Mainstreaming Gender: Lessons Learned from the HIV/AIDS Care and Support Program in Ethiopia

Ethiopia HIV/AIDS Care and Support Project
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Why Gender Matters

By addressing gender roles and inequalities and the resulting power dynamics that impact both men and women, USAID will strengthen the effectiveness of its development programming. This is not only the right thing to do; it is “smart development.” (Guide to Gender Integration and Analysis, USAID, EGAT/WID, 2010)

From 2007 to 2011, the United States Agency for International Development (USAID) supported the Government of Ethiopia, through the HIV/AIDS Care and Support Program (HCSP), to dramatically increase access and uptake of comprehensive HIV/AIDS services by the poorest and most vulnerable people of Ethiopia. This effort represented the largest national expansion of HIV/AIDS services in Africa in terms of geographic coverage and number of health facilities. HCSP’s mandate was to make these services available at 550 health centers in Addis Ababa and the four most populated Ethiopian regions of Amhara, Oromia, SNNPR and Tigray. Covering less than 50% of Ethiopia’s land, these regions are home to over 80% of the country’s almost 80 million people.

At present, Ethiopia’s adult HIV prevalence of 2.3% remains considerably lower than in many neighboring countries. However, with an estimated 1.2 million people infected, Ethiopia has one of the largest HIV positive populations in Africa. In Ethiopia, as elsewhere in sub-Saharan Africa, nearly...
Gender is a social construct referring to the relationships between the sexes. Gender roles are culturally constructed around power, control, and socio-cultural values.

Mainstreaming gender means identifying gender roles and inequalities and taking them into account to ensure equitable service delivery.

HCSP incorporated gender issues into the program’s very design by considering the root causes of gender inequality found in Ethiopia’s social structures, institutions, values and belief systems and by integrating comprehensive HIV/AIDS services into health centers. As a result, HCSP succeeded not only in making comprehensive HIV/AIDS services available throughout Ethiopia, but in creating equitable access for HIV-infected and affected men, women, boys and girls alike. This document describes HCSP’s experience and offers some valuable lessons about incorporating gender mainstreaming into rapid and large-scale HIV/AIDS service expansion in resource poor countries.

Focus on the family

Recognizing that access to health care begins at home, HCSP made the family and household the focal point for needs assessment and service delivery. In Ethiopia, women are traditionally charged with caring for their husband’s and children’s well-being while men remain the decision-makers. However, women are usually the catalyst for seeking health care and therefore wield significant influence over health care decisions at home. In this cultural context, a woman is first in line not only to recognize that she or her family may be affected or infected with HIV but to be the primary care giver of the sick within the family. Understanding the family dynamics and
how they affect women was therefore essential to develop interventions that strengthen and enable women to negotiate access to household resources. However, empowering women and creating an enabling environment for them to identify and act on their and their families’ health needs requires support not only from within but also from outside the family. Active community participation in health service delivery is also essential so that health improvements will be sustained in both the family and society at large.

**Beginning in the community**

HCSP’s strategy to identify families infected and affected by HIV was women centered and employed gender sensitive community outreach by civil society, faith based organizations and others that involved village, parish, and sub-county leaders, village health teams, women leaders, and other religious, business, traditional, and elected leaders. This “safety net”, when mobilized, enabled poor and highly vulnerable infected and affected families to access community resources, encompassing the range of services covered under basic palliative care and comprehensive community-based HIV/TB services, including adherence to treatment regimens and assisting patients to deal with side effects.

In the highest HIV prevalence areas, this network of community-based service providers included kebele-oriented outreach workers (KOOWs), as well as program supported national NGO community outreach volunteers.

KOOWs were local residents who were trained by HCSP to conduct home visits with the goal of identifying and referring individuals and families in need of HIV/AIDS services to health centers and other appropriate providers. In partnership with local leaders and organizations, KOOWs also mobilized communities, using traditions such as the Ethiopian coffee ceremony, and educated them about HIV related matters. Themselves HIV-positive, KOOWs built trusted relationships with affected families in their community and served as a “lynchpin” between patients and the health and social services they needed.

For women who may not be empowered to speak outside the home, KOOWs provided a safe and ongoing opportunity to voice health concerns related to both themselves and their families. During home visits, KOOWs identified pregnant women and referred them to a variety of services, including antenatal care (ANC). Often, KOOWs were the first to identify signs of gender-based violence and to refer women to counseling and support services. KOOWs also recognized family
The Ethiopian coffee ceremony is an old tradition that brings together friends and neighbors to drink coffee surrounded by the pleasant aromas of roasting coffee beans and burning incense. When HIV arrived, fear of transmission was so great that women suspected of being infected were asked to bring their own cups. Some were excluded from the coffee ceremony altogether. By reclaiming the coffee ceremony as a tool to fight stigma and discrimination through community conversation, HCSP supported the KOOWs to host coffee ceremonies in their communities. Themselves HIV-positive, KOOWs invited prominent community leaders to engage in an informed dialogue about HIV/AIDS and thus broke the silence and stigma around HIV. Today, KOOWs are a valued source of vital information and their coffee ceremonies became popular, sought after events.
members with danger signs for respiratory infections and referred them for tuberculosis (TB) testing.

They promoted voluntary counseling and testing (VCT) for HIV and through family counseling and educating women, adolescents and couples about family planning. KOOWs helped address barriers to access care by sharing information about transportation issues and mitigating the opportunity costs associated with taking time out from household responsibilities.

An important contribution made by the KOOWs was “asset mapping”, which was introduced by HCSP and involved KOOWs and other community based volunteers to map resources or “assets” that
already existed in the community and could help HIV infected and affected families. Asset mapping particularly involved women to identify resources in their neighborhoods.

By meeting women and their families in their own homes and linking them to formal health services and community resources, KOOWs were at the frontline for achieving gender equity in HIV/AIDS care.

**Figure 3: Asset mapping**

Working through the health center’s management and multidisciplinary team, health center staff could be sensitized about gender issues and the differential health needs of men and women, boys and girls. Most ANC clinics were staffed by women and where ANC providers included men, health centers offered patients a choice to see a male or a female health worker. The same was true for comprehensive HIV/AIDS services.

VCT clinics were typically staffed by at least one male and one female provider. Each HIV positive patient was assigned a case manager who was him or herself HIV positive and provided personalized care and help to the patient by navigating the health care system. At high patient load health centers that had more than one case manager, HCSP strived to offer patients the choice, whenever possible, between a male or female case manager. HCSP’s strategy for deploying case managers involved task shifting a role that traditionally has been assumed by trained nurses to HIV-positive lay counselors whose most important quality was a commitment and willingness to serve HIV positive patients. HCSP encouraged both male and female HIV positive people to apply for case manager positions. After an initial training, they were deployed at ART clinics and supported through monthly on-the-job mentorship by HCSP staff. At the end of the program, there were 406 case mangers working at 350 ART health centers supported by HCSP.

**From community to the health center**

Once an individual or family was referred or taken to the health center, HCSP was committed to maintaining a gender sensitive environment.
Because gender mainstreaming is not only about women, HCSP also maintained a family focus at the health center.

By emphasizing provider initiated HIV testing and counseling (PITC), health center clients who only sought non HIV related services were given an opportunity to discretely learn their HIV status and access care and treatment. For HIV-positive pregnant women, prevention of mother to child transmission (PMTCT) services were offered within the ANC clinic,
which in turn linked to maternal, neonatal, and child health (MNCH) services. At 134 typically high patient load ART health centers, newly identified HIV-positive mothers were given the option to connect with HCSP supported mother support groups (MSGs) where HIV-positive “mother mentors” provided peer support and facilitated enrollment in additional support services like HIV Exposed Infant (HEI) programs. Like KOOWs, MSGs and case managers were trained to recognize signs of gender based violence and to counsel patients on prevention and remedy.

Gender issues were also very prominent in prevention with positives (PwP) services, which included disclosure counseling and family screening using the patient’s family matrix, a tool that lists all family members and encourages them to seek VCT services. PwP further addressed gender issues through education about safe sex and family planning and paying attention to signs of gender based violence.

Lastly, all HIV-positive patients were encouraged to invite their partners for couples counseling so that concerns of both parties could be discussed in an open, safe, and supportive environment. During couples counseling, men were educated about women’s reproductive health. Couples counseling could also address gender based violence and make tools available for anger management and conflict resolution.

Linking, tracing and engaging patients and their families to this wide range of integrated, gender sensitive continuum of HIV care services could not happen, however, without diligent record keeping and use of health center and community data. The huge task of record keeping, data summarizing and timely submission of health center reports to both the health center and woreda (district) management teams was the responsibility of data clerks.

Figure 5: Number of Data Clerks, by sex, in 5 Regions (N = 350)

Committed equally to quality of service data and gender equity, HCSP deployed data clerks for each of the 350 ART health centers through open solicitation that encouraged women applicants.
However, female candidates were only selected over male applicants if they had equal or better credentials. Due, in part, to the cooperation with and commitment of the regional health bureaus to gender mainstreaming, a majority of data clerks were women.

**From the health center back home**

Patient care does not end when s/he leaves the health center. Therefore, the HCSP model included extensive follow-up and support services as part of a continuum of gender sensitive care.

KOOWs worked with non-governmental organizations, faith-based and other civil society groups and community volunteers to provide a variety of services including peer-to-peer education among youth and testimonials intended to fight stigma and discrimination against people living with HIV.

They also helped HIV infected and affected women care for their families by cooking, washing, and carrying out household chores. They provided home-based care to bedridden family members. KOOWs remained active in the lives of patients’ families after the HIV positive patients left the health center. They continued PwP services in the home, encouraged partners to participate, and monitored patients’ adherence to treatment, including anti-retroviral therapy (ART) and TB treatment. In a context of significant power differentials between men and women, KOOWs provided vital support to vulnerable women during difficult processes like HIV status disclosure and family screening. By maintaining a close and confidential relationship with families after their visit to the health center, KOOWs and community volunteers ensured that patients were not lost to follow-up.

Working in the community, KOOWs became a source of vital information about HIV/AIDS. They also were a sign of hope for HIV infected and affected people alike, and became role models in the community. Over time, as previously bed-ridden HIV patients became healthy and returned to work, families and communities began appreciating the KOOWs. KOOWs gained an elevated status in their community. While being an unpaid community volunteer used to be the domain of women, being a KOOW became a status symbol that subsequently began to attract an increasing number of men.
Figure 6: Community volunteer caring for a bedridden patient
In a context of significant power differentials between men and women, KOOWs provided vital support to vulnerable women and were a sign of hope for HIV infected and affected people alike.
Results

By mainstreaming gender into HCSP’s design and implementation, many more women were able to readily access health services for themselves and their families. HCSP’s integrated approach linking families and communities with health centers enabled over 6 million people, of whom 55% were women, to get tested for HIV and provided comprehensive HIV/AIDS care and support services to those who were HIV positive. Among them, almost 120,000 women and 51,000 men were enrolled on pre-ART care. By the end of the program, close to 68,000 women and 31,000 men were accessing ART. Survival for men and women after 12 months on ART, was respectively, 77% and 79%.

Furthermore, many more pregnant women than had been possible before were tested for HIV during their pregnancy. The number of pregnant women seen at HCSP supported health centers in the last quarter of 2008 was 56,505 and steadily rose thereafter to almost 100,000 in the last quarter of 2010. The proportion among them who were offered to be tested for HIV went up from 86% in 2008 to 97% in 2010 and those who accepted to be tested also rose from 83% to 96%. This means that by the end of 2010, 93% of all ANC clients received an HIV test, up from 71% in December 2008.

With every HCSP supported health center providing prevention of mother to child transmission (PMTCT) services at ANC and labor & delivery, HIV positive pregnant women were able to access services that not only improved their own health and chances of survival, but that greatly reduced the risk of mother to child transmission of HIV.

While bringing services closer to where people lived, the national scale-up efforts would invariably have led to greater access to HIV/AIDS services. However, HCSP’s gender sensitive approach that promoted the active participation of women and HIV positive people in both communities and at health centers contributed to creating more equitable access to services.
Institutionalizing gender

If gender mainstreaming efforts are to be sustained and expanded, they must be institutionalized. Gender mainstreaming must be policy and practice in Ethiopia and within the organizations that work here.

Partnership and close collaboration with both Ethiopian government and non-government institutions alike was therefore of utmost importance from the onset through the end of HCSP.

It had been the Government of Ethiopia’s vision since 2005 to create universal access to comprehensive HIV/AIDS services. When, in 2007, HCSP became the Government of Ethiopia’s major technical assistance partner in the rapid expansion of these services to
health centers, the Government of Ethiopia had enshrined the rights of women in its Constitution and made significant progress in passing legislation to protect the political and civil rights of women, including property rights, rights to safe working conditions, prohibition of harmful traditional practices, prohibition of early marriage, and equal access to education and health services. While the Government of Ethiopia had promoted gender mainstreaming in all its development policies, execution at the local level continued to be challenging.

Mainstreaming gender in service expansion therefore required HCSP to work with all levels of the Government of Ethiopia. One success of this collaboration was the acceptance of the case manager and data clerk positions within the national strategy for scaling up HIV/AIDS services. HCSP partnered with regional health bureaus to promote the recruitment of women for these positions.

At the woreda and health center levels, HCSP partnered with the public sector to train, deploy and mentor health workers once they started their job. As the Government of Ethiopia increasingly fills these now accepted positions within the human resource requirements for health centers, women as well as men in these positions will benefit from increased job security, and with that greater economic independence and a stronger status in the community. By demonstrating its trust in women’s abilities as government employees, the Government of Ethiopia began reshaping gender roles. Such measures have significant social and cultural implications and over time will help alleviate the root causes of gender inequality.

Similarly, HCSP also emphasized the importance of gender mainstreaming in its partnerships with non-governmental service providers. Using performance-based contracting principles, which tie deliverables to funding, HCSP provided an important incentive for civil society organizations to achieve their contractual objectives.

By systematically including gender issues in the contractual objectives, HCSP required service organizations to define how they will incorporate gender mainstreaming into their activities, and to report sex-disaggregated data. By incorporating gender issues in the performance-based contracting mechanism, HCSP made gender mainstreaming part of partner organizations’ regular activities and increased their understanding of gender issues.
Conclusion

HCSP’s experience showed that with careful planning and some creative innovations, gender mainstreaming can be successfully incorporated into a national scale-up of comprehensive HIV/AIDS services in a resource-poor country.

HCSP built on social networks and cultural traditions that already existed in Ethiopian communities and used them as communication channels to disseminate health information and connect families to care. Recognizing their vulnerability to infection and abuse as well as their pivotal role in guiding families toward health care, HCSP made a concentrated effort to directly link women to the resources they need. By employing women in service delivery, HCSP elevated their status in the community and promoted their empowerment and independence.

However, all this could not have been achieved without a close partnership with the Government of Ethiopia, whose vision, commitment, and leadership for gender equity and universal access to HIV/AIDS services underpinned HCSP’s successes.
Mainstreaming gender does not require extensive resources but rather a commitment to identify gaps and seek opportunities to develop effective responses.

Traditional communities are more likely to take ownership of the gender agenda if it is framed in a context of improving the well-being of the family rather than that of individual women.

Women wield significant influence over health care decisions but face barriers in accessing services; they are more likely to access health care for themselves and their families when health systems are strengthened to assist their linkage to services.

Cultural traditions can be reshaped or used as effective tools for gender mainstreaming.

Gender mainstreaming must be institutionalized in the laws and policies of the government and organizations on the ground in order to ensure its success and sustainability.

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