HUMAN CAPACITY DEVELOPMENT FOR AN EFFECTIVE RESPONSE TO HIV/AIDS

THE COMMUNITY RESPONSE –

ADDIS ABABA, ETHIOPIA

by

Family Health International (FHI) – Ethiopia

in collaboration with the

Addis Ababa AIDS Council Secretariat

Addis Ababa

Ethiopia

June 2002

HIV/AIDS Prevention and Control Office

PREFACE

This report summarizes discussions with community representatives including idir representatives, women's group representatives, youth, religious leaders and others, from the 5 weredas initially targeted by the Ethiopian Multi-Sectoral AIDS Project (EMSAP) in Addis Ababa. The discussions focused on gaining a better understanding of the human capacity developed by community representatives engaged in the project. We thank the Wereda AIDS Council members and the Wereda AIDS Facilitators of weredas number 5, 7, 15, 19 and 20 as well as the staff of the Addis Ababa HIV/AIDS Prevention and Control Office for their support and assistance in conducting this assessment. This Human Capacity Development assessment is one of five assessments conducted in Addis Ababa to inform efforts for an expanded and comprehensive response to AIDS in the region. The assessments were conducted by Family Health International in collaboration with the Addis Ababa HIV/AIDS Prevention and Control Office and stakeholders involved in the response. Funding for these assessments was received from USAID and CDC.

It is clear that the impact of HIV/AIDS prevention, care and support efforts is enhanced by engaging communities themselves in the response. This report shows that community representatives are concerned about the quality and effectiveness of programs and want to build their skills to better coordinate efforts.

The discussions started during the dissemination of the preliminary findings of this as well as the other baseline assessment already have led to a dynamic of enhanced engagement of community groups in the response to AIDS in Addis Ababa. We look forward to working with partners in the response to AIDS to improve the understanding best practices in expanded and comprehensive response programming and to empower communities to apply these best practices.

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
BCC	Behavioral change communication
EMSAP	Ethiopia Multi-Sectoral AIDS Project
FGD	Focus group discussion
FHI	Family Health International
HCD	Human capacity development
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IMPACT	Implementing HIV/AIDS Prevention and Care Project
NGO	Non-governmental organization
PLWHA	People living with HIV/AIDS
VCT	Voluntary counseling and testing

DEFINITIONS

Idir	A community burial and support association
Kebele	The smallest administrative unit under the *wereda*
Wereda	Administrative unit (equivalent to district)

EXECUTIVE SUMMARY

In May 2002, Family Health International (FHI) – Ethiopia, in collaboration with the Region 14 Administration – Addis Ababa HIV/AIDS Council Secretariat, conducted a human capacity development (HCD) base-line assessment at community and district levels in Addis Ababa, Ethiopia. The study aimed to identify practical steps for the implementation of HCD in country development plans and programs for HIV/AIDS, as well as in follow-up actions at the community level. Results of the assessment were intended to assist HIV/AIDS programs in Ethiopia to respond more effectively to the current HIV/AIDS crisis.

Numerous groups, associations, and committees were active participants in community HIV/AIDS projects. These dedicated groups provided their communities with a wide variety of HIV/AIDS prevention, care and support activities. Most of these groups worked on a voluntary basis.

Focus group discussions (FGD) were used to obtain data on the past, present and future status of human capacity in HIV/AIDS organizations and groups at the *wereda* and *kebele* levels. FGD participants were members of *wereda* AIDS councils, *wereda* facilitators and members of community groups/associations involved in HIV/AIDS intervention activities at the community level.

Study participants reported that since the emergence of the HIV/AIDS epidemic in Ethiopia, positive changes had occurred both in the openness to discuss HIV/AIDS issues and in the number of people living with HIV/AIDS (PLWHA) who had publicly shared their status and experiences.

At the time of the study, however, there were gaps in the HIV/AIDS programs and activities in terms of human capacity and HCD; these gaps affected quality and effectiveness of the projects. HCD was needed urgently at all levels of HIV/AIDS programming. Commonly, the upper levels of HIV/AIDS administrations decided which projects the community associations should implement. Despite their dedication and willingness, most of the community groups (implementers) lacked the knowledge, experience and skills to make these decisions. Even when the implementers wanted to increase their knowledge in order to deliver projects effectively, there were almost no references available to give them guidance.

Ultimately, the community suffers when HIV/AIDS programs are inadequately designed, managed, implemented, monitored and evaluated. Current activities were designed without monitoring and evaluation systems to transfer feedback to the program planners; such data would have assisted the upper managers to plan more effective activities for the future. There was also almost no coordination and/or collaboration between the groups involved in the intervention activities. The importance of coordination/collaboration was not understood. Furthermore, obvious gaps were observed in the human capacity of the HIV/AIDS programs in terms of BCC activities, psychological support, home-based care, and condom promotion and distribution.

Overall, the results indicated that investment in HCD could help to lessen the burden of HIV/AIDS in Ethiopia. Multiple channels for HCD existed and could be targeted to increase the impact of current activities. All players in the HIV/AIDS prevention, care and support projects needed training in project management, finance and administration, project design, project implementation, coordination/collaboration, and monitoring and evaluation. The implementers of the various activities were aware of their needs and wanted to improve their skills. It is concluded that if HCD needs were met, the effect of current activities would be magnified.

1. INTRODUCTION

Across the world, the number of people and families living with HIV/AIDS who need care and support services is increasing continuously. Consequently, health care and community systems coping with and responding to HIV/AIDS are facing enormous challenges. The response to HIV/AIDS is often limited by a lack of human capacity and human capacity development (HCD).

Assessment of human capacity and the subsequent development of this capacity are essential to the provision of an effective response to HIV/AIDS. Data from HCD base-line assessments indicate strengths and weaknesses in existing activities and enable the development of more effective HIV/AIDS interventions. Importantly, assessment results can be used: to strengthen the continuum of prevention, care and support interventions; to help the various HIV/AIDS organizations at community level to achieve their objectives; and to enable implementing partner organizations to understand the dynamics of HCD (e.g. differences between parts of a country and with HIV prevalence levels) so that they can invest in human resources and become better equipped to respond to the HIV/AIDS epidemic. In addition, the HCD assessment process itself increases awareness of the importance of HCD among HIV/AIDS groups.

In Ethiopia, the FHI/IMPACT (Family Health International/Implementing HIV/AIDS Prevention and Care Project) aims to decrease HIV prevalence and to improve the quality of life of people living HIV/AIDS (PLWHA) by strengthening the continuum of prevention, care and support. Currently, FHI/IMPACT is preparing to support implementation of an expanded response to HIV/AIDS, which involves engaging implementing partners to work within a continuum of prevention, care and support. In this respect, FHI/IMPACT recognizes that it is important to understand the existing human capacity at community and district levels.

Consequently, this study, conducted in May 2002 by FHI-Ethiopia in collaboration with the Region 14 Administration-Addis Ababa HIV/AIDS Council Secretariat, examined the existing human capacity and the need for HCD at community and district levels in relation to HIV/AIDS programs and activities in Addis Ababa, Ethiopia. The knowledge and attitudes of HIV/AIDS workers, at the government and community levels, towards HCD and its role in the design and implementation of prevention, care and support activities were assessed.

The purpose of this study was not to provide statistically generalizable quantitative data but rather to obtain qualitative information exposing underlying knowledge, attitudes and opinions in the understanding of human capacity in HIV/AIDS interventions and HCD needs for the effective design and implementation of HIV/AIDS intervention activities.

Specific objectives of the study were as follows:

1- To assess the current human resource situation and the human capacity involved in the different HIV/AIDS intervention activities at the community level;

2- To identify the gaps in human capacity for an effective response to HIV/AIDS; and

3- To assess the needs for HCD and identify various methods by which to develop the human capacity of HIV/AIDS implementing partner organizations.

2. METHODOLOGY AND DATA ANALYSIS

2.1 Study design and study area

Addis Ababa has 328 *kebeles*; these are located within the 28 *weredas* that constitute the six zones of the city. Twenty-three *kebeles* are rural whilst 305 are urban areas. In addition to this variation, the characteristics of the various zones and *weredas* of Addis Ababa are diverse.

Data were collected using focus group discussions (FGDs) over a five-day period in May 2002. Because of time constraints, representation from all the districts of Addis Ababa was not possible. Instead, this study focused on five *weredas* of Addis Ababa (namely *weredas* 5, 7, 15, 19 and 21), which had been identified previously as areas of concentrated vulnerability to HIV/AIDS by the Addis Ababa HIV/AIDS Council Secretariat and the National AIDS Council Secretariat. These *weredas* had been prioritized for HIV/AIDS implementation activities; at the time of the study, interventions had been in place for over one year.

Although results of the HCD assessment were specific to the five *weredas* studied, it was conceived that the assessment process and results would also help other *weredas* in Addis Ababa and would provide an example to other regions and cities in Ethiopia that were planning HIV/AIDS intervention activities or scaling-up their current programs.

2.2 Source of data

For sustainable HCD the direction for such activities needs to be drawn from the target audience. The target group for this study was the group of people involved in the community response to HIV/AIDS. Therefore, individuals working intimately with HIV/AIDS interventions in the five selected *weredas* of Addis Ababa participated in the study and were the information source. Data were collected using FGD; participants included *wereda* AIDS council members, *wereda* facilitators and community group members.

2.3 Data collection

Ten focus group discussions (FGDs) were used for data collection. One facilitator and one note taker led each FGD. These individuals were employed specifically to conduct the study, after selection based on their qualifications and work experience in the field of qualitative research data collection.

A FGD topic guide was prepared initially in English and was later translated into Amharic. A complete set of the topic guides, in English and Amharic, is presented in Appendices A to D. Objectives of the study and the FGD topic guide were discussed with the facilitators and note takers to acquaint them with the topics; feedback from these sessions led to modification of the topic guide, which strengthened the FGD topics.

2.4 The sample: sample size and sampling procedures

The three target groups in this study were *wereda* AIDS council members, *wereda* facilitators and members of community groups who were involved in HIV/AIDS intervention activities at the community level.

Wereda AIDS councils	Each of these councils was composed of a coordinator (who was the overall project/program coordinator) and representatives of youth groups, women's associations, religious groups, the *wereda* finance office, the *wereda* health bureau, *idirs* and the *wereda* social desk.
Wereda facilitators:	Employees of the Addis Ababa AIDS Council Secretariat whose duties and responsibilities were to pass down projects or activities designed by the secretariat. The facilitators were also responsible for monitoring and evaluating the activities, and reporting the results back to the secretariat.

Community groups: Representatives of *idirs*, women's associations, youth anti-AIDS clubs or youth associations, and religious groups.

They were the various implementers of HIV/AIDS intervention activities at the community level (*wereda* and *kebele*). Some representatives were also members of the *wereda* AIDS councils.

Ten FGD were conducted to ensure representation from each target group (see Table 1). The number of participants in each FGD was determined by the sample size needed to allow equal representation from each target group.

The selection procedure adopted was the probability sampling method, which gives each member of the target group an equal probability of being selected. Lists of individuals within each target group were prepared. Each list was modified so that it only included individuals who met the pre-selection criteria (see Section 2.4.1). Finally, FGD participants were selected randomly from the lists.

The number of FGD conducted with each target group and the numbers of participants in each FGD are presented in Table 1.

2.4.1 Pre-selection criteria for participants in the FGD

Within the selection process, homogeneity of participants within each FGD was emphasized. The selection criteria for each target group are detailed below.

(i) *Wereda* AIDS councils

- Individuals with full commitment to and valuable participation in HIV/AIDS activities.
- Individuals with a clear understanding of the activities, who also had good communication skills.

(ii) *Wereda* facilitators

- Individuals who were recognized by the Addis Ababa AIDS Council Secretariat for their consistent participation and commitment to the activities.

- Individuals who were seeking changes in the activities and who had been involved in the implementation of HIV/AIDS intervention activities from the beginning of the HIV/AIDS programs.

(iii) Community groups

- Individuals who had long-term, productive experiences of working on HIV/AIDS programs.

Table 1. Number of focus group discussions (FGD) conducted with each target group and number of participants allocated to each FGD.

No.	Target group	Number of participants	Number of FGD conducted
1	***Wereda* AIDS council members**	8–12 individuals from each of the five priority *weredas*	5 (1 per *wereda*)
2	***Wereda* facilitators**	7 individuals = 5 *wereda* facilitators (1 per *wereda)* plus one project coordinator and one finance officer	1
3	***Community groups***		
3.1	*Idir* members	10 individuals = 2 individuals per *wereda*	1
3.2	Youth associations/clubs	10 individuals = 2 individuals per *wereda*	1
3.3	Women's associations	10 individuals = 2 individuals per *wereda*	1
3.4	Religious groups	10 individuals = 2 individuals per *wereda*	1
Total			**10**

2.5 Data analysis

FGDs began with general open-ended questions that were designed to generate ideas and discussion; subsequently, as information emerged, the FGDs focused on detailed HCD issues. The method of data analysis simplified processing and interpretation of the information in the FGD transcripts and field notes. The data could then be used to address the study objectives.

The initial method of data analysis used the study questions as a guide and then grouped the data around the questions. Differences and similarities between the answers were examined. The second method, described in detail by Ulin *et al.* 2002, allowed a more in-depth and inductive approach to analysis of the data. This approach followed a sequence of interrelated steps, which are presented below.

Step 1. Goals of this step, were first to see if the information obtained was what was intended by the study and secondly, to check that the responses were full and detailed rather than superficial.

Step 2. Patterns in the data were identified and the themes that emerged from these patterns were defined. For each theme, all information was extracted and combined to address the study objectives.

Step 3. An inventory of the themes was made. The frequency of occurrence of the various themes was examined. Additionally, data were examined to determine the frequency with which specific themes emerged from the data and whether or not these themes tended to come from specific subgroups or from all the target groups.

Step 4. Data were refined in order to determine the overall sense of the information and to make visible the essential concepts and relationships.

3. FINDINGS OF THE STUDY

The topic guide, its rationale and results of the FGDs are presented in Table 2. Results are presented in terms of the themes and details gathered in response to the various discussion points (see Section 2.5).

Table 2. Focus group discussion (FGD) topic guide, brief explanation of the questions and results.

No.	Discussion points	Description/explanation	Responses/results
A1	What HIV/AIDS intervention activities are being implemented in your respective *weredas*?	To identify and understand the different HIV/AIDS activities, as a basis for subsequent questions on changes in each of the activities and the possible role of human capacity in these changes.	a) Provision of care and support for: people living with HIV/AIDS (PLWHA), AIDS orphans and elderly people who have lost their children and/or relatives because of AIDS. b) Provision of voluntary counseling and testing (VCT). c) Sensitization and awareness creation regarding HIV/AIDS at the community level (*wereda* and *kebele*). d) Provision of training at the community level (*wereda* and *kebele*) for individuals involved in HIV/AIDS intervention activities. e) Establishment and organization of anti-AIDS associations, clubs and committees at the community level (*wereda* and *kebele*). f) Condom distribution. g) Provision of home-based care. h) Participation of PLWHA in teaching other members of the community (identified as the most effective way to communicate HIV/AIDS messages to the community).

			i) Peer education (education of the community as a whole, especially the in-school and out-of-school youth, on HIV/AIDS). For example, through the organization of sport festivals, the use of mini media events and trade fairs. j) Provision of housing units or money for paying house rent to PLWHA. k) Organization of fundraising activities to raise money for the implementation of HIV/AIDS intervention activities.
A2	Who is implementing these activities at the community level?	To identify the people involved in the response to HIV/AIDS at the community level and to expand on this information when asking about the human capacity development (HDC) needed to respond effectively to HIV/AIDS. The issue of integration and collaboration between the implementers will also be discussed (see question A3).	a) *Wereda* AIDS councils. b) *Kebele* AIDS committees. c) Community-based organizations (CBOs)/anti-AIDS clubs and associations (e.g. youth associations, youth anti-AIDS clubs, women's associations, *idirs* and religious groups). d) Non-governmental organizations (NGOs; e.g. CARE Ethiopia, Propride, Abebech Gobena, CCF Christian Children Fund, Goal Ethiopia, OSSA and NASTAD.

No.	Discussion points	Description/explanation	Responses/results
A3	Is there collaboration and/or integration between the implementers mentioned in question A2 above?		a) Collaboration exists: between *wereda* AIDS councils and NGOs; *kebele* AIDS committees and NGOs; and CBOs and NGOs. This is particularly evident when training is provided for clubs and community groups, such as youth clubs, women's associations, *idirs*, peer educators and volunteers. b) Members of youth associations, women's associations, *idirs* and religious groups are included in the *wereda* AIDS councils and *kebele* AIDS committees. c) When mass education and training are conducted, human resources and materials are shared. d) All organizations, institution, associations, clubs etc. are involved during evaluation of activities undertaken by any of these groups. e) NGOs work in collaboration with the *wereda* AIDS council, especially to identify gaps in HIV/AIDS intervention activities and to prevent duplication of activities

No	Discussion points	Description/explanation	Responses/results	
			Problems	**Causes**
A4	What are the problems in the different HIV/AIDS interventions in your area? What are the causes of these problems?	First, to understand the overall problems of the HIV/AIDS intervention activities and secondly, to determine whether or not these problems result from a lack of capacity of the people involved in the activities. Note: During analysis, data were examined to determine whether a lack of human capacity was mentioned as a cause. The intention here was to observe and understand whether or not human capacity was ever thought of by the participants as one of the key factors in achieving the goals set by the activities or programs. The question was also used to see if human capacity was thought to be an integral part of the activities.	1. The discontinuation of information, education and communication and/or behavior change communication (IEC/BCC) programs in the *wereda*s.	1. Lack of sufficient IEC/BCC materials and human resources (lack of qualified personnel).
			2. Insufficient and unsatisfactory coordination and collaboration between implementers of HIV/AIDS intervention activities.	2.1 Individuals involved in the HIV/AIDS intervention activities give priority to their own salaried jobs; most of them are working voluntarily in the HIV/AIDS intervention activities. 2.2 Integration and collaboration are not considered to be crucial factors in the implementation of activities or in making activities effective.
			3. The secrets of PLWHA are not kept confidential at the *wereda* or *kebele* level.	3. Probably because of negligence or lack of knowledge regarding the importance of secrecy and confidentiality in the private matters of PLWHA.

			4. Priority is given only to care and support activities rather than IEC/BCC and other activities.	4.1 IEC/BCC is not considered important and relevant as an HIV/AIDS intervention activity. 4.2 There is limited knowledge of BCC and of implementing BCC activities amongst people involved in HIV/AIDS activities, especially at the community level.
			5. Home-based care is provided by volunteers but is not satisfactory.	5. There has been no appropriate training on provision of home-based care.
			6. Psychological support is given on a limited basis.	6. Psychologists are not available to provide psychological care for PLWHA.
			7. Legal support is not given to PLWHA or AIDS orphans.	7.1 The importance of providing such legal support is not recognized. 7.2 The required human resources are not available within the community groups implementing HIV/AIDS intervention activities.

			8. Anti-AIDS clubs, especially youth anti-AIDS clubs, are formed but no emphasis is given to their capacity and ability to implement activities; furthermore, their activities are not monitored or evaluated and consequently, are less effective.	8.1 A bureaucratic approach, especially amongst *wereda* level organizations, has to be dealt with by these clubs. 8.2 Youth club members lack knowledge of project implementation and financial procedures.
			9. Although clubs and associations attempt to work together, existing levels of collaboration and integration are unsatisfactory.	9. Commitment to collaboration and integration of activities is lacking amongst the responsible club/association members, probably because they have insufficient materials and skills to organize the collaboration and integration.
			10. There is a lack of commitment from the government to HIV/AIDS issues.	
			11. There is a lack of qualified personnel to design, plan and implement activities effectively. Moreover, there is a lack of qualified personnel to manage implementation and monitoring of the activities.	

			12. The skilled human resources available are not used effectively in the HIV/AIDS activities.	12. The lack of skilled human resources and involvement of unqualified personnel tend to promote reliance on one person to do all the work.
			13. There is no common understanding of project design and implementation, a management system or financial procedures.	13. Guidelines for undertaking HIV/AIDS activities at the community level are not available.
			14. Although education has been provided, on various occasions through various media and communication channels, people have not changed their behavior.	14.1 Education is not provided on a continuous programmed/planned basis. 14.2 When education is provided there is no attempt to involve or even invite support from subject experts. 14.3 The education provided is not designed specifically for the type of audience or type of people addressed.
			15. Sex workers infected with the HIV virus are still working and are therefore transmitting the infection to other people.	15. Sex workers are among the most destitute segment of the population; they cannot afford to stop working.

			16. The various activities implemented at the community level are not monitored or evaluated.	16.1 There are no guidelines for monitoring and evaluating HIV/AIDS activities. 16.2 There are no qualified personnel to undertake the monitoring and evaluation of the activities.
			17. There is no office or concerned body at the government level for submission of comment or complaint.	17. The government shows a low level of commitment to HIV/AIDS issues.
			18. There is a lack of information relating to existing HIV/AIDS activities e.g. what activities are being implemented at the various levels and where are these services being provided?	18.1 There is no system of information exchange between the various implementers. 18.2 There is a lack of awareness of the importance of information and information exchange.
			19. It is difficult to identify and select the individuals (PLWHA, orphans and others) who should receive support from the government. Selection is often based on the personal judgment and decisions of judges in the *wereda* courts.	19. There are no selection criteria or selection guidelines.

			20. In general, short-term projects are designed and implemented but the funds allocated to these projects are delayed unnecessarily.	20. *Wereda* finance officers are responsible for the administration and finance of HIV/AIDS activities in their *wereda.* These duties are considered additional to their routine work; therefore, the finance officers prefer to do this work at weekends so that they will be paid overtime.
			21. Reference materials are not available at the *wereda* level or even at the Addis Ababa AIDS Council Secretariat (e.g. guidelines for conducting training on home-based care or peer education).	

No.	Discussion points	Description/explanation	Responses/results
A5-1	**<u>For *wereda* AIDS council members and *wereda* facilitators only</u>** With regard to the human capacity of the implementers, what constraints prevent them from achieving their objectives?	This question directly addresses human capacity as a constraint to the effective implementation of HIV/AIDS activities. Moreover, this question helps to determine whether the participants have understood and recognized the issue of human capacity as a major factor in the effective response to HIV/AIDS.	a) There is insufficient knowledge of data/information collection and exchange. b) There is a lack of skilled and knowledgeable personnel to provide psychological support and BCC. c) There is a lack of in-depth and specific knowledge on: project design, implementation and monitoring, and efficient utilization of finance and financial procedures. d) Overburdening of one person with all the work at the *wereda* level is an inefficient way to use human resources.

No.	Discussion points	Description/explanation	Responses/results
A5-2	For community group representatives only Among the members of your group who implement HIV/AIDS activities, what constraints do you observe in terms of their capacity to effectively perform their duties and responsibilities?	This question examines the constraints observed in human capacity, which limit the effective implementation of HIV/AIDS activities. Moreover, the question helps to determine whether the community groups have understood and recognized the issue of human capacity as a major factor in the effective response to HIV/AIDS.	a) A lack of knowledge of financial procedures creates complications in the utilization of money allocated for activities. b) There is a lack of qualified personnel to carry out IEC/BCC activities and counseling. c) There is a lack of comprehensive/extensive knowledge about all aspects of HIV/AIDS. d) There is a lack of skill in the provision of home-based care for PLWHA. e) There is a lack of follow-up on activities, particularly in the evaluation of completed projects.

No.	Discussion points	Description/explanation	Responses/results
A6-1	Since the start of HIV programming in your area, what changes have you noticed? **Why do you think these changes occurred?** **<u>At the community level in terms of:</u>** ➲ Motivation ➲ Mobilization of the community ➲ Involvement of PLWHA ➲ Ability to respond to crises	This question examines overall changes observed in HIV programs at the community level. This question also examines the causes of these changes and asks for specific examples that have been observed. This question aims to assess whether changes in human capacity underlie the changes; however, the FGD facilitator never raises the issue of human capacity.	***<u>At the community level</u>*** a) HIV/AIDS is now discussed openly among community members, members of *idirs*, the in-school youth and other segments of the population. b) Nowadays, PLWHA are willing to speak publicly of their experiences in order to sensitize and create awareness among the population at large. Involvement of PLWHA in the sensitization program has contributed greatly to the belief that HIV/AIDS does exist among the population. c) The number of activities provided for the care and support of PLWHA and AIDS orphans has increased; however, quality of the activities has not changed. d) Nowadays, the use of condoms is widespread across the city; the consumption rate is reported to be high. e) Attitudes towards PLWHA have changed and the extent of stigmatization has decreased. f) In response to HIV/AIDS, numerous anti-AIDS clubs are being formed within *weredas*, factories, associations etc.

			g) Community members have begun to be involved in HIV/AIDS intervention activities, especially in the care of AIDS orphans. Moreover, attitudes towards PLWHA have changed; at least members of the community now attend funerals of AIDS victims. h) Nowadays, radio and television coverage of HIV/AIDS issues is better than that provided previously.

No.	Discussion points	Description/explanation	Responses/results
A6-2	Since the start of HIV programming in your area, what changes have you noticed? **Why do you think these changes occurred?** **<u>At the coordination level in terms of:</u>** ➲ Management capacity ➲ Priority setting ➲ Mobilization of additional resources ➲ Securing and utilization of EMSAP funding (Ethiopia Multi-Sectoral AIDS Program; funded with a loan from the World Bank)	This question examines overall changes observed in HIV programs at the coordination level. This question also examines the causes of these changes and asks for specific examples that have been observed. This question aims to assess whether changes in human capacity underlie the changes; however, the FGD facilitator never raises the issue of human capacity.	***<u>At the coordination level</u>*** a) As a result of training and experience acquired since HIV/AIDS intervention programs started, management at the *wereda* level has improved. b) An increased proportion of money allocated for HIV/AIDS intervention activities is being utilized, especially at the *wereda* level. Nevertheless, use of funds is not monitored effectively. c) Nowadays, in a few *weredas*, accountants, law and psychology graduates are members of the *wereda* AIDS councils. Accordingly, a minimal amount of psychological support and legal support is being provided for PLWHA and AIDS orphans.

No.	Discussion points	Description/explanation	Responses/results
A7	For the changes mentioned, which (if any) do you think involved changes in human capacity?	This question focuses directly on the changes associated with human capacity.	***At the community level*** A7.1 Numerous anti-aids clubs are being formed within *weredas*. A7.2 An increasing number of care and support activities is being provided for PLWHA and AIDS orphans. ***At the coordination level*** A7.3 See A6.2 (a). A7.4 See A6.2 (c).
A8	In relation to you as an individual, members of your group, *wereda* facilitators and/or members of the *wereda* AIDS council, do you think that human capacity development (HCD) is needed to achieve an effective response to HIV/AIDS? If so, what HCD is required?	This question focuses on HCD requirements. It determines whether participants consider that HCD is needed and whether they know what HCD they require.	a) Training on management of HIV/AIDS related activities and financial administration is needed for *wereda* AIDS council members. b) Work management training is needed for anti-AIDS clubs and associations, especially if it can be provided by NGOs engaged in HIV/AIDS intervention activities. c) Human resource management and financial management training is needed for *wereda* AIDS council members and *wereda* facilitators. d) Training on community-based project design and implementation is needed for members of community-based groups, *kebele* AIDS committees and *wereda* AIDS councils.

			e) Training on how to establish and implement coordination/integration of the various activities undertaken at different levels by different implementing groups is needed by the *wereda* facilitators. f) Training on information/data collection, information exchange, and monitoring and evaluation of activities is needed for members of community-based groups, *kebele* AIDS committees and *wereda* AIDS councils. g) Training on financial administration and procedures is required for members of *wereda* AIDS councils, *kebele* AIDS committees and community groups involved in HIV/AIDS. h) Extensive training on counseling, care and support is required for members of the *wereda* AIDS councils, *kebele* AIDS committees and community groups involved in HIV/AIDS activities. i) Extensive training on BCC is required for members of *wereda* AIDS councils, *kebele* AIDS committees and community groups involved in HIV/AIDS activities. j) Extensive training on the provision of legal support for PLWHA and AIDS orphans is needed for *wereda* AIDS council members and *wereda* facilitators. k) Continuous and planned refresher training on condom use is required, especially for youth and sex workers.

			l) PLWHA need basic knowledge that will allow them to engage in income generating activities; often PLWHA give up their careers and/or efforts to make a living. Therefore, *wereda* facilitators should be equipped with the basic skills needed to promote income generating activities. m) Training on prioritization of activities is needed for *wereda* AIDS council members. n) Education relating to HIV/AIDS is required by *wereda* court judges who need to: supply legal documents for PLWHA which certify that they are unable to sustain themselves; and who have to decide which of the PLWHA are the most in need of support from the *wereda* AIDS councils. o) There is a need for experience sharing between the various clubs and associations engaged in HIV/AIDS interventions activities at the *kebele* level. p) The involvement of famous people in HIV/AIDS activities (e.g. awareness raising initiatives) has proven successful; the famous individuals require extensive training, especially on counseling relating to HIV/AIDS. q) To increase knowledge and share experiences, it would be advantageous for all health professionals (e.g. psychologists, medical doctors and health officers) to avail themselves for consultation to members of the *kebele* AIDS committees.

No.	Discussion points	Description/explanation	Responses/results
B1	Please describe the coordination/collaboration between: *wereda* AIDS councils and the Addis Ababa AIDS Council Secretariat; and between the *wereda* AIDS council and *kebele* AIDS committees?	Note: Only the wereda facilitators discussed this question.	Coordination/collaboration between *wereda* AIDS councils and Addis Ababa AIDS Council Secretariat a) The secretariat monitors and compiles reports on the activities and financial resource utilization of the *wereda* AIDS councils. b) The *wereda* AIDS councils are always invited to the workshops and seminars organized by the secretariat. The secretariat expects representatives of the *wereda* AIDS councils to attend any workshops that are relevant to the activities of their *wereda.* c) The secretariat provides training, materials and money to the *wereda* AIDS councils. d) *Wereda* facilitators make day-to-day contact with the *wereda* AIDS council coordinator and other council members. Coordination/collaboration between the *wereda*

			AIDS councils and *kebele* AIDS committees a) *Kebele* AIDS committees assist the *wereda* AIDS councils in the various HIV/AIDS activities. b) Every 15 days, the *kebele* AIDS committees attend meetings held by the *wereda* AIDS councils to discuss activities undertaken during the previous two weeks. c) The *wereda* AIDS councils monitor the care and support provided through the *kebele* AIDS committees d) The *kebele* AIDS committees are involved in the design of projects by the *wereda* AIDS councils. e) The *kebele* AIDS committees undertake the various activities included under the *wereda* AIDS council umbrella.

No.	Discussion points	Description/explanation	Responses/results
B2	What human capacity development (HCD), relating to coordination and collaboration between the various levels, do you think is necessary? (Addis Ababa HIV/AIDS Council Secretariat, *wereda* AIDS councils and *kebele* AIDS committees)	This question considers the HCD needed for effective collaboration and coordination between the various levels.	a) An extensive course on project design, implementation and monitoring is required. b) Training is needed on: information gathering/data collection, and the importance and systems of information exchange. c) See A8 (a). d) See A8 (c).

4. SUMMARY OF FINDINGS

4.1 Human capacity involved in the various HIV/AIDS intervention activities

- ✓ There is very limited knowledge of the monitoring and evaluation of activities implemented and the importance of collaboration and integration of activities.
- ✓ Management skills at the *wereda* level and project implementation skills are satisfactory.
- ✓ Most people involved in the activities are volunteers who have little or no expertise in matters relating to HIV/AIDS prevention, care and support.

4.2 Gaps in human capacity for an effective response to HIV/AIDS

- ✓ There is a lack of skills relating to the formation of networks among the various implementers. People involved are unaware of the importance of experience sharing, information exchange and division of labor in terms of activities.
- ✓ People involved are unaware of collaboration/integration of activities as an important contributing factor to an effective response to HIV/AIDS.
- ✓ There is ineffectiveness and sometimes discontinuation of HIV/AIDS intervention activities because qualified, skilled and experienced people are not involved in the design, implementation and monitoring stages of the activities.

There are clearly demarcated gaps in human capacity amongst those deployed to provide the following HIV/AIDS intervention activities:

- BCC activities;
- Home-based care;
- Psychological support; and
- Condom promotion and distribution.

4.3 The human capacity development needs

4.3.1 For members of *wereda* AIDS councils

- Management of HIV/AIDS activities (specific activities);
- Human resource management;
- Financial management;
- Community-based project design and implementation;
- Establishment, implementation, coordination and integration of various activities;
- Counseling, care and support skills;
- BCC concept and implementation strategies;
- Prioritization of activities; and
- Monitoring and evaluation skills.

4.3.2 For members of *kebele* AIDS committees

- Community-based project design and implementation;
- Data collection, information exchange and monitoring of activities;
- Financial administration and financial procedures;
- Counseling, care and support skills;
- BCC concept and implementation strategies; and
- Establishment, implementation, coordination and integration of various activities.

4.3.3 For community group members

- Work management (HIV/AIDS-related activities);
- Community-based project design and implementation;
- Data collection, information exchange and monitoring of activities;
- Financial procedures;
- Counseling, care and support skills; and
- BCC concept and implementation strategies.

4.3.4 For *wereda* facilitators

- Community-based project design and implementation;
- Establishment, implementation, coordination and integration of various activities;
- Prioritization of activities; and
- Monitoring and evaluation at regional level.

5. RECOMMENDATIONS

1. There needs to be awareness raising about the spectrum of existing activities and referral networks amongst people implementing HIV/AIDS activities – most implementers seem to be engaged in unspecific, narrow ranging activities.

2. Implementers of HIV/AIDS intervention activities should either acquire broad skills encompassing many fields of work or specialize in a specific field.

3. The importance of coordination and integration of activities needs to be recognized and understood.

4. Resources such as manuals, guidelines and training modules need to be made available.

5. Training in monitoring and evaluation should be given to build the capacity of the individuals currently implementing HIV/AIDS activities.

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