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**Assessment of Effective Implementation of Internal HIV/AIDS Mainstreaming
The case of Finance and Economic Development Sector of the Southern
Nation, Nationalities and Peoples Regional State of Ethiopia**

**A research project submmited to Larensteien University of Applied sciences in
Partial Fulfilment of the Requirements for the Degree of Master of management of
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Acknowledgment

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Abbreviations

ACORD   Agency for Co-operation and Research Development

ART	Antiretroviral Therapy
BOFED	Bureau of Finance and Economic Development
BOH	Bureau of Health
BPR	Business Process Reengineering
CBO	Community-Based Organization
CSA	Central Statistical Agency
CSO	Civil Society Organizations
DHS	Demographic and Health Survey
EDHS	Ethiopian Demographic and Health Survey
EFY	Ethiopian Fiscal Year
FBO	Family-Based Organization
FGD	Focused Group Discussion
FHAPCO	Federal HIV and AIDS Prevention and Control Office
FHI	Family Health International
FEDS	Finance and Economic Development Sector
FMOH	Federal Ministry of Health
GTZ	German Technical Cooperation
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ILO	International Labor Organization
IMF	International Monetary Fund
KI	Key informant
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
NGOs	Nongovernmental Organizations
OVC	Orphaned and Vulnerable Children
PLWHA	People Living with HIV/AIDS
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PMTCT	Prevention of Mother-to-Child Transmission
SDC	Swiss Agency for Development and Cooperation
SNNPR	Southern Nations and Nationalities Peoples Region
SPM	Strategic Planning and Management
UCBP	University Capacity Building Program
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Abstract

Ethiopia is among the hardest hit countries of the world by HIV/AIDS catastrophe. Multi-sectoral Approach has been implemented as one of the national prevention strategies against the impacts of the pandemic in public, private sectors at all levels. However, HIV/AIDS issue is not yet seriously taken as a top priority development agenda. Hence, taking this implementation gap

into consideration, this study was conducted with the main objective to assess whether this HIV/AIDS mainstreaming has been effectively implemented or not in the Finance and Economic Development Sector (FEDS) of the Southern Nations and Nationalities Peoples Region (SNNPR), Ethiopia.

The survey conducted had an open and semi- structured questionnaire and a qualitative focus group discussion. A cluster sampling was employed, in which 13 zonal geographical clusters offices of the sector in the region were considered for the quantitative study. For the qualitative part of the study, purposive sampling technique, in which a focus group discussion composed of the regional bureau and 2 central zones officers were included.

Accordingly, in this survey 1 staff from the regional bureau and 13 from zonal (branch offices), a total of 14 HIV/AIDS mainstreaming officers, as well as 14 planning officers from respective offices with 2 key informants from regional health sector, which is a total of 30 respondents were involved for interviews. Furthermore, the survey was supported by one focus group discussion (a group of 12 participants) comprising relevant staff members from the regional bureau and from 2 central zonal offices (Sidama and Hawassa City Administration). The focus group discussion was composed of participants from Human resource, Gender mainstreaming, public relation and Monitoring and Evaluation secondary processes of the 3 respective offices of the sector.

The findings of this study had revealed that all of the 14 offices (100%) had HIV/AIDS mainstreaming focal persons that have a clear job description. In addition it was established that all of the sector offices, 14 (100%), were undertaking condom promotion and distribution activities. Similarly, the majority, 12 (86 %) of the sector offices were found promoting and advocating for their staff to receive the HIV VCT services so as to demand the necessary care and support if positive. However, despite the existence of care and support activities for HIV positive people and other vulnerable children in all study institutions, only limited, (a total of 13 HIV positive staff members and only 1 orphan), had received the aforementioned care and support in the sector offices. A finding which might indicate that still people do not want to disclose themselves as the level of stigma and descrimination is high.

Hence, this study concludes that the response of the FEDS in SNNPR through HIV/AIDS mainstreaming activities into their core–sector specific activities remained to be ineffective as only the activities indicated at the early implementation stage of the UNDP,2005 HIV/AIDS mainstreaming guideline, that could not move beyond stage-I of HIV/AIDS mainstreaming, were undertaken in almost all levels the sector offices. However, major activities in the guideline like AIDS risk analysis of sector workers, Impact analysis to assess the impact of AIDS on the sector, Actions to mitigate impact implemented, Analysis of sector policies, strategies and actions and reflection on these policies and interventions and the like were found to be untouched by any of the office found under the study sector. Taking the findings of this study as a baseline, continuous capacity building on the concept and details of HIV/AIDS mainstreaming and taking practical measures to enhance the top leadership commitment to implement all activities of HIV/AIDS mainstreaming were the major recommendations of this research.

CAPTER -1: INTRODUCTION

1.1 Research Background

HIV/AIDS has killed more than 28 million people worldwide since it was first recognized in 1981.Because of this it is one of the most destructive epidemics in recorded history (UNAIDS,2006). About 33.3 million [31.4 million–35.3 million] people living with HIV at the end of 2009 compared with 26.2 million [24.6 million–27.8 million] in 1999. Although the annual number of new HIV infections has been steadily declining since the late1990s, this decrease is offset by the reduction in AIDS-related deaths due to the significant scale up of antiretroviral therapy over the past few years. Sub-Saharan Africa has 10% of the HIV patient compared with the world's population. So, sub-Sahara region remains the hardest-hit, and is home to the majority, 22.4 million (67.2 %) of people living with HIV. In 2009 alone, an estimated 1.8 million people in this region became newly infected, while 1.3 million adults and children died of AIDS (UNAIDS, 2010).

Among the Sub-Saharan countries, Ethiopia is the second most populous country and the most seriously affected by the drastic effects of HIV/AIDS pandemic. The HIV epidemic has evolved in Ethiopia from two reported AIDS cases in 1986. The national prevalence rate of adult HIV infection is estimated to be 2.4 % in 2010.The epidemic is on the decline in major urban settings and stabilizing in rural areas, there is significant variation in the epidemic among geographic areas and population groups. The cumulative number of people living with HIV/AIDS was about 1.2 million, and which makes Ethiopia one of the countries that have the largest populations of HIV infected people in the world. There were about 90,311 HIV-positive pregnancies and an estimated 14,276 HIV positive births occurred in the year 2007 (FMOH and FHAPCO, 2010).

The SNNPR is one of the 11 regions in Ethiopia (SNNPR-BoH,2011).The HIV/AIDS situation in this region is characterized by an estimated adult HIV prevalence of 1.7%, (2.0% in female and 1.4% in males), with the urban and rural prevalence distribution of 6.9% and 0.8% respectively. The estimated number of people living with HIV was 169,700, of which 52,167 (30.7%) were estimated to be eligible for Anti-Retroviral Therapy (ART). HIV Positive pregnancies were estimated to be 14,692 and annual HIV positive births of 2,456. The annual AIDS deaths, HIV positive children under 15 years of age and the number of AIDS Orphans in this region were also estimated to be 3,908, 12,312 and 115,926 respectively (FMOH and FHAPCO (2007).

The major mode of HIV transmission in Ethiopia is heterosexual (sexual activities with persons of opposite sex), which accounts for 87% of infections. The second largest infections occur due to mother to child transmission which accounts 10%. Utilization of unsafe sharp and skin piercing instruments particular play a role in HIV transmission in the rural setting and accounts the remaining 3%. A number of underlying factors were identified to contribute to the spread of HIV/AIDS in Ethiopia. Some of them include Poverty, illiteracy, stigma and discrimination, high rate of unemployment, wide spread of commercial sex work, gender disparity, population movement including rural to urban migration and harmful traditional practices were among these factors (National AIDS Council, 2004).

Regarding to the response to the HIV/AIDS epidemic, the government of Ethiopia has taken different policy-related and programmatic measures. The multi-sectoral response to HIV/AIDS in Ethiopia is guided by the National HIV/AIDS Policy since 1998, the Strategic Plan for Intensifying Multi-sectoral HIV/AIDS Response, SPM I (2004- 2008); the Plan for Accelerated and Sustained Development to End Poverty, PASDEP (2007- 2010); the Road Map for accelerated access to HIV prevention, treatment and care in Ethiopia, (2007-2010); and the Plan of Action for Universal

Access to HIV prevention, treatment, care and support in Ethiopia, (2007-2010) and the current strategic plan, SPM II (2010/11- 2014/15) are some of the measures taken to the response (FMOH and FHAPCO, 2011). Furthermore, reversing the aforementioned catastrophic impacts and maintaining the prevalence of HIV/AIDS along with TB and Malaria is among the top priorities of the health sector agendas incorporated in the newly approved nation growth and transformation plan that will be implemented from 2010/11 – 2014/15 (FMOH, 2010).

Mainstreaming HIV/AIDS activities into sectoral policies and strategies was considered as the strategies mainly to protect employees of the respective sectoral institutions and their customers from the impacts of the pandemic. This strategy has begun implemented since the launching of the World Bank supported Ethiopian Multi-sectoral AIDS Project (EMSAP) in 2001 (HAPCO, 2005). However, there is no sector specific study has been conducted in the sectors in SNNPR whether the existing development sectors have been effectively implementing the HIV/AIDS mainstreaming strategy or not. Hence, this study was conducted with aim to assess and to fill the gap to the effective implementation of mainstreaming of HIV\AIDS in respect to FEDS of the SNNPR of Ethiopia.
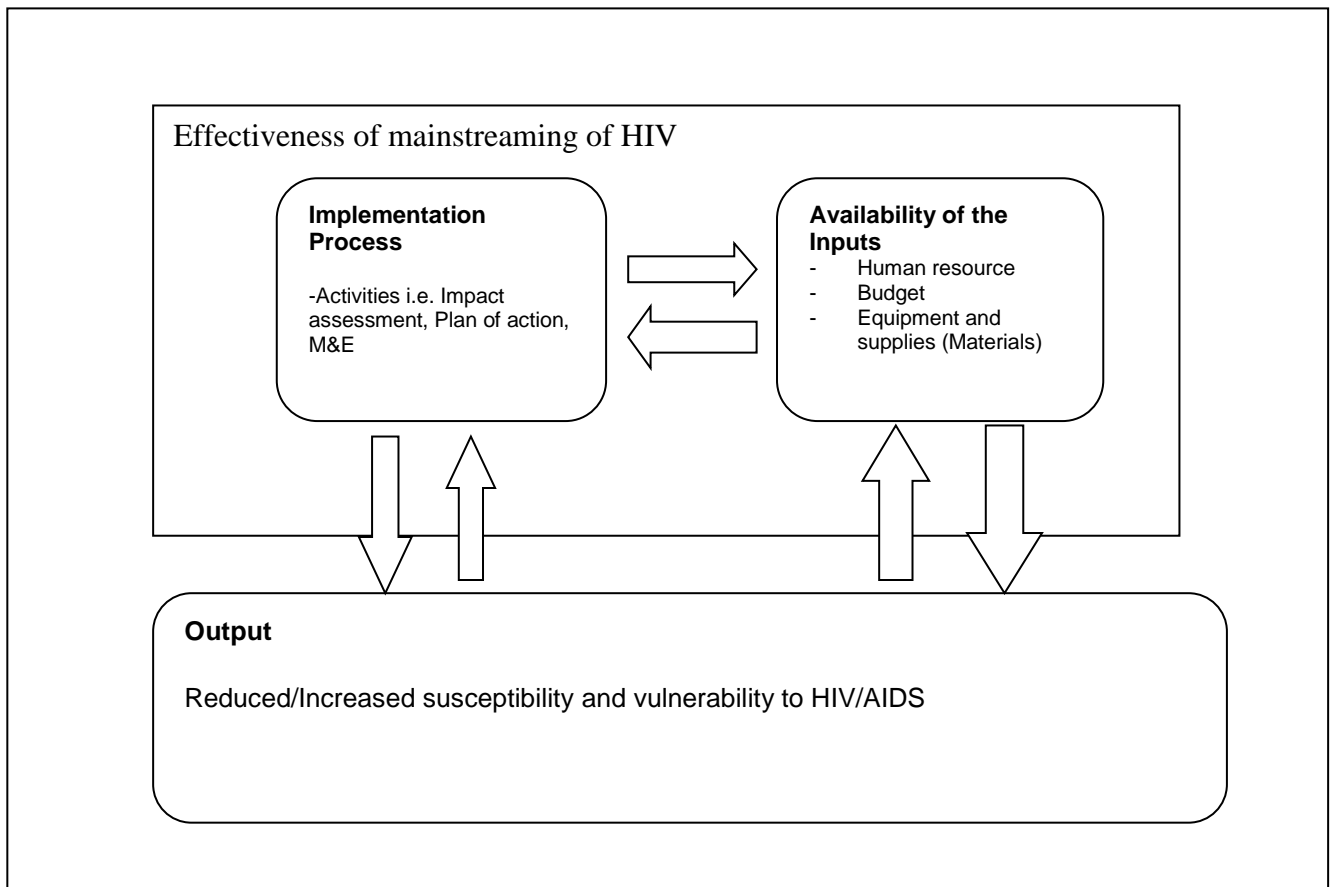

1.2. Problem statement

HIV/AIDS has been exerting its detrimental impacts in development sectors. HIV\AIDS affects persons in their productive age group in all sectors. Absenteeism from job , low productivity, slow progress of work, increased cost of medical care, funerals\High replacement costs, reduced profits, increase in workload, loss of unique skills, financial loss on premature deaths, privilege and insurance payments and so forth were some of those impacts of HIV/AIDS. It is widely expanded throughout the workplaces of all governmental and nongovernmental sectors in the country (FMOH and FHAPCO, 2007).

The government of Ethiopia has taken policy measure by incorporating HIV/AIDS mainstreaming as one of the national strategy. Every governmental and non-governmental sectors and institutions should include HIV/AIDS agenda into their mandate and major workplace policies. All sectors, be it government, non-government or community based organizations are required to implement HIV/AIDS mainstreaming as one of the social mobilization tools. They carried out at various levels along with their regular functions and mandate. This strategy is output oriented approach that requires sustainable implementation of HIV/AIDS prevention and control activities to mitigate and reverse the spread of the epidemic and its negative impacts.

Therefore, HIV/AIDS mainstreaming has been implemented particularly in most regional governmental sectors in SNNPR since 2005. The 2010\11 review of the SNNPR Regional Health Bureau annual performance report (SNNPR-RHB, 2011) disclosed that all the 41 (100%) regional and more than 3100 (out of the 3395 or 91%) zonal and district sectoral institutions had incorporated the HIV/AIDS mainstreaming activities in their strategic plan. However, the implementation status varies from sector to sector and from institution to institution. Moreover, the implementation has been criticized with the response was not strong enough with the gravity of the problem. The implementation often characterized by lack of capacity, collaboration, networking and sustainability with in different sectors and particularly across down structure of the sector offices. Inadequate mainstreaming was reported as one limitation of the implementation of SPM I (FMOH and FHAPCO 2011). Hence, particular focus on assessing the effective implementation of internal HIV/AIDS mainstreaming and the major factors driving and/or hindering this implementation in the FEDS of SNNPR was the whole purpose of this research.

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│  │ Effectiveness of mainstreaming of HIV                          │ │
│  │                                                                │ │
│  │  ┌──────────────────┐          ┌──────────────────────┐        │ │
│  │  │ Implementation   │   ───▶   │ Availability of the  │        │ │
│  │  │ Process          │   ◀───   │ Inputs               │        │ │
│  │  │                  │          │ -  Human resource    │        │ │
│  │  │ -Activities i.e. │          │ -  Budget            │        │ │
│  │  │ Impact           │          │ -  Equipment and     │        │ │
│  │  │ assessment, Plan │          │    supplies          │        │ │
│  │  │ of action, M&E   │          │    (Materials)       │        │ │
│  │  └──────────────────┘          └──────────────────────┘        │ │
│  └────────────────────────────────────────────────────────────────┘ │
│  ┌────────────────────────────────────────────────────────────────┐ │
│  │ Output                                                         │ │
│  │                                                                │ │
│  │ Reduced/Increased susceptibility and vulnerability to HIV/AIDS │ │
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Figure 1.1 Conceptual Frame work: The relationship between HIV/AIDS, internal mainstreaming of HIV/AIDS, implementation process, availability of the Inputs and out puts

1.3 Research objectives

1. Assess the effectiveness of internal HIV/AIDS mainstreaming implementation in FEDS.
2. Contribute for better HIV/AIDS mainstreaming in the sector in FEDS.

1.4 Main research question

How effective is the implementation of internal HIV/AIDS mainstreaming in FEDS?

1.5 Sub questions

A) What are the competencies of the HIV/AIDS mainstreaming officers with respect to their qualifications in undertaking internal mainstreaming of HIV/AIDS?

B) How is the quality of different inputs for mainstreaming of HIV\AIDS?

C) How efficient is the implementation activities of mainstreaming?

D) How the outcomes are related to the planned objectives?

E) What are the challenges and opportunities of HIV/AIDS mainstreaming?

1.6 Scope of the research

The scope of this study is limited only to regional and zonal levels of one sector of the region. That is FEDS of SNNPR. However, the district level offices of the sector were not the part of this research.

1.7 Limitation of the research

In order to make the research manageable with time and research budget, the implementation of external HIV\AIDS mainstreaming was beyond this research. Unavailability of related literatures and studies in the area of HIV/AIDS mainstreaming has made the substantiation and comparison of the finding difficult.

CAPTER- 2: LITRATURE REVIEW

The notion that states "HIV/AIDS is not only a public health issue but also it is a workplace issue, a development challenges of different countries (FHI, 2002). Today AIDS is showing a dramatic impact on different sectors, as education, transport, health, agriculture, economic and many others. Whether HIV/AIDS is a problem of the health sector or a multi-sectoral problem is not only a fashionable academic question. It determines what budgets are made available and which sectors and human resources get involved in the fight and allows addressing root causes of the epidemic as the most important factor of poverty (Bodiang, 2000). This has been shown that there is increasing pressure for development sectors to play significant role in developing an 'AIDS-competent' society. So that everyone is able to assess and make decisions about factors related to the causes and consequences of HIV/AIDS, to generate the means and mobilize the resources to respond to HIV/AIDS. Mainstreaming HIV/AIDS into the core business of development has been seen as an important part of the process of achieving this vision of society. It has also been shown that mainstreaming HIV\AIDS into national development pro-cesses remains a key approach to addressing both the direct and indirect causes of the growing epidemic (ACORD, 2005;UNAIDS, 2004).This enables a multi-sectral and multi-stakeholder response. Furthermore, comparative advantages are obtained from mainstreaming of HIV prevention and AIDS care information and services into sectors that deal with religion, workplaces, sports and the media to address the young people. Before its application for HIV/AIDS, it is learnt that the concept of ' mainstreaming ' appears to have originated in the late 1960s to 1970s (UNAIDS, 2004). So far different definitions have been delivered by different scholars or organizations. For instance, UNAIDS (2005) has proposed the following working definition of mainstreaming AIDS:

"Mainstreaming HIV\AIDS is a process that enables development actors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplace" (UNAIDS,2005).More or less similar definition was give by the Swiss Agency for Development and Cooperation, as follows

"Mainstreaming HIV/AIDS means realizing that we all work in a context more or less affected by the HIV/AIDS epidemic and analyzing whether consequently we need to adapt our activities to this reality. It means thinking differently, wearing AIDS glasses while working in all sectors and at all levels" (SDC, 2005).

It is also clearly shown that mainstreaming is essentially a process whereby a sector analyses how HIV\AIDS can impact the sector at present and in the future. It also considers how sectoral policies, decisions and actions might influence the longer-term development of the epidemic and the sector. Another working definition of HIV\AIDS mainstreaming is developed by HIV/AIDS Mainstreaming Working Group (2002).

> *"Mainstreaming HIV/AIDS can be defined as the process of analyzing how HIV\ AIDS impacts 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 definition of mainstreaming has been reflected by UNDP (2005) and suggests that mainstreaming should be the response to the following questions:

(i)   What is the impact of HIV\AIDS and gender on development? What policies, strategies and actions do we need to put in place to minimize adverse 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? What policies, strategies and actions should be put in place to enhance these positive impacts?

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

Similarly, the concept, the rationale and the overall principles of mainstreaming was also discussed by the IDS Health and Development Information Team in such a way that;

"As the global HIV/AIDS pandemic has expanded beyond high risk groups of the population, it has become widely recognized that sectors outside of health need to be involved in responding to the disease. Mainstreaming is defined as the process of analyzing the impact that HIV/AIDS has, and will have, on all sectors. The aim of mainstreaming is to reduce the unintentional, and sometimes negative, effects of development work on HIV and to ensure that all activities contribute to reducing the impact of HIV/AIDS" (IDS Health and Development Information Team, 2008).

In addition, what mainstreaming is not was well explained in this ACORD (2005) training guideline as follow
"It is NOT simply providing support for a Health Ministry's program.
It is NOT trying to take over specialist health-related functions.
It is NOT changing core functions and responsibilities (instead it is viewing them from a different perspective and refocusing them).
It is NOT business as usual – some things must change". (ACORD, 2005)
On top of theoretical approach, there is increasing pressure for development sectors to play significant role in developing an 'AIDS-competent' society. This helps for everyone to assess and make decisions about factors related to the causes and consequences of HIV/AIDS, generate the means and mobilize the resources to respond to HIV/AIDS. Mainstreaming HIV/AIDS into the core business of development has been shown as an important part of the process of achieving this vision of society. It has also been revealed that mainstreaming HIV\AIDS into the national development processes remains a key approach to addressing both the direct and indirect causes of the growing epidemic which enables a multi-sectoral and multi-stakeholder response. Different classifications of mainstreaming of HIV/AIDS have been shown by different disciplines. Mainstreaming is typically classified using two major sets of categories, namely internal and external mainstreaming. Based on the stage of implementations, HIV/AIDS mainstreaming activities ranging from 0 to IV, The internal mainstreaming/workplace intervention involves measuring and predicting the impacts of HIV/AIDS specifically within the internal workplace, which involves activities to reduce vulnerabilities and risks to HIV infection and providing care and support for all staff (UNDP, 2005). According to the Agency for Co-operation and Research Development internal mainstreaming is explained as follow;

"Internal mainstreaming: refers to changing organizational policy and practice to reduce the organization's susceptibility to HIV infection and its vulnerability to the pandemic's impact" (Sue, 2003).
Various activities have been developed to address the organization's internal or workplace environment. These activities mostly consist of preventive education, treatment, care and support. However, this research considers the NUDP 2005 HIV\AIDS mainstreaming implementation guide for national responses, and with some adaptation the following five stages

of implementation of HIV\AIDS mainstreaming could be applicable to the case of FEDS of the SNNPR of Ethiopia.

Table 2.1 Stages of Implementation of HIV/AIDS Mainstreaming

No	Stage	Activities to be done/Indicators
1	0	The sector has not yet started HIV/AIDS mainstreaming.
2	I	1. The sector has made HIV/AIDS risk analysis of sector workers.
		2. Focal point persons designated.
		3. Financial resources made available.
		4. Condom promotion is practical.
3	II	1. Components in stage one have been implemented.
		2. The impact of HIV/AIDS on the sector has been analyzed.
		3. Strategies, plans and programs have been revised in light of HIV/AIDS.
		4. Actions to mitigate impacts of HIV/AIDS on the sector have been implemented.
4	III	1. All components in stage II have been practiced.
		2. Analysis of the impact of sector's policies, strategies programs and plans on the community has been made.
		3. Actions have been taken to determine the negative or positive influence on the spread of HIV/AIDS in the community they serve.
		4. Implement change to ensure that positive actions are maintained.
		5. Implement change to end negative actions.
		6. Develop and implement monitoring and evaluation Frame work.
5	IV	It incorporates: 1) Components in stage III
		2) In corporate lessons learned in to sector policies, strategies & actions.

Adopted from UNDP (2005)

In aforementioned five stages of HIV/AIDS mainstreaming, the sector needs to have made HIV/AIDS risk analysis of sector workers, designation of the HIV/AIDS focal point persons, allocation of the necessary financial resources for HIV/AIDS prevention and control activities, promotion and distribution of condom, analysis of the impact of HIV/AIDS on the sector, revision of the sector Strategies, plans and programs in light of HIV/AIDS, implementation of actions to reduce impacts of HIV/AIDS on the   sector, analysis of the impact of sector's policies, strategies programs and plans on the community, taking actions to determine the negative or positive influence on the spread of HIV/AIDS in the community they serve, taking action to maintain the positive actions, implementation of change to end negative actions, development and implementation of monitoring and evaluation frame work and incorporation of lessons learned in to sector policies, strategies and actions (UNDP, 2005).

Furthermore, the sector is required to design a clear HIV/AIDS workplace policy as part of the internal mainstreaming (UNDP, 2005), as it was well explained by SAFAIDS in such a way that;

> *"An HIV\AIDS work place policy is a written statement that defines an organization's position and practice for preventing the transmission of HIV\AIDS as well as handling cases of HIV infection among employees. It provides guidelines on managing employees who are infected and affected by HIV\ AIDS" (SAFAIDS, 2000).*

The seriousness of HIV/AIDS was recognized and so that it had been implementing workplace intervention in order to respond effectively to the negative impacts of the pandemic (EAC, 2008). It was witnessed that the EAC has resolved to enhance the capacity of its employees in internalizing the risk and impact of the infection to themselves and their families to provide them with the requisite skills for self awareness and protection. In this guideline, it was stated that the EAC workplace policy is intended to guide and to provide policy direction to management and all employees on how to deal with internal mainstreaming of HIV\AIDS and provides priority strategies that should be implemented to contain the situation. Arranging the HIV counseling and testing services is expected to be integrated into existing health and social welfare services and promoted in all settings: government, non-governmental, private sector, cooperatives, workplace, faith-based organizations etc (FMOH and FHAPCO, 2007).

Many companies in different countries have comprehensive HIV/AIDS policies and prevention and care programs that includes; Information on HIV/AIDS, ways of preventing transmission, places to seek further information and services and ongoing company and union support for responsible sexual behavior; Condom distribution at readily accessible points around the workplace; STI diagnosis and treatment, whether within the company, in community clinics or in other centers where employees receive healthcare; Treatment for HIV and associated diseases, such as tuberculosis; counseling and testing for HIV on a voluntary and private basis, with means to provide support for employees and/or family members who are HIV-positive; Mitigation services designed to provide such follow-up activities as counseling, community support and home-based care (FHI,2002).

So far several efforts have been made to combat the overall impacts of the epidemic in Ethiopia since the appearance of the first cases of HIV in 1984. As the first national response, the country first established a National Task Force on HIV in 1985 and designed and implemented two medium-term prevention and control plans between 1987 and 1996. The activities which had been carried out were those related to information, education and communication (IEC), behavior change and communication (BCC), condom promotion, HIV surveillance, patient care and expansion of HIV screening laboratories in different health institutions. However, the response obtained from different countries and institutions was not equivalent to the catastrophe of the pandemic. A survey of 2003, in 63 countries have found that all respondents reported key sectors had started mainstreaming, but only 13% had actually made progress in implementing sectoral plans (UNAIDS, 2004).

Mainstreaming HIV/AIDS externally refers to adapting development and humanitarian program work in order to take susceptibility to HIV transmission and vulnerability to the impacts of AIDS into account. The focus is on core program work in the changing context of HIV/AIDS. For example, an agricultural project which is tuned to the needs of vulnerable households in an AIDS affected community. Various consequences of HIV/AIDS on the organizational capacity of different companies and sectoral institutions have been documented starting from the emergence of the pandemic in this world. The study conducted by Oxfam (2001) in Mulanje district of Malawi stated that, the existence of absenteeism, lower productivity, vacant posts, high

cost and overloading of others were the main findings of this study; The situation that the internal response on mainstreaming is predominantly AIDS work, not mainstreaming and Challenge for improving internal policies. These appear to be difficult for most managers at district level. For the better understanding of the bi-directional impact between the HIV/AIDS epidemic, the sectoral system should be made clear first before implementation of the whole package of sectoral mainstreaming of HIV/AIDS (UNDP, 2005).

CHAPTER- 3: RESEARCH AREA AND RESEARCH METHODOLOGY

3.1 Research Area

Ethiopia is located in the eastern horn of Africa with a total surface area of 1.1 million square kilometers. The country is bounded on the northeast by Eritrea and Djibouti, on the east and southeast by Somalia, on the southwest by Kenya, and on the west and northwest by Sudan. Addis Ababa is Ethiopia's capital city. It has a projected population of 81.9 million for 2011, with about 84% living in rural areas. Administrative boundaries are composed of nine regional states, two city administrations and around 800 woredas (districts).The woredas are the basic units of planning and political administration. Below the districts there are approximately 15,000 village associations and urban neighborhood associations known as Kebeles (Population and Housing Census, 2007).

The SNNPR is one of the 9 regions and 2 city administrations in Ethiopia, and located in the southern and south western parts of the country. The region encompasses an area of 118,000 Sq.kms and represents about 10 percent of Ethiopia's land mass. It borders Kenya to the south, Sudan to the south west, Gambella regional state to the west and Oromia regional state to the north and northeast of Ethiopia. Administratively the region is divided in to 15 zones, 4 special woredas/districts, 135 woredas, 22 town administrations, and 3553 rural kebeles (The smallest geopolitical structure in Ethiopia) and 324 urban kebeles (Population Census Commission,2008).The current population of the region is estimated to be 17.2 million and accounts for approximately 20 % of Ethiopia's total population. It is one of the least urbanized regions in the country so that only an estimated 9 % of the population lives in urban areas. In addition, The SNNPR is a unique region of considerable ethnic diversity, harboring more than 2/3 of the country's ethnic compositions. By the current estimate more than 56 ethnic and cultural groups, each with its own linguistic and socio-cultural identity reside in this region.
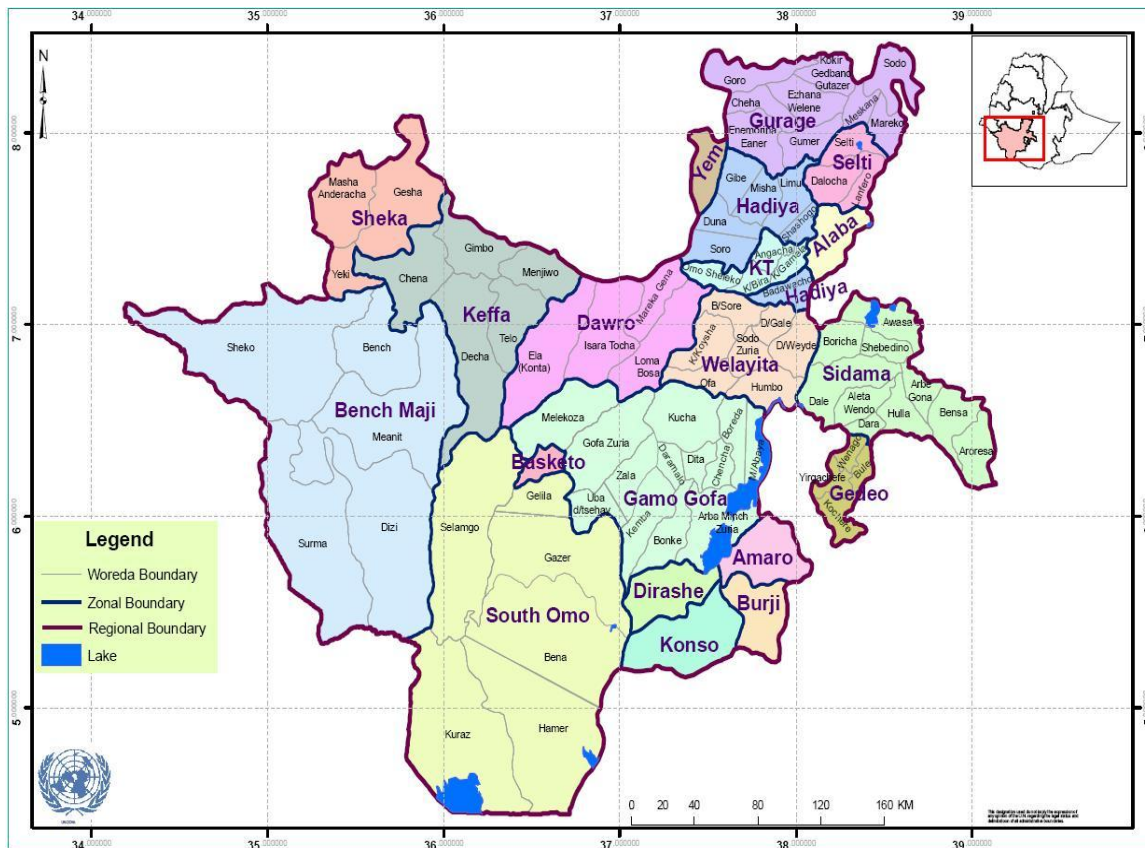
Figure 3.1: Map of Southern Ethiopia (BoFED,2009).

There are various developmental sectors operating at each respective geo-political structure (Region, Zone, Woreda/District and Kebele) in the region. These sectors can broadly be categorized into two; governmental sectors and non-governmental sectors (bi and Multi lateral donors and creditors, the community based organizations, private sectors/Investors and perhaps others).

The FEDS in SNNPR is one of the government sector in the region that has been established since 2001 by integration of the two giant regional bureaus namely, Bureau of Finance and Bureau of Planning and Economic Development. Then after, it went through several incremental transformational changes to meet its mission. The last radical transformation was implemented in 2008 due to the national transformation program of Business Process Reengineering (BoFED, 2009). As a result of this new design, the mission of the sector is to create a system that will enable the efficient use of resources, to take part in the economic policy reform by creating an efficient assets and financial management system and to strengthen the regional income by utilising research studies and information for developing the region**.** The vision is to see the living standards of the people improved, by creating a transparent, accountable financial and administrative planning system based on modern technology, and which can be seen as a role model for other institutions. The strategy is to increase the income of government by 100%, and to improve the monitoring and evaluation activities on governmental and non-governmental sectors and financial management system of the region (BoFED, 2009).

3.2. Research Methodology

The sector has been implementing HIV/AIDS mainstreaming in work place as one of the national social mobilization tools. Mainstreaming of HIV\AIDS carried out at various levels\offices along with the regular functions of the sector since 2005.The fact that the implementation status varies from offices to offices within the sector.The fact that, there was lack of base-line data in HIV/AIDS mainstreaming implementation status in the study area. Therefore, for this research triangulation approach was employed for better understanding of the implementation of internal HIV/AIDS mainstreaming in this particular area. Hence,1 from the regional bureau and 13 from zonal (branch offices), a total of 14 HIV\AIDS mainstreaming officers, as well as 14 planning officers from respective offices, and with 2 key informants from regional health sector, which is a total of 30 respondents were involved for interviews. Furthermore, the survey was supported by 1 focus group discussion (a group of 12 participants) comprising relevant staff members from the regional bureau and from 2 additional zonal offices (Sidama and Hawassa City Administration) of Finance and Economic Development Sector. The focus group discussion was primarily composed of participants from Human resource, Gender mainstreaming, public relation and monitoring and evaluation secondary processes of the 3 respective offices of the sector.

Effective implementation of HIV/AIDS mainstreaming can relatively be determined by examining the extent of the process of the implementation of mainstreaming within the sector. As a result, the existing national HIV/AIDS policy and HIV/AIDS mainstreaming guideline was referred in order to design the data collection instruments\tools so as to sort out the relevant indicators during assessing whether there is effective implementation of Internal HIV/AIDS mainstreaming in FEDS of SNNPR or not. Therefore, the semi-structured questionnaire was prepared for assessment. Accordingly, it consists of questions that help to assess the socio-demographic characteristics of the respondents/ mainstreaming officers, whether there has been the inclusion of the HIV/AIDS mainstreaming activities in the sector strategic and specific annual operational plans, The approach and status of implementation, monitoring and evaluating HIV/AIDS mainstreaming activities, the existence and implementation of HIV/AIDS workplace policy, and the factors that hinder effective implementation of HIV/AIDS mainstreaming in the sector

The data collection was undertaken after an official contact made with the head of the regional Bureau to get permission and support for the study to be conducted among the regional bureau and the respective line zonal offices. The data collection for the quantitative part of the research was done by using the HIV/AIDS mainstreaming officers /focal persons. Whereas the focus group discussion was undertaken with a facilitator (selected from the group). The overall procedure of the data collection was coordinated by the researcher. Data editing, coding and verification were done using table by categorizing in to different topics with frequency. Proportions mainly were compiled for each indicator and for the qualitative part of the study.

CHAPTER– 4: RESEARCH FINDINGS

Among the 15 selected offices for this study, completed questionnaire was obtained from 14 offices (13 zonal and 1 regional) of FEDS. This made the response rate of the study 93.3%. The data collected from the survey, FGD and KI was analyzed accordingly and the following are the findings and the discussion of the findings.

4.1. Existence of   Focal Person for HIV/AIDS mainstreaming

The finding from the focus group discussion indicated that the term HIV/AIDS mainstreaming is well understood that it is the process of making the issue among the core agendas of the sector institution. However, the participants said that it is differently conceptualized by different workers/staff of the study sector. The study intended to find out whether the different levels of the sector had Focal persons (HIV\AIDS mainstreaming officers) to run the day to day internal HIV/AIDS mainstreaming activities in the respective office. It is explained that all of the 14 offices (100%) had focal persons. most, 9 (64%), were female and 8 (57%) have diploma education level respectively. With regard to the type of assignment and work experience of the focal person, it was found that the vast majority, 13 (93%) of them were permanently assigned and most of them, 8 (57 %) had below 2 years service on HIV/AIDS interventions.

In addition, this study has shown that all of the HIV/AIDS mainstreaming focal persons (100%) had a clear job description that shows their roles and responsibilities, most of them, 11 (79%), were trained on HIV/AIDS mainstreaming activities and all of them, except one (93%), were moderately authorized or empowered for decision making on issues of HIV/AIDS prevention and control interventions was when deemed necessary.

Table 4.1: Indicators to assess the profile of Focal Person

Indicator	Characteristics	Frequency	Percent (%)
Existence of HIV/AIDS focal Person	Present	14	100.0
	Absent	0	0.0
	Total	14	100.0
Educational Status of HIV/AIDS focal Person	Diploma Level	8	57.1
	First Degree Level	6	42.9
	Total	14	100.0
Type of assignment of HIV/AIDS focal Person	Temporary	1	7.1
	Permanent	13	92.9
	Total	14	100.0
Existence of Job description for the focal person	Yes	14	100.0
	No	0	0.0
	Total	14	100.0
Whether the focal person was trained on HIV/AIDS mainstreaming	Yes	13	78.6
	No	1	21.4
	Total	14	100.0
Authorization status of the focal person for decision making	Less authorized	1	7.1
	Moderately authorized	13	92.9
	Highly authorized	0	0.0
	Total	14	100.0
Gender of HIV/AIDS focal Person	Male	5	35.7
	Female	9	64.3
	total	14	100.0

4.2. Commitment of top leadership in HIV/AIDS mainstreaming planning

In the attempt done to identify the extent of the top leadership commitment in considering the issue of HIV/AIDS mainstreaming into the sector's agenda, it was found that all the 14 (100%) offices of the FEDS had incorporated the internal HIV/AIDS mainstreaming interventions in their five year (2010/11 to 2014/15) strategic plan as well as annual (2010/11) operational plan and. However, the finding from the focus group discussion revealed that there were limitations in effectively implementing the HIV/AIDS mainstreaming activities as per the plan.

In the attempt done to assess whether the study offices had workplace HIV/AIDS intervention guideline or not and whether the offices had allocate budget or not, it was learnt that the vast majority, 13 (93%), of them explained that they had the workplace HIV/AIDS guideline, Furthermore, it was established that all zonal and regional Bureau had allocated the minimum 2% of the annual sectoral budget and the top leadership in all the 14 (100%) study offices were practically supporting the implementation of the internal HIV/AIDS mainstreaming interventions being undertaken in their respective offices.

However, from FGD none of the offices develop sector specific work place HIV\AIDS guideline and the 2% budget was in adequate to implement the activities planned.

Table-4.2: Indicators to assess the commitment of the top leadership in planned activities

Indicator	Characteristics	Frequency	Percent (%)
If HIV/AIDS is included in the 5-year strategic plan	Yes	14	100.0
	No	0	0.0
	Total	14	100.0
If HIV/AIDS is included in the 2003 EFY annual Plan	Yes	14	100.0
	No	0	0.0
	Total	14	100.0
If HIV/AIDS prevention and control activity incorporated in this year plan	Yes	14	100.0
	No	0	0.0
	Total	14	100.0
If the office has workplace HIV/AIDS intervention guideline	Yes	13	92.9
	No	1	7.1
	Total	14	100.0
If 2% budget allocated for HIV/AIDS mainstreaming	Yes	14	100.0
	No	0	0.0
	Total	14	100.0

The finding of this study also revealed that 91 to 100% of the work force in 12 (86%) of the study offices were contributing the required 0.5% AIDS fund from their own monthly salary for the care and support of HIV/AIDS positive people and orphans and other vulnerable children of the staff member of the sector office. The proportion of the staff members contributing 0.5% of one's monthly salary to the aforementioned AIDS Fund in the remaining 2 sector offices were found to be 25 to 50% in one of and 50 to 75% in the other sector offices respectively.

In an attempt made to identify wether there is additional external support given to each levels of offices of the FEDS to support their efforts of HIV/AIDS mainstreaming, it was learnt from the key informant that are from the regional Health Bureau, Multi-sectoral HIV/AIDS prevention and control office that each level of the sector office had contineously been supported with financial, technical and material (supplies like condom, different Information education and communication materials and so forth) support to their efforts on their sector.

In assessing wether each level of the regional FEDS was providing care and support services for PLWHAS and OVCs from the already collected 0.5% AIDS Fund or not, It was revealed that,7 (50%) of the study offices were providing the care and support services for HIV positive staff members. As a result, a total of 13 HIV positive staff members had received the aforementioned care and support AIDS Fund. In the contrary, only 1 (7%), of the sector offices(regional office) was providing the care and support for OVCs. As a result, a total of 2 OVCs that lost their families had received care and support from the aforementioned one sector office.

Table -4.3: Indicators to assess the commitment of the top leadership in support

Indicator	Characteristics	Frequency	Percent (%)
If there is any support from top leadership	Yes	14	100.0
	No	0	0.0
	Total	14	100.0
Proportion of staff contributing to the 0.5% AIDS Fund from own monthly salary	25 to 50%	1	7.1
	75 to 90%	1	7.1
	91 to 100%	12	85.7
	Total	14	100.0
If the office is providing care and support for people living with HIV/AIDS	Yes	7	50.0
	No	7	50.0
	Total	14	100.0
Number of PLWHAs that received care and support service in the last 2003 EFY	0	7	50.0
	1	3	21.4
	2	3	21.4
	10	1	7.1
If the office is providing care and support services for orphans and other vulnerable children	Yes	1	7.1
	No	13	92.9
	Total	14	100.0
Number of OVCs that received care and support service in the last 2003EFY	0	13	92.9
	2	1	7.1
	Total	14	100.0

4.3. Monitoring and Evaluation of HIV/AIDS mainstreaming

Similarly, it was seen that all 14 (100%) of the sector offices used to monitor and evaluate their internal HIV/AIDS mainstreaming performances, from which the majority, 9 (64%), monitor and evaluate their performances in a quarterly basis. However, the majority of participants from the FGD had reported that the monitoring and evaluation system is not yet strong. Analysis has been made to see whether the office assed the impact of HIV/AIDS or not and the finding shows that none of the offices made impact assessment at sector level. Inclusion of lessons learned is important to improve the weakness and focus on the strong points for future implementation, inline to this incorporation of lessons learned had been asked. The result showed that none of the offices incorporated the lessons learned into their strategies. Similarly, none of the offices has revised their strategic plan.

Table – 4.4: Indicators to assess monitoring and evaluation of the implementation

Indicators	Characteristics	Frequency	Percent (%)
If the office assessed the impact of HIV/AIDS on the sector office	Yes	0	0
	No	14	100
	Total	14	100.0
If the lesson learned incorporate into the sector policies, strategies and actions	Yes	0	0
	No	14	100
	Total	14	100.0
If the strategic plan have been revised in light of HIV/AIDS impact	Yes	0	0
	No	14	100.0
	Total	14	100.0
	Total	14	100.0
If the performance is monitored & evaluated	Yes	14	100.0
	No	0	0.0
	Total	14	100.0
Frequency of monitoring & evaluation of performance	Every month	3	21.4
	Quarterly	9	64.3
	Every 6 month	2	14.3
	Total	14	100.0

In addition, findings from the FGD is indicated that, lack of uniform understanding of the councept of HIV/AIDS mainstreaming among the workforces, the knowledge and skill of the focal person for mainstreaming, the level of commitment of the top leadership of the sector office and availability of clear sector specific implemetation guidelines were the factors which hinder effective implementation of internal HIV/AIDS mainstreaming.

4.4. Major activities undertaken for HIV/AIDS prevention

The other area of concern on which the research question to be answered was, the identification of whether the zonal offices and the regional bureau of the FEDS were carrying out condom promotion, distribution and advocacy activities or not. Consequently, it was revealed that all of them, 14 (100%), were undertaking condom promotion and advocacy activities. Similarly, all of them, 14 (100%), were distributing the condom for their staffs and customers in a continuous supply. With regard to the continuous availability of condom in these respective offices, this

study have shown that condom is usually freely available in the vast majority, 13 (93%), of the study offices for free pick by the staffs and customers.

Table – 4.5: Indicators to asses HIV/AIDS prevention

Indicator	Characteristics	Frequency	Percent (%)
If the office promote & advocate for condom use	Yes	14	100.0
	No	0	0.0
	Total	14	100.0
If the sector distribute condom for the staff	Yes	14	100.0
	No	0	0.0
	Total	14	100.0
Frequency of condom distribution for the staff	Rarely	1	7.1
	Usually	13	92.9
	Total	14	100.0
If awareness raising discussion is conducted in a regular basis	Yes	14	100.0
	No	0	0.0
	Total	14	100.0
Frequency of awareness raising program conducted	Monthly	7	50.0
	Quarterly	4	28.6
	Annually	3	21.4
	Total	14	100.0
If the office is promoting voluntary HIV counseling and testing for the staff	Yes	12	85.7
	No	2	14.3
	Total	14	100.0
How many times the VCT service is arranged for the staff in 2003EFY	None	3	21.4
	Once	2	14.3
	Twice	6	42.9
	Three Times	2	14.3
	Four Times	1	7.1
	Total	14	100.0
Estimated Proportion of staff that received VCT	None	3	21.4

Table – 4.5: Indicators to asses HIV/AIDS prevention

Indicator	Characteristics	Frequency	Percent (%)
If the office promote & advocate for condom use service	Yes	14	100.0
	No	0	0.0
	Less than 25%	3	21.4
	25 to 50%	6	42.9
	50 to 75%	1	7.1

This study also revealed that all the 14, (100%), sector offices used to conduct awareness raising discussions on HIV/AIDS on regular basis and these discussions are mainly done on monthly basis in half, (50%) of the study offices, followed by in quarterly basis in 4, (29%), of the study offices. The average number of people participated in each awareness rising session was 50, with the minimum 35 and maximum 80.

The study also indicated that the majority, 12 (86 %) of the sector offices were promoting and advocating for their staff to receive HIV VCT services so as to provide the necessary care and support if their status is positive. Accordingly, 6 (43%) of the offices had arranged this VCT service twice in the past fiscal year. In the contrary, 3 (21%) of them had arranged none in that fiscal year. With regard to the service uptake of this VCT service, which was arranged in collaboration with the regional health bureau, 25 to 50% of the staff had received the service in 6, (43%) of the study offices. In the contrary, none of the staff had received the VCT service in 3, (21%) of the sector offices as the service was not arranged for them.

CAPTER– 5: DISCUSSION

The finding from the focus group discussion has indicated that the term HIV/AIDS mainstreaming is well understood theoretically. It is the process of making the issue among the core agendas of the sector. Furthermore, they explained that it is poorly conceptualized by the majority of the workforces of the study sector.

The fact that all of the offices had assigned focal persons that run the day to day internal HIV/AIDS mainstreaming activities in their respective offices is a good indicator that if these officers are well coordinated and empowered, they are able to mainstream HIV/AIDS according to the guideline of the UNDP. However, since most of these focal persons, were less experienced (had below 2 years service) on HIV/AIDS related interventions, they were not well trained. Hence, system should be designed to capacitate the focal persons. Furthermore, networking and collaboration from different institutions approach is not well established for better use of expertise knowledge.

The indication of the finding with respect to the implementation of major areas of HIV/AIDS mainstreaming intervention like the provision of awareness raising activities, assignment of HIV/AIDS focal persons, advocacy and promotion as well as distribution of condom for staff, contribution of the 0.5% AIDS Fund for care and support of PLWHIV and OVCs and so forth is in line with the second national strategic plan. The second national strategic plan (FMOH, FHAPCO 2011) and regional health bureau annual performance report (SNNPR-RHB, 2011) which disclosed that all the 41 (100%) and more than 3100 out of the 3395 (91%) zonal and district sectoral institutions had been implementing the aforementioned activities in the respective institutions.

With regard to top leadership commitment, this study revealed that all, 14(100%), sector offices under the regional FEDS had allocated the necessary financial resources (2% from the annual budget) for HIV/AIDS intervention, incorporated the HIV/AIDS prevention and control activities in

the current strategic and annual work plan and were supporting the overall implementation of mainstreaming activities. Similarly, these findings of the survey were in agreement with the second national strategic plan (FMOH, FHAPCO 2011) and the regional health bureau annual performance report (SNNPR-RHB, 2011) which disclosed that all the 41 (100%) and 3100 out of the 3395 (91%) zonal and district sectoral institutions had incorporated the HIV/AIDS mainstreaming activities in their strategic and annual operational plan and all the 41 regional sectoral offices assigned HIV/AIDS focal person that coordinates the overall activities in the respective institutions.

Almost all of the respondents from the survey sector offices 13 (93%), had confirmed that they have used workplace HIV/AIDS guideline that dictates and facilitates the way activities of internal HIV/AIDS mainstreaming systematically implemented. This finding is in line with the national HIV/AIDS mainstreaming guideline (FMOH, FHAPCO, 2005). However, participants of the FGD had reported that there is lack of clear sector specific HIV/AIDS mainstreaming implementation guideline. This is a big weakness which leads to lack of uniformity in the provision of work place interventions.

Although the sector offices under this study were found implementing different HIV/AIDS mainstreaming activities like awareness raising activities, condom promotion and continuous distribution and promotion and providing regular VCT services in a better manner, only less than 50% of the workforces in the vast majority, 12 (86%) of the sector offices received the HIV VCT services arranged in their respective office in collaboration with the health sector. This is against the national HIV counseling and testing guideline that dictated every adult sexually active individual should take this test and search for the necessary care and support if found positive and stay with safer sexually behavior if found negative(FMOH, FHAPCO, 2007). In addition, none of the respondents from these sector offices could indicate the impacts of the pandemic. The absence of impact assessment and absence of inclusion of lessons learned from the past experience in the implementation weakens the effort made to establish continuous and effective mainstreaming throughout the sector.

With regard to the care and support activities for PLWHA and OVCs, only limitted, (a total of 13 HIV positive staff members and only 1 (7%) orphan had received the aforementioned care and support from the sector office. This finding might indicate that still people do not want to disclose themselves as the level of stigma and descrimination against them is still high. This finding was not in favor of the national HIV/AIDS mainstreaming guideline and workplace policy (FMOH, FHAPCO, 2005) as well as the experiences of other South African Countries (SAFAIDS, 2001).

CHAPTER – 6: CONCULUSION AND RECOMMENDATION

6.1 Conclusions

Although it had been indicated that successful implementation of HIV/AIDS mainstreaming requires effective implementation of all the activities indicated in all the 5 stages of HIV/AIDS mainstreaming (FMOH, FHAPCO 2005, UNDP, 2005), This study conducted on the regional Finance and Economic Development sector in SNNPR, Ethiopia had revealed that the overall implemented activities indicated, the mainstreaming implementation lies at the early implementation stage and could not move beyond stage I of HIV/AIDS mainstreaming in each level of the sector. Major activities in the guideline like AIDS risk analysis of sector workers, impact analysis to assess the impact of AIDS on the sector, actions implemented to mitigate the impact, analysis of sector policies, strategies and actions and reflection on these policies, and interventions in order to determine their negative or positive influence on the spread of HIV in the communities they serve, and incorporation of lessons learned into sector policies, strategies and actions were learnt to be untouched by any of the office found within the sector.

In aware of the facts obtained from this study, this research concludes that the response of the Finance and Economic Development sector in SNNPR through mainstreaming HIV/AIDS prevention and control activities into their core-sector specific activities remained to be ineffective. Hence, the following major recommendations for improvements and effective HIV/AIDS mainstreaming in the Finance and Economic Development sector is suggested for all relevant bodies and stakeholders.

6.2. Recommendations

1. Continuous Capacity Building on the concept and details of HIV/AIDS Mainstreaming

As the research findings revealed that different people within the sector understand the meaning of HIV/AIDS mainstreaming differently, this knowledge and skill gap negatively affect its effective implementation in the sectors. Hence, there should be continuous capacity building activities until the concept of mainstreaming HIV/AIDS both theoretically and practically is well internalized by all workforces and implemented accordingly in such a way that it could bring the desired outcome.

2. Enhance the Top Leadership commitment

Although experiences of some of the HIV/AIDS mainstreaming activities like the inclusion of HIV/AIDS prevention activities in the current strategic and annual plans, assignment of focal person for HIV/AIDS in the sector could be considered as some of the evidences that showed the level of commitment of top leaders at each level with in the sector, the failure of any of the sector offices to implement most important activities other than the aforementioned ones weakens the mainstreaming. The findings from the FGD had indicated that commitment of the top leaders at each respective level with in the sector was inadequate, which might contributed to the in-effective implementation of HIV/AIDS mainstreaming in the sector. Hence, it is recommended to enhance the commitment of these top leaders to effectively implement those untouched businesses like development of sector specific HIV/AIDS mainstreaming guideline, conducting the HIV/AIDS impact assessment and other activities listed on the national guideline (FMOH, FHAPCO 2005).

References

ACORD (2005) ACORD- HIV\AIDS Support and Advocacy Program: Generic Training Guide on HIV and AIDS Mainstreaming.

Bodiang,K.(2001)The multisectoral approach. A Focus on Africa. [online] Available at: http://www.sdchealth.ch/priorities_in_health/communicable_diseases/hiv_aids/the_multisectoral_approach__a_focus_on_africa [Accessed 4 June 2011]

BoFED,.2009.Strategic Plan of Finance and Economic Development Bureau. Annual plan of action 2009.Hawassa.

EAC (2008) East African Community HIV\ AIDS Workplace Policy.

Elsey, H & Kutengule, P. (2003) HIV/AIDS Mainstreaming: A Definition, Some Experiences and Strategies : A resource developed by HIV/AIDS focal points from government sectors and those that have been working on HIV/AIDS mainstreaming

FMOH. (2010) Health Sector Development Program IV In line with GTP 2010/11 – 2014/15

FMOH, FHAPCO (2011) Strategic Plan II for Intensifying Multisectoral HIV and AIDS Response in   Ethiopia (SPM II) 2010/11 – 2014/15

FMOH, FHAPCO(2005) A Hand Book for HIV/AIDS Mainstreaming :For a scaled up Gender sensitive Multisectoral Response.

FMoH (2004)AIDS in Ethiopia, 5th edition, Addis Ababa, Ethiopia.

FHAPCO(2003) Mainstreaming Guideline on HIV/AIDS Interventions in Federal Ministries and Organizations, Ethiopia.

Family Health International (FHI) (2002) WORKPLACE PROGRAMS HIV/AIDS: An Action Guide for Managers

Federal Democratic Republic of Ethiopia Population Census Commission (2008) Summary and Statistical Report of the 2007 Population and Housing Census

FMOH, FHAPCO (2007) Guidelines for HIV Counseling and Testing in Ethiopia

FMOH, FHAPCO and WORLD BANK(2007)HIV\AIDS in Ethiopia: an epidemiological synthesis

FMOH, FHAPCO (2007) single point HIV prevalence estimate

FMOH, FHAPCO (2007) Accelerated Access to HIV/AIDS Prevention, Care and Treatment in Ethiopia: Road Map 2007 – 2008/10

Hoffman,C.,Rockstroh, J.and Kamps, B. (2007) HIVMedicine 2007 [online]. Paris: Flying Publisher[cited 28th July 2011]. <www.HIVMedicine.com>

IDS Health and Development Information Team (2008) Mainstreaming HIV and AIDS: HIV and AIDS reporter

SAFAIDS (2001) Steps in developing a WORK PLACE POLICY that addresses HIV and AIDS

SNNPR-BoH (2011) Annual report of 2010/11: Hawassa.

SDC (2005) Mainstreaming HIV/AIDS in Practice: A toolkit with a collection of resources, checklists and examples on CD Rom for SDC and its partners

Sue, H (2003) Putting AIDS on the Agenda: Adapting development and Humanitarian programs to meet the Challenges of HIV/AIDS.

UNAIDS, WHO(2006) AIDS epidemic update: December 2006.

UNAIDS (2004): 2004 Report on the global AIDS epidemic.4th global report

UNAIDS (2010)Global report: UNAIDS report on the global AIDS epidemic 2010.

UNAIDS: Mainstreaming HIV/AIDS: A conceptual framework and Implementing principles, Final draft 2002.

UNAIDS,World Bank and UNDP (2005) Mainstreaming HIV AND AIDS in sectors and programs: An   Implementation Guide for National Responses. University Capacity Building Program (2008) HIV/AIDS mainstreaming approaches and strategies

Appendices

Appendis 1: Survey instrument/Questionnaire

UNIVERSITY OF VAN HALL LARENSTEIN

QUESTIONNAIRE PREPARED TO ASSESS EFFECTIVE IMPLEMENTATION OF INTERNAL HIV/AIDS MAINSTREAMING IN FINANCE & ECONOMIC DEVELOPMENT SECTOR IN THE SOUTHERN NATIONS, NATIONALITIES & PEOPLES REGION OF ETIOPIA

<u>Section – I: General Information</u>

Please fill in the box with √ symbol or write on the blank space where appropriate

1.   Name of Zone _____

2.   What is the total number of staff in your office?

    1. Male_____   2. Female _____   3. Total _____.

3.   Is there HIV/AIDS focal person/mainstreaming officer in your office? (1) ▢ Yes   (2) ▢ No

4.   If the answer to question # 3 was ″Yes″, then

    a. The Sex of the focal Person?   (1) ▢ Male   (2) ▢ Female

    b. Educational status of the focal Person?

        1 ▢ Less than 12th Grade Level   4 ▢ First Degree Level

        2 ▢ Certificate Level   5 ▢ Second Degree Level

        3 ▢ Diploma Level

    c. Type of assignment as HIV/AIDS focal Person/mainstreaming office?
        1. ▢ Temporary   2. ▢ Permanent

    d. Total Years of service as HIV/AIDS focal Person/mainstreaming office? _____ Years

    e. Is there a clear job description for the assigned focal person/mainstreaming office?
        (1)   ▢ Yes   (2) ▢   No

5.   If the answer to question # 3 was ″yes″, is he/she trained on HIV/AIDS mainstreaming?
        (1)   ▢ Yes   (2) ▢   No

6. If the answer to question # 3 was ″Yes″, How is he/she authorized to make decision when deemed necessary?

        (1) ☐ less authorized

        (2) ☐ moderately authorized

        (3) ☐ highly authorized

7. Is HIV/AIDS prevention and control activity incorporated in the 5-year strategic plan of your office?

        (1) ☐ Yes   (2) ☐ No

8. Is HIV/AIDS prevention and control activity incorporated in the past 2003EFY (2010/2011) annual operational plan of your office?

        (1) ☐ Yes   (2) ☐ No

9. If the answer to question # 8 was ″yes″, was the activities performed as per the operational plan?

        (1) ☐ yes sufficiently performed   (3) ☐ yes weakly performed

        (2) ☐ yes moderately performed   (4) ☐ none is performed

10. If the answer to question # 9 was ″yes″, Please state the main activities performed in the past 2003EFY (2010/2011)?

        1. _____

        2. _____

        3. _____

        4. _____ _____

11. If the answer to question # 9 was ″yes″, was the performance monitored & evaluated in a regular basis?

        (1) ☐ Yes   (2) ☐ No

12. If the answer to question # 11 was ″yes″, how often you monitor & evaluate the performance?

        (1) ☐ every month   (3) ☐ every Six month

        (2) ☐ Quarterly   (4) ☐ Yearly   5. Any other,

specify_____

13. Does your office have allocated the expected 2% the annual sector budget for HIV/AIDS mainstreaming on the past 2003EFY (2010/11)? (1) ☐ Yes   (2) ☐ No

14. Was there any support from the top leadership in the implementation of HIV/AIDS prevention activity?   (1) ☐ Yes   (2) ☐ No

15. If the answer to question # 14 was ″yes″, what kind of support do they provide?

    1. _____ _____

    2. _____ _____

16. Is the HIV/AIDS prevention & control activity incorporated in this 2004EFY (2011/2012) annual operational plan of your office?   (1) ☐ Yes   (2) ☐ No

17. If the answer to question # 16 was ″No″, what do you think the possible reasons are?

    1. _____ _____

    2. _____ _____

    3. _____ _____

18. Does your office have workplace HIV.AIDS intervention Guideline?

       (1) ☐ Yes   (2) ☐ No

19. If the answer to question # 18 was ″No″, what do you think the possible reasons are?

    1. _____ _____

    2. _____ _____

    3. _____ _____

20. Have you ever assessed the impact of HIV/AIDS on your sector office?

       (1) ☐ Yes   (2) ☐ No

21. Have the lesson learned incorporate into the sector policies, strategies and actions?

       (1) ☐ Yes   (2) ☐ No

22. Did the strategic plan have been revised in light of HIV/AIDS impact?

       (1) ☐ Yes   (2) ☐ No

23. If the answer to question # 20 was ″No″, what do you think the possible reasons are?

    1. _____ _____

    2. _____ _____

    3. _____ _____

24. If the answer to question # 20 was ″yes″, what were the main findings of your assessment?

    1. _____ _____

    2. _____ _____

    3. _____ _____

Section – II: HIV/AIDS Prevention

25. Do you carry out promotion and advocacy for condom use?

(1) ☐ Yes   (2) ☐   No

26. Do you distribute condom for your staffs and customers in your office?

(1) ☐ Yes   (2) ☐   No

27. If the answer to question # 24 was ″Yes″, How often you distribute condom?

(1) ☐ Rarely   (3) ☐   Usually

(2) ☐   Sometimes   (5) any other, specify_____

28. Do you Conduct awareness raising discussion on HIV/ADS on a regular basis for your staffs?

(1) ☐ Yes   (2) ☐   No

29. If the answer to question # 26 was ″yes″, how often do you conduct discussions?

(a) ☐ weekly   (b) ☐ monthly   (c) ☐ quarterly (d) If any other, specify _____

30. If the answer to question # 26 was ″Yes″, Please state the main issues covered in the discussions?

1. _____ _____
2. _____ _____
3. _____ _____

31. If the answer to question # 26 was ″Yes″, Can you estimate the average number of people who participated in one discussion session? _____

32. Have you been promoting for Voluntary Counseling & Testing for HIV in your office?

(1) ☐ Yes   (2) ☐   No

33. If the answer to question # 30 was ″Yes″, how many times you have arranged (In collaboration with   the   Health Sector) the VCT service for your staff in the past 2003EFY (2010/11) ?

(1) ☐ None   (3) ☐ Twice   (5) ☐ Four times

(2) ☐ Once   (4) ☐ Three times   (6) ☐ More than four times

34. If the answer to question # 30 was ″Yes″, what estimated proportion of your staff has received VCT service in the past 2003EFY (2010/11)?

(1) ☐ None   (3) ☐ 25 to 50%   (5) ☐ 75 to 90%

(2) ☐ Less than 25%   (4) ☐ 50 to 75%   (6) ☐ 90 to 100%

Section – III: Care and Support

35. What proportion of your office staffs is contributing the 0.5% AIDS Fund from own monthly salary?

(1) ☐ None   (3) ☐ 25 to 50%   (5) ☐ 75 to 90%

(2) ☐ Less than 25%   **(4)** ☐ 50 to 75%   **(6)** ☐ 90 to 100%

36. Do you provide care & support services for People Living with HIV/AIDS in your office?

(1)   ☐ Yes   (2) ☐   No

37. If the answer to question # 34 was ″Yes″, how many PLWHAs have received care & support services in past 2003EFY (2010/11) your office?

Male _____   Female _____   Total _____

38. Do you provide care & support services for Orphans & other vulnerable children (OVC)?

(1) ☐ Yes   (2) ☐ No

39. If the answer to question # 36 was ″Yes″, how many OVCs have received care & support services in past 2003EFY (2010/11) your office?

Male _____   Female _____   Total _____

Thank You Very Much!!

Appendix 2: Focus group Discussion points

<div align="center">UNIVERSITY OF VAN HALL LARENSTEIN</div>

QUESTIONNAIRE PREPARED FOR FOCUS GROUP DISCUSSION TO ASSESS EFFECTIVE IMPLEMENTATION OF INTERNAL HIV/AIDS MAINSTREAMING IN FINANCE & ECONOMIC DEVELOPMENT SECTOR IN THE SOUTHERN NATIONS, NATIONALITIES & PEOPLES REGION OF ETIOPIA

1. Do you think that staff members of your sector are vulnerable to HIV/AIDS (Perceived Vulnerability)?

2. What do you understand by the concept of HIV/AIDS mainstreaming?

3. Do you believe that staff members of your sector well understood the concept of HIV/AIDS mainstreaming?

4. Is HIV/AIDS mainstreaming important in your opinion? If 'yes' what are the advantages of it, If 'No' what is the problem with it?

5. Do you think the HIV/AIDS mainstreaming activities have been implemented effectively in your sector? If ″yes″ what are the evidences, if ″Not″, what do you think are the possible reasons?

6. What are the conditions that influence effective implementation of HIV/AIDS mainstreaming in your opinion?

7. What measures need to be taken to improve the implementation of HIV/AIDS mainstreaming in your sector?

<div align="center"># Thank You Very Much!</div>