

Addis Ababa University
Faculty of Business and Economics
Department of Public Administration and Development
Management

The Challenges of HIV/AIDS Program Implementation in
Addis Ababa City Administration with Particular
Reference to Lideta Sub City

By:
Mesfin Derso

June, 2010
Addis Ababa

Addis Ababa University
Faculty of Business and Economics
Department of Public Administration and Development
Management

The Challenges of HIV/AIDS Program Implementation in
Addis Ababa City Administration with Particular Reference
to Lideta Sub City

By:
Mesfin Derso

Submitted to:
Dr. Mulugeta Abebe (advisor)

Approved by Board of Examination

Mulugeta Abebe

Advisor

[Signature]

Signature

2 July 8, 2010

Date

Jemal Abagissa

Examiner

[Signature]

Signature

6 July 2010

Date

Acknowledgement

Almighty deserves the first praise for giving me the strength and capacity to reach this stage. If there is something I learnt about God, he is a true comforter.

Next, I extend my deepest gratitude to my advisor Dr Mulugeta Abebe who sacrificed his precious time to review my thesis and gave me constructive comments and criticism which have contributed positively to the final state of my thesis. I would like to thank Roman Kebede, Emebet Yohannes and my baby son Dagmawi Mesfin who helped me throughout my study. I am also indebted to Ato Abate Getahun who kindly assisted me in providing materials & sharing his experiences during my study.

Last but not the least I would like to acknowledge all those who gave me the necessary information during my research.

Table of Contents

	Page
Acknowledgement	i
Table of Content	ii
List of Tables	v
List of Figures	vi
Acronyms	Vii
Abstract-----	viii
Chapter One: INTRODUCTION	
1.1. Background of the study	1
1.2. Statement of the Problems.....	2
1.3. Research Questions.....	3
1.4. The objectives of the study	4
1.4.1 The general objective of this study.....	4
1.4.2 Specific Objectives	4
1.5 The Significance of the study	5
1.6 Scope of the study	5
1.7 Limitation of the study	5
1.8 Design of the study	6
1.8.1 Research Methods.....	6
1.8.2 Samples and Sampling Instruments.....	6
1.8.3 Data Gathering Instruments.....	7
1.8.4 Data Analysis Tools.....	7
1.9 Operational Definitions.....	8
Chapter Two: REVIEW OF LITERATURE	10
2.1 Introduction.....	10
2.2. Why Planning is Important for program implementation	10
2.3. Planning a Successful Program Implementation	12

2.4. Human Resource Allocation and Budget Monitoring	13
2.5. Establishing Monitoring Teams	14
2.6. Technical Support and Advisory Groups	14
2.7. AIDS in the context of Policy Development	15
2.8. The Multi-Sectoral Approach to the control of AIDS	15
2.9. Policy Implementation	17
2.10. HIV/AIDS Policy Implementation In Ethiopia	18
2.11. HIV/AIDS Policy Implementation Elements	20
2.11.1 HIV/AIDS Policy Management	20
2.11.2 Implementation Strategies	20
2.11.3 National HIV/AIDS Research Agenda	21
2.11.4 Rights and Responsibilities of Stakeholders.....	21
2.11.5 Transmission and Prevention	23
2.12 HIV/AIDS Programs Coordination and Integration ...	24
2.12.1 Coordination	25
2.12.2 Collaboration	26
2.12.3 Integration	26
2.13 Coordinated Versus uncoordinated system of HIV/AIDS	
Case Management	26
2.14 Key Elements of Successful Collaboration and Coordination....	28
2.14.1 A formalized system of communication	29
2.14.2 A coordinated approach to services delivery.....	29
2.14.3 A Client centered approach	29
2.14.4 Comprehensive in scope	29
2.15 Conclusion.....	30
Chapter Three: RESULTS AND DISCUSSIONS	31
3.1 Introduction	31
3.2 Analysis of Situations, Opportunities and Needs	31
3.3 Conclusion.....	49

Chapter Four: SUMMARY, CONCLUSION AND

RECOMMENDATION 51

4.1 Summary of the Findings 51

4.2 Conclusion..... 53

4.3 Recommendations..... 56

References

Annexes

List of Tables

	Page
Table I: Situations, opportunities and beneficiary needs.....	31
Table II: Making early agreement on Expected outcomes and evaluation	33
Table III: Level of coverage of priority needs of different groups.....	35
Table IV: Key elements of collaboration and coordination.....	37
Table V: HIV/AIDS mainstreaming practices.....	39
Table VI: Government and non-government organizations joint plans and pooling	41
Table VII: Levels of Participation of PLHA Association and HIV/AIDS infected people.....	43
Table VIII: Service Linkages among Government and non- Government Organization.....	44
Table IX: Impact of Clientele towards Coordination and the 'Three Ones' Principles.....	45
Table X: Project Sustainability while NGO's withdraw from the Area	48

List of Figures

	Page
Figure I ealth Implementation Framework.....	11
Figure II tages of Integration	25
Figure III n Uncoordinated Case Management Environment or the Client	27
Figure IV Coordinated and Collaborative Case management nvironment for the Client.....	28

Acronyms

AAHAPCO	Addis Ababa HIV/AIDS Prevention and Control Office
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BSS	Behavioral Surveillance Survey
CBO	Community-based Organization
CM	Case Management
CSW	Commercial Sex Workers
EMSAP	Ethiopian Multi-sectoral HIV/AIDS Project
FBO	Faith-based Organization
FDG	Focus Group Discussion
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FMOH	Federal Ministry of Health
GIPA	Greater Involvement of People Living with HIV
HBC	Home-based Care
HC	Health Center
HIV	Human Immunodeficiency Virus
LTFU	Lost To Follow-up
MACA	Multi-Sectoral Approach to the Control of AIDS
MDT	Multidisciplinary Team
MoFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
NGO	Non-governmental Organization
PLWHA	People Living With HIV/ AIDS
PMTCT	Prevention of Mother-to-Child Transmission
TB	Tuberculosis
UNAIDS	Joint United Nations HIV/AIDS Programs
VCT	Voluntary Counseling and Testing

Abstract

The study was designed to explore the 'Challenges of HIV/AIDS Program Implementation in Addis Ababa City Administration, Lideta Sub-city'. It was mainly focusing on the challenges of coordination and collaboration within and across different organizations which were working against the exponential spread of HIV/AIDS. To conduct the research, mixed research approach was employed to triangulate one set of finding against the others. The subjects of the study were ten sub-cities in Addis Ababa city Administration. From them Lideta sub city was selected purposefully. In this sub-city, there were nine kebeles from which eighteen health supervisors and nine Kebele Health Office Heads; four directors and four core processors of HC; four Anti-HIV/AIDS associations (chairpersons, secretaries and cashiers, totally twelve persons); four Faith-based organizations one from each (Orthodox Christian, Catholic Christian, Protestant and Muslim); eight representative from private higher clinics and six NGOs who were working against HIV/AIDS in the Lideta sub-city were selected by using available sampling technique. This was because they were manageable sizes to the researcher.

Data were mainly collected from 65 respondents using questionnaire for quantitative research and key interviews (4 top level NGO Chairpersons, 2 AAHAPCO office heads, 1 sub-city HO head) and two Focus Group Discussions (male FGD and female FGD separately). Frequency tables were used to see the rate of repetitions and interaction of the dependent and independent variables. All the gathered information was tallied and converted to percentiles. Percentile was used to compute in accordance with each category.

The general results of the study revealed that though commendable achievements have been obtained, there are still gray areas that should be addressed meticulously by all government and NGOs. A case in point was that, most of the strategies and programs seemed to lack coordination and collaboration within and across different organizations

Based on the overall results, it was recommended that both governmental and non-governmental organizations should create formalized system of communication, coordinated approach to the service, comprehensive client centered approaches and services to combat the ravages of HIV/AIDS pandemics easily.

CHAPTER ONE

1. INTRODUCTION

1.1 Background of the study

According to long lines of literature(Singhal, 2001 quoted in Rogers, 2003: 212; MOH 2004:2,to mention some)when AIDS first emerged, no one could have predicted how the epidemic would spread across the world and how many millions of lives it would change. There were no real ideas what caused it and consequently no real idea how to protect against it. As a result, with its blurred picture, HIV/AIDS was spreading in all corners of the globe unevenly like a wild fire and HIV/AIDS is the most serious worldwide public health problem of the current generations. Virtually there are no areas that have not reported cases of infection. Although the infection rate is increasing in other regions, such as part of Asia and the Caribbean, the worst affected region is Sub-Saharan Africa. 'Ethiopia is one in the sub-Saharan countries hardest hit by HIV/AIDS. The number of children who are orphaned by AIDS is estimated to reach about 1.2 million' (UNAIDS, 2005: 5).

Sexually transmitted diseases are known all over the world and in our country since many years. However, because of their wide distribution, the danger they pose if they are not treated on time and because of their close relationship with HIV/AIDS, their transmission is becoming a serious concern. In spite of this, special focus and relentless effort have been made more than ever to the prevention and control of these diseases. HIV/AIDS creates heavy social pressure on families and communities and psychological stress on those who are living with the virus since there have been no protective vaccine or medicine against it. Because of AIDS, marriage is destroyed, family is disintegrated, children

are left without parents and old people remain with no one to support and care them. Children who lost their parents are going and living on the street, the boys are exposed to crimes and the girls to prostitution. The population in the 15-49 age brackets is more affected by HIV/AIDS. This includes the farmer, intelligentsia, the worker, youth, commercial sex workers, long distance truck drivers, members of the military etc. Since these social groups are the national backbones of production and reproduction, and for the creation of a new generation, the general crisis that emanates from the illness and death on these social groups is very high. An AIDS person, apart from being separated from production as a result of AIDS, has other economic challenges. He/she needs money for treatment and his/her burial ceremony. Since his/her compatriots refrain from work to care him/her and attend his/her burial ceremony, the impact is not only on the individual himself/herself but also on the country. Because of this, AIDS at the present moment is becoming a problem beyond health and a hindrance to national growth and development. Currently, an all round effort is being made to prevent and control the spread of HIV/AIDS.

1.2 Statement of the Problems

The first AIDS Patients in the world were found in North America in the first half of 1981. The HIV virus which causes AIDS was known in 1984 by American and French scientists. This virus, which does not differentiate race, color, sex, age and religion is widely spreading and creating heavy toll on many millions of people. According to the joint UN AIDS program and WHO report of 2002, 42.0 million people in the world live with the virus and 27.9 million have died due to AIDS.

As cited in the bulletin entitled 'AIDS in Ethiopia'(2002:10) which was published by the Ministry of Health, 107,575 AIDS patients have been reported from all regions from the time the first two AIDS patients were found in 1984 to July 8, 2002. Out of these AIDS patients, 92 percent are adults of 15-49 years of age. These are patients who reported to health facilities and got laboratory examinations and treatment. A country that loses this age group would face different challenges such as economic, social and development, because this is a production age group. On top of that there are many people who have not gone for blood examination and living with the virus and also most people infected show no symptom and are healthy for a long time, however, being able to pass the virus to others without even knowing. Because of this the prevention efforts are being difficult. For example Addis Ababa city administration where this study deals with the HIV/AIDS prevalence rate is 9.2 percent and the very threatening is the incidence rate i.e. every year about 22,217 people are newly infected (AAHAPCO 2009: 45).

Though it has been three decades where tremendous actors are engaged in HIV/AIDS prevention activities still many are infected with the virus. Having exerted this much efforts; why could not make a difference? There must have been some gaps. The researcher of this study believes that these problems are emanated from lack of coordination of all stakeholders' efforts. Based on these gaps research questions are formulated.

1.3 Research Questions

The following research questions of the study are formulated to examine HIV/AIDS program implementation in Addis Ababa City Government:

1. What are the challenges towards coordination among governmental and non-governmental organizations in Addis Ababa?

2. To what extent does the interest of the clientele of the fund donor's influence the efforts towards coordination?
3. Has there been effective coordination among government organizations and non-government organizations to implement the HIV/AIDS programs?
4. To what extent does lack of coordination among different organizations affect HIV/AIDS program implementations?
5. How has lack of human and financial resource capacity affected implementation?
6. What mechanism/measures should be used in order to resolve the challenges of implementations?

1.4. The Objectives of the Study

1.4.1 The general objective of this study: is to investigate the challenges of HIV/AIDS program implementation

1.4.2 Specific objectives

1. To examine the extent to which absence of coordination among actors affected HIV/AIDS program implementation.
2. To examine how capacity problems hindered program implementation.
3. To analyze whether the implementing agency/government organization employ a more participatory approach by involving key stakeholders.
4. To suggest possible measures that might deal with the challenges of program implementation

1.5. The Significance of the Study

It is hoped that the result of the study will benefit:

- A. Primarily the FMOH since they will be able to take appropriate and immediate remedial measures in order to alleviate the detected problems.
- B. policy, strategy and program designers and any other bodies might use it as a spring board while designing or revising the training and implementation manuals
- C. The Addis Ababa city administration will identify the gaps of the existing policy on HIV/AIDS.
- D. Other researchers will use it as a beginning for some issues that will be recommended in this study for further study.

1.6 Scope of the study

The national HIV/AIDS policy has been implemented across the country by various stakeholders since the strategic plan for intensifying the multi-sectoral HIV/AIDS response was introduced in 2004. To make the research manageable and due to financial & time constraints, the scope of this study is limited to Addis Ababa City administration with particular reference to the targeted sub city (Lideta).

1.7 Limitation of the study

It is clear that the national HIV/AIDS policy implementation seeks all actors to involve through multi-sectoral approach as the policy applies to all stakeholders, from government, civil society, private sector and development agencies involved in AIDS response. However, this study is limited only to the assessment of HIV/AIDS program implementation by the implementing agencies in Addis Ababa city administration.

1.8. Design of the study

This section subsumes the various steps that are to be adapted by a researcher in investigating the problems. These are research method, samples, sampling and data gathering instruments and method of data analysis.

1.8.1. Research Methods

The method that was employed in this study was a Mixed Research Method. According to Cresswell (2009:67) mixed method research has been increasingly seen as a third approach in research methodology. It involves the collection or analysis of both qualitative and quantitative data in a single study with an attempt to integrate the two approaches at one or more stages of the research process. The purpose of mixed method research is to achieve a fuller understanding of a target phenomenon by triangulating or corroborating findings to verify one set of findings against the other (Cresswell,2009:70)).This method also geared towards two fundamental questions: What happened in the past, and what is happening now in the sampled sub-city?

1.8.2. Samples and Sampling Instruments

The population of the study was ten sub-cities in Addis Ababa city Administration. From the ten sub-cities, Lideta was selected by using purposive sampling technique. This was because the problems which were prevalent in the Lideta sub-city were assumed to be representative of all the ten sub cities in Addis Ababa in connection with levels of coordination and collaboration within and across the government/non-government organizations. In the Lideta sub-city, there are nine kebeles. Two health extension supervisors and one kebele health office head from each kebele (totally twenty-seven health extension supervisors & health office heads); four directors and four core processors from Lideta subcity governmental health centers(totally eight persons); from four Anti-HIV/AIDS associations:

chairpersons, secretaries and cashiers(totally twelve persons); four Faith-based organizations one from each (Orthodox Christian, Catholic Christian, Protestant Christian and Muslim); eight physicians and head nurses from private higher clinics and six NGOs who are currently working against HIV/AIDS in the Lideta sub-city were selected by using available sampling technique.

1.8.3 Data Gathering instruments

The city administration was divided into 10 sub-cities and 99 Kebeles. The primary data were collected from 65 respondents using questionnaire, key interviews (four top level NGO Chair persons, one AAHAPCO office Head, one sub city HAPCO core processor, one sub city Health office Head and one sub-city Idirs' Council chair person) and two Focus Group Discussions (male FGD and female FGD separately). The secondary data were collected basically from strategic plans, journals, working papers, documents, previous studies, statistical documents, national policies, and unpublished documents (reports) from different offices including federal, regional, and from each kebele related to health program implementation.

All the gathered information were tallied and converted to percentiles. Percentile was used to compute in accordance with each category. Since frequency tables were used to see the rate of repetitions and interaction of the dependent and independent variables. Finally, conclusion was drawn and recommendations were given in line with the magnitude of the problems which were prevalent in the sub-city.

1.8.4 Data Analysis Tools

The collected data were analyzed using percentile and interpretation was made for the interview results obtained from the officials of AAHAPCO, Sub-city Health Office and HIV/AIDS Prevention and Control Core Processor, NGOs, private higher clinics, PLWHA associations and IDIR councils.

1.9 Operational Definition

Below is a glossary of terms and definitions as they apply to implementation of case management in the context of HIV/AIDS programs in Ethiopia.

AIDS (Acquired Immune Deficiency Syndrome): the late stage of HIV infection, characterized by a deterioration of the immune system and a susceptibility to a range of opportunistic infections and cancers.

Adherence: refers to patients' ability to stick to or be devoted to ART. It involves taking medications in the correct amount, at the correct time, and in the way they are prescribed.

Adherence support group: a group of people who are taking ART and who support each other through sharing their experiences about treatment and care in order to promote adherence.

Case Management/care management-is a client-focused process that expands and coordinates existing services to clients (HIV/AIDS infected people).It is program coordination or service coordination that reflects a more client/consumer-centered approach (WWW.dhss.mo.gov/HIV_AIDS/CaseMgmt.html).

Care plan: a client- and family-centered action plan which is developed by an Adherence Case Manager and clients at-risk for non adherence or caretaker through a comprehensive need assessment in order to promote client's adherence to treatment and care.

Clientele: is funder of the program(s)

Client: HIV/AIDS patient receiving HIV/AIDS case management services.

Clients at-risk for non adherence: clients who may likely not adhere to treatment and care and potentially become lost to follow-up (LTFU).

• • •

Community mobilization: involves ensuring a supportive environment for HIV- infected or HIV- affected people in order to promote adherence and reduce LTFU.

Documentation: recorded information in the client file or other source documents.

Evaluation: the process of determining the worth of something, e.g., in order to evaluate a service.

Health facilities: public hospitals and health centers which deliver ART services.

HIV: (Human Immunodeficiency Virus): the virus that causes AIDS by killing or damaging cells of the body's immune system. HIV progressively destroys the body's ability to fight infections and certain cancers.

Idir: a voluntary association working on care and support beyond facilitating and covering the costs of burial and mourning ceremonies.

Kebele: the lowest unit of government administration in both rural and urban setting.

Need: Physiological, psychological, or social requirement for well-being that may or may not be expressed by the client in need.

Non-adherence: not taking ART medications as they are prescribed (i.e., the right drugs, the right way, and at the right time).

Primary caregivers: the friends, family or neighbors that do most of the day-to- day, home- based caring for sick clients.

Resource: a term used to describe something tangible that is supplied to, or can be accessed by, the client to help achieve goals.

Services: a term used to describe a more formal, well-defined group of activities intended to accomplish a specific task.

Support: an activity or intervention that encourages strengthens, or otherwise helps a client care for her/himself.

Sub-city: district or collection of kebeles

CHAPTER TWO

2. REVIEW OF LITERATURE

2.1 Introduction

Collaboration and coordination are essential components of any effective multi-agency community case management system. When collaboration and coordination among case managers is not practiced, this can undermine the efficiency of case management in HIV health care systems. Uncoordinated systems of case management can also keep clients from accessing services and cause duplication of efforts and gaps in service, waste limited resources, and prevent case managers from achieving shared goals of facilitating quality client care. Therefore, it is useful to work collaboratively during planning, implementation and evaluation within and across all organizations to avert the rampant spread of HIV/AIDS.

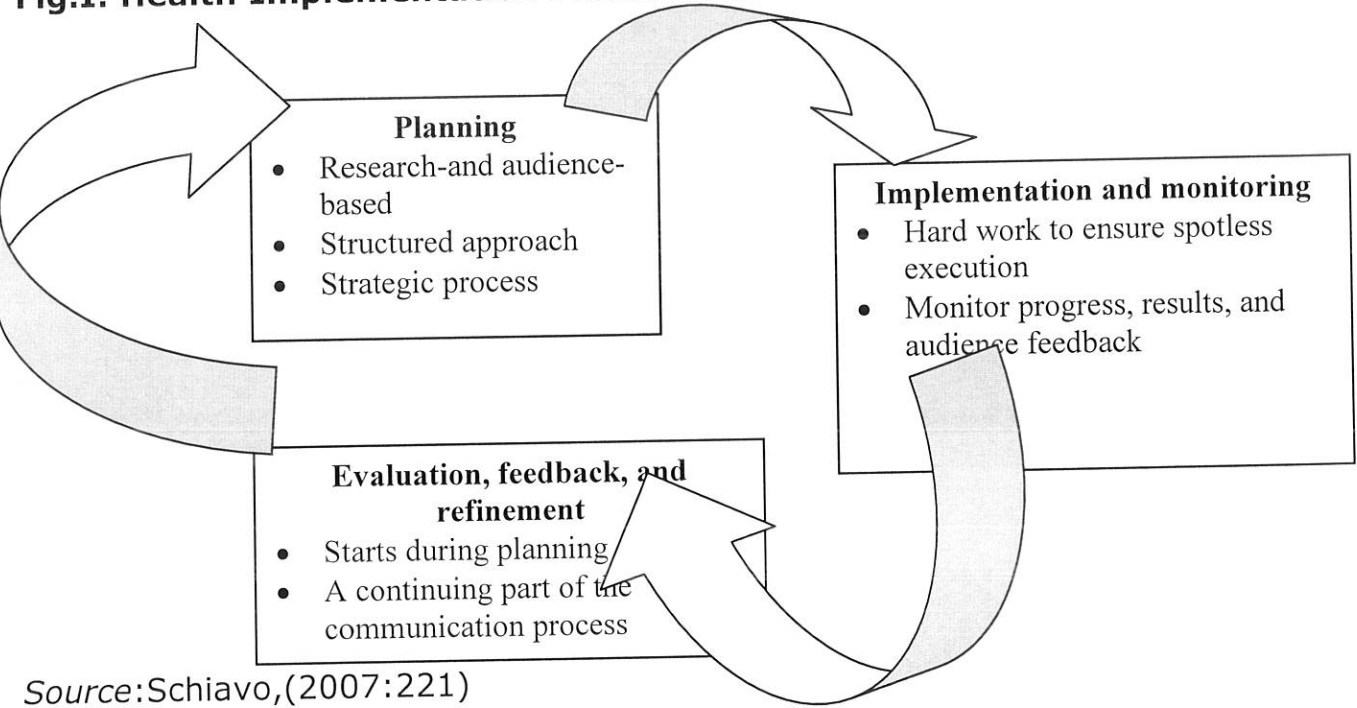
It is conceived that planning for a spotless program collaboration and coordination entail several steps that are related to establishing and maintaining standard practices for the management of funds, human resources, specific activities (for example, monitoring and data collection), and internal communication team. It is also related to anticipating and preparing for potential issues that may arise during program implementation and affect expected outcomes. The student researcher believes that a team-oriented mind-set, as well as attention to detail is critical to the implementation of all practices and steps in health program implementation (Schiavo2007:200).

2.2 Why Planning is Important for program implementation?

Wheelen,T.and Hunger,J.(2006:216)stated that planning is one of the standard protocols and activities of the organization since planning is a

research-driven process. An in-depth understanding of the health environment as well as the needs, preferences, and expectations of key audited and well-orchestrated interventions those are far more effective than single and sporadic approaches (Schiavo, 2007:337-338). Fig.I: Down below describes the phases of health planning and strategic planning is directly connected to the other two stages of the health cycle (program implementation and monitoring, and evaluation, feedback, and refinement). In fact, effective strategic planning influences the success of the implementation experience, as well as the overall evaluation process and potential outcomes. In turn, planning is influenced by observations and lessons learned during the implementation and evaluation phases, which may validate or call for changes in all or some of the elements of the initial communication plan. It is believed that all steps of the planning phase are interdependent. Failure to complete all steps may limit the program's ability to meet the expectations and needs of intended beneficiaries as well as effectively address any given health issue (Wheelen,T.& Hunger,J.2006:206).

Fig.I: Health Implementation Framework



In brief terms, it is believed that all the building blocks of the health intervention program should be cohesive and have a strong evidence-based foundation. Therefore, many great expectations about the programs implementation and potential outcomes seem to be stable and strong. Yet, even sturdy and balanced plans may falter or even fall in the absence of adequate maintenance or in the case of unforeseen difficulties. Clearly, it is important to maintain the health intervention program through management and monitoring of activities that ensure a spotless execution of all the plan elements (Schiavo, 2007:210).

Implementing a health intervention program is similar to implementing any other type of plan. It is a combination of managing economic and human resources with monitoring program activities and audience feedback as well as measurement parameters and all the external factors and trends that can influence the program's potential outcomes. It requires hard work, perseverance, problem-solving skills, and a team-oriented mind-set. The implementation for evaluation plan is part of this process (Schiavo, 2007:215).

2.3. Planning a Successful Program Implementation

It is conceived that planning for a spotless program execution entails several steps that are related to establishing and maintaining standard practices for the management of funds, human resources, specific activities (for example, monitoring and data collection), and internal communication team. It is also related to anticipating and preparing for potential issues that may arise during program implementation and affect expected outcomes. The researcher in this paper believed that a team-oriented mind-set, as well as attention to detail is critical to the implementation of all practices and steps in health program implementation (Schiavo, 2007:200).

2.4. Human Resource Allocation and Budget Monitoring

Dozens of scholars (Faton, 2005:225 and others) suggested that the tactical plan should include a detailed budget estimate as well as a description of the roles and responsibilities of specific team members and partners. This should ideally incorporate an approximate evaluation of the time each team member is committing to the program. Tactical plans should also identify the program's management team. However, sometimes programs get funded long after they were planned and call for a reassessment of these elements. The first step in program implementation is to make sure that no changes in the original program's team are necessary in the light of recent career moves, loss of interest in the project, or conflicting and unexpected priorities. Program staff substitutions should be strategic and should look at the specific skills and contribution the original team member or partner was bringing to the program. Perhaps, a patient group that is well known for its research and advocacy work in the field of mental illness decides to withdraw from a specific health communication program for a variety of reasons. In this case, program planners should identify another organization with similar reputation, skills, interests, expertise, and constituencies in the same disease area. In other words, human resources are allocated to a program on the basis of their skills and experience. The same principle should apply to potential substitutions or integration of partners and staff (Hofsson, 2009:150).

Finally, the program's team should include specific individuals who are responsible for budget monitoring, that is, making sure that all program tactics are implemented within the budget that has been estimated and allocated for each of them. This is normally the responsibility of the management team with the help of one or two additional team members.

Budget reports, which include itemized expenditures and remaining amounts, may be a useful tool to record and share budgets status.

2.5. Establishing Monitoring Teams

According to many scholars (Schiavo,2007;Wheelen & Hunger,2006:216),monitoring is an essential function in program implementation and is related primarily to four areas: (1) program activities and the related process; (2) audience and stakeholders' ongoing feedback on the program's elements, overall content, and messages; (3) news and trends about the specific disease areas, key policies, audiences, and other relevant facts and events; and (4) the collection and analysis of evaluation data. Different skills and collection methods are required for each of these areas. For example, monitoring program activities, which is part of process evaluation and serves to assess whether program implementation occurs within the parameters envisioned by the program plan, is frequently a management function. However, it also involves the participation of all team members dedicated to a specific activity. If a team member has strong relationship with, for example, the HIV patient and advocacy community, he or she is the best candidate to secure on-going reactions to and feedback on the program's key elements and contents from this audience. Finally, evaluation data should be monitored and collected on the basis of the indicators and methods described in the evaluation plan. Early in program implementation, specific team members should be assigned to each of these areas of monitoring.

2.6. Technical Support and Advisory Groups

Schiavo(2007:220) pointed out that involving agencies and consultants early in the process and in any case not later than during the strategy development phase, is good practice in health intervention program and helps maximize the strategic contribution and dedication of all consultants.

In other words, early in program implementation, all agencies that have participated in program planning should be invited to a team meeting to define the implementation process, confirm the program's time line, and develop a checklist of all logistics related to the execution of program activities. It is also possible that additional consultants may need to be interviewed and hired in this phase of the program. Obviously, funds for hiring other consultants that are not part of the strategic communication process should have been included in the original budget estimate. If specific needs arise or preliminary conversations with key stakeholders have confirmed the importance of a specific advisory that could lend technical support to the program, these groups should be established and involved as early as possible.

2.7. AIDS in the Context of Policy Development

The implications of the AIDS epidemic cut across all sectors and sections of society and therefore require to be addressed within the various relevant policy frameworks. This National AIDS policy highlights the need to place AIDS in the broader context of national policies, especially of poverty eradication and protection of human rights. It is also aligned to relevant international policy frameworks (Singhal, 2001 quoted in Rogers, 2003: 300; MOH 2004:120).

2.8. The Multi-sectoral Approach to the Control of AIDS

The Multi-sectoral Approach to the Control of AIDS (MACA) advocates for the active involvement of all members and levels of society, individually and collectively, in HIV prevention, control and AIDS mitigation activities. It seeks to address not only HIV prevention but also the active response to and management of all perceived consequences of the AIDS epidemic. MACA also emphasizes institutional capacity building for sustainable containment of the epidemic. This policy builds on the MACA to provide further policy guidance in

the various aspects of management of the epidemic.

- A. To prevent the transmission of HIV
- B. To provide treatment and care to all those infected and affected by HIV and AIDS
- C. To minimize the socio-economic consequences of HIV and AIDS on the population and to national development
- D. To address HIV and AIDS concerns amongst the disadvantaged populations and those at higher risk of HIV infection, to reduce vulnerability and promote equal access to impact mitigation services.
- E. To promote and guide HIV and AIDS-related research to ensure standards, promote innovation and access to reliable information to maximize the attainment of the policy objectives
- F. To guide the coordination and management of the national response to the epidemic
- G. To provide a coordinated, participatory, transparent approach to HIV and AIDS, which incorporates HIV and AIDS policy and programmes in all sectors

Explanation- Ethiopia subscribes to the coordination principles of the 'Three Ones,' namely One Coordination Authority that brings together all partners in the response; One National Framework for Action, and One Monitoring and Evaluation Framework. Central coordination, by the National HIV/AIDS Prevention and Control Office (NHAPCO), has been vital to ensure harmony, focus on common priorities and optimal utilization of available resources to avoid duplication.

The National framework will have an in – built mechanism to ensure mobilization of key actors throughout all branches of government and include all policy areas to ensure a well integrated and coordinated approach to address HIV and AIDS.

2.9. Policy Implementation

Policy implementation deals with the resources available, who should be involved and how implementation should be enforced (Walt 1996: 45). The health sector in Ethiopia has taken a new form since the national HIV/AIDS prevention and control office (NHAPCO) was created out of the MOH. As an authorized agency, the NHAPCO has the responsibility to implement the HIV/AIDS policy in the country whereas the MOH is responsible for policy development and agenda setting. The establishment of the NHAPCO is an essential part of the key strategies in the Health Sector. Set technical guidelines to achieve policy standards set by the ministry (MOH), Promote health modes of healthy living and good health habits by people establish effective mechanisms for disease surveillance, HIV/AIDS prevention and control.

This policy would be implemented throughout the country albeit at district levels, to aid the decentralization process of the MOH. In implementing the policy, the NHAPCO as an important actor needs to starkly corporate with regional HAPCOs and all sectors at the international, national and local levels. NGOs, FBOs and IOs are indispensably vital for the success of the implementation. Going beyond policy formation to actual implementation allocating resources, mobilizing personnel, and providing institutional support to implement a policy usually require stronger commitment than formulating or approving a policy. Celebration of the adoption of a policy must quickly be followed by steps to ensure its implementation. Some policies items have already been implemented through operational or strategic plans and technical guidelines. The policy will initiate a comprehensive implementation of plans and will sustain and scale up the already ongoing plans and prevention efforts.

What is the role of policy? One possible interpretation is that policy development plays a marginal role. It serves mainly to systematize and legitimize existing principles and practices and communicate those to the organization, which may listen or ignore the messages. And also provide a framework for assistance and cooperation from international, regional and national development partners.

2.10. HIV/AIDS Policy Implementation in Ethiopia

The government of Ethiopia has established the Health Sector Development Program (HSDP), which incorporate a 20-year health development strategy, through a series of five-year investment programs (MOH 1999 cited in BSS 2005:2). The first two phases have been completed and HSDP III has began, focusing on poverty-related health conditions communicable diseases such as HIV, malaria and diarrhea, and health problems that affect mothers and children with particular attention to rural areas (MoFED 2005 cited in BSS 2005:3).

Analyzing the worsening situation of the HIV epidemic in Ethiopia, the enormous implications of human suffering and the social effects and costs of health services, the Ministry of Health drafted a National HIV/AIDS policy in collaboration with various stakeholders in 1998. During the first half of 1998, the Ministry of Health and Regional Health Bureaus formulated HIV/AIDS Strategic Plans for the period of 2000-2004 for all the nine Regions and two city Administrations(HAPCO & FMOH 2004:2).In April 2000 the National AIDS Council (NAC) was established under the chairmanship of the country's president . The council was composed of representatives from relevant government, Private, Faith based, Non Government Organizations and prominent figures. A secretariat accountable to the Prime Minister's Office was also established to coordinate the national multi-sectoral response.

Similar structures with similar constituencies were also established in the regions and at lower administrative levels. (BSS 2005: 4).

The legal establishment of HIV/AIDS Control and Prevention Office in 2002 and the launching of multi-sectoral HIV/AIDS control and prevention programs were some of the major steps forward in the battle against HIV/AIDS.(MOH & HAPCO 2004:3). The national AIDS priority Strategies for the period 2001-2005 were identified and the National Strategic Framework provided for the implementation of the Ethiopian Multi-Sectoral HIV/AIDS Project is Known as EMSAP.

The priority intervention areas of the strategic framework of the national response to HIV/AIDS epidemic in Ethiopia have been designed to guide the implementation of programs to prevent the spread of the epidemic are:

- A. Information, Education and Communication (IEC) and Behavior Change Communication (BCC)
- B. Condom promotion and distribution
- C. Voluntary Counseling and HIV Testing (VCT) services/HCT
- D. Management of Sexually Transmitted Disease (STI)
- E. Blood Safety
- F. Universal Precautions and Infection Prevention
- G. Prevention of Mother to Child Transmission of HIV (PMTCT)
- H. Care and Treatment
- I. Legislation of Human Rights
- J. Surveillance and Research
- K. Monitoring and Evaluation (M&E)
- L. Management and Coordination

2.11. HIV/AIDS Policy implementation Elements:

2.11.1 HIV/AIDS Policy Management

The implementation of the policy is based on partnership with civil society, including the private sector, trade unions, NGOs, CBOs, FBOs and other stakeholders. In addition to this multi-sectral approach, the implementation of the policy needs to be participatory, such that it needs to involve all beneficiaries including persons living with and affected by HIV/AIDS and the most vulnerable groups, in the design, delivery and evaluation of the program. In Ethiopian case, the National HIV/AIDS Prevention and Control Office has the responsibility to coordinate the national response, provide leadership and technical guidance, and address the mobilization of adequate local and international resources for an effective response to the epidemic. Sector ministries, NGOs and private sector entities will implement various aspects of the policy. Strengthening and sustaining partnerships between the Government and all relevant stakeholders is critical to the success of the policy.

2.11.2 Implementation Strategies

- A. Mainstreaming HIV/AIDS issues into all relevant policies, plans and programs or establishing a specific focal point in each organization.
- B. Strengthening the role of the NAC (National AIDS Council) in advising the government of Ethiopia on HIV/AIDS issues based on best practices, and coordinating the involvement of stakeholders and partners, including adolescents, youth and other vulnerable groups in the implementation of the national response.
- C. Ensuring that resources for HIV/AIDS are allocated and managed to ensure an effective and efficient national response.

2.11.3 National HIV/AIDS Research Agenda

HIV/AIDS research is required to address gaps in existing knowledge about HIV/AIDS and to inform policy, practice and HIV/AIDS related interventions.

2.11.4 Rights and Responsibilities of Stakeholders

Government is a facilitator, to ensure coherence and coordination of the national response including setting the comprehensive and inclusive legislative and policy framework, within an environment of multi-sectoral participation. Government is also implementer, through the delivery of health protection and promotion, clinical services, development of guidelines, social protection research, financial resources and enforcement.

Civil Society needs to partner with government to implement various aspects of the policy, but also has a watchdog role to ensure that government fulfils on its commitments. Civil society, through faith based organizations, community based organizations, non - governmental organizations and the private sector also has the responsibility to advocate for interventions in keeping with fulfillment of human rights for all; and care for those infected and affected. There is an imperative that all stakeholders ensure that they provide accurate HIV-related prevention information and education as well as care and support for people living with HIV/AIDS and not make false claims of HIV/AIDS cures or promote behaviors that increase the risk of HIV infection.

People living with HIV/AIDS (PLWHA) – needs to be involved in all aspects of policy development, implementation and evaluation. The policy will help to affirm the rights of PLWHA; to ensure that exclusion from work, social services or participation in events is not based on their HIV status; to normalize HIV/AIDS by reducing stigma and discrimination associated with it; to improve the quality of life for PLWHA; and to reduce the risk of infection

by PLWHA through adherence to consistent condom use or abstinence. No person should be obliged to disclose his or her status for purposes of employment or social involvement. PLWHA have the responsibility to ensure that they do not willingly or unwillingly spread HIV and to be involved in lobbying for access to interventions and legal redress.

Most Vulnerable Groups- Adolescent and Youth should have the right to knowledge of HIV modes and transmission and prevention methods of abstinence, mutual faithfulness and consistent condom use. They have the right to participate as a key resource during policy and program development, implementation and evaluation and given the opportunity to voice their concerns about strategies and interventions developed for them. Strategies designed for students within the formal education system should be determined with the involvement of the Ministries of Education and Youth and Sport. Both in-school and out-of-school adolescents and youth should have access to culturally appropriate, gender and age sensitive interventions and support material within a life skills context. No child should be denied a place in school on the basis of real or perceived HIV status.

Street & Working Children should have the right to HIV prevention knowledge and skills including abstinence, condom use, and to treatment, care and support, protection from statutory rape, sexual assault and VCT. Commercial sex workers have a responsibility for protecting themselves, their clients and their sexual partners from the risk of HIV infection. They should have access to peer education training, condom-use and condom negotiation skills, VCT and proper diagnosis and treatment of STIs. More user friendly clinics should be established and sustained to improve the non-threatening access of CSWs to prevention information, skills and services.

Inmates/people in prison should not be denied the right to access prevention knowledge, skills and services and voluntary counseling and testing. They should have access to treatment, care and support. Access to HIV/AIDS /STI prevention information, treatment care and support should take into account protection from rape, sexual violence and coercion. Juveniles should be segregated from adult inmates to protect them from abuse. inmates should not be subjected to HIV testing without their informed consent, isolation or any of quarantine on the basis of real or perceived HIV/AIDS status.

Policy implementation assessment tools consider seven dimensions these are:

- A. The policy, its formulation, and dissemination
- B. Social, political, and economic context
- C. Leadership
- D. Stakeholder involvement
- E. planning and resource mobilization
- F. Operation and services; and
- G. Feedback on progress.

The tool enables stakeholders to gather information about a multifaceted process in a systematic, user friendly manner. With this evidence, they can better understand what is and what is not working, explore root causes, and begin to devise solutions to identified barriers.

2.11.5 Transmission and Prevention:

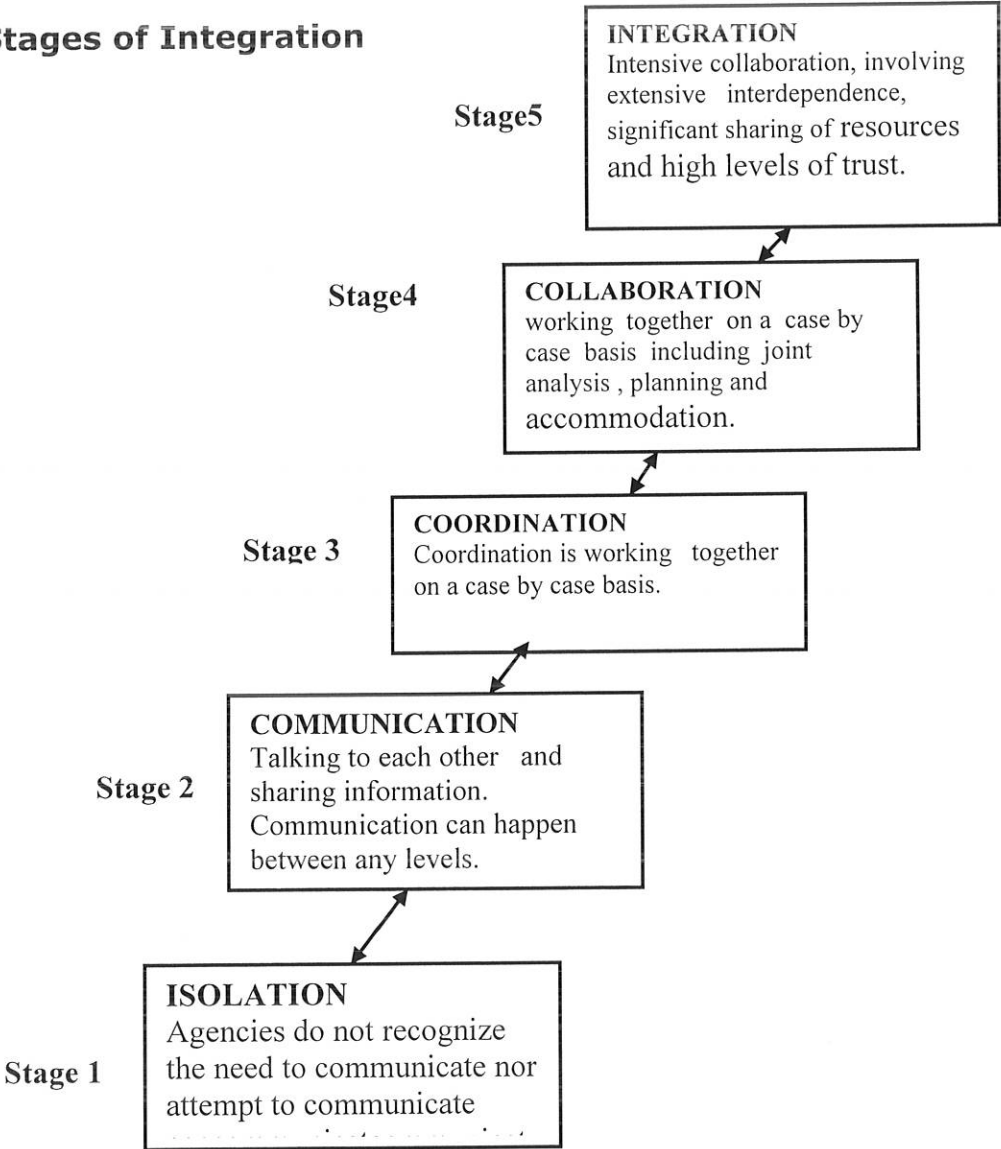
The HIV virus spreads from person to person through blood-to-blood or sexual contact with someone who has the virus. A mother living with HIV can pass the virus on to her baby during pregnancy, delivery or through breast milk. The virus does not spread from person to person by casual everyday contact and is not spread through the water or air. Body Fluids containing HIV Blood, Semen, Vaginal Fluids, Breast Milk, Other body fluids containing blood, you can contract HIV by sharing needles and syringes with someone

who is living with HIV; by having unprotected anal, vaginal, and oral sex with someone who has the virus; A newborn's exposure to his or her HIV positive mother during pregnancy, birth or through breast feeding. Sex between two mutually monogamous, uninfected partners who do not share needles and syringes with anyone; massaging one's own genitals or masturbation; activities that do not include touching a partners penis, vagina or anus; activities that do not include sex, whether oral, anal or vaginal are Safer forms of sexes.

2.12. HIV/AIDS programs Coordination and Integration

Program coordination or service coordination is one of the methods to avert the exponential spread of HIV/AIDS by using care management or case management. According to Hopson and Fenton (2008:20)), case management (care management) reflects a more client/consumer-centered approach. It is depicted in the following figures (II_IV)

Fig.II Stages of Integration



Source: Hopson&Fenton(2008:20) as adapted from Burt Spellman (2007)

2.12.1 Coordination is the third stage after isolation and communication (information sharing net working) and generally involves staff of different agencies working together on a case by case basis to ensure that clients receive appropriate services. It can involve front line case managers, supervisors and organizational leaders. Unlike collaboration, coordination does not change the way agencies operate or the types of services they provide, rather it represents an agreements between them to avoid duplicating each other efforts and engage in some level of cooperation in the delivery of available services.

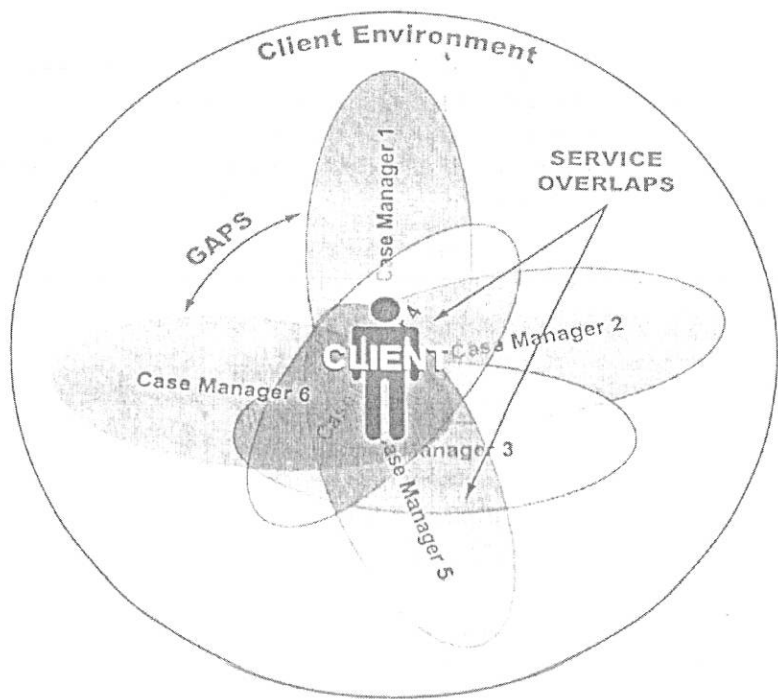
2.12.2 Collaboration builds on coordination and includes joint work to develop shared goals. It also requires participants to follow certain protocols that both support and complement the work of others. Unlike coordination, collaboration requires the commitment to agency or system leadership to be effective and produce the kind of sustained change that is central to its objectives. Collaboration has a greater potential to create seamless, client centered system of case management, has a greater capacity for extending the reach of limited resources and gets participants closer to establishing a foundation for true systems integration. Collaboration usually results in varying degrees of systems change.

2.12.3 Integration is the most intensive form of collaboration, involving extensive interdependence among participants, significant sharing of resources and high levels of trust. Integration has tremendous potential to streamline efforts and maximize the use of resources by changing the way program function internally. Full integration of HIV/AIDS programs would necessitate policy and legislative changes to reduce funding and administrative barriers, and thus is not the focus of this study.

2.13 Coordinated versus uncoordinated system of HIV/AIDS case Management

While there is general agreement in the HIV/AIDS community that collaboration and coordination in the delivery of case management services is beneficial to both case managers and clients, these approaches have not yet become standard practices within systems of care. For a variety of systemic reasons already discussed, case managers sometimes work in isolation from each other with only a partial view of the services that the client is receiving.

Fig. III **An Uncoordinated Case Management Environment for the Client**

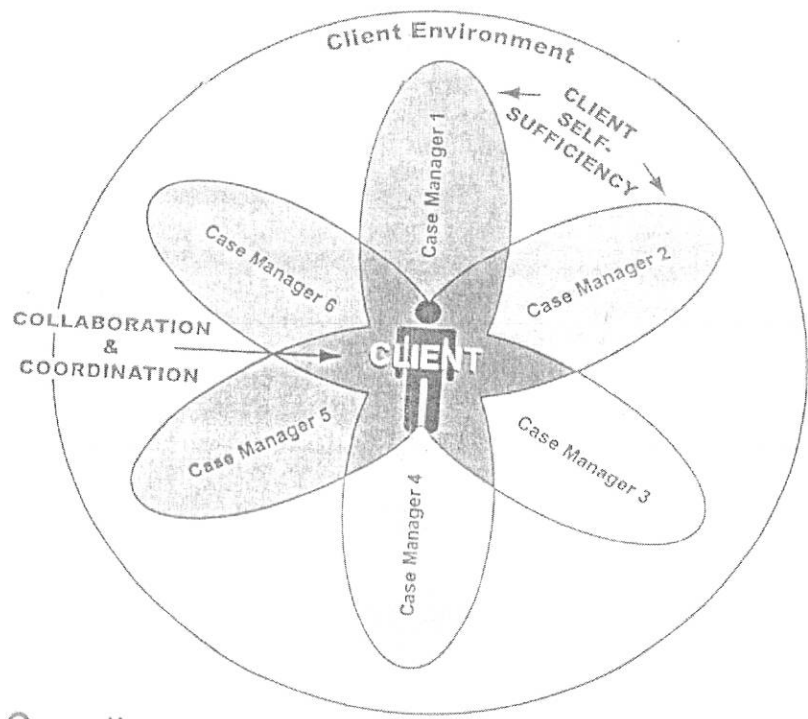


Source, Hopson& Fenton (2008:20)

The figure above depicts an uncoordinated system of care. The outer circle represents the total client environment. Each case manager's discipline of service represented by the shaded ovals in the figure which may cover either a specific or several different needs of the client, such as medical care, housing substance, abuse treatment, mental health, HIV prevention or benefits management.

It is clear that lack of collaboration or coordination results in duplication of services as signified by the areas where the ovals overlap with each other or gaps in services that leaves client needs unaddressed as represented by the spaces between and around the ovals.

Fig.IV **A Coordinated & Collaborative Case Management Environment for the Client**



Source: Hopson and Fenton (2008:23)

In redrawing, this case management system, each oval now represent the unique contributions of individual case managers to a more coordinated or collaborative effort. In this system, each case manager supports and enhance the role of other case managers to address client needs in a comprehensive manner. Areas in which the ovals overlap with each other represent efforts by case managers to line their services rather than duplicating their efforts and waste resources. The white space between the ovals now represent areas of client self sufficiency, areas that expand as the client moves away from his or her dependence on case management services.

2.14 Key Elements of Successful collaboration and coordination

The parameters of collaborative or coordinated arrangement can change from situation to situation. The level of engagement depends on many factors

mentioned already. Despite the difference, there are several key elements of effective collaboration or coordination. These included:

2.14.1 A formalized system of communication: case managers who serve the same client populations should establish methods of regular communication so that they can align their activities with each other. These could include monthly conference calls at designated times, regular case conference or other approaches that keep them informed and updated about shared client's progress.

2.14.2 A coordinated approach to services delivery: to avoid duplication and services gaps, case managers effort must be in sync with each other. In cases where clients are eligible for case management services programs, a "lead" case manager could be designated to coordinate services and communicate regularly with other case managers about a clients progress/ status. Such leadership could rotate between team members depending on a client's assessed needs and services priorities.

2.14.3 A client centered approach: services should be based on clients' assessed need rather than services availability, and should accord clients both rights and responsibilities for their own care. Case managers should recognize and address client barriers to care.

2.14.4 Comprehensive in scope: since most clients with HIV/AIDS face multiple and persistent barriers to care, case management systems should, to the extent possible, enhance, client access in a broad range of services in seamless manner. This could involve development of a 'one-stop' model that provides clients with wrap around services to meet their needs.

2.15 Conclusion

To conclude, planning is a cooperative and interactive process between the case manager and the client that involves the development of an individualized treatment and service plan based on client needs and available resources. Planning also includes the establishment of short-term and long-term goals for action. Coordination and linkage connect clients to appropriate services and treatment in accordance with their service plans reduces barriers to access and eliminates/ reduces duplication of effort between case management programs. Coordination includes advocating for clients who have been denied services for which they are eligible. Monitoring and re-assessment is an ongoing process in which case managers continually evaluate and follow up with clients to assess their progress and to determine the need for changes to service and treatment plans. To avoid duplication and service gaps, program implementers' (service providers') efforts must be in sync with each other. And services should be based on clients' assessed need rather than services availability, and should accord clients both rights and responsibilities for their own care.

CHAPTER THREE

3. Results and Discussions

3.1 Introduction

This part deals with presenting analyzing and interpreting the information gathered from Addis Ababa city administration, Addis Ababa HAPCO and from Lideta sub-city administration and non government organizations which have been working in connection with HIV/AIDS. All results in tables have been obtained from the questionnaire respondents and the results obtained from interview and FGD support and strengthen the questionnaire responses.

3.2. Analysis of Situations, Opportunities and Needs

Table I: Situations, Opportunities and Beneficiary Needs

o	Items	Yes		No		Total		If 'yes' to what extent		
		F	%	F	%	F	%	3	2	1
	Did government and non-government organization make careful analysis of the:									
	A. Situations,	14	22	50	78		100	7.14	14.4	78.6
	B.Opportunities	24	37.5	40	62.5	64	100	4.2	8.3	87.5
	C.Beneficiary needs before designing program implementation?		46.8	34	53.13	64	100	3.3	6.7	90.0
	Average	22.6	35.5	41.3	64.54	64	100	4.9	9.8	85.4

Source: Survey Data, 2010

Table I depicted that government and non-government organizations do not seem to make careful analysis of the situations 78 percent, opportunities 53 percent and beneficiary needs 53 percent before designing program implementation. In relation to these points, although it is quite clear that only well-planned and well-executed health activities with the concerned beneficiaries that have the potential to achieve long-term and sustainable results, the Focus Group Discussants (FGD) pointed out that in most implementation programs, the needs of the client or the program beneficiary seem to have been sidelined and downgraded by the program designers. To verse it differently, they have not been allowed to participate while different HIV/AIDS programs have been designed. As a result, most of the programs do not reflect the interest of the beneficiaries.

The other important point is that though program designers have one common objective (i.e. preventing and controlling HIV/AIDS) they do not have coordination and collaborations while launching and designing anti-HIV/AIDS activities. Moreover, well-orchestrated interventions, collaboration and an in- depth understanding of the health environment as well as the needs and preferences of all beneficiaries are far more effective than single and sporadic approaches (Schiavo, 2007:337).

Table II: Making Early Agreement on Expected Outcomes and Evaluation Parameters

	Yes		No		Total		If 'yes' to what extent		
	F	%	F	%	F	%	3	2	1
Do governmental and Non-governmental organizations have made early agreements of expected outcomes and evaluation parameters with key stakeholders in connection with HIV/AIDS?	31	48.43	33	51.56	64	100	3.22	6.45	90.33
Average	31	48.43	33	51.56	64	100	3.22	6.45	90.33

Source: Survey Data, 2010

As can be mentioned in Table II above, most of the governmental and non-governmental organizations 51 percent were not participating and making agreements on the expected outcomes and evaluation parameters with key stakeholders. Almost all the respondents proclaimed that they either did not participate 51 percent or nominally participated since most of the programs were imposed by the funding organizations.

Some NGOs during the interview mentioned that donors were not satisfied with the results of some programs in Ethiopia in general and in Lideta sub city in particular. The main reason for this is that the partners, donors,

constituencies or clients were not involved in defining expected outcomes or parameters before the launching of the programs.

It is believed that establishing mutually agree-on outcome objectives and evaluation parameters with key stakeholders is the latest wisdom that should be employed in all organizations horizontally. Some recent findings suggest that vertical funding can overwhelm a weak health system. Since there is a finite amount of health aid funding, focusing it on a few diseases has meant that the health needs of many go unaddressed. As an alternative, there should be a more efficient balance between vertical and horizontal investments collaboratively. It is recommended that horizontal programming that funds primary health care initiatives will guarantee a more cost-effective and sustainable return on investment collaboratively. For this reason, it is proposed that by 2015 fifteen percent of the budgets of vertical disease oriented programmes like HIV/AIDS, Tuberculosis, and Malaria be invested in strengthening local primary health care systems in communities around the world (WHO, 2009:3).

Table III- Levels of coverage of priority needs of different groups

Q	Item	Yes		No		Total		If 'yes' to what extent		
		F	%	F	%	F	%	3	2	1
	Do the existing (present) health interventions against HIV/AIDS cover priority need of different groups, such as									
	A. Youth	24	37.5	40	62.5	64	100	4.16	8.33	87.5
	B. CSW	15	23.43	49	76.56	64	100	6.67	20	73.33
	D. People with disabilities	12	18.75	52	81.25	64	100	8.3	16.67	75.03
	Average	17	26.56	47	73.44	64	100	6.38	15.00	78.62

Source: Survey Data, 2010

Table III stated that the existing (present) health interventions against the spread of HIV/AIDS do not seem to cover priority needs of different groups, such as youth (63 percent), CSW (76 percent) and disabled (81 percent). According to many research findings, in Ethiopia youth, CSW and people with disabilities are the prime sufferer of HIV/AIDS. The young population, especially unmarried sexually-active females carry the greatest risk of HIV infection in Ethiopia, with prevalence rates much higher than the average for both urban and rural areas as well as all women of reproductive age (MOH, 2008:17). This report further made clear that girls are at a much greater risk at an earlier age because of both biological and cultural factors. Young girls in Ethiopia are more vulnerable to HIV than boys because of early age at sexual debut, early marriage, sexual abuse and violence such as rape

and abduction (AAHAPCO, 2008:12). Some studies (Abebaw Ferede and Erulkar 2009:35) have shown that girls, in Ethiopia often form sexual relationships with men who are on average ten years older. As well, adolescent girls are at risk because they are unlikely to have had anything or experience in sexual negotiation skills and are especially vulnerable in situations with older men where age, wealth, physical strength and other power dynamics put them at a disadvantage.

Dozens of findings confirm the widely-held belief that girls start having sex earlier than boys. Many findings suggest that due to lack of collaboration or coordination the primary needs of youth, commercial sex workers and disabled individuals have not got proper support to prevent and control HIV/AIDS. As a result, high burden of new HIV infections concentrated among young women, especially those sexually active, never married, both in the rural and urban areas of Ethiopia.

Aside from failing to reach its stated goal, vertical funding can actually harm a populations' health by skewing treatment priorities. Patients contacting health care facilities are likely to seek a range of treatments, spanning curative care, relief from suffering, reassurance, prevention and advice on use of health services – not just control of one single cause of ill health. Although HIV/AIDS is a major health problem in Sub-Sahara Africa, the need for non-HIV/AIDS related health care in the populations affected is even larger, as the average HIV-prevalence (ages 15-49) is seven percent where as the moderate and severe acute malnutrition in the under-5 population is ten percent. To illustrate the problem: while acute respiratory infections represent twenty six percent of the total developing world burden within the 20 most important communicable diseases, it receives less than two point five percent of direct funding. AIDS, comprising thirty one percent of the

burden, receives forty six percent of all direct donor funds. Vertical disease-oriented programmes, in their single-minded focus, largely ignore patients' needs for access to wider health care services.

Table IV: key elements of collaboration and coordination

	Yes		No		Total		If 'yes' to what extent		
	F	%	F	%	F	%	3	2	1
Are the key elements of successful collaboration and coordination parameters, such as:									
A. a formalized system of communication	30	46.9	34	53.1	64	100	3.33	6.66	90.0
B. a coordinated approach to service delivery	28	43.8	36	56.3	64	100	3.57	7.14	89.3
C. a client centered approach	28	43.8	36	56.5	64	100	3.57	7.14	89.3
D. Comprehensive in scope addressed to avoid duplication and service gaps?	20	31.3	44	68.8	64	100	5.00	10	85.0
Average	26.5	41.4	37.5	58.6	64	100	5.2	7.8	88.4

Source: Survey Data, 2010

Table IV stated that 59 percent of governmental and non-governmental organizations do not seem to have coordinated and collaborative environment for HIV/AIDS patients. 53 percent lack formalized system of communication regarding this, the HIV/AIDS infected people during the Focus Group

Discussion (FGD) proclaimed that organizations which are working against HIV/AIDS do not seem to establish methods of regular communication with the HIV fatalities so that they can align their activities with each other to attain coordinated effect. These include, monthly conference calls at designated times, regular case conferences, activity report or other approaches that keep the HIV/AIDS patients informed and updated about shared clients' progress.

The Focus Group Discussants further depicted that some organizations are found adopting 'old patterns' of organizational behavior, such as 'isolationism' and 'territoriality' which inhibit the development of effective, collaborative or coordinated relationships within and across governmental and non-governmental organizations. As a result, as to the loud voices of the FGD participants, most HIV/AIDS affected and infected individuals face multiple and persistent barriers to care and support in a broad range of services.

In brief terms, though there are many governmental and non-governmental organizations which are working to stop the exponential spread of HIV/AIDS, as stated by the organizations themselves and FGD participants, they lack formalized system of communication (53 percent), lack coordinated approach to the service 56 percent, lack client centered approach (56 percent) and the services are not comprehensive in scope sixty nine percent. As can be seen in Table IV, above, the remaining levels of coordination and collaboration is found in lowest extent (85 percent) within and across organizations on average.

It is recognized that effective collaboration and coordination take time and resource, which case managers, agency directors, and grantees have in short supply. Members further recognize the implications of asking

case managers, agency directors, and grantees to balance the needs of clients against the time require to develop and sustain effective partnerships. However, it is anticipated that through greater collaboration and coordination, case managers and clients will experiences improvements in service delivery, reduced stress, more efficient use of both financial and human resources and other advantages that will make the effort seem beneficial and valuable.

Table V: HIV/AIDS Mainstreaming Practices

	Yes		No		Total		If "yes" to what extent		
	F	%	F	%	F	%	3	2	1
Do government organizations launch HIV/AIDS mainstreaming and practice it such as									
A. Assigning HIV/AIDS focal person	30	46.87	34	53.13	64	100	3.33	6.66	90.00
B. Budget allocation	20	31.25	44	68.75	64	100	-	-	100
D. establish AIDS fund	28	43.75	36	56.25	64	100	-	-	100
Average	26	4.63	38	59.37	64	100	1.33	6.66	96.67

Source: Survey Data, 2010

Table V depicted that HIV/AIDS mainstreaming such as assigning HIV/AIDS focal person, budget allocation and AIDS fund raising appeared to be in its inception rather than being practice fully on the ground in all organizations

because of a multitude of ups and downs. As stated by the respondents in the questionnaire and during the interviews, although Ethiopia has produced the implementation guideline on sector mainstreaming with joint participation of key partners and few organizations have been assigning a focal person to act as catalyst for HIV/AIDS mainstreaming purpose, they were constrained by over work, lack of training, support and recognition. As a result, nearly 60 percent of the governmental organizations have not practiced HIV/AIDS mainstreaming in their organizations even though Ethiopia has been supporting mainstreaming activities at public and non-public institutions since 2002.

In consonant with the information gathered from some respondents, Federal democratic republic of Ethiopia: Federal HIV/AIDS Prevention and Control Office reported in March, 2008 in Addis Ababa stated that there are laws and regulation as well as work place guidelines that protect people living with HIV in Ethiopia against discrimination. These, as to the report, include the 'labor proclamation No. 262/2001 and 377/2003 Article 14.1 d', which strictly prohibits mandatory HIV/AIDS testing for employment, and the Civil Service Work place HIV/AIDS guideline, 2005, which prevent discrimination of HIV positive employees. However, most of the respondent against these mainstreaming issues pointed out that such guidelines and other mainstreaming principles remain on the paper gathering dust on the shelf. For example, in some organizations such as Ethiopian Airlines, HIV/AIDS testing is mandatory (FDRE, 1998: 29).

Table VI-Government and non-government organizations joint plans and pooling

	Yes		No		Total		If 'yes' to what extent		
	F	%	F	%	F	%	3	2	1
Do both governmental and non-governmental organizations have joint plan, committee and/or pooling to stop the rampant spread of HIV/AIDS?	28	43.75	36	56.25	64	100	-	3.5	96.50
Average	28	43.75	6	56.25	64	100	-	35	96.50

Source: Survey Data 2010

Table VI pointed out that governmental and non-governmental organizations have not designed workable joint plans, committee and/or pooling to mobilize both human and non-human resources against the rampant spread of HIV/AIDS. Respondents in this research paper stated that 56 percent of the organizations have no joint plans and pooling systems, of the remaining 44 percent of the organizations 96 percent seem to have lowest, nominal joint and/or pooling plans.

It is essential to have a joint plan to alleviate the above problems. This is because planning is a cooperative and interactive process between the case manager and the client that involves the development of an individualized treatment and service plan based on client needs and available resources. Planning also includes the establishment of short-term and long-term goals for action. Moreover, coordination and linkage connect clients to appropriate services and treatment in accordance with their service plans reduces barriers to access and eliminates/ reduces duplication of effort between case management programs.

Coordination includes advocating for clients who have been denied services for which they are eligible.

In brief terms, although a coordinated approach to service delivery is essential to avoid duplication and service gaps, almost all of the FGD participants and interviewees assured that there are unceasing service gaps and duplications of resources among different organizations

Table VII- Levels of Participation of PLHA Association and HIV/AIDS infected people

	Yes		No		Total		If 'yes' to what extent		
	F	%	F	%	F	%	3	2	1
Do PLHA Associations and HIV/AIDS infected people have active participation in identifying priorities, program design, program implementation, Monitoring and Evaluation?	10	15.63	54	84.37	64	100	10	20	70.00
Average	10	15.64	54	84.37	64	100	10	20	70.00

Source: Survey Data, 2010

Table VII indicates that 84 percent of the people who are living with HIV/AIDS have not participated in designing program implementation, monitoring and evaluation parameters. The Focus Group Discussants mentioned that most of the programs and parameters were designed without the knowledge of the beneficiaries.

It is believed that services should be based on client’s assessed needs rather than service availability to accord clients both rights and responsibilities for their own care. Nonetheless, for a variety of systemic reasons, most organizations seem to create their own Islands and work in isolation from each other with only a partial view of the services that the client is receiving. The FDG participants further stated that almost all PLWHA associations are becoming non-functional because of lack of fund and collaborations.

They clearly mentioned that some association coordinator have not got their salary for nearly nine months so far in 2009/2010.

Table VIII- Service Linkages among Government and non-Government Organizations

	Yes		No		Total		If 'yes' to what extent		
	F	%	F	%	F	%	3	2	1
Are there service linkages among private, government, NGOs and other service providers during HIV/AIDS prevention and control Activities?	18	28.13	46	71.86	64	100	11.11	16.7	72.22
Average	18	28.13	46	71.86	64	100	11.11	16.7	72.22

Source: Survey Data, 2010

Table VIII portrayed that most of health service providers (72 percent) do not seem to have service linkages. Though it is conceived that coordination can be an important strategy for improving service linkages and communications across agencies in promoting greater use of resources and achieving greater efficiency in the delivery of services, most NGOs, private organizations and government health institutions are found uncoordinated vertically and horizontally. Lack of collaboration or coordination between service providers in turn result in client confusion about where and how to get needed services. For example, as witnessed by one of the female Focus Group Discussants, a client who undergoes multiple assessments with several health organizations to qualify for services may feel frustrated and overwhelmed by the amount of time and energy needed to secure health

care and social services. The FGD further stated that due to lack of coordination, some home based care providers have given ART drugs to one chronic AIDS patient more than the prescription repeatedly.

Table IX: Impact of Clientele towards Coordination and the 'Three Ones' principles

Items	Yes		No		Total		If 'yes' to what extent		
	F	%	F	%	F	%	3	2	1
Do the clientele (Donor/source) of the fund donors' impact on efforts towards coordination and 'Three Ones' principles?	60	93.75	4	6.25	64	100	-	6.25	93.75
	60	93.75	4	6.25	64	100	-	6.25	93.75

Source: Survey Data, 2010

Table IX pointed out that (94 percent) of the global response to the HIV/AIDS epidemic has been unprecedented though financing for prevention, treatment, care and support activities in developing countries has increased tenfold over the past several years. In 2005, for the first time, resources were sufficient for appropriate response although maintaining resources in the longer term remains a challenge (94 percent) for 'One action plan, One national authority, One monitoring system' with increasing resource gaps projected which mainly stemmed from lack of Clientele coordination (Hellevik, 2007:12). However, in many cases the sheer number of donors with differing stipulations on how the money should be spent, handled, monitored and reported has overwhelmed resource-poor countries with limited human resources. Trying to dramatically increase the delivery of

services to communities in a short period of time has also challenged national capacity. This may be especially true in countries experiencing 'brain drain' or loss of staff from HIV-related morbidity and mortality.

A quarter-century into the epidemic, the global response must be transformed from an episodic, crisis-management approach to a strategic response that recognized the need of the beneficiaries for long-term commitment and capacity building, using evidence-informed strategies that address the structural drivers of the epidemic.

The response must become stronger, more strategic and better coordinated if the world is to achieve universal access to comprehensive HIV prevention, treatment, care and support by 2010. This in turn requires that the many actors responding to AIDS at the global, national and local levels fully coordinate and harmonize their efforts.

To tackle this problem, in September 2003 a working group at the 13th International Conference on AIDS and Sexually Transmitted Diseases in Africa approved a set of guiding principles for making the money work best at country level. In April 2004, the Consultation on Harmonization of International AIDS Funding – bringing together representatives from governments, donors, international organizations and civil society endorsed the 'Three Ones' principles as follows (Hellevik, 2007:45): 'One agreed AIDS action framework that provides the basis for coordinating the work of all partners One national AIDS coordinating authority, with a broad-based multi-sectoral mandate One agreed country-level monitoring and evaluation system'.

According to many research findings (Hellevik, 2007:12) national ownership of plans and priorities is the overarching theme of the 'Three Ones'. These principles also emphasize the idea that urgently needed responses should

contribute to developing national capacity and fit into broader national development strategies. They are also fully aligned

with ongoing efforts for UN reform, which aim to streamline and harmonize multilateral assistance, as well as with the Millennium Development Goals, which provide an internationally-agreed upon framework for improving lives.

Scaling up towards universal access to prevention, treatment, care and support is the internationally agreed-upon goal of the global response to HIV/AIDS. This will require a massive scaling up of the most effective program, and will require strengthening HIV prevention and HIV treatment program simultaneously – building on existing synergies – to increase impact and ensure sustainability. At the 2005 World Summit, the international community agreed to provide universal access to reproductive health by 2015. A 2006 political declaration calls for universal access to comprehensive prevention, treatment and care for HIV or AIDS by 2010.

Achieving universal access will require broad participation and a strong country focus, as called for in the Three Ones. It demands finding practical ways to overcome obstacles to scaling up, building on decisions already made. The Three Ones process encourages countries to set their own roadmaps – including midpoint targets and milestones – for them in order to advance toward universal access and to achieve the Millennium Development Goal on HIV/AIDS.

Table X: Project Sustainability while NGO’s withdraw from the Area

Items	Yes		No		Total		If 'yes' to what extent		
	F	%	F	%	F	%	3	2	1
Is there a taskforce to take over the projects so as to sustain while the NGOs withdraw from area?	24	37.5	40	62.5	64	100	4.2	8.3	87.5
	24	37.5	40	62.5	64	100	4.2	8.3	87.5

Source: Survey Data, 2010

Table X depicted that (62 percent) project lack sustainability while NGO’s withdraw from the area. One of the most perplexing concerns confronting development specialists working in the health sector is the sustainability of externally sponsored project activities and outcomes, once external funding ends. Too often, when international assistance ends, the activities initiated on the ground also die with little left to show for the effort. Yet, a key challenge in assessing sustainability is the diversity of views about what should be sustained.

In its simplest terms, sustainability is the ability of an activity or system to persist. The heightened attention of international development assistance organizations to sustainability is, in part, an offshoot of the increased focus on outcome-based funding in development assistance work. Outcomes must be evident and they must remain long enough to have an impact. The lack of

sustainable impact is widely seen as a key threat to continued flow of international development assistance. However, one of the challenges in assessing sustainability is the diversity of views about what should be sustained.

As to different literature (Fenton, 2008:15 and Singh and Nakya, 2009:46, to mention some), whenever projects and funding from donor agencies are about to end, AIDS NGOs are always alarmed and frightened about this situation. Although this is understandable, what is making this situation unbearable is that as if there is no life to the NGO or project after funding ceases from donor. NGOs would cram for planning and most of the time tension would grip the NGO office. The worse is that staff would lose motivation and project implementation would suffer, even though, there is still a lot of time before the project ends. As the issue of sustainability has been a perennial problem to NGOs doing HIV/AIDS work, and a lot of probable solutions have been drafted to address this challenge, still NGOs would have problems about this. This paper presents a perspective in going about this challenge of sustainability. It will remind NGOs even at the start of implementing an HIV/AIDS project that they should also start thinking and planning how to continue these projects. Giving more weight to project sustainability is like giving more focus and values to HIV/AIDS work as continuity of the AIDS project will most of the time be assured. Even the pandemic rages on, projects on HIV/AIDS continue to prevent communities from its impact and provides care and support to the infected and affected.

3.3 Conclusion

Lack of coordination results in duplication of services, overlap of services with each other, or gaps in service that leave client needs unaddressed, whereas coordination represents an agreement between agencies to avoid duplicating each other's efforts and engage in some level of cooperation in the delivery of available services.

For a variety of systemic reasons, most organizations included in the study seem to create their own Islands and work in isolation from each other

with only a partial view of the services that the client is receiving. To change these trend agencies i.e. all the stakeholders involve in the prevention of HIV/AIDS and mitigating its impact should come together under collaborative and coordinated framework where they consistently complement each other's effort. This will require new ways of thinking and address old patterns of organization behavior such as isolation. But for some it seems threatening (lack of trust, fear of losing organizational authority/autonomy).

CHAPTER FOUR

4 SUMMARY, CONCLUSION AND RECOMMENDATION

4.1 SUMMARY OF THE FINDINGS

In practice, coordination and collaboration reflect different levels of cooperation among agencies or staff. Coordination, for example, generally involves staff of different agencies working together on a case-by-case basis to ensure that clients receive appropriate services. It can involve front-line case managers, supervisors and even organizational leaders. Coordination does not change the way agencies operate or the services they provide, rather, it represents an agreement between partners to avoid overlap in each other's efforts and cooperate to some degree in the delivery of services they already provide.

Collaboration builds on coordination and includes joint work to develop shared goals. It also requires participants to follow set protocols that support and complement the work of others. Unlike coordination, collaboration requires the commitment of agency or system leadership to be effective and produce the kind of sustained change that is central to its objectives. Collaboration has a greater potential to create seamless, client-centered systems of case management, has a greater capacity for extending the reach of limited resources and gets participants closer to establishing a foundation for true systems integration.

While collaboration yields greater benefits for agencies, systems, and clients, instances exist where collaboration is not possible or appropriate. But coordination can be an important strategy for improving interagency communication and promoting more efficient delivery of case management services to HIV-infected persons. Coordination can help lay the groundwork for future collaboration. Hopson and Fenton (2008:25)

Thus, this study was intended to investigate the levels of coordination and collaboration within and across governmental and NGOs. To this end the following leading questions were formulated:

1. What are the challenges towards coordination among governmental and non-governmental organizations in Addis Ababa?
2. To what extent does the interest of the clientele of the fund donor's influence the on efforts towards coordination?
3. Has there been effective coordination among government organizations and non-government organizations to implement the HIV/AIDS programs?
4. To what extent does lack of coordination among different organizations affect HIV/AIDS program implementations?
5. How has lack of human and financial resource capacity affected implementation?
6. What mechanism/measures should be used in order to resolve the challenges of implementations?

In order to answer the above leading questions, Mixed Research Method was employed. According to Cresswell (2009:67) mixed method research has been increasingly seen as a third approach in research methodology. It involves the collection or analysis of both qualitative and quantitative data in a single study with an attempt to integrate the two approaches at one or more stages of the research process. From the ten sub-cities in Addis Ababa, Lideta sub-city was selected by using purposeful sampling technique. All the secured information was tabulated, converted into percentile, analyzed, interpreted and discussed.

In brief, the overall result of this research has shown that there is very little coordination and collaboration within and across different organizations. To verse it differently, stakeholders are expected to engage in greater cooperation toward pursuit of mutual goals. There are no formalized systems of communication and coordinated service delivery which are comprehensive in scope and client-centered approaches.

4.2 CONCLUSION

After the data were gathered and analyzed the researcher arrived at the following conclusions:

1. Both government and non-government organizations do not seem to make careful analysis of the situations (78 Percent), opportunities (62 Percent) and beneficiary needs (53 percent) before designing program implementation. The needs of the program beneficiary seem to have been sidelined and downgraded by the program designers. In other words, the program beneficiaries have not been allowed to participate while different HIV/AIDS programs have been designed. As a result, most of the programs do not reflect the interest of the beneficiaries
2. Most of the governmental and non-governmental organizations (51 percent) were not participating and making agreements on the expected out comes and evaluation parameters with key stakeholders. Almost all the respondents proclaimed that they either did not participate (51 percent) or nominally participated since most of the programs are imposed by the funding organizations.
3. The existing (present) health interventions against the spread of HIV/AIDS do not seem to cover priority needs of different groups and lack coordination and collaborations, such as youth (62 percent), CSW (76 percent) and disabled (81 percent). The young population, especially never-married sexually-active females carry the greatest risk of HIV infection in Ethiopia, with prevalence rates much higher than the average for both urban and rural areas as well as all women of reproductive age (MOH, 2008:17).

4. 58 percent of governmental and non-governmental organizations do not seem to have coordinated and collaborative environment for HIV/AIDS patients. They lack formalized system of communication (53 percent), lack coordinated approach to the service (56 percent), lack client centered approach (56 percent) and the services are not comprehensive in scope (69 percent). The remaining levels of coordination and collaboration are found in lowest extent (85 percent) within and across organizations on average.
5. HIV/AIDS mainstreaming such as assigning HIV/AIDS focal person, budget allocation and AIDS fund raising appeared to be remain on the paper since 60 percent of the governmental organizations have not practiced HIV/AIDS mainstreaming in their organizations. For example, in some organizations such as Ethiopian Airlines, HIV/AIDS testing is mandatory currently. This provokes stigma and discrimination unless a remedial action taken.
6. Governmental and non-governmental organizations have not designed workable joint plans, committee and/or pooling to mobilize both human and non-human resources against the rampant spread of HIV/AIDS. These research paper respondents stated that 56 percent of the organizations have no joint plans and pooling systems. Out of the remaining 44 percent of the organizations 96 percent seem to have lowest, nominal joint and/or pooling plans.
7. 84 percent of the people who are living with the HIV/AIDS have not participated in designing program implementation, monitoring evaluation parameters. The Focus Group Discussants mentioned that most of the programs were designed with out the knowledge of the beneficiaries.

8. Though it is conceived that coordination can be an important strategy for improving service linkages and communications across agencies in promoting greater use of resources and achieving greater efficiency in the delivery of services, most of the health service providers (72 percent) do not seem to have service linkages or they are found uncoordinated. Lack of collaboration or coordination between service providers in turn result in client confusion about where and how to get needed services.
9. 94 percent of the global response to the HIV/AIDS epidemic has been unprecedented though financing for prevention, treatment, care and support activities in developing countries has increased tenfold in developing countries over the past several years. Resources were sufficient for an appropriate response although maintaining resources in the longer term remains a challenge (94 percent) for 'One action plan, one national authority, one monitoring system' with increasing resource gaps projected.
10. 62 percent of HIV/AIDS projects lack sustainability while NGO's withdraw from the area. In other words, when international assistance ends, the activities initiated on the ground also die with little left to show for the effort. Yet the key challenge is in assessing the sustainability of the diversity of views about what should be sustained.

Absence of collaboration and coordination could minimize the positive impact of case management for HIV-infected clients. For example, in situations where clients have multiple case managers who do not work

together or communicate, gaining access to services can prove time-consuming and cause client confusion about each manager's role in his/her care. Lack of coordination and collaboration leads to overlap of efforts and ineffective use of resources, consequences case mgt agencies can ill afford given tight budgets and high caseloads.

In brief, the overall result of this research has shown that there is very little coordination and collaboration within and across different organizations.

4.3 Recommendations

In the light of the finding of the study, it is possible to suggest the following recommendations:

1. Both government and non-government organizations should make careful analysis of the situations, opportunities, and beneficiary needs before designing program implementation. The needs of the program beneficiary should not be sidelined and downgraded by the program designers. In other words, the program beneficiaries should be allowed to participate while different HIV/AIDS programs have been designed.
2. All the governmental and non-governmental organizations should make agreements on the expected outcomes and evaluation parameters with key stakeholders before launching the programs.
3. The existing health interventions against the spread of HIV/AIDS should cover the priority needs of different groups, such as CSW and persons with disability. Attention should be given to the young population, especially never-married sexually-active females carry the

greatest risk of HIV infection in Ethiopia, since the prevalence rates is much higher than the average for both urban and rural areas as well as all women of reproductive age (MOH, 2008:17).

4. Both governmental and non-governmental organizations should create coordinated and collaborative environment for HIV/AIDS patients. They should have formalized system of communication, coordinated approach to the service, client centered approach and the services should be comprehensive in scope.
5. HIV/AIDS mainstreaming programs should be practiced such as assigning HIV/AIDS focal person, budget allocation and establishing AIDS fund to strengthening the multi-sectoral responses.
6. Governmental and non-governmental organizations should have workable joint plans, committee and/or pooling to mobilize both human and non-human resources against the rampant spread of HIV/AIDS.
7. Enabling environment has to be created for people who are living with the HIV/AIDS to participate in designing program, implementation, monitoring evaluation parameters.
8. All the health service providers should have service linkages or coordination among themselves to give effective client services about where and how to get needed services. This is because coordination can be an important strategy for improving service linkages and communications across agencies in promoting greater use of resources and achieving greater efficiency in the delivery of services.

9. The government of Ethiopia should strive to minimize (or if possible to avoid) the dependency syndrome that prevail among the HIV/AIDS infected people specially the destitute section of the society and should enable them to engage in different activities because the global response to the HIV/AIDS epidemic has been unprecedented though financing for prevention, treatment, care and support activities in developing countries has increased quadrupled and more in developing countries over the past several years. Resources were sufficient for an appropriate response although maintaining resources in the longer term remains a challenge for 'One action plan, one national authority, one monitoring system' with increasing resource gaps projected.
10. HIV/AIDS projects should be sustainable while NGO's withdraw from the area. In other words, there should be fertile ground to sustain projects when international assistance ends.

References

- Abebaw Ferede and Erulkar (2009). *Adolescent Girls in Urban Ethiopia: Vulnerability and opportunity*. A.A. Accessed Jan, 2010. <http://www.popcouncil.org>.
- FMOH and HAPCO (2005) *HIV/AIDS Behavioral Surveillance Survey (BSS) Ethiopia Round Two*, Addis Ababa. Menno P.P
- Abebe Bekele, Mengistu Kefale and Mekonnen Tadessie (2008). *Preliminary Assessment of the Implementation of the Health Services Extension Program: The Case of SNNP*. Addis Ababa. Menno P.P
- Cresswell Hofsson (2009). *Designing and Conducting Mixed Methods Research*. London: Sage publication.
- WHO (2007). *The Health Extension Program (HEP) of Ethiopia: Summary of Concepts, Progress, Achievements & challenges*. Addis Ababa: MoH
- Federal Democratic Republic of Ethiopia (August, 1998) *Policy on HIV/AIDS* Addis Ababa
- Hopson, P. & Fenton, K.A (2008). National Center for HIV/AIDS. USA: *Public Health Service*. Accessed March, 05, 2010, WWW.dhss.mo.gov/HIV_AIDS/CaseMgmt.html
- Federal Government of Nigeria (2003) *National Policy on HIV/AIDS*
- The United Republic of Tanzania Prime Ministers Office (2001), *National Policy on HIV/AIDS* Dar es Salaam
- UNAIDS. (2006). *HIV/AIDS Policy* for Addis Ababa University. A.A.: MOH.
- Republic of Ghana (January, 2003). *Draft National HIV/AIDS and STI Policy Document*
- Richard T. Schaeter (2000): *Sociology a brief introduction (3ed)*, DePaul University. University Press.
- Barnett, T. & A. Whiteside (2002): *AIDS in the Twenty-First century*. Disease and Globalization. New York
- FMOH (2006): *AIDS in Ethiopia*. Disease prevention and control Department, Six Edition, Addis Ababa: Birana P.P
- Schiavo. Rog. (2007). *Health Communication – From Theory to Practice*. U.S.A: Jossey- Bass
- Singal, A. & Rogers, E. (2003) *Combating AIDS: Communication Strategies in Action*. London: Stage Publication.

- FMOH (Ministry of Health (2002): *ADIS in Ethiopia*. Disease prevention and control department, Forth Edition Addis Ababa.
- MOH (2004) *HIV/AIDS and Tuberculosis Prevention and Control Extension Package*. Addis Ababa: MOH
- FMOH (2007) *Single Point HIV Prevalence Estimate*. Addis Ababa: MOH.
- MOH (2007). *Annual Performance Report of HSDP*. III Addis Ababa: MOH
- UNAIDS (2006): *Report of the global AIDS epidemic*. A UNAIDS 10th anniversary special edition, Geneva.
- IGAD (2007): *Disaster risk Management Training manual*
- Fenton,K.(2008). *Recommendation for Case Management Collaboration & Coordination in Federally Funded HIV/AIDS Programs*. U.S.A: HRSA
- The Mc Graw- Hill Company (2000) *Heath Net: A Health and Wellness Guide to the Internet*. (3rd ed).U.S.A Mc Graw- Hill Company.
- UNAIDS. (2006). *HIV/AIDS Policy for Addis Ababa University*. A.A: MOH. Univesity Press.
- Varner,I. & Beamer,L. (2005). *Intercultural Communication in the Global work Places*. Bosten: Mc Graw- Hill.
- HAPCO. (2007). *Multi-Sectoral Plan of Action for Universal access to HIV Prevention, Treatment, Care and Support in Ethiopia (2007-2010)*. Addis Ababa: HAPCO
- Bjerkreim, Hellevik 2007. Making the money work: Global AIDS actors and challenges towards coordination of HIV/AIDS programs in Africa. Unpublished PhD thesis, Norwegian Institute for Urban and Regional Research, Oslo, Norway.
- WHO (1995) *AIDS- Prevention Through heath Promotion: Facing Sensitive issues*. Geneva: WHO
- WHO (2003) *Expanding Capacity for operations Research in Reproductive Health: Summary report of a consultative meeting*. Geneva: population council.

- WHO (2007). *The Health Extension Program (HEP) of Ethiopia: Summary of Concepts, Progress*, Geneva: WHO
- WFP (2007) *Nutrition and HIV/AIDS Training Manual for partners*. Urban HIV/AIDS project, Addis Ababa
- FHAPCO & FMOH (2007): *Guideline for prevention of mother- to- child Transmission of HIV in Ethiopia*: Addis Ababa MOH
- DFID (Department for International Development) (1999): *Sustainable livelihoods guidance sheets*, London.
- CARE (2001): Report on baseline survey on *HIV/AIDS/STD knowledge, Attitudes and practices and result dissemination workshop May 15-18, 2001*, CARE International in Ethiopia, Addis Ababa.
- CSA (Central Statistic Authority) (2006): *Ethiopia Demographic and Health Survey 2005*, AA, December 2006
- UNICEF (2001) *Policy Response to HIV/AIDS in the nineties*, New York
- UNADIS (2004) *Focus on Ethiopia- HIV/AIDS a Major Humanitarian and Development Issue*, Country Team Ethiopia
- Mehta, S. & Sodhi (2004). *Understanding AIDS: Myths, Efforts and Achievements*. New Delhi: A.P.H Publishing.
- Zambia (2004) *National policy on HIV/AIDS*, Lusaka Free downloads from www.healthpolicyinitiative.com
- Wheelen, T. and Hunger, J (2006) *Health Communication Strategies and practices*, Boston: McGraw- Hill.
- FMOH (1998) *Policy on HIV/AIDS of the Federal Democratic Republic of Ethiopia*. Addis Ababa.

Appendix-I

Addis Ababa University

Faculty of Business and Economics School of Graduate studies

Department of Public Administration and Development

Management

In-depth Interviews for Policy Designers (AAHAPCO, AAHB), Sub city HAPCO, Sub city Health office head, PLHA association chair Persons & representatives from private higher clinics, NGOs and Sub city Idir council chairperson

I. General instruction

The questions are prepared to gather information about the challenges of HIV/AIDS Program implementation in Addis Ababa city Administration (one Sub-City Lideta). I am Mesfin Derso. I came from Addis Ababa University Faculty of Business and Economics Department of Public Administration and Development Management. You are one of the resourceful persons in connection with HIV/AIDS; thus, thank you in advance for being volunteer to be interviewed and devote your time. Your genuine and accurate information has paramount importance for the success of this research paper. Yet, be confident that whatever ideas you forward will be kept confidential and used only for research purpose. So, would you mind introducing yourself and answer the following questions? You can interpret the question the way you are intended to carry out.

Part I. Background Information

For the questions given below write your response using the appropriate word or phrase.

- 1) Sex: Male___ Female___
- 2) Age_____
- 3) Marital Status: Married____, Single____, Divorced____, Widowed____
- 4) Sexuality: Active____, Inactive____
- 5) Educational status/Qualification:- Completed
 - a) Elementary School b) High School c) Diploma
 - d) Degree e) Masters Degree and above
- 6) Current position at office _____

Part II. Interview Questions

Questions on implementation & coordination programs

1. Did government and non government organizations make careful analysis of the:
 - A. Situations
 - B. Opportunities
1. Beneficiaries needs
before designing HIV/AIDS programs implementation?
2. Does governmental and Non-governmental organization have made early agreements of expected outcomes and evaluation parameters with key stakeholders in connection with HIV/AIDS?
3. Do the existing (present) health interventions against HIV/AIDS cover priority need of different groups, such as
 - A. Youth
 - B. CSW
 - C. People with disabilities?
4. Are the key elements of successful coordination and collaboration parameters, such as:
 - A. a formalized system of communication
 - B. a coordinated approach service delivery
 - C. a client centered approach
 - D. comprehensive in scope addressed to avoid duplication and service gaps?
5. Do government organizations launch HIV/AIDS mainstreaming and practice it such as
 - A. Assigning HIV/AIDS focal person
 - B. Budget allocation
 - C. Establish AIDS fund
6. Do both governmental and non-governmental organizations have joint plan, committee and /or pooling to stop the rampant spread of HIV/AIDS?
7. Do PLHA Associations and HIV/AIDS infected people have active participation in identifying priorities, program design, program implementation, Monitoring and Evaluation?
8. Are there service linkages among private, government, NGOs and other service providers during HIV/AIDS prevention and control Activities?
9. Do the clientele (funder of the programs) of the fund donors' impact on efforts towards coordination and the 'Three Ones' principles?
10. Is there a taskforce to take over the projects so as to sustain while the NGOs withdraw from the area?

Appendix-II

Addis Ababa University

Department of Public Administration and Development

Management

Faculty of Business and Economics School of Graduate studies

Questionnaire for Kebele health extension supervisors, kebele

Health office head, Anti-AIDS clubs committee members,

Health Centers Directors and Core process owners, faith based

organizations, higher private clinics physicians and NGOs staff

The questionnaire is prepared to gather information about the implementation of HIV/AIDS Program in Addis Ababa city Administration Lideta Sub-city). You are not required to write your name. You are simply expected to generate (fill) genuine and accurate information freely and openly. Whatever ideas you forward will be kept confidential and used only for research purpose. Thank you in advance for doing the questionnaire.

Mesfin Derso

Addis Ababa University

Part I. Background Information

For the questions given below write your response using the appropriate word or phrase.

1) Sex: Male___ Female___

2) Age_____

3) Martial Status: Married____, Single____, Divorced____, Widowed____

4) Sexuality: Active____, Inactive____

5) Educational status/Qualification:-

Completed a) Elementary School b) High School c) Diploma

d) Degree

e) Masters Degree and above

6) Current position at office _____

Part II. Put tick mark (✓) under 'Yes' or 'No' to assess the implementation & coordination process of HIV/AIDS programs and then number 3=highest, 2=medium and 1=lowest to describe the degree of each issue, if your answer is 'yes'.

		yes	No	To what extent		
				3	2	1
1	Did government and non government organizations make careful analysis of the:					
	A. Situations					
	B. Opportunities					
	2. Beneficiaries needs before designing HIV/AIDS programs implementation?					
2	Does governmental and Non-governmental organization have made early agreements of expected outcomes and evaluation parameters with key stakeholders in connection with HIV/AIDS?					
3	Do the existing (present) health interventions against HIV/AIDS cover priority need of different groups, such as					
	A. Youth					
	B. CSW					
	C. People with disabilities?					
4	Are the key elements of successful coordination and collaboration parameters, such as:					
	A. a formalized system of communication					
	B. a coordinated approach service delivery					
	C. a client centered approach					
	D. comprehensive in scope addressed to avoid duplication and service gaps?					
5	Do government organizations launch HIV/AIDS mainstreaming and practice it such as					
	A. Assigning HIV/AIDS focal person					
	B. Budget allocation					
	C. Establish AIDS fund					
6	Do both governmental and non-governmental organizations have joint plan, committee and /or pooling to stop the rampant spread of HIV/AIDS?					

		yes	No	To what extent		
				3	2	1
7	Do PLHA Associations and HIV/AIDS infected people have active participation in identifying priorities, program design, program implementation, Monitoring and Evaluation?					
8	Are there service linkages among private, government, NGOs and other service providers during HIV/AIDS prevention and control Activities?					
9	Do the clientele (Source of fund) of the fund donors' impact on efforts towards coordination and the 'Three Ones' principles?					
10	Is there a taskforce to takeover the projects so as to sustain while the NGOs withdraw from the area?					

Appendix-III

Addis Ababa University

Department of Public Administration and Development

Management

Faculty of Business and Economics School of Graduate studies

Focus Group Discussion with PLHA Association Members and HBC (home based care providers)

The questions are prepared to gather information about the implementation of HIV/AIDS programs in Addis Ababa city Administration (targeted at Lideta Sub-City). You are not required to mention your name. You are simply expected to generate genuine and accurate information freely and openly. Whatever ideas you forward will be kept confidential and used only for research purpose. Thank you in advance for being volunteer in the *Focus Group Discussion*.

Mesfin Derso

Addis Ababa University

I. Questions for FGD on program implementation

1. Did government and non government organizations make careful analysis of the:
 - A. Situations
 - B. Opportunities
 - C. Beneficiaries needbefore designing HIV/AIDS programs implementation?
2. Does governmental and Non-governmental organization have made early agreements of expected outcomes and evaluation parameters with key stakeholders in connection with HIV/AIDS?
3. Do the existing (present) health interventions against HIV/AIDS cover priority need of different groups, such as
 - A. Youth
 - B. CSW
 - C. People with disabilities?

4. Are the key elements of successful coordination and collaboration parameters, such as:
 - A. a formalized system of communication
 - B. a coordinated approach service delivery
 - C. a client centered approach
 - D. Comprehensive in scope addressed to avoid duplication and service gaps?
5. Do government organizations launch HIV/AIDS mainstreaming and practice it such as
 - A. Assigning HIV/AIDS focal person
 - B. Budget allocation
 - C. Establish AIDS fund
6. Do both governmental and non-governmental organizations have joint plan, committee and /or pooling to stop the rampant spread of HIV/AIDS?
7. Do PLHA Associations and HIV/AIDS infected people have active participation in identifying priorities, program design, program implementation, Monitoring and Evaluation?
8. Are there service linkages among private, government, NGOs and other service providers during HIV/AIDS prevention and control Activities?
9. Do the clientele (Source of fund) of the fund donors' impact on efforts towards coordination and the 'Three Ones' principles?
10. Is there a taskforce to take over the projects so as to sustain while the NGOs withdraw from the area?