CAPACITY DEVELOPMENT INTERVENTIONS AND ACCESS TO HIV/AIDS SERVICES AT ARUA REGIONAL REFERRAL HOSPITAL, UGANDA

By

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REG: 04/MPPMM/040

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A DISSERTATION SUBMITTED TO THE SCHOOL OF MANAGEMENT SCIENCE IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE MASTER IN MANAGEMENT STUDIES DEGREE (PROJECT PLANNING AND MANAGEMENT) OF UGANDA MANAGEMENT INSTITUTE

~~NOVEMBER~~DECEMBER, 2013

ACRONYMS AND ABBREVIATIONS

ACDI/VOCA:	Agricultural Development Cooperation International/Volunteers Cooperative Development Assistance
ACP:	AIDS Control Programme
AHAP:	Arua Hospital AIDs Programme
AIDS:	Acquired Immune Deficiency syndrome
ART:	Antiretroviral Therapy
ARV:	Anti-Retro-Viral
CAO:	Chief Administrative Officer
CBO:	Community Based Organization
CDC:	Centre for Disease Control and Prevention
CDDPs:	Community drug distribution points
CIDA:	Canadian International Development Agency
DHE:	District Health Educator
DHO:	District Health officer
FGDs:	Focus Group Discussions
GIPA:	Greater Involvement of People Living with HIV/AIDS
HBHCT:	HIV Counseling and Testing
HC:	Health Centre
HIV:	Human Immunodeficiency Virus
HUSBS:	HIV/AIDS Sero-Behavioral Survey
IGAs:	Income Generating Activities

IFAD:	The International fund for agriculture
MDGs:	Millennium Development Goals
MoH:	Ministry of Health
MSF:	Medicins sans Frontiers
NACWOLA:	National community of Women Living with HIV/AIDS
NSP:	National Strategic Plan
NGO:	Non-Governmental Organization
OECD:	Organization for Economic Cooperation and Development
OVC:	Orphans and other Vulnerable Children
PHAs:	People living with HIV/AIDS
PMTCT:	Prevention of Mother-To-Child Transmission of HIV
PTB:	Pulmonary Tuberculosis
RATN:	Regional AIDS training network
RCT:	Routine Counseling and Testing
SCOT:	Strengthening HIV/AIDS Counselor Training
SIDA:	Swedish International Development Agency
SNV:	Stichting Nederlandse Vrijwilligers (Netherlands Development Organization)
STD:	Sexually Transmitted Diseases
STSP:	Support of TASO Strategic Plan (2003-2007)
TEACH:	TASO Experiential Attachment to Combat HIV/AIDS
TASO:	The AIDS Support Organization

TNU SP:	TASO's Northern Uganda Strategic Plan
UNAIDS:	United Nations Joint Programme on AIDS
UNDP:	United Nations Development Programme
UNESCO:	United Nations Education, Scientific and Cultural Organization
UNSD:	United Nations Statistical Division
USAID:	United States Agency for International Development
VCT:	Voluntary Counseling and Testing
WFP:	World Food Programme

DECLARATION

I, Johnson Masiko, declare that this study is my original work and has not been published or submitted before for any other academic award to any university or institution.

Johnson Masiko

Signature …….

Date ……..

APPROVAL

This dissertation entitled "**Capacity Development Interventions and Access to HIV/AIDS Services at Arua Regional Referral Hospital, Uganda**" is an original work of **Mr. Johnson Masiko** and was done under my supervision and has been submitted for examination with my approval as supervisor.

Signature: ……

Dr. Gerald Karyeija

(Supervisor)

Date: ……..……

DEDICATION

This research is dedicated to my parents, Mrs. Margret Wise and Late John Wise, for raising me to adulthood and giving me the foundation that made production of this dissertation possible.

ACKNOWLEDGEMENT

First, I thank the almighty God for enabling me complete this study. Secondly, I wish to acknowledge the contributions made by various individuals and entities that played different roles towards the accomplishment of this work. My sincere thanks go to The AIDS Support Organization (TASO), under the leadership of Dr. Alex Coutinho for the financial and other logistical support; My supervisor Dr. Gerald Karyeija for their guidance and professional advice in polishing up this work. Further, I wish to express my gratitude to other members of staff at Uganda Management Institute for their guidance and support. I also extend my heartfelt appreciation to my employer, The Inter Religious Council of Uganda (IRCU), for allowing me time off to do research. My appreciation would be incomplete if I do not extend my appreciation to the respondents who provided the data and information I needed for this study and gave me their time whenever I approached them- May God reward you for your tireless efforts and fruitful contributions you exhibited during my research study.

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ABSTRACT

This study examined the contribution of capacity development approaches towards access to HIV/AIDS services in Arua Regional Referral Hospital (ARRH). Specifically, the study sought to: examine the contribution of mobilizing political leaders towards improved access to HIV/AIDS services at ARRH; study the contribution of training of health workers towards improved access to HIV/AIDS services at ARRH and; investigate the contribution of monitoring towards improved access to HIV/AIDS service at ARRH. The study ~~adopted~~ used a triangulation of cross sectional survey and case study research designs, adopting both qualitative and quantitative research approaches. A sample of 120 respondents was targeted to participate in the study and out of these, 112 responded, representing a response rate of 93%. Questionnaires and interview guides were used to collect quantitative and qualitative data. Frequencies and percentages were used to show the distribution of ~~staff~~ respondents on different items, while Pearson's Linear Correlational Coefficient (r) was used to determine the degree of relationship between the variables. The study findings showed that; political mobilisation had a significant and positive relationship with access to HIV/AIDS services (r=.666**), training affected access to HIV/AIDS services by 12%, while surveys, informal discussions that were conducted helped to monitor the performance and therefore enhanced access to HIV/AIDS services in ARRH. On the basis of the findings, the researcher concluded that political leaders have a fundamental role of helping communities access HIV/AIDS services; that while training can help to improve access to ~~H~~HIV/AIDS services, it is necessary that the selection of the trainees is done with a clear purpose and that the training itself should be linked to HIV/AIDS service delivery. The researcher therefore recommended that: management of ARRH should regularly involve political establishments at all stages, in order to reach out to as many people in the community at all stages of service delivery; the ministry of health should enhance budgetary funding towards training of health staff; and ARRH should have in place more strategies to monitor health staff and ensure that they are in the health facility whenever they need to be there.

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

The HIV/AIDS phenomenon is a crisis that deeply affects individuals, institutions, and communities. Various studies have found out that for better implementation of HIV/AIDS programmes, building the capacities of staffs and service providers is equally important (Bharat& Mahendra, 2007).This study was about the contribution of capacity development approaches towards access to HIV/AIDS services in Arua Regional Referral Hospital (ARRH). This chapter covers the historical, theoretical, conceptual and contextual background to the study, statement of the problem, purpose and objectives of the study, research questions and hypothesis, justification, significance and scope of the study, limitations and conceptual framework.

1.2 Historical Background

The first case of HIV/AIDS was first detected in 1982 (Okware, Opio, Waibale & Musinguzi, 2001). By end of 2010, approximately 34 million persons were infected with HIV globally, and 68 percent of those infected were in Sub-Saharan Africa (SSA)—a region which has 12% of the global population (UNAIDS, 2011). Sub-Saharan Africa (SSA) had 70 percent of the estimated 2.7 million new HIV infections during the same period. It is indicated that risky sexual behaviors such as having multiple sexual partners and having unprotected sex, are the main drivers of HIV/AIDS infections (Kasirye, 2012).

According to the 2004-2005 Uganda HIV/AIDS Sero-Behavioral Survey (UHSBS), 6% of Ugandan adults aged 15-49 were infected with HIV and prevalence among women was higher at 8% and among men 5%. Current reports show that HIV is still a major epidemic in Uganda with about 1.1 million people infected in the country and 1.3 million people were expected to get the infection in 2012.

1.3 Theoretical background

A number of theories have been advanced to explain the concept of capacity development. Key among such theories is the Social Development theory developed in 1978 by Lev Vygotsky (1896-1934). The theory argues that social interaction precedes development and that consciousness and cognition are the end product of socialization and social behavior. Harlan & Jacobs, (1999) argue that the theory describes the process of organizing human energies and activities at higher levels to achieve greater results. Commenting on the same theory, Davis (2012) observes that according to Vygotsky, (Ibid) stress is the fundamental role of social interaction in the development of cognition, as he believed strongly that community plays a central role in the process of "making meaning". The theory assumes that development increases the utilization of human potential. It also assumes that advances in development theory can enhance our social success rate by the same order of magnitude that advances in theoretical physics have multiplied technological achievements. Social development theory is adopted for the study because; as a process of organizing human energies and activities at higher levels to achieve greater results, it gives relevance to the main objective of this study which is; the development of capacity to better access to HIV/AIDS service in ARR.

1.4 Conceptual Background

Capacity development refers to the approaches, strategies and methodologies used by developing country, and/or external stakeholders, to improve performance at the individual, organizational, network/sector or broader system level (CIDA, 2010)**.** In this study, Capacity development was conceptualized as the transfer of skills and knowledge to individuals and the strengthening of communities and social networks in order to enable individuals and groups make decisions and engage in activities that are aimed at improving their health.

Armstrong (2004) defines training as "the planned and systematic modification of behaviour through learning events, programmes and instruction which enable individuals to achieve the levels of knowledge, skill and competence needed to carry out their work effectively."

In this study, training was used in reference to an educational process where individuals and the community members can learn new information , re-learn and reinforce existing knowledge and skills, and most importantly have time to think and consider what new options can help them overcome the scourge of HIV /AIDS in improve individual as well as community health.

Mobilization is to organize and encourage people to act in a concerted way in order to bring about a particular political objective (Perry, 2005). In this study, mobilization was conceptualized as an act of encouraging people to support efforts aimed at combating HIV/AIDs at the individual and community levels.

Monitoring is an observation system for the project managers to verify whether the project activities are happening according to planning and whether means are used in a correct and efficient manner (IFAD, 2012). For the present study, Monitoring referred to a regular

observation and recording of activities aimed at combating HIV/AIDS with the aim of ascertaining the level of progress.

1.5 Contextual background

Arua Regional Referral Hospital is a government hospital situated in Arua district, West Nile sub-region of Northern Uganda. ARRH has a bed capacity of 278 beds and it is a regional referral hospital for seven districts namely; Arua, Adjumani, Koboko, Nebbi, Maracha, Yumbe and Zombo.

The HIV/AIDS services in ARRH started in 1992 (TASO, 1995). By 2002, the scope of HIV/AIDS services had further increased and was integrated into the mainstream hospital services. After a review in the year 2002, the HIV/AIDS activities were transformed into a full-fledged programme, hence the Arua Hospital AIDS Programme (AHAP). This move was meant to achieve comprehensiveness in AIDS services delivery then, and also open opportunities for partners to join and support AIDS-related services. Unfortunately, outcomes of such interventions had not been clearly articulated, an issue that this study intended to explore.

1.7 Statement of the Problem

Arua Regional Referral Hospital has carried out several activities aimed at combating the effects of HIV/AIDS. Such efforts included: direct services such as VCT, management of opportunistic infections (OIs), counseling, laboratory investigations of HIV related infections, and education support to school children. Indirect capacity building and advocacy for the rights of PHAs to receive equitable health care and support have also been implemented. Despite such efforts, access to HIV/AIDS services by the community had not been realized as desired. For instance, the annual report from Arua regional referral hospital for 2012 showed that the characteristics of

the providers are not always in tandem with those of their clients; the information, explanation, and treatment provided is not cognizant of the local illness concepts and social values. As a consequence, patients do not feel welcome and cared for at times and patients' trust in the competence and personality of the health care providers is low. All these led to a state of affairs whereby health care seemed not to meet the clients' expectations. The researcher felt that if this situation persisted then clients would lose confidence in the HIV/AIDS services, hence retarding the fight against AIDS.

Whereas several studies have been carried out by the ministry of health, such as the Uganda Service provision survey (2007); Kwesiga (2010), among others, not much attention has been directed towards assessing the role of capacity building on improving access to HIV/AIDS services. It was expected that when capacity development initiatives such as training, mobilization and monitoring are in place, then delivery of HIV/AIDS services would improve, leading to improved access for clients. Unfortunately, this information was not readily available and this is the gap that this study sought to cover, by studying ARRH.

1.8 General Objective of the study

The general objective of this study was to assess the contribution of capacity development interventions to the access of HIV/AIDS services for people infected with and affected by HIV/AIDS at Arua Regional Referral Hospital.

1.8.1 Specific Objectives of the study

Specifically, the study sought;

1. To examine the contribution of mobilizing political leaders towards improved access to HIV/AIDS services at ARRH

2. To study the contribution of training of health workers towards improved access to HIV/AIDS services at ARRH
3. To investigate the contribution of monitoring towards improved access to HIV/AIDS service at ARRH

1.8.2 Research Questions

The study sought to address the following questions;

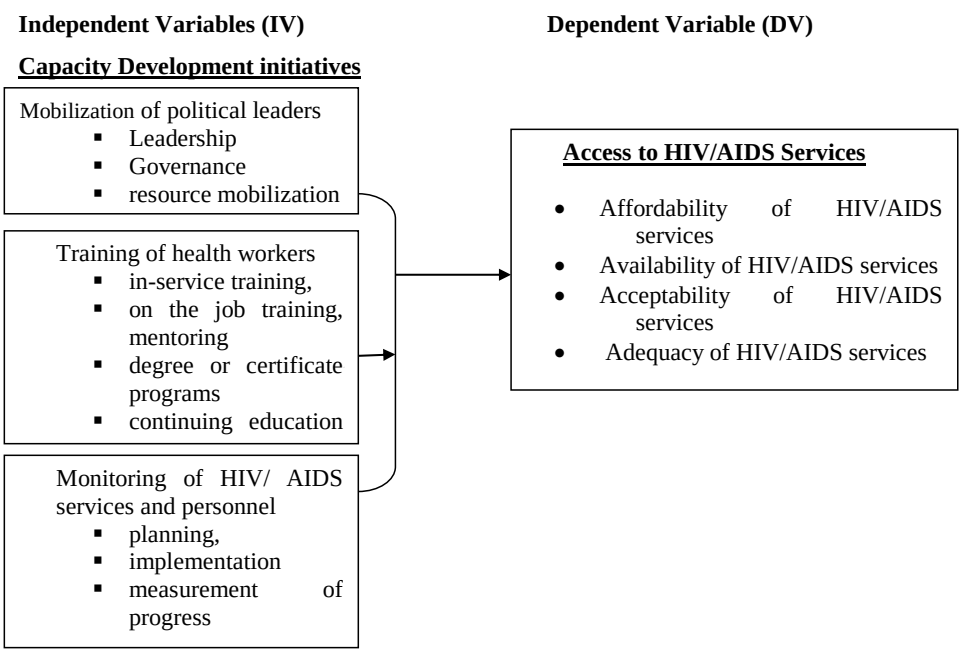
1. How has the mobilization of political leaders contributed to improved access to HIV/AIDS services for the people of ARUA Municipality?
2. How has training of health workers contributed to improved access to HIV/AIDS services?
3. How has monitoring contributed to improved access to HIV/AIDS services in ARRH?

1.8.3 Hypotheses

1. Mobilizing of political leaders has a significant contribution towards improved access to HIV/AIDS services.
2. Training has a significant contribution towards improved access to HIV/AIDS services.
3. Monitoring has a significant contribution towards improved access to HIV/AIDS services.

1.9 Conceptual Framework showing the contribution of CDI to access of HIV/AIDS services

Figure 1: Conceptual Framework



Source: *Adopted from Rondinelli D. A. (1994) and modified by the researcher*

It was hypothesized that capacity building initiatives such as mobilization of local leaders, training and monitoring of services and personnel in Arua Regional referral hospital would lead to improved access to HIV/AIDS services for people infected and affected by HIV/AIDS along the different dimensions of access, which were; Affordability, Availability, Acceptability, Accessibility and Adequacy.

1.10 Significance of the Study

The findings of this study contribute to national efforts aimed at reducing the prevalence of HIV/AIDS and improving the quality of life of people infected with and affected by HIV/AIDS in Uganda. The study would also help policy makers and program managers by way of providing data to inform decision making and programming.

1.11 Justification of the Study

This study adds to the existing body of knowledge of capacity development for HIV/AIDS service delivery in Uganda by exploring the extent to which the Social Development theory applies in terms of access to service delivery. It was established through this present study that political mobilisation and training, as aspects of capacity development interventions, greatly and significantly contribute to enhancing access to HIV/AIDS services.

1.12 Scope of the Study

1.12.1 Geographical scope

The study covered Arua Regional Referral Hospital (ARRH) located in the West Nile sub-region of Uganda. ARRH was chosen because it is major referral facility implementing a model HIV/AIDS programme (Arua Hospital AIDS Programme [AHAP]). This provided the opportunity for the research to elicit first-hand information from mostly the clients and staff, regarding AHAP.

1.12.2 Time scope

The study covered the period 1994-2010, because it is within this period that capacity development initiative programme was running, having been established in Arua Regional

Referral Hospital in 1994. The researcher assumed the time scope would enable for an informed evaluation of the contribution of the capacity development initiatives towards improved access to HIV/AIDS services.

1.12.3 Content

The study had the independent variable as Capacity development initiatives, conceptualized as training and mentoring, mobilizing political leaders, and monitoring; whereas the dependent variable was access to HIV service delivery in Arua Regional Referral Hospital, conceptualized in terms of affordability, availability, acceptability and adequacy.

1.13. Operational definitions of key terms and concepts

Capacity is defined as ―the ability of individuals and organizations or organizational units to perform functions effectively, efficiently and sustainably

Capacity building is an evidence-driven process of strengthening the abilities of individuals, organizations, and systems to perform core functions sustainably, and to continue to improve and develop over time.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction.

This chapter gives a reviews and analysis of the literature on Capacity Development Interventions (CDI). The section mainly focused on the theoretical review and the review of related literature. All sources cited were acknowledged accordingly.

2.2 Theoretical Review

2.2.2 Social Development Theory

According to Jacobs and Harlan Cleveland (1999) Social development is defined as the process of organizing human energies and activities at higher levels to achieve greater results Development increases the utilization of human potential. Social development Theory leads to the discovery of the infinite creative potentials of the human being. The theory contends that social development consists of two interrelated aspects – learning and application. Society is said to discover better ways to fulfill its aspirations and it develops organizational mechanisms to express that knowledge to achieve its social and economic goals. The process of discovery expands human consciousness. The process of application enhances social organization.

The theory, according to Vygotsky (1896-1934), contends that society develops in response to the contact and interaction between human beings and their material, social and intellectual environment. The incursion of external threats, the pressure of physical and social conditions, the mysteries of physical nature and complexities of human behavior prompt humanity to experiment, create and innovate. Just like in this study, capacity development is both an

experiment and innovation to overcome challenges to service delivery. The experience resulting from these contacts leads to learning on three different levels of our existence. At the physical level, it enhances our control over material processes. At the social level, it enhances our capacity for effective interaction between people at greater speeds and distances. At the mental level, it enhances our knowledge.

Garry Jacobs, Robert Macfarlane, and N. Asokan (1998) argue that while the learning process takes place simultaneously on all these planes, there is a natural progression from physical experience to mental understanding. Historically, society was developed by a trial and error process of physical experimentation. Physically, this process leads to the acquisition of new physical skills that enable individuals to utilize their energies more efficiently and effectively. Socially, it leads to the learning and mastery of organizational skills, vital attitudes, systems and institutions that enable people to manage their interactions with other people and other societies more effectively. Mentally, it leads to organization of facts as information and interpretation of information as thought. The outcome of this learning process is the organization of physical skills, social systems, and information, which are then utilized to improve the efficiency and effectiveness of human activities. It is a cyclical process in which people are continuously learning from past experiences and then applying that learning in new activities.

The theory was relevant to this study because it provided a conceptual framework for discovering the underlying principles common to the development process in different fields of activity, countries and periods. It also provided a framework for understanding the relationships between the accumulated knowledge generated by many different disciplines.

Capacity development and access to HIV/AIDS services

According to a document by Center for Disease Control (CDC) (no date), Capacity building is holistic and developmental by nature. A competent and capable individual, organization, or community depends upon many different systems or aspects operating together effectively. Capacity building is achieved in stages, from individual to organization to community. If the capacity of an individual is increased, he or she will be more capable and valuable to the organization. If the value of the organization is increased, the community will benefit directly. If the community has strong capacity for providing HIV prevention services or care, then people at risk for HIV infection, or already infected, will have access to better health services.

2.3 The contribution of Mobilization political leaders towards access to HIV/AIDS services

Although a lot of money has been used for HIV/AIDS interventions, HIV rates continue to rise, stigma remains and most notably access to HIV/AIDS services remains low (Gregson et al., 2007). Efforts to address access to services for people infected and affected by HIV/AIDS should not be focused only on the formal health-care delivery system. Given that resources are very scarce to reach all in need, it has become necessary to go beyond a focus on health professionals and established service providers and beyond facility-based service provision to include other actors like lay people, families, people living with HIV, community organizations and local politicians. Mobilizing community groups and politicians in particular is increasingly seen as a vital precondition for creating health enabling social environments that enable and support people in their efforts to access HIV/AIDS services (Campbell and Cornish, 2010).

2.3.1 Benefits of mobilizing political leadership

Campbell and Cornish, (2010) argue that community based groups like local leadership play a central role in taking responsibility for HIV/AIDS. They further observe that the scale of the HIV/AIDS problems as well as social marginalization of many affected groups make it difficult for the health and welfare professionals and HIV services to reach the vast number and variety of people vulnerable to HIV and affected by AIDS. The argument is that community groupings such as the local leaders are better placed than formal public services to reach the hard to reach groups such as such as prostitutes, men who have sex with other men and residents of remote or poorly served rural areas and so on.

Scarcity of health workers renders mobilization of political leadership important especially in the developing countries in which HIV/AIDS is rampant. Political mobilisation for the purpose of improving access to AIDS services is in line with the internationally promoted agenda of task shifting (World Health Organization, 2008).

Finally, mobilizing politicians at the community level provides valuable opportunities through which people can develop a stronger sense of urgency, especially in tackling problems that undermine their health (Hlophe and van Rensberg, 2008)

Resource challenges are likely to hinder sustainability of such an approach to curbing HIV/AIDS; it takes a substantial amount of resources to mobilize community members to participate, resources which may not be readily. On the other hand there is an opportunity cost for local leaders to participate in such community activities at the expense of their routine duties. Politicization may also become a challenge as those mobilized may want to associate all benefits

to their party of affiliation, a factor that may bar others' corporation. However adequate sensitization and extensive planning can ease the mobilization of political leaders.

Mobilization of political leaders can become challenge and can, to the contrary, hinder access to services: for instance, a study by Campbell (2003) found that a project in Summertown (a rural mining town in South Africa) failed due to lack of political will. Political will referred not only to formal political leadership, but also the will of groups and individuals in the wider range of micro and micro-social contexts within which economic and gendered power relations are produced. At the macro level, the inappropriate response of politicians and the failure of government to deal with the HIV/AIDS problem from the onset contributed to the failure of the project that aimed at mobilizing for HIV/AIDS interventions in Summertown. Campbell (2003) also noted that lack of political will with the traditional leadership system in the community was due to the variance in goals of the project against those of the traditional leader who derived his political power from his position as guardian of tradition. Vaughan (2010) on the other hand observes that the age gap between youth and elderly often becomes a challenge in the use of political leaders for mobilization. It becomes difficult to create fruitful dialogue between the influential adults and the young people.

Summarily, implementation of such initiatives can be opposed if the local leaders are not engaged from the onset. Leaders must be made to appreciate the benefits of such interventions, by providing adequate information, through sensitization and consultation. In addition, other than the contextual and social factors, inadequate resources may also hinder efforts to engage political leaders through mobilization.

The study findings showed that political mobilisation plays a key role when it comes to promoting access to HIV/AIDS services. They reach areas where health workers would not reach and in many cases, the communities have confidence in them, by virtue of their leadership positions and roles.

2.4 The contribution of Training towards the access to HIV/AIDS services

One of the biggest challenges in scaling up access to HIV prevention, treatment and care is the shortage of adequately prepared human resources (WHO, 2007). The shortage of health workers is recognized as one of the critical bottlenecks in the efforts to reach international health and development goals, including the goal of universal access to HIV treatment, prevention, care and support. Conversely, the HIV epidemic has further exacerbated the health workforce crisis by significantly increasing workloads while simultaneously devastating existing workforces (WHO, 2007)

When focusing specifically on individuals, two approaches have shown to be effective. The first is a bottom-up approach that provides staff of an organization with information and skills that benefit them and their organization. Examples of this approach include further training in HIV counseling and testing for health practitioners or broadening the skills and knowledge base of HIV prevention outreach workers. With this approach, the organization involved must be committed to continuous learning and investment in the development and advancement of the staff (CDC, not dated).

Other related literature reveals that insufficient financial resources are an impediment to universal access to HIV/AIDS services, which as well affects the countries' ability to engage their health human resources in meaningful training to enhance service delivery. Most

developing countries are heavily dependent on donor support to finance HIV/AIDS program activities, including; training and salary support for health workers. Only in Thailand, thanks to significant government commitment and incorporation of HIV/AIDS services into the health insurance, have financial resource issues been largely overcome (WHO, 2009). In Ivory Coast for example, the number of health workers recruited into the health care system from 1996 to 2006 represented only 40 percent of the needs identified by its ministry of health and in Mozambique, the health budget has not increased for the past three years - affecting government's ability to train and provide incentive payments for medical staff serving remote areas (WHO, 2009).

However, it would appear deceitful to hide behind limited resources as barrier to recruitment and retention of health worker, because even when recruited, health workers in developing countries have often preferred private practice or abscond from duty at the expense of their clients. In addition, even when resources are available, some governments have found health expenditure less of a priority. Therefore, such situations have in many cases limited access to HIV/AIDS services. When clients walk in to a facility and they have no one to attend to them, they resort to other strategies to address their predicament, including to witch doctors in some instances.

Secondly dissatisfaction with low salaries, large workloads and difficult working conditions, are factors that reduce health workers morale, increase absenteeism and lead to high attrition among highly skilled government practitioners, particularly in rural hardship areas and among the hard to reach areas. In Ethiopia, attrition of health workers from public health facilities to the NGO sector has been observed. Such factors affect access to services especially for the rural poor who cannot pay for services in the private sector (WHO, 2009). Other than the low salaries,

corruption may significantly affect the way in which health personnel carry out their duties; it common in the developing to find that medical people may not even have the basic requirements a such as gloves or adequate power supply to perform medical or treatment procedures. However, while training may not replace the availability of medical equipment, it avails the health workers with other skills to be more creative amidst scarcity. This reduces their stress on the job, and therefore their intentions to leave their jobs.

Thirdly, systems to recruit, hire, pay, supervise and support workers are not clear and cannot be relied upon. For example, the decentralized systems of Ivory Coast and Mozambique lack the capacity at both central and local level to develop and implement policies, empower managers and motivate workers WHO (2009). Therefore as long as managers are not empowered and workers not motivated, access to services will be more difficult for those suffering from HIV/AIDS. In some settings, those seeking to become health personnel may have to pay bribes if they must be deployed.

Literature shows that efforts have been adopted to improve access to HIV/AIDS services, however deliberate capacity development efforts directed towards improved access to HIV/AIDS service delivery were not in most of the reviewed studies. This study sought to explore and address this knowledge gap. Findings showed that while training was conducted, there were several gaps enumerated in the manner that trainees were selected. Despite the short comings, the results showed that training of health workers significantly contributed to increasing access to HIV/AIDS services.

Reviewed literature further revealed that government ownership, commitment and political will to counter the HIV/AIDS epidemic are essential in expanding human resource for health which

can lead to improved access. In addition, donor support to supplement government's commitments to treatment and care has been found to be essential in improving access to HIV/AIDS service delivery (WHO, 2007). In Ethiopia, 88 percent of HIV/AIDS financing was provided in 2006 by external sources. Mozambique financed its AIDS expenditures (85 percent) from external sources in 2006 with approximately 19 major donors.

Task shifting, one of the benefits of training, has been identified as the other major option in improving access to AIDS service especially in resources poor setting. According to the WHO (2007) task shifting is the assignment of clinical roles by shifting tasks to different cadres of health workers. Nurses may become involved in prescribing drugs, lay counselors may be involved in testing, other new cadres may be introduced to perform specific tasks and patients may be engaged to take over some elements of their own care (WHO, 2007). Community health workers can deliver a range of quality services while freeing time of qualified medical personnel. The main purpose of task shifting is to relieve health professionals from the work load while maintaining quality standards for patients and increasing access for interventions. The option of task shifting has repeatedly been identified as an effective strategy for addressing shortages of health workers in HIV treatment and care. Task shifting is believed to offer quality, cost-effective care to more patients than a physician centered model. The main challenges to implementation will be training, support and pay for the staff carrying out new roles, the integration of new members into the health care teams and compliance of regulatory bodies (Callaghan, 2010). The findings of this present study showed that while some staff have been trained in the expectation that service delivery would improve, there were still challenges of staff shortage, especially with the ever growing number of clients who visit ARRH, yet the number of health workers is still stagnant. Efforts to train community members, especially some HIV/AIDS

clients to reach out to the communities have been done, but the challenge still remains with the inadequate finances, yet the community workers need to be facilitated. A similar challenge was also reported about the political leaders who would be very helpful in passing on HIV/AIDS related information but the inadequacy of funding, as was noted through the various responses, has been a big impediment to their role. The political leaders need facilitation in terms of transport and other needs in order to traverse the rural communities, a budget which ARRH does not have. This hinders their contribution.

2.5 The contribution of monitoring towards the access to HIV/AIDS services

Monitoring and evaluation are activities used to determine if a program is producing the desired results, and if the results are equally valuable to the capacity-building assistance provider and the recipient organization. For an organization to assess the success of its programs and related programmatic activities, it is critical that monitoring and evaluation mechanisms are in place from the planning phase to the outcomes. Each evaluation component is designed to answer specific programmatic questions.

People living with and households affected by HIV/AIDS require services, including psychological, social, legal and clinical. These needs reflect an environment in both industrialized and resource-constrained settings in which stigma; discrimination, fear, neglect and impoverishment surround HIV/AIDS to various degrees in the community, workplaces and health care settings (WHO, 2004). In order to address these needs, HIV/AIDS care and support programmes should meet the objectives of: ensuring equitable access to diagnosis; health care, pharmaceuticals and comprehensive supportive services; reducing morbidity and mortality from HIV/AIDS and related complications; promoting opportunities for preventing HIV transmission

within the delivery of care and support services; and improving the quality of life of both adults and children living with HIV/AIDS (WHO, 2004, p.9). Ensuring that objectives are met in the context of service delivery for HIV/AIDS means that close attention should be paid, from the conception through to implementation stage.

WHO (2004) observes that as efforts to increase access to health care, pharmaceuticals and supportive services for people living with HIV/AIDS and their families are strengthened, the need for information on monitoring and evaluation also grows. HIV/AIDS Care and support indicators are meant to provide information for local, national and international programmes on key trends regarding access to services. The information required to measure progress can be drawn from data sources such as national surveys of HIV/AIDS care and support, programme reports or other documents.

Monitoring and evaluation activities allow country health authorities and their partners to assess the extent to which programmes are being implemented and are achieving the intended objectives. Despite similarities, monitoring and evaluation differ in the extent to which findings at each level of service delivery can be attributed to a specific intervention or programme (WHO, 2004). Monitoring aggregates information across sites and time and optimally serves as a tool to highlight for programme managers which programme components may need to be strengthened or modified to reach specific goals. Monitoring frequently counts the number of people receiving programme services (such as the number of people receiving pretest counseling).

In light of the literature reviewed, results showed that there were various mechanisms through which monitoring and evaluation was conducted, so as to get feedback from the clients, and to know which areas needed more attention. This too was noted to be an important aspect through

which ARRH would realize better access to HIV/AIDS services. From the study findings, it was noted that ARRH carried out surveys with their clients, in order to gauge the quality of the services delivered. These centred on waiting time for the patients, the number of clients visiting the facility (if it was increasing) and in some cases, it was done on a one-to-one basis, where the health workers engaged the clients, with the intention of establishing their views in respect to the services offered.

2.6. Summary of Literature Review

Improving access to health services in general is the obligation of the government of Uganda and in carrying out this obligation; the government must work with the different stakeholders. It is paramount therefore for government and other stakeholders to develop context specific strategies to deal with the challenges involved in HIV/AIDS care and support for people and families infected with and affected by HIV/AIDS.

As various stakeholders ponder the best practices to improve access to HIV/AIDS service for people infected with and affected by HIV/AIDS, it has become apparent that there is need to look beyond the traditional formal mechanisms of delivering health services. Political leadership must be mobilized for the benefits that come a long working with this groups. Training stakeholders and monitoring how HIV/AIDS activities are carried out is suggested to help shape how services can better be accessed by those in need.

The main gaps identified in the literature included: limited leadership with the conviction and will to fight the HIV/AIDS epidemic, both at the national and local level. It was also noted that there were human resource constraints to the fight against HIV/AIDS, which shortages must be dealt with; and finally delivery of services was not well monitored to assess the gaps and

progress made. Study findings showed that there was a close association between capacity building interventions and access to HIV/AIDS services. On the basis of the study findings, recommendations as to how the gaps identified through the literature can be addressed, are made in Chapter five of this study.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents a detailed description of the methodology that was adopted for this study. The research design, area of study, study population, sample size, sample selection and procedure, methods of data collection and data analysis, geographical area where the study was conducted are described. The instruments used to collect data, including methods which were implemented to maintain validity and reliability of the instrument are also presented in this chapter.

3.2 Research Design

This study adopted a triangulation of cross sectional survey and case study research designs. A cross sectional survey provides accurate portrayal of the characteristic for example behaviour, opinion, beliefs and knowledge of a particular individual or group, at one point in time. The design was chosen because it would help the researcher use less time as compared to other designs like a longitudinal survey**.** A case study design was preferred because it allows for in-depth investigation of the study phenomenon for purposes of generalization (Odhiambo, Kakooza: 2002). Focus was placed on understanding how ~~TASO's~~ Capacity Development Interventions that had been put in place by TASO contributed to the access of HIV/AIDS services in ARRH. The study employed both the qualitative and quantitative research approaches, the reason that ~~it~~ both approaches complement each other; while the quantitative approach facilitates the quick collection and analysis of large volumes of data, the qualitative approach allows for the conduct of in-depth study and description of the findings on the topic of study.

3.3 Study Population

The research was conducted in Arua district, particularly in Arua regional referral hospital-among its clients, staff and other opinion leaders. Hospital Management Committee members, Hospital Top Management Team, Doctors, Medical assistants, Nurses and midwives, were selected for the study. Overall, the study population comprised of five members of the hospital management committee, 10 hospital top management team members, 15 doctors, 16 medical assistants, 20 nurses and midwives and 125 clients, totaling to 191 subjects.

3.4 Sample size and Selection

Out of the population of 191 subjects, a sample (S) of 120 respondents was selected as shown in the table below

Table 1: Determining Sample Size and Sampling technique from a Given Population

Category	**Population Size (N)**	**Sample Size (S)**	**Sampling technique**
1. Hospital Management Committee	5	2	Purposive
2.Hospital Top Management Team	10	4	Purposive
3.Doctors	15	4	Simple random
4. Medical Assistants	16	4	Purposive
5. Nurses and Midwifes	20	6	Simple random
6. Clients	125	100	Simple random
Total	**191**	**120**	

Overall, the study sample comprised of 120 subjects. Two hospital management committee members, four top management committee members and four medical assistants were

purposively selected, while four doctors, six nurses and midwives, as well as 100 clients were selected using the simple random method.

3.5 Sampling techniques and procedure

3.5.1. Purposive sampling

Two hospital management committee members, four top management committee members and four medical assistants were purposively selected to participate in the study on account of the fact that they were deemed to have deeper knowledge about the capacity building interventions in ARRH. Hospital management and administration staff were also given questionnaires where they expressed their views and opinions on issues of management, accountability, and service delivery. In total, the study subjects involved 10 purposively selected respondents, while 110 were randomly selected to take part in the study.

3.5.2 Simple random sampling

Simple random sampling is a type of probability sampling where every element in the population has a known and equal chance of being selected as a subject (Sekaran, 2003). Simple random sampling technique was used to select 110 respondents, who included active clients currently benefiting from the HIV/AIDS services from ARRH, medical doctors and nurses and midwives. Simple random sampling method has the advantage of generalizability of the findings to the whole population and obtaining sufficient numbers of a study. In this case, respondents were subjected to questionnaires which the researcher administered, with the help of research assistants.

3.6 Data Collection Methods

The researcher deployed key informant interviews, questionnaire survey, documentary analysis and observation. Both quantitative and qualitative techniques were used for this study. According to Amin (2005), the triangulation of both data collection methods is helpful; because results from one method help to inform the other while at the same time neutralizing any inherent bias.

3.6.1 Questionnaire Survey

A questionnaire is a reformulated written set of questions to which respondents record their answers usually with closely defined attitudes (Sekaran, 2003). While questionnaires can provide evidence of patterns amongst large population, qualitative interviews often gather more in-depth insights on respondents' attitudes, thoughts and actions (Kendall, 2008). Mugenda and Mugenda (1999) contend that questionnaires enable respondents to answer without bias, are low cost and can conveniently reach many people in a short period of time. Therefore, due to those advantages, the researcher found them suitable for this study; so as to generate authentic data that would enable ARRH and other service providers faced with similar challenge, take a leaf to improve their service delivery to HIV/AIDS clients.

3.6.2 Interview method

An interview is where the researcher uses a face to face interaction to exchange views (Amin, 2005). The researcher conducted interviews with key informants who included members of the hospital management committee and top management team members of the hospital. These were selected on the basis of their key roles in the management of the hospital's affairs and were thought to have the necessary information on the study variables. The interviews provided the researcher with the chance to probe the respondents in cases of vague responses. The data

captured from the interviews helped the researcher to interpret the quantitative data and to also answer some of the research question, like the one on monitoring and evaluation, where in-depth information was needed to get a deeper understanding of the study variable.

3.6.3 Documentary review

The study involved the review of both internal and external documents so as to obtain information related to the research area. The documents were studied and reviewed in relation to the set objectives of the study. These included Journals, articles, Internal from ARRH and external reports, budgets and work plans of ARRH.

3.7 Data collection instruments

The researcher employed in-depth interviews with the help of interview guide for key respondents. This method gives respondents flexibility as they have freedom to formulate their responses (Kendal, 2008; Sekaran, 2003). The researcher was also in position to uncover new areas of the research, which would otherwise have not been discovered by use of other restrictive methods.

The researcher used both primary and secondary data sources. Primary sources included questionnaires, interviews and observation which the researcher used for getting firsthand information, and secondary sources which included use of text books, newspapers, magazines and other works such as journals.

3.7.1 Semi-structured questionnaires

Semi structured questionnaires are based predominantly on closed questions which produce data that can be analyzed quantitatively for patterns and trends which help to describe what is happening and provide a measure of respondents' opinions, attitudes, feelings and perceptions

about issues of particular concern to the researcher (Sekaran, 2003). It also helps to identify patterns and trends that merit further exploration using quantitative methods. To collect primary data, semi-structured questionnaires were administered to purposively select health workers (nurses), hospital management staff, and lower health centre staff. The essence was for the key informants to express their views on the benefits of the different capacity development interventions. Editing was done in the field so as to help the researcher to trace for the respondents in cases of inaccuracy and incomplete answers. The researcher made sure that the respondents address themselves to the questions, give relevant answers which were in line with the research topic. After editing, the researcher coded and tabulated various responses that were developed.

3.7.2 Interview guide

Data from Hospital Management Committee Heads, Hospital Top Management Team, Doctors, Medical Assistants, Nurses and Midwifes will be collected using interview guide. This allowed for in-depth questioning and to avoid any distortion of information that was collected. The researcher conducted face to face interviews in order to benefit from probing and observation of body language. They also helped to cut down costs and saved a lot of time during data collection.

3.7.3 Documentary checklist

Official records were used to gather information on the effectiveness of the HIV/AIDS capacity-building interventions in the district since the inception of the Arua Regional Referral Hospital HIV/AIDS Program. Information was gathered from published and unpublished sources such as; books, annual reports, journals, papers, strategic plans, newspapers, and newsletters. This

secondary information was used to triangulate the primary data collected through other techniques.

3.8 Quality Management of data collection instruments

3.8.1 Pretesting questionnaire

Pre-testing enables the researcher to determine whether questions and directions are clear to respondents and whether they understand what is required from them (Polit & Hungler 1995, p711). The researcher pre-tested the questionnaire on 10 respondents meeting the criteria. All of them answered the questions and no single question was changed following the pretest. The pretest was done in Jinja Referral Hospital because it had similar characteristics with the research site

3.8.2 Validity

The validity of an instrument is the degree to which an instrument measures what it is intended to measure (Polit & Hungler 1993, p448). Content validity refers to the extent to which an instrument represents the factors under study. To achieve content Validity, questionnaires included the variety of questions as per objectives.

Content validity was ensured by consistency in administering the questionnaires. All questionnaires were distributed to respondents by the researcher. The questions were formulated in a simple language for clarity and ease of understanding. Clear instructions were given to the respondents and researcher completed the questionnaires for those respondents who could not read and or write.

All respondents were expected to complete the questionnaires on spot. This was done to prevent respondents from giving questionnaires to other people to complete on their behalf. Burns & Grove (1993, p270) refer to external validity as the extent to which study findings can be generalized beyond sample used. Majority of the persons approached for the survey completed the questionnaires and consented to participate in the study.

The researcher constructed questions and then tabled them among course-mates for constructive criticisms. The questionnaire items were then discussed with the supervisor. Finally, the researcher tested for content validity using the Content Validity Index (CVI) using the following formula;

$$CVI = \frac{\text{Sum of agreement of every relevant item}}{\text{Total Number of Questions}} \times 100$$

This was arrived by using two expert judges namely Judge 1 and 2. The recommended validity is 0.6, therefore if the value of content validity is 0.6 and above, then the instrument is valid.

3.8.3. Reliability

Polit and Hungler (1993, p445) refer to reliability as the degree of consistency with which an instrument measures the attribute it's designed to measure. The questionnaires given to the respondents were expected to reveal consistency in responses. Reliability was ensured by minimizing sources of measurement error like data collector bias. Data collector bias was minimized by giving the researcher assistants prior one week training before they started administering questionnaires and standardizing conditions such as exhibiting similar personal attributes to all respondents, e.g. friendliness and support. The physical and psychological environment where data was collected was made comfortable by ensuring privacy,

confidentiality and physical comfort. Thereafter, the Cronbach's Alpha Coefficient was computed and the results showed as follows;

Table 2: Reliability test results

Variable dimension	Cronbach's alpha	Number of items
Accessibility to HIV/AIDS services	.753	6
Political mobilisation	.760	13
Training	.723	10
Monitoring	.713	05

Source: Primary data

Reliability results showed that all the questionnaire items were regarded as acceptable, since they were all above the threshold of 0.7, as recommended by Amin, (2005). On the basis of the results of the validity test, the instrument was adopted, since the instrument was considered to register consistency across time and space.

3.10 Procedure of data collection

With granted permission, the researcher accessed various officers to collect the required data for the purpose of this study. A meeting with key informants was arranged three days in advance and modalities that were to be followed were agreed upon. The questionnaires were administered by the researcher. The process involved moving to the field to look for the respondents.

3.11 Data Analysis

3.11.1 Quantitative data analysis

For analysis of data generated through the closed ended questionnaires, SPSS computer software programme was used. The raw data was coded and fed into the SPSS data analyst. Descriptive statistics such as percentages and frequencies were generated to explain the pattern of responses

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on each questionnaire item. In order to explain the relationship between the variables, correlation statistics were computed and were calculated to ascertain whether there was a significant difference or relationship between variables under study. For questions which were open- ended, content analysis was used, with the aim of quantifying emerging characteristics and concepts.

3.11.2 Qualitative Data Analysis

Qualitative data was analyzed using the content analysis which involves identification and transcribing the qualitative findings into different themes. Data was classified into content categories, themes and sub themes closely examined and compared for similarities and differences in order to deduce conclusions and recommendations. Bivariate analysis was used to determine the association between the dependent and independent variables and multivariable analysis to determine contribution of capacity development to improved access to HIV/AIDS services were also conducted.

Interviews and questionnaires were reviewed, transcribed, sorted and classified into themes and categories in order to support the hypotheses set. Patterns and trends were established; the information from the interviews and questionnaires was scrutinized and analyzed just as proposed by Mugenda & Mugenda (2003).

3.12 Measurement of variables

All the variables under study were measured using a Likert scale that has five categories to respond to: 5=strongly agree, 4=agree, 3=undecided, 2=disagree and 1=strongly disagree. According to Mugenda and Mugenda (1999) this scale is suitable for measuring perceptions, attitudes, values and behaviors that relate to capacity development and service delivery.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS

4. 1. Introduction

This chapter gives the presentation, analysis and interpretation of the study results. It is arranged into three major sections. In the first section, the response rate for the study is given. The second section presents results on respondents' (clients and staff) socio-demographic factors or background information. The third section presents results on the contribution of capacity development interventions towards improved access to HIV/AIDS services, beginning with ARRH clients' responses, followed by responses from ARRH staff. The findings from ARRH staff are presented in form of frequencies and correlation statistics for the two objectives, that is, 'The contribution of political mobilisation towards improved access to HIV/AIDS services in ARRH' and 'The contribution of health workers training towards improved access to HIV/AIDS services in ARRH'. The third objective; 'The contribution of monitoring and evaluation towards improved access to HIV/AIDS services' was analysed and presented using the qualitative approach.

4.2. Response rate

In this study, a sample of 120 respondents was targeted, and these included clients of ARRH, health personnel and other opinion leaders. Out of these, 112 managed to respond to the questionnaire and the key informant interviews. The study response rate was therefore computed as follows;

Number of respondents x 100
Number of study sample

Therefore, the response rate of the study was

112 x 100

120 = 93%

Nulty (2008) considers an acceptable response rate of 50% as adequate and 60% as good. The response rate of 93% in this research was therefore considered as good and representative of what would have been obtained from the population.

4.3. Socio-demographic factors

In this section, the socio-demographic characteristics of the respondents are presented. The socio-demographic characteristics for the study included; gender, age distribution, highest level of education attained and position in the health facility (for the health personnel). Emerging results are presented in the tables below, showing both the frequency counts and the percentages.

4.3.1. Clients' Gender and age distribution

Table 3: Gender distribution of the HIV/AIDS clients in ARRH

Gender		
	Frequency	*Percent*
Male	45	45
Female	50	50
Non response	5	5
Total	101	100.0

Source: Field data

Age

Table 4: Age distribution of HIV/AIDS clients in ARRH

Age category	*Frequency*
20 and below	**7**
21 to 30	**28**
31 to 40	**35**
41 to 50	**20**
51 to 60	**11**

Results revealed that majority of the HIV/AIDS clients of ARRH who took part in the study were female (50), while the male respondents were 45. Five of the respondents did not respond to the item about their gender. This shows that the different gender categories were well represented and there was less likelihood of the results being biased in favour of one gender category. The results further reveal the fact that in many instances, females demonstrate better health service seeking habits, compared to the males.

Most of the HIV/AIDS clients of ARRH who participated in the study (35) were in the age bracket of 31 to 40, followed by 28 who were in the category of 21 to 30, while those who were 20 years and below were least represented at only seven (7) respondents. It should be noted that generally, most statistics related to trends in accessing health care show that females tend to be more regular at health care facilities than their male counterparts. However, the national surveys in Uganda also indicate that the HIV/AIDS prevalence is higher among the females than the males, which could further explain the variations in the gender of respondents in ARRH. Further, results showed that majority of the respondents were in the age categories between 21 and 50 years. This too is a reflection of the trends in HIV/AIDS infection in Uganda, with most of the clients being in that age group of people who are more sexually active and therefore more likely to be exposed to the risk of HIV/AIDS infection.

4.3.2. Highest level of education attained

Table 5: Distribution of ARRH HIV/AIDS clients' by highest level of education attainment

Level of education	*Frequency (f)*
No formal education	11
P1-P4	12
P5-7	26
Secondary	34
Tertiary Post Graduate Degree	18
Total	**100**

Source: Field data

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Majority of the clients accessing HIV/AIDS services in Arua Regional Referral Hospital, who took part in the study had up to Secondary level education (34), followed by 26 who had attained education level of primary five to primary seven, while 18 had tertiary postgraduate degrees, 12 had attained education of up to lower primary (P. 1 to P.4) and 11 had no form of formal education. With majority of the respondents having some form of formal education, it implies that they were likely to adequately respond to the questions, implying high validity of the survey results. For the few who had no formal education and did not know how to read, the researcher collected data from them with the assistance of research assistants who were familiar with either Swahili or whichever language the respondent was conversant with. The results on the levels of education show that overall; most of the clients had some form of formal education. The ability to express oneself, especially when a person has some level of formal education, increases their ability to seek services, such as health related services. Such people are able to easily read and follow instructions regarding drugs or even report about any health related concerns they may be experiencing with more ease, compared to those with no education at all.

4.3.3. Socio-demographic statistics of the health personnel

4.3.3.1. Highest level of education attained

Views were sought on the health staff' levels of highest education attainment, as presented in Table 6

Table 6: distribution of ARRH staff by highest level of education attained.

Highest level of education attained		
	Frequency	*Percent*
Certificate	4	33.3
Diploma	6	50.0
Degree	1	8.3

Master degree	1	8.3
Total	**12**	**100.0**

Source: Primary data

Out of the 12 medical workers who participated in the study, six of them had diplomas, four held certificates, while one had a degree and another had a master's degree. This implied that the medical staff had the required level of education and health training and would therefore be likely to offer the expected level of service delivery to their clients. The high levels of education for the staff were a reflection of their ability to effectively offer the appropriate services to their clients, thus increasing access to HIV/AIDS service delivery in ARRH.

4.3.3.2. Position in the facility

The researcher sought to establish the respondents' position in the medical facility, so as to validate the kind of data generated. Results are presented in Table 7

Table 7: Respondents by position in the facility

Position in the facility		
	Frequency	*Percent*
Medical Assistant	2	16.7
Nurse	10	83.3
Total	**12**	**100.0**

Source: Primary data

Concerning their positions in the facility, majority of those who were interviewed (10) were nurses, while 02 were medical assistants. Most of the health care in hospitals, like prescription of drugs, getting patients' medical history and other related care, is offered by nurses, apart from key areas that require doctors' intervention. Therefore the distribution of health service providers

in ARRH in favour of the nurses implied that the clients would have easy access to the required services.

4.3.3. Gender

The researcher sought to establish the gender representation of the respondents, as presented in Table 8

Table 8: Distribution of ARRH staff by gender

	Gender	
	Frequency	*Percent*
Male	4	33.3
Female	8	66.7
Total	12	100.0

Source: Primary data

Majority of the medical staff who took part in the study were female, while only two were male. This helped to have views of both gender categories represented in the study, so as to rule out any possibilities of drawing conclusions from gender biased views and opinions. Further, it is generally noticed that females are better care givers compared to the male counterparts, they are perceived to be nurturing. Given the nature of HIV/AIDS and its psychological dimensions, with this kind of distribution, clients not only stood high chances of accessing quality services but also, many more would be willing to visit the facility for the services. Besides, the nursing profession in Uganda is dominated by females, which too explains the variation.

4.4. Access to HIV/AIDS services

In this section, views in respect to access to HIV/AIDS services are presented, showing the descriptive statistics, where frequencies and percentages for the various items that were used to measure access to HIV/AIDS services. Access to HIV/AIDS services was conceptualised in terms of affordability, availability, acceptability and adequacy and was the dependent variable of the study. The variable was measured using nine (9) questionnaire items as Table 9 shows.

Table 9: Access to HIV in ARRH

Statements on access to HIV/AIDS services in ARRH	Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
1. Patients find the services in ARRH to be affordable	1(1.0%)	0	0	31(30.7%)	69(68.3%)
2. Medicine usually given here is adequate	8(7.9%)	3(3.0%)	30(29.7%)	50(49.5%)	10(9.9%)
3. Patients usually receive HIV drugs whenever they need them	0	1(1%)	28(27.7%)	72(71.3%)	0
4. The health workers attend to the patients well	0	0	5(5.0%)	54(53.5%)	42(41.6%)
5. Patients usually find it convenient to come to ARRH for the services	7(6.9%)	14(13.9%)	30(29.7%)	46(45.5%)	4(4.0%)
6. Patients don't wait long to get services in this hospital	7(6.9%)	14(13.9%)	4(4.0%)	46(45.5%)	30(29.7%)
7. Patients usually have enough privacy to share their concerns	2(2%)	1(1%)	3(3%)	51(50.5%)	44(43.6%)
8. Patients perceive ARRH services as professional	0	1(1.0%)	0	41(40.6%)	59(58.4%)
9. Medical workers usually give thorough explanation to the patients	0	1(1%)	0	37(36.6%)	63(62.4%)

Source: Primary data

Results in Table 9 show the views, perceptions and attitudes of the staff of ARRH concerning access to HIV/AIDS services. Nearly all the respondents indicated that patients found the services of ARRH to be affordable, over 50% were of the view that the medicine given at the facility is adequate, while 71% indicated that patients receive drugs whenever they need them. This trend, as one of the key informants revealed, could be attributed to the intervention of Medecins San frontiers, which helped ARRH with drugs and therefore enabled them to meet the demands of the patients.

However, as one key informant observed, with the winding down of the programme, ARRH may find itself in a situation where drugs may not be easily available, owing to the fact that the drugs the hospital gets from NMS do not have a constant supply pattern, leading to frequent stock-outs. In terms of attention to the patients, 95% of the respondents were of the view that health workers

attend to the patients well, a factor that would encourage many more HIV/AIDS patients to attend the facility for HIV/AIDS services. Noted also was that 75% of the respondents were of the view that patients do not wait long to get the HIV/AIDS services, while 99% indicated that patients perceived the services at ARRH as professional and would therefore not hesitate to recommend others who would be in need of similar services.

Much as the quantitative results showed that nearly all patients indicated that medicines were always available at the facility, the qualitative results showed that drugs were often inadequate, especially those that are supplied by government. Even for those drugs that are supplied, one respondent noted that their delivery is often not timely and this affects treatment and adherence.

Commenting on access to HIV/AIDS services, one key informant noted that the number of patients is often overwhelming given that AHAP services are extended beyond the borders of Uganda, such as Democratic Republic of Congo and South Sudan, which has stretched the already small facilities that ARRH has. He also noted that quite often the staff available are few and at times fail to give timely services. "*Currently the staffs we have for the AHAP programme were recruited and belong to MSF and since MSF will be withdrawing their assistance soon, this leaves the establishment extremely worried on how we are going to cover that void*", he shared. This view showed that there were several efforts to increase access to HIV/AIDS services, including increasing the number of health care givers in partnership with other agencies.

It was further noted that adequate follow-up had not been fully achieved due to inadequate staffing within the AHAP programme. The negative outcome of inadequate follow-up is that some of the clients may not adhere properly to the recommended treatment which is detrimental to the achievements already made.

4.5. Findings on the contribution of Capacity Development Interventions on access to HIV/ADS services in ARRH

In this section, findings on the contribution of the various capacity development interventions are presented. In order to address the research questions adequately and objectively, the researcher collected data from both the service providers (staff of ARRH) and the clients of ARRH. The results presented show responses from the two categories of respondents and they are presented in form of: descriptive statistics, highlighting frequency scores and percentages to show the trend of responses on each of the items on the study questionnaires; correlation matrices which are used to show the relationship between the study variables. Further, the coefficient of determination was computed, using the correlation results, so as to ascertain the effect of the independent variable on the dependent variable. For ease of data collection and analysis, two variable dimensions, that is; political mobilisation and training if health workers were handled quantitatively and data was mainly collected using the questionnaire, though interviews and documentary reviews were done to collect qualitative data, in order to triangulate with the quantitative data. For monitoring, the researcher primarily used a qualitative approach, where data was collected through interviews, observation and documentary review. This approach was chosen because the researcher wanted to conduct an in-depth investigation of the study variable.

4.5.1. The contribution of political mobilisation towards improved access to HIV/AIDS services in ARRH

In this section, descriptive statistics results from the clients and staff of ARRH are presented, showing their views and perceptions in respect to whether mobilisation of political leaders can impact on access to HIV/AIDS services in ARRH. Respondents were given a set of items on the questionnaire, to indicate their level of agreement or disagreement in respect to the questionnaire

items that were used to measure their attitude and perception towards political mobilisation. The responses presented in the subsequent sections, showing descriptive statistics (frequencies and percentages) and correlational statistics.

ARRH HIV/AIDS clients' views on the contribution of mobilizing community leaders towards improved access to HIV/AIDS

Table 10: descriptive statistics on mobilizing political leaders

Statements on the contribution of mobilizing political leaders towards improved access to HIV/AIDS services in ARRH	Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
1. I am aware political leaders are mobilised to improve access to services	15(14.9%)	16(15.8%)	5 (5.0%)	44(43.6%)	21(20.8%)
2. Political leaders help improve access to services	12(11.9%)	24(23.8%)	6(5.9%)	42(41.6%)	16(15.8%)
3. Political leaders are available to community members	8(7.9%)	19(18.8%)	11(10.9%)	50(49.5	12(11.9%)
4. Political leaders are easily accessible	9(8.9%)	30(29.7%)	11(10.9%)	36(35.6%)	14(13.9%)
5. I am comfortable discussing my problems with political leaders	11(10.9%)	30(29.7%)	6(5.9%)	36(35.6%)	17(16.8%)
6. Clients are comfortable sharing their problems with political leaders	9(8.9%)	31(30.7%)	21(20.8%)	24(23.8%)	15(14.9%)
7. Political leaders do not segregate among the local population	9(8.9%)	36(35.6%)	10(9.9%)	33(32.7%)	12(11.9%)
8. Political leaders reach more people than would the formal health officers	12(11.9%)	30(29.7%)	9(8.9%)	32(31.7%)	17(16.8%)
9. Political leaders reach hard to reach areas	7(6.9%)	21(20.8%)	8(7.9%)	43(42.6%)	21(20.8%)
10. Political leaders help local people solve their own problems	8(7.9%)	34(33.7%)	13(12.9%)	38(37.6%)	7(6.9%)
11. Political leaders help solve the problems of scarcity of health workers	5(5.0%)	23(22.8%)	13(12.9%)	49(48.5%)	9(8.9%)
12. Political leaders reach all community members who need attention	4(4.0%)	40(39.6%)	11(10.9%)	37(36.6%)	7(6.9%)
13. HIV/AIDS services are more accessible with the help of political leaders	8(7.9%)	20(19.8%)	13(12.9%)	41(40.6%)	17(16.8%)
14. There is political will to improve access to HIV/AIDS services	8(7.9%)	13(12.9%)	10(9.9%)	36(35.6%)	31(30.7%)
15. Age gap differences do not fail political leaders in mobilising locals	9(8.9%)	15(14.9%)	6(5.9%)	38(37.6%)	31(30.7%)
16. Political leaders carry out adequate sensitisation of community members	12(11.9%)	18(17.8%)	12(11.9%)	31(30.7%)	26(25.7%)

Source: Primary data

Results in Table 10 show that majority of the clients of ARRH (64%) agreed to the statement that; 'I am aware political leaders are mobilized to improve access to services'. Further, more than half of the respondents agreed that political leaders help improve access to services, while 66% agreed that there is political will to improve access to HIV/AIDS services. The findings implied that the clients felt assured of accessibility to the HIV/AIDS services. However, some views from the qualitative findings seemed to suggest otherwise.

It was noted the challenge of transport to the remote areas had affected the political mobilisers. Notably, one key shared; *"Transport challenges have hindered greatly our services, given that we cannot do support supervision and follow up of clients for adherence purposes".* This was a pointer to the financial limitations which affect the political mobilisers' work. Consequently, some clients may miss out on some of the services since they too at times were not in position to move to the health facilities.

Noted also was the challenge of inadequate infrastructure which was perceived to be a main hindrance to services delivery in the hospital. *"There is a lot of congestion in the clinics and this has made service delivery a big challenge really"*, noted one key informant. The congestion at the facility may hinder some clients from accessing the services and in addition, some may end up getting other opportunistic infections.

Related views from the respondents on access to HIV/AIDS services showed that the medical personnel were constrained in terms of funding and they frequently had drug stock-outs –, though partners like Medecin Sans Frontiers could supplement drug shortages. There was also noted to be a challenge of having a large cohort, yet the staffing levels are still low, especially in the event that the partners ceased to work with them. Noted also was the issue of political,

having too many patients, language barrier when it comes to Congolese & Sudanese, among others.

Over 60% the respondents were of the view that political leaders are available to community members. In addition, half of the respondents also agreed to the statement that 'political leaders are easily accessible'. More so, 52% of the respondents indicated that they would be comfortable discussing their problems with political leaders, though in a follow-up statement, a significant number of them (40) indicated that clients are uncomfortable discussing their problems with political leaders. As regards to whether political leaders carry out adequate sensitisation of community members, majority of the respondents (56%) agreed to the statement, while about 30% indicated disagreement. These views imply that the clients' perception is that political leaders play a pivotal role which can enhance access to HIV/AIDS service delivery. However, despite the positive contributions, one key informant faulted some politicians who have negative views;

> The negative response of some politicians towards efforts aimed at engaging local leadership in the fight against HIV/AIDS has become a big challenge. This frustrates mobilising local leadership in the fight against HIV/AIDS. Since political leaders must first be reached before one can reach the community members, some of them have taken advantage of this to frustrate such efforts through directly declining to give help and others ask for unrealistic amounts of money from the AHAP.

From this, one can note that the leadership has made a significant contribution in terms of helping the community get access to HIV/AIDS services in ARRH.

Concerning whether the respondents felt HIV/AIDS services would be more accessible with the help of political leaders, 58% of the respondents indicated agreement, while 28 were in disagreement with the statement. Most of the respondents (64%) agreed to the statement that 'political leaders reach hard-to –reach areas'. However, a significant portion of the respondents did not seem to agree that political leaders reach such areas. This view concurred with what one key informant noted that; *"Some communities live in hard to reach areas and therefore mobilising these groups is a big challenge. It involves travelling long distance to coordinate efforts of various groups".* This showed that whereas many of the political leaders would wish to reach as many people in the community, the geographical limitations are in some cases a big setback, given the fact that most of the rural communities are sometimes too far apart. This also suggested an issue of finances which may not be adequate to address all the needs, as one key informant noted;

> Lack of funds handcuffs efforts to mobilise local leadership to participate in the different programmes. The lack of adequate funds has forced the programme to operate under a consortium where all associations and groups in the region are registered and through this, quarterly meetings are organized where experiences are shared. Such meetings would be frequent had there been more funds.

This showed that whereas there was political will from the leadership to work hand in hand in improving access to HIV/AIDS services, the financial challenges were a huge limitation, especially considering the transport limitations in the region. This, if not addressed, can negatively affect access to HIV/AIDS services, with some clients failing to progress with their treatment, a concern that can affect their drug adherence. This further illustrates that unless such

challenges are addressed, the HIV/AIDS interventions may not yield meaningful results as would have been expected, especially in the rural setting similar to that of ARRH.

It was also noted through one of the key informants that due to involvement of political leaders, much had been registered in the area of access to HIV/AIDS services. He noted added;

> Adherence among the HIV clients has greatly improved. Stigma and discrimination has been minimized considerably. Issues of awareness and reproductive health among the couples and youth have greatly improved due to the recruitment of the local leadership. More people are accessing the services through the collaboration of AHAP (a drama programme) and community leaders.

The results from the descriptive statistics and those collected through the key informant interviews therefore highlighted the major contributions of political leadership in helping the communities access HIV/AIDS services in ARRH. To explain the variable further and triangulate the findings, views were sought from the service providers at ARRH, as shown in Table 11.

4.5.1.1. Views from staff of ARRH on Political mobilisation

Table 11: Descriptive statistics showing the health workers' views on political mobilisation

Statements on political mobilisation	Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
1. I am aware political leaders are mobilised to improve access to services	4(33.3%)	4(33.3%)	1(8.3%)	3(25.0%)	0
2. Mobilising political leaders has increased access to services for HIV/AIDS patients	3(25.0%)	4(33.3%)	2(16.7%)	3(25.0%)	0
3. Mobilising political leaders has reduced resource constraints to service delivery	3(25.0%)	2(16.7%)	1(8.3%)	5(41.7%)	0
4. Political leaders are available to community members	0	4(33.3%)	2(16.7%)	6(50.0%)	0
5. Political leaders are easily accessible	1(8.3%)	6(50.0%)	1(8.3%)	1(8.3%)	3(25.0%)
6. I am comfortable working with political leaders	1(8.3%)	5(41.7%)	2(16.7%)	3(25.0%)	1(8.3%)
7. I believe community members are comfortable dealing with political leaders	2(16.7%)	0	3(25.0%)	4(33.3%)	2(16.7%)
8. Political leaders help with mobilisation of the local population	0	0	5(41.7%)	5(41.7%)	2(16.7%)
9. Political leaders do not segregate among the local population	1(8.3%)	1(8.3%)	8(66.7%)	1(8.3%)	1(8.3%)
10. Political leaders reach more people than would the formal health officers	1(8.3%)	4(33.3%)	5(41.7%)	1(8.3%)	1(8.3%)
11. Political leaders reach hard to reach areas	3(25.0%)	2(16.7%)	3(25.0%)	1(8.3%)	3(25.0%)
12. Political leaders help the local people solve their own problems	2(16.7%)	4(33.3%)	3(25.0%)	1(8.3%)	2(16.7%)
13. Political leaders help to solve the problem of scarcity of health workers	2(16.7%)	0	6(50.0%)	3(25.0%)	1(8.3%)
14. Political leaders reach most community members who need attention	1(8.3%)	3(25.0%)	5(41.7%)	0	3(25.0%)
15. HIV/AIDS services are easy to deliver with the help of political leaders	1(8.3%)	3(25.0%)	1(8.3%)	5(41.7%)	2(16.7%)
16. Age gap differences do not fail political leaders in reaching all age groups of the population	1(8.3%)	0	3(25.0%)	5(41.7%)	1(8.3%)
17. Political leaders carry out adequate sensitisation of community members	1(8.3%)	3(25%)	4(33.3%)	0	1(8.3%)

Source: Primary data

Descriptive statistics from the health workers at ARRH indicated that generally, the staff fairly appreciated the role of political mobilisation in improving access to HIV/AIDS service delivery. Half of the respondents affirmed the fact that political leaders are available to community members, five of those who responded indicated that mobilising political leaders had increased access to services for HIV/AIDS patients, seven of them agreed that political leaders helped with mobilisation of the local population and seven also were of the view that HIV/AIDS services are easier to deliver with the help of political leaders. The views from the health workers confirmed what the client respondents shared, where they in most of the cases concurred with the view that political leaders significantly contribute to access to HIV/AIDS services.

In other related views on the role of political leaders, medical workers shared that political leaders play the role of support supervision, resource mobilisation through NGOs, infrastructure provision. Others also indicated that political leaders can help to mobilise people to come for VCT, they closely monitor the activities of ART sites, address the issue of drug stock-outs, help to focus and change negative attitude of health care providers such as late coming, and they can advocate for more accreditation of ART sites. It was further noted that political leaders can help in lobbying for donor funding & more allocation to health budget by government or even facilitate local resource mobilisation e.g. local labour, materials for health facility construction.

The views showed that for success to be registered in terms of increasing access to HIV/AIDS services, it is not only necessary that political leadership be involved, but also that they should be fully involved at all the different stages of service delivery. The responses clearly showed that in order to register maximum success in terms of access to HIV/AIDS services, the role of political mobilisation cannot be underestimated, given the great voice and command that they have on the communities.

4.5.1.2. The relationship between political mobilization and access to HIV/AIDS services

Table 12: correlation between political mobilisation and access to HIV/AIDS services

Political mobilisation (IV dimension)		*Access to HIV/AIDS services (Dependent variable)*
	Pearson Correlation	.666**
	Sig. (2-tailed)	.000
	N	101

***. Correlation is significant at the 0.01 level (2-tailed).*

Source: Primary data

The results from the correlation test indicated a strong degree of association between political mobilisation and access to HIV/AIDS services in Arua Regional Referral Hospital. This was illustrated through a correlation coefficient value of (r= .666**; p<.000). This meant that there was a strong relationship between political mobilisation and access to service delivery. The relationship was also subjected to a significance test (p), which showed 0.000, which was far less the recommended critical significance value of 0.05, showing that the effect of political mobilisation on access to HIV/AIDS service delivery was statistically significant. N represents the total number of respondents, who were 101. The coefficient of determination ($r^2 = .666^2$), showed that political mobilisation accounted for 44.3% of the variation in access to HIV/AIDS services. On the basis of these findings, the alternative hypothesis which stated that *"mobilising political leaders has a significant contribution towards improving access to HIV/AIDS services"* was validated.

Thus, this finding implied that political mobilisation had a significant effect on access to HIV/AIDS services. The positive and strong correlation meant that any improvement in political

mobilisation would result into a strong and significant change in terms of improved access to HIV/AIDS services.

4.5.2. Views from ARRH staff on training of medical workers

Responses were sought on the attitude and perceptions of the medical workers, concerning training, in order to establish whether it had a significant effect on access to HIV/AIDS services in ARRH. Items were given to the respondents (medical workers), where they were required to respond along a five-point Likert scale, as Table 14 shows.

Table 13: The contribution of training towards improved access to HIV/AIDS services

Statements on training	Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
1. There is a training programme for community workers aimed at improving access to HIV/AIDS services	2(16.7%)	1(8.3%)	3(25.0%)	4(33.3%)	0
2. Training of health workers has improved service delivery	2(16.7%)	1(8.3%)	1(8.3%)	8(66.7%)	0
3. I have received additional training on HIV/AIDS from ARRH	3(25.0%)	5(41.7%)	0	4(33.3%)	0
4. I believe the training I received has helped improve service delivery this facility	1(8.3%)	4(33.3%)	1(8.3%)	5(41.7%)	0
5. I believe service delivery is unique for this facility	2(16.7%)	0	1(8.3%)	8(66.7%)	1(8.3%)
6. Patients always get relevant tests done and treatment is given in this facility	1(8.3%)	0	0	8(66.7%)	3(25.0
7. Health services in ARRH are delivered professionally	0	2(16.7%)	1(8.3%)	9(75.0%)	0
8. Staff attitudes have always been good towards patients	1(8.3%)		2(16.7%)	8(66.7%)	0
9. Staff attitudes have improved due to training undergone by medical officers	0	1(8.3%)	1(8.3%)	10(83.3%)	0
10. Medical officers always explain to patients what they must know about their sickness	1(8.3%)	1(8.3%)	1(8.3%)	9(75.0%)	0
11. Patients don't wait long to get treatment in this facility	3(25.0%)	2(16.7%)	2(16.7%)	5(41.7%)	0
12. Patients do not wait long to get results in this facility	1(8.3%)	2(16.7%)	3(25.0%)	6(5.0%)	0
13. Medicines are always available in this facility	1(8.3%)	3(25.0%)	1(8.3%)	5(41.7%)	2(16.7%)
14. Patients always express satisfaction with tests done in this facility	2(16.7%)	1(8.3%)	1(8.3%)	7(58.3%)	1(8.3%)
15. Adequate privacy and care are always given to patients in this facility	0	1(8.3%)	0	11(91.7%)	0
16. Patients are always willing to continue having care in this facility	0	1(8.3%)	0	9(75.0%)	2(16.7%)
17. I would recommend other patients to visit this facility in future	0	0	2(16.7%)	9(75.0%)	1(8.3%)

Source: Primary data

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Majority of the respondents agreed that raining of health workers had improve service delivery. Nine out of the twelve respondents in the medical workers' category indicated that they believed service delivery in ARRH is unique, many believed that staff attitudes had changed as a result of the training, eleven indicated that patients are always willing to continue having care in the facility, and ten shared that they would recommend other patients to visit the facility. Their views generally highlighted the fact that the training offered to the health workers has yielded tremendous positive results. However, it was also noted that there were concerns on the criteria used to select the trainees, while some staff viewed the training as just another opportunity to make some money, rather than an avenue to improve service delivery.

In line with the same views, one key informant emphasized that; '*the reason for continuous staff training is the expectation that through training the quality of services provided will improve. Time of accessing these services is also expected to be made shorter'*. These views showed that ARRH was making deliberate efforts to beef up access to HIV/AIDS services. It was however noted from the qualitative results given by the medical personnel that the training given was not short of challenges of funds, implying that only few staff could get trained, which could compromise access to HIV/AIDS service delivery. Further, other views from some of the respondents showed that in many cases, some of the training offered was not directly related to HIV/AIDS service delivery, while others decried the fact that the selection criteria for the trainees was not usually transparent.

Other respondents noted that the criteria used in selecting the trainees was more of a mystery, where the same training would be given to the same people who were not even directly involved in service delivery, while some trainees simply attended training to get per diem, as one respondent noted. Such would possibly compromise on the expected outcome of the training and

could partly explain why many clients indicated that they were taking a long time waiting for their results or medicine. This finding shows that if the concerns raised concerning staff training are left unattended to, ARRH may not realize the much needed improvement in access to HIV/AIDS services.

4.5.2.1. Clients' views on ~~The contribution of health workers' training to improved access to~~the nature of HIV/AIDS services offered in ARRH, which could be attributed to health worker training.

In this section, the views of the clients concerninging~~ing the contribution of training of health workers to improved~~ access to HIV/AIDS services as a result of health worker training are given. The opinions of the clients were sought along a five-point likert scale of one to five, where one (1) indicates strong disagreement, while five (5) shows strong disagreement, as indicated in the table below.

Table ~~13~~14: Descriptive statistics on ~~the contribution of training to improved access to~~nature of HIV/AIDS services offered in ARRH

~~Nature of~~~~The contribution of training towards access to~~ **HIV/AIDS services in ARRH**	**Strongly Disagree**	**Disagree**	**Not sure**	**Agree**	**Strongly Agree**
1. Patients always get tests done and treatment is given in ARRH	1(1.0%)	0	0	31(30.7%)	69(68.3%)
2. Health services in ARRH are very good	1(1.0%)	1(1.0%)	3(3.0%)	35(34.7%)	61(60.4%)
3. Staff attitude towards patients in ARRH is good	0	3(3.0%)	11(10.9%)	48(47.5%)	39(38.6%)
4. Positive changes have occurred in staff attitudes in the last one year	8(7.9%)	3(3.0%)	10(9.9%)	50(49.5%)	30(29.7%)
5. Medical officer explained to me what is needed to know about my illness	1(1.0%)	0	0	29(28.7%)	71(70.3%)
6. I didn't wait for a long time to get treatment in this facility	10(9.9%)	15(14.9%)	6(5.9%)	46(45.5%)	24(23.8%)
7. Medicines are always available in this facility	0	0	1(1%)	28(27.7%)	72(71.3%)
8. I didn't wait long to get test results	7(6.9%)	14(13.9%)	4(4.0%)	46(45.5%)	30(29.7%)
9. I am satisfied with the tests done in this facility	0		5(5.0%)	54(53.5%)	42(41.6%)

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10. I am happy with the privacy and care I get from this facility	2(2%)	1(1%)	3(3%)	51(50.5%)	44(43.6%)
11. I am willing to continue having care in this facility	0	1(1.0%)	0	41(40.6%)	59(58.4%)
12. I would recommend others to visit this facility in future	0	1(1%)	0	37(36.6%)	63(62.4%)

Source: Primary data

Findings showed that most of the ARRH HIV/AIDS clients (99%) affirmed the statement that 'patients always get tests done and treatment is given in ARRH'; 95% indicated that the health services in ARRH are very good. Concerning the attitude of the staff towards the patients, 86% agreed that the staff attitude in ARRH is good, while 79% indicated that positive changes had occurred in staff attitudes in the last one year. In terms of waiting time, most clients (69% and 75%) indicated that they had taken a long time waiting to get treatment and results, respectively. This trend could be attributed to the large numbers of clients that the staff have to attend to, yet their numbers have remained constant over the years, despite the growing clientele.

Overall, the results from the descriptive statistics showed that there were several positive results registered as a result of staff training, which have translated into better service delivery to the clients, as well as the ability to serve the growing numbers of the clients efficiently and effectively.

In terms of availability of medicines, nearly all the clients agreed that medicines are always available at ARRH, while 94% found the services to be acceptable in terms of the privacy and care they got. Nearly all of the respondents agreed to the statement that they would recommend others to visit the facility in future. This too clearly showed their satisfaction with the services, which would translate into having more HIV/AIDS people getting to know about the services in ARRH and therefore enhance access to the HIV/AIDS services.

4.5.2.1. Views from ARRH staff on training of medical workers

Responses were sought on the attitude and perceptions of the medical workers, concerning training, in order to establish whether it had a significant effect on access to HIV/AIDS services in ARRH. Items were given to the respondents (medical workers), where they were required to respond along a five-point Likert scale, as Table 14 shows.

Table 14: The contribution of training towards improved access to HIV/AIDS services

	Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
There is a training programme for community workers aimed at improving access to HIV/AIDS services	2(16.7%)	1(8.3%)	3(25.0%)	4(33.3%)	0
Training of health workers has improved service delivery	2(16.7%)	1(8.3%)	1(8.3%)	8(66.7%)	0
I have received additional training on HIV/AIDS from ARRH	3(25.0%)	5(41.7%)	0	4(33.3%)	0
I believe the training I received has helped improve service delivery this facility	1(8.3%)	4(33.3%)	1(8.3%)	5(41.7%)	0
I believe service delivery is unique for this facility	2(16.7%)	0	1(8.3%)	8(66.7%)	1(8.3%)
Patients always get relevant tests done and treatment is given in this facility	1(8.3%)	0	0	8(66.7%)	3(25.0
Health services in ARRH are delivered professionally	0	2(16.7%)	1(8.3%)	9(75.0%)	0

Staff attitudes have always been good towards patients	1(8.3%)		2(16.7%)	8(66.7%)	0
Staff attitudes have improved due to training undergone by medical officers	0	1(8.3%)	1(8.3%)	10(83.3%)	0
Medical officers always explain to patients what they must know about their sickness	1(8.3%)	1(8.3%)	1(8.3%)	9(75.0%)	0
Patients don't wait long to get treatment in this facility	3(25.0%)	2(16.7%)	2(16.7%)	5(41.7%)	0
Patients do not wait long to get results in this facility	1(8.3%)	2(16.7%)	3(25.0%)	6(5.0%)	0
Medicines are always available in this facility	1(8.3%)	3(25.0%)	1(8.3%)	5(41.7%)	2(16.7%)
Patients always express satisfaction with tests done in this facility	2(16.7%)	1(8.3%)	1(8.3%)	7(58.3%)	1(8.3%)
Adequate privacy and care are always given to patients in this facility	0	1(8.3%)	0	11(91.7%)	0
Patients are always willing to continue having care in this facility	0	1(8.3%)	0	9(75.0%)	2(16.7%)
I would recommend other patients to visit this facility in future	0	0	2(16.7%)	9(75.0%)	1(8.3%)

Source: Primary data

~~Majority of the respondents agreed that raining of health workers had improve service delivery. Nine out of the twelve respondents in the medical workers' category indicated that they believed service delivery in ARRH is unique, many believed that staff attitudes had changed as a result of the training, eleven indicated that patients are always willing to continue having care in the facility, and ten shared that they would recommend other patients to visit the facility. Their views generally highlighted the fact that the training offered to the health workers has yielded tremendous positive results. However, it was also noted that there were concerns on the criteria used to select the trainees, while some staff viewed the training as just another opportunity to make some money, rather than an avenue to improve service delivery.~~

~~In line with the same views, one key informant emphasized that; '*the reason for continuous staff training is the expectation that through training the quality of services provided will improve. Time of accessing these services is also expected to be made shorter'*. These views showed that ARRH was making deliberate efforts to beef up access to HIV/AIDS services. It was however noted from the qualitative results given by the medical personnel that the training given was not short of challenges of funds, implying that only few staff could get trained, which could compromise access to HIV/AIDS service delivery. Further, other views from some of the respondents showed that in many cases, some of the training offered was not directly related to HIV/AIDS service delivery, while others decried the fact that the selection criteria for the trainees was not usually transparent.~~

~~Other respondents noted that the criteria used in selecting the trainees was more of a mystery, where the same training would be given to the same people who were not even directly involved in service delivery, while some trainees simply attended training to get per~~

~~diem, as one respondent noted. Such would possibly compromise on the expected outcome of the training and could partly explain why many clients indicated that they were taking a long time waiting for their results or medicine. This finding shows that if the concerns raised concerning staff training are left unattended to, ARRH may not realize the much needed improvement in access to HIV/AIDS services.~~

4.5.2.2. The relationship between training of health workers and access to HIV/AIDS services

Table 15: Correlation between training and access to HIV/AIDS services

Training (IV dimension)		*Access to HIV/AIDS services (Dependent variable)*
	Pearson Correlation	.343**
	Sig. (2-tailed)	.000
	N	101

**. *Correlation is significant at the 0.01 level (2-tailed).*

Source: Primary data

Pearson correlation was used to test the hypothesis; 'Training has a significant contribution towards improved access to HIV/AIDS services. The correlation results on training of health workers and access to HIV/AIDS services revealed a mild but statistically significant relationship ($r=.343$; $p<0.05$). The p-value of 0.000 showed that the relationship was highly statistically significant. Besides, the correlation result also indicated a positive trend, which meant that any improvement in training of health workers would be likely to result into an improvement in access to HIV/AIDS services, and the reverse is also true. Further analysis by computing the coefficient of determination (r^2), so as to determine the effect of training on access to HIV/AIDS services showed 11.8%. This therefore meant that the variance in access to HIV/AIDS services which was attributable to training was 11.8% or 12%. Thus, on the basis of

the study findings, the hypothesis that stated; *'training has a significant contribution towards improved access to HIV/AIDS services'* was verified and substantiated.

4.5.3. Monitoring of HIV/AIDS services

In order to assess monitoring, the researcher collected in-depth views from the respondents. Results showed that as part of scaling up the monitoring aspect in ARRHAs far as monitoring and evaluation is concerned, it was noted that surveys are conducted, where staff assess the opinions of the clients in terms of services delivery. In such surveys, people give their opinions and the hospital management is able to gauge the quality of the services delivered and the satisfaction of the clients. Such surveys have been carried out periodically usually after every one year.

One respondent noted that among the benefits of the monitoring programme was the realization that there was positive attitude towards change, towards HIV/AIDS treatment. People were expressing positive responses towards the services and the fact that they appreciated aspects like adherence to drug use. He added; *"Initial results of such surveys were discouraging however with time we started to see positive changes as far as services delivery was concerned. Surveys have always centered on waiting time for patients, attitude of staff towards patients and availability of staff".*

He noted that the various indicators have greatly improved over the years as far as AHAP is concerned, emphasizing;

> "For instance the waiting time for clients to receive services has greatly become shorter, now that the client database is better structured and especially aided by the use of appointments. Medicines have not always been a problem but our

> partners have always been by our side with the provision of drugs. Staff attitudes have also greatly improved, through refresher trainings, and also the fact that we have assimilated many of the HIV/AIDs clients to become part of staff".

Another key informant shared that feedback is based on clinical assessment on the effectiveness of the services offered. He added that the influx of more people preferring to come to ARRH for AHAP also helps them to know their performance. It was further noted that most of the feedback is got from the district as they get most information from the hospital. The district also gives feedback on what the community thinks about ARRH services.

Others noted that results from the laboratory (CD4), increasing body weight of the clients who had previously lost a lot of body weight, verbal appreciation from the clients, growing numbers of clients visiting the hospital, self-reports, quality assessment surveys, partner feedback, among the various means through which they got feedback from the clients, so as to address the emerging gaps in terms of service delivery.

For some medical workers, feedback was got through close discussions with the clients. Others also observed that when clients don't miss appointments, it was another way of receiving feedback. Some clients were also noted to report improvements as regards to infections and how they had been cured. In some cases, it was noted that political leaders could recognise the efforts of the hospital, while others noted the issue of question sessions during health education and during counselling and consultation, where they could get views and concerns of the clients. This was noted to have significantly helped ARRH improve access to HIV/AIDS services.

Qualitative results showed that health staff conducted consultations with clients who reported to them their health progress. In other cases, CD4 count of patients was constantly monitored

through regular laboratory tests, so as to ascertain who was due for ARVs and who was not. This helped to restore the confidence of the clients in the facility, therefore increasing access to the HIV/AIDS services, since such clients could inform their friends who would be in need of similar services to go to ARRH.

Further, it was noted that there were efforts to monitor patients' adherence to drugs and those who were found to have poor adherence were given continuous education. The health staff also took note of the numbers of patients, which were noted to be increasing, a sign of positive feedback about access to HIV/AIDS services. In addition, quality assessment surveys were conducted, HIV/AIDS clinics were held every week, Monday to Friday and there was a group of PLAs who represented other clients on different for a of service delivery. Another indicator in monitoring and evaluation was patients' attendance, which showed that patients regularly attended the clinic, further confirming their access to HIV/AIDS services realized through effective monitoring and evaluation system at ARRH.

CHAPTER FIVE

SUMMARY, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

This chapter presents the summary of the key findings, discussion, conclusions and recommendations. It is divided into four major sections. In the first section, the summary is presented, followed by the discussion of the key findings, conclusions are drawn and then finally, recommendations are given.

5.2. Summary of key findings

5.2.1. Mobilisation of political leaders

It emerged from the findings that mobilisation of political leaders significantly contributes to access to HIV/AIDS services in ARRH. Over 50% of the clients were of the view that political leaders reach hard-to-reach areas and make HIV/AIDS services more accessible. It was noted that political leaders play a significant role in terms of lobbying and advocacy. They reach hard to reach areas where health workers would hardly reach. The correlation results from the staff of ARRH showed mobilisation of political leaders was closely associated with improvement of access to HIV/AIDS services, with a Pearson correlation value of .666** and a corresponding coefficient of determination of 44.3%, implying that any efforts in political mobilisation would yield an effect of boosting access to HIV/AIDS services in ARRH by 44.3%. It was further noted that people in the communities had confidence in the political leaders, which makes it easy for them to rally support from the masses and conduct sensitisation and awareness creation sessions. This helps to effectively mobilise the communities, people get tested and those who are found to have the virus are notified on how and where to access the services.

5.2.3. Training

Training was conducted in various forms. Most staff had attended training, though not all. In some way, the training helped staff to get knowledge on how to address HIV/AIDS related concerns. However, it was noted that some staff were not being trained and in some cases, the training lacked focus since it did not address the issues of concern in the context of HIV/AIDS. Statistics revealed that training of health workers was crucial in respect to improving access to HIV/AIDS services in ARRH. From the clients, it emerged that as a result of training given to the health workers, 99% of them (clients) were of the view that patients would always get tests done and treatment would be given in good time. Moreover, 88% of the clients also noted that due to the training the staff got, the staff attitude towards patients was considered as exceptional and therefore giving confidence to many HIV/AIDS clients to seek the services at ARRH. From the staff of ARRH, the correlation results showed that there indeed was a significant relationship between staff training and access to HIV/AIDS services, with a Pearson coefficient of .343**, implying a positive and significant relationship. This therefore meant that with more effort in training of health workers in ARRH, there was likely to be improvement in access to HIV/AIDS services.

5.2.3. Monitoring and evaluation

M & E was analysed qualitatively and results showed that in order to ensure effective service delivery and increased access to HIV/AIDS services in ARRH, surveys were conducted periodically, centering on the waiting time for the patients, attitude of staff towards the patients and availability of staff. The survey results had shown that the waiting time for patients had improved over time, especially with a new data base which was based on the use of appointments and staff attitudes had improved, especially after the training and assimilation of

many HIV/AIDS clients to become part of the staff. The increasing numbers of clients who were noted to be attending ARRH for HIV/AIDS services further confirmed the huge strides taken in improving access, as a result of monitoring and evaluation efforts.

5.3. Discussion of findings

5.3.1. Political mobilisation

Results showed that there is a close association between political mobilisation and access to HIV/AIDS services. These findings concur with the argument of WHO (2008) that political mobilisation helps to improve access to health services, especially in developing countries where there is scarcity of health workers.

It was also noted from the findings that political leaders reach hard-to-reach areas, which helps to boost access to HIV/AIDS services in such areas. This view is in line with Hlophe and Van Rensberg's (2008) argument that mobilising politicians at community level provides variable opportunities in tacking problems that would undermine their health. In other words, politicians help to raise awareness about HIV/AIDS and how people can access the HIV/AIDS related services. The finding further concurs with Campbell (2010) who observes that the scale of the HIV/AIDS problems, as well as social marginalization of many affected groups, make it difficult for health professionals to reach the vast number and variety of people most vulnerable to HIV and affected by HIV/AIDS.

Noted through the findings was that political mobilisation in ARRH had a challenge of financing, which affected the implementation of many activities related to political mobilisation. This finding was in line with the literature of Hlophe & Van Rensberg (2008), who posted that resource challenges were likely to hinder sustainability of political mobilisation in curbing

HIV/AIDS, since it requires a substantial amount of resources to mobilise community members. Besides, it also involved an opportunity cost for leaders to participate at the expense of their routine duties.

Findings further revealed that mobilising political leaders had increased access to services for HIV/AIDS patients and there was a general feeling that political leaders significantly contribute towards mobilisation of the communities. This not only helps to create awareness about HIV/AIDS and the need for HIV/AIDS testing for people to know their status, but also helps communities to know where and how they can access HIV/AIDS related services. It was noted that to date, there are still some areas where people had not got to know their about HIV/AIDS, its transmission and management. In such cases, political leaders, since they are part of all such communities, would help in terms of awareness creation.

From the responses given by the health workers, it clearly emerged that there was general consensus on the fact that HIV.AIDS services are easy to deliver with the help of political leaders. Political leaders have the mandate to monitor operations in their own areas of jurisdiction and can effectively monitor the activities of the ART sites, which health personnel, given their few numbers, may not be able to effectively handle. Besides, political leaders were also noted to play a significant role in focusing and changing the activities of health providers, such as late coming and many others. Given that their work involves advocacy, political leaders can help to lobby government and advocated for more accreditation of ART sites and health human resource, all of which help to improve access to HIV/AIDS services.

5.3.2. Training

Findings showed that whereas it was generally agreed by majority of the respondents that training of health workers was a crucial aspect in terms of access to HIV/AIDS services, its modalities in ARRH left a lot to be desired by a good number of the staff. Some respondents felt that the selection of participants for training was unfairly done, with some indicating never to having received any training, yet their line of duty requires certain key skills. In other cases, the training gap was attributed to financial limitations, citing that government funding for health does not put into account the ever rising health needs. The findings were in agreement with a report by WHO (2009), where it was noted that corruption may affect the way in which health personnel carry out their duties, hence affecting access to service delivery.

It was further noted that besides training the same people almost all the time and training those who were not directly involved in HIV/AIDS service delivery, the training given is more of routine, with very little focus on practical application of the knowledge acquired through the training. This leaves a very big gap in terms of service delivery and access to HIV/AIDS services. Coupled with the limited number of staff who are quite often overwhelmed by the workload, the deficiency in training which could help to quicken systems and operations exacerbates the whole situation. This finding concurred with that of WHO (2007), who note that one of the limitations to access of HIV/AIDS services is shortage of workforce, which in turn increases workload of existing staff and in the end compromises service delivery.

While there is a challenge of some staff not getting trained, results showed that in some cases, it is hard for many staff to go for further training, since they are already few on the ground. It was also noted that some top administrators are reluctant to initiate their trainings. Some staff were noted to have a negative attitude towards the training, with some viewing it as an income

generating project, rather than an initiative to get new skills. For some employees, the problem had to do with a negative attitude towards HIV/AIDS, implying that no matter what kind of training they got, if it did not have an aspect of attitude change, it was unlikely to translate into better HIV/AIDS service delivery.

Responses showed that whereas a number of health workers had got some form of training, much of it was not directly relevant for HIV/AIDS, compared to key areas that would necessitate training, such as counseling, HIV/AIDS patient care management, and the like. The training was generally perceived as incomprehensive and little efforts were taken to identify gtraining needs of the staff, prior to the training.

5.3.3. Monitoring

Results showed that feedback from political leaders was used as a monitoring and evaluation strategy, to keep track of ARRH performance in delivery of HIV/AIDS services and to also get information on access to the services, where gaps could be and what needed to be done in order to improve service delivery.

The results showed that there were efforts to ensure that the people who needed the HIV/AIDS services got them and could fully benefit from those services. Results also showed that the health workers considered it essential to monitor the progress of their clients, for instance through conducting regular laboratory tests to establish patients'CD4 counts, interviewing clients to know their drug adherence and giving them continuous education where necessary, among others. This was noted to not only help to improve the quality of life for those with HIV/AIDS, but also that more people got access to HIV/AIDS services as required.

The results concerning monitoring and evaluation also showed that the growing numbers of patients accessing services at ARRH was used as an indicator of effective service delivery. However, this too came with a challenge of numbers outgrowing the available infrastructure at the facility. This finding was in tandem with those of Population Council (2009) and Walley et al. (2008) which showed that as the number of people accessing ARV services grows, space at centers can become inadequate for patient waiting areas, consulting rooms, and counseling services

5.4. Conclusions

5.4.1. Political mobilisation

The role of political mobilisation in increasing access to HIV/AIDS services is very fundamental. The contribution of the political leaders, which involves mobilizing communities and creating awareness, is very often affected due to lack of adequate funding. This undermines their very vital contribution in improving access to HIV/AIDS services.

The capacity of health staff is quite often very limited to the effect that they can hardly reach all communities. To this end, having political leaders on board becomes a necessity so as to broaden the approach to accessing HIV/AIDS services.

Political leaders can significantly champion advocacy and lobbying in order to increase access to HIV/AIDS services. This can be through directly lobbying government for funding and advocating more ART centres to increase access to HIV/AIDS services.

Since political leaders have the mandate to monitor and evaluate performance in different sectors, their contribution can help to reduce the problem of negative attitude of health workers

who absent themselves or report late for work. In fact, the improved attitude of health staff at ARRH can be attributed to the role played by political leaders.

5.4.2. Training

Training was found to have a direct impact on access to HIV/AIDS services. However, when the criteria used to select trainees seems flawed to the beneficiaries, where in some cases, the same people always attended the same training, while others never attend, this may underscore the would-be positive benefits from training.

Whereas there were efforts to train staff, key areas of service delivery had not been paid attention to. This would imply that in some cases, the training received may not necessarily address the areas that need to be addressed, and therefore may yield little or no significant results. Most health staff generally felt there was an improvement in service delivery, as a result of the training received, though they felt they needed to have more training directly in the HIV/AIDS service related areas.

5.4.3. Monitoring

Monitoring the health of HIV/AIDS clients through testing for CD4 count; checking body weight and others motivated clients to keep attending AHAP for the HIV/AIDS services. This shows clients that there is care, they find the services more meaningful and it helps them to see their role in securing their health.

Following up patients' adherence to drugs also served to increase clients' access to the services. Not only does that show care on the part of the service providers, but also serves as an encouragement to the patients who have to daily grapple with the burden of taking the drugs. This therefore serves to improve access to the HIV/AIDS services.

The increasing numbers of clients were an indicator of more people getting access to HIV/AIDS services, since clients who were satisfied with the services could go back and come along with their friends who needed to access the same services.

Political leaders play a significant part of giving feedback to ARRH through various forms of media, which increased the number of people attending the health facility to access the services. With the limited number of health care service providers, involving political leaders in M & E can help to increase access to HIV/AIDS services.

5.5. Recommendations

In order to address the gaps identified earlier in the study, the following recommendations were drawn.

5.5.1. Increasing access to HIV/AIDS services

As a strategy to increase access to HIV/AIDS services, ARRH together with the ministry of health should consider recruiting more health staff so as to satisfactorily meet the needs of the growing numbers of patients going to ARRH to access HIV/AIDS services.

Since advocacy is one effective tool in reaching the masses with health related communication, ARRH should consider using more forms of media for advocacy and creating more awareness about the HIV/AIDS services in the facility.

The management and administration of ARRH and the district administration should put in place mechanisms for having more health centres accredited to offer ART services. This could include empowering such identified centres so that people do not have to travel very long distances to come to ARRH. In some cases, long distances to a health facility may be a limiting factor in regards to access to HIV/AIDS services.

The management of ARRH should liaise with National Medical Stores (NMS) and the Ministry of Health to buffer stock for ART. It is also necessary that NMS ensures timely delivery of drugs from NMS, in order to avoid stock-outs that may discourage some clients from seeking HIV/AIDS services in ARRH.

While several campaigns may be carried out to address the issue of access to HIV/AIDS services, such as VCT, adherence to ARVs and others, ARRH should consider having in place a programme for continuous outreach so as to consolidate the gains already registered and avoid a situation of communities backsliding after some time.

ARRH needs to beef up efforts to create awareness of the benefits of ART and the demand for formal health services through information, education, and communication activities such as radio and television spots and print messages, as well as public campaigns.

MoH and the management of ARRH should reinforce support for civil society organizations and networks, particularly associations of PLHIV and organizations working to combat common misconceptions and myths around HIV. This will help to increase access to HIV/AIDS services and therefore mitigate against the negative effects of the failure to deal with the HIV epidemic.

Since many clients are based in villages and remote places where there is hardly access to health facilities, there is need to train community health workers to provide basic clinical care and support to such communities.

ARRH should spearhead the campaign to implement ART adherence activities to increase ART literacy so that communities and clients are fully informed and aware of the prerequisites needed to initiate it, as well as its costs and benefits.

5.5.2. Political mobilisation

The management of ARRH together with MoH should regularly involve political establishments in an effort to strengthen community sensitisation. This will help to ensure behavioral change among the communities, especially in respect to accessing HIV/AIDS services.

ARRH needs to increase their efforts in lobbying for more funding and more health budget allocation. This can be ensured through political mobilisation, since the political leadership is usually at the helm of policy development.

The management of ARRH should encourage political leaders to solicit for local resource mobilisation from the communities, such as local labour and materials for health facility construction, so as to take care of the growing numbers of clients

While the management of ARRH has taken great strides in bringing political leaders on board, there is great need to have the political leadership involved at all stages of service delivery, son that their role in M&E may be meaningful.

Much as ARRH involves political leaders in matters of access to HIV/AIDS services, they should be empowered adequately, so that they can be in position to monitor the activities of ART sites. This will involve having a vote for their activities when it comes to budgetary allocation.

5.5.2. Training

Government of Uganda should provide adequate budget for capacity building for health staff and the responsibility should not be left for individual health facilities to grapple with. This will help to ensure that health workers have meaningful training in order to improve their services.

The management of ARRH should raise efforts to conduct frequent trainings and endeavor to have every staff access the training. This will require development of serious policy decisions, in order to address the disparities in awarding training opportunities.

Whereas there are efforts to train staff in ARRH, there is need to put place mechanisms to ensure that specialised training that addresses the concerns of HIV/AIDS patient care is offered to the concerned staff.

The hospital administration should devise ways and means of conducting training needs analyses before any kind of training is given to the staff. Conducting training in a manner that is haphazard only makes training appear more of a routine programme, rather than one that is intended to meet specific objectives.

Despite the fact that field staff are usually the ones that are sent out to address the HIV/AIDS related matters, they hardly receive any training to conduct the services. The focus of ARRH therefore should be more geared to training field staff.

ARRH's management should make efforts to make the training delivered to staff more relevant, practical and continuous. This will not only help to motivate the trainees but it will also serve to enhance the effectiveness of training in addressing the issue of improving access to HIV/AIDS services.

5.5.3. Monitoring & Evaluation

ARRH should increase monitoring of health staff to ensure their presence in the facility at all times. This will go a long way in ensuring that the much needed HIV/AIDS services in the facility are delivered in the most efficient and effective manner.

Management of ARRH and MoH should consider establishing a logistics management information system for collecting, reporting, and analyzing data on consumption and stock levels of ARVs and other commodities at the facility and national levels. This will help to address the challenge of drug stock-outs in the health facilities and ensure a continuous and secure supply of quality drugs and Laboratory commodities

5.6. Areas for further research

Future researchers should consider addressing areas such as;

i. Community Capacity Development Programmes and their contribution to HIV/AIDS prevention.

ii. Capacity Development Interventions and their effect on behavioral change HIV/AIDS among adolescents living with HIV/AIDS

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Appendix I

Questionnaire for HIV/AIDS Clients of Arua Regional Referral Hospital

CAPACITY DEVELOPMENT INTERVENTIONS AND ACCESS TO HIV/AIDS SERVICES AT ARUA REGIONAL REFERRAL HOSPITAL, UGANDA

Hello, my name is (Your name); I am conducting a study on ***Capacity Development Interventions and access to HIV/AIDS services at Arua Regional Referral Hospital.*** I would like to ask you to participate in this study by answering a few questions. The information you will give will be kept strictly confidential and used purely for the purposes of the study. The information you give will not be used against you in any way and will not interfere with normal care you receive in the future. I would therefore request that we proceed with the interview, unless you have any other issue that you would like to clarify.

Interviewer's Name: ……

Date of interview: _ _ / _ _ /_ _ _ _ dd/mm/yy

SECTION A: BACKGROUND INFORMATION.

Please tick the most applicable.

1. Gender. Male Female

2. How old are you? (Complete years) ……..

3. What is the highest level of education attained?

1. No formal education

2. P1-P4

3. P5-P7

4. Secondary

5. Tertiary Post Graduate Degree.

SECTION B: CONTRIBUTION OF MOBILISING POLITICAL LEADERS TOWARDS IMPROVED ACCESS TO HIV/AIDS SERVICES.

1. Do you believe that mobilization of political leaders contributes towards improved access to HIV/AIDS services?

Strongly disagree	Disagree	Neither	agree	Strongly disagree
1	2	3	4	5

Please Tick appropriate

	1	2	3	4	5
I am aware political leaders are mobilized to improve access services					
Political leaders help improve access to services					
Political leaders are available to community members					
Political leaders are easily accessible					
I am comfortable discussing my problems with political leaders					
Clients are comfortable sharing their problems with political leaders					
Political leaders do not segregate among the local population					
Political leaders reach more people than would the formal health officers					
Political leaders reach hard to reach areas					
Political leaders help local people solve their own problems					
Political leaders help solve the problem of scarcity of health workers					
Political leaders reach all community members who need attention					
HIV/AIDS services are more accessible with the help of political leaders					
There is political will to improve access to HIV/AIDS services					
Age gap differences do not fail political leaders in mobilizing locals					
Political leaders carry out adequate sensitization of community members					

2. In your opinion, how can political leaders better be mobilized for improved HIV/AIDS service delivery……..
……
……
……..……..…
……

3. What measures would you recommend to improve access to HIV/AIDS for members in your community?

……
……
……
……
……

SECTION C: THE CONTRIBUTION OF TRAINING HEALTH WORKERS TOWARDS IMPROVED ACCESS TO HIV/AIDS SERVICES.

4. Do you believe the training of health workers has contributed to improved access to HIV/AIDS services in Arua Regional Referral Hospital?

Strongly disagree	Disagree	Neither	agree	Strongly disagree
1	2	3	4	5

Please Tick appropriate

	1	2	3	4	5
Patients always get tests done and treatment is given in ARRH					
Health services in ARRH are very good					
Staff attitudes towards patients are good in ARRH					
Positive changes have occurred in staff attitudes last one year					
Medical officer explained to me what i needed to know about my illness					

I didn't wait for a long time to get treatment in this facility					
Medicines are always available in this facility					
I didn't wait long to get test results					
I am satisfied with the tests done in this facility					
I am happy with the privacy and care I get from this facility					
I am willing to continue having care in this facility					
Would recommend others to visit this facility in future					

16. What in your opinion should be done to further improve access to HIV/AIDS services delivery in ARRH?

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.....

.....

.....

Appendix II

Questionnaire for staff (Doctors, Medical assistants, Nurses and Midwifes)

Hello, my name is (Your name); I am conducting a study on ***Capacity Development Interventions and access to HIV/AIDS services at Arua Regional Referral Hospital***. I would like to ask you to participate in this study by answering a few questions. The information you will give will be kept strictly confidential and used purely for the purposes of the study. The information you give will not be used against you in any way and will not interfere with normal care you receive in the future. I would therefore request that we proceed with the interview, unless you have any other issue that you would like to clarify.

SECTION A: BACKGROUND INFORMATION.

Please tick the most applicable.

1. Gender. Male ☐ Female ☐

2. How old are you? (Complete years) ……..

3. Level of qualification

1. Certificate

2. Diploma

3. Degree

4. Master Degree

5. PhD

4. Position in the facility

1. Doctor

2. Medical Assistant

3. Nurse

4. Midwife

SECTION B: Access to HIV/AIDS services

Strongly disagree	Disagree	Neither	agree	Strongly disagree
1	2	3	4	5

	1	2	3	4	5
Patients find the services in ARRH to be affordable					
Medicine usually given here is adequate					
Patients usually receive HIV drugs whenever they need them					
The health workers attend to the patients well					
Patients usually find it convenient to come to ARRH for the services					
Patients don't wait long to get services in this hospital					
Patients usually have enough privacy to share their concerns					
Patients perceive ARRH services as professional					
Medical workers usually give thorough explanation to the patients					

SECTION C: Contribution of mobilizing political leaders towards improved access to HIV/AIDS services

5. Do you believe that political mobilisation contributes towards improved access to HIV/AIDS services?

Strongly disagree	Disagree	Neither	agree	Strongly disagree
1	2	3	4	5

Please Tick appropriate

	1	2	3	4	5
I am aware political leaders are mobilised to improve access services					
Mobilising political leaders has increased access to services for HIV/AIDS patients					
Mobilising political leaders has reduced resource constraints to service delivery					
Political leaders are available to community members					
Political leaders are easily accessible					
I am comfortable working with political leaders					
I believe community members are comfortable dealing with political leaders					
Political leaders help with the mobilization of the local population					
Political leaders do not segregate among the local population					
Political leaders reach more people than would the formal health officers					
Political leaders reach hard to reach areas					
Political leaders help local people solve their own problems					
Political leaders help solve the problem of scarcity of health workers					
Political leaders reach most community members who need attention					
HIV/AIDS services are easy to deliver with the help of political leaders					
Age gap differences do not fail political leaders in reaching all age groups of the population.					
Political leaders carry out adequate sensitization of community members					

2. In your opinion, how can political leaders help improve access to HIV/AIDS services
……

3. What measures would you recommend to improve access to HIV/AIDS for members in your community?

……

……

SECTION C: Training of medical workers for improved access to HIV/AIDS services

6. Do you believe the training of health workers has contributed to improved access to HIV/AIDS services in Arua Regional Referral Hospital?

Strongly disagree	Disagree	Neither	agree	Strongly disagree
1	2	3	4	5

Please Tick appropriate

	1	2	3	4	5
There is a training programme for community workers aimed at improving access to HIV/AIDS services					
Training of health workers has improved service delivery					
I have received additional training on HIV/AIDS from ARRH					
I believe the training I received has helped improve service delivery in this facility					
I believe service delivery is unique for this facility					
Patients always get relevant tests done and treatment is given in this facility					
Health services in Arua Regional Referral Hospital are delivered professionally					
Staff attitudes have always been good towards patients					
Staff attitudes have improved due to training undergone by medical officers					
Medical officers always explain to patients what they must know about their sickness					
Patients don't wait long to get treatment in this facility					
Patients don't wait long to get test results in this facility					
Medicines are always available in this facility					
Patients always express satisfaction with tests done in this facility					
Adequate privacy and care are always given to patients in this facility					

Patients are always willing to continue having care in this facility					
I would recommend others patients to visit this facility in future					

7. What in your opinion should be done to further improve access to HIV/AIDS services delivery in ARRH?

.....

.....

8. What in your opinion are the existing challenges to the training of health staff?

.....

.....

In your opinion, what can be done to improve training so that HIV/AIDS service access can be improved?

……

……

SECTION C: Contribution of monitoring of HIV/AIDS services towards improved access to HIV/AIDS services

Please describe how you receive feedback from your clients regarding the quality of HIV/AIDS services provided by ARRH

……..

……..

What challenges do you face in responding to the demands of HIV/AIDS in ARRH and how do you overcome these demands?

……

……

Appendix III

Key informant interview guide for Hospital Management committee and Hospital management team

Hello, my name is (Your name); I am conducting a study on Capacity Development Interventions and access to HIV/AIDS services at Arua Regional Referral Hospital. I would like to ask you to participate in this study by answering a few questions. The information you will give will be kept strictly confidential and used purely for the purposes of the study. The information you give will not be used against you in any way and will not interfere with normal care you receive in the future. I would therefore request that we proceed with the interview, unless you have any other issue that you would like to clarify.

1. Please describe the operations of ARRH in the area of HIV/AIDS services (what is your mandate, working relationship with the ministry of health, partners and other hospitals)
2. What is the coverage of your HIV/AIDS services; do you cover all the area in your jurisdiction?
3. How long have you been mobilising political leaders for improved access to HIV/AIDS? Please describe the process.
4. What do you expect to achieve by mobilising political leaders?
5. What are the benefits of engaging political leaders in the HIV/AIDS initiatives
6. What makes this intervention special and unique
7. Please explain the challenges faced during mobilization of political leaders and what measures do you put in place to overcome such challenges?
8. Please describe the training programme for health workers involved in delivery of HIV/AIDS services.
9. Please explain the benefits of training health workers for HIV/AIDS service delivery.
10. Explain the system of monitoring HIV/AIDs activities of ARRH.
11. What challenges do you experience in responding to the demands of HIV/AIDS services
12. Describe how you receive feedback information concerning the delivery of HIV/AIDS services to the people.
13. Please make general recommendations for ARRH for the improvement in the delivery of HIV/AIDS services

Thank you for your time