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**Plenary: Human Capacity Development Panel Discussion
PEPFAR The Global Fund to Fight AIDS, Tuberculosis and
Malaria; UNAIDS; UNICEF; The World Bank and The World
Health Organization
June 4, 2008**

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MUBASHAR SHEIKH: Thank you once again for a very comprehensive presentation and informing us about the steps, which the government of Ethiopia has taken to strengthen and to increase the war on human resource capacity within the health system by not only introducing a new cadre of workers of community health workers and health officers but also looking at some of the existing workforce and making an effort and taking steps for the retention, for the quality of training and for increasing the capacity of the institutions.

I would really appreciate and I am sure we would also like to know a little more about how did you sort of - what steps you have taken to increase this enrollment, sudden jump from a few hundred to a few thousand. How did you manage to - maybe in our discussion, we will discuss these issues a little further and also the task shifting process. How many success you have achieved because that is certain tensions, certain issues among the health professional organizations and other cadres of workers on the whole issue of task shifting. So how did you work on or sort of some of the obstacles or the challenges that you are facing.

So I think we have heard two very interesting and stimulating information. One which basically set the scene on human capacity development and the other, which helped us

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understand some of the issues from the government perspective taken with the participation involvement of the community to address the critical issue of the shortage of health workers.

Now I will sort of request now that our distinguished panel who will basically now bring different perspectives from - as they represent different constituencies in the private sector, the faith-based organizations, the government, as well as the people living with HIV and issues related with that.

I hope that their comments will help us understand how they are applying the approach of human capacity development in this specific area of work and some of the issues and challenges, which they are faced if they have applied this approach and if not, do they see any value from the two presentations, which we have seen on how do they want to take this forward in the respective affairs.

But we also want to concentrate a bit on the whole issue for looking at the human resource development or the capacity realting or the task shifting within that context but not only what we have learned so far but we would also like to hear from the panelists if there are any alternative innovative models, which they also have adopted or they are aware or if they have utilized during their sort of operational, during the performance of work.

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So we have - originally we were supposed to have five panelists. One is still missing if he is in the audience, please come up. We will not sort of save you anything. Please come join us but other than that, we have four panelists with us. We have Ms. Christy Wistar who represents the private sector. We have Alex Coutinho who is the NGO representative. We have Cece Abinas [misspelled?] who represents the faith-based organization, and then finally Elsa Uko [misspelled?] who is the executive director of Canapote [misspelled?], which is the teachers' association dealing with HIV/AIDS.

So I will start by requesting CeCe Abinas who is the technical officer, palliative care, Ethiopian Orthodox Church please.

CECE ABINAS: Good afternoon to you all. I am CeCe, but I am no more working with the Ethiopian Orthodox Church but I do not leave the country [inaudible]. My experience actually among other things, working for HIV/AIDS responding faith-based organizations context specifically the Ethiopian Orthodox Church.

So I will try to draw the possible roles of faith-based or community-based organizations in the field of human capacity development for HIV/AIDS response.

This presentation will provide you with a large amount of information from a different perspective especially on HCD

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and [inaudible] human resource from a [inaudible]. I begin by reflecting on what HCD is to us. As human capacity development in having the potential in each individual being HIV positive or otherwise, teacher or student, priest or a laity to make them to be a part of HIV's complacency response, the building blocks of human capacity development is a participation and participation opportunities.

Human capacity development is a way of working with existing organizations like faith-based organizations, which have so commonly [inaudible] and also community-based organizations. The reason being as [inaudible] 70-percent of all the people identified themselves as a member of faith communities, so this faith-based organization has a leadership, which is greatly influenced the lives of many people.

Community of the faith also have a very large network. For example, in the Ethiopian Orthodox [inaudible] context we have around 40 million followers. So they could easily influence the societal [inaudible] of people with HIV. I just want to say that I hope that the different case studies including ours to be presented in this conference show that the FBOs are a great asset in building human capacity, which is foundation of effective HIV/AIDS response.

I just want to make two points like [inaudible] this bill is most affordable, sustainable, and a strategy to

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building human capacity development. And when you say human capacity development, which not limits ourselves in treatment or service area, we should also include communities and also consider prevention. And I tried to elaborate our case studies if you are in the breakout sessions. And thank you for the opportunity [applause].

MUBASHAR SHEIKH: Thank you CeCe for sharing your experience and thoughts with us as a representative of a faith-based organization. I move straight to Alex Cuttino who is Executive Director of Infectious Disease Institute in Uganda and he is representing NGOs here. Alex?

ALEX COUTINHO: Thank you and good afternoon. Prior to joining the IDI, I was the Executive Director of TASO in Uganda for six years and my comments are just to the experiences in TASO during those six years.

Over the 25 years that I have been involved with the HIV epidemic, one thing has been very clear in all the countries where we have high HIV prevalence and that is despite HIV, there is no shortage of people in these countries and these people are often idle, unemployed, and poor.

Therefore it is very important that when we are putting together policies and approaches to tackle HIV that these be pro-people policies and human capacity development and task shifting are examples of pro-people policies. It is no use

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bringing huge amounts of technology and continue to sustain unemployed idle people on the streets.

Now very quickly, two examples - one for human capacity development. Now TASO adopted, in 1987 at the same time as Ian Campbell was talking of the program in Chikankata and human capacity development, by coincidence and independently, have been the foundation of TASO's work in Uganda and over 25 years, has mobilized 100 communities with a [inaudible] population of 500,000 people.

One of the more novel approaches to human capacity development has appeared in recent times in terms of GIPA in action, greater involvement of people living with HIV and AIDS and today in TASO, out of the 100,000 HIV positive people who are supported by TASO, 2,000 have been mobilized, trained, and deployed to provide HIV education, HIV prevention messages, and treatment adherence support.

In terms of the latter, this is quite unique because one HIV positive person is given ten other positive people - usually people who have just started treatment, in their communities - to visit, to encourage drug adherence, in a sense to form adult support individual and that person is identified by other HIV positive people. When they start treatment, they have a panel of photographs and they select the one they are comfortable coming into their homes.

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The other aspect is task shifting and I am very pleased to hear of the massive scale-up going on in Ethiopia and in TASO, we have done radical task shifting for ART adherence and HIV testing.

In 2004, when we initiated a community-based home delivery of antiretroviral therapy to ensure equity in access to antiretroviral therapy, to ensure that people who could not to facilities were not disadvantaged. We recruited 150 lay people who were not doctors. They were not nurses. They were not even health workers and over a period of six weeks, trained them to be drug distributors and to be able to ride motorcycles to deliver drugs in people's homes.

Over the next four years, we have seen these individuals take on more tasks and today, not only are they drug distributors, most of them are qualified HIV counselors. They can all do rapid HIV testing in people's homes. They are also primary healthcare workers promoting hygiene and safe water and malaria prevention in the home. They are also food security advisors because they go to homes and they advise on what crops can be grown in the homes. They are friends and become trusted allies of the homestead. They provide an MMD [misspelled?] service and they are also educators on a wide range of services.

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So in conclusion, if we believe that there is tremendous potential in human beings regardless of their life experience, regardless of their educational status, if we truly believe and we invest in that human spirit, we are able to do tremendous human capacity development - not just for HIV but for the development of our nations. Thank you [applause].

MUBASHAR SHEIKH: Thank you Alex for really reminding us of the need for improved policies and to the potential and the strength, which lies in the community, the inherent strength among the people. Sometimes we undermine, sometimes we do not understand and sometimes we do not know how to maximize and optimize that potential and you have given some real life examples and we really appreciate that and I am sure there are many, many more among the audience, which can enrich our understanding further in this area but I really appreciate that.

And now I would request Christy Wistar who is the Vice President of the Abbott Fund and she is representing the private sector. Christy?

CHRISTY WISTAR: Thank you. Good afternoon. Okay. First of all, let me say that I am fully in agreement with an approach that recognizes that community ownership is essential to turning the tide of the global HIV/AIDS pandemic

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particularly at the community level where stresses are felt most.

Working with Abbott Fund in Tanzania, I have witnessed a remarkable difference that fostering hope, encouragement, and responsibility at the individual and neighborhood levels can have in promoting that sustainable response.

I believe this is an essential approach to prevention, orphan, and vulnerable children program, and other community-based programs that are not steeped in the need for technical expertise and knowledge transfer.

Community sharing can reduce stigma, offer comfort, and consolation for those who are impacted by HIV fulfilling many of the emotional needs that are not met by an overstretched institutional health system.

Where HCD may fall short is in the transfer of technical knowledge and expertise that is required for treatment and some care programs. The need for increasing human resources for health and strengthening existing health systems is urgent. We must continue to develop the capacity of physicians, hospitals, and laboratories as these institutions are the foundations of clinical care. Community mobilization will only help an HIV positive person when clinical care is available.

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The two approaches, in my opinion, need to work together. A patient is in the clinic for one hour per month but in the community for the other 29 days, 23 hours. The one hour in the clinic though is critical but that hour can be leveraged by connecting the knowledge of the clinic to the community via community health workers.

The approach I would prefer is therefore one that is balanced and addresses all stages of the pandemic. I believe communities must be engaged in the response and must feel the responsibility to support their own - their constituencies. For example, in Tanzania, the Abbott Fund supports the formation of local community led, most vulnerable children committees whose responsibility it is to identify children who need support and then marry those children with local resources.

I also believe that donor organizations have a significant role to play in the scaling up of financial resources and technical expertise that is not available locally.

With clinical laboratories, for instance, Abbott Fund does not merely renovate a laboratory, put in new equipment, and train the operators. For sustainable change, our approach has been to place an experienced laboratorian onsite for six months or more to work side by side with the laboratory staff.

It is time consuming and resource consuming but it works. At

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Mount Meru hospital in Tanzania where we used this dual approach, the formal training was operationalized and institutionalized and the end result is the laboratory that is operating at a much higher level, producing high quality results, faster, and more accurately.

In the last year, Mount Meru Regional Hospital has tripled the number of tested offers, has tripled the number of patients it serves and has increased the number of patient results delivered by nine times. By any measure a tremendous success.

One approach, very often used, invigorate community ownership even in technical areas is the train the trainer model. My experience has been that without onsite technical support, the train often is not translated into change in the working habits and environment that evoke sustainable improvements in quality.

A balanced approach recognizes the ownership of communities in developing a locally driven response while, at the same time, allowing for the importance of the introduction of outside technical expertise in a sustained way that ensures effective knowledge transfer.

So in summary, I believe in supporting both sides of the equation, support larger healthcare institutional change through infrastructure improvements and healthcare worker

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capacity building and at the same time, motivate a model change through the community [applause].

ELSA UKO: [Inaudible] who are monitoring an evaluation system. By most of PLHS [misspelled?] oriented networks due to serious set target by donors. Challenges in governments of most networks, the [inaudible] and work productivity slows performance.

You will find in those community-based organizations, the people who can write and can come up with the reports - they are very few and if this person is sick because the person is HIV positive - is down with an opportunistic disease, then you find this group cannot do anything because one or two of their members who can write cannot do it at that moment. So that is also a problem. It affects our human capacity.

Another one, which is serious matter is not really too serious but you bear with me, it is going to touch some people. Territorial control competition among donors as of late gained currency. For example, this is just an example, where CDC operates, our part may not be comparable to operate in the same area even if their services would be better than the organization.

This is a problem and it is a challenge that you find that when a big donor has taken place somewhere then you find

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even if they are lousy, you have to bear with them as we are dying.

Recommendations. We need to train more clinical officers in dispensing ARVs and roll it down to nurses and health workers within the community but we have to strengthen the referral system so that ARVs, you know, is a technical thing so that we do not overdose.

PLHS needs to be trained in advocacy to improve the current situation as role models and celebrities. Due to the constraints, that HIV and AIDS have caused, we should be prepared to bring down home-based care facilities in our communities.

Network management requires training skills in the following areas - communication skills, financial matters, proposal and report writing. This will enable them to express themselves and be accountable. This limitation has been a major hindrance in realizing and achieving the desired results. Since the PLHA's organization cannot handle lump some money while the work outside there is overwhelming. Thank you [applause].

MUBASHAR SHEIKH: Thanks also for raising the voice of the people who are actually suffering and were in the center of the discussion and the response. Thanks also for sharing your frustrations and expectations and I think some of the issues

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and challenges, which are raised actually can lead us to the next phase of our session.

We would like to then go into some of the further sort of next level of discussion on some of the key issues, which might have come up during the presentation by the two speakers as well as by the panelists and here would I encourage the panelists or the speakers to raise these issues with each other and try to articulate some explanation.

We would like to know that whether the HCD approach does provide answers to some of the challenges, which we have heard so far in different settings, some different constituencies and would Ian maybe help us to understand, from his experience and also Alex, they responded to some of these challenges and obstacles and the constraints, which sort of is directly relevant to human capacity development.

But we would also like to know how do we learn from the experiences and how do we start working with each other so that some of - again the issue of competition, the issue of overlap, the issue of [inaudible] and the lack of the resources both in terms of human and financial, we can utilize them in a better way. So I sort of - anyone, Alex would you like to sort of start - say something?

ALEX COUTINHO: Ian will start.

MUBASHAR SHEIKH: Ian do you want to say something?

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IAN CAMPBELL, M.B.B.S., M.R.C.P. (UK), D.R.C.O.G.:

Okay. I think I am quite surprised at the comprehensiveness of the reflections today and also the synchronicity. There is some consistency of values and experiences.

I see that there is a commonality, I think, about the view that local neighborhood-based community response is actually possible and very necessary. It has to be encouraged.

I am very excited about what is going on in Ethiopia regarding experientially based training - 75 percent of the content is experientially based in local settings almost certainly. I am excited about what Alex has brought about an update with TASO. What I hear in that is motivated people who were not health workers by a label but they become stimulators of encouragement and response in a vast array of ways.

Now what I think is coming through is the obligation for a transition in organizational behavior. We are 25 years into being practitioners of this epidemic and we are still fixed, mentally, on the idea that communities are out there and sure they can respond and we have to upscale our work in terms of finance and technology.

I propose that we have to do far more than that in terms of organizational culture. We have to become the learners and mentors whether we like it or not as organizations, as policy makers, as donors. The time has come for a tradition

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that is based in technical capacity development to shift to a tradition of human capacity development, which involves not only communities but involves the policy makers at the very top and the organizational chief executives of all kinds and I wonder what the panelists want to say about that because I feel that there is a gap in the articulation there.

ALEX COUTINHO: Just two comments - not necessarily an answer but may point in the same direction. When I was joining medical school in 1978, the rage of the time was primary healthcare and Alma Ata [misspelled?] and somehow it floundered.

It is amazing to see in 2008 as we look at approaching to achieve universal access that the language and the rhetoric is coming out and we might not say it but we actually mean primary healthcares and I hope that as learning communities, we start finding ways to revise a concept that floundered for many reasons but might have come much earlier than its time was due and this might be its time.

The second is an important caution about the approaches we take with communities because most of our approaches are in rural communities but if you look around in any country in Africa and Uganda is no exception, there is increasing urbanization and peri-urbanization and the population of

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Kampala, for instance, during the daytime is three million and during the nighttime is one million.

We are surrounded by large peri-urban communities and these communities are not your traditional communities that are well knit together and where the classical approaches that we have described work well. They really need to research and find out ways in which we can replicate many of the approaches we are - that are effective in rural communities into urban and peri-urban settings.

CECE ABINAS: Thank you very much. I think one of the major things we do see is that aside from TASO, medical potential, the potential in the community, and the potential in the institutions. We are not saying that unlimited potential but there is untapped potential in the decisions and untapped potential in the communities. The very thing that we have got to do is bringing people with [inaudible] decisions to realize their potential.

Sometimes, what we cannot, may not be well defined. We are asking that we can increase performance [inaudible]. We are asking that community, we can have demand in communities. Of course, the demand once igniting the community could be so strong that you have to always be ready to respond and that is what is happening and that is what we are getting now.

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So basically, on the young [misspelled?] side, creating a good wheel, changing the thinking so that a difference, a dramatic difference, can be achieved and there are experiences in countries, in the neighborhood countries in Africa and elsewhere, that reaching universal access through partnerships [inaudible] capacities in the communities, [inaudible] capacities by the government, and from partners working together as a team, it is possible and that is what well learned. And we are often encouraged by similar experiences from other countries that they are also making a difference by looking and integrating capacities working towards that line.

So basically, what we did was when we have staffed in the health [inaudible] program, some 15 years ago, we could say that we are planning to reach universal access by - in 20 years but experience is now following that. It is possible.

And that [inaudible] health extension workers program we are to reach universal access at the community level by the beginning of 2009, which means that 1,000 health extension workers have deployed at every community, two per community, who should enable to liberate in the community capacity.

Communities do have the values. They have the values to prevent. They have the values to care. They have the power to promote treatment and it is this value who could be linked with the [inaudible] arrangements at health centers, also at

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hospitals by mentoring and creating a capacity that links and feeds into what is really moving for the community.

So basically experience in showing that it is possible but it is not easy. It requires support from local as well as from the global level. Thank you.

ELSA UKO: In my observation of what I have seen, for us to enhance this human capacity development in our communities, what I saw with my HIV positive teachers, they decided on their own in a place called - it is a very rural place in Kenya called Combaya [misspelled?]. The Combaya teachers, positive teachers, went out, you know the community has respect for teachers.

So if you use our HIV positive teachers as an entry point, you will at least move somewhere because they are the opinion leaders in the communities. Remember that they are the only learned people who are staying with the community people. Most of the people in [inaudible] and doctors are in towns.

So these teachers took this opportunity and started training grandmothers who are taking care of HIV positive children, their grandchildren. In my country, most of the children are being taken care of with grandmothers and these grandmothers; they did not know what we call [inaudible].

So these teachers who teach them in their own language and why the blood [inaudible] is important and why they should

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keep that child and why the child must take that ARV for the rest of the child's life and they believe in hope in these grandmothers.

Then the grandmothers started saying if the - teacher, the headmaster of my grandchild is HIV positive and is living and is just talking about it, you know it is even again breaking the stigma and it is talking about it and is Mr. So-and-so. What about my son who did not go to school who is just a fish monger and is refusing to access and take this drug? I will convince my son that Mr. So-and-so is taking the drugs and he is talking about it.

So you just talk about it because after all, a teacher has got a more reputation than that fish monger because a teacher is somebody at the communities at an international level.

So this thing really helps to break that stigma at the grassroots level. Again, it means that the grandmothers to give drugs to their grandchildren in time and I am seeing that drug adherence is being taken care of by grandmothers who are very old, who do not even know how to read. So we can take it down to the grassroots if we want [applause].

MUBASHAR SHEIKH: I think as we are closing the session, I think it is one thing is very apparent - that there

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is a lot of experience. There are so many different approaches and there are so many success stories.

But at the same time, there are a number of challenges, a number of issues, which still needs to be developed further in which we keep on enhancing our knowledge, our learning processes but there is no single solution or there is no part-time isolated approach, which can help us. We have to have a comprehensive approach, a comprehensive solution to the overall problem if you want to have an effective response to prevention, treatment, and care.

Task shifting can help us. Community participation is absolutely critical, scaling up is important. The leadership and the political commitment is critical but all these elements have to come together and for that, I think the organizational change and culture, which Ian sort of mentioned, I think that is very important. We must understand, we must appreciate, and we must accept that the change needed and that change is absolutely essential if we want to succeed in our effort to overcome this crisis.

So I appreciate the two presenters and the panelists for being here, for sharing their experiences, and for being here, for your patience, for your presence, and I am sure many of these issues will be discussed further in our various

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conversations. So thank you very much. Please enjoy your day
[applause].

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