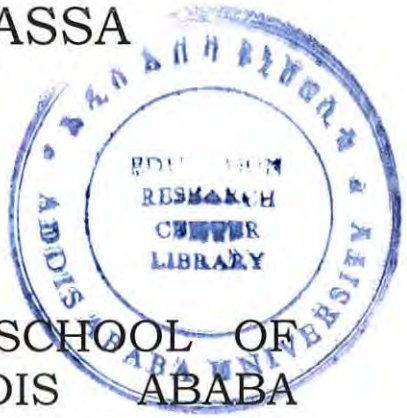
Practices and Challenges of Alternative Basic Education in Addis Ababa: The Case of Arada Sub – City

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ABBREVIATIONS USED

A.A.U	Addis Ababa University
AABE	Alternative Approaches to Basic Education
AAE	Action Aid Ethiopia
ABE	Alternative Basic Education
ADEA	Association for the Development of Education in Africa
BEUPA	Basic Education in Urban Poverty Areas
CMC	Center Management Committee
EFA	Education For All
ESDP	Education Sector Development Program
ESSSR	Ethiopia Social Sector Study Report
ETP	Education and Training Policy
FAWE	Forum for African Women Educationists
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
IIZ/DVV	Institute for International Development of the German Adult Education Association
MDG	Millennium Development Goal
MIS	Management Information System
MoE	Ministry of Education
NFBPE	Non-Formal Basic Primary Education
NFE	Non-Formal Education
NGO	Non- Governmental Organization
NLCCC	National Literacy Campaign Coordinating Committee
OSC	Out of School Children
REB	Regional Education Bureau
SNNPR	Southern Nations, Nationalities People's Region
TGE	Transitional Government of Ethiopia
UBEP	Undugu Basic Education program
UNESCO	United Nation Education & Science Organization
UPE	Universal Primary Education
WEO	Woreda Education office

Abstract

Basic Education is a foundation of all development endeavors and a fundamental right of every member of a society. Providing basic education for all children the principal assets and future bases of a country is the wisest investment. Ethiopia is one of those sub- Saharan African countries with the least participation of school age children in primary schools. To provide basic education to all citizen and achieve universal primary education by the year 2015, the government has launched different programs i.e Non – formal and Alternative basic education.

The Alternative basic education program, thus, the program has served as an alternative approaches to complement the formal education program, so that it plays a great role in providing educational access for adults and children.

Therefore, the purpose of this study was to assess the practice and challenges of implementation of ABE in Arada sub city Addis Ababa City administration. Based on the purpose of the study, the learning environment, the practice of the program, support for ABE program facilitators in terms of training, the availability of curriculum materials and challenges encountered were assessed .To this end, survey method was used for the study. Data were gathered from officials, facilitators and adult learners. Data collection tools were questionnaire, interview and focus group discussion. The data gathered through questionnaire were analyzed using appropriate statistical tools the percentage, mean, standard deviation and one way ANOVA. Whereas the data gathered through interview and focus group discussion were transcribed, analyzed and triangulated with the quantitative data where necessary and appropriate. Findings of the study revealed that the practice of the ABE program have contributed a lot to providing, learning opportunity for adults and out-of school children. Addis Ababa Education bureau used one curriculum for both adults and out- of school children, facilitators training, their salary and the incentives provided were not sufficient, supervision and monitoring and awareness creation for the stakeholder were found to be low, there were problems of text books and facilitators manual. Based on the major findings certain recommendations were made. Addis Ababa education office should revise the ABE curriculum, supervision and follow up should be strengthened, the community awareness should be promoted, facilitators should be provided with short- term up grading training, and fair incentives for facilitators should be in place to motivate them.

CHAPTER ONE

THE PROBLEM AND ITS APPROACH

This Chapter deals with the problem and its approach. It Contains background of the study, statement of the problem, objectives of the study, significance of the study, delimitation of the study, limitation of the study, definition of terms and organization of the study.

1.1. Back ground of the Problem

Education has been considered as an indispensable weapon in fighting against poverty and a necessary first step in a long march towards social, economic, political and technological development. As stated by Tekeste (1990:27), Education is considered an important instrument, which plays a key role to social, economic and political development. It helps the society to change their environment for their benefit, and enables its members to make wise use of valuable resources in their environment.

Most developing countries are involved in the struggle to provide education for more and more children and also at the same time provide some form of education for the large number of adults who have received no education at all. One way of coordinating and providing this dual obligation is through basic education (Bishop, 1985). As stated by Bohn (1992), basic education involves, besides acquiring the basic skills of reading, writing and arithmetic, above all, the acquisition of the basic knowledge and skills which people need to improve their living conditions and develop their abilities and which enable them to understand and contribute to the development of the society. It includes non-formal education programs such as literacy, to meet the learning needs of young people and adults who have never attended school or who have left school early.

The benefits of education, particularly that of primary education has been recognized internationally, as a result the United Nation general assembly in 1948 adopted the Universal Declaration of human Rights that aimed at expansion of the primary education. The declaration made education both necessity and fundamental human right irrespective of differences in gender, age, wealth or social status (MOE, 2002:1).

Basic education is recognized as human right to be provided for citizens. Several international events contributed to the promotion of institutional reforms of the education system in order to include NFE and ABE initiatives to address the demand of education for citizens and achieve universal education .In relation to this various conferences were conducted and discussions were made on strategies to achieve universal primary education in Africa through alternative form of education.

The education for all conference which was held in Jomtine- Thiland (1990)which sets of the stages for a rethink of the "why" and "how" of basic education the EFA declaration and frame work for action provide the general principles and modalities which are expected to guide the efforts the education for all (RABE,2006 :14).

Moreover, the world declaration forum held in Dakar (2000), ten years after the Jomtine conference, which was attended by 183 countries and many international organizations revised what had been achieved in making basic education an accessible to all and came up with the following results (MOE,2002:15).

- Some 113 million of whom 60 percent were girls had no access to primary school;
- At least 880 million adults were illiterate one in three illiterate adults was found in developing countries, the majority of whom were women.

- Ensure the learning needs through equitable access of relevant education.
- Achieve 50 percent improvement in levels of adult literacy for both sexes.
- Eliminate gender disparities in primary and secondary education by the year 2005

Despite the effort and sacrifices made over the decades as the Dakar forum acknowledged, several developing countries are far from achieving the goal of universal primary education. The implementation of alternative basic education has many problems particularly in developing nations for instance in Uganda there is high rate of turn over of teachers because of under paid , high dropout of adult learner ,lack of effective supervision of the programs, lack of sufficient reading materials and inefficient coordination and management(Obuna and Rogers, 1993). Ethiopia as one of developing country, developed ESDP III emphasized the importance of ABE. However, many challenges are encountered to access Abe center like shortage of text books , selection and training of facilitators , management and supervision of ABE centers and large community participation (RABE;2006;23).

Moreover, Ethiopia strives to achieve the Millennium Development Goals (MDGs) which includes the achievement of universal primary education. Though the country has given much emphasis to achieve UPE, the government has realized that Ethiopia can not achieve UPE by the year 2015 by providing education through the formal schooling alone. Therefore, it has designed and implemented Alternative basic Education (ABE),referred to also as non-formal education (NFE),as an integral part of the education system (MOE,2006:ii)

Ethiopia is firmly committed to achieve universal primary education. The country developed various policy, strategies and programs that

help to universal primary education. In line with this, reviews of education sector development program (ESDP)-II identified the fact that about one- third of the school age children (over 4 million) were still out of school. The burden of over aged children who missed out of schooling due to inaccessibility of education services was also noted. Moreover, ESDP-III emphasized the need to strengthen NFE and other alternative modes of delivery to address these out-of- school children. Further more, the country's main guiding planning document, the plan for accelerated sustainable development to end poverty (PASDEP), also emphasizes the need to strengthen ABE(MOE, 2006).

This implies that with out provision ABE, the country will not achieve the EFA goals adopted in Dakar and MDG targeting universal primary education (MOE, 2006: iii). Accordingly, the notion of ABE daft strategy for out of school children was designed in 2006 by Federal Ministry of Education.

Although the government of Ethiopia has the target to achieve UPE by the year 2015, the NER of Addis Ababa City administration count 72.7% in 2007/08, still considerable numbers of children are out of schooling (ESAA.2006/07:40) Although in the country dropout rate is decreasing in primary schools, it was 11.8% in 2004/05, which means, of the total of 11.2 million children in primary schools in 2005 out of which 1.3 million did not return to school in 2006 (ANFEAE 2008). That is why Addis Ababa Education Bureau gives emphases to the ABE program and currently it has 257 centers, a total of 55,526 learners enrolled (ESAA, 2007/08/80). In this regard Mputu (2001: 5) non-formed basic education is found highly effective in providing learning opportunities to different target groups such as children who do not get enrolled in the primary schools, those who dropout from schools, youths and adults who released in to literacy and those who have never received and schooling. This implies that ABE Program is one of the appropriate mode of delivery to realize UPE in the region.

To this end the purpose of this study asses the current practices and challenges of ABE in Addis Ababa city administration in the care of Arada Sub city.

1.2. Statement of the Problem

To realize universal primary education (UPE) an innovative alternative approach has been already started in different regions of Ethiopia (MOE,2002:24). For example, ESDP 111 of Addis Ababa city administration that NFBE programs serve to complement the formal education program, it increase enrolment at primary level and plays great role in providing educational opportunities to all school age children and adults so that all of them complete primary education by the year 2015(ESDP-III(2005).

Addis Ababa Region, which has large number of out of school children and illiterate adults, is implementing Adult Basic education & ABE in accessing basic education to out of school children for instance, GER of primary education which was 64.1% in 2001/02 among which 6.8% in ABE centers, has increased to 68% in 2004/05 among which 7.9% in ABE centers (ESAA, 2006/07).

Derebsa (2002) states that the issue of curriculum implementation is linked to how efficiently learning takes place, effective implementation is also based on training of teachers, availability of text – books curriculum materials and facilities.

Based on the above idea, it seems that NFBE and ABE needs proper attention. The coordination between NFBE centers and formal school to use resources efficiently and to share experience, training and supervision provided to NFBE implementers, etc have not been critically studied.

The researcher also have experience of working on the management of the ABE center and guiding the facilitators and the learners. To this end the researcher initiated to conduct research on the practice and the challenges that hinder to run the program.

Hence, the study attempts to answer the following basic questions.

1. What are the practices of the existing alternative basic education for out of school children in Addis Ababa region in the case of Arada sub city?
2. What are the major challenges that hinder the implementation of ABE program?
3. What are the successes of ABE program?

1.3. Objective of the Study

The study has the following General and Specific objectives.

1.3.1 General Objectives

The general objective of this study is to assess the current practice, challenges and results related to ABE program in Addis Ababa city administration, particularly in Arada sub city. The study also aimed to investigate the problems they have encountered in designing and implementing ABE programs and to provide possible recommendations that help alleviate the problems in Arada sub city.

1.3.2 Specific Objectives

The study has the following specific objectives.

- To assess the practice of ABE in Arada Sub city.
- To investigate ABE center curriculum, learners and facilitators related problems in ABE program.
- To identify administrative /instructional impediments in ABE program.
- To assess results achieved by ABE program .

1.4. Significance of the Study

The effectiveness and efficiency of educational program depends on the thorough understanding of the problems that affect the achievement of its goal and objectives. The challenges and practices identified in the process of investigating ABE implementation will helps to look for clear and applicable solutions that may alleviate the problems. Hence, this study will be use full to:

1. Increase awareness of educational policy makers and planers at different levels, about the current challenges of ABE implementation in Addis Ababa particularly in Arada sub city.
2. It contributes additional knowledge to sub-city education experts and other stake holders on how to improve implementation of ABE in Addis Ababa city administration, particularly Arada sub city.
3. Serve as a reference for those educational planners and other professionals who intend to carry out further in-depth study.

1.5. Delimitation of the Study

To make study manageable and within the capacity of the researcher financial, material and time resource, the study is delimited geographically to eight ABE centers in Arada sub city . In addition, the study is confined to the practices and challenges of ABE centers in Arada sub city in the year 2009/10. The conclusion of the study also drawn based on the practices and major challenges of ABE centers in the sub city.

1.6 .Limitation of the Study

In conducting this study the researcher has faced the following problems that contributed for the limitation of the study.

1. There is a problem of literature particularly in the area of alternative basic education

2. Financial constraints hinder the researcher to include more centers in order to obtain more data.

1.7. Definition of Terms

In order to avoid ambiguity and to have consistency in the study, the following terms and defined:

Alternative Basic Education: system of learning which is mainly characterized by flexibility, transparency in terms of the degree of openers- opens access, open learning, and give more opportunities for children to learn.

Alternative Basic Education Center: is an instructional site in which ABE is given. It is one two-class room school constructed by the community or NGOs. Formal schools, farmers' training centers, health posts/centers, agricultural development offices, privet extra houses.

Basic Education: is a learning outcome, i.e. Knowledge ad skills acquisition and application, positive attitudes formation, internalization and exhibition of values for a variety of life and work enhancing purpose and for the good that is inherent in knowledge itself (Befekadu, 2006:12).

Facilitator: is a Para- professional teacher employed to teach for free, mainly to get certificate of participation for later employment opportunity, in ABE centers.

Illiterate: one who has no basic skills of reading, writing and computing.

Literate: one who has basic skills of reading, writing and computing.

1.6. Organization of the Study

The study consists of five chapters. The first chapter deals with the problem and approach. The nature of the problem and its magnitude, the importance and urgency of the study, and the areas to which the conclusions will be confined are briefly discussed in the chapter. The review of the related literature is treated in the second chapter. This

chapter presents the conceptual frame works or a brief review of related studies that serve as grounds and evidence to support the basic questions of the study. Chapter three addresses research design and methodology. It explains the methods, approaches, procedures and tools that were used to achieve the purpose of the study. The fourth chapter focuses on the analysis and interpretation of the data collected. In the chapter the data collected from the field were organized, processed and interpreted. The last chapter treats summary, conclusions and recommendations. It briefly discusses the major findings, the researcher's judgment drawn from the major findings and the suggestions forwarded to alleviate the existing problems in implementation of ABE programs. Besides, references used and other necessary documents were attached at the end of the chapter.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Definition of Education

The term education describes the total process of human learning by which knowledge is imparted, faculties developed, and skills trained. The concept of education as life long process comes along with change in developmental thinking. In the history of education it has passed change which depends on the needs and interest of the society.

Education provides people with important benefit that is not immediately reflected in the form of increased earnings. This benefit is social development (World Bank, 1988:24).It is required by human beings to be able to survive, to develop full capacities to live and work in dignity, to participate fully in development decisions and to improve the quality of life(Colclough and Lewis, 1993:40).

2.2. Forms of Education

The provision of education for citizens has many forms. Formal educations are not the only but one method to reach and fulfill the demand for more education with in the society. There are also informal and non formal ways of education to provide for the society.

As stated by Coombs and Ahmed (1974:8) Informal education is defined as the life long process by which every person acquires and accumulates knowledge, skill and attitudes and insights from daily experiences and exposure to the environment at home, at work, at play; from the example and attitudes of family and friends; from travel, reading, newspapers and books; or by listening to the radio or viewing films or television. This implies informal education is unorganized and often unsystematic; yet it accounts for the great bulk of any person's total life time learning including that of even a highly 'schooled person.

They further stated that formal education as highly institutionalized chronologically graded and hierarchically structured education system; spanning lower primary school and the upper reaches of the university.

Moreover, non formal education is considered as any organized systematic, educational activity carried on outside the framework of the formal system to provide selected types of learning to particular sub-groups of the population, adults as well as children. Thus the definition of non formal education includes, for example, agricultural extension and farmer training programs, adult literacy programs, occupational skill training given out side the formal system, youth clubs with substantial educational purposes, and various community programs of instruction in health, family planning, cooperatives and the like (Coombs and Ahmed, 1974:8).

This implies that non-formal education takes place within the context of immediate and meaningful action, work and use. What is learned is put to use. It is thus, education with the outlet for the learning; it provides experiences for which there is practical use (Bishop, 1989:133). Learning and doing, doing and learning are so interrelated that it is hard to differentiate them. This recognition has been the result of the shift of focus during the 1970s from education to deliberative learning (UNESCO, 2000: 46; Coffield, 2000: 12).

Mani (1984:54) also defined non-formal education is as" an alternative system of education outside the formal system, based on the learners' needs and interests, for the illiterates, drop-outs, pushed-outs and left-outs/non-starters." Courtney and Kuts (1978: 30); and ICDR (1999: 6) have also supported the view that non-formal education is "an alternative" or "a substitute" (not supplementary) to formal education.

UNESCO (2000:49) has synthesized the NFE conceptions in such away that supplementary alternative programs can help meet the basic learning needs of children with limited or no access to formal schooling, provided that they share the same standards of learning applied to schools, and are adequately supported.

Hilliard's (1973) broad yet succinct description can sum up the concepts of non-formal basic education as:

- valid, high quality education for imparting 'life' skills and knowledge;
- education designed to reach large numbers of people where they live and work, without removing them from their normal environments and responsibilities;
- highly diverse in organization, funding and management, emphasizing local initiative, self-help, and innovation on the part of large numbers of people and their local institutions;
- education designed to pay its own way through increased employment, productivity, and social participation;
- having objective that makes learning a national, lifelong learning experience, compatible with the interests of individuals and communities, for all economic levels of a society (Bishop, 1989:131).

In general, non-formal education has been seen as flexible and adaptable to meet the minimum essential learning needs of children within the broad conceptual framework of a life long learning system. In this paper, it has been conceptualized as alternative and complementary educational provisions for the children who, for various reasons, are not served from the formal provisions.

2.3. Rationales for Non-Formal Education

Universal primary Education, which has become a target to all nations of the world, is still a long way off for many developing countries

including Ethiopia. Illiteracy, and inequality in education still remain; few of the children are retained in primary schools particularly in developing countries. Consequently, a search has been made "for better alternatives than pouring more scarce resources in to a small conventional school system that has no chance of becoming universal in any reasonable period of time" (Coombs, Prosser, and Ahmed, 1973 in Courtney and Kutsch, 1978: 14).

The Ethiopian Social Sector Study Report (1998:1) has also indicated "developing countries like Ethiopia cannot meet the basic learning needs of their people through the formal education alone". Rigid curriculum, bureaucratic administration and management, elitist nature, inefficiency in resource utilization, and high costs of running the programs in the formal system forced all concerned stakeholders to look for alternative modes of educational delivery system namely NFE.

According to FAWE (2001: 22) in Ethiopia NFE has served only a partial segment of school age children leaving out many to lead the sad world of illiteracy. Therefore, it has to be revitalized so as to play a prominent role in satisfying the learning needs of children, and the demands of the community and the requirements of the economy.

Historically, the search for effective alternatives to the traditional content and delivery of primary education became evident in the late 1960s and continued in the 1970s and 1980s, and many of the same concerns remain today (Lockheed and Verspoor 1991:21). Consequently, non-formal education, which was viewed with "disdain" and "under-utilized in the past" (Bishop, 1989), has now been "viewed as one of the new favored areas of inquiry in education' (Paulston, 1972:vi; in Courtney and Kutsch, 1978: 5).

It has been found relevant in addressing a number of school barriers, especially those related to the educational demand factors, nature of work, utility and expenses. Since many disadvantaged children live and work in areas where schools are non-existent or do not fit their circumstances or work times, non-formal education provision has become necessary (UNESCO, 2001:5; Lockheed and Verspoor, 1991:159).

The relationship between education and the world of work is also an area, which magnifies the need for non-formal education. For Harbison (1973) as cited in Courtney and Kutsch (1978:7) "linkages between formal education and employment are neither direct nor clear". Evidently in Ethiopia, the school leavers and graduates that come out of the system are increasingly finding it difficult to cope with changing environment in spite of the high costs incurred on the system. Alternative teaching centers and methods so as to overcome the high opportunity and direct costs of schooling are, thus, recommended (ESSR, 1994: 2; World Bank, 1998:104).

In short, most of the rationales for NFE that have been reviewed so far, take their starting point from the failure of formal schooling as a means to achieve both educational and non- educational ends. Precisely, frustrations with the expense, rigidity and perceived poor quality, low coverage, irrelevancy of the formal education programs, are among the reasons for increased attention to non-formal education.

2.4. NFE in Ethiopia: Historical Overview

Ethiopia, which is currently typified as "a predominantly illiterate country", a long way back in history, had been the second in Africa after Egypt to develop a written language (Habtamu, Habtegiorgis, and Wanna, 1999:9; NLCCC, 1989:10). Not only the Language but also the then education system was very small at the base and permitted a

privileged few to reach the top and exercise new skills at national level (MOE, 1989:13). Nonetheless, it has been serving as a departure to study the historical perspectives of NFE in the country.

Different sources indicate that during the early times, the Ethiopian society traditionally passed its cultural knowledge and skills to the subsequent generation through different means that could be interred as NFE or informal learning (FAWE, 2001: 22). Later when modern education introduced to Ethiopia in 1908, the literacy efforts used to focus mainly in giving communicative skills and the rudiments that was necessary to run the modern bureaucracy that was being established then (ESSR, 1994: 1). The then formal education lacked responsiveness to actual conditions of the country and also couldn't accommodate more than 20% of the primary school age children (MOE, 1979:2). This means, the education needs of those outside the formal school system had received little attention. The then educators and policy makers saw such issues seriously. Consequently, some affirmative actions were taken, some of which have been briefed in this sub-section.

The Ministry of Education issued the proclamation in 1955 that Adult Education would be "one of the project for the future". The proclamation on Literacy stated that all persons need to acquire "fundamental education." It further stated that all boys and girls between ages of 7 and 18 should receive at least an elementary education (MOE and Fine Arts, 1961: 39; MOE, 1989: 13).

In order to provide fundamental education to citizens the National Literacy Campaign Organization, was set up by a voluntary body in 1962. Consequently, the non-formal delivery mode of education had got special attention in our country (Mamo, 1999:20). Besides, in 1967 a Division for Adult Education was formed in the Ministry of education so as to coordinate the growing non-formal delivery mode

and in the following year, UNESCO opened its own pilot, work-oriented adult literacy project for Ethiopia (MOE, 1999: 11).

In addition to this, in 1969 NGOs working in the field claimed that there were a total of 80,000 participants. Between 1963 and 1970, one million people had become literate. At about the same time, the UNDP/[UNESCO-financed project for Work Oriented Adult Literacy Program (WOALP) gained a total of 43,440 participants over its six-year life. It served to extend experiences, raise professional capacity to engage in literacy work, and as an introduction to the task of preparing literacy-teaching materials (MOE, 1989:13,). Moreover, special mobile schools were also developed during the Imperial period to provide basic literacy to the nomadic tribes (MOE and Fine Arts, 1961; MOE, 2000:4).

NFE was given a high priority during the Military regime. At the Ministry of Education department was established for this purpose (MOE, 2000:4). Direct and indirect preconditions to enhance literacy actions were taken at large. In relation to this, National Work Campaign for Development through Cooperation was launched in 1974 and mobilized nearly 60,000 young people who remained in the rural countryside. Besides, in 1976, the Provisional Military Administrative Council announced the Program of the National Democratic Revolution of Ethiopia. This included the general pledge that 'There will be an educational program that will provide free education, step by step to the broad mass, and specifically that "All necessary measures to eliminate illiteracy will be undertaken" (MOE, 1989: 16).

The National Revolutionary Development Campaign and Central Planning Supreme Council was established 1978 with broad objectives to eradicate hunger, poverty, disease and illiteracy from Ethiopia. Seven months later, in May 1979, the National Literacy Campaign

Coordinating Committee (NLCCC) was established by the Council of Ministers and launched action with the broad goals of eradicating illiteracy and enhancing national development (MOE, 1987:1; MOE, 1989: 17; MOE, 1999:1 1).

An International Committee, which was established in 1980 by UNESCO to evaluate candidates for UNESCO Prizes for meritorious work in Literacy, gave the International Reading Association Literacy Award to the NLCCC. Among the citations for this, was the preparation of innovative literacy materials, which was published in five nationality languages that in three phases grew to 15 distinct vernaculars spoken by 93% (MOE, 1989; MOE, 1999: 12). Similarly, in 1982 The Peasants' Association of Ethiopia got an international Honorable Prize award during the UNESCO literacy award ceremony for the year.

In short, from June 1979 to April 1981, nearly 4 million people became functionally literate, reducing the illiteracy rate of the country from 93% to 65%. Attempts were made to enable the participants move very quickly to the application of the new life skills of reading, writing and calculating to the practical aspects of new knowledge (MOE, 1987; MOE ,1989; MOE, 1999:12).

Some authorities, however, argue that the implementation of the non formal education program that had been practiced before the commencement of the current Education and Training Policy was most properly working and its impact remained very low (TGE, 1994: 2). It has also been argued that the process of curricula development did not involve local communities or their representatives at the grass root levels, It was said to be a prescription of objectives, contents and by-and-large, wholesale adoption. Overall, however, the literacy program implementation had moved far a head of the formal education and left magnificent imprints.

Since 1991, NFF has been envisaged to be provided beginning and integrated with basic education and at all levels of formal education. Emphasis has been given to initiate immediate and practical solutions to avert the crises (ETP, 1994: 15). Local commonalities or their representatives have been encouraged to participate in the preparation implementation and evaluation of their respective curricula. This is to make the content of NFE concrete focusing on enabling the learners develop problem-solving attitudes and abilities (ETP, 1994: 16). To mediate the implementation of these policy intents, ICIDR in collaboration with regional states have developed a syllabus for adults of age 15 and above. It was intended to serve as a blue print from which the regions could adapt their own curricula materials. Its completion warrants credentials equivalent to the completion of fourth grade level of education in the formal system. Consequently, "...almost all regions have prepared curricula materials for literacy and non-formal basic education programs that they are running" (ICDR, 1988, ICDR, 1999: 40).

Currently, the planning and implementation of NFBE programs in Ethiopia, in most cases, are collaborated with local and international NGOs. As MOE (1999: 70) indicates, in almost all sampled regions (Afar, Amhara, Oromia, and SNNPR) by ICDR survey study, there are NGOs who run NFE programs. Most of them differentiate between classes for out- of-school children and classes for adults. The children's program in most cases lasts for 10 months per year (September to June). The subjects taught are: local language, numeracy, environmental science and English. The implementation practices, overall, are flexible and adoptable to local circumstances (IIZ/DVV-ETH, 2000, No. 9).

Such practices were originally initiated by AAE, which is a large international NGO. Six regions (SNNPR, Addis Ababa, Oromia, Amhara, Tigrai and Afar) are replicating the experiences of AAE.

Particularly, there are many innovative NFBPE centers in SNNPR, Addis Ababa and Oromia. In 2000/1 there were 191 and 6,180 NFBPE centers in Addis Ababa and Oromia respectively (IIZ/DVV-ETH, 2000, No. 9).

2.5. Definition and Concepts of Alternative Basic Education

Alternative approaches to basic education is those non-formal education services for children at the primary level with non-formal domain it is a new field of study which came to existence in the developing countries where the inadequacy of the conventional school system and the costs of rapid growth in education place high demands on available fiscal resources (Hamadache, 1995).

Befekadu (2006), defined alternative basic education as "a system of learning which is characterized by flexibility, capacity to recognize and creatively utilize diversity and transparency in terms of the degree of openness-open access, open learning and limit opportunities to release the creative potential of the learners."

Furthermore, as it was explained in ESDP-III document, ABE is the component of non formal education which serves as an alternative approach to complement formal education program to increase access to basic primary education for out—of-school children in the age range of 7-14 (OEB,,2005:49).

The document further explained that ABE program has a three- year cycle in three levels, which is equivalent to formal basic education (Grade 1-4). It helps the children to attend first cycle primary education (Grade 1- 4). The program serves as an alternative approach to complement the formal education program and increase enrollment of primary education and plays a great role in providing education

opportunity to all school age children so that it helps them to complete primary education by the year 2015 (OEB,,2005:49).

2.5.1. Historical Foundation of Alternative Basic Education

The search for alternative mode of delivery had been started before thirty years. The event of searching for alternative means of delivery was directly related to satisfying educational need of the society. The event of searching for alternative mode of delivery was in a time of rapid expansion of formal education. The important reason for searching of alternative approach was to complement formal education system. In relation to this, MOE (2002), noted that, meeting basic education needs of all school age children, let alone vast majority of illiterate youth and adults, through formal system were impossible.

In addition to this, MOE (2002), explained that, high population growth rates and the escalating cost of building and running school were exerted heavy pressure on the meager resources of development countries.

Araya (2002), also explained the necessity of ABE, using the 'formal education mode of delivery, a strategy is a futile attempt in terms of reaching all citizens within a given period of time.

The failure of the formal education system to satisfy societies need for basic education, clear way to search for innovative and alternative delivery method, which is flexible and cost effective to complement the expansion and development form of education, especially in developing countries including that of ours.

2.5.2. The Impact of Education Philosophical Thoughts on Alternative Modes of Learning

Educational thought and practice have been revolutionized by one of the most influential thinkers, Paulo Freire (1974). His philosophy of concintization has had tremendous impact on educational discourse globally. Participation, empowerment, freedom, and consciousness raising were some of the themes he addressed through his dialogical approach. Other thinkers on education include Malcolm Knowles, (1970) and Susane Kindervattcr (1979). Rudolf Steiner (1909) occupies a special place in view of his unique contribution to educational philosophy, the arts, and science.

2.6. Alternative Approaches

In every country there are groups of children who remain un reached by the classical pattern of formal primary education.

In this regard, there has been aspiration of action and sustained efforts to provide alternative educational opportunities for the millions of children and youth who have missed formal education (WCEFA, 1990b: 2).

It is instructive to recall the strong debate which happened in the late sixties following the revelation that a global crisis in education existed. The signs of an emerging or potential crisis included escalation of costs and expenditure, declining quality, doubts about the relevance of the curriculum, a growing problem of educated unemployment in many countries and widening gaps between standards and participation in rural and urban areas (Coombs cited in Hallack, 1990: 25). He further stated that the debate on the world education crisis were many and varied from criticizing formal education, resulting in calls for reform of education systems, to the actual design and implementation of alternative educational programs.

The discourse of Non-formal education (NFE) which was initiated in the 1960s has continued to influence the change agenda in the domain of education and training. NFE and Alternative Approaches to Basic education (AABE) have gained prominence on the change agenda due in part to the inadequacies and problems of the formal education system. These were manifested in low levels of both the internal and external efficiency of the system, high rate of dropouts and questionable learning achievements (Coombs, 1985:147). This implies the inadequacies of formal education to suit the needs and circumstances of its clientele constitute a source of justification for NFE and AABE. Another source of justification is the right of every one to education.

2.6.1. The Rights Based Approach to Basic Education

The right to education has different facets, both quantitative and qualitative. According to UNESCO (2000:16) when the Universal Declaration of Human rights was drawn up let alone a choice among different kinds, only a few of the world's young people had access to any kind of formal education. The rights based approach to basic education is predicted on the conviction that for the sustainable expertise of basic rights. Duty bearers are expected to fulfill their duties and obligations not only in providing opportunities for the expertise of the rights but also in taking appropriate measures to ensure that they are exercised(Thompson, 2001:4). To this end, the objective of basic education must facilitate the exercise and enjoyment of basic rights and fulfillment of basic needs.

2.6.2 Need Based Alternative Forms of Learning

The number of out- of -school children is an indication of the need for alternative form of learning. Many children have either no access to formal schooling or have dropped out due to a variety of reasons including school and out of school factors.

The growth of the non-formal sub-sector is an indication of demand. The absence of relevant and culturally appropriate learning opportunities calls for the persistence of alternative approaches. With reared to this, Thompson (2001: 13) reveals that alternative forms of learning employed in the pastoral areas of Kenya, have the characteristics of flexible time and duration, cost effectiveness in terms of finance and opportunity cost, absence of uniforms, functional curriculum contexts and high participation of the community in determining what is taught and learned.

Thompson (2001: 17) further stated that in Zambia, the policy on basic education and training contained in "educating our future" makes reference to out- reach learning programs for children who do not have access of schooling. This indicates the importance of ABE to provide basic education and to reach children's who have no access to formal education due to various reasons.

2.7. Meeting the Basic Learning Needs of Children

The long-term goal in education is nothing less than to ensure everyone completes a basic education of adequate quality which enables him/her meet basic learning needs-the knowledge, skills, attitudes, and values necessary for survival, to improve the quality of his/her life, and to continue learning (World Bank, 1999:vii ; WCEFA, 1990: ix). Basic education can help meet the intrinsic needs of the learners, assist them to meet other basic human needs, and promote social and economic development. In line with this, two reasons for basic education to claim public resources can be mentioned. First, a sound basic education lays the base for the subsequent learning. Second, deterioration at this level of learning strongly affects the incidence of poverty (Vandycke, 2001: 27). Increasing relevance, improving quality, promoting equity, and enhancing efficiency, which are said to be applicable to both in-school and out-of-school settings can, thus, be ascertained the basic learning needs of children.

2.7.1 Increasing Relevance

Research findings demonstrate that basic education can improve labor productivity and entrepreneurial skills, help develop appropriate values, attitudes, and behavior, and have positive intergenerational effects on families and communities. These results justify the importance attached to the relevance of basic education (WCEFA, 1990: 46). Basically, the relevance of curriculum/program is determined by the extent it meets the educational objectives. Which at basic level are: to impart essential cognitive skills and knowledge and to prepare students for further learning. The key to relevance is thus, the identification of needs (MOE, 1999:7).

Research on needs identification has confirmed that the content of basic learning should focus on literacy, oral expression, numeracy, and problem-solving general skills and essential learning tools that are applicable across locations and over time. An implementation of NFBE program that graduates learners who do not have these core contents has failed, as a program regardless of how effective it may have been in meeting other cultural, social, or political needs.

2.7.2 Improving Quality

Of the three pillars of a good education system (access, quality, and delivery), quality is the key (World Bank, 1999: 7). Virtually, the quality and standard of education in a given country is mainly determined by the essence of its curriculum and the process of its implementation (ETP, 1994: 3). Currently, quality has high attention on the agendas of many governments. Their activities are aimed at improving quality in basic education. NFBE program implementation practices must enhance the quality of education that children have access to.

For two reasons, however, quality at implementation level rarely achieved. First, implementation is a forgotten area; all talk about the

planned, not the implemented program. Second, quality itself is difficult to measure and define. Moreover, the quality of learning outcomes influences and is influenced by factors outside the education system such as the home environment and perceptions of the future labor market (World Bank, 1999:7).

The provision of education of acceptable quality thus, depends on two determining factors i.e. adequate system of school management and a reliable information system enabling the operation of the education system at the local level to be monitored (World Bank, 1999:9).

Discussions on learning quality, many of the times, depend on four sets of indicators- educational inputs, processes, educational output /outcomes, and learner characteristics. A systematic effort to improve learning quality in the implementation process of NFBE program requires identification of how the multiple inputs of the system interact within the learning process to produce the desired outputs. The understanding of these relationships suggests the following priorities for NFBE reform:

- improving the availability and use of instructional materials;
- enhancing facilitator effectiveness by emphasizing subject mastery, communication skills, and motivation;
- improving managerial skills, community and institutional structures, and individual and organizational incentives;
- Increasing the time actually spent on learning (WCEFA, 1990:49; Lockheed, and Verspoor, 1991:4).

When these properties linked with improved preconditions for learning that enhance pupils' initial capacities, and with community environments that reinforce learning, true gains can be made in learning quality of the NFBE programs.

2.7.3 Promoting Equity

Inequities most commonly relate to gender, economic status, location, religious, linguistic, and ethnic identifications, and special needs. As World Bank (1995:3; 45) depicts, "girls, the rural poor, children from linguistic and ethnic minorities, nomads , refugees, street and working children, and children with special needs, go to school less than others".

Gender difference in participation is a persistent concern. WCEFA (1990:54) has indicated that with the exception of Latin America, female rates of enrolment in primary schooling continue to lag behind those of males: the rates fix 6-11 year-olds in Africa were 69 percent for males and 56.5 percent for females, in Asia the respective rates were 77.4 and 59.3 percent in the early 1990s. The gap has actually widened since 1970 in Afghanistan, Nepal. and Pakistan, and in many other nations where female enrolments remain very sensitive to economic or social disturbance.

Practically, poverty affects both the ability of the family to support schooling and its willingness to bear the costs. Unequal distribution of schooling in a nation causes unequal access. According to one estimate, only half the rural children in most countries (and as few as 10 percent in some others) have the opportunity to complete four years or more of schooling. The barriers to learning attainment in rural areas include the limited quantity and poor quality of schools, poor reinforcement from the non-school environment, irrelevant curriculum, high opportunity costs for children whose labor is needed at home, and long distances between the home and the school. Another disadvantage is that the language of instruction used in schools often differs from that used in the home. These disadvantages translate into differences in learning achievement (Frdissa, 2002).

Practically, equity in meeting basic learning needs may come at a cost, but in the long run it will be a lower cost to society than the continuation of inequity. Closing the persistent historical gap requires concerted compensatory efforts. Not simply an expansion of access. Thus, all should seek complementary programs, which are "different but equal" programs to fulfill the learning needs of out-of-school children.

2.7.4 Enhancing Efficiency

Efficiency, which is production of output relative to input, helps us to understand how the education system works in terms of using available resources (Pratt, 1994: 343; FAWE, 2001:4). Efforts to improve efficiency in today's basic education programs emphasize reducing costs without significantly altering the desired effects, or enhancing effectiveness without increasing costs. For example, the introduction of split shifts to increase the utilization of facilities is an appropriate way to enhance efficiency in locations with sufficient pupils to justify extra shifts. Similarly, literacy, ABE for out-of-school children and other basic skill programs can make use of primary school teachers, facilities, and appropriate materials when school is not in session and thus reduce the proportion of the Cost of these resources that must be charged to basic primary schooling (WCEFA, 1990:60; ESSSR, 1998:50).

Unfortunately, education systems in developing countries have difficulty in improving efficiency for three reasons:

a. inadequate knowledge about the importance of inputs,
b. inadequate knowledge about the cost of inputs, and
c. difficulty obtaining appropriate information (lockheed and Verspoor ,1991: 39; cited in Lockheed and Hanushek, 1988).

A special form of educational inefficiency is that described as 'wastage'. This normally refers to the effect of pupils repeating a grade

or dropping out of school. Since both actions increase the number of years of schooling provided relative to the number of graduates produced such wastage is seen as synonymous with inefficiency. A special endeavor should, thus be made to at least minimize wastage, enhance efficiency, and prepare learners for meaningful and productive life in the community (ETP, 1994). Strengthening career guidance and consulting services for learners, encouraging them to play crucial roles in the implementation of the NFE programs, be it individually or in groups, help to avoid both attrition and repetition. Such endeavors lead to true gain from the implementation practices of NFBE programs.

2.8. Guiding Principles of ABE and their Implications for Facilitators

Ahmed (1999:6), Firdessa (2003:125) Sharafeddin (2000:3) identified general guiding principles of ABE from different documents and reports of field practices and lessons of many NGOs is planning and implementing the ABE program. Accordingly the success of an ABE program depends on how well these principles are made operational across all its components and activities. These principles are:

- Community participation and ownership
- Flexibility
- Adaptability ad relevance
- Accessibility
- Gender equity
- Linkage and integration with formal school
- Cost-effectiveness
- Program integration with development work
- Sustainability
- Integrated and condensed curriculum
- Local resources focus and
- Learner centered approach.

The implications of Guiding Principles of ABE for facilitators

Action Aid Ethiopia (2003:26) explained the implication of the general guiding principles of ABE for facilitators as follows:

Principle 1- Community participation and ownership: Facilitators are supposed to be members of the community and are accountable the community. Beyond regular classroom duties they should be able to mobilize and sensitize community members and children's parents to participate in decision making process and to support the education program. Facilitators need to be trained how to facilitate community participation in an ABE program.

Principle 2: Flexibility: Facilitators are expected to negotiate and adjust school calendar and programs according to local needs and realities. They are also required to ensure that the necessary and agreed contents and total hours of learning are covered. Hence, facilitators need to be trained on how to understand local situations, negotiating, with people and create a workable plan agreeable to specific locality.

Principle 3: Adaptability and relevance: ABE curriculum and delivery approaches should be relevant and adaptable to local realities and the needs of learners. It is the tasks of facilitators that these requirements are met. Therefore, facilitators have to be equipped with the necessary knowledge and skills on how to adapt learning and make it relevant to learners' needs.

Principle 4: Accessibility: ABE centers have to be accessible to children and particularly to girls. This means the centers have to be located near the vicinity of village settlements that can easily and safely be reached by children. Facilitators have to know and device ways of influencing community leaders and members to make land and other resources available for locating the school in a suitable, safe and attractive position for children.

Principle 5: Gender equity: One of the key objectives of ABE is to address gender inequity by creating access for girl children to basic education. Facilitators are expected to play important roles in sensitizing community members on gender issues and the right of girl children to go to school. They have to be given gender training with a particular emphasis to education.

Principle 6: Integration and linkage with formal school: Facilitators should be able to initiate and maintain linkage with neighboring formal schools and teachers for collaborative work and exchange of experience as well as to facilitate transfer of children from ABE centers to formal schools. This implies, facilitators need to be trained on how to do these things properly and effectively.

Principle 7: Cost-effectiveness: One of the essential features of ABE is its cost effectiveness. However, undertaking a cost-effective program requires skills in careful identification, planning and utilization of local resources on the part of facilitators. It is necessary to train facilitators on how to identify and mobilize local resources, how to plan on available resources and efficiently utilize them and how to increase internal efficiency of education.

Principle 8: Program integration with development work: Academic learning alone does not prepare children for their life needs. Hence, learning has to be linked to the development needs and practices of the locality of the ABE centers. Facilitators need to have the capabilities and skill required to relate learning to development of the area where the schools operate. They have to be trained on those skills that enable them to integrate learning with local development needs.

Principle 9: Sustainability: ABE programs initiated by NGOs, local government and other development agencies have to endure and continue providing access to basic education so long as they are

required even if those who introduced the program withdraw. Facilitators have to enable institutions and' their members to develop strategies for sustaining the program. This calls for training of facilitators on knowledge and skills on how to design strategies for different aspects of sustainability.

Principle 10: Integrated and condensed curriculum: The time and other resources available to ABE is limited while the learning centers have to be compatible with the requirements of formal schools that the learners have to eventually join. This situation calls for skills for condensing and integrating the curriculum that facilitators use. Hence they need to be trained on how to produce and use condensed and integrated curriculum in an ABE learning environment.

Principle 11: Local resource focus: Facilitators should be able to use the local environment and resources within it to enrich their lessons, to make learning relevant to local reality and assist children to properly understand their environment. Therefore, facilitators have to be trained on how to do these things.

Principle 12: Child centered and activity based approach: The learning process in an ABE program should based on approaches that put the child at the center of the learning process. The child should be actively involved in practical activities that promote self learning and interactive experience. Thus facilitators have to be acquired the necessary techniques and skills of organizing in a child centered manner and they have to also be trained on how to prepare activity based learning materials.

2.9. Practice of Some Countries in the Provision of Urban Alternative Basic Education.

2.9.1. Kenya Urban, Undugu Basic Education Program (UBEP)

The Undugu Basic Education Program (UBEP) was established by the Undugu Society of Kenya in 1978. The programme's objective was "to offer opportunities for the acquisition of functional literacy and practical skills to street, and other disadvantaged children in the slums of Nairobi.

The programme is organized in three phases, and each phase lasts for a year. The subjects offered in phases 1, 2 and 3 are similar to those offered in formal primary schools. After phase 3, the learners receive vocational training in carpentry, sheet metal and tailoring. The processes of learning are generally learner-centered. Aspects of indigenous learning practices such as apprenticeship (learner ship) are integrated into the focuses of learning. Learners with a preference for vocational training are apprenticed to artisans in the informal sector for the purpose of enhancing their practical skills and having insights into the world of work (Thompson 2007:27).

2.9.1.1. Success Factors

Thompson (2007) have identified the following factors which have accounted for UBEP's success.

a) The learners are able to use the skills which they acquire to earn a living.
b) UBEP is contributing to the reduction of wastage in the education system, and to the rehabilitation of street children.
c) The similarity of UBEP's core curriculum and the formal school curriculum facilitates entry to formal education for those who desire to do so.
d) The teaching of functional literacy and numeracy provides a foundation for vocational training. Vocational education and training equip the learners with skills to earn a living. Learning

is linked to production, and production-oriented functionality increases motivation for learning.

e) The apprenticeship or learner ship system provides a link between learning and work, and facilitates transition from learning institutions to working life.

The apprentices serve as vital links between the community (informal sector of the economy) and non-formal institutions of learning.

2.9.1.2. Lessons Learned

a) The success of Undugu Basic Education Programme has shown that education which is relevant and oriented to the needs of the learners can contribute to the rehabilitation, and change in the behavior of street children.

b) Alternative Approaches to Basic Education and Non-formal Education should not be seen as cheap alternatives to formal basic education. Vocational training, for example, requires certain inputs which may require capital expenditure. This could increase the cost of education.

c) When developing AABE-NFE programs it is important to establish horizontal and vertical links with formal education in order to facilitate movement between the two sub-sectors.

d) AABE-NFE programs for disadvantaged children are, in general, more relevant and sustainable when they include a skills development component in their curricula.

e) AABE-NFE programs for out of-school children are potentially helpful towards the achievement of the goal of education for all.

f) Provision of lunches for the children greatly improved their health and nutritional status.

g) Education and training enhance the chances of learners to participate in the processes of socio-economic development(Thompson 2007, 29)

2.9.2. Uganda Basic Education in Urban Poverty Areas (BEUPA)

BEUPA aims to improve the life perspectives of out-of-school children and adolescents between the ages of 9 and 18. The essential features of BEUPA include:

- Mother-tongue education;
- Integrated approach to learning;
- Similarity between the primary school curriculum and the BEUPA curriculum. The core curriculum of BEUPA is a condensed version of the primary school curriculum (Mathematics, Integrated Science, Social Studies and English). There is also instruction in psycho-social life skills, and living values education.
- The close relation between BEUPA and formal primary school facilitates interaction between the two. If they drop out from one sub-sector they can drop into the other.
- The delivery of the curriculum is shortened to 3 years from 5 years. The curriculum contents are organized into learning areas; a learning area is equivalent to one term's instruction.
- Utilization of expertise from the community in skills training provides a vital link between the school and the community, and makes the school a part of the community.
- Learning takes place three hours a day leaving the rest of the day for the learners to engage in other survival activities (Thompson: 2007:31).

2.9.2.1. Success Factors

As Thompson (2007) indicates the success factors that exhibits to meet basic education in Uganda urban poverty areas:

a) Facilitation of learning through child-centered and flexible approaches.
b) Focus of the curriculum on life after school. Transition from school to work is organized through career guidance.

c) Collection of relevant data for planning. NFE has been included in the Education Management Information System (EMIS). This ensures that planning is informed by relevant and accurate data.

d) Involvement of the community in the implementation of BEUPA with regard to:

- community mobilization
- identification and registration of children for the learning centers
- Pre-selection of instructors from the community. Monitoring of the processes of learning
- Provision of Community Own Resource Persons (CRPs)
- Facilitation of pre-vocational skills by members of the community.

2.9.2.2. Lessons Learned

a) Learner friendly pedagogical processes and learning environments contribute a great deal to facilitating learning acquisition.

b) Utilization of the services of community facilitators harmonizes the relationship between the school and the community. Instead of being apart from the community the school becomes a part of the community thus enhancing school-community relations.

c) The integrated nature of the curriculum enhances the holistic development of the learner in terms of intellectual, physical, emotional and social development.

d) Provision for entry into formal education through the organization of the curriculum promotes interaction

2.9.3. Indian Experience

In 1976, India had virtually achieved universal primary education for boys (97.5 percent) at the lower grades, fewer that 64 percent of the girls ever- started schooling. Most of the unschooled children were workers. Responding to the persistent social and economic problems

created by millions of working children, the government of India, in collaboration with donors and NGOs, initiated need- based projects in areas where child workers were concentrated (Tietjen, 1991: 65: Lockheed and Verspoor, 1991: 162). Some of them are: Pune (Maharashtra) primary education project. The Tilonia experiment, and Comprehensive Access to Primary Education (CAPE). The implementation practices of these projects have succeeded in attracting the attentions of many countries of which Ethiopia is not an exceptional.

2.10. Challenges of NFE And ABE Program

Currently the issue of non- formal education is getting increasing attention since there is a consensus that formal educations are not coping with the increasing demand for education.

However, the challenges that confront Non-formal education emanate from its own characteristics. Because, NFE does not strictly follow rigorous procedures as it follows different approach of delivery (Mamo, 1999:44). So due to these multi-variant approaches of delivery, most programs suffer from resource (financial, human, material) constraints.

The other challenge of NFE and ABE is the coordination and integration of the essential elements of the various sectors working in the field (Mamo, 1999: 45). Mamo further indicates the measures to be taken to over come and/or minimize these challenges, such as popularize NFE through a series of advocacy work; organizing workshops, seminars and using print, electronics and talk media.
In line with this, Befekadu (2006:26) noted that Negative attitude given to NFE and ABE to provide basic education to adults and out of school children. For instance, at woreda education office the NFE expert is paid less monthly salary compared to other experts with an equal educational qualification and Experiences. ABE should not be

seen as cheap alternatives to formal basic education. ABE programs for out of school children are potentially helpful towards the achievement of the goal of education for all by the year 2015. In addition to this, shortage of facilitators, students' text books, lack of stationary materials and low motivation of facilitators are the main challenge that encountered (Befekadu,2006: 27)

Where as in India's sarva shiksha Abhiyn challenges provision of alternative basic education states,

- Insufficient involvement of the local community, the Village Education Committees (VECs) and the Panchayati Raj Institutions (PRIs).
- The absence of linkages for entry at different levels into formal schools and for tie-ups with the National Open School.
- Insufficient decentralization of administrative and financial powers.
- Insufficient flexibility. NFE needs to recognize that different children's groups have different educational needs and modify itself accordingly.
- Lack success with girls. The attendance at girls' centers and the number of women functionaries in the program have been noticeably low.
- Delay in release of funds at all levels.
- Poor completion rates for the primary level by children studying in NFE centers. Very low transition rates to the formal system.
- The notion that the alternative system is inferior, second-rate and second-grade, both qualitatively and quantitatively.
- Low overall coverage of the scheme. It covers less than 10% of out of school children.
- Poor coordination of the work of Vas [village associations] with state governments.

This has led to the revision and renaming of non-formal education in India's education plan to 'Alternative and Innovative Education' (AIE) in 2000 which builds on the more successful experiences of Lok Joinbish and the District Primary Education Program(DPEP). In the development of this, the Sarva Shiksha Abhiyan (Universalisation of Elementary Education Program) provides an outline of the 'ideological' debate surrounding alternative education, and its responses (Government of India Ministry of Human Resource Development, 2002).

2.11. Advocacy for Legal and Policy Framework for NFE and ABE

It would seem that the circumstances for policy advocacy in favor of NFE and ABE are propitious given the on-going reforms in many countries. The economic, social and political reforms in a number of countries are having tremendous implications for non- formal education policy articulation and development. Proposals for poverty alleviation as enunciated in the Poverty Reduction Strategy Papers (PRSPs) recognize the critical role of basic education in poverty alleviation. In Uganda, for example, Article 30 of the Constitution provides for education as a human right. In Kenya Parliament passed The Children Act of 2001, which provides that, "every child shall be entitled to education the provision of which shall be the responsibility of the Government and parents". The Bill further provides that, "Basic primary education shall be compulsory and the Government shall take measures to reduce the costs of education and eventually provide such education free and the Minister shall make regulations for the implementation of this object" (Thompson , 2007).

The Children Act is a concrete manifestation of action to domesticate the 1989 U.N. Convention on the Rights of the Child, and other international Conventions, Treaties and Declarations which have implications for the protection, care and education of children. These

examples are instructive for policy advocacy for ADEA Non-Formal Education Working Group.

2.11. 1 Construction of an Institutional Framework

It has been suggested that, the provision of non-formal education, and alternative approaches to basic education should be within an institutional framework. In Kenya, for example, the NFE Desk in the Ministry of Education, Science and Technology has been upgraded to a Unit with the appointment of a Deputy Director. Under the 1999-2003 UNICEF-Kenya Government Program of Cooperation, action on a policy for non-formal education has been initiated; a non-formal education curriculum, and curriculum support materials have been developed; the training of NFE teachers' program is now in progress. The Ministry of Education, Science and Technology has initiated action to assign Teachers' Service Commission (TSC) teachers to non-formal schools, some of which have been recognized as examination centers for the Kenya Certificate of Primary Education (KCPE) Examination (Thompson, 2007:48).

2.12. Ethiopian Experience on ABE Program

In the concept of Alternative Basic education Muhamed (2009), Firdissa (2002) and Abebe (2008) stated that alternative basic education (ABE) as any forms of basic education out side the formal school system undertaken by any organization including government. Organizations, community based organizations (CBO) and other civil society organizations save children USA (2003:4) also it is a form of education that does not follow a rigid structure, time table and mode of delivery and management. It is not different kind of education but rather a complementary process that uses different approaches delivering lower primary education. Its major objective is to enable children to access education with their vicinity, a relatively short time frame and less cost as compared to formal schooling thus, the focus of ABE program is taking education closer to children, creating flexible

learning environment for marginalized children and making basic education community owned and managed. Firdissa (2002) and Muhamed (2009) emphasizes Non formal basic education (NFBE) is highly significant in solving problems of equity, access to education and promotion of citizen's effective participation in national development program Basic goal of any nation development program is to provide an education for its entire citizen. At the moment hundreds of millions of people have been deprived of education. The purpose of non-formal basic education there fore is to serve this disadvantaged group as an alternative approach to basic education.

In relation to inhibiting factors of Non- formal basic education practice Lack of budget to recruit facilitators, Shortage of human resource to recruit facilitators in particularly low land wereda, lack of interest to facilitate in the case where formal school teachers are assigned due to lack of incentives, lack of due concern from government bodies, lack of attention from the community due to lack of awareness and therefore, the community did not believe that the education in NFBE centers have the same value as that of formal school and CMC also did not properly perform their duties and responsibility are major problems. In addition to this except the WEO other concerned bodies did not involve in the program.

On the other hand, flexible in terms of learning time, place, and management, in line with this, community involvement in planning, monitoring and evaluation of the program, facilitator selection, and control the learner centered approach, cost- effectiveness, low drop out rate, high female participation, boosting commitment of facilitators, NGOs and committee members, localizing curriculum and the implementation practices, local resource mobilization or utilization, multi grouping and multi – grading approaches were commonly indicated as the best implementation practices of the ABE program.

CHAPTER THREE

THE RESEARCH DESIGN AND METHODOLOGY

3.1. Research Methodology

In undertaking the study, both qualitative and quantitative research approaches were used. Descriptive survey research method was employed as it was the appropriate method which enables the researcher to assess and describe the current practices and problems of ABE programs in a broad and wider magnitude.

3.2. Sources of Data

Both primary and secondary data sources were used to conduct the research. Primary data were obtained from educational officials, alternative basic education facilitators and learners. Secondary data sources like annual reports, educational abstracts and directives were used to obtain data on the practice of ABE program whereas published and unpublished materials were used to obtain data on conceptual frame works or to discuss review of related literatures that support the study.

3.3. Sample Population and Sampling

All ABE learners, facilitators and employees working in Arada sub city education office were the population of the study. Probability (simple random sampling) and non probability (purposive and availability sampling) methods were used to select sample respondents. Simple random sampling was used to select eight (8) from 23 ABE centers (33.3%) from all kebles found in the Arada sub city. These are Beherawi Betemengest, Kelemework, Agaziyan, Atse Naod, Atse Fasil, Betelhem , Kedamawi Minilik and Belay Zeleke . Lottery method was used to identify the sample ABE centers and to give them equal chances to be included in the sample.

In addition to this, Addis Ababa Education Bureau non- formal education focal person, the sub city education office head, the teaching learning process owner, cluster supervisor that are directly concerned with ABE program as non- formal education component were purposely included in the sample. This is due to the fact that they are responsible in coordinating and implementing ABE programs and it was believed that they have the chance to know more and can provide relevant and adequate information about the current practices and problems of ABE programs in the sub city.

Moreover, to obtain adequate and relevant data, sixteen education officials, all the available twenty seven facilitators and one hundred twenty learners from eight sample ABE centers were included as respondents of the study, by employed the stratified sampling technique from each strata or level selected 8 learners through lottery method in order to give them equal chances to be included in the sample. In general, a total of one hundred sixty three respondents from eight sample ABE centers were involved in the study.

Table 1 .Type and Size of Population and Sample Respondents

Sample ABE centers	Learners			Facilitators			Education Officials
	Pop	Sample		Pop	Sample		
		No	%		No	%	
Atse Fasil	165	16	10	3	3	100	Addis Ababa Education Bureau = 1 Arada Sub City Education Office =2 Kebele Education Office =3 Cluster Supervisor =2 School Director=8
Atse Naod	240	24	10	5	5	100	
Agaziyan	160	16	10	3	3	100	
Beherawi Betemengest	142	16	11	2	2	100	
Betelihem	203	16	8	5	5	100	
Belay Zeleke	105	8	7.6	2	2	100	
Kelemework	128	16	12	3	3	100	
Kedamawi Minilik	112	8	7.1	4	4	100	
Total	1,255	120		27	27		16

3.4. Data Gathering Tools

To collect relevant and adequate data, four basic instruments, namely: questionnaires, interview, focus group discussion and document analysis were used.

3.4.1. Questionnaires

Questionnaires were prepared based on the review of literature and were used to collect data from relatively large number of respondents. Most of the questions in the questionnaire were close- ended supplemented with few open-ended items. The questions were prepared in English and then translated in to Amharic. Amharic was used for the reason that majority of the respondents working at ABE centers may not clearly understand English language. Thus, the researcher believed that this might have avoided language barrier while gathering appropriate data. Different set of questionnaires were prepared and distributed for facilitators and educational officials.

3.4.2. Interview

Semi-structured interview was employed as instrument to gather more detailed information. Based on this, Addis Ababa Region Education Bureau non formal focal person and Arada sub city education office head were interviewed. The interview was focused on practices, results and problems of ABE programs. The information obtained using interview was used to substantiate responses collected through questionnaires.

3.4.3. Focus Group Discussion

Focus group discussion was conducted with learners from each levels(level 1-3).The method was selected for the reason that first cycle primary students may not be able to fill the questionnaire properly and the researcher believed that the method help to obtain

detailed and relevant information about the practices and problems of ABE program from the learners.

3.4.4. Document Analysis

To enrich the data obtained through questionnaires, interviews and focus group discussion and to solicit additional information relevant documents like annual reports, educational abstracts and directives were used to obtain data on the selection of trainers, enrolment of learners, methods used, curriculum, implementation and problems of ABE centers programs.

3.5. Data Gathering Procedures

First, the questionnaires and interview guides were prepared in English and then translated in to Amharic. This helps to avoid communication barrier and to make the respondents freely and confidently react to the questions. After that the researcher went to Arada sub city education office and all sample ABE centers to collect data. Before the questionnaires were distributed to the respondents, the researcher has made the first contact with head of Arada sub city education office and all sample ABE centers to obtain permission and necessary support to administer and collect the questionnaire. After obtaining permission the researcher distributed the questionnaires to respondents to fill the questionnaire individually. Following this, the researcher made an interview with Addis Ababa Region Education Bureau non formal focal person and Arada subcity Education Office head and consulted available documents related to ABE program implementation to obtain additional data for the study.

Further more seventeen focus group discussion were held with in eight ABE centers first, the researcher distinguish the sample population age group from 7 to 14 from each strata (level 1-3) with in eight ABE centers. Then, the discussion group arranged by eight

members the discussion time, place and others necessary facilities arranged collaboratively with the learners finally the discussion were made and the response captured with a letter of note and the data discussed qualitatively where necessary and appropriate. (Appendix D)

I have check out the validity of the questionnaire in the way that, randomly selected ABE center from non- sampled ABE centers New Era ABE center which is not chosen as a sample selected to comments on questionnaire items collegially, because the researcher works as a school director in the same sub city. These respondents which is the director, vice director and facilitator of that school gave necessary corrections and suggestions.

In general comments helped the researcher reduce number of items, avoid errors related to clarity of language, ideas and contents and to include some important concepts which were not included in the questionnaire After the necessary improvements were made the questionnaires were distributed to be filled by the respondents.

3.6. Methods of Data Analysis

Data collected through questionnaires (close-ended) were presented in table form. Frequency counts, percentages and mean scores were used to identify the frequency of observations that fall in to different categories for interpretation. The interpretations were made for all five point scale measurements based on the following mean score results:

1. 1.00 – 1.49 = very low
2. 1.50 – 2.49 = low
3. 2.50 – 3.49 = medium
4. 3.50 – 4.49 = high
5. 4.50 – 5.00 = very high

The responses obtained from open- ended item of the questionnaires, interview, focus group discussion and document analysis were used to

substantiate the analysis following each tables. Depending on the results of the analysis, interpretations and necessary discussions were made to clarify the issue. Finally, the major findings of the study were clearly reported and workable recommendations were forwarded.

CHAPTER FOUR

PRESENTATION AND ANALYSES OF DATA

This chapter deals with the presentation and analysis of the data gathered from ABE program implementers at different levels and, discussions of major investigations under basic research questions. Different tools were used to gather the data: questionnaire, focus group discussion, interview guide and document analysis.

The chapter is categorized in to two parts. The first part deals with the characteristics and background of the sample population involved in the study in terms of sex, age, education level and years of experience. The second part presents the analysis concerning the practice and challenges of ABE program implementation in Arada sub-city: Addis Ababa city administration.

4.1. Characteristics of Respondents

4.1.1. Categories of Respondents

Respondents were categorized in to three groups. There were 16 (10%) of educational officials, 27(16.5%) facilitators, 120 (73.6%) learners. All respondents were actively participating in ABE implementation as supervisor's directors, non-formal education experts, facilitators and ABE learners.

4.1.2. Characteristics of Respondents in Terms of Sex and Age

Table 2: **Respondents by sex and Age Group**

Respondent Group	Sex				Total	Age									
	male		female			<25		25-30		31-35		36-40		>40	
	No.	%	No.	%	No.	No.	%	No.	%	No.	%	No.	%	No.	%
Officials	6	38	10	63	16	1	6.3	6	38	2	13	2	13	5	31
Facilitators	21	78	6	22	27	5	19	14	52	6	22	2	7.4	0	0
Total	27	63	16	37	43	6	14	20	47	8	19	4	9.3	5	12

Table 2 presents the distribution of respondents by sex and age characteristics. About 63% of the respondents are males and close to 37% are female. Looking the sex distribution by respondent groups, the majority of officials (62.5%) are females while 77.8% of the facilitator respondents are males. This indicates that there is a gender imbalance in all categories Thus; female participation as facilitators in implementation of ABE programs was not adequate though in principle the lower grade teaching learning process giving priority to female facilitators.

With regard to age of the total respondents, Table 2 shows 32(75.3%), are in the age range of 25 to 40 years followed by 11(26%) in the age range below 25 years and above 40 which is respondents in the extreme age group are relatively few thus one can understand that the majority of respondents were found in the working group.

4.1.3. Characteristics of Respondents in relation to Educational Level and work experience

Educational level and work experience of ABE program implementers are necessary for effective implementation of the programs. Hence, the researcher examined the educational level and work experience of officials and facilitators.

Table 3: **Respondents characteristics By Educational level**

Educational level		Respondent Group		Total
		Officials	Facilitators	
below Grade 12	No.	0	1	1
	%	0.00	3.70	2.30
Grade 12 Complete	No.	0	14	14
	%	0.00	51.90	32.60
Certificate/TTI	No.	0	8	8
	%	0.00	29.60	18.60
College Diploma	No.	3	4	7
	%	18.80	14.80	16.30
First Degree	No.	12	0	12
	%	75.00	0.00	27.90
MA/MSC	No.	1	0	1
	%	6.30	0.00	2.30
Total	No.	16	27	43
	%	100.00	100.00	100.00

As shown in the table, the minimum educational level attained by officials is college diploma, by 3 (18.8%) of them. The majority of officials, 12(75%), have first degree. Only one of the sixteen officials has second degree.

Unlike the officials, facilitators' educational attainment does not go beyond college diploma. The majority of them 14 (51.9%) are grade 12 complete. 8 of the facilitators, about 30%, have certifications. This shows that, the educational level of facilitators was appropriate to the AAEB standard An interview made with AAEB revealed that the educational level of facilitators for non formal basic education should be grade 12 complete in the older curriculum or equivalent to grade 10 complete in the new curriculum or above.

Table 4: **Respondents characteristics by years of service**

Years of Service		Respondent Group		Total
		Officials	Facilitators	
< 6	No.	1	18	19
	%	6.30	66.70	44.20
6-10	No.	6	9	15
	%	37.50	33.30	34.90
11-15	No.	3	0	3
	%	18.80	0.00	7.00
16-20	No.	1	0	1
	%	6.30	0.00	2.30
>20	No.	5	0	5
	%	31.30	0.00	11.60
Total	No.	16	27	43
	%	100.00	100.00	100.00

Regarding the service years, all the facilitators have served up to 10 years where two-third of them served only below six years. Officials are found to have a much longer years of service as 5 (31.3%) of them reports to have served beyond 20 years. This long experience of respondents may help in providing valuable information to enrich the study.

4.2. Issues Related To Instructional Hours

Table 5: **Educational officials and facilitators responses concerning Instruction hours and School Days**

Respondent Group	Instructional hours per day							School days per week			
	1-2 hours		2-3 hours		>4 hours		Total	5 days		>5 days	
	No.	%	No.	%	No.	%	No.	No.	%	No.	%
Officials	9	56.3	7	43.7	0	0.0	16	13	81.3	3	18.8
Facilitators	19	70.4	8	29.6	0	0.0	27	27	100.0	0	0.0
Total	28	65.1	15	30.2	0	0.0	43	40	93.0	3	7.0

As shown in table 4, most of the officials and facilitators have teaching load of 1 - 2 hours per day. While nearly 35% of the respondents in each group are found to teach up to 3 hours per day.

As to the number of days engaged in teaching, all of the respondents from each group have classes 5 days per week. Some of the officials, 3 (18.8%), are found coming to classes for more than 5 days each week. This implies that Ahmed (1999.6) firdessa (2003-125) identified general guiding principles of ABE and one of the major principles is that flexibility of the program. The focuses group discussions were also indicated that initially facilitators were negotiate and adjust the total hours of learning are covered and it was important to create a workable plan and agreeable to specific locality.

Table 6: **Educational officials and facilitators responses concerning ABE centers opening & closing of academic year**

When do centers open/close?		Respondent Group		Total
		Officials	Facilitators	
similar to formal schools	No.	15	22	37
	%	93.8%	81.5%	86.0%
upon agreement between facilitators and officials	No.	1	1	2
	%	6.3%	3.7%	4.7%
when sub-city education office gives direction	No.	0	4	4
	%	.0%	14.8%	9.3%
Total	No.	16	27	43
	%	100.0%	100.0%	100.0%

From the majority of responses, 15 (93.8%) of officials and 22(81.5%) of facilitators, ABE centers opens according to formal schools' academic calendars. Overall, 37(86%) of the respondents believe that opening and closure of their centers is similar with formal schools. According to relatively very few respondents, about 14%, ABE centers academic calendar may be adjusted upon agreement between facilitators and officials or when sub-city education office gives direction. However, learners are found to have no say in the determination of the opening and closure of centers. The respondents further indicated that the programs that were implemented in the formal schools were carried out after the regular working hour's classes as well as sometimes in same schools on Saturdays.

Table 7: **Educational officials response concerning selection criteria of facilitators**

Selection Criteria	No.	%
political contribution	5	19.2
experience of teaching	7	26.9
educational background	9	34.6
their acceptance by the community	5	19.2
personal relationship with kebele education office	0	0.00

Asked for the criteria used in recruiting facilitators, officials' responses are presented in the table above. Accordingly 9 (34.6%) of them, the most cited criterion is educational background. None of the other criteria are believed as a standing selection criterion by more than 50% of the respondents. All of the respondents believed that personal relationship with kebele educational office is not used as selection criteria to recruit facilitators. This shows that in order to secure quality education in ABE program in addition to other factors the educational back ground of the facilitators has great contribution to subject mastery and to bring quality education.

Table 8: **Facilitators responses concerning types of training and length of training**

Attend any training?	No.	%		Type of Training	No.	%	Length of Training	No.	%
Yes	26	96.3		Induction	10	38.5	< 1 month	25	96.2
No	1	3.7		on the job	16	61.5	1-3 months	1	3.8
Total	27	100		Total	26	100	Total	26	100

Responding whether they have attended any training, all but one of the facilitators said to have received some form of training. Among the

26 facilitators who attended training, 10 (38.5%) of them described the type of training received was induction type. Most of the facilitators, 16 (61.5%) said they have received on the job training. The length of training, according to 25(96.2%) of the facilitators response, does not span for a month.

Although, the interview made with AAEB indicated that, even if, their was a problem to put in to practice, in principle facilitators should get preserves training for minimum of 15 days on children and adult's behavior and their difference, on preparation and utilization of teaching aids, on instructional planning and on arrestment mechanism to implement ABE program Regarding to on job training the AAEB interview describes at each quarter of the year a minimum of three days training were provided and to a sure quality education training updates the capacity of the facilitators.

Table 9: **Facilitators response concerning benefits obtained from the training**

Benefits obtained from the training	**No.**	**%**
enhanced knowledge of subject matter	6	14.2
enhanced the skills on how to teach	21	50
enhanced how to effectively communicate with learners	15	35.7

The training received benefited 21 (50 %) of facilitators in enhancing their teaching skills. According to 15 (35.7%) of the respondents, the training helped them to effectively communicate with their learners. Only 14.2% of facilitators acknowledge the training for enhancing their knowledge of the subject matter. This implies that of the three pillars of a good education system (access, quality, and delivery), quality is the key (World Bank,1999:7), Virtual, the quality and standard of education in a given country is mainly determined by the essence of its curriculum and the process of its implementation (ETP,

1994:3). Improving quality in basic education lays in the process of implementation which focuses in the appropriate training of facilitators is necessary in order to achieve the goals and objectives of ABE curriculum implementation.

Table 10: **Educational officials and facilitators respondent concerning average class size**

Respondent Group		Average class size				Total
		31-40	41-50	51-60	> 60	
Officials	No.	5	7	3	1	16
	%	31.30%	43.80%	18.80%	6.30%	100.00%
Facilitators	No.	13	6	4	4	27
	%	48.10%	22.20%	14.80%	14.80%	100.00%
Total	No.	18	13	7	5	43
	%	41.90%	30.20%	16.30%	11.60%	100.00%

As to the average class size, the relative majority of officials, 7 (43.8%) 9 in the range from 41 to 50; while 13 (48.1%) of facilitators observe class sizes in the range 31 to 40 students. According to both groups responses, only few classes, about 11.6%, have class size beyond 60 students. Although, recommended class size is 30, most of the ABE center classes range beyond 40 students according to the responses from 58% of the respondents.

In the benchmarks (Camilla 2008) indicate on average class size, should be a ratio of at least one facilitators to 30 learners. So, it can assure personal treatment and quality education.

Table 11: **Educational officials and facilitators responses concerning pupil to book ratio**

Respondent Group		Pupil to book ratio				Total
		1: 1	1: 2	1: 3	1:4 & above	
Officials	No.	4	2	7	3	16
	%	25.00%	12.50%	43.80%	18.80%	100.00%
Facilitators	No.	8	3	9	7	27
	%	29.60%	11.10%	33.30%	25.90%	100.00%
Total	No.	12	5	16	10	43
	%	27.90%	11.60%	37.20%	23.30%	100.00%

Relative majority of the respondents in both groups said the pupil to book ratio being 1:3. Overall, 16 (37%) of the respondents observe single book used for about three students. There are cases where this ratio is 1:4 according to 23% of the respondents. Only 28% of the respondents believed for a 1-to-1 pupil to book ratio.

From the above data, one can understand that to bring quality education for the ABE program the provision of adequate educational inputs are one decisive factor. Specially, to conduct effective teaching learning process the provision of one to one text books are vital. More over the participants in FGD and interview revealed that text books and necessary educational materials were very scarce In addition the FGD members mentioned during the discussion session, "As we know, when we join this ABE program, the facilitators told us, you can enrolled with out any direct cost including exercise books, pens, & pencils. But the provisions of these materials are very low." On top of this "Scarcity of text books is a sever problem for us because during in the day time we will not meet for the education purpose. We can't borrow each others." There fore, in order to secure quality ABE program text books have greater roll.

Further more, the children were given home works and notes on black boards. They pointed out that they faced difficulties for doing their home work. And they were spent more time simply by copying notes from the black board. This indicates the deterioration of quality basic education.

4.3. Issues Related to Practices of ABE Program

Table 12: **Educational officials and facilitators responses concerning results achieved in ABE program**

Result Achieved	No.	%
Enhance participation rate	13	39.3
Reduce the dropout rate	8	24.2
Enhance efficiency	5	15.1
Help to understand their environment	7	21.2

As to the achieved results by the alternative basic education Program, 39.3% of the officials witnessed for the enhancement of participation rate. The second result achieved is reduced dropout rate; according to half of the respondents. The alternative basic education program is found to have helped the learners in understanding their environment. As to the benefits in enhancing efficiency, only 5 (15.1%), of the officials gives their assertions. This shows that positive results were achieved, which means improving the enrollment and participation of primary education and contributing to achieve UPE by the year 2015.

Table: 13 : **Educational Officials Responses concerning ABE program practices Success**

One-Sample Statistics			Test Value = 3					
			t	df	p-value	Mean Difference	95% Confidence Interval of the Difference	
PRACTICE	Mean	Std. Deviation					Lower	Upper
ABE program provided quality education	3.38	1.088	1.4	15	0.188	0.375	-0.2	0.95
ABE program implementation has reduced direct costs	4.00	1.211	3.3	15	0.005	1.00	0.35	1.65
ABE program minimized the year of schooling	3.06	1.389	0.2	15	0.860	0.063	-0.68	0.8
ABE supported achievement of Education for all Goal	4.38	1.088	5.1	15	0.000	1.375	0.8	1.95
ABE flexibility has effectively solved dropout problem	3.56	0.727	3.1	15	0.007	0.563	0.17	0.95
ABE program addressed the need of disadvantaged groups	4.63	0.500	13.0	15	0.000	1.625	1.36	1.89
ABE program enabled learners to get basic contents on literacy and numeracy	4.63	0.500	13.0	15	0.000	1.625	1.36	1.89
ABE program enabled learners to understand their social environment	4.63	0.500	13.0	15	0.000	1.625	1.36	1.89
ABE program enabled learners to continue formal education	4.75	0.447	15.7	15	0.000	1.75	1.51	1.99

In valuing the ABE program practices officials are asked to provide their rating as to the fulfillment of the practices listed in table 12. The rating was made using five-level liker scale: Very high, high, medium, low, or very low. Using the responses from the 16 officials, Table 13 presents the data analysis result of the one-sample t-test using the medium value, i.e. 3, as a test value. Using this test it is possible to assess how each practice are fulfilled as a result of the ABE program implementation.

As to the practice in fulfilling the provision of quality education, the mean value, 3.38 is computed. The one sample t-test compared this value with the medium value the 95% Confidence Interval of the Difference between these values ranges from -0.2 to 0.95, which contains a zero value, and the resulting p-value, i.e. 0.188 > 0.05 level of significance. This indicates that the mean value in providing quality education is not significantly different from the medium value, i.e. 3. Hence, ABE program implementation in fulfilling the provision of quality education is rated to the medium level.

This implies that the quality of education provided by the ABE program is not that much improve and requires improvement although currently the quality is not inferior. The result agree with the opinions of interviewees from AAEB and Arada sub-city education office who claimed achieving quality of ABE program needs considerable attention through course of time.

The average rating by officials, concerning ABE program implementation in direct costs reduction, is computed to be 4. The one sample t-test compared this value with the medium value. The 95% Confidence Interval of the Difference between these values is well above zero value. Also the resulting p-value, i.e. 0.005 < 0.05 level

of significance. This result shows that the mean value in reducing direct costs is significantly different and above from the medium value, i.e. 3. Hence, ABE program implementation in fulfilling the practice for direct cost reduction is rated to level high.

The ABE program implementation, there fore, is much cost effective as it is capable of reducing direct costs. The interviewees also believed this achievement which is attained as a result of the flexible nature of the ABE program.

As to the practice in fulfilling to minimize the year of schooling, the mean value, 3.05 is computed. The one sample t-test compared this value with the medium value the 95% Confidence Interval of the Difference between these values found to contains a zero value, and the resulting p-value, i.e 0.860 > 0.05 level of significance. This indicates that the mean value to minimize the year of schooling is not significantly different from the medium value, i.e 3. Hence, ABE program implementation in fulfilling to minimize the year of schooling is rated to the medium level.

Hence, the result believed in ABE program can not be said more than satisfactory in minimizing school year implying the need for further shortening of school year which, as the current practice three years.

The average rating by officials, concerning ABE program implementation in support achievement of Education for all Goal, is computed to be 4.38. The one sample t-test compared this value with the medium value. The 95% Confidence Interval of the Difference between these values is well above zero value. Also the resulting p-value, i.e. 0.000 < 0.05 level of significance This result shows that the mean value in support achievement of Education for all Goal is significantly different and above from the medium value, i.e. 3. Hence,

ABE program implementation in fulfilling the practice for support achievement of Education for all Goals is rated to level high.

This implies that the ABE program is an adequate means in promoting the "Education For All" goal. The interviewees also believed that the ABE program has indispensable role towards meeting the MDGs and the EFA goal, which, they think, can't be achieved only through formal education.

The average rating by officials, concerning ABE program implementation in effectively solved dropout problem, is computed to be 3.56. The one sample t-test compared this value with the medium value . the 95% Confidence Interval of the Difference between these values is well above zero value. Also the resulting p-value, i.e. 0.007 < 0.05 level of significance. This result shows that the mean value in effectively solved dropout problem is significantly different and above from the medium value, i.e. 3. Hence, ABE program implementation in fulfilling the practice for effectively solved dropout problem is rated to level high.

This result indicates that the practice in the ABE program can be said highly effective in reducing dropout rate. This discussion also supported by interviewees as flexibilities in the ABE program helps learners to tackle their challenges from dropping their schooling. Similarly it creates opportunity to rejoin schooling for those who can't continue their education in the formal schools

In assessing the fulfillment of the other three practices, namely: addressed the need of disadvantaged groups, enable learners to get basic contents on literacy and numeracy, and enable learners to understand their social environment, ABE program implementation is rated by officials. In all the three practice areas the respective average rating computed to be 4.63. The one sample t-test compared this

value with the medium value. The 95% Confidence Interval of the difference between these values is well above zero value in all the three practice areas. Also the resulting p-value, i.e. 0.000 < 0.05 level of significance, shows that the mean value for each practice area is significantly different and above from the medium value, i.e. 3. Hence, ABE program implementation in fulfilling these practices is rated to level high.

From these results, it can be concluded that ABE program, in addition to helping learners to get literacy and numeric skill and understanding their environment, it also paves the way for disadvantaged groups to meet their needs for education. Alternative basic education program, thus, can be viewed as the means to address education needs of disadvantages groups as the interviewees said, it creates access opportunity for marginalized out - of - school children In the FGD the participants indicated that by attending the program learners enabled understand their social environment and in the future can compute for juniter's work opportunity " so, we will continuo our education" they said discussion even though the FGD discussion participants adhere to the idea of getting job as a janitor may be due to lack of awareness about the objective of ABE.

As to whether ABE program implementation enable learners to continue formal education, officials average rating results in 4.75, which is relatively higher than the average ratings to the rest eight practice areas. The 95% Confidence Interval of the difference between this value and the medium value is well above zero value. Also the resulting p-value, i.e. 0.000 < 0.05 level of significance, shows that the mean value enable learners to continue formal education is significantly different and above the medium value, i.e. 3. Hence, ABE program implementation in fulfilling the practice enable learners to continue formal education is rated to level high.

The interview made with professionals from AAEB and Arada Sub-City education office supports the finding that there were smooth transfers from ABE to formal school.

4.4. Issues Related to Challenges of Practicing ABE Program

4.4.1. Challenges Related to Human Resource

In implementing ABE, there are some challenges that impede the implementation of ABE. Table 13 assesses three areas of challenges that are related to human resource. The one way ANOVA test result presented in table 13 evaluates the two group of respondents (officials and practitioners) in rating these challenges as very high, high, medium, low or very low. This test helps in answering two questions: the extent of the challenge as perceived by each group of respondent, and whether the two groups have similar or different level in rating the challenges. The first question can be answered using the 95% confidence interval for the mean, and the p-value helps answering the second question.

Table 14: **Educational Officials and Facilitators Responses to Challenges Related to Human Resource**

		N	Mean	Std. Deviation	95% Confidence Interval for Mean		F	p-value
					Lower Bound	Upper Bound		
Lack of trained facilitator	**Officials**	16	3.44	1.365	2.71	4.16	1.196	0.281
	Facilitators	27	3.00	1.209	2.52	3.48		
	Total	43	3.16	1.271	2.77	3.55		
Lack of trained supervisors	**Officials**	16	3.13	1.258	2.45	3.8	0.004	0.952
	Facilitators	27	3.15	1.199	2.67	3.62		
	Total	43	3.14	1.207	2.77	3.51		
Lack of trained focal person	**Officials**	16	3.31	1.352	2.59	4.03	0.055	0.816
	Facilitators	27	3.41	1.248	2.91	3.9		
	Total	43	3.37	1.273	2.98	3.76		

The first human resource related challenge, which is lack of trained facilitator, is rated 3.44 by officials, and 3.00 by facilitators. The respective 95% CIs for the means are found to contain the medium value, i.e. 3. This indicates that both groups have rated lack of trained facilitator being a moderate challenge. Moreover, as the p-value=0.281 > 0.05 indicates that the average rating by the two groups are similar, i.e. do not have statistical difference.

Concerning the challenge from Lack of trained supervisors, officials and facilitators average ratings are very close, 3.13 and 3.15 respectively. For each group response the resulting 95% Confidence Interval for Mean contains the medium value; and the one way ANOVA test to compare these groups' average ratings results in p-value = 0.952 > 0.05. Hence, the analysis result indicates that both groups similarly rated the challenge of lack of trained supervisors as medium level challenge.

As to the challenge from Lack of trained focal person, the two groups give average ratings slightly above the medium value. However, as the corresponding 95% Confidence Interval for Mean found to contain the value medium value, the ratings by the two groups are not significantly above 3.00. Hence both officials and facilitators rated Lack of trained focal person as medium challenge.

In all the three challenge related to human resource, both groups rated them as a medium challenge and there is no statistical difference between their respective average ratings.

The result indicates that the challenges in relation to human resource are not to the lower level, although, they are not highly pressing challenges. How ever, the interviewees addressed the need for further training of facilitators and supervisors even if their education level satisfies the minimum requirement in the ABE program of AAEB.

4.4.2. Challenges Related to Financial Resource

The two groups of respondents were asked to rate six proposed challenges in relation to financial resources. Table 14 shows the results obtained from one way ANOVA test. The p-value column helps in judging whether the two groups' average ratings are statistically different or not. The p-value computed in all the six financial related challenges are above the 0.05 level of significance. This indicates that officials and facilitators have equal average level of rating to each financial resource related challenges. So it is good to see the aggregate result instead of individual group's rating while examining the extent of the each areas of financial challenge. The rows marked "Total" provide the necessary information obtained from all the 43 respondents.

Table 15: **Educational Officials and Facilitators responses to Challenges Related to Financial resource**

Items		N	Mean	Std. Deviation	95% Confidence Interval for Mean		F	p-value
					Lower Bound	Upper Bound		
Lack of adequate budget for facilitator salary	Officials	16	3.81	1.424	3.05	4.57	0.612	0.439
	Facilitators	27	4.15	1.322	3.63	4.67		
	Total	43	4.02	1.354	3.61	4.44		
Lack of adequate budget for stationary materials	Officials	16	3.63	1.204	2.98	4.27	0.371	0.546
	Facilitators	27	3.85	1.167	3.39	4.31		
	Total	43	3.77	1.172	3.41	4.13		
Lack of adequate budget for textbooks, exercise books, pen, pencil, etc for learners	Officials	16	3.44	1.263	2.76	4.11	1.644	0.207
	Facilitators	27	3.93	1.174	3.46	4.39		
	Total	43	3.74	1.217	3.37	4.12		
Lack of adequate budget for conducting training	Officials	16	3.94	0.929	3.44	4.43	0.018	0.893
	Facilitators	27	3.89	1.251	3.39	4.38		
	Total	43	3.91	1.13	3.56	4.25		
abscence of incentive schemes for facilitators	Officials	16	4.25	0.577	3.94	4.56	0.389	0.536
	Facilitators	27	4.04	1.285	3.53	4.55		
	Total	43	4.12	1.074	3.79	4.45		
lack of finance to support learners to remain in the program	Officials	16	3.94	0.929	3.44	4.43	0.001	0.974
	Facilitators	27	3.93	1.207	3.45	4.4		
	Total	43	3.93	1.1	3.59	4.27		

Lack of adequate budget for facilitator salary is rated 4.02 on average for being one of financial challenge facing ABE implementation. The 95% CI for the mean is well above the medium value. This indicates budget appropriate for facilitators salary is highly inadequate.

As the average rating, 3.77, and the 95% CI for man (3.41-413) are significantly above the medium value, lack of adequate budget for stationary material is also rated for being highly inappropriate.

The ABE program implementation is also challenged for lack of adequate budget to provide learns with the necessary materials such as text books, exercises books, pens, pencils, etc. The inadequacy of budget for such materials is rated 3.74 on average and 99% CI of (3.37-4.12).

Conducting training in the ABE program also highly lacks for adequate budget. Respondents rated the inappropriateness of allocated budget to conduct training as 3.19 on average with 95% CI ranging from 3.54 to 4.25.

Absence of incentive scheme for facilitators is rated for being the most challenging area to successfully implement ABC program. This is clearly indicated by 4.12 average level of challenge.

The ABE program implementation is also challenged by lack of finance to support learners to remain in the program. The average level of challenge in this aspect is 3.93 with 3.59 to 4.27 range for 95% CI for the mean In addition to this findings in FGD mentioned "the absence of financial support to the learners is the main cause to hindered their schooling in ABE". This may be a prominent case to the dropouts of learners In addition to this findings in FGD mentioned the absence of financial support to the learners is the main cause to hindered their

schooling in ABE." This may be a prominent case to the dropouts of learners.

Generally, ABE program implementation is faced with high level of budget inadequacy in all areas of financially related resources. Both officials and facilitators are found to equally express lack of financial resources as a highly challenging concern to successfully implement ABE programs.

From these results, it is evident that the ABE program faced a serious challenge to effectively achieve its expectations Interviewees and FGD also expressed the inadequacy of budget operated for purchase of stationary materials and printing of text books coupled with in adequate salary and incentive schemes for facilitators.

4.4.3. Challenges related to Material and other resources

Table 16: **Educational officials and Facilitators responses with regard to challenges to material and others resources**

		N	Mean	Std. Deviation	95% Confidence Interval for Mean		F	p-value
					Lower Bound	Upper Bound		
Lack of student chairs in the class	**Officials**	16	1.19	0.403	0.97	1.4	7.678	0.008 *
	Facilitators	27	2.26	1.509	1.66	2.86		
	Total	43	1.86	1.32	1.45	2.27		
Lack of teachers seats in the class	**Officials**	16	1.31	0.479	1.06	1.57	6.087	0.018 *
	Facilitators	27	2.37	1.668	1.71	3.03		
	Total	43	1.98	1.439	1.53	2.42		
Lack of teaching aid in the class	**Officials**	16	2.75	1.342	2.04	3.46	0.296	0.589
	Facilitators	27	3	1.519	2.4	3.6		
	Total	43	2.91	1.444	2.46	3.35		
In adequate use of teaching aids	**Officials**	16	3.19	1.047	2.63	3.75	0.008	0.931
	Facilitators	27	3.15	1.61	2.51	3.79		
	Total	43	3.16	1.413	2.73	3.6		
Lack of teaching aids in CRC	**Officials**	16	3.5	0.966	2.99	4.01	0.024	0.877
	Facilitators	27	3.44	1.219	2.96	3.93		
	Total	43	3.47	1.12	3.12	3.81		
Lack of supplementary teaching materials	**Officials**	16	4	0.966	3.49	4.51	0.259	0.614
	Facilitators	27	3.78	1.577	3.15	4.4		
	Total	43	3.86	1.373	3.44	4.28		
Lack of training institutions for facilitators	**Officials**	16	3.81	1.167	3.19	4.43	0.291	0.593
	Facilitators	27	4.04	1.4	3.48	4.59		
	Total	43	3.95	1.308	3.55	4.36		
Distant to the center from home	**Officials**	16	2.63	1.31	1.93	3.32	2.249	0.141
	Facilitators	27	2.07	1.072	1.65	2.5		
	Total	43	2.28	1.182	1.92	2.64		
High dropout of learners	**Officials**	16	3.69	1.078	3.11	4.26	0.042	0.839
	Facilitators	27	3.78	1.553	3.16	4.39		
	Total	43	3.74	1.382	3.32	4.17		

*Significant at 0.05 alpha level of significance.

To assess the challenges regarding materials & related resources, respondents were asked to give their ratings for nine practice areas. The data obtained from both groups of respondents is analyzed using one-way ANOVA and the result is depicted in table 15

The first challenging practice concerned for lack of students chair in the class room. This is rated 1.19 and 2.26 on average by officials and facilitators respectively. The 95 % CI for these mean values fall below the medium value, i.e. 3. This indicates that both groups agreed to face low level of challenge concerning availability of chairs in the classroom for students. However as the p-value, 0.008 <0.05 level of significance the rating for this challenging practice by the two groups has shown significant difference. As a result, lack of students chair is a very low level challenge according to officials, while the challenge is only to the low level according to facilitators.

The two groups are also significantly different in their average rating to assess the degree of challenge faced as a result of lack of seats for teachers in the class. This is indicated by the p-value, 0.018 <0.05 level of significance. The average rating by officials is 1.31 with (1.06-1.57) 95% CI; while facilitators average rating is 2.37 with (1.71-3.03). From this result, lack of teachers seat is viewed as low level challenge by both groups. Relatively, however, facilitators tend to say that, lack of teachers seats is high challenge composed to officials average rating.

In all the other seven practice areas, the two groups average ratings have no significant difference. This is explained by the ANOVA test that results with p-values above 0.05 level of significance. Hence, the

challenge in this area is well evaluated according to the average ratings obtained from all individual respondents.

Regarding teaching aids, respondents gave a medium level of challenges faced. As to the availability of teaching aids in the class, the average rating is 2.91. For the challenge regarding in adequate use of teaching aids, the average rating is 3.16. In both comes, free 95% CI for mean contains the medium value. i.e.3. Hence, their ratings for these practices doesn't significantly vary from the medium level of challenge.

Rating the challenge for the distance to the center from home, respondents' average response is 2.28 with 95% CI (1.92-2.64). This indicates that distance from center to home is a low level challenge.

The learners' opinion gathered through FGD also indicates that distance being not a challenge to them mainly because they register in the ABE center considering proximity.

The other four practices are found to be highly challenging in the ABE program implementation. These are lack of training institutions for facilitators, lack of supplementary teaching materials, high dropout of learners, and lack of teaching aids in CRC. The respective mean value for average ratings are 3.95, 3.86, 3.74 and 3.47 with the corresponding 95%CIs for the mean values are well above the medium value.

The result indicates the need for training institutions that addresses the local particularities of ABE program centers which conforms with the results from interview. As to lack of supplementary teaching materials, the challenge could be mitigated by creating link with the formal schools to use the existing teaching materials and other related

resources such as teaching aids found in CRC. Learners in FGD, also complain for lack of text books and other reading materials.

Although, the ABE program believed to create opportunity for learners to rejoin schooling, the current practice shows there is high dropout of learners. The basic reason indicates in the FGD, is learner unstable location that is "mostly home made". Hence, it is due to the broad social and economic factor in the sub-city.

The interviewees recommend a smooth transfer of learners from one ABE center to another, in order to accommodate, learners in the program.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter deals with summary, conclusion drown and possible recommendations of the study

5.1. Summary

The main purpose of the study was to assess the practice and challenges of ABE program in Addis Ababa city administration, particularly in Arada sub city. Accordingly, the study was guided by the following basic research questions

1. What are the practices of the existing Alternative Basic Education for out of school children in Addis Ababa region in the case of Arada sub city?
2. What are the major challenges that hinder the implementation of ABE program?
3. What are the success of ABE program?

In dealing with the basic research questions, descriptive survey method was employed and relevant related literature was reviewed eight ABE centers were selected randomly from the Arada sub-city centers, and 163 respondents: that is 16 officials 27 facilitators, and 120 adult learners have participated in the study. The data for the study were collected by means of questionnaire, interview, focus group discussion and document analysis.

The data collected through questionnaire was analyzed using a (appropriate statistical tools the percentage, mean standard deviation and one way ANOVA). While the data collected through interview and

focus group discussion were transcribed, analyzed and triangulated with the qualitative data where necessary and appropriate.

The data analysis led to the following major findings:

1. 96.3% of facilitators revealed that attended training, among them 38.5% described that type of training received was induction type. The remaining 61.5% said they have received on the job training. With the regard of the benefits obtained from the training 77.8% of facilitators in enhancing their teaching skills, others indicate the training helped them to effectively communicate with their learners.
2. The most common criteria used to select facilitators 56.3% of them wore cited educational background. Secondly, supported by 43.8% of facilitators were indicated experience in teaching.
3. With regard to the pupil to book ratio the study revealed that 43.8% of officials and 33.3% of facilitators observe a single book used for about three students. In addition, there are cases where this ratio is 1:4 according to 23.3% of the respondents.
4. Regarding to ABE implementation practice provision of quality education, with out the reduction of quality minimize the year of schooling, the study revealed that rated to the medium level. But the ABE program implementation in fulfilling the support achievement of "Education for All" Goal and effectively solved dropout problem rated high level by officials.

   In addition to these, three practices, namely; addressed the need of disadvantaged groups, enable learners to get basic contents on literacy and normalcy, and enable learners to understand their social environment, ABE program implementation was rated by officials high level
5. The study showed that the first human resource related challenge, which is lack of trained facilitator, was rated 3.44 by officials and 3.00 by facilitators.

This indicates that both groups have rated lack of trained facilitator being a moderate challenge.

Concerning the challenge from lack of trained. Supervisors and officials average ratings were very close, 3.13 and 3.15 respectively. The finding indicates both challenges in relation to human resource rated as a medium challenge.

6. Findings showed that one of financial challenge facing ABE program was lack of adequate budge for facilitator salary, providing learners with the necessary materials such as text books. Exercises books, pens pencils, stationary materials and conducting training in the ABE program was rated 4.02,3.74 3.77 and 3.19 respectively by officials & facilitators. Thus, ABE program practices is faced with high level of budget inadequacy.
7. With regard to the challenge distance to the center from home, the average response is 2.28. This indicates that distance from the center to home is a low level challenge.
8. The availability of training institutions for facilitators, lack of supplementary teaching materials, high dropout of learners and lack of teaching aids in cluster resource centers, mean value for average ratings were 3.95, 3.86, 3.74 and 3.47 respectively. These showed the medium level of challenge were accounted.
9. The ABE curriculum was condensed and equivalent to formal school which helps to ensure smooth transfer to the formal school and it was prepared by AAEB experts.
10. The study revealed that positive results were achieved by provision of ABE program, further indicates through ABE program children got a second chance to learn. Thus, it improved enrollment and participation of primary education and contributing to achieve UPE by the year 2015.

11. With regard to length of hours to stay in the center, learning takes place two hours day, leaving the rest of the day for the learners to engage in other survival activities.

5.2. Conclusions

Based on the findings from the study, the following conclusion were drown

1. The result of the study indicated that inadequate training, low payment and lack of incentive scheme might have lead to lack of interest and commitment on the part of facilitators. This in turn would have a negative impact on the effective practices of the ABE program.
2. The study revealed that, highly inadequate budget for stationary materials, text books, exercises books, pens, pencils for the learners, conducting training and financial support to the learners to remain in the program were the major challenges for practicing the ABE program in the Arada sub-city.
3. Challenges in relation to ABE center, as they are currently conceived and executed, from several angles including lack of teaching aids in the class, inadequate use of teaching aids, lack of teaching aids in the cluster resource centers and lack of supplementary teaching materials, which is consistent with the result obtained from the question presented in the questionnaire for facilitators and educational officials. This emanate from loosely linkage between formal primary school and ABE centers. Which hinders the practice of ABE program in the sub-city.
4. Distance to the center from home were rated low both facilitators and officials. Although learners assure distance

home to ABE center is not hindering factor the participation of children in ABE program.

5. Regarding the support of the ABE centers through supervision and monitoring, the study revealed that there is no programmed supervision support. And because of the lack of trained supervisors and educational officials.

5.3. Recommendations

1. As study showed the Addis Ababa Education Bureau experts made ABE curricula to address the need of out of school children. Which is supportive to create access for basic primary education and very important to reach EFA goal in 2015. And the curriculum was organized four years Formal schooling condensed in to three years. By doing so, there is valuable numbers of students attending 2nd cycle (grade 5). But the ABE program in Addis Ababa city administration serves in the age range from 7 to 45, the need of age range 15 to 45 not addressed.

   In Kenya urban experience after phase 3, the learners receive vocational training in carpentry, sheet metal and tailoring. The processes of learning are generally learner-centered. Aspects of indigenous learning practices such as apprenticeship are integrated in to the processes of learning. So, the learners achieve practical skills and having insights in to the world of work.

   There fore, Addis Ababa City, Alternative basic education program curriculum should be improved by adapting other regions experience (for instance Oromyia region shift to functional adult literacy) to address both the needs of children and Adults.

2. The interview made with official revealed that, even though the ABE centers found in the formal school building, the linkage between formal schools and ABE centers was inadequate. But it

is believed that there should be strong link between the two institutions.

There fore by putting rules and regulations should create and develop strong relation ship between ABE centers and the formal primary schools in experience sharing at exchanging learning materials.

3. The study depicted that there is lack of supervision and monitoring. Thus, supervision and follow up should be implemented and strengthened as indicated in the guidelines to achieve the goals of ABE program. Hence, cluster resource centers (CRC) around the ABE centers should organize training in collaboration with responsible bodies from the sub-city office on the importance of supervision and monitoring for facilitators.
4. Facilitators are the back bone of ABE program. The study indicated that they did not receive continues and specific training to teach both children and adults. Thus, Addis Ababa Education bureau need to prepare and implement ABE strategy and guide line specific to the needs of the facilitators clearly about the training & future career development path of ABE facilitators.
5. In order to alleviate the inadequacy of budget to run the ABE program, the Addis Ababa Education bureau should organize and conduct awareness creation programs like conferences, seminars, discussion forums etc... for the stakeholders (parents, community members, non-governmental organizations) to develop a common understanding of the importance of the program.
6. In addition, the government allocate 0.5% of the education budget to the adult and non-formal education but This should be improved by understanding almost 50% of the Ethiopian adult population is not literate. (ANFEAE, 2008).

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Appendix A

ADDIS ABABA UNIVERSITY
COLLEGE OF EDUCATION
SCHOOL OF GRADUATE STUDIES

Department of Curriculum and Teachers

Professional Development Studies

Adult and Life Long Learning Program

Questionnaire to be Filled by Educational Officials

A Study on the ''Practices and Major Challenges of Alternative Basic Education in Addis Ababa The case of Arada Sub-City Administration''

The purpose of this questionnaire is to collect relevant data regarding the practices and major challenges to provide Alternative Basic Education; and also to identify the major challenges encountered in implementation of Alternative Basic Education.

The Findings of this study and the recommendations to be forwarded are valuable in suggesting possible solutions for the problems identified. There fore, your sincere cooperation and objectivity in answering each of the question items is of great importance, and your responses would be kept strictly confidential.

General Direction:

1. You are not required to write your name
2. Please put''√'' mark in the space provided for your answer
3. Please circle the appropriate choice
4. Pleas give short answer(s) in the space provided.

Tank you for filling out the questionnaire in time.

Part I: personal Back ground Information

Name of your organization / Institution _____

1. sex ☐ Female ☐ Male

2. Age: ☐ below 25 years ☐ 31-35

☐ 25-30 years ☐ 36-40 years

☐ above 40 years

3. your educational level

☐ Below Grade 12 ☐ College diploma

☐ Grade 12 completed ☐ First degree

☐ Certificate /TTI ☐ MA/MSC

If any other, specify _____

4. Your years of Service: ☐ below 6 ☐ 16-20

☐ 6-10 ☐ above 20

☐ 11-15

5. Current position/Responsibility _____

Part II: Questions Related to Practice and Challenges of Alternative Basic Education

Please Circle the Appropriate Answer

1. Duration of class/instructional hours per day at the center:

A. 1:00-1:59 hours B. 2:00-2:59 hours

C. 3:00-3:59 hours D. >4hours

2. Total number of school days per week at the center

A. <3 days B. 3 days

C. 4 day D. 5 days

E. >5 days

3.When did Alternative Basic Education centers open and close?

A. Similar to formal schools (open in September and close in June)

B. Depend on the agreement made with facilitators and kebele education officials

C. Depend on the agreement made with facilitators and learners

D. When sub-city education office gives direction/order

E. Other (if any) _____

_____

4.Are there supportive results achieved from Alternative Basic Education program in addressing Education for All goal?

A. Yes B. No

5. If your answer for question No 4 is ''yes'', what results are obtained (multiple Response can be possible).

A. Enhance the participation rate

B. Reduces the drop out rate

C. Enhance efficiency

D. Helps to understand their environment

E. Other (if any) _____

_____

6. The Alternative Basic Education program implementation has enabled the learners to continue formal education.

A. yes B. No

7. If your answer for question No 6 is ''No'', explain the reasons

_____

_____

_____

_____

_____

8. Please rate your valuing / assessment of Alternative Basic Education program implementation in fulfilling the practices listed in the left column of the following table: response rating: 5: very high; 4: High; 3:Medium; 2:Low;1 very low.

No	ABE PROGAM IMPLEMENTATION PRACTICE	5	4	3	2	1
8.1	The Alternative Basic Education (ABE) program implementation has provided quality education to learners					
8.2	The ABE program has minimized the year of schooling with out quality reduction					
8.3	The ABE program has minimized the year of schooling with out quality reduction					
8.4	The implementation of ABE has been supporting the achievement of Education for All Goal					
8.5	The flexibility of the ABE program implementation has effectively solved dropout problem					
8.6	The ABE program implementation has addressed the need of disadvantaged groups					
8.7	The ABE program implementation has enabled the learners to get the basic learning contents on literacy and numeracy					
8.8	The ABE program implementation has enable the learners to understand their social environment					
8.9	The ABE program implementation has enabled the learners to continue formal education.					

9. Which parties were involved in recruitment and selection of facilitators?

A. ----------

B. ----------

C. ----------

D. ----------

10. What are the criteria used for recruitment and selection of facilitators?

A. Political contribution

B. Experience of teaching

C. Educational background

D. Their acceptance by their community

E. Personal relation ship with kebele education office

F. Other (if any) _____

_____

11. What is the average class size in your center?

A. Below 30 B. 31-40 C. 41-50

D. 51-60 E. Above 60

12. What is the pupil book ratio in your center?

A.1:1 B. 1:2

C. 1:3 D. 1:4 and above

13. Indicate the challenges related to resource (human, financial, material) in implementing Alternative Basic Education program by putting''√'' mark in the box provided using the following rating scale, that is 5= Very high, 4=High,3=Medium,2=Low , and 1=Very low.

No	Items	Rating scale				
		5	4	3	2	1
1	**Challenges Related to Human Resource**					
1.1	Lack of trained facilitators					
1.2	Lack of trained supervisors					
1.3	Lack of trained focal person					

No	Items	Rating scale				
		5	4	3	2	1
2	**Challenges Related to Financial Resource**					
2.1	Lack of adequate budget for facilitators salary					
2.2	Lack of adequate budget for stationary materials					
2.3	Lack of adequate budget for text books, exercise books, pen, pencil, etc for learner					
2.4	Lack of adequate budget for conducting training					
2.5	Absence of incentive schemes for facilitators?					
2.6	Lack of finance to support learners to remain in the program					

No	Items	Rating scale				
		5	4	3	2	1
3	**Challenges Related to Material Resource and others**					
3.1	Lack of student chair in the class					
3.2	Lack of teachers seat in the class					
3.3	Lack of teaching aid in the class					
3.4	In adequate use of Teaching Aids					
3.5	Lack of teaching aids in cluster-resource centers (CRC)					
3.6	Lack of supplementary teaching materials like readers / story books, fun booklets etc					
3.7	Lack of training institution for facilitators					
3.8	Learners' home to Alternative Basic Education center distance					
3.9	High dropout of learners from Alternative Basic Education center					

Please Give Short Answers

1. In your view, what benefits where achieved by implementing Alternative Basic Education program at your center?

   ---

2. What problems you have encountered in implementing Alternative Basic Education program at your center? ----------

   ---

   ---

3. In your opinion, what possible solutions do your recommend to alleviate the problems

   ---

   ---

4. Is there any comment you may add?

Thank you very much Again!

Appendix B

ADDIS ABABA UNIVERSITY
COLLEGE OF EDUCATION
SCHOOL OF GRADUATE STUDIES

Department of Curriculum and Teachers
Professional Development Studies
Adult and Life Long Learning Program

Questionnaire to be Filled by Facilitators

A Study on the ''Practices and Major Challenges of Alternative Basic Education in Addis Ababa The case of Arada Sub-City Administration''

The purpose of this questionnaire is to collect relevant data regarding the practices and major challenges to provide Alternative Basic Education; and also to identify the major challenges encountered in implementation of Alternative Basic Education.

The Findings of this study and the recommendations to be forwarded are valuable in suggesting possible solutions for the problems identified. There fore, your sincere cooperation and objectivity in answering each of the question items is of great importance, and your responses would be kept strictly confidential.

General Direction:

1. You are not required to write your name
2. Please put''√'' mark in the space provided for your answer
3. Please circle the appropriate choice
4. Pleas give short answer(s) in the space provided.

Tank you for filling out the questionnaire in time.

Part I: personal Back ground Information

Name of your organization / Institution _____

1. sex ☐ Female ☐ Male

2. Age: ☐ below 25 years ☐ 31-35

☐ 25-30 years ☐ 36-40 years

☐ above 40 years

3. your educational level

☐ Below Grade 12 ☐ College diploma

☐ Grade 12 completed ☐ First degree

☐ Certificate /TTI ☐ MA/MSC

If any other, specify _____

4. Your years of Service: ☐ below 6 ☐ 16-20

☐ 6-10 ☐ above 20

☐ 11-15

5. How much is your current salary?

☐ Less than 150 birr ☐ 151-200 birr ☐ 201-250

☐ 251-300 birr ☐ More than 300 birr

Part II: Questions Related to Practice and Challenges of Alternative Basic Education

Please Circle the Appropriate Answer you think in relation to your center

1.Duration of class/instructional hours per day at the center:

A. 1:00-1:59 hours B. 2:00-2:59 hours

C. 3:00-3:59 hours D. >4hours

2. Total number of school days per week at the center

A. <3 days B. 3 days

C. 4 day D. 5 days E. >5 days

3.When did Alternative Basic Education centers open and close?

A. Similar to formal schools (open in September and close in June)

B. Depend on the agreement made with facilitators and kebele education officials

C. Depend on the agreement made with facilitators and learners

D. When sub-city education office gives direction/order

E. Other (if any) _____

_____

4.The Alternative Basic Education program implementation has enabled the learners to continue formal education.

A. Yes B. No

5. If your answer for question No 4 is ''No'', explain the reasons

_____

_____

_____

_____

6. Have you attended any training?

A. yes B. No

7. If your answer for question No 6 is ''yes'' what kind of training you have attended?

A. Induction training

B. In –service/training

C. On the job training

D. Other (if any) _____

8. If your answer to question number 6 is ''yes'' for how long you have attended the training?.

A. Less than one month B. 1-3 months

C. 4-6 months D. More than 6 months

9. In your opinion, what benefits you have obtained form the training?

A. Enhanced the knowledge of the subject matter

B. Enhanced the skills on how to teach

C. Enhanced how to effectively communicate with learners

D. Other (if any) _____

_____

10. What is the average class size in your center?

A. Below 30 B. 31-40 C. 41-50

D. 51-60 E. Above 60

11. What is the Pupil book ratio in your center?

A. 1:1 B. 1:2 C. 1:3 D. 1:4 and above

12. Indicate the challenges related to resource (human, financial, material) in implementing Alternative Basic Education program by putting''√'' mark in the box provided using the following rating scale, that is 5= Very high, 4=High,3=Medium,2=Low , and 1=Very low.

No	**Items**	**Rating scale**				
		5	4	3	2	1
1	**Challenges Related to Human Resource**					
1.1	Lack of trained facilitators					
1.2	Lack of trained supervisors					
1.3	Lack of trained focal person					

No	Items	Rating scale				
		5	4	3	2	1
2	**Challenges Related to Financial Resource**					
2.1	Lack of adequate budget for facilitators salary					
2.2	Lack of adequate budget for stationary materials					
2.3	Lack of adequate budget for text books, exercise books, pen, pencil, etc for learner					
2.4	Lack of adequate budget for conducting training					
2.5	Absence of incentive schemes for facilitators?					
2.6	Lack of finance to support learners to remain in the program					

No	Items	Rating scale				
		5	4	3	2	1
3	**Challenges Related to Material Resource and others**					
3.1	Lack of student chair in the class					
3.2	Lack of teachers seat in the class					
3.3	Lack of teaching aid in the class					
3.4	In adequate use of Teaching Aids					
3.5	Lack of teaching aids in cluster-resource centers (CRC)					
3.6	Lack of supplementary teaching materials like readers / story books, fun booklets etc					
3.7	Lack of training institution for facilitators					
3.8	Learners' home to Alternative Basic Education center distance					
3.9	High dropout of learners from Alternative Basic Education center					

Please Give Short Answers

1. In your view, what benefits where achieved by implementing Alternative Basic Education program at your center?

   ---

2. What problems you have encountered in implementing Alternative Basic Education program at your center? ----------

   ---

   ---

3. In your opinion, what possible solutions do your recommend to alleviate the problems

   ---

   ---

4. Is there any comment you may add?

Thank you very much Again!

Appendix C

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

COLLEGE OF EDUCATION

Department of Curriculum and Teachers

Professional Development studies

Adult and Life Long Learning program

Interview Items for REB and sub-city Education Office Heads and Experts

Purpose

The purpose of this interview is to gather information on the practices and major challenges of Alternative Basic education Program (ABEP) for out- of – school children. In so doing valuation of ABE program current practices and challenging factors will be will be thoroughly discussed. The success of this study, thus, depends on the honesty and frankness of your response. The researcher would like to assure you that your responses are strictly confidential.

The Findings of this study and the recommendations for worded are valuable in suggesting possible solutions for the problems identified. Therefore, your sincere cooperation and objectivity in answering each of the question items is of great importance, and your responses would be kept strictly confidential.

Leading questions

1. How was the ABE program planned?
2. Is there a strategy for ABE? If there is what is its target?
3. How were the curriculum materials develop?
4. Is there adequate resources (Human and financial) allocated to implement. ABE program?
5. How were facilitators recruitment and training procedure?
6. What are the challenges of implementing ABE program curriculum?
7. Please if any additional comments, opinion and suggestion. . . .

Appendix D

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

COLLEGE OF EDUCATION

Department of Curriculum and Teachers

Professional Development studies

Adult and Life Long Learning program

Focus group discussion Guide set for learners in the ABE centers

Leading Questions

1. Where do you get writing materials (exercise book, pens, pencils. . . .)?
2. Do you have text books for subjects taught in the center?
3. When you complete level III, do you like to continue with your education?
4. Is the time table in the ABE center flexible or similar to formal schools?
5. What are the major challenges that hinder children to go to ABE centers?
6. Please, if any additional comments, opinion and suggestion . . . .

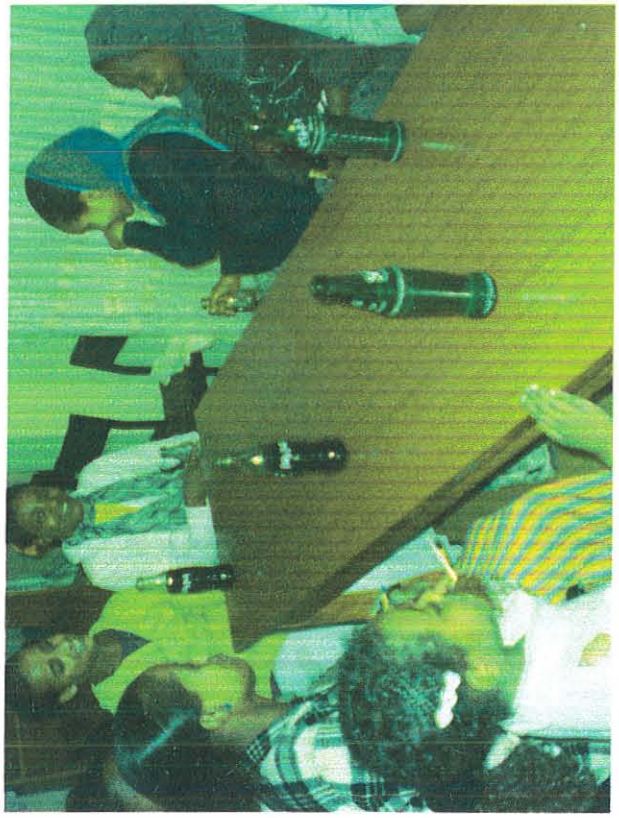
Appendix E

Learners that involved in the focus group discussion by sex and Age distribution

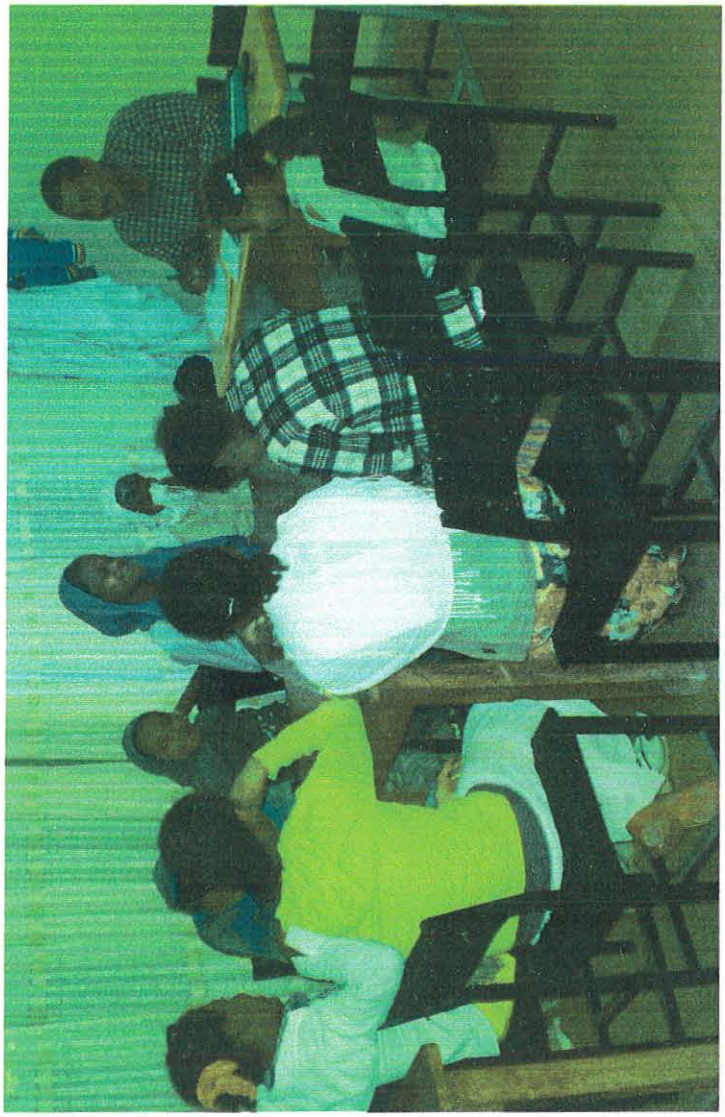
Sample ABE Centers	Sex				Total	Age							
	Male		Female			748		9&10		11&12		13&14	
	N	%	N	%	No	No	%	N	%	N	%	N	%
Atse Fasil	2	10	14	14	16	3	18.5	7	43.7	6	37.5	-	-
Atse Naod	3	15	21	21	24	7	26.9	6	13	-	-	11	42.3
Agaziyan	1	5	15	15	16	1	3.8	4	8.7	9	40.9	2	7.7
Beherawi Betemengist	5	25	11	11	16	2	7.7	10	21.7	2	9.1	2	7.7
Betelihem	2	10	14	14	16	4	15.4	8	17.4	-	-	4	15.4
Belay Zeleke	1	12.5	7	87.5	8	4	15.4	4	8.7	-	-	-	-
Kelemework	4	20	12	12	16	1	3.8	5	10.9	4	18.2	6	23.1
Kedamawi minilik	2	10	6	6	8	4	15.4	2	4.3	1	4.5	1	3.8
Total	20	100	100	100	120	26	100	46	100	22	100	26	100

Appendix– F

Sample Photograph from FGD







Appendix G

ነፃ የግል ማሰልጠኛ ተቋማትንና አማራጭ መሰረታዊ ትምህርትን አስመልክቶ ጽ/ቤቱ ለማስፈቀድ የተዘጋጀ መጠይቅ

፡ የምትልኩልን መረጃ በጀመርን ዓመት ተመዝግበዉ በመማር ላይ ያሉትን መሰረት ያደረገ መሆን አለበት

፡ስ ክተማ ..... አዲስ አበባ .....

ገራዊ የግልማሰች ትምህርት አሰተባባሪ ባለሙያ ተመደባል----------አልተመደበም-------

ጊያ ብዛት ..... 23 .....

ነድ አመቻች ክፍያ በወር ..... 2500 .....ብር

	8ኛ ክፍል ያጠናቀቁ			9ኛ-- 10ኛ ክፍል			11ኛ--12ኛ መሰናዶ			መደበኛ መምህራን			ጠቅላላ ድምር		
	ወ	ሴ	ድ	ወ	ሴ	ድ	ወ	ሴ	ድ	ወ	ሴ	ድ	ወ	ሴ	ድ
መቻች ብዛት ምህርት ደረጃ	1	2	3	5	5	10	19	63	82	17	15	32	42	85	127

ልጠና ወስደዉ የሚያስተምሩ አመቻች ብዛት ..... 69 .....

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ግኞችን በተመለከተ	1ኛ ዓመት ጀማሪ			2ኛ ዓመት ድሕረ ሀ			3ኛ ዓመት ድሕረ ለ			ጠቅላላ ድምር		
	ወ	ሴ	ድ	ወ	ሴ	ድ	ወ	ሴ	ድ	ወ	ሴ	ድ
ባራዊ የግልማሰት ህርት(ዕድሜ ከ15 በላይ)	1483	1361	2844	674	958	1632	165	433	598	912	2352	3264
ራጭ መሰረታዊ ህርት(ዕድሜ ከ7-15)	194	610	804	46	191	237	35	87	122	274	888	1163

1154 1396

ሕጻናትና ለጎልማሶች ትምህርት የሚሰጠዉ በአንድነት ..... ተለያይተዉ .....

ግዛራዊ የግልማሶች ትምህርትና አማራጭ መሰረታዊ ትምህርት ፕሮግራም አተገባበር ላይ ፡ሰለ ክተማችሁ የሚታዩ ችግሮች ካሉ ያዘርዝሩ

፡ የአመጋገብ ዓይነቱ በሳኒ አለመሰጠን፣ የልጓጓህፃት አሽርሶት ሪህጠቦችና ሙ.

፡ ለጽዕዕቻቸዉ ሲለጠና አለመኖራና ማነስ ፣ ተመጣጣኝ ያለመሆን ለጉንፉ

፡ የአመጋገብ ሰዓቱ ጠባብ መሆን ፣ የማቆህያ ችግሮች ...

፡ ወሰጠቱ ትምህርት ቤቶች ... የሰጡ ክለሰ ዉይይቶች ... ዓላማ

ክፍተኛ ... ክለ ...

Addis Ababa City Administration Office

SIGNED DECLARATION

I, the undersigned, declared this thesis is my original work and has not been presented for a degree in any other university, and that all sources of materials used for the thesis have been duly acknowledged.

Name: **Solomon Getachew Kassa**

Signature : ----------

Place and date of submission: **Addis Ababa University, June, 2010.**

This thesis has been submitted for examination with my approval as a university advisor.

Name Tilahun Fanta

Title Assistant Professor

Signature ----------

Date of Submission 23/06/2010

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Appendix-D: Clients' Focus Group Discussion Format

Appendix-E: Knowledge and Practice Level of Counseling Skills between Government and Non-government HIV/AIDS counselors

ACRONYMS AND ABRIVATIONS

ART	Anti Retroviral Treatment
CDC	U.S. Center for Disease Control and Prevention
CRDA	Christian Relief and Development Agency
FHI	Family Health International
GATHER	Greeting, Asking, Listening, Telling, Helping and Return to Follow-up
MOH	Federal Ministry of Health
NGOs	Non-government Organizations
OPD	Opportunistic Diseases
OSSA	Organization for Social Service for AIDS
PMTCT	Preventing Mother to Child Transmission
PLWHAs	People Living with HIV/AIDS
RHIRS	Rochester HIV Interview Rating Scale
RHO	Regional Health Office
SNNPR	South Nation Nationalities People Region
SOLER	Sitting Squarely, Open Posture, Lean Forward, Eye Contact, and Relaxed
STDs	Sexually Transmitted Diseases
UNAIDS	Joint United Nation Program on HIV/AIDS
VCT	Voluntary Counseling and Testing

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Table 8: One-Way ANOVA summary for practicing HIV/AIDS counseling skills that may be attributed to variations in duration training.....69

of related information and should make use of them efficiently. Yusuf (1998) attempts to summarise the existence of different specialised techniques to be employed whenever necessary and also he tried to reveal the skills of quality relationship between the client and counsellor as an alternative way and determinant factors to effect the desired objectives.

Thus, undoubtly to mitigate, if not get rid of HIV/AIDS concerned bodies whether governmental and/ or non-governmental institutions are performing an integrated services sometimes and independent services at another times so as to constrain the circulation of the pandemic through out the world.

A research conducted in Swaziland by Magagula et al., (1997) revealed that the existence of weak collabration among NGO_s and it is difficult to evaluate how far each NGO's contributions is effective in preventing and controlling the spread of HIV/AIDS due to the observed compition to the donor agencies, absence of formal structure that harmonizes each of them along together, inadequate capacity to supply goods and services and the abcense of charging fees for their services. Furthermore, the intgration among the government sector is also seemed to be weak and less successful which might be due to red tape and bureaucracy, centralized decision making, lack of clear policy that gives meaning to the nature of collaboration among them.

The National Report on HIV/AIDS activites in Turkamenistan disclosed that though in the government organizations people living with the virus are not entitled to anti-retroviral therapy coverage at the government expense, at every AIDS control center, psychological counselling office is accessible, staffed with specially trained skilful psychologists with further way to deliver psychological counselling through telephone hotline. Furthermore, though the non-government organizations whether at the local or international level attempt to address the issue of HIV/AIDS counselling and the over all activities, much of their efforts bounded with doner agencies such as WHO, UN –organizations that may adversely affect the sustainability and the effectiveness of the programme.

Reasonably, one can argue that provided that counselling is one way to prevent and control HIV/AIDS, counsellors must be competent and confident attracting and doing well clients to have voluntary HIV blood testing with disclosure and/or to develop positive life skills with out getting blood test, which in turn, to curve the bridles movement of this deadly disease whether in the government and/or non-government HIV/AIDS counselling providing centers. As a result, the present study helps to investigate counsellor's knowledge profile regarding fundamental counselling skills, and also observing the extent to which they put those skills in to action between the government and non-government counselling providers since the two organizations are the dominant service providers in relation to HIV/AIDS counseling.

1.2 Statement of the Problem

The main point that seems having less attention and investigation in the area of HIV/AIDS counselling might be the quality of HIV/AIDS counselling provided by government and/or non-government organizations. For instance, an investigation undertaken in South Africa by Rohleder and Swartz (2005) delivers inspiring hint on the concern from one of the participants voice 'as the NGO – run clinic posses a trend of practicing for counselling processes properly, while the reality seems opposite in the government organiztion. Similarly, government run – clinics are suffering from numerous problems such as- clash between holistic counselling activities and other activity oriented health system with serious budget constraints. Consequently, the following basic questions were formulated for investigation:

- Is there statistically significant difference between government and non-government HIV/AIDS counsellors' knowledge of HIV/AIDS counselling skills?
- Is there statistically significant difference between government and non-government HIV/AIDS counsellors in practising HIV/AIDS counselling skills?

- Is there a statistically significant difference in HIV/AIDS counsellors' knowledge of HIV/AIDS counselling skills that may be attributed to variations in selection procedures?
- Is there a statistically significant difference among HIV/AIDS counsellors' practicing HIV/AIDS counselling skills that may be attributed to variations in selection procedures?
- Is there a statistically significant difference among HIV/AIDS counsellors' knowledge of HIV/AIDS counselling skills that may be attributed to variations in duration of training?
- Is there a statistically significant difference among HIV/AIDS counsellors' practicing HIV/AIDS counselling skills that may be attributed to variations in duration of training?
- Do government and non-government HIV/AIDS counselling providing centres differ in relation to possessing available resources such as chairs, tables, ventilations, and shelves?

1.3 Objectives

The major objectives of the study are to compare:

- Government and non-government HIV counsellors' knowledge of HIV counselling skills.
- Government and non-government HIV counsellors in practising of HIV counselling skills.

More specifically, the study has the following specific objectives:

- Investigating whether differences in selection procedures affect counsellors' knowledge of counselling skills.
- Examining whether differences in selection procedures affect counsellors' practicing counselling skills.

- Exploring whether differences in duration of training affect counsellors' knowledge of counselling skills.
- Observing whether differences in duration of training affect counsellors' practicing counselling skills.
- Comparing government and non-government HIV counselling providing centres in relation to possessing available resources such as chairs, tables, ventilations, and shelves.

1.4 Significance

The study has paramount contributions to pin point preventive and intervention strategies from counselling point of view, which in turn, enhancing efficiencies in fighting and ceasing the rampant distribution of the plague through identifying the strengths and limitations of HIV counsellors in the government and non-government counselling providers in relation to employing fundamental HIV counselling skills (i.e., facilitative skills, communication skills, intervention skills, termination skills and follow-up skills) for desired behavioural changes (i.e., attracting individuals to get HIV blood test and knowing ones own HIV status, maintaining positive life styles living with/with out the virus namely reducing risk behaviours such as avoiding bare sexual intercourses, drug and alcohol addictions , psycho-social problems and others.

1.5 Delimitation

The study conducted at Gamo-Gofa Zone so as to investigate the self-perceived knowledge and practise level of HIV/AIDS counselling skills among HIV/AIDS counsellors' who were working at the government and non-government HIV/AIDS counselling centers.

1.6 Operational Definition

HIV/AIDS Counselling: A confidential communication between the counsellor and the counselee aimed at reducing HIV/AIDS development and transmission through delivering accurate and reliable information

about the pandemic, and through conducting HIV/AIDS prevention counselling mainly dealing with facilitating conducive environment to the client to explore own peculiar facets and risks, which in turn, assisting him/her plan and achieve clear behaviour- change target to minimize the probability of developing or passing HIV, and even adjust with psycho-social problems and develop independent choice with regard to the plague (CDC , 2001; MOH, 2002). Consequently, under this study all kinds of HIV/AIDS counselling such as Voluntary Counselling and Testing, Home –based counselling and PMTCT counselling were included.

HIV/AIDS Counselling skills: Techniques and /or competencies that may involve the following: (Yusuf, 1998 Hubley, 2002; MOH, 2003/5; Norwegian church Aid, 2005; Fischer et al., 2005).

- ***Facilitative Skills:*** Pre-condition for effective delivery of HIV/AIDS counseling such as accessibility and convenience of counselling office with waiting areas, congruence, establishing rapport, securing privacy, greeting, getting empathic, conformability and well arrangement, introducing the topic, respecting the client, unconditionally accepting the client, using ice breaker, maintaining confidentiality. (Ethiopian Minstry of Health, 2003)
- ***Communication skills:*** The counselling skills that typically significant to explore client's risk factors through conducting mutual discussion via asking, silence, pause, responding, acceptance, leading (i.e., clarification, reflection, questioning, restatement), summarizing, effective listening, encouragements, providing possible explanation, attending, using non-verbal cues properly. (Ethiopian Minstry of Health, 2003)
- ***Intervention skills:*** The skills of counselling that may help to avoid and/or minimize risk induced behaviours on the basis of different theoretical approaches such as cognitive – behaviour and/or affective oriented skills.

- ***Termination skills***: Ending of counselling relationship between the client and the counsellor whether through referring the client to other senior counsellor, when there is nothing to be discussed. (Yusuf, 1998)
- ***Follow up skills:*** The counselling skills that assist the counsellor and the client to check whether there was desirable behavioural change or not and/or to investigate client's problem even more thoroughly through face-to-face contact with the counsellor, referring to another individual or organization etc

HIV/AIDS Counselors: All the para- counselors (i.e., the non-professionals) namely the influential and respected persons of community, dedicated schoolteachers, motivated health workers, peer counselors/volunteers, PLWHAs (people living with HIV/AIDS), social workers, psychologists, and/or religious leaders are the salient service providers. (MOH, 2002; Norwegian Church Aid, 2005).

Government organizations refer to public agencies that are directly under the jurisdiction and control of the government such as ministries, departments, and units, which provide public services. (Magagula et al., 1997)

Non-government organizations (NGOs) are registered, non-profit, voluntary, independent, and charitable organizations (Cernea, Willard and Copestake quoted by Magagula et al., 1997)

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Nature of HIV/AIDS Counseling

The concept HIV/AIDS counseling is the newly emerging idea in the sphere of counseling. Scholars may try to deliver its meaning comprehensively from different corners. For example, UNAIDS (2000); MOH (2003) and the Norwegian Church Aid (2005) attempt to define it as confidential interpersonal relationship between an individual who seeks help and the one who is capable of assisting the counselee so as to manage Psychosocial hurdles related to HIV/AIDS. As Rogers cited in Rushton and Davis (1992) clearly visualize counseling including the HIV concern as the process of communicating to the counselee of the central affects of empathy, unconditional acceptance and genuine and which it necessarily encompasses client's experiences of the conditions. Even more, Chaava (1990) consider the meaning of counseling in terms of HIV/AIDS as the process focusing at delivering quantitative and qualitative psychological, and social support to the patient, families (i.e., nuclear and extended) and the community in the general. There by also added that counseling process dismantles the wrong notions conceived by some individuals with the pandemic and its mode of transmission through making more emphasis on inculcating no risk induced behaviors.

Center for Disease Control as cited by Kinnel (2001) here again puts a light on the previous and the contemporary meaning of counseling as the former merely revolves around securing information about the disease, while the later helping the client to assist himself/herself; and instigate and maintain behavior change. As Carballo quoted by WHO and UK Government, 1988 counseling is a device that leads marshaling the psychosocial and material inputs of the individuals living with HIV/'AIDS, health professionals, families and the

community as a whole. Moreover, a study conducted in Ghana by Chester cited by Brugha (1994) strives to describe counseling as the skilled and principled utilization of communication to create conductive involvement in order to help the client to know assets and liabilities, emotional acceptance, improve and advance growth and personal resources optimally.

Counseling containing HIV concern has common features. The Ethiopian Ministry of Health (2003) further attempts to reveal almost similar ideas with the above scholars as it emphasizes on changing voluntary behaviors of the client, facilitating conditions to the counselee to develop self-help skills specified with limits such as an interview, listening, attending and understanding each other, conducting privately and maintaining confidentiality. For instance, Patterson quoted by Yusuf (1998) described the characteristics of counseling as it is not giving information though it involves whenever necessary; not giving advice, suggestion and/or recommendations; not challenging client's attitudes, beliefs through persuasion or coercion; not affecting individual's behaviors through admonishing, warning threatening or compelling, not interviewing rather it is instrumental to counseling.

In line with the scholar strive to delineate the boundary of counseling as it depends on informed consent and desire for change on behalf of the client; providing conditions for independent behavioral modifications; determining the limits like time, goal etc; employing interviews to make all the things possible through listening and understanding the client. Center for Disease Control (2001) specifically underscores that as HIV prevention counseling used to be delivered on the basis of client's informed and unique conditions (risks) and that in turn, helps him/ her set and attains concrete and observable behavioral changes in preventing and controlling the spread of the plague. In addition to Hubley (2002) and Ethiopian Ministry of Health (2002) state about other fundamental and peculiarly issues that individuals need to maintain and put into action while delivering HIV/AIDS counseling are confidentiality,

anonymity, pre-and -post test counseling, if any, informed consent, the right to choose own action, and dealing with psychological, financial and spiritual needs'. In the words of Grinstead quoted by UNAIDS (1997) identified further distinguishing qualities of HIV/AIDS counseling that comprising HIV prevention counseling aimed at behavior change for not to contract the disease, while the other one counseling for care and support focusing on improving the physical, social and psychological well beings of people living with HIV and relinquishing the extent of stigma, discrimination, abuse and/or abandonment. Similar idea, but different authors such as Chaava (990) and Brugh (1994) bitterly underscored on emotional support to be conducted at the rate of interface among the unique feature of the client, health workers, families and the community at large so as to secure opportunities for the health professionals to buffer prevention schemes of counseling and awareness raising via open exchange of ideas and reaching at consensus.

Another prominent feature that makes HIV/AIDS counseling unique from other counseling programs may be its difficulty of counseling job it self. Several literatures and research evidences reinforce this fact unquestionably. For instance, Ginwalla et al., (2002) claims that some counselors are suffering from stress and burnout syndromes due to one or another reason; for example, work load, lack of training, supervision and/or support. Moreover, a study conducted in Kenya and Tanzania by Grinstread et al., (2000) confirms that counselors' job are both rewarding and stressful because of the nature of the task that they perform and other external influences like economic and political pressures. A very recent investigation in South Africa by Rohleder and Swartz (2005) contend that since counselors are dealing with the client on the emotionally loaded topics such as sex, death and dying and work related problems; they tend to get stress, anxiety and other intrusive psychological consequences as well as economic complexes. Actually the scholars may not emphasize exclusively on the nature and causes of career strain rather attempts were made to pin point directions to reverse such consequences. Among which

organizing regular support, supervision and training, alternating counseling with other activities (allowing work flexibility), delivering options to client desirable behavioral change as the result of counselors' performance, accepting and informing about emotional labor in counseling, availing regular and latest information and quality training, and reinforcing counselors to take part in the development of research scheme (Grinstread et al., 2000; Ginwalla, et al., 2002; Kelly et al., cited by Martin et al. , 2001). Furthermore, these scholars boldly suggest community intervention as effective way in preventing risk behaviors so as to curve transmission of infections in some areas.

2.2 HIV/AIDS Related Psychosocial Problems

It is common to enumerate myriads of psychosocial ailments in line with the pandemic HIV/AIDS. Individuals are forced to experience intrusive emotional numbness and behavioral constrictions before and/or after knowing HIV status. Infact the magnitude of exposure and/or practice of risk-induced behaviors may be the underlying factor so as to feel and suffer with such emotional anguishes and social impairments. For instance, some people become so fearful about contracting HIV/AIDS. The most important psychological stressors that may reinforce to such induced unhelpful psychosocial torments; for example, long incubation period and latent development to AIDS' Stigma; isolation, loss of job, housing. Friends; disability; dependency; death etc. Consequently, counselors should help those individuals at least to mitigate such non-desirable thought and behavioral manifestations (Bruhn, 1989). Furthermore, Hubley (2002) notes as counseling become the stepping-stone for people who are worrying about contracting HIV/AIDS. To mean, the fear may posses an actual ground; for example, having sexual relation with commercial sex works, and/or any other risks. Therefore, assisting such individuals to have an access about counseling, this in turn, results in relinquishing the adverse psychosocial consequences.

The aversive psychosocial significances of HIV/AIDS are not maintained only before. The recognition of HIV status rather it extends even more after definitely knowing the existence of the virus in ones own blood. As a result, countless government and non-government agencies are still in tact pursuing their endeavor in managing not only on the proactive HIV-related crises, rather on the reactive restoration of impaired emotional and social facets. As the Ethiopian Ministry of Health (2003) people with HIV infection consciously or unconsciously experience sever pain, mental suffering and/or unhappiness/ as ego-defense mechanisms, which in turn, puts a light on the counselors' so as to conduct counseling relationship on the need and socio-cultural context of the clients.

Specifically people living with HIV encounter a number of social and emotional problems among which shock primarily affect the individuals' life. In the words of Venkat (2004) shock as the primary psychological reaction among people living with HIV/AIDS. The Ethiopian Ministry of Health (2003) also attempts to describe shock as a potent emotional expression considered as a normal response among people who encounter dangerous situations in life and characterized by emotional numbness, confusion and uncertainty, despair, instability, withdrawal, crying etc.

Denial is another emotional consequence that pervades among the individuals who are living with HIV/AIDS. This psychological reaction typically known by safeguarding oneself from the debilitating and stressful events through refusing the acceptance and integration of the reality into ones own cognitive schema (Ethiopian Ministry of Health, 2003; Hubley, 2002; CRDA, 1995). Ministry of Health (2003) even more contends the state as initially reality based, which helps to minimize pervasive stress situations due to the new event occurred in life, while its persistence may result in psychological block impinging upon the individual in utilization of the existing preferred coping strategies and acquiring new problem solving skills so as to make the effect less likely hazardous. The

Toronto AIDS Committee (1998) further classified the existence of denial response among the newly disclosed individuals and its effect as refuting one's possible course of actions and consequences are not usually hurting rather dwindling stress, maintaining people happy intact and adjusting and generally keep positive living.

Stress is a further concomitant psychological reaction among people living with HIV/AIDS characterized by physical and psychological lethargy and tension through vacillating to be tested or not, premature death and knowing about HIV status, which in turn, results in reduction of decision making skills, declining facts about the disease and change of behavior (Ethiopian Ministry of Health, 2003). According to CRDA (1995) people who have been exposed to HIV/AIDS may feel and experience stress response due to numerous reasons like uncertainty about future life, anticipating about misfortunes of marriage mate and children, about social stigma and lack of support from others. Venkat (2004) also strives to reveal, stress as one of the emotional calamity of HIV/AIDS having an impoverishing consequences on the part of the infected persons.

There are several other psychosocial impacts of HIV/AIDS that each of them has distinct qualities. According to the Ethiopian Ministry of Health (2003) one can find a number of psychological and social consequences of HIV/AIDS among which fear due to the presence or anticipation of danger due to HIV/AIDS, and other unpleasant stimuli and anxiety because of chronic uncertainties of the infection; anger because of the feeling that considering oneself as misfortune so as to contract HIV/AIDS; suicidal thoughts or actions since they think that they loose personal value; therefore, they are responsible for not living with in the societal and personal expectations; isolation due to fear of abandonment; depression because of getting helplessness and inadequacy. On the contrary, it could be viewed as the result of accepting the reality (i.e., causes, intensity, treatment, permanence, consequences and

alterative ways to cope with it). Further complications may be guilt which is due to the thought that unguarded personal behaviors lead to contraction of the infection; loss of self-esteem may happen because of the social stigma occur in different settings; hypochondriacs is typically exists due to preoccupation of various psychological and physical symptoms.

The Norwegian Church Aid (2005) uncovered a number of psychological ailments due to the contraction of HIV that can be expressed as anxiety, guilt feeling, withdrawal, depression, shock and the like. Still another investigation by Venkat (2004) shows numerous psychological and social torments that can be summarized as shock, confusion, emotional isolation, anxiety, stress, fear and psychophysical disorders as the primary continuum, while sadness, atilt, helplessness, worthlessness, social withdrawal, suicidal tendencies and depressions are another secondly group along the continuum of reactions and finally the individual depicts discrimination, depression, right violation, marginalization, alienation and revenge in the third phase. The Toronto AIDS Committee (1998) even more claims as the extreme stress of HIV infection may result in denial, distress, anxiety, anger, guile, disruption and confusion.

2.3 Significance of HIV/AIDS Counseling

It is quite valuable to describe the contributions of the value laden scheme, HIV counseling. One may enumerate tremendous specific practical implications of the program. Though the fact may remain here, it could be easy to categorize into two major headings.

2.3.1 Prevention Counseling

A large number of research evidences as well as a number of other scripts clear up the cloud on how really HIV/AIDS counseling results in preventing the swift invasion of the pandemic. Hubley (2002) confirms that HIV/AIDS counseling is an essential instrument to be utilized with any individual who is confused about the disease and in need of counseling on the best way of clarifying life

styles so as to dwindle the opportunities of getting infected. According to the Canadian Ministry of Health (1992) counseling about HIV infection underscored as the best alternative way to reverse transmission, and also it could be more valuable than the test itself since the quality of counseling that clients obtain will have paramount consequences (i.e., change of behavior and/or positive living with the infection).

An investigation made in Botswana reveals that counseling was happened into view as one of the integral elements on the health program so as to pursue the increasing rate of HIV infection through prevention, counseling. (Fobad, 2001). Ethiopian Ministry of Health (2002) even more attempts to visualize the strategies and specific concerns under prevention counseling. It has been contended that the scheme may be delivered through face-to-face individual counseling and/or group counseling. Risk assessment for risk reduction; skimming wrong notions on the nature, causes and consequences for constructive forward movement and further issues are under discussion. Center for disease Control (2001) endeavors to categorize HIV counseling in to two: information delivery and HIV prevention counseling though both are aimed at reducing the infection, and transmission, while the latter one exclusively bound with the nature of counseling and explained as the counselor emphasize on investigating counselor's subjective risks, behaviors and supporting the client develop and end up with specific and measurable risk managing skills.

A study conducted in USA by Kamba et al., cited in Kawichai et al., (2004) vividly uncover about effective counseling approach so as to constrain the rampant flooding of HIV/AIDS as brief counseling utilizing a personalized risk reduction scheme was as successful as intensive enhanced counseling when comparing deductive delivery of message. Another perceived research finding from Zambia by Chaava (1990) operationalize the subsequent effect of counseling and its nature as the scheme is the seedbed to the overall HIV/AIDS

prevention and control through maintaining specific programs – such as inclusive counseling, pastoral care, education and administration.

HIV/AIDS counseling is still the corner stone even where testing is non-existence for individuals with symptomatic HIV, families and services providing HIV prevention counseling (i.e., counseling about protected sex in the service delivery centers). (UNAIDS Best Practice Collection-Technical Update, 2000). In the words of Dezoya et al., quoted by Grinstead et al., (2000) and Kipp (2002) the need for HIV/AIDS counseling with and without blood testing mounting in the developing nations and counseling tasks are becoming more usual. Nevertheless, in many of clinics and community centers the testing is conducted without counseling and possibilities for prevention counseling is void (Lavollay cited in Grinstead et al., 2000).

2.3.2 Care and Support Counseling

Counseling may take different forms depending upon the need of the client and the scheme is being considered as fundamental element of HIV/AIDS care and an essential component of HIV testing (Rohleder and Swartz, 2005). The Canadian International Development Agency (2001) endeavors to clarify the fundamental features of HIV/AIDS support counseling as it could be delivered on the basis of client's need, aimed at internalizing hope in the client and reframing the client's interest in life and it is center-based (i.e., conducted at different setting like home based). Marcus et al., (2000) and Green and Smith (2004) vividly revealed counseling as one of the major components such as group psychotherapy, psycho education, cognitive – behavior therapy and stress and anxiety; management in order to manage HIV/AIDS – related complexes, which each of them has its own unique qualities.

Carballo cited in Brugha (1984) counseling at the grassroots level of different hospital settings may respond four fundamental needs which are delivering psychological and psychosocial support to the individuals who have been

infected, changing undesirable behaviors, maintaining sustainable economic, intellectual and social productivity, and mainstreaming HIV-positive individuals with in the major network of the family and community. Moreover, reducing the psychosocial and physical morbidity through minimizing the challenges in medical aspects.

Psychosocial support even more extended as crucial not only for individuals who have been affected by HIV/AIDS, rather for non-infected children of HIV-positive parents (Gunther, et al., 1998). A study conducted in Zambia by Chaava (1990) strove to identify comprehensive and fundamental purposes of counseling as primarily exploring the existing inputs of the individuals' families, and community so as to bear the responsibilities to care patients through pursuing change of behavior among the families. The investigator even more specifically claim counseling focuses on delivering psychological help to the patient, his/her family and concerned individual in the extended families followed by facilitating conditions in such away that the patient and his/her family learn reliable information and communicate with the remaining community members.

According to Miller cited WHO and UK Government (1988) the consideration of significant others vitally indicated in care and support program due to the person with HIV may perceive himself/herself as burden and feel guilt that may enhance the psychosocial significances, significant others may feel hypothetical fear about the transmission of the disease, those salient individuals in life for people living with the virus may get in distressing situations on the disease, causes, treatment and consequences even more than the victims, and the influence related to HIV/AIDS may result in family discordance by per se. Consequently, the requirement of proper counseling and discussion with such noticeable individuals become paramount.

2.4. Demand for HIV/AIDS Counseling

Some written documents testify that HIV/AIDS counseling is mandatory and need to be conducted any where to secure desirable behavioral changes. For instance, the case in point dealt by UNAIDS (2000) as in certain areas HIV/AIDS counseling is accessible in the absence of testing in order to promote changes in sexual risk behaviors, and also it has been evident in the rural areas of Uganda as community- based counseling radically enhanced the rate of condom utilization among adults. Carballo cited in WHO and UK Government, 1998 strongly asserts the demand for counseling as the fundamental element in any health related scheme for proactive and reactive HIV related crises management and its value and significance is remained at the social level; however, its most basic contributions lie at the personal and familial position. Similarly, the United Nations HIV/AIDS Program (1997) confirms that counseling services available to HIV – negative and HIV –positive individuals outside the testing contexts should be supported to deliver care, support and prevention.

A study conducted in America by Grinstread et al., (2000) openly viewed about the swift and sharp demand of counseling in the sphere of HIV prevention and control as the need for HIV/AIDS counseling services with or without testing increasing in developing nations. Though the existence of scanty investigations that indicate counselors' role and experiences delivering HIV oriented counseling in developing states.

As Martin et al., (2001) the future trend in HIV/AIDS counseling as hereafter focuses on the endorsement to therapy in patients with HIV infection necessarily targeted to individual counseling and should be intensive enough and long lasting. Further study by Golin et al., (2004) in the Northern Carolina underscores on the adherence counseling practices in HIV/AIDS as physicians treating for HIV patients require more training and extensive time to provide

anti-retroviral adherence counseling which may increase the demand of counseling services. In addition, Rohleder and Swartz (2005) conducted a study in South Africa even more discloses that counseling as being considered as an essential part of HIV/AIDS care, and the integral component of HIV testing though relative absence of consideration to the systematic and managerial problems encountered by counselors and counseling programs. Even more, HIV counseling services are highly required without getting blood test (Kipp et al., 2002).

Some scholars still attempt to disclose the need of counseling for pregnant women to prevent and control the spread of the pandemic. For example, World Health Organization (1999) HIV/AIDS counseling of pregnant women need to be carried out by trained and competent health care workers either within the antenatal health center or in close collaboration with a VCT center in the area. The health care professionals in the antenatal care centers need to be aware of the VCT process and capable of referring women for pre- and –post test counseling as well as on going counseling whenever necessary.

Golin et al., (2004) describes counseling as the milestone for people who take ART; however, many health workers' feel inadequately skilled to offer Anti-Retroviral adherence counseling due to lack of proper training in the concerned areas.

According to Ethiopian Ministry of Health (2002) HIV/AIDS counseling in Ethiopia started around the end of 1980s with the program growing throughout the 1990s which might be due to a great deal of country wide training for nurse counselors and social workers and due to also the establishment of several counseling centers via the joint effort of government and non-government institutions.

2.5. Implications of Counseling Skills to Deliver Quality HIV Counseling

The Norwegian Church Aid (2005) contends that counselors whether directly or indirectly should have the skills to know the principles and process of counseling in relation to the latest information with further technical and content knowledge of the disease. Carballo cited in WHO and UK Government, 1988 seriously underscored on counseling skills for the desired change and to fight against HIV/AIDS as though it is not a novel service, a number of caring professionals possess in one direction or another acquainted with and utilize the skills and techniques through the renewed application of principles and practices, persistent integration of people living with the virus with the wider society for optimal use of social, economic and intellectual inputs, and maximizing patients role in fighting against the pandemic.

Though it has been targeted towards the skills to which HIV/AIDS counselors endeavor to reveal that skilful counselors exert much effort in assisting the youth in order to stop contracting HIV, maintaining positive and long term behavioral changes, expanding opportunities for other health related and care services getting free from unwanted pregnancy and designing future strategies for effective management of the HIV/AIDS (Fischer et al., 2005). As the Ontario Ministry of Health (1992) reflect a flash of light on the counselors' effort so as to deliver productive counseling as counselors are supposed to remain their personal knowledge of counseling skills during the counseling relationship via modifying HIV-related information whenever necessary in order to address clients problem. Furthermore, counselors are expected to consider the culture, language, perception of HIV disease, client's self-esteem, and a number of other issues may put on pressure on the client's to perceive the nature of the disease and make positive change in life. An investigation made in Kenya and Tanzania by Grinstead (2000) contend that counseling is perceived as a respected interpersonal relationship where communication of individual's subjective issues could happen since the 'secure environment' focusing to the

maintenance of confidentiality and special skills that counselors brining to the 'counseling' relationship. Current changes in medicine focus on community care, through developing professional knowledge and patient self-responsibility (Davis and Butcher; Miller and McConachie quoted by Rushton and Davis, 1992). Furthermore, such changes need a greater modification of services to end personal needs and possess enhanced demand for counseling/communication skills in any profession (Cunningham and Davis; Fallowfield cited in Rushton and Davis, 1992). A further study by Brugha (1994) reveals that under a team approach to HIV infection care and counseling with effective recruitment and assistance of the staff with proper training of counseling skills is mandatory.

Stickley (2002) comprehensively underscores on the importance of counseling skills as to growing element under mental health nurses training scheme in England. In the words of Epstein et al., (2001) health professionals often did not provide opportunities for patients to express their issues, and communications tended to utilize unclear languages to convey risk behaviors and to be ignored at "awkward moments." Despite the fact that physicians perceived video tapes of their own inadequate communication behavior, which enables to look for wrong communications and discover strategies to promote HIV risk assessment skills. Relatively similar ideas have been forwarded by Bowles (2001) nurses communication skills have been criticized for a number of years due to the inadequate training offered and the absence of well organized theoretical or practical approaches for communication skills that the nurses receive which might led to less quality services.

2.6 Profile of HIV/AIDS Counselors' Skills

HIV/AIDS counselors may emerge from different social and academic background. Though the demand of counseling dramatically increasing due to the happening of different psychosocial ailments, the trained and competent personnel in relation to the extensive rampage of the challenges is quite meager

and misbalanced. According to Grinstead et al., (2000) there are scanty scripts on counselors' experiences of delivering HIV oriented services in developing nations. In order to meet the urgent and critical requirements of the service delivery it could be the cornerstone to recruit, train and make use of individuals from a range of background. Hubely (2002) attempted to reveal the Uganda situation as HIV/AIDS counselors come from areas of health, teaching and social work having the training for six months on the issues of counseling skills, workshop and super vision work which might be due to increased need of HIV counseling for testing, support and care. Relatively similar understanding has been coined by Carballo cited by WHO and UK Government, 1988 though counseling has been instrumental since long time for the effective management of chronic and acute illnesses, its implementation to HIV/AIDS may require special attention due to the nature and effect of the disease. For that matter, individuals who have been trained a head in counseling and/or possibly exploitation of the existing locally available knowledge and skills with specific additional training need to be underlined to reverse the bridles progression of the pandemic. Numerous individuals who have received the necessary training in the scheme can provide HIV counseling specifically; for example, health professionals like physicians and nurses, social workers and psychologists, religious leaders' local/village 'leaders Volunteers, PLWHA, Peers and so forth (Norwegian Church Aid, 2005).

Moreover, an investigation made in Ghana by Brugha (1994) shows that effective HIV/AIDS counseling programme is subject to the integration of multidisciplinary team constituted from highly motivated individuals having the component such as counseling clinical care, nursing, health education, pastoral care, administration management and data processing, etc with flexibility and the skill to satisfied the needs of clients. All such members of the team necessarily obtain special training in counseling approaches and techniques (Campbell and Williams cited in Brugha, 1994). This idea even more strengthened by Green and Smith (2004) under the British HIV Association as

the complex psychosocial characteristics of HIV/AIDS gears individuals towards multidisciplinary scheme as the needed for HIV care and support constituting to professionals such as doctors, nurses, midwives, health obvious psychologists, counselors, dentists, pharmacists, other professionals combined to medicine, social workers and people with HIV/AIDS.

An investigation made by Ginwalla et al., (2002) strives to visualize the efficacy of HIV counseling through the comparison of nurse counselors and community volunteers as in nurse counselors posses better communication skills than community volunteers which might be due to the nurse counselors see fewer clients than the community volunteers since they passes and further additional duties to be attended. Further explanation comes from the view that nurse counselors relatively experience interpersonal relationship while conducting the usual routine tasks that might non-existent to community valentines. Still another reason could be community volunteers may acquire low level of counseling skills since the trainings many times undertaken in secondary/ tertiary language, which is English.

2.7 Theoretical Foundation of HIV/AIDS Counseling

Counseling in general, HIV/AIDS counseling specifically, has its own theoretical basis so as to pursue the goal of the relationship successfully. All the fundamental psychotherapeutic thoughts from psychoanalytic to family approach deliver understandings of personal and family change with behavioral problems and suggest comprehensive principles towards the solutions of problems (Weakland and Jordan, 1992). According to Ethiopian Ministry of Health (2003) counseling theories are the cornerstones for counseling since counselors are dealing with individuals and their psychosocial facets, and exposure to different risk induced behavioral constrictions. Respective professionals are supposed to conduct supportive actions on the basis of concrete and practical ground. To mean, the purposeful specific interventions employed by the counselors should base on theory rather than random

assignment and implementation of principles. Consequently, counseling involves sequential well-organized implementation of counseling skills owing various theoretical frameworks considering the socio-cultural milieus of the society, the need, age and political aspects of the clients.

An investigation made in South Africa by Richeter et al., quoted by Rohleder and Swartz (2005) contend that there are a number of approaches to HIV/AIDS counseling constituting client-centered, cognitive – behavioral, psychoanalysis, health, education, and others. Though the approaches may vary almost all of them focus on the significance of trusting, confidentiality, and dignified relationship between the client and the counselor. There are still numerous counseling theories that each of them with specific features and branches among which psychoanalysis, behavioral- cognitive, humanistic and eclectic approaches (Ethiopian Ministry of Health, 2003).

Green and Smith (2004) reflect as cognitive–behavioral therapies and other psychotherapeutic approaches are underlined clearly as significant interventions so as to dwindle psychiatric cases of individuals with HIV/AIDS. Cognitive-behavior therapy even further noted by Molassiotis et al., (2002) as it is reducing psychological distresses and changing the quality of life among the clients AIDS patients. In addition, skills training, methods such as cognitive-behavior therapy are basically important for intellectually active and mild to moderate residual pain reductions related to HIV/AIDS (Marcus et al., 2000).

According to Bor et al., (1989) confirms to describe another approach, which is known as a system theory to AIDS counseling referring the involvement of understanding the context of the problem; obtaining a clear meaning of problem regarding to dynamic nature of the problem over time; and specifying whom the problem affects. Inability to take into account all the above issues may put pressure/ difficulties in the counseling relationship.

Further theory of HIV/AIDS counseling has been forwarded by Rachman cited in Gunther (1998) group therapy considered as more appropriate for

adolescents of parents with HIV/AIDS since the group itself becomes an instrument to help adolescents with identify development and consolidation. In addition Levin cited in Gunthers (1998) describes the group as representing a transitional object that helps adolescents to personalize and identify from their families. Aaronson quoted by Gunther (1998) thrown further explanation as the method even more applicable to children of HIV-infected parents.

A study conducted by Arthur (1998) reveals that the communication models tailored by nursing courses come from humanistic (client – centered approach) which is characterized by respect, genuineness, empathy, attending, listening probing and generally quality relationship. In addition client – centered counseling has been suggested by CDC as interactive counseling approach that has been translated as face-to-face sessions between the counselor and the client though misinterpretations and lack of experiences of the model exists as if basically focuses on face-to-face information delivery, advice giving and directing the client to perform certain selected tasks rather than encouraging and facilitating active listening attending, respecting the clients and his/her concerns, maintaining on going quality assurance so as to obtain reasonable benefit (CDC, 2001; Grinstead et al., 2000).

2.8. Factors Affecting HIV/AIDS Counseling

Nothing is right perfect rather it has limitations or challenges that impair quality delivery of services. Likewise HIV/AIDS counseling still encountering such challenging situations having adverse consequences in the program. According to Family Health International (2001) summarizes all the challenges in the governmental and non-governmental institutions of voluntary testing and counseling programs as non-integration of the service with the existing medical activities and problems to secure continuous follow-up, expensiveness to establish and operate that require sustainable external assistance, non-equitability, stigmatizing effect due to the association of all issues with HIV/AIDS are the most hurting/damaging impediments to the freestanding or

direct HIV counseling program. Similarly, integrated program of HIV counseling has the characteristics of affecting quality of other tasks and lower quality VCT service, not permitting non-health care workers; for example, people living with HIV/AIDS, teachers, social workers, community workers, volunteers as counselor, little motivation in the public sector employees, difficulty to maintain quality assurance, bounded administrative and managerial potentials so as to run these complex tasks.

Another issue which may be considered as the limestone for delivery of quality counseling could be counselors' counseling **competency.** The UNAIDS (2000) claims that counselors always come from different background, and with various health and social beliefs requiring training in special communication skills like welcoming friendly, sensitive and non-judgmental attitudes towards clients. Another important component as a determinant issue in the efficacy of HIV counseling could be mentioned as on going support and care for counselors. Rohleder and Swartz (2005) clearly uncover the fact as counselors requiring more support from health sector on their tasks, feeling isolated from main stream services, and requiring to be a member of as initiative element in the functional and referral net work for clients and they indicate that counselors need to be organized into the health services via the delivery of constant post. Furthermore, the Canadian International Development Agency (2001) reveal that counselors spend most of their time listening to clients and delivering other individuals support; however, to perform their tasks well, they too require support; for example, back-up support and personal protection, an incentive for motivation psychosocial support retreat (time a way), adequate logistic support, updated professional development and training networking, exchange visits and counselors support group.

The United Nation Agency for International Development (2000) further notes some of HIV/AIDS counseling centers offer longer, more in-depth training need for refresher courses and continuous training. Counselors who are working at

VCTs will require training that focus on basic information on HIV, and possible and available interventions as well as the role and processes of pre-test, post-test and on going counseling. Actually, counselors may need new skills to be employed for on going counseling that contain different models of training (i.e., a short course 1-2 weeks) followed by practical tasks, and then additional 1-2 weeks is a reasonable time scale. (Miller cited in WHO and UK Government, 1988).

Counselors **extrinsic motivation for counseling and recognition** are again further concerns need to be underscored for effective delivery of HIV counseling. As it has been indicated under the UNAIDS Best Practice Collection (2000) as a number of individuals in pervasive HIV – prevalent areas are receiving training in HIV/AIDS counseling; however, are usually not utilize their skills properly due to counseling is not considered by workmates as being significant. Moreover, other day-to-day tasks frequently take primary attention over counseling or counseling trained staffs are changed to other positions where they are unable to perform their responsibilities. If counselors are trained and provided with farther tasks in HIV/AIDS counseling, the role must be understood and appreciated, and the counselors necessarily allowed with adequate time to pursue these tasks. Training in basic skills and techniques of counseling, a good knowledge of HIV, and an understanding of the underlying principles and goals of counseling are prerequisites to effective and safe counseling particularly on the part of lay counselors. CDC (2001) notes among a number of issues need to be considered while undertaking HIV/AIDS counseling; counselors are required to complete a standard of training courses in client-centered HIV prevention counseling or other risk managing counseling approaches.

2.9. Major HIV/AIDS Counseling Skills

2.9.1 Facilitative Skills

As it has been noted, counseling requires basic/ fundamental/ skills to be employed. The joint United Nations program on HIV/AIDS (1997) as a general rule testing should be conducted only with quality pre-and-post test counseling consistent with the existing counseling guidelines. Moreover, the Untied Nations Technical Update (2000) HIV/AIDS counseling can be tailored to the needs of the client/s and can be for individuals, couples, families and children and need to be modified to the needs and capacities of the context in which it is to be offered.

Baggaley et al., (1998) attempt to disclose about the skills related to establishing some operational aspects of counseling scenarios – such as the site (i.e., need to be accessible and convenience), private with waiting area; ensure confidentiality and with linkage with other services (i.e., medical, social, emotional, family planning activities, STI tasks, antenatal services, home-based care services and palliative care services); spiritual services and traditional healers; support groups for people living with HIV/AIDS; community groups and NGOs. Furthermore, an appropriate environment (i.e., free from interruption, pleasant, quiet, comfortable, accessible and threatening which could be in the client's home, suitable place (i.e., accessible to where the patients exist), in or near hospital ward or outpatients sections (Jackson cited by Brugha, 1994; Arthur, 1999).

Evidently, even more stated in WHO, 1999 in several cases antenatal care – hardly performed privately. Nevertheless, for VCT and MTCT intervention to be undertaken properly and effectively, privacy must be maintained. Dealing of risk factors and sexual relations is components of VCT infection, and basic information necessary to the process will not be elicited unless the woman can discuss these issues privately. Additional space or rearrangement of clinic

accommodation will be needed. Besides, women attending antenatal health centers may usually have other children with them. Furnishing, spaces where children can entertain supervised by further waiting mothers or health care staff would enable counseling to proceed without intervention. Moreover, UNAIDS (2000) clarifies that counselors must be able to "user friendly", need to deliver counseling in non-threatening, safe, and easily accessible environment.

According to the UNAIDS Technical Update: Voluntary counseling and Testing (2000) establishing good rapport, respecting and understanding the client and client's problem as the most important conducive skills so as to manage difficult situations during HIV/AIDS counseling. The Norwegian Church Aid (2005) additionally confirms that the counselor should attempt to assist the client to express their life styles openly and transparently through establishing rapport such as–expressing love, respect, greetings; introducing oneself, topic, purpose of HIV/AIDS counseling maintaining confidentiality encouraging the client so as to visualize the reason that he/she needs HIV/AIDS counseling and so forth. Relatively, similar ideas have been forwarded by Kambat et al., cited in Kinnel (2001) initially the counselor should introduce himself/herself as health counselor, define the purpose of HIV/AIDS counseling, the presumed time consumption, the specific objective of the session, seeking and maintaining agreement between the counselor and the client. In addition, Chester cited in Brugha (1994) endeavors to define pre-conditions of counseling as the core qualities that are fundamental to counseling constituting the skills to show empathy, unconditional positive regard, and genuineness.

The idea of confidentially specifically indicated as that of pre-supposes a relationship of intimacy or trust between two or more persons in whom private or secrete information is shared on the understanding that the information will not be repeated to an unauthorized person. Consequently, such confidential relationship pertains between an HIV/AIDS patient and every HIV counseling and others who offer care for such individuals (Fombad, 2001).

Ginwalla et al., (2000) reveal professional differences in the implementation of such counseling skills as nurse counselors generally perform better than community volunteers in developing a rapport with the clients and even also they seem to be more confident in offering information and responding to questions raised from clients. Some scholars still made an effort to disclose non-professionals or lay counselors may posses particularly advantages especially if they are counseling people with the same or similar, language or cultural background (Jackson cited in Brugha, 1994; Arthur, 1999). This idea also strengthened by the Join United Nations Program on HIV/AIDS (1997) as counselors need to consider clients' socio-cultural backgrounds and should be sensitive and appropriate with the issues of sexual identify, developmental and linguistic aspects.

Detailed features for effective delivery of counseling has been forwarded by the Ethiopian Ministry of Health (2003) are availability of time and space, establishing working relationship, making consistent and accurate information available, maintaining privacy and confidentiality, emphatic understanding of the client and client's problem, respecting the client and showing warming and getting genuine. In addition, HIV/AIDS counseling is undertaken in offices where sheltered space, intimacy, trust, and confidentiality can be secured. The intimacy can enhance rapport and overcome some of the problems of social distance that are inevitable where individuals are by formal desk or the classic white uniform (Hall quoted by WHO and UK government, 1988).

2.9.2 Communication Skills

In relation to communication skills abundant scripts offer clear evidences. For example, Hubley (2002) attempts to reveal the skills of counseling with a word as 'GATHER' that may conote: G: Greeting the client, A = Asking about the client and LISTEN to what he/she says, T = Telling clients any relevant information they need, H: Helping clients make decision, E = Explaining any

misunderstanding, R=Return to follow-up. In similar, way but differently Arthur (1999) explicitly discloses a number of communication skills as attending skills that expressed as SOLER with each letter stands for different expressions: S: Sitting squarely, O: Open posture, L: Lean forward, E: Eye contact, and R: Relaxed. Moreover, some more skills have been mentioned such as listen to and understand verbal and non-verbal messages, using emphatic expressions, employing lead through using non-threatening open-ended questions, demonstrating reflective listening, expressing logical warmth, inform during self and clarifying the purpose of HIV counseling in a more passionate context.

Communication and listening skills are central to counseling which might include active listening using open and circular questions properly reflecting client's feelings, summarizing main points during be sessions, challenging contradictory ideas, providing concrete ideas immediately and assisting the client to develop problem solving skills (Chester; Jackson quoted by Brugha, 1994). Similarly, counseling should be undertaken through interactive approach with 'the counselor' listen to the client so as to offer assistance and determine some specific prevention strategies (CDC cited in Kinnel, 2001). Even more by CDC (2001) a number of skills to be categorized under communication skills as the counselor need to employ such skills as – active listening, using open ended rather than closed ended questions in order to elicit the deep sited client's internal self, becoming interactive negotiating style rather than a persuasive' approach, feeling comfort in dealing with specific HIV transmission risks, well motivated in developing new counseling and skills building techniques, securing a supportive environment and establish trust with the counselee.

UNAIDS Tools for Evaluating HIV/AIDS Voluntary Counseling and Testing (2000) and Ginwalla et al., (2002) mentioned about the existence of several communication skills described under different headings such as the skills in collecting data (i.e. using proper and balanced open and close ended questions,

easily. In addition, Webster Booth et al., cited in Bowles et al., (2001) strongly contends that nurses actively attempt to remove or block communications such as ignoring patients problems spontaneously changing the client and/or emphasizing in the least threatening issues of conversation.

Excellent communication is the corner stone for positive relation with young client's; for example, utilizing simple, short, non-judgmental language with avoiding technical jargons and awaring the expression and slang that are being used by adolescent. Moreover, active listening through paraphrasing client's statements and repeating/reflecting them back; asking proper open-ended questions; maintaining appropriate eye contact, gestures, and verbal responses to reveal that the counselor is listening, reading body language, checking and assuring client's understanding what the counselor to say them. Helping the client in order to develop problem-solving skills independently; getting genuine and so forth (Fischer et al., 2005). The UNAIDS Technical Update on Voluntary Testing and Counseling (2000) counseling communication should be age – appropriate, utilizing examples of objective realties of client's environment that are familiar and relevant to the client and language that are non-technical and easily understandable.

Buranrd and Morrison cited in Bowles et al., (2001) make attempt be reveal the inadequacy of nurse counselors in practicing communication skills and the reason that might be due to lack of formal organizational structure, shortage of time, emotional labour of nurses, considering nursing as practical activity based profession and understanding communication exclusively as a means of offering information. Furthermore, Epstein et al., (2001) attempt to confirm that to the less success of different programs in enhancing the communication skills of HIV counselors, which might be improved through training and learning. Besides, the investigators endeavor to depict most important interview skills under Rochester HIV Interview Rating Scale (RHIRS) such as verbal and non-verbal communication, setting clear issue, eliciting clients concern and perspective, using non-judgmental languages, avoiding racial/cultural

how these problems could be managed to facilitate ventilation of feelings and to develop supportive and encouraging roles towards other members of the group.

Improving coping and adaptation intervention focusing on improving coping style for HIV patients are important (Grassie et al., quoted by Brown et al., 2000). A therapeutic strategy taken from more comprehensive study on adult adaptation to chronic problems stress the practice of 'active' skills such as problem-solving and help-seeking rather than 'inactive' skills such as self-blaming or resignation (Brown et al., 2000). According to Haghighatgov and Paterson; Mackenzie, Sloan, Hobfoll and Jackson quoted by Brown, 2000) the utilization of any skill subject to the exact nature of the problem, resource available and individual abilities. For example, many times 'active' skills are preferred most by 'Western cultures, while the 'passive' ones may be functional to non-western cultures/traditions. Besides, helping the client so as to develop coping strategies (i.e., the cognitive and behavioral efforts made by the person with who has HIV/AIDS to alter to manage the problems occurred due to the disease (Ashton et al., 2005).

The specific skills that contribute to manage HIV/AIDS related pain are cognitive restructuring /appraisal such as eliciting patients' thoughts about pain, helping patients to minimize thoughts that enhance distress and pain intensity. Problem solving skills such as role-play with patients to identify problems, analyses the situation, produce potential solutions, plan solution, implement solution and evaluate result; relaxation techniques (i.e., progressive muscular relaxation, visual/guided imagery diaphragmatic breathing through helping the client practice various techniques in one or more session, permit patient to select the approach most comfortable for him/her and most convenient for life styles; time based pacing. For example, planning activity – rest schedule with patients general health promotion like based on symptoms assisting patients to develop sleep diary, daily food long, exercise plan and diary and so froth (Marcus et al., 2000). As in Canadian International Development Agency (2001) there are again a number of specific therapeutic techniques that

may be suitable to PLWHAs such as mediation, relaxation, massage, aromatherapy, herbal remedies, reflexology, orthography and hypnotherapy.

Fischer et al., (2005) states that the most significant activity of counselor is to deliver to the young clients with accurate, and scientific facts in a clear and concise manner such as on HIV/AIDS, contraception like condom use, life skills development such as critical thinking and confidence building, conducting research and scientific program summaries.

Family Health International (2001) similarly attempted to uncover detailed intervention strategies particularly for youth groups among which psychosocial support for people living with HIV/AIDS; under taking formal research schemes that consider the objective realties of the youth group; considering individuals who may influence the young people, such as – immediate and extended families, teachers, community leaders and media icons; net working HIV program to other sectors like religion, schools, job training, agriculture, sport and media; linking HIV from other reproductive health and life events; for example, life skills development, which may result in acquiring problem-solving and decision making skills; creating direct linkages to trained, adolescent – friendly health care providers, pharmacists, community- based distribution workers, out reach, peer education, media, hotlines, information and education, referral services etc. In line with, intervention strategies such as using condoms, abstain and/or separations are also recommended for discordant couples (Bunnell et al., 2005).

The community intervention has been effective in the prevention of risk-induced behaviors to mitigate transmission of HIV (Kelly et al., cited in Martin et al., 2001). Moreover, homosexual patients are more receptive towards community educational tasks and there are natural leaders among them with a great skill to change the frequent behaviors (Martin et al., 2001). Besides, Chaava (1990) claims about that HIV counseling, which mainly focus on delivery of information on the transmission, development of the disease and

prevention, variation of the status of the infection in relation to the phase of HIV disease; establishing quality relationship of trust with the client; buffering quality and meaning of life particularly in the 'pastoral' counseling as life exists after death.

According to UNAIDS Technical Update: Voluntary Counseling and Testing (2000) and Ethiopian Ministry of health (2002), when counseling women in the antenatal setting for PMTCT interventions special considerations need to be given to counseling about infant feeding, counseling about all available PMTCT opportunities, family planning counseling, for sero-positive women referrals for on going medical and emotional support, for negative women counseling about prevention of HIV infection during pregnancy and breast-feeding counseling; the merits and demerits of disclosure particularly to her partner, involving the partner in the counseling and decision making.

Bowles et al., (2001) expresses about the type of intervention that nurses need to develop as nurses communication skills have been improved due to solution focused training that has been conducted on four dimensions such as competence, confidence, willingness and frequency with which the nurses deal with individuals who are troubled.

2.9.4 Termination and Follow-up Skills

Counseling has its own distinct time to be terminated between the counselor and the client. The numbers of the sessions depend upon the need of the client and the nature of the problem. A number of strategies might be employed to quit the relationship between the two individuals among which a referral system need to be established in collaboration with NGOs, community-based organizations, hospital directors, and other service officers as well as with network of people living with HIV/AIDS. Regular meetings among service providers need to be conducted to review and improve the referral system (UNAIDS, 2000). In the words of Fombanne (1998) reviewing progresses and

changes that were accomplished in the counseling relationship and to assess residual symptoms of the disease with the involvement of both the client and parents underlined boldly. Moreover, an open discussion about termination between the last session should be initiated by the counselor and giving credit to the difficulties of terminating the therapeutic relationship need to be encouraged in order to promote the skills of self-reliance in assisting oneself. According to Yusuf (1998) client –counselor relationships can be terminated through different ways such as referral system, summarizing main session points, when dissatisfaction occur on the client part or when there is no ideas to be triggered and discussed by the client and the counselor as well.

Another point that should be considered in the counseling relationship is follow-up counseling or on going counseling. This process also may take different forms. For example, Ethiopian Ministry of Health (2003) on going counseling can be undertaken at any suitable environment where privacy is maintained such as health clinics, counseling centers, home, church, working place etc. Relatively in similar manner, Rohleder and Swartz (2005) inform that clients need to be assisted through systematically follow-up programm. An investigation made by Bunnell et al., (2005) discloses that clients recommended several interventional strategies continuing individuals as well as couple follow-up counseling and others.

The Majority of individuals receiving VCT, whether they test positive or negative will attend one or at the most two post testing counseling sessions. Research findings have disclosed that even when further counseling session are offered or referral to specialized counseling services is available, many individuals do not want additional counseling, at least not in the immediate future. Though this is the fact some people may need on going counseling and some will attend for further counseling in the 1-5 years. On the other hand, a number of clients may find other informal services or resources in the community to assist them with their psychosocial supports. Such service givers may be church groups; family members, friends and traditional medial workers usually undertake emotional support (Baggaley et al., 1998).

According to the Canadian International Development Agency (2001), after the initial post-test counseling, an individual living with HIV will usually need additional supportive counseling sessions that may cover a comprehensive issues based on the client's needs so as inculcate hope in the client and strengthen the client's will to live on. Moreover, the service may be center-based. The clients visit the counselors when they need emotional support, or it may be home based (i.e., seeing the clients in their own environment.

CHAPTER THREE
METHODS AND PROCEDURES

3.1 Participants

A total of 215 (99 male and 116 female) participants were purposely selected to take part in the study. Furthermore, five government organizations (i.e., Arbaminch Health Center, Arbaminch Hospital, Sawla Health Center, Chencha Health Center, and Mi-erab-abaya Health Center), and five non-government organizations (OSSA, Arbaminch Birhan Anti-AIDS Association, Ethiopian Orthodox Church Sunday Schools Coopration against HIV/AIDS, Ethiopian Orthodox Church Development Coopration aginst HIV/AIDS and South west Synodos) were purposefully selected on the basis of the availability of HIV/AIDS counselling services and the prevalence of the pandemic around these areas. The participants who were nominated as HIV/AIDS counsellors (i. e., 84 from government and 114 from non-government) who had necessarily a training on HIV/AIDS counselling and capable of providing among one and/or more HIV/AIDS counselling services such as voluntary counselling and testing, home -based emotional care and counselling, preventing mother to child transmission counselling, Anti-retroviral Treatment Adherence counselling and/or HIV prevention counselling. Moreover, 8 volunteer clients for Focus Group Discussion, who received counselling from the government and the non-government organizations for different purposes, while 2 clients for case studies each from government and non-government counselling providers. Three volunteer coordinators were selected from government counselling centres, while four had been obtained from the non- government organizations.

3.2 Sampling

Purposive and availability sampling techniques were employed to select the participants as well as HIV/AIDS counselling providing centers from government and non-government organizations.

3.3 Instruments

- **Questionnaire** was the primary instrument employed to gather information from the counsellors related to their knowledge and practice level of counselling skills. The first part dealt with 14 background items that except two of them all were closed and open ended as well. The counsellors were supposed to tick the alternative that fits with them and provide their own response if they did not find the appropriate choice in the questionnaire.

  The second part concerned with rating items on each types of counselling skills. Primarily, 52 items under five major headings (i.e., facilitative skills, communication skills...) were developed from different HIV/AIDS counselling Manuals. Five point rating scale were prepared for knowledge rating (i.e., 0=Do not know, 1 = Need more information, 2 = Fairly know, 3 = Know well, 4 = Know very well, while in the practice rating 0 = Not done, 1 = Need for improvement, 2 = Fairly done, 3 = Done well, 4 = Done very well). Secondly, the items were given to different individuals in order to maintain quality items. The first group of individuals who were in charge of to see these items were experts in the field of counselling and after some modifications the items were re-written and translated in to Amharic language. Then, given to language experts to check up many grammatical errors and phrasing problems. Here after some professional counsellors checked up the content parts. After having mutual communications 52 refined items were produced and became ready for pilot test.

  A pilot test was undertaken with 100 available counsellors; however, five were not fill the questionnaire properly. Participants for the pilot test were chosen directly from both institutions (i.e., government and non-government). These include 70 PMTCT counsellors, (i.e., 50 non –

government and 20 governments), 25 non-governmental home based emotional care and counselling and 5 governmental VCT counsellors. Conducting the pilot study secured both qualitative and quantitative improvements. On the qualitative part; for example, 4 most crucial items were added; long, complex, and unclear items were improved; possibility of response set were identified and five items were reversed in the final so as to mitigate, if not, eliminate such tendencies; instructions were clarified; initially knowledge and practise ratings were described separately; however, the pilot revealed that participants became bored and tired to fill two separate sheets of paper at the same time. Consequently, in the final instrument both were described separately on the separate sheets of paper and delivered at different times .In line with the quantitative improvements, items were reduced from 52 to 36 which means 16 items were eliminated through inter item-to-total correlation procedure. From each set of items specific number, of items were rejected (i.e., from facilitative skills one item, from communication skills one item, from intervention skills nine items, from termination skills two items and from follow-up skills three items). Items that were the correlation coefficient 0.30 and above were maintained to the final data gathering instruments. (Appendix –A and Appendix -B)

- **Semi-structure interview** was conducted to obtain additional data from coordinators. Initially there were eight background items and five interview items on counselling skills, and four items related concluding remarks. It was mandatory to refine and improve interview questions, as well as doing some background assignments on the interviewees to know about who were going to be interviewed. To end this objective two coordinators (i.e., one from government and the other one from non-government organization) were interviewed. On the basis of the accomplishment certain improvement were secured; for example, non-practical questions were rejected, phrasing styles were improved (e g, yes

or no closed ended response types were eliminated); three specific issues primarily non-visible but later considered as serious by the coordinators were included on the basis of their response delivery, and concluding remark questions were reduced from four to two.(Appendix - C)

- Data collection was made to maintain further information through **Focus Group Discussion.** The participants that involved in each FGD were homogeneous with common problems, which were clients received counselling services at different setting at different times. The first FGD team comprised of five members and people living with HIV/AIDS. Moreover, they received counselling from government VCTs, all of them were taking Anti Retroviral Treatment through passing adherence counselling, at A/minch hospital and even more they were receiving home- based emotional care and counselling from non – government organizations. Surprisingly, this FGD visualized comprehensive scenario about the government and non-government institutions regarding HIV /AIDS counselling processes as a whole.

  The second FGD comprised of three pregnant women passed through PMTCT counselling by the Birhan Anti AIDS counsellors and received comprehensive counselling and blood test at A/minch health centre so as to prevent the transmission of the virus from the mother to the fetus. There were certain background points to be dealt such as - HIV status, the kind of counselling service received and the centre where the service was given. Thereafter, the main point of discussion came in to view separately viewing specific aspects (i.e., facilitative issues, communication issues, intervention issues, termination and follow – up issues). In relation to the above points the most salient problems during counselling, their presumed causes and potential remedial tasks were focused paramount. Finally, credit was given for each member to say something so as to prevent HIV transmission through developing and improving HIV counselling skills. (Appendix -D)

- **Case studies** were employed to observe the issue under investigation thoroughly, and the clients were encouraged to narrate the steps and perceived counseling skills from the beginning to the end of HIV/AIDS counselling processes.

3.4 Procedures

Questionnaire was employed as main instrument to collect data from counsellors. Hence, it has gone through certain steps to secure the necessary information from the informants. The following were involved under it:

- Strong working alliance was created with each organization as a steeping stone for further relationship. At the same time the purpose of the study briefed to coordinators and consent had been secured. Moreover the discussion times were set to distribute questionnaire to the concerned participants and even more strategies how to find counsellors at ease.
- Questionnaire was distributed to counsellors at different community settings (i.e., some were at the respective kebele, while others were at their home) with the help of motor vehicle. In addition, brief orientation made on the purpose of the study and procedures to fill questionnaire. Furthermore, the date and time to return the questionnaire were determined with the participants.
- Still questionnaire was distributed to nurse counsellors at their working station with thorough discussion on the purpose and procedures to fill the questionnaire. Moreover, planning was made to collect the questionnaire back from the participants.
- Finally, incomplete and non-filled questionnaires were identified and other substituting questionnaire distributed to other counsellors with orientation and collected back at spot.

Semi -structured interview was the second device that had been utilized to obtain further information from coordinators. As what had been done in the

questionnaire case, certain steps were undertaken to gather the necessary information from coordinators that were:

- Establishing rapport with the coordinators was the first step was done.
- The interview format was delivered to the coordinators a head so as to help them get prepared to deliver reliable information and to be ready with mentally and psychologically. During this session the time and place that the interview was conducted determined. Actually, the time was working time altogether, and coordinators room was the place where the interview undertaken.
- Gathering the data was taking place staring with brief introduction of self, the organization, and job responsibility. Tape recorder was employed for all of them so as to simplify things easy for recording and analysis.

The third data-gathering tool was **Focus Group Discussion** with clients. This was performed through the following procedures:

- Five clients with homogenous characteristics (i.e., people living with HIV and receiving three different types of counselling namely VCT counselling by government and non-government counsellors, home-based counselling by non-government counsellors and ART counselling by government counsellors) were identified by the Ethiopian Orthodox Church Sunday Schools Development Co-operation. In addition, three pregnant women who passed through two types of PMTCT counselling such as home-to-home PMTCT counselling by non-government counsellors and office-based PMTCT counselling and blood test by government counsellors identified by the investigator.
- Rapport was established with the clients which was supposed to elicit more ideas during the discussion
- Planning was undertaken to determine the place, time, and procedure to collect the data. The two groups conducted their discussion at different time and place. The former one made at the EOC office, while the later one

conducted at the residence of a client. Tape recorder also utilized since it could be difficult and time consuming to note ideas that flow during the discussion.

Two volunteer clients (i.e., one who received HIV counselling from the government counselling providers, while the other one from the non-government counselling providers) were selected for **case studies**. To accomplish these tasks the following steps were gone through:

- Clients who received HIV counselling were identified through HIV counselling providers.
- Introduction with rapport establishment was made with each client.
- Permission was obtained from each client, and consent was maintained to work together.
- Planning was made on the proper time and place.
- Each client was narrating step by step what had been done during VCT session on the basis of questions forwarded by the investigator.
- Important scripts from counselling point of view were considered and recorded.

Data was analysed through the following steps:

1. Dichotomizing the knowledge scale in to two. Items that were responded as '0=Do not know, 1 = Need more information' considered as 'No' response and assigned with '0' value reffering to the absence of knowledge to the HIV/AIDS counseling skills, while items with the responses '2 = Fairly know, 3 = Know well, 4 = Know very well' understood as 'Yes' response having the coded value of '1' assuming the counselors know the requested HIV/AIDS counseling skills.

2. Dichotomizing the practice scale in to two. Counselors who chose '0 = Not done, 1 = Need for improvement' considered as 'No' answer gaining the coded value '0', and they were supposed as not practicing the noted HIV/AIDS counseling skills, whereas responses such as '2 = Fairly done, 3 = Done well, 4 = Done very well' regarded as 'Yes' given with the coded value of '1' having the idea in mind such counselors practice the specified HIV/AIDS counseling skills.
3. Raw score for every counselor for each sub-scale and for the total knowledge and practicing HIV/AIDS counseling skills were drawn.
4. The means of sub-scales for knowledge and practice dimensions were computed separately, and the mean of the total scores for both variables (knowledge and practice) also were calculated, and the sub-scale means became cut off to identify counselors with high level of knowledge and high level of practice at each category of counseling skills.
5. The number of counselors who scored above the mean for sub-scales as well as above the mean for the whole scales in the knowledge and practice dimensions was determined.
6. The mean for individuals who scored above the mean again computed for each sub-scal and to the whole scale of the knowledge and practicing of HIV/AIDS counseling skills.
7. For all the above processes as well as for further analysis such as percentage, measure of central tendencies, measure dispersion,t-test and for one way Analysis of Variance SPSS 12.00 for Windows was employed

Moreover, tables and graphs were used to depict certain findings.

CHAPTER FOUR

FINDINGS

4. 1 Demographic Data

The following two Tables describe certain background characteristics of counselor participants

Table1: Age and Sex Distributions by Type of Organization

Age	Gov't		Non-Gov't		Sex	Gov't		Non-Gov't	
	n	%	n	%		n	%	n	%
15-20	9	10.71	79	69.29	Male	36	42.86	54	47.37
21-25	19	22.62	12	10.53					
26-30	19	22.62	11	9.65	Female	48	57.14	60	52.63
31-35	19	22.43	6	5.26					
36-40	18	21.43	6	5.26	-				
Total	**84**	**100**	**114**	**100**	**-**	**84**	**100**	**114**	**100**

As it has been depicted in Table 1, the least individuals who were from the age interval 15-20 in the government counseling centers, while the reality was quite opposite in the non-government organizations.

In relation to sex distribution the female counselors were relatively exceeded the male counter parts under both organizations.

Table 2: Educational Level and Professional Backgrounds of Counselor Participants

Educational Level	Gov't		Non-gov't		Area of Profession	Gov't		Non-gov't	
	n	%	n	%		n	%	n	%
1st Degree	3	3.57	-	-	Nurses	16	19.05	1	0.88
Diploma	16	19.05	5	4.39	Health Officers	2	2.38	-	-
Certificate	12	14.20	11	9.65	Health Assistants	3	3.75	-	-
Others (i.e., grade 9-12)	53	63.10	98	85.96	Community Counselors	63	75	13	11.40
	84	**100**	**114**	**100**	Volunteers	--	-	95	83.33
					Social Workers	-	-	3	2.59
					PLWHAs	-		2	1.72
						84	**100**	**114**	**100**

As shown in Table 2, above, individuals who were from grade 9-12 (63.10%) in the government organization and (87.72%) in the non-government organization dominated HIV/AIDS counseling service providing, while the degree holders (3.57%) in the government organization, but nil in the non-government organization. Dealing about specific area of profession community counselors (75%) in the government and volunteer counselors (83.33%) in the non-government constituted the lion's share.

4. 2 Knowledge and Practice Difference

4.2.1 Knowledge Difference

The first research question expressed as: "Is there statistically significant difference between government and non-government HIV/AIDS counsellors' knowledge of HIV/AIDS counselling skills?"

The total knowledge difference between the two organizations revealed through Student t-test for the knowledge of government with the knowledge of non-

government and it was found that there was no statistically significant differences existed between HIV/AIDS counselors who were working at the two organizations since the obtained t- value =0.83 with the mean value of government and non-government counselors were 24.51 and 24.36 respectively having the standard error of the mean=0.18.

Moreover, t-test was computed for each sub-scale and revealed as follow:

Table 3: Student t-test about the Knowledge of Counseling Skills between Government and Non-government Counselors

Skills	Gov't Means	Non-gov't Means	Difference	St.error	t
Facilitative	6.50	6.00	0.50	0.73	0.68
Communicative	6.20	6.00	0.20	0.76	0.26
Interventions	5.40	5.01	0.39	0.76	0.51
Termination	1.50	1.20	0.30	0.73	0.41
Follow-up	1.02	1.50	-0.48	0.73	-0.67
	P>0.05	P>0.01			

Table 3, above, depicts there was no statistically significant difference in all category of HIV/AIDS counseling skills between government and non-government HIV/AIDS counselors.

4.2.2 Practice Difference

The second research question stated as: "Is there statistically significant difference between government and non- government HIV/AIDS counsellors in practising HIV/AIDS counselling skills?"

The total practice difference between the two organizations revealed through student t-test for the practice of government with the practice of non-government, and it was found that there was statistically significant differences between HIV/AIDS counselors who were working at the two organizations since the obtained t-value was =2.38 with the mean value of government and non-

government counselors were 22.86 and 22.48 respectively having the standard error of the mean=0.16 at two tailed α= 0.05.

Specifically, whether there was statistically significant difference or not between government and non- government counselors with regad to practicing each cluster of HIV/AIDS counseling skills.

Table 4: Student t-test about the Practice of Counseling Skills between Government and Non-government Counselors

Skills	Gov' t Mean	Non-gov't Mean	Difference	St. error	t
Facilitative	6.00	5.50	0.50	0.24	2.08*
Communicative	4.50	5.33	-0.83	0.20	-4.15**
Interventions	5.25	5.00	0.25	0.20	1.25
Termination	1.21	1.12	0.09	0.15	0.60
Follow-up	1.09	1.20	-0.11	0.17	0.65

*P<0.05 **P<0.01

As indicated in Table 4, t-test reveals that practicing of Communication skills seemed to be significantly different between the government and the non-government HIV/AIDS counselors at two tailed α =0.05 and 0.01, but Facilitative skills at two tailed α= 0.05.

The data obtained from qualitative analysis on counseling skills more importantly revealed certain realities about how far each cluster of HIV/AIDS counseling skills was being practiced by the counselors who were working at both organizations.

4.2.2.1 Facilitative Skills

Facilitative skills are the pre-conditions for successful counseling process since they are potentially dismantle the tensions, fears and misconceptions among the clients during the visit of the counselor, and also other skills have their own ground implications in the sphere of counseling. Responses from different

coordinators and clients revealed certain ideas about counselors' effectiveness in practicing facilitative skills of counseling, among that a coordinator from the government office said that:

> *I am not confident to tell you that all our counselors are lacking the facilitative skills all in all rather sometimes certain problems like apathy, anger etc may occur due to work load, role confusions etc.*

A counselor and coordinator from parent organization revealed ideas about counselors' Facilitative counseling skills with very few words as:

> *Generally, our counselors seem to be competent and confident to delivery quality HIV/AIDS counseling though I failed to tell you on which category of facilitative skills they are tougher and on which part they are less skillful.*

The third coordinator also with similar position endeavored to depict the situation as:

> *No problem with facilitative skills since utilizing these skills like greeting, using the icebreaker etc during HIV/AIDS couseling is our usual tasks.*

The Focus Group Discussion also uncovered a number of specific evidences about the Facilitative skills of counselors. From the first FGD the following scripts have been taken:

> ***A_1:*** *The man/nurse/ called my name and I entered to the room. Then, he invited me to take chair followed by requested my interest to have blood test. The sitting arrangement was face-to-face that I liked the comfort of the chair rather I didn't see any relation between the arrangements of sitting and its impact on the counselor, and on me*
>
> ***A_2:*** *MY name was called from the mates who we were sitting together in the waiting area. The counselor told me that to have a sit right in front of her.*
>
> ***A_3:*** *We were together, A2 and me. Actually, the discourse between me and the counselor was good. Primarily, I was called from the list of women and then I entered to the room:*
>
> ***Counselor: 'What all this sweating?'***
> ***A_3:*** *"I don't know! May be fear and tension!"*

Counselor: *"Calm down, please! Have a chair; this is not special for you rather it is universal. You can live whether you get positive or negative? You don't' need to worry about.*

A3: *"Ok!"*

The case study undertaken with regard to Facilitative skills revealed the following facts.

> *Very difficult to remind the existence of such skills, rather quiet easy to say no at all. For instance, the nurse counselor was seriously angry with the staff and me for unknown reason.*

The data obtained from the non-government organation concerning the Facilitative skills of counselors described as one of the c oordinator of the center as:

> ***Our counselors tend to practic Facilitative skills such as greeting and using the icebreaker since thes skills are the pre-conditions to the remaining counseling processes.***

The second coordinator from the parent organization contended about home-based care and counseling as:

> ***I am not sure to speak obout the profile of our counselors' Facilitatve skills during HIV/AIDS counseling processes.***

The following scripts considered from FGD_2 and uncover the situation as:

B3: *I have yet not observed problems on our home-based counselors rather they are even curious about their verbal and non-verbal cues. They respect mak and us all the endouvers to help us.*

B2: *With regard to Facilitatve skills, our counselors are not bad. They atemp to greet us, maintain our personal issues secrect, respect us, tell us the advantages and disadvantages of HIV/AIDS, ART, Home- based counseling etc. Really, I like their services.*

The case study conducted on a client about one of the non-government counselor indicated that:

> *The counselor greeted and invited me to have a seat. It was not bad approach rather I was impressed with his smiling, and also maintained confidentiality through coding which*

made me really confident and relaxed to narrate all my risk factors. Brief introduction about HIV/AIDS counseling and its purpose were made. Moreover, I had been told that, as it is possible to live even if I got HIV+

The qualitative data could be summarized as counselors at the government and non-government counseling centers likely to know and practice Facilitative skills such as greeting friendly, releasing clients' tension for testing, maintaining empathy, maintaining confidentiality etc. However, sometimes some counselors seemed to be become reluctant to keep clients' feelings positively like teasing, delivering counseling in the presence of colleagues etc whether due to lack of the skills or some other extra factors.

4.2.2.2 Communication Skills

Communication skills are the core for successful counseling process since they are potentially powerful to make rigorous risk assessments about the clients' life styles during the counseling relationship. Different coordinators and clients uttered a lot about them among them a coordinator and counselor from the government office said that:

In relation to communicative skills some limitations may occur due to communication barriers. For example, I would get discouraged and get in angry when clients with no information about HIV/AIDS visit me. Despite the fact that I usually endeavor to manage them. However, I don't' have any problem withregard to language since I am fluent about all the verbal and non-verbal cues of the local language.

From similar organization, a counselor and coordinator disclosed about Facilitative skills of counselors' as:

I am really interested in the task and in the profession. Secondly, friendly relationship is my typical behavior even with those of clients whom I do not know. Thirdly, the face-to-face sitting arrangement that I prefer is really making a difference in enhancing my communication with my clients. Moreover, I try to see overall clients' reactions and think aloud whether, for instance, telling a certain embarrassing event on the client affects his/her psychology or not. From the language aspect we don't have any problems. Since I am treating with those

The third research question stated as: "Is there statistically significant difference in HIV/AIDS counsellors' knowledge of HIV/AIDS counselling skills that may be attributed to variations in selection procedures?"

Table 5: One way ANOVA summary for knowledge of HIV/AIDS counseling skills that may be attributed to variations in selection procedures

Skills	Source	SS	df	MS	F
Faciilitative	Between Within Total	662.16 3064.70 3726.86	1 193 194	331.08 15.72	21.06**
Communication	Between Within Total	905.67 5420.52 6326..20	1 193 194	452.84 27.80	16..29**
Intervention	Between Within Total	631.86 3421.41 4053.27	1 193 194	215.93 25.80	8.37**
Termination	Between Within Total	23.25 505.41 528.66	1 193 194	11.63 2.59	4.49**
Follow-up	Between Within Total	26.30 335.69 365.01	1 193 194	13.16 1.72	7.65**

**P<0.01

Table 5, in the above summarizes variations in the independent variable (i.e., Selection Procedures) resulted in statistically significant deference on knowing all kind of HIV/AIDS counseling skills at two tailed α =0.05 and 0.01.

The mean comparisons revealed that the mean knowledge of HIV/AIDS counslors who had been selected by coordinators surpassed those of voluntary counselors on all categories of counseling skills. (i.e., facilitative, communicative, intervention, termination and follow-up skills).

The fourth research question described as: "Is there statistically significant difference among HIV/AIDS counsellors' practicing HIV/AIDS counselling skills that may be attributed to variations to selection procedures?"

Table 6: One Way ANOVA summary for practicing HIV/AIDS counseling skills that may be attributed to variations in selection procedures

Skills	Source	SS	df	Ms	F
Facilitative	Between Within Total	933.60 2042.74 2976.34	1 193 194	466.80 10.48	44.54**
Communication	Between Within Total	1143.21 3694.61 4837.82	1 193 194	571.60 18.95	30.16**
Intervention	Between Within Total	881.38 1789.68 2671.06	1 193 194	340.69 19.43	17.51**
Termination	Between Within Total	35.75 243.59 279.35	1 193 194	17.88 1.19	15.03**
Follow-up	Between Within Total	38.97 279.87 318.84	1 193 194	19.48 1.44	13.53**

**P<0.01

As in Table 6 above, Variations in the selection procedures resulted in statistically significant difference in practicing all types of counseling skills at two tailed α= 0.05 and 0.01.

The mean comparisons indicated that HIV/AIDS counslors who had been nominated by coordinators were more likely practice HIV/AIDS counseling skills than those of voluntary counselors on all cluster of counseling skills. (i.e., facilitative, communicative, intervention, termination and follow-up skills).

Furthermore, data obtained through questionnaire and interview revealed the selection procedures of HIV/AIDS counselors were influenced HIV/AIDS

counselors counseling skills. For instance, a nurse counselor and coordinator from government hospital contended the following ideas:

> *Selection was made through assignment to be HIV/AIDS counselor by the officer (i.e., the medical Doctor) since I speak the local language very well*

Another counselor and coordinator from family institution responded as:

> *I was the available person while the health center in need of voluntary counselor*

Further, a nurse who has dual responsibilities said that:

> *Morally good, committed and motivated prospective nurses are getting in the eyes of the management committee and trapped in to the service.*

Even more, further exclusively coordinating body from similar category of organization clarified about the strategies of counselors' selection as:

> *The trend that we have in selecting HIV/AIDS counselors the management is in charge of recruiting female nurses primarily since the women are highly vulnerable groups and therefore they may be passionate about the service and female clients.*

In the contrary, counselors who were working in the non-government organizations still claimed about selection procedures of counselors. The following quotes may reflect. A top project coordinator from one of the non-government institutions contended that:

> *The management committee of this organization on primarily decides individuals on the basis of the service that they delivery in church. The trainees supposed to be dedicated, honest and sociable to be spotted by the committee followed by they would be told whether they are volunteer to work as a counselor or not. Hereafter, they are expected to receive counseling training for at least 15 days whenever possibly through reaching at mutual agreement often for the forth coming responsibilities.*

Another exclusively vice coordinator among one of the non-government organizations and also other main coordinator from the family organization explained relatively similar ideas one to each other as:

> *The direct contact through letter and physical communication that we have with the church, Idir, clubs and/or the kebeles*

facilitate situations so as to find motivated, dedicated, with free – time to help others and volunteer counselors. Consequently, on the basis of the selection made by such institutions, our organization includes those candidates with the existing counselors

The government organizations most frequently seemed to select HIV/AIDS counselors through assignment by the coordinators and some times available and dedicated Nurses or Health assistants were picked and nominated as HIV counselors, while in the non-government offices the reality somewhat different. The management committee was duly engaged to identify interested, dedicated, and individual with available leisure time through decentralizing power even to the kebele and church level.

The fifth research questions stated as: "Is there statistically significant difference among HIV/AIDS counsellors' knowledge of HIV/AIDS counselling skills that may be attributed to variations in duration of training?"

Table 7: One way ANOVA summary for knowledge of HIV/AIDS counseling skills that may be attributed to variations in duration of training

Skills	Source	SS	df	MS	F
Facilitative	Between	648.68	1	324.34	20.54**
	Within	3078.19	196	15.79	
	Total	3726.87	197		
Communication	Between	747.07	1	373.53	13.06**
	Within	5579.13	196	28.61	
	Total	6326.20	197		
Intervention	Between	456.92	1	228.46	7.96**
	Within	3596.35	196	28.70	
	Total	4053.27	197		
Termination	Between	21.65	1	10.83	4.17**
	Within	507.01	196	2.60	
	Total	528.66	197		
Follow-up	Between	23.38	1	11.69	6.72**
	Within	338.63	196	1.74	
	Total	362.01	197		

* *P<0.01

The above, Table 7, shows changes in the independent variable (i.e., Duration of Training) had statistically significant impacts on the knowledge of all HIV/AIDS counseling skills among HIV/AIDS counselors at two tailed α= 0.05 and 0.01.

The mean values of each cluster of counseling skills disclosed that counselors who had been trained for more than a month (i.e., from one month to four months) seemed to have relatively better level of knowledge on Facilitatve, Communication, Intervention and Follow-up counseling skills than counselors who had been trained for less than a month, while counselors who had been trained for less than a month likely exceded counselors who had been trained for more than a month in Termination counseling skills.

The sixth research questions revealed as: " Is there statistically significant difference among HIV/AIDS counsellors' practicing HIV/AIDS counselling skills that may be attributed to variations in duration of training?"

Table 8: One way ANOVA summary for practicing HIV/AIDS counseling skills that may be attributed to variations in duration of training

Skills	Source	SS	df	Ms	F
Facilitative	Between Within Total	926.93 2049.40 2976.34	1 196 197	463.47 10.51	44.10**
Communication	Between Within Total	1163.65 3674.17 4837.82	1 196 197	581.82 18.84	30.88**
Intervention	Between Within Total	860.49 1810.57 2671.06	1 196 197	330.24 19.54	16.90**
Termination	Between Within Total	35.41 243.93 279.35	1 196 197	17.71 1.25	14.17**
Follow-up	Between Within Total	36.92 281.92 318.84	1 196 197	18.46 1.47	12.56**

**P<0.01

Table 8 shows that changes in the duration of training resulted in statistically significant difference among all HIV/AIDS counselors with regard to practicing all category of counseling skills at two tailed $\alpha = 0.05$ and 0.01.

The mean values of each category of counseling skills showed that counselors who had been trained for less than a month more likely practice Communication and Intervention counseling skills than counselors who had been trained for more than a month (i.e., from one month to four months), while counselors who had been trained for more than a month seemed to practice Facilitative, Termination and Follow-up counseling skills better than counselors who had been trained for less than a month.

Moreover, the data obtained through questionnaire and interview revealed that all counselors received training on counseling regardless of the duration time that each of them attended. A nurse counselor and coordinator from government hospital contended the following ideas:

> *The training was given for 20 days in Addis, which means two years ago in 1996 on voluntary Testing and Counseling. The contents treated during the training were the skills required for counseling, problems that occur during counseling process, strategies how to handle such problems and further specific issues. The trainers were senior counselors (i.e., Doctors) who were from ", Torr Hiloch". The typical manual was prepared by Ministry of Health, which is known as the Quick Reference Card.*
>
> *No continuous training since after the initial training (i.e., 1996) undertaken Even more, we have hardly been supervised in relation to practicing the technical skills of counseling protocol properly or not through visiting sessions so as to make any critical investigations on the counselors' part.*

Another counselor and coordinator from family institution responded as:

> *I have been given training two years ago for 15 days. The topics that were treated:*
>
> - *Pre-test counseling, post-test counseling and on going counseling (i.e., follow-up counseling)*

- *Psychosocial problems identification with regard to establishing remedial actions through effective communication.*

The Doctors were using, and referred us to use the manual known as 'Quick Reference Card that was published by Ethiopian Ministry of Health.

No single in-service workshop and/or experience sharing has been undertaken since our initial training and also no supervision at all.

Further counselor and coordinator revealed that:

Despite the fact that new counselors immediately get recruitment and training could be offered for at least 15 days in Addis or in the regional town Awassa. However, continuous capacity building and supervision were absolutely non-existent.

Even more, further exclusively coordinating body from similar category of organization clarified about the access of training and other related issues as:

Training has been conducted twice or trice on counseling process though I am not confident to tell you which area of counseling skills has been focused. The Doctors and M.Sc holders were the salient professionals who were in charge of to undertake any training, related to HIV counseling. We have the manual also that we use it as a guideline; however, I am afraid to tell you its name since it is with the counselors. Finally I would like to inform you that we have no experience to supervise our counselors' technical skills.

In the contrary, counselors who were working in the non-government organizations still possessed training on counseling in general and on counseling skills specifically. The following quotes may reflect. A top coordinator from one of the non-government institutions contended that:

Counselors are expected to receive training for at least 15 days whenever possibly through reaching at mutual agreement often for the forth coming responsibilities. You have asked me the specific focus areas of counseling skills during training that I may have little idea on it rather you had better to ask other experts in the office. In relation to the professionals who frequently conduct

HIV counseling goes to Doctors followed by Community Health Workers and Health officers. We have two counseling manuals in response to your question related to manual. The first is 'HIV/AIDS Counseling Training Guidelines'; while the second one is 'Junior HIV Counselors Service Guidelines'. Both of them published by Ethiopian Orthodox Church Christian Development Cooperation.

Another exclusively vice coordinator among one of the non-government organizations and also other main coordinator from the family organization explained relatively similar ideas one to each other as:

For any type of counseling the organization delivers initial training for not more than 15 days by different professionals such as Doctors, Health Officers, Nurses, and Social workers respectively focusing on the general nature of HIV counseling including counseling skills; however, we are not able to identify which skills stressed more, and which one is less.

The counseling manual that still we use and the counselor were being trained named as 'HIV Counseling Service Guideline for People Living with HIV and AIDS Patients; which was published by OSSA, and 'Home based Counseling Service' Produced by Ethiopian Evangelical Church. Continuous capacity building not been undertaken due to budget constraints. Regular supervision through checklist hardly performed in our organization due to many of our home based caregivers and counselors are volunteers, the client feels insecure to tell risk factors openly and also we may violate the ethical code of confidentiality.

In addition another coordinator who has strong linkage with the youngster's group conveyed the experiences that his association developed and practicing as:

No specific individuals who have been trained solely in counseling rather we all have been trained as family planning educators, coordinator of the youth group, and counselors (i.e., from mother –to-child, prevention and referring tough cases for OSSA with a slip of CARD for detailed counseling and testing. Inspite The topic of training determines the one who deserves the training. The committee determines new individuals, at ease having the motivation, sociability and committeement as prerequisites requirements.

Continuous capacity building is not the unusual task to our team members. We would like to appreciate different organizations such as Organization for Social Service Agency, South West Synods and the German Population Fund (DSW).

In relation to regular supervision we have no culture to observe technical skills of counselors', rather intermittently, we prefer to use peer counselors to reconsider what each of them did previously one to each

Initial training on the processes, problems and techniques of counseling were secure in both organizations. However, continuous refreshment trainings and regular supervisions on the technical aspects of HIV counselors' counseling skills were almost non –existent under both organizations.

4.3 Related Aspects of HIV/AIDS Counseling Skills

This section contains the analysis of data obtained through interview from the coordinators, and Focus Group Discussion with the clients. Getting competent and skillful is not only fixed into implementing counseling skills but also in any sort of procedure may be a function of numerous variables among which the following are the major ones.

The seventh research question disclosed as:"Do government and non-government HIV/AIDS counselling providing centres differ in relation to availability, accessibility, privacy, and physical arrangements of HIV/AIDS counsellingoffices?

4.3.1 Physical Facilities

The availability, accessibility, privacy, organization of counseling office and qualities of waiting are the integral and determinant factors to conduct effective counseling session. It is up to the counselors' attempt and skill to suggest at least, if not, to find the proper office that naturally suits for successful counseling. One can reconize the following realties in relation to the office. A nurse counselor and coordinator among one of the government institutions

described the above features like accessibility and privacy of the office as in the following manner:

> *I don't think the office was private and that reinforces to maintain confidentiality. Integrating OPD patients with HIV clients believed to be proper by the Management Committee of the Hospital due to lack of extra rooms. In relation to accessibility we have no problem since we have guest reception center at the information desk right to the left of main gate and even more direction indicators that may assist new comers to find the center easily. The waiting area that we have has dual purposes; the clients stay with individuals who come for other opportunistic disease treatments. Moreover, the waiting area as well as the counseling room seem to be well furnished and equipped with resources including chairs, tables, shelves, different electronics such as tape player, TV, video etc. Thanks for FHI and World Visions.*

The second coordinator also attempted to visualize the counseling room in such away that:

> *We have two separate rooms with some of the necessary facilities like chairs tables and shelves. The first one exclusively for Voluntary Testing and Counseling, while the second one belongs to counseling pregnant women though the former one is narrow, but privately situated. Beneficiaries could identify easily since it has been located in the front side of the blocks even though information centers are non-existence. However, I am afraid to tell you that the waiting area is like of the room separate and well furnished rather we have aggressive flow of clients the existing resources, are not enough to accommodate them.*

The other counselor and officer from similar category of organization reflected the scenario related to office as:

> *This office and the waiting area have double purposes for OPD and VCT as well due to the dearth of free rooms. Actually, it is I to do all. I am sure you are looking service seekers whether for OPD and/or VCT outside the corridor as well as inside in the office. Consequently, dealing about privacy unthinkable, and less practical. In relation to chairs, tables, and shelves we have no problem rather we need ventilation, TV, tape recorder, video etc.*

A Focus Group Discussion Conducted by PLWHAs clearly reflected the non-existence of private rooms for HIV/AIDS counseling. For instance, a man from FGD_2 uttered that:

B_1: *The counseling center that I received counseling was really narrow and located at the rear side of the other rooms. People who were coming for another investigation get the service there, which I was felt discomfort.*

B_3: *The room was not private and easily accessible particularly for individuals who have little ideas about the hospital.*

Focus group discussion conducted by pregnant women also confirmed the two cases as:

A_1 + A_2: *Actually the room was not difficult to identify rather it is at the front block of the rooms. You could find it easily coming through from out side to the station. I like its privacy; we were pregnant women only on the bench waiting for counseling and blood testing. Though the privacy was secured, the room again needs further space to avail chairs, tables and benches. Some of us exhausted due to standing for long period of time.*

A_3: *Really, I was not satisfied with some of the things there. For example, a number of other colleague nurses were in the room simultaneously with me, which made me feel insecure to narrate all the risk behaviors and also I was not confident about how for my private issues could be confidential.*

A_1 + A_2: *The government should try to furnish the counseling room or the center should tell us to take chairs from our home.*

A_3: *Quite unrealistic and embarrassing, think of please service seekers who are from distant areas.*

A case study on a 30-year-old client that was obtained counseling service at the government-counseling center reflected the reality as:

It was in the Hospital that I had been forced to get HIV blood test by the medical staff in order to obtain further examination on my pneumonia case. However, the office was not private, and accessible rather it was integrated with OPD room. Moreover, the room was furnished with two chairs and a table as the table was the demarcation in between us and rendered the counselor to note few points about me.

The third counselor and coordinator also from similar category of organizations and came up with quiet opposite ideas, and narrated the general situations in relation to counseling office as:

> *I am confident to tell you that the counseling room has its own block line with separate waiting areas and sitting benches, relatively calm and free from any destruction, separate from other OPD rooms at the rear side of other blocks that encourages clients to come to the center. More over, they get access to the service without any difficulties. We have direction indicators beginning from out side the gate to the counseling office; educated clients may easily identify the center. Further, there is information desk that every new comer asks any idea at the front gate. However, we have newly started service PMTCT counseling and testing), which has yet not been acquitted with special room rather we are trying to integrate the service with VCT since both relatively involve similar process and/or skills. The point in case I would like to mention as a threat is the room actually narrow that may be difficult to add even more facilities as well as the requirement of more important resources like TV, tape recorder and audiovisuals so as to educate individuals who are coming for medical examination.*

On the other side the non-government organizations still are engaged at HIV /AIDS counseling. The coordinator reflected the scenario may differently among them the only who conduct VCT and home-based counseling described as:

> *In relation to privacy as you see we have no problem. There are rooms at the rear side of this office. The main office also is not difficulty to find rather it is accessible for every body that wants to get blood test and counseling since it is adjacent to the main street. We have an advert also on the gate, which might have critical importance to identify the office as well as the kind of service that we pursue.*

A young coordinator to the youth group disclosed that:

> *We have three separate offices. The one that located at Sikela is private, accessible and suitable for counseling; however, the two are not as such valuable. You can see in front, the bus station where you can find a great number of people that are capable of destructing our work, and at the back the main street you can hear of different sounds such as motor vehicles, and human beings as well. The one that located at Secha also has similar characteristic.*

The third individual also from similar category of organization reflected that:

> *I have no problem in terms of accessing and maintaining the privacy of counseling. Look this way; it has been prepared right for clients so as to come through towards me without any social and/or psychological destruction. Actually, I feel that I should hang on an advert at the gate. However, clients frequently are required to ask the guard to find my office, which might be challenging to them.*

A case study conducted on 18 years client who got HIV counseling at the non-government institute disclosed relatively similar idea with the above individuals as:

> *Generally, the office that I received counseling was not secured rather you could see different destructions such as social (i.e., individuals such as students and other people were moving around there). Physical noises like the sound of vehicles were pertinent due to the location of the office right adjacent to the main street. However, the counseling room specifically sited back to the general room, which might be considered as private. Resources like chairs, tables, ventilation etc seemed to be available even to the waiting area.*

The other coordinator from the colleague organization who exclusively works on home-based counseling attempted to state the situation quiet differently:

> *No counseling office with all facilities since we have serious budget deficit. Furthermore, we priorities supporting people living with the virus with the existing meager budget in order to secure economic self-reliance instead of organizing counseling office.*

The Focus Group Discussion also revealed consistent ideas about the privacy and accessibility of non-government counseling offices. For instance, FGD_1 showed that:

> ***A_2 + A_3:*** *We obtained information about PMTCT primarily from our village dwellers, while later Miss 'Y' and 'Z', the two high school students who were responsible to sensitize, orient and conduct counseling services of pregnant mothers so as to get blood test and counseling. Consequently, our home – was our office so we couldn't say anything about accessibility and privacy of counseling office.*

Participants from the second Focus Group Discussion also contributed some ideas with regard to the above idea:

B3: *Despite the fact that we are the regular beneficiaries of this organization; however, we have yet not treated (counseled) in any specialized counseling office. This is not an office for counselors' rather it belongs to the project officers. In any way there is no fixed counseling office rather the office for counselors exists at the home of each client.*

B2: *I know an organization that works on home-based care and counseling. It has no organized office rather the counselors utilize one of the room from symmetry buildings in the church compound. Imagine how far could it be logical to discuss about such hidden issues like sex and sexual behaviors in the area of worshiping and praying?*

B1: *Actually I have been there twice or trice before visiting this organization. The office a little bit non-accessible particularly for new comers since there was no advert at the main gate; however, it has structured for privately for counselor-client relationship, nothing can be done in the office except undertaking counseling process. Moreover, the counselors are very tough, diligent and well planned. They are trying to manage clients in relation to setting convenient time that is suitable for them and the clients. They are volunteers who have their own occupation and the clients too. As a result, I would like to appreciate them how they are really active to pursue all these things through mutual communication.*

The investigation made through different methods evidently indicated that HIV /AIDS counseling offices under both organizations relatively seemed meagerly possessed with fundamental guidlines of counseling such as making counseling offices available, private, conveniente, accessible to the clients ; separating the waiting areas from the counseling rooms; equipping the the counseling room as well as the waiting area with mandatory faciliites etc. For example, the perceived realities refelect that HIV clients and patients for other opportunistic diseases wait for examination in the same area in the government counseling centers, which might potentially, inflict the principle of confidentiality. Furthermore, waiting areas were almost absent in the non-government counseling centers, and even the centers had not structured formally,

equipped, and capable of accommodating more than two clients to conduct group counseling. Despite the fact that no body gets confused to find counseling offices since direction indicators and notice boards were available at different sites and even the Information Desk at the government centers served this way.

4.3.2 Physical Arrangements

Furthermore, government and non-government counselling providers compared whether they differ in terms of office arrangements to conduct successful HIV/AIDS counselling.

Proximics and sitting arrangements are the points need to be dealt as the most important factors as a counselor, as a coordinator and/or a client to consider and make proper organizations and improvements in order to conduct successful counseling. The government organizations and the non-government counselors may prefer to employ similar or different style of sitting arrangements and/or distance between the counselor and the client during the counseling processes. The following sections may help to visualize the conditions in relation to the two organizations. A counselor and a coordinator of certain VCT center strove to depict the style of sitting and the gap between her and the clients as:

> *I frequently prefer to employ face-to-face (i.e., 90^0) with around 70-100 cm gap so as to encourage clients' free expressions of his/her true inner self and also in order to accelerate the development of fraternal relationship between him/her and me. Moreover, I usually wear this white gown during counseling service that I didn't consider its effect on my clients*

The other counselor and section coordinator and also the other executive coordinator share relatively similar ideas about proximics and sitting arrangements that can be described as:

> *Face-to-face is appropriate to many counselors, as they have been trained in to facilitate conditions for effective risk assessment, risk identification and manage them effectively. Unless you look in into the*

eyes of the client's directly, you may stare up on any other irrelevant objects in the room; for example, on the wall or through the window that may potentially damage your relationship with the client, and ends up with becoming non-volunteer to get blood test or not endorsing the result.

The point in case also visualized by one of the counselor and coordinator from the parent organization as:

Face-to-face counseling that I usually perform so as to help the client to think as the counselor is reading what all inside of him/her, which in turn, releases all facts related to risk factors. Secondly, the sitting itself an indicative of empathy.

The method of Focus Group Discussion even more fertilized the ideas considered by coordinators. The following scripts directly taken from FGD_1:

A_1: *We were sitting on similar chairs with no table in between us. He was looking at my forehead and asking me all about my life styles and my husband. In fact, I told him all the things genuinely.*

A_2: *I had been invited to have a sit, and I was terrified to take chair straightforward with the counselor with no demarcation in between us; however, gradually the sweating, the heartbeat, and all confusions bit by bit gone. We were dealing with a number of personal issues she was asking me and I respond, she was telling me and I accept the realities, sometimes and reject on another time and so on... It was good.*

Focus Group Discussion Two also refelected some hints about the issue raised under FGD_1 as:

B_1: *Whatever table exists in between the counselor and I, and he wore white Gown; we were communicating freely face-to-face. It was my problem so I should tell him and release whatever I feel inside to get physical and psychological lull.*

B_2+B_5: *We were communicating very friendly during the session. The chairs arranged in such away that suitable for singletons and couples.*

The case study also seemed to reveal the fact consistently.

The counselor and I were seated face-to- face with certain centimeter distance between us with out any table demarcation in between us.

The extent of office-based counseling seemed to be rare with in the non-government counseling providers rather home-based care giving and counseling were eminent. Despite the fact that some arrangements and degree of contacts were still mandatory to happen. The coordinator of certain Anti-AIDS Association depicted the realties in relation to his association as:

> *Face-to-face or 90^0 having 80-100 cm physical distance between the counselor and the client is our favorite sitting arrangement to establish strong relations between the two colleagues, and to make effective diagnosis about clients' risk factors.*

The consistent information obtained from the case study as:

> *We were sitting face-to-face with no boundary in between us at all.*

The second individual who exclusively focused on home-based care and counseling uncovered the facts as:

> *The physical distance couldn't be expressed in terms of centimeter or millimeter rather the actual touch involved in the caring processes, and the emotional gap also can be described and seen in terms of the counselor's true feeling and interest to visit and care people living with the virus via rounding one by one at the residence of each patient.*

In the Focus Group Discussion participants also communicated about proximics and sitting arrangement. In the first FGD all the three expressed relatively similar ideas:

> ***A_1+A_2+A_3:*** *The counselor (i.e., the two high school students) who were the members of A/MINCH Anti-AIDS Association visited our home and delivered us information and how to seek for PMTCT Counseling and Testing. We didn't see any special style of clothing, speech and sitting arrangements that was different from our life styles and/or educational level.*

Participants in the second FGD also confirmed that the existence of reasonable physical as well as psychological relationship as:

> ***B_1:*** *when I discontinued using ART drug, a counselor found my home through asking people. I was amazed whether how and why he did come to my home! To mean, counselors are so passionate to feel our problems with a great loss of energy,*

time, money, etc; however, sometimes we (i.e., people living with the virus) make things mess that may potentially inflict our relationship with our community.

Solely a counselor's and another coordinator's interview responses from the same category of organization, but undertaken home-based care and counseling as well as office-based counseling revealed that:

This is the room that we conduct office based-counseling. We are feeling shame because no proper chair, table, shelves, ventilation, and even the wall is not painted very well. The sitting arrangement and the physical distance between our counselors and the clients may be variable, some prefer face-to-face with approximately 100cm, while others prefer to employ the forty-five degree in order to prevent onself and the client from contagious diseases, and to avoid physical attractions.

The most preferred sitting arrangement was face-to-face at the government and non-government HIV/AIDS counseling centers, which might be thought that the counselor makes attempt to see the clients' problem from the clients' point of view, and also risk assessment becomes much easier than the other arrangements. However, in some non-government counseling centers slightly 45° sitting arrangement were employed.

CHAPTER FIVE
DISCUSSION

This section focuses on the major findings against basic questions and other related literatures. Furthermore, justifications for any contradictory result were averred.

5.1 Differences among Para-counselors in the two types of institutions

The primary issue was related to whether there were statistically significant differences between counselors who were working at the government and non-government organizations in relation to their knowledge and practice of HIV/AIDS counseling skills. As the findings confirmed that there was no statistically significant variation was found between the government and non-government HIV/AIDS counselors with regard to knowledge of counseling skills though significant difference was eminent in practicing the counseling skills at two tailed α =0.05. However, from the mean comparisons made on the two variables, (i.e., knowledge and practice), the counsrelors from the government organization relatively tended to be more knowledgeable and practice oriented than the non-government counselors. This difference primarily might be due to the professional contributions of the counselors, which mean around 21 of government counselors contained under Nurses, Health Officers and Health Assistants that supposed to possess relatively tough interpersonal relationship skills, while just only a nurse counselor was identified from the non-government counselors. Secondly, the extent of contacts with clients and/or other patients probably resulted the government counselors to be even more knowledgeable and practical than their counter parts. The other point, as had been discussed in the Focus Group Discussion, the non-government counselors more likely focused on resource management like money and assisting PLWHAs

to be self-reliant in economically than engaging at helping client with emotional support.

The observation made on the sub-category HIV/AIDS counseling skills regarding the knowledge and practice dimensions uncovered that the government and non-government counseling providers were not significantly different with the knowledge of all sub-classes of counseling skills at two tailed α =0.01 and 0.05, but significantely differed with the practice of Communication skills at two tailed α 0.05 and 0.01, and Facilitative skills at two tailed α= 0.05.

Rohleder and Swartz (2005) disclosed the existence of difference between the government and non-government counselors in line with respecting and practicing counseling processes very well due to the existence of plain working environment as natural experiences of non-government organizations, where as the government organization possessed quite contradictory realities. A little bit similar statement but through slanting direction Ginwalla et al., (2002) revealed that nurse counselors possessed better communication skills than community volunteers that might be due to the nurse counseling providers dealt with fewer clients than the community volunteers since they have been occupied with further responsibilities in the office. Secondly, the community volunteers, who were less educated and unable to comprehend trainings that were conducted through non-vernacular languages, which likely caused in to low-level of skills development.

5.2 The Role of Selection Procedures in Making Differences among Para-Counselors

The analysis of variance also specifically rendered to observe selection procedures whether had significant impacts on knowing and practicing counseling skills among HIV/AIDS counselors. The investigation uncovered that selection procedures effected statistically salient differences on the

knowledge and practicing of all kinds of counseling skills (i.e., facilitative, communication, intervention, termination and follow-up skills) at two tailed α=0.05 and 0.01.From the mean comparison, counselors who have been recruited through coordinators or the head of the office, Idir, Church, Kebele revealed better knowledge of HIV/AIDS counseling skills and seemed to implement them very well. It might be asserted, as the coordinators were cognizant with individuals who were actively dedicated to know the skills as well as to practice them very well. Moreover, the selection procedures in many of counseling providers based on the commitment, interest, and relative academic background of the clients. The management committee at the office level and different social groups with in the community were the responsible parties to know and recurite delingent and hard working counselors. Thirdly, it could be claimed as counselors problably considered themselves as individuals who were bearing the responsibilities in this regard, and therefore, who seemed to show endeavors to know and practice these skills very well.

5.3 The Role of Duration of Training in Making Differences among Para-Counselors

One way ANOVA clearly revealed that the existence of real knowledge and practice difference among HIV/AIDS counselors due to variation in duration of training at two tailed α=0.05 and 0.01 on all cluster of HIV/AIDS counseling skills. Moreover, the mean comparisons indicated that ounselors who received trainings for more than a month revealed permissible knowledge on Facilitative, Communication, Intervention and Follow-up counseling skills, while counselors who received trainings for less than a month likely to gain better knowledge on Termination counseling skills. With regard to practicing counseling skills, counselors who got trainings for less than a month seemed to impliment Communication and Intervention skills better than their counter parts, whereas counselors who obtained trainings for more than a month seemed to practice Facilitatve, Termination and Follow-up counseling skills. This may be contended as the training probably bolstered the knowledge and practice

behaviors of the counselors. However, the paradox, counselor who had been trained for less than a month revealed better knowledge on Termination skills and tended to practice Communication and Intervention skills better than counselors trained for more than a month. Consequently, this finding probably gives homework for those of organizations working at HIV/AIDS counseling and engaged at recuriting counselors to end their puroposes as critical investigations on the counselors' competencies; personalities, academic background, experinces etc may become the corner stone to attain the wanted goal.

Some previous findings confirmed with the above findings. (UNAIDS, 2000; Miller quoted by WHO and UK Government, 1988; Campbell and Williams cited in Brugha, 1999; CDC, 2001; Golin et al., 2004). Some literatures even more refer to acquaint HIV/AIDS counselors not only with continuous training, but also with psychological, social as well as financial supports. (Rohleder and Swartz, 2005; Canadian International Development Agency, 2001). Further more, counselors who have been supervised regularly likely to possess positive knowledge and practice effectivcly; which may reveal supervision has cogent effect in the acquisition as well as practicing counseling skills properly. Actually, Family Health International (2001) and UNAIDS (2000) claimed about the necessity of regular supervision so as to investigate any progress and/or barren the limitations.

5.4 Pre-requisites for HIV/AIDS Counseling

The data obtained and examined through qualitative approaches rendered to investigate some of the issues once again. Among which availability of physical facilities, arrangements and proximics were the salient elements need to be properly tailored in such a way to effect the desired ends. With reference to the investigation made, both organizations probably missed some qualities. For example, dearth of commodious and private counseling offices and waiting areas were prevalent. However, non-existence of counseling offices with all

facilities, even the existing non-furnished rooms were less likely accessible to the new visitors were the typical characteristics of non-government counseling centers, whereas absence of convenient time to different clients to provide the service became the visible impediment in the government organizations. Several previously conducted literatures confirmed that counseling should be undertaken in reasonably organized and private areas. (Baggaley et al., 1998; Jackson quoted by Brugha, 1994; Arthur, 1999; UNAIDS, 2000; Federal Ministry of Health, 2003).

The physical distances also incredibly significant so as to enhance and build positive relationship between the counselor and the client, and even to canvass intervention mechanisms effectively. Consequently, the most preferred sitting arrangement that was utilized by the two-organization face-to face, which was assumed to decree establishment of empathic understanding of the client and to address the assessment of risk behaviors successfully. Although the style of sitting has its own merits, it has imbroglio. For instance, what ever the counselors' attempts to be ethical and dedicated to his/her profession, the sitting style may potentially divert the attention of the counselor or the client since there is a probability of coming with bare body with some parts. Secondly, contagious diseases like TB can easily transmit from one to the other through direct entry to the respiratory organ of the client or the counselor. However, on some occasions in the middle of sessions some clients may reflect unusual behaviors such as negative transference, including physical movement like stretching fists and knocking and/or banging the counselor etc. Imagine in such cases face-to-face sitting probably exposes the counselor and victimize him/her to physical attacks. As a result, choosing the best suited sitting arrangement that enhance risk assessment and secures empathy become the corner stone to all counseling situation.

CHAPTER 6

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Summary

The objective of the study was to examine whether there were differences between government and non-government HIV/AIDS counselors regarding their knowledge and practice of HIV/AIDS counseling skills. To end these objectives purposive and availability sampling techniques were employed to select research participants (i.e., counselors, clients and coordinators). Four different instruments namely questionnaire, interview, FGDs, and case studies were used to collect information. Data was analyzed through t-test, one-way ANOVA and descriptive statistics. The findings revealed that there was no significant difference between government and non-government HIV/AIDS counselors in relation to knowing counseling skills. However, on the practice dimension counselors from both organizations were significantly different. Furthermore, training for sufficient period of time was found to be helpful to gain and practice counseling skills effectively. In addition, counselors who had been nominated by coordinators tended to practice counseling skills effectively than voluntarly engaged counselors. Generally, with regard to counseling skills, physical facilitates and pre-requisites for counseling processes; for example; availability, accessibility, privacy of counseling office and waiting areas etc were poorly existed at both organizations particularly the non-government counseling centers were suffering from them. As a result, both, government and non-government HIV/AIDS counseling providers need to be active in developing fundamental counseling skills among HIV/AIDS counselors as well as should be practical in relation to furnishing counseling contexts with all conducive physical, social and psychological aspects so as to conduct effective (quality) HIV/AIDS counseling, which in turn, to prevent and control the spread of the disease.

6.2 Conclusions

Based on the results of the study, the following conclusions were made:

- Althogh there was no statistically significant difference between government and non-government HIV/AIDS counselors in relation to the knowledge of HIV/AIDS counseling skills, there was slight variation between the counselors who were working at the two organizations.
- There was statistically significant difference between government and non-government HIV/AIDS counselors in relation to practicing HIV/AIDS counseling skills.
- Changes in selection procedures likely affected the knowledge and practice of HIV/AIDS counseling skills among HIV/AIDS counselors. Counselors who had been nominated by coordinators seemed to reveal better level of knowledge and practicing HIV/AIDS counseling skills than volunteer counselors.
- Variation in duration of training seemed to have impacts on the knowledge and practice of HIV/AIDS counseling skills among HIV/AIDS counselors. Counselors who had been trained for relatively long period of time seemed to gain and implement HIV/AIDS counseling skills better than those who had been trained for short period of time
- The pre-requisites for effective HIV/AIDS counseling processes such as the physical facilitates, privacy, availability, accessibility of counseling offices and waiting areas were poorly existed in the government and non-government HIV/AIDS counseling centers particularly the non-government counseling centers were suffering from it even a number of them had no HIV/AIDS counseling offices.
- Proximics (i.e., physical distance between the counselor and client) was 80-100 cm considered as reasonable. Moreover, face-to-face sitting arrangement typically employed in almost all office counseling

providers under both organizations, while only two (i.e., one from government and the other, from non-government) who preferred 45^0 sitting arrangement were identified. The former preferred in order to create empathy, and to assess individuals risk factors thoroughly, whereas the later one chosen just to cover the bottom part of client's as well as counselor'sbody with table boundary, to mitigate if not, get rid off the spatial transmission of contagious diseases.

- In the non-government organization counselors more frequently focused on helping client's how to manage money instead of delivering emotional support.

6.3 Recommendations

In these section things to be done so as to improve HIV/AIDS counseling at both organizations or at one of them was stated. Much expectation is valuable from different concerned individuals such as the counselors, clients, coordinators, donor agencies and/or the community at large. The following are basically certain recommendations made in such away that concerned individuals to put on action:

- Government and non-government HIV/AIDS counseling providers should strive to conduct standardized HIV/AIDS counseling services through enhancing counseling competencies among their counselors.
- Demographic variables and other factors such as educational level of counselors, competencies of trainers, selection procedure, regular training and regular supervision have their own impacts on the counselors' knowledge and practice of counseling skills. Consequently, selection of counselors, training and assigning needs critical investigations and all the tasks need to be tailored in such away that fitting the gaps that occur due to miss-nomination and/or other factors.
- In the non-government organizations counselors as counselors need to prioritize emotional support followed by other related tasks.
- The physical facilities such as private offices, writing areas, accessibility, convenience and also other resources like tables, chairs shelves, Video,

Tape recorder etc should be made available whether from any source, fund and/or from the community.

- Counseling as a profession and counselors as professionals need to have formal administrative structures in the health system of the state.
- Professionals should be equipped with the skills of interrelated multiple tasks such as conducting research, coordinating, training and mobilizing the community with regard to HIV counseling and behavior change scheme.
- Counselors, in both organizations, need to be more practical and the trainings should focus on practical aspects through employing diversified methods of trainings namely practice, role-play, discussion etc in order to enhance counselors skills in relation to the objective realities of clients.
- HIV/AIDS counselors, in the government and non-government centers, should try to adopt the trend to supervise HIV/AIDS counselors' technical skills of counseling.
- HIV/AIDS counseling that works need to be shifted to theory and solution focused through seriousely considering and getting acquinted with the skills such as Facilitative skills, Communication skills, Intervention skills, Termination skills, Follow-up skills and even with further feasible counseling skills instead of undertaking through traditional ways, advice giving and imparting knowledge through deductive ways.
- Team and interdiciplinery approaches that including the client and its family, religious leaders, community leaders and the community at large; professionals such as psychologists, medical experts, social workers, and others need to be integrated together so as to work on fighting against the pandemic through utilizing the meager resources effectively and efficiently.
- It is necessary to establish HIV/AIDS counseling courses that address the problems of living with AIDS, the counseling of caregivers and children and bereavement counseling.
- In areas where non-manageable clients flow, the numbers of volunteer para-counselors need to be increased.

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Appendix -A

Questionnaire Format on the Counselors' Self-Perceived Knowledge of HIV/AIDS Counseling Skills

Objective: This study is mainly aimed at to investigate whether there is statistically significant difference between Governmental and Non-governmental organizations regarding the knowledge of counselors' counseling skills while undertaking HIV counseling. Unquestionably, the study has paramount implications to prevent and control the rampant spread of HIV/AIDS through visualizing gleaming directions on the profile HIV counselors' skill under both organizations for quality delivery of HIV counseling. As a result, worth mentioning that your honest response becomes the stepping-stone for quality out put.

Note: Do not write your name!

Directions: You have given below around 14 background items with sub-questions. For each of them you are required to write or select the appropriate response in the space provided. The remaining are items related to your counseling skills and therefore, you can find cluster of items in the chart with regard to HIV counseling skills. The extent to which you know each specific counseling skill indicated by rating scale (i.e., 0 = Do not know to 4 = Know very well). Consequently, you may tick (✓) the alternative that exactly indicates your level of knowledge interims of each counseling skill disclosed on the chart.

Description* on *knowledge rating

0 = Do not know

1 = Need more information

2 = Fairly know

3 = Know well

4 = Know very well

1. Background

1.1 Age _____ 1.2 Sex _____

1.3 Academic Level

(a) MA ☐ (b) B.A ☐ (c) Diplôma ☐ (d) Certificat ☐

(e) If other specify _____

1.4 Name of employer organization (a) Government ☐ (b) Non-government ☐

(c) Mention the Name of the Organization _____

1.5 The kind of counseling that you deliver in your organization, club or society is:

(a) VCT ☐ (b) PMTCT ☐ (c) Home –based ☐

(d) Prevention ☐ (e) ART ☐ (f) If any other, describe_____

1.6 Do you think the counseling service that you deliver helps to prevent and control the spread of HIV/AIDS?

(a) Yes absolutely ☐ (b) To some extent ☐ (c) Not at all ☐

- If your response is 'Yes', how? Would you explain briefly?
- If your response is 'To some extent' or 'Not at all', how do you say so?

1.7 The trained professional background mostly belonged to:

(a) Nurse ☐ (b) Social Worker ☐ (c) PLWHA working as counselor ☐

(d) Community Volunteer ☐ (e) Psychologist ☐ (f) If other specify _

1.8 Answer the following questions on the basis of training given on HIV counseling

(a) Describe the Organizations that Provided Training _____

(b)Which one of the following professionals most frequently conducted HIV counseling for prospective counselors?

(a) Doctors ☐ (d) Nurses ☐ (e) Health Officers ☐

(b) Psychologists ☐ (f) others ☐

(c) Social workers ☐

(c) List types of counseling courses given, if any _____

(d) Write the name of training manual and its publisher _____

(e) Reveal the average duration of training whether in daily, monthly or annually ___

(f) Have you received a training exclusively focusing on counseling skills?

Yes, absolutely ☐ Yes, but not sufficient ☐ Not at all ☐

- If your response is 'Yes, absolutely' on which part of counseling more focused?

➢ Facultative skills ☐ ➢ Intervention skills ☐

➢ Communication skills ☐ ➢ Termination skills ☐

➢ Follow up skills ☐

➢ If any other describe _____

- If your response is 'Yes, but not sufficient' or 'Not at all', why do you think such happened? Explain briefly.

In your opinion what should be done to mitigate the existing problems from the counselors, clients, project officers, your organization, and from the society at large.

1.9 From the following theoretical approaches of counseling which one do you prefer more?

(a) Behavioral ☐ (b) Client –centered ☐ (c) Cognitive ☐

(d) Eclectic ☐ (e) Do not know ☐ (f) If any other mention_____

1.10 How have you been selected to be HIV counselor?

(a) Nominated by Senior Colleagues ☐ (c) Self-Motivated ☐

(b) Contest ☐ (d) If any other specify _____

1.11 As an HIV counselor do you get regular capacity building training?

(a) Yes, absolutely ☐ (b) Yes, but rarely ☐ (c) Not at all ☐

- If your response is 'Yes, absolutely' which of the following counseling skills were the focus of training?

➢ Facultative skills ☐ ➢ Intervention skills ☐

- Communication skills ☐ - Termination skills ☐
- Follow up skills ☐
- If any other describe _____

- Who were the professionals that regularly conduct the training?

(a) Doctors ☐ (b) Nurses ☐ (c) Health Officers ☐

(d) Psychologists ☐ (e) Social workers ☐ (f) others ☐

- What do you suggest to solve problems with regard to these issues from the point of view of different individuals such as counselors, clients, project officers, your organization and the community at large?

1.12 As a counselor, continuous and regular supervision is mandatory to see whether the counselors practice the skills properly or not. Consequently, is this being done properly in your organization?

Yes, regularly ☐ Yes, but rarely ☐ Not being done at all ☐

- If your response is 'Yes, regularly' what is the time interval?

(a) Annually ☐ (b) Six month ☐ (c) Three months ☐

- What is the name and publisher of the manual for supervision? _____
- If your response is 'Yes, but rarely or Not at all' why do you think such happened? And what is expected from different authorities like the counselors, clients, project officers, the community etc.

1.13 Do you think that you implement the existing counseling skills properly regardless of the amount of skills you posses?

Yes, absolutely ☐ Yes, to some extent ☐ Not done at all ☐

- If your response is 'Yes, to some extent' or 'Not at all' why do you think?

(a) Work load ☐ (b) Lack of incentives ☐ (c) Boring task ☐

(d) Absence of formal administrative structure ☐

(e) If any other, mention _____

1.14 How did you manage to HIV counselor?

(a) For salary increment ☐ (b) To urban promotion ☐

(c) Being PLWHA ☐ (d) Forced by the office ☐

(e) Loving the profession ☐ (f) If any other, mention _____

2. Counseling Skills

No.	Skills	Knowledge					Comments
		0	1	2	3	4	
1 1.1	***Facilitative Skills*** Establishing fundamental pre-conditions that help to the success of the counseling relationship such as greeting, smiling etc.						
1.2	Not getting curious to introduce ones own professional background, work experiences etc to the client.						
1.3	Introducing the main issues considered under HIV/AIDS counseling.						
1.4	Introducing the purpose of HIV/AIDS counseling.						
1.5	Forming working alliance through determining actions. specific objectives of HIV/AIDS counseling etc.						
1.6	Getting congruent with ones own words and actions						
1.7	Less likely attempting to conduct HIV counseling in the private environment that is free from any noises.						
1.8	Maintaining confidentiality of clients' personal, social, economical, cultural issues.						
1.9	Unconditionally accepting the client whether who is beautiful or ugly, black or white etc.						
1.10	Getting emphatic about the clients HIV/AIDS and /or sexual or any risk behaviors.						
2 2.1	***Communication skills*** Utilizing the appropriate non- verbal communication skills such as proper facial expressions, gestures interims of clients age. academic background etc.						
2.2	Actively listening the client verbal expressions.						
2.3	Attending the verbal and non-verbal reactions of the clients during HIV/AIDS counseling probably has no effects on the counseling relationship.						
2.4	Increasing understanding through paraphrasing unclear words, phrases, sentences of the client's that are related to HIV/AIDS.						

3.9	Observing clients' problems from the point of view of the client and arranging all the things in such a way to help the clients.						
3.10	Encouraging clients to substitute sexual behaviors with another constructive tasks such as engaging at sport, music etc.						
3.11	Employing various projective mechanisms such as meaningful or meaningless pictures so as to clear out risk factors related to HIV/AIDS.						
4	***Termination Skills***						
4.1	Finishing counseling processes through transferring the case to another senior counselor.						
4.2	Terminating counseling process if there are no points to be dealt with the client.						
5	***Follow-up skills***						
5.1	Encouraging and arranging peer groups, families or organizations to meet with the client to help each other.						
5.5	Meeting with the client again and again through appointment.						
	Total						

Appendix -C

Interview Format for Coordinators

Greeting and Welcome!

Direction: I am going to present basically interrelated significant questions on the HIV counselors' skills, counselors' training schemes, support and supervision. You are supposed to visualize whether you believe that the counselors are effectively skillful to deliver HIV counseling for risk reduction so that to prevent and control HIV/AIDS. Moreover, you are expected to reveal your ideas in relation to the production of qualified counselors.

- Date: _____
- Place: _____
- Coordinator's Name (Code):_____

A. Preliminary Issues

1. Age _ 2. Sex 3. Field of specialization _4. Name of your organization

5. Do you think counseling has paramount contributions to prevent and control HIV/ AIDS?
   Yes ☐ No ☐
   - If 'yes,' how? Would you explain briefly?
   - If 'no,' could you tell me the reasons why do you say so?

6. How do you select the prospective counselors in your organization?
   Contest ☐ By senior colleagues ☐ voluntarily ☐ If any other specify

7. Is/was the training given on HIV counseling adequate or not in terms of duration, quality etc.
   - If 'adequate,' can you tell me specific focus areas with their strengths?
   - If 'not adequate' why do you think such happened?
   - What is/or are your intention to improve the service?

8. Which manual did you use to train the counselors? Mention its name and publisher

9. Do the counselors obtain frequent/continuous capacity building training (i.e., short term or long term work shops?) Yes ☐ No ☐

- If 'yes,' (a) How frequently? Would you tell me the time interval whether monthly, annually or weekly?

  (b) Who provides the training? Can you name some of the names of the organization and the professional profile of the trainers?

- If 'no,' why do you think?

10. Is your office makes any supervision? Yes ☐ No ☐

    If yes (a) How frequently? Quarterly, with in six month, annually or

    (b) Which supervision manual do you utilize as reference?

11. Do you have an idea on the professional profile of trainers? Doctors ☐ Nurses ☐

    Social workers ☐ Counselors/ psychologists ☐ If any other specify

B. Counseling Skills

Would you tell me about the facultative skills and conditions that the counselors know and employ during counseling process and/ or before? For example, in relation to physical arrangements and preparation, getting empathetic, establishing relationship, getting congruently, accepting the client and client's unhelpful behaviors, introducing self and purpose of counseling?

Done very effectively ☐ Done intermediately ☐ Need more improvement ☐

- If 'done very effectively,' would you give me evidences?
- If 'intermediately done or need more improvement,' why?
- What is/ are your intention to make change in the service delivery?

2. Let me take you now to the general communication skills of the counselors with the client. How do you see them in terms of knowing and practicing; for example, the appropriate non-verbal communication skills, effective listening, attending, responding, paraphrasing, summarizing ideas etc.?

Skillful ☐ Intermediate ☐ Need more improvement ☐

- If 'skillful,' would you mind to suggest few instances how they are utilizing?
- If 'intermediate or need more improvement,' why?
- What do you think to acquaint the counselors with such fundamental skills altogether?

3. Obviously, counseling without intervention going to be referred as dead. Consequently, do you think HIV counselors in your esteemed organization deliver and/or help clients make use of certain action- oriented and emotional strategies so as to dwindle the rate of risk behaviors?

   Yes ☐ No ☐

   - If 'yes,' would you mention some of them on the basis of different theoretical approaches?
   - If 'no,' why?
   - What is/are your further plan to internalize and make use of such interventions?

4. How do you see termination procedures? Do you think counselors finish the counseling relationship effectively?

   Yes ☐ No ☐

   - If 'yes,' would you come h up with an idea how really they conduct that?
   - If 'no,' why?
   - How do you attempt to build skills with regard to their major skill?

5. Finally, I would like to pose a question on follow-up procedures. Do counselors conduct any follow-up investigation so as to check any change of behavior and/ or need for further examination?

   Yes☐ No☐

   - If 'yes,' may I ask you to give me specific strategies?
   - If 'no,' why?
   - Recommend, if any plan to establish skills with this regard?

C. Summary Points

1. What do you think the most perceived and practiced skills among the counselors?

2. Can you mention also the most non-existent and non- practiced skills among the counselors?

Appendix- D

Focus Group Discussion Format for Clients

Greeting and Welcome!

Direction: I am going to present fundamentally important questions in relation to the skills of HIV counselors, and you are expected to express whether you have really experienced counseling skills while you were getting HIV counseling services. In addition, you may attempt to describe the reasons for the absence or presence of counseling skills followed by you may be required to suggest any remedial activities so as to enhance counselors' skills for effective delivery of HIV counseling in order to meet the desired objectives, preventing and controlling HIV/AIDS.

- Date: _____
- Place: _____
- Clients' Name (Code):_____

A. Preliminary Issue

1. Age _____ 2. Sex_____

3. HIV Status

a) Positive ☐ b) Negative ☐

4. Counseling service you received a) VCT ☐ b) Home-based ☐ c) PMTCT ☐

d) Prevention ☐ e) Among two or all ☐

5. Would you tell me the name of the organization that delivered and/or being delivering the counseling service?

6. Do you think HIV counseling has paramount importance to prevent and control HIV/AIDS?

Yes ☐ No ☐

- If ' yes,' how? Would you explain briefly?
- If 'no,' why do you think?

DECLARATION

I, the undersigned declare that this thesis is my original work, has not been presented for a degree in any other university and that all sources of material used for the thesis have been dully acknowledged.

June 21/06

Tarekegn Tadesse Gemeda

This thesis has been submitted for examination with my approval as a university advisor.

June 21/06

Dr. Sentayehu Tadesse