3: Developing a vision and strategy for mainstreaming AIDS and Gender in development

- Define a clear vision of what development will look like once gender and AIDS have been mainstreamed.
- A clear strategy on how and what will be mainstreamed.
- Characteristics of a vision:
- Imaginable, Desirable, Feasible, Focused, Flexible, Communicable
- Potential Methods and tools
- Strategic thinking and planning for mainstreaming HIV/AIDS.
- UNDP classification for mainstreaming to give future sector.

Step 4: Communicating the change vision

- Clear communication for the change processes that must take place in the sector to ensure that AIDS and gender are mainstreamed.
- Clarity of message.
- Medium of message.
- Well targeted.

Box 8: Continued

Step 5: Empowering employers for broad based actions

- Give the appropriate skills and knowledge for mainstreaming AIDS and gender in the development.
- Provide enabling policies and regulations to facilitate mainstreaming AIDS and Gender into the development.
- Provide appropriate financial and material resources where necessary to mainstream gender and AIDS in development.
- Barriers to empowerment (Workers boxed in)
- Formal structures
- A Lack of needed skills
- Personnel and information systems make it difficult.
- Bosses discourage workers
- Potential methods and tools
- System's thinking, SWOT and PEST Analysis

Step 6: Creating short term wins

- Clear input, process, output and outcomes indicators that are regularly monitored--- any signs of success are shared to all. . Monitoring and evaluation framework using the stages of mainstreaming has to be developed.

Step 7: Those gains that have been achieved should be consolidated and continue the process of change

- Methods and tools
- SWOT and PEST
- Adult learning cycle

Step 8: Anchoring new approaches in the culture

- Introduce new guidelines and regulations that make AIDS part of the culture of development. For example, Personnel and management policies reflect mainstreaming HIV/AIDS.
- Methods and tools:
- System's thinking,
- Strategic thinking and planning

Turning breakdowns into breakthrough!

* Develop a vision and strategy
* With complete answers
- Vision & visionary team
-     Guiding coalition (learning team)

2

Box 9: Process of Creating an AIDS Competent Organization

Stages, Tools and Methods

1. **Establish sense of Urgency**
*   Exploring Organization/Sector concern (Defining core mandate)
*   Defining Sector AIDS Reality (SWOT and PEST, Demand and Supply, Rapid Assessment Sector Impact)
*   Make people see and feel the reality (Systems Thinking with a Mental Model of the situation)
*   Reflection and Review

2. **Develop a Vision and Strategy**
*   Guiding coalition (learning team)
*   Leadership enrolling
*   Cross-Impact matrix
*   Vision & visionary team (Strategic planning and thinking – Scenario building)
*   Ken Wilber Quadrant Analysis (can be used in all stages)
*   Reflection and Review

3. **Communicate Shared Vision**
*   Learning & sharing vision (Individual and Collective learning)
*   Strategic Thinking
*   Learning to learn (Empowering Staff)
*   Relative and Review

4. **Practice the vision (Action)**
*   Capacity building
*   Empowerment
*   Specific –Plans & Guidelines
*   Financial allocation, implementation of plans
*   Relative and Review

5. **Reflection and Review (RR) = M & E**
*   Regenerating vision and guiding coalition,
*   Record and communicate short term wins
*   Consolidation of change culture

1

* Establish sense of Urgency (conversation for Generating background relatedness)
  a. Relationship building (ensure common understanding)
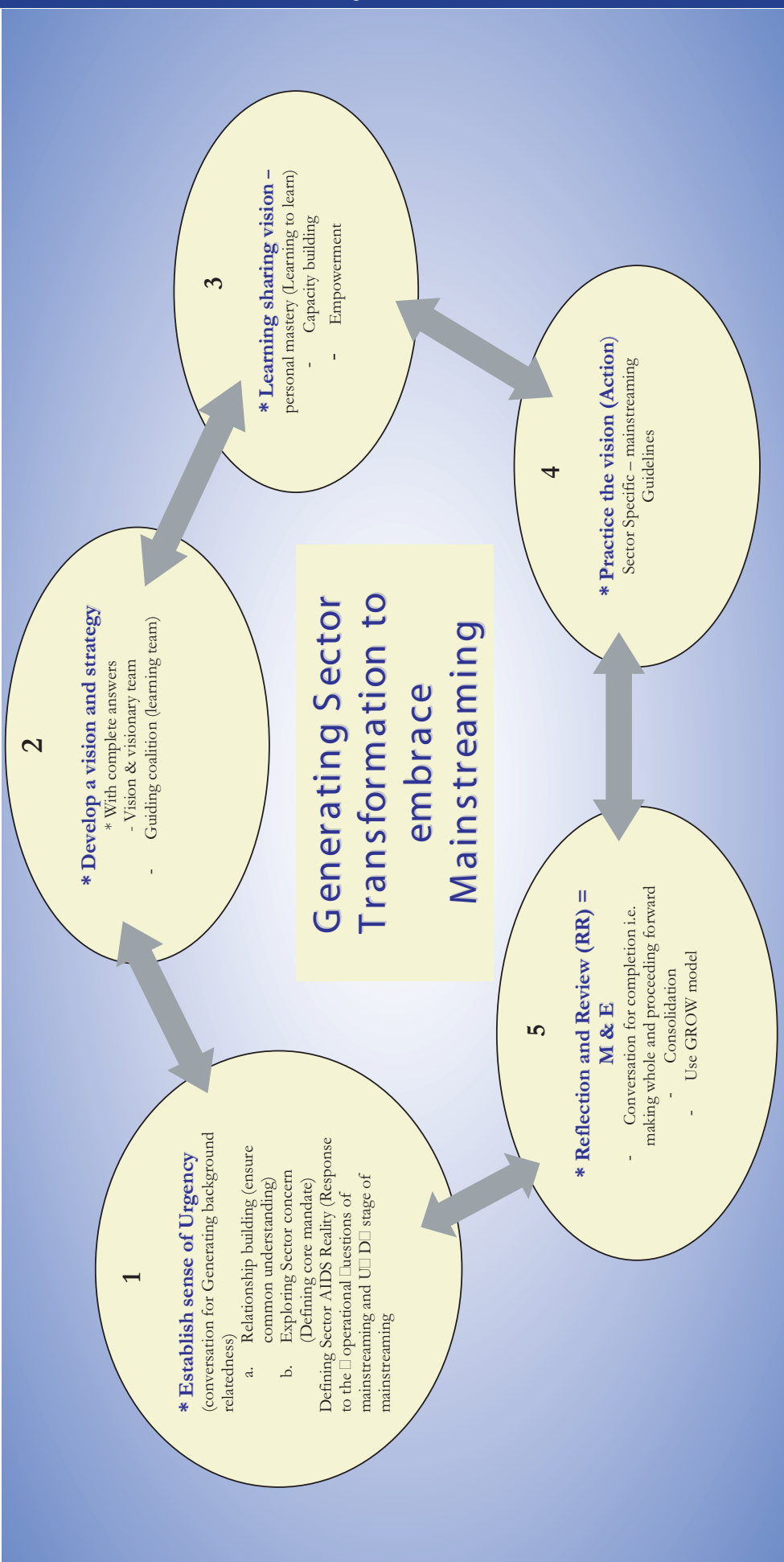 b. Exploring Sector concern (Defining core mandate)
Defining Sector AIDS Reality (Response to the 3 operational questions of mainstreaming and UNDP stage of mainstreaming

3

Generating Sector Transformation to embrace Mainstreaming

* Learning sharing vision → personal mastery (Learning to learn)
-     Capacity building

-     Empowerment

FIGURE 18: Process of Creating AIDS/Poverty Competent Organization/Society

Generating Sector Transformation to embrace Mainstreaming

1

* Establish sense of Urgency
(conversation for Generating background relatedness)
- a. Relationship building (ensure common understanding)
- b. Exploring Sector concern (Defining core mandate)
Defining Sector AIDS Reality (Response to the □ operational □uestions of mainstreaming and U□ D□ stage of mainstreaming

2

* Develop a vision and strategy
- * With complete answers
- - Vision & visionary team
- - Guiding coalition (learning team)

3

* Learning sharing vision –
personal mastery (Learning to learn)
- - Capacity building
- - Empowerment

4

* Practice the vision (Action)
Sector Specific – mainstreaming Guidelines

5

* Reflection and Review (RR) = M & E
- - Conversation for completion i.e. making whole and proceeding forward
- - Consolidation
- - Use GROW model

Internal Mainstreaming
Workplace Intervention

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The Internal Mainstreaming - Workplace Intervention

The Secretary-General, Kofi Annan, in his speech to the United States Chamber of Commerce, Washington, D.C on 01/06/2001 addressed the following: "The first line of action begins in the workplace. Those of you with employees in the developing world can draw up effective AIDS policies in consultation with them. Programmes to educate your work force about HIV can become a cornerstone of our global prevention campaign. And when your staffs are affected by HIV/AIDS, you can and must support them and their families, notably, by providing voluntary and confidential testing, counselling and treatment."

4.1. General Overview of Internal Mainstreaming

Internal Mainstreaming or Workplace Intervention is crucial in that it provides a very sound opportunity and entry point to respond to the epidemic. According to the International Labour Organization, a workplace intervention is indispensable because of the following reasons:

Firstly - HIV/AIDS has a huge impact on the world of work – reducing the supply of labor and available skills, increasing labor costs, reducing productivity, threatening the livelihood of workers and employers, and undermining human rights.

Secondly - the workplace is a good place to tackle HIV/AIDS. Standards are set for working conditions and labor conditions. Workplaces are communities where people come together and they discuss, debate, and learn from each other. This provides an opportunity for awareness raising, education programs, and protection of rights.

Thirdly - employers and trade unions are leaders in their communities and countries; leadership is crucial to fight against HIV/AIDS.

Internal HIV and AIDS Mainstreaming or workplace interventions focus' attention on measuring and predicting the impacts of HIV/AIDS, undertaking HIV/AIDS activities to reduce vulnerabilities and risks to infection, providing care and support to affected workers and families, and work to minimize the impacts of AIDS on the organization, sector, program, project, etc.

The challenge of HIV/AIDS can be addressed within the workplace by formulating workplace/workforce policies and guidelines that will deal with day-to-day practices and activities, thus contributing to the protection of the workforce and a deepened understanding of the multidimensional impacts of the epidemic.

4.2. Measuring and Predicting HIV/AIDS impacts

Measuring and predicting the impacts of HIV/AIDS is necessary in order to prepare and launch comprehensive responses in the workplace. All organizations should develop appropriate strategies to understand, assess and respond to the impact of HIV/AIDS in their particular workplace and sector.

An impact assessment should take into account the number of people, which are and will be sick and could die of AIDS, the impacts associated with the morale of staff and the associated impacts of costs on the organization, etc. Essentially, impact assessments should include: risk profiles and the vulnerability of individual employees or categories of employees to HIV infection, assessment of the direct and indirect costs of HIV/AIDS such as costs to employee benefits, medical costs and increased costs related to staff turnover such as training and recruitment costs and the costs of implementing an HIV/AIDS programs.

To measure and predict future impacts, there are a number of tools, which are described in Module III of this handbook; particularly a combination of Rapid assessment and Scenario building tools that may be exercised.

To begin such an analysis, an initial assessment should be conducted to assess the impacts of HIV/AIDS on the workforce. This should include identifying, monitoring and tracking the trends and changes among employees that will give dynamic view of what is occurring at a workplace level. This method is considered more appropriate and cost effective in estimating the human and economic impacts. The indicators used for such an assessment are briefly outlined below:

Absenteeism

A person living with HIV/AIDS is likely to experience increased periods of illness and absenteeism. Moreover, those caring for an HIV positive family member or attending funerals of family members and co-workers will require absences from work as well. Such frequent absences will have long-term effects on a sectors capacity.

Employee Turnover

Death as a result of various reasons, retirement, and hiring of new employees must be monitored. This data can be combined with data on the associated costs of retirement packages, death benefits and hiring and training of new employees to elicit the economic impacts. The resulting figures are one aspect of the potential financial costs of HIV/AIDS to an organizations operation.

Medical Costs

Medical costs are an effectual indicator of the impact of HIV/AIDS on an organizations expense. Organizations offer some form of medical coverage or support to employees, through insurance, cost reimbursement, on-site clinics or other mechanisms. It is essential to track these costs effectively including the costs of staffing a clinic, referrals to external hospitals or specialists, and in some cases, the costs of providing or subsidizing ARV treatment. An upward trend of medical expenses, negating other potential sicknesses, could be attributed to the emergence of HIV/AIDS related medical costs.

Organizational Benefits

The benefits that are offered by organizations are impacted by HIV/AIDS. Benefits likely to be affected include health insurance and life insurance for select employees. Each type of benefit can be tracked to assess the costs resulting from HIV/AIDS.

Disruption of Production and Services

There could be disruption of production or service delivery processes as a result of the absence or early retirement of an important employee. Likewise, the training of new employees or retraining of existing employees to fill gaps can impact productivity and profits. Equipment upkeep suffers with inexperienced employees.

However, all of these situations can be monitored for changes and trends that may be related to HIV/AIDS. Given good baseline data on these aspects of the work environment, regular monitoring of routinely collected data can provide reasonable estimates with which to assess the impact of HIV/AIDS on company operations. The numbers will not be definitive, because factors other than HIV/AIDS can also influence absenteeism and benefits. Yet, the data can help monitor changes once prevention interventions are put in place. It will be possible over several years to assess the benefits derived from effective prevention and care programs.

4.4. Reducing the susceptibility of HIV/AIDS on staff and the Organization

Activities which deal with the HIV/AIDS prevention, care and support should be undertaken in order to make staff aware of the basics of the epidemics. This is in an effort to bring about behavioral change which could diminish the spread of the virus. These activities should be coordinated to ensure effective implementation and sustainability of such HIV/AIDS preventative and supportive interventions.

An initial step that should be undertaken by all sectors and institutions should be to devise and implement a workplace policy and program addressing HIV and AIDS. This should detail activities which guide the long - and short-term measures to internally deal with the epidemic both socially, and economically.

4.5. A Workplace Policy

Applying the term "policy" in a workplace context became a point of strong dialogue in trainings and meetings with the perception that the term should only be applied at a macro level for sectors. For the purpose of clarity in this handbook, a workplace "Policy" could be safely interpreted as a set of "Guidelines" and "Rules" directing a given sector/institution on how best to address with the impacts of HIV and AIDS.

In Ethiopia, many organizations to date have workplace policies in place, typically called 'codes of conduct.' For those sectors and institutions that have yet to devise a workplace policy, there are minimum standards that should be followed. For the purpose of this document, the following minimum standards for a workplace policy have been elicited from examples set out by Sheraton Addis and the Telecommunication Corporation.

- The organization's position on HIV/AIDS;
- An outline of the HIV/AIDS programme in place;
- Details on employment policies (e.g. position regarding HIV testing, employee benefits, performance management and procedures to be followed to determine medical incapacity and dismissal);
- Express standards of behavior expected of employers and employees and appropriate measures to deal with deviations from these standards;
- Set out the means of communication within the organization on HIV/AIDS issues;
- Details of employee assistance available to persons affected by HIV/AIDS;
- Details of implementation and coordination responsibilities; and
- Monitoring and evaluation mechanisms.

Ultimately, the development of the HIV/AIDS policy should be in consultation with key stakeholders within the workplace including trade unions, employee representatives, occupational health staff and the human resources department. Furthermore, the policy should reflect the nature and needs of the particular workplace. Since the development and implementation of the policy is a dynamic process, the workplace policy should be communicated to all concerned staff, routinely reviewed in light of epidemiological and scientific information, monitored for its successful implementation and evaluated for its effectiveness.

4.6. Workplace HIV/AIDS Programs

It is recommended that every workplace make an effort towards developing and implementing a workplace HIV/AIDS program aimed at preventing new infections, providing care and support for employees who are infected or affected and managing the impact of the epidemic within the organization.

According to UNAIDS (when?), the recommended components of any workplace HIV/AIDS prevention program are:

- An equitable set of policies that are communicated to all staff and properly implemented.
- Ongoing educational programmes on HIV/AIDS for all staff.
- Availability of condoms.
- Diagnosis and treatment of sexually transmitted diseases for employees and partners.

- Voluntary HIV/AIDS testing, counseling, care and support for employees and families.

The nature and extent of a workplace program should be guided by the needs and capacity of each individual workplace. However, it is recommended that every workplace programme attempt to address the following in cooperation with the sectoral, local, regional and national initiatives:

- Hold regular HIV/AIDS awareness programmes;
- Encourage voluntary testing;
- Conduct education and training on HIV/AIDS;
- Promote condom distribution and use;
- Encourage health-seeking behavior for STDs.
- Create an environment that is conducive to openness, disclosure and acceptance amongst all staff;
- Endeavor to establish a wellbeing program for employees affected by HIV/AIDS;
- Provide access to counseling and other forms of social support for people affected by HIV/AIDS;
- Maximize the performance of affected employees through reasonable accommodation, such as investigations into alternative sick leave allocation;
- Develop strategies to address direct and indirect costs associated with HIV/AIDS in the workplace;
- Regularly monitor, evaluate and review the program.

4.7. HIV/AIDS Focal Point

The implementation of any workplace intervention should ideally begin with the appointment of focal point ("person") within the organization. This requires identifying a person or group of persons who have the responsibility to act as the medium to mainstream HIV/AIDS. Typically, the number, and composition of such a group can vary from organization to organization; some comprised of three members, while others comprised of eight.

For example, the Ethiopian Ministry of Youth, Culture and Sports have devised a taskforce (when?) comprised of eight individuals with more influential positions. On the other hand, the focal point in the Ministry of Agriculture has been located within the Extension Department, with the HIV/AIDS activities carried out with the full support of the whole department staff. While the number and structural placement of the focal points may be different, a working group which gathered for a workshop in the Liverpool School of Tropical Medicine, during December 2002, identified some

Box 1 - A Model Workplace HIV/AIDS Policy

BACKGROUND

This Section may include:

- A brief paragraph about the seriousness of HIV/AIDS and the risk it poses to the wellbeing of the workplace, community and the social fabrics of the country should be included.
- A statement that the staff requires a strong workplace intervention to coordinate the fight against HIV/AIDS at a workplace. It should be stated that the organization is susceptible to the effects of HIV/AIDS, and its ability to deliver its core mandates and services will be threatened by the epidemic.
- A statement on the need to develop and implement a comprehensive workplace HIV/AIDS policy and program so that the organization can minimize the impact of HIV/AIDS on its own functioning.
- A statement on how the workplace program complements the HIV/AIDS strategy of the country should be addressed.

PRINCIPLES

This section sets out the core principles of the organizations approach to HIV/AIDS. These may include, but not be limited to:

- The principle of consultation with employees and representatives in developing and implementing the policy.
- The principle of affording the same rights and responsibilities (non-discrimination) to employees living with HIV/AIDS, supported by the confidentiality regarding their HIV status.
- The principle that HIV testing will not be imposed on employees and where it is done, it will be done with informed consent and accompanied by care and support (ex. Counselling).

COMMITMENT

This section describes:

- The commitments of the necessary human and financial resources to develop, implement, and sustain the workplace HIV/AIDS program and should also address the budgetary arrangement that will support the program.
- The commitment of the organization's leadership and focal points to translate the policy into practice.

KEY ELEMENTS OF HIV/AIDS PROGRAM

1. Coordination and Management
- Nomination of an HIV/AIDS focal point who will be supported by an HIV/AIDS task force/team with representation from all departments and mandates to report to the senior management.
- Assumption of responsibility of this person for translating workplace HIV/AIDS Policy into the workplace HIV/AIDS program.
- Regular reports on progress within the program to be made to the organizations executive/management committee.
- Pledge that the leadership of the organization will utilize appropriate opportunities to demonstrate support for the workplace HIV/AIDS program.
- Recruitment: statement that provides a prospective employee is deemed fit to perform the job applied for, and not be denied employment if their HIV positive is disclosed.
- The organization will conduct an annual internal needs review of the implementation of the workplace HIV/AIDS policy, including a review of the implementation of the workplace HIV/AIDS program as the epidemic progresses.

Box 1 (continued):

- The organization will commission an impact assessment (including an assessment of the costs incurred as a result of the epidemics impacts to the organization) as it becomes needed in order to strategically plan the activities.
- The organization will regularly review employee benefits in the context of the impact of the epidemic.
- The organization will develop a skills succession plan as part of human resource development in the context of HIV/AIDS.
- The workplace program will be subject to regular monitoring and review. Data will be collected and analyzed for this purpose.
- Any amendments to the policy will be communicated to all employees.

2. Prevention
- Information and Education: access to comprehensive and on-going education programs including awareness activities and distribution of small media materials.
- Peer Education: the use of peer educators within areas of the workplace who will be trained and supported to disseminate information on HIV/AIDS.
- Barrier Methods: Free access to condoms for protection against STIs and HIV.
- HIV testing and counselling: in a confidential manner
- STI management
- Occupational exposure: addressing HIV/AIDS vulnerability among sexually active colleagues.

3. Care and Support
- Health Care: Although there is no cure for HIV infection, preventive health care and lifestyle adjustments (including dietary information) can significantly affect the quality and length of life for a person living with the virus. The organization should commit itself to offering all employees with affordable interventions and education relating to healthy lifestyles as part of their health services.
- Counselling: The organization should seek to provide access to counselling for infected and affected employees at workplace.
- Disclosure: When an employee is no longer able to perform his/her duties as a result of HIV disease, he/she is encouraged to inform his/her supervisor in a confidential manner.
- Protecting the rights of employees with HIV: Non-discriminating and the protection of the rights of employees with HIV/AIDS are necessary to create an environment for an effective non-discriminating Workplace HIV/AIDS Program. The organization will act decisively to prevent discrimination and to promote equal rights

common challenges and also, some positive experiences of working as an HIV/AIDS focal point at any level. A list of some challenges outlined by this group have been listed below to shed light on various inherent predicaments that need to be overcome in order to effectively mainstream HIV/AIDS into the workplace.

- Focal points and those around them have limited knowledge and experience of what is involved in the job, what the difference between mainstreaming and HIV/AIDS integration is, and how they should implement a mainstreamed response.
- Many focal points have described how they received a letter or formal request from a superior to take on the role HIV focal point but had very little support in establishing what was expected of them and how they

should go about mainstreaming HIV/AIDS into their sector/institution.
- In the majority of cases, the workload involved with mainstreaming HIV/AIDS was overbearing in addition to the existing workload of the focal points. Very few focal points shed any existing tasks to take on mainstreaming work. The implications of this are quite large since such mainstreaming tasks warrant proper attention, yet workers cannot fall behind in completing their designated duties at work. Such a dilemma came to light for government focal points, particularly concerned about spending too much time on HIV/AIDS related work, and neglecting their official post which could result in a risk of losing their job and all associated benefits (i.e. pension).
- Focal points have found it difficult to convince others within their department or ministry that mainstream-

ing HIV/AIDS is an important issue within the sector, especially when no training on how to address mainstreaming has been provided.

- HIV/AIDS focal points often had problems mobilizing funds for carrying out mainstreaming activities. Many focal points must also negotiate complicated and time-consuming bureaucratic processes to access money for HIV/AIDS related work. Often a program outside the confines of their sector holds the funds earmarked for HIV/AIDS mainstreaming work. This then requires separate reporting and monitoring systems, often directly to the donor providing funds.

4.8. Advice to managers supporting HIV/AIDS Focal Points

In an effort to provide some solutions to the above mentioned obstacles, we have therefore compiled some recommendations that sectors and focal points may take into consideration.

When appointing focal points, supervisors and managers must:

- Ensure that they are at a high enough level of superiority and in a strategic position to influence the core work of the sector; to mobilize attention and commitment of staff.

- Ensure that the focal point's job description is rewritten to include the new HIV/AIDS mainstreaming responsibilities, and to ensure that enough time is allowed within the focal point's existing workload to carry out the new mainstreaming responsibilities.
- Build strategic alliances in order to link mainstreaming objectives with other relevant organizations. For example, the development of strong ties with the national AIDS Secretariat (HAPCO) could assist in providing technical support (i.e. training of focal points on the concepts, and tools of HIV/AIDS mainstreaming, what mainstreaming means for their sector and what the role and responsibilities the focal point should be prepared to embrace.
- Define the reporting lines of the focal point. The focal point may effectively have two managers, one for their existing work and one for the HIV/AIDS mainstreaming work. The managers must decide how the system can be coordinated, so that unrealistic and conflicting demands are not placed on the focal point.
- Provide the focal point with the office and transport facilities necessary for them to carryout their mainstreaming work (i.e. trainings, workshops, etc).
- Consider the possibility of having a small fund which HIV/AIDS focal points could draw on as needed to carry out their mainstreaming work. Structures to limit abuse of such a system would also have to be thought thoroughly.

Box 3- Duties and Responsibilities of the Focal Person/Unit

- Identify the needs and properly formulate an HIV/AIDS program budget and get endorsed or approved by the highest executive management, as part of the overall plan of the respective organization.
- Assure corresponding activities are adequately designed for implementation at project or branch level as appropriate to the organization in question/program.
- Accelerate and ensure programs / projects are being efficiently implemented through suitable HIV/AIDS and related social and economic interventions.
- Monitor implementation of the planned activities within the scope of resources.
- Monitor whether or not there is effective communication between the organization and task force at all levels within the organization and other relevant sectors to share experiences and information in the control and prevention of the epidemic.
- Ensure whether mechanisms exist to facilitate this communication and sustainability of the program.
- Create conducive atmosphere for the participation of all individuals and units for joint management of HIV/AIDS prevention and care to ensure full interpretation of intervention.
- Solicit funding for the prevention and control programs.
- Represent the organization in all HIV/AIDS matters locally and abroad in their respective organizations.
- Be responsible for program execution, reporting and evaluation.
- Ensure that a mainstreaming guideline for internal organization functions is developed and disseminated to all involved in HIV/AIDS program.

4.9. Minimization of HIV/AIDS Impact on the functioning of people and the Organization

HIV/AIDS has an impact on every facet of an organization's functioning, over the short, medium and long term. It hampers the capacity of a given sector to achieve it core mandates through associated losses in manpower including the loss of experience and institutional memory.

This situation underpins the necessity to take urgent action to mitigate HIV/AIDS impacts and protect organizations from collapse. Therefore, instigating an urgent and a comprehensive response is vital at all level of organizations. This entails an instantaneous application of preventative and supportive efforts leading towards a sustainable improvement of management capacity to avert a consequent reduction in the ability of organizations to carry out their work effectively.

There are clear and strong linkages between prevention, care and support work with staff and work that can help to minimize the wider impacts on the functioning of the organization. Nevertheless, to *respond strategically to this challenge it is necessary to move beyond the continuum of awareness, prevention and care and frame a management approach that uses appropriate information* for decision-making. The objective should be to mitigate, at all levels, and in all organizations, through better management and focus on those issues that both drive and impede the regular course of action.

There are several measures which could be taken in this respect such as:

Impact due to loss of Staff: In response to the anticipated loss of staff due to sickness and death, it is recommended that the development of strategies to prolong the lives of people living with the virus and the provision of support to ensure that they can continue working for as long as they are able to be undertaken. This should include psychosocial and medical support not only to those infected, but also include their affected immediate families. To achieve this objective, the workplace policies should support a positive environment free from stigma and discrimination. There is also a need for curtailing bureaucratic delays in the provision of sickness and disability benefits so that morale is not infringed upon. The medical costs, if possible, should cover, expenses associated with up-to-date treatments, including ART, and counselling.

Impact on loss of institutional memory: A strategy should be devised to ensure institutional memory is passed from key staff to workers hired to replace those affected. This could be done through mentoring and coaching plans where staffs share skills, knowledge and experiences to one another so that the absence of one will not affect the activity of the organization. This program should not be targeted only to areas or particular works where people living with ADIS are engaged. It should be put into practice in a manner that does not infringe upon the confidentiality of an individuals HIV/AIDS status. An introduction of multi-skill programs to develop the skills of staff could help to deal with the difficulty related of the loss of staff. In addition, documentation of works and procedures should be adequately compiled. An appropriate record of procedures, track records of activities, proceedings, minutes, accounts, reports guidance, etc. of every action carried out by all staff is very important to ameliorate the impact due to loss of critical staff.

Impact associated with absenteeism: As the number of deaths of staff rises, there is an increase in the absence of staff to attend funeral ceremonies. This problem could be dealt with by openly discussing the issue at the workplace, and finding joint solutions that should be abided by all. Some of the subjects to be conversed on might be the formal arrangement of additional annual leaves to allow staff to attend funerals.

Ultimately, this Module has identified the workplace as an effective starting point to begin mainstreaming HIV and AIDS. The concept of mainstreaming begins with looking within a sector/institution and analyzing how it can better prepare for the impacts of HIV and AIDS within itself and eventually, on those sector/institutions that rely on its output. In order to effectively begin planning for the impacts of HIV and AIDS policies, strategies and programs need to effectively begin tackling the problem from within. Both assessment analyses and a revision of policies targeting the epidemic for staff should be undertaken. It is only when we begin analyzing "our" role in propagating the spread of HIV and changing our mentalities towards AIDS competence that changes towards HIV an AIDS mitigation will be realized.

ANNEX I

Examples of Checklists on sector specific applications of HIV/AIDS Mainstreaming

General to All sectors and organizations:
- Make analysis of policies, strategies and action in the sector/organization and identify opportunities and barriers for the response to HIV/AIDS. Identify ways of amending/revising them to create an enabling environment for the response.
- Compile information on number of workforce centrally and at peripheries
- Number of families/dependents of the workforce.
- Number of beneficiaries from the sector/organization's services
- Information on estimation of the number of people infected (using the appropriate tool) in the sector or organization.
- Information on the number of deaths of all causes in the workforce and family for the last __ years
- Information on the number of deaths related to HIV/AIDS – trend analysis of deaths and age distribution or extrapolation
- Information on sick leave and absenteeism – make trend analysis
- Translate the deaths, sick leaves and absenteeism in to productivity loss per specific time.
- Magnitude of the beneficiaries of the sector/organization infected/affected
- Conduct a quick KAP survey in the sector/organization addressing risks, prevention, stigma, care & support, treatment and impact.
- Revise and amend HIV/AIDS and Gender sensitive HR policy (in recruitment, maintenance, termination, etc.)
- Conduct SWOT analysis of the sector/organization
- Make analysis of the sector's/organization's works on HIV/AIDS so far to identify what is working and what is not working
- Adapt or revise HIV/AIDS workplace policy/strategy based on the above finding
- Apply rules for confidentiality at workplace for VCT and other supports.
- Allocating budgets and assigning responsible individual

or team towards HIV/AIDS interventions such as prevention, care, treatment, (i.e. covering costs of Medicare)
- Prepare sector specific mainstreaming guideline that details both the internal and external domains and is inline with the tools in the generic guideline.

For Education Sector:

Planning training of teachers:
- College workplace policy and strategy for HIV/AIDS that could help create low risk environment for college students, student – teacher interaction that addresses gender as a central issue
- Consider revising training curricula in colleges
- Consider death and attrition of teachers due to HIV/AIDS in deciding the number of admissions for training
- Prepare prospective teachers for the reality in the field prior to deployment
- Laws against sexual relationships between teachers and students

Planning construction of new schools:
- Sensitivity to site location of school construction – make sure that the location is not a risk for sexual violence against girls
- Designing the school building – make sure that locations of classrooms, toilets and other utilities are not a risk for sexual violence and also create temptation among students for consented sexual interaction.

In managing the school work environment
- Organize forum for girls to discuss issues related to abuses in the school environment
- Make/strengthen laws against teachers sexually harassing their students OR having sexual relationships with their students.
- Transparency in grading students and having rules for complaints –transparency in grading is the most frequent strategy that some teachers take unfair sexual advantage of schoolgirls.
- Organize psychosocial support to students affected (orphans, under stress and infected).

- Assess frequent absenteeism and dropouts due to HIV/AIDS and design strategy to address the special needs of affected students and mitigate dropouts. Disaggregate data on absenteeism and dropout by gender address accordingly.
- Consider contingency planning for the school so that the system can cope in dealing with absenteeism and dropouts.
- Organize AIDS awareness activities in the school environment
- Setup workplace interventions for teachers and students.

For Agricultural Sector:

Internal to the agricultural sector/ organizations: General to all +:
- Conduct analysis of the policy and strategy of the sector and ensure food security and other policies & strategies to be HIV/AIDS compliant. This would include a review of the current policies and strategies on their unintended effect on the spread of the infection.
- Conduct assessment of the magnitude how HIV/AIDS has impact impacted on the sector's/organization's workforce and capacity
- Transcribe the loss in labor to productivity
- Design/adapt a workplace policy at office and field level to address extension workers.
- Assess the magnitude of the effect on the beneficiaries of the sector.
- Production centered agricultural policies and strategies may have to be revised to not only accommodate changes in farming system, but in the supply of labour as a result of the demographic structure.

In addressing the beneficiaries:
- Conduct an assessment of the burden of the problem in the agricultural community and hence its effect on production and productivity.
- Assess production days spent from being sick, on caring of the sick, funerals related HIV/AIDS.
- Analyze the culture and gender relationships in the community that might predispose the agricultural community to infection.
- Analysis of the spending habit of the community (males) during high harvest seasons and cash crop production areas – sex work migration in Ethiopia is observed to be in its maximum to coffee and other cash crop location during harvesting seasons.
- Create a forum for dialogue and opportunities to farmers for saving and long-term investment as an option to spending on risky environment.
- Analysis of coping mechanisms at times of food crises – migration for labor and sex works to other areas (urban?) by both sexes.
- Analysis of the rural-urban relationship and the risk associated with it.
- Any labor immigration from other location – associated
- Investing on labor and power saving technologies for those affected
- High yielding and fast to harvest food products for elderly and child headed families.
- Include HIV/AIDS issues in the curricula of agricultural extension workers

For Health Sector:

Internal to the Health Sector (inclusive of clinics, hospitals, and ministry):
- Assessment of the resultant loss of skilled labour workers and a thorough analysis of staff vulnerabilities –attitudes, knowledge and awareness of the staff and appraising the risk situations exposing the staff to infection.
- Training of the health professionals on potential occupational exposure.
- Distribute guideline to ensure Universal Precautions for use of new single-use disposable injection equipment for all injections and single use of equipment OR strict sterility documented with Time, Steam and Temperature indicators in resource-limited conditions.
- Ensure Adherence to Universal Precautions through training and monitoring
  - Staff understanding of universal precautions - Healthcare personnel should assume that the blood and other body fluids from all patients are potentially infectious
  - Reduce unnecessary procedures
  - Make adequate supplies available
  - Adopt locally appropriate policies and guidelines
  - Preventing Occupational HIV Transmission to Healthcare Personnel
- Ensure the provision of Post Exposure Prophylaxis (PEP).

In addressing the demand:
- Contingency planning for HF visits and admissions to cope with increase in the number of cases due to opportunistic diseases.
- Additional budget for purchase of drugs and, medical supplies and equipments for additional burden and ensuring safety purposes in the workplace.
- Training and retraining of health professionals in dealing with the complex presentation opportunistic infection
- Increase in the number of health professionals trained to cope with the loss and absenteeism due to AIDS as well as increasing demand from the increase in the number of cases visiting HFs and care at home.
- Improving the capacity of HFs (additional rooms at OPDs and wards, and more beds in wards) to manage the increase service demand due to AIDS.

Further readings

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