THE PERCEPTIONS OF HEALTH CARE WORKERS AND HIV-POSITIVE CLIENTS OF HIV/AIDS CARE AND TREATMENT CENTRES IN KOGI STATE, NORTH-CENTRAL NIGERIA, ABOUT THE INTEGRATED MODEL OF HIV/AIDS SERVICE DELIVERY

by

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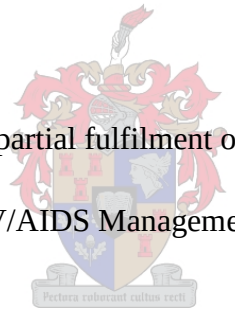

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DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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December 2012

SUMMARY

The early response to the HIV/AIDS pandemic in Nigeria had supported the set-up of specialized stand-alone clinics as the major model of providing care and treatment service to PLWHA. Over time, several challenges have been linked with this model of service delivery for PLWHA including the exposure to HIV-associated stigma risks, the considerable burden on the already weak health system resources as well as the attendant costs of multiple referrals to clinics specializing in a small range of health services with increased potential for client loss to follow-up.

In response to these issues and partly due to declining funding for HIV/AIDS programmes locally and internationally, public health practitioners are increasing advocating the use of the Integrated Clinic Model for HIV and AIDS service delivery. This model utilizes the same resources (focus on personnel, space and systems) to provide medical services to both HIV-positive clients and other patients accessing services in the hospitals.

Despite opposing views expressed by advocates and opponents as regards the risk of HIV-related stigma to PLWHA, the ease of accessing or providing services and the patient outcomes of this model of service delivery, few studies have actually focused on the perceptions of those who utilize and operate this model. Hence, this study uses a simple questionnaire-based survey to assess the perceptions of health care workers and HIV-positive clients at the Kogi State Specialist Hospital in North-Central Nigeria, about the integrated model of HIV/AIDS clinic service delivery being practiced in the hospital along these three themes.

Findings from the study shows that the clients and the health providers do not perceive the integrated clinic setting to increase the risk of exposure of PLWHA to HIV-related stigma but believe rather to the contrary that this model may actually reduce this risk. As regards the ease of accessing or providing services, the clients and health workers expressed a mutual belief that did not raise any major complications and actually reported a preference for this model. Also, both study groups identified positively with client outcomes of integrated clients.

The main conclusion from this study is that the integrated HIV clinic model presents a workable alternative to standalone HIV and AIDS treatment clinics and can contribute to the reduction in HIV-related stigma targeted at PLHIV in the course of accessing treatment services.

The major limitation of this study is the inability to compare the perceptions of clients and workers in the integrated clinics with that of similar populations in stand-alone clinics for comparative analysis.

OPSOMMING

Met die aanvanklike reaksionêre optrede teen die MIV/VIGS-pandemie in Nigerië is daar gesteun op gespesialiseerde, onafhanklike klinieke as diensleweringsmodel om behandeling en sorg aan mense wie met MIV/VIGS leef (PLWHA) te verskaf. Met verloop van tyd het verskeie vrae rondom die diensleweringsmodel vir PLWHA ontstaan, wat blootstelling aan MIV-geassosieerde stigma-risiko's en aansienlike las op die swak gesondheidstelsel ingesluit het. Die bywoningskoste as gevolg van veelvuldige verwysings na klinieke, wat in 'n klein reeks gesondheidsdienste spesialiseer en waar die potensiaal vir kliënteverlies aan die groei was, was 'n bykomende uitdaging.

In reaksie op dié aangeleenthede, onderskryf openbare gesondheidspraktisyns toeneemend die gebruik van die geïntegreerde Kliniese Model vir MIV- en VIGS-dienslewering. Dié model gebruik dieselfde hulpbronnne om geneeskundige dienste te bied aan MIV-positiewe kliënte, sowel as aan ander pasiënte wat dienste in hospitale benut.

Ondanks opponerende sienings wat betref die risiko van MIV-verwante stigma vir PLWHA, die saak van benutting of voorsiening van dienste, asook die pasiënte-uitkoms van dié diensleweringsmodel, het min studies nog gefokus op die persepsies van diegene wat die model toepas. Dié studie gebruik 'n eenvoudige vraag-gerigte opname om persepsies van gesondheidswerkers en MIV-positiewe kliënte aan die Kogi Staatspesialis-hospitaal in noord-sentraal Nigerië oor die geïntegreerde model van MIV/VIGS kliniekdienslewering te assesseer.

Bevindinge van die studie dui daarop dat die kliënte en gesondheidsvoorsieners die geïntegreerde klinieksamestelling nie sien dat dit die risiko van blootstelling van PLWHA aan MIV-verwante stigma verhoog nie, maar dat dit eintlik so risiko verminder. Wat betref die benutting of voorsiening van dienste, het die kliënte en gesondheidswerkers 'n gedeelde siening uitgespreek wat nie ernstige komplikasies na vore bring nie, en hulle het basies 'n voorkeur vir hierdie model getoon. Albei studiegroepe het ook positief met die kliënte-uitkoms van geïntegreerde kliënte geïdentifiseer.

Die vernaamste gevolgtrekking uit dié studie is dat die geïntegreerde MIV-kliniekmodel 'n werkbare alternatief bied vir onafhanklike MIV- en VIGS-behandelingsklinieke en dat dit tydens die verloop van die assessering van behandelingsdienste tot die vermindering van die MIV-verwante stigma kan bydra.

Die vernaamste tekortkoming van dié studie is die onvermoë om met die oog op mededingende analise die persepsies van kliënte en werkers in die geïntegreerde klinieke te vergelyk met diegene in onafhanklike klinieke.

ACKNOWLEDGEMENT

I wish to acknowledge the kind support I received in conducting this study from the Management and Staff of the Kogi State Specialist Hospital, Lokoja, Kogi State, Nigeria. I am particularly grateful to teams in the General Out-patient clinic and the Ante-natal clinics of the hospital and the hospital clients who agreed to participate in the study. Special appreciation goes also to my study leader, Mr. Burt Davis for his sustained guidance and patience and to my family for their support in the fulfilment of this life-long dream.

EXPLANATION OF TERMS

Vertical health programme - Vertical programmes (also known as stand-alone, categorical or free-standing programmes or the vertical approach) refer to instances where "the solution of a given health problem [is addressed] through the application of specific measures through single-purpose machinery". Vertical delivery of health services implies a selective targeting of specific interventions not fully integrated in health systems (Mbuya, 2005). Vertical approaches are generally disease specific and promote targeted clinical interventions delivered by a specialized service. Critics of vertical programmes insist that they may fragment care, cannibalize funding and resources, and create inefficiencies, resulting in missed opportunities to treat multiple issues in an integrated fashion.

Horizontal health programme - Horizontal approaches tackle several interrelated health issues by strengthening health systems and developing integrated delivery systems. It is defined by World Health Organization, focuses on "all the activities whose primary purpose is to promote, restore or maintain health." In contrast to vertical programmes, these programmes (also known as integrated programmes, integrated health services or horizontal approaches) seek to "tackle the overall health problems on a wide front and on a long-term basis through the creation of a system of permanent institutions commonly known as 'general health services'" and include "a variety of managerial or operational changes to health systems to bring together inputs, delivery, management and organization of particular service functions" or are described as "a process where disease control activities are functionally merged or tightly coordinated with multifunctional health care delivery". In essence, horizontal programmes focus on the individual as a person and on the community as opposed to vertical programmes which focus on the disease. (Billings, De Maeseneer et al, 2007).

Stand-alone HIV Clinic Model - Stand-alone HIV clinics are products of the vertical implementation of the HIV/AIDS programmes in which HIV-related clinic services (counselling and testing or care and treatment) are provided in specialized units within a hospital or whole clinics. These clinics or units typical have separate funding, staffing, protocols and coordination systems separate from those for general medical service delivery systems.

Integrated Service Delivery – In a recent technical brief, WHO defined integrated service delivery as "the organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money" (WHO 2008). This describes the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system. It also refers to the delivery of services or multiple

interventions together on the same patient visit by the same health worker or clinical team and often requires the blending of either some or all elements of one service into the regular functioning of another service. A key prerequisite to successful integration is the strength of the primary service into which elements of another service are to be integrated (World Health Organization, 2008).

Integrated HIV/AIDS Clinics - This term refers to a hospital service delivery model that utilizes the same resources to provide medical services to both HIV-positive clients and other patients accessing services in the hospitals. The model integrates service delivery at several levels for all patients and ensures that HIV-positive clients can access services same as any other hospital client and are not easily identified by people who are not hospital personnel. It is opposed to the stand-alone HIV clinic model.

LIST OF ABBREVIATIONS

AIDS	Acquired Immune-Deficiency Syndrome
ANC	Ante-Natal Clinics
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCC	Behaviour Change Communication
HCT	HIV Counselling and Testing
HIV	Human Immune-deficiency Virus
LGA	Local Government Area
MSH	Management Sciences for Health
NACA	National Agency for the Control of AIDS
NGO	Non-Governmental Organization
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PABA	People Affected By AIDS
PEP	Post Exposure Prophylaxis
PEPFAR	U.S President Emergency Programme for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
ProACT	Prevention, Organizational strengthening, AIDS Care and Treatment Project
SACA	State Action Committee on AIDS
SMOH	State Ministry of Health
STIs	Sexually Transmitted Infections
TB-DOTS	Tuberculosis Direct Observation Treatment Short course

UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
WHO	World Health Organization

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1. CHAPTER 1 – INTRODUCTION

1.1. HIV/AIDS Treatment in Nigeria

At the end of 2009, about 33.3 million people were estimated to be infected with HIV globally. Of these, 22.5 million (representing 68% of the global total) were in Sub-Saharan Africa and about 2.98 million in Nigeria. The country thus has the 2nd highest number of people living with HIV in the world after South Africa (UNAIDS, 2010).

Since the first case of AIDS in Nigeria was reported in1986, the HIV and AIDS epidemic has continued to evolve. ANC-based sentinel surveys have documented a progressive rise in median National HIV prevalence from 1.8% in 1991 when the first survey was conducted a maximum high of 5.8% in 2001. Since the commencement of the National Anti-retroviral Treatment programme in 2002, there has been a gradual decline in these rates. The most recent survey conducted in 2010, puts the figure at 4.1% suggesting a stabilizing epidemic at the brink of reversal if response efforts are sustained (FMOH, 2010).

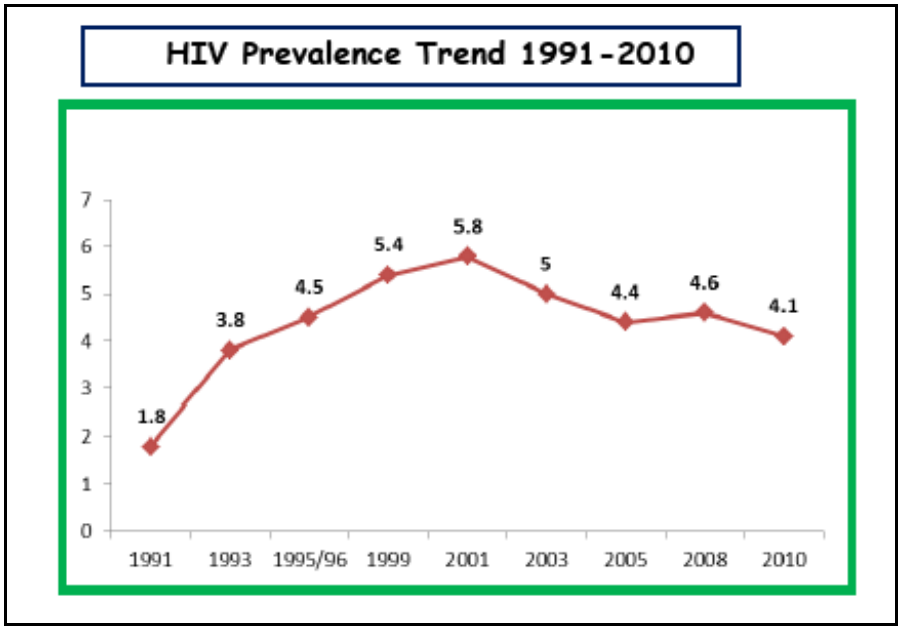


Figure 1 – Median National HIV prevalence rates in Nigeria from 1991-2010 (NACA, 2011).

The decline in national prevalence trends has been supported by Government-led HIV/AIDS response efforts which commenced in 2002 with the launch of the Nigerian HIV/AIDS Emergency Action Plan and has since been scale-up through the ensuing support of various donor groups

including PEPFAR, the Global Fund, World Bank, UNICEF and Clinton Foundation to mention but a few. Through the support of these donors, PLHIV living with HIV in Nigeria have had increasing opportunities to access free (or subsidized) Anti-retroviral treatment. The number of HIV and AIDS treatment facilities has increased from 20 in 2002 to 445 in 2010 (NACA 2011).

The increased availability of treatment has dramatically improved survival rates and lowered the incidence of opportunistic infections in people with AIDS (UNAIDS, 2005). Those who have access to ARVs and the care needed to maintain therapy can live for many years with what is now considered to be a complicated but manageable chronic disease. Though not a cure, ARVs are very effective in controlling the virus, and can even reduce the level of the virus to a point where it is no longer possible to detect any HIV in the blood. These medicines prevent HIV from multiplying rapidly and, at the same time, boost the body's immune system. In this way, they can increase the length and quality of life and enable people to lead full and productive lives.

Despite the successes, Nigeria continues to contend with a huge service delivery gap for HIV and AIDS care and treatment. Currently, only 23.7% of the 1,512,720 people (Adult – 1,300,000; Children – 212,720) estimated to be in need of HAART are actually receiving treatment. The annual AIDS Death is estimated to be around 215,130 (Male – 96,740; Female – 118,390) while 281,180 (Adult – 126,260; Children – 154,920) are estimated to have occurred in the year preceding 2011 (NACA, 2011). Also, only 30% of HIV-positive pregnant women are able to access ARVs for the PMTCT. The Nigerian Government recognizes the "inadequate number and geographical spread of sites providing ART services" (characterized by preponderance of treatment centres in urban communities at the expense of rural communities) and the poor integration of HIV and AIDS care and treatment services (leading to multiple "missed opportunities" for HIV and AIDS treatment within the context of broader health services delivery) as some of the major reasons for these coverage gaps (NACA, 2011).

This recognition informs the recent recommendations by health experts in Nigeria (and world-over), for the improved integration of HIV and AIDS treatment services into existing hospital services to create more opportunities for these services to be made available to those in need.

This research paper largely attempts to investigate the acceptability of this integration to both clients who utilize the services and the health workers who provide these services, forms the central construct of this research.

1.2. Background/Rationale for the Study

The urgency of early donor-funded HIV/AIDS mitigation efforts in Nigeria, initially favoured the proliferation of "stand alone clinics" due to the focus on a "vertical" approach to HIV/AIDS service delivery in health facilities. This may have been partly because most HIV/AIDS treatment knowledge was fairly new in the Nigerian health environment and therefore required the specialized attention of health workers who were newly trained in this area of medicine. It may have also been due to the donor requirements to meet specified service delivery targets in other to justify the continued investment in these interventions. PEPFAR and similar donor-driven interventions have contributed in part to this situation as it sought to rapidly scale-up HIV/AIDS Care and Treatment in partner countries.

At hospital level, this vertical or stand-alone arrangement often requires separate staffing, space, equipment and client flow and is often run parallel to existing service delivery systems and pulls away resources from existing health systems (Baird, Baptista, Gloyd and Gimbel et al., 2010). Experts in the local and international community have however identified the potential for "stand alone" models of HIV/AIDS service delivery to fuel the incidence of HIV/AIDS associated stigma and discrimination (because HIV-positive clients could be more easily identified in the separate clinics) often leading to high rates of client drop-out and poor adherence. It may also to contribute to poor resources utilization (human and material) as well as fuel unhealthy competition amongst health care workers and diminish morale – especially as these parallel systems are often characterized by different remuneration packages and conditions of service for the health workers (Buve, Kalibala and McIntyre, 2003).

The "integrated model" of HIV/AIDS service delivery is promoted as one of the strategies to minimize these challenges due to its potential to reduce the incidence and opportunities for stigma and discrimination of PLHIV in the providing of health services (by maintaining client anonymity). This model is also touted to be a more efficient management strategy for the provision of HIV/AIDS services in health facility because it eliminates the need for parallel systems for delivery of these services. This model is thought to be more appropriate for resource-limited settings prevalent in Sub-Saharan Africa especially with regards to long-term programme sustainability and diminishing donor funding and support (Alticea, Bruce, Kamarulzaman, and Sylla, 2007; Dehne, Greener, Maier, Obure, Sweeney, and Vassall, 2011)

Despite the abundance of evidence in favour of the integrated clinic model for HIV/AIDS treatment service delivery, some health workers, health programme managers and clients of "standalone" HIV/AIDS clinics have continue to express some reluctance to embrace this service delivery model. This study will investigate the perceptions of Health Care Workers and their HIV-positive clients about the integration of HIV/AIDS care and treatment into general hospital services with the intention to capture the perspective of these vital stakeholders as it weighs on this debate and for other related health policy implications.

1.3. Research Problem

Despite the much lauded potentials of the "integrated model" of HIV/AIDS service delivery in minimizing stigma and discrimination of PLHIV as they access health services and promoting more effective and efficient utilization of health resources, we do not yet know the perceptions of health care workers and HIV-positive clients with respect to the extent that integrated models can successfully deliver HIV/AIDS Care and Treatment services in Kogi State, North-Central Nigeria.

1.4. Research Question

The research question is stated - What are the perceptions of health care workers and HIV-positive clients of HIV/AIDS Care and Treatment Centres in Kogi State, North-Central Nigeria, about the integrated model of HIV/AIDS service delivery?

1.5. Aims and Objectives

Aims of the Study

The aim of the study is to determine the perceptions of health care workers and HIV-positive clients of HIV/AIDS Care and Treatment Centres in Kogi State, North-Central Nigeria, about the integrated model of HIV/AIDS service delivery in order to recommend strategies for improvement in the delivery of HIV/AIDS care and treatment services.

Objectives

a) To establish the characteristics of the integrated HIV/AIDS clinic model
b) To assess the perceptions of the health care workers about the integrated HIV/AIDS clinic model

c) To assess the perceptions of the HIV-positive hospital clients about the integrated HIV/AIDS clinic model
d) To proffer some recommendations for the improvement of HIV/AIDS clinic service delivery.

1.6. Significance of Study

The study considers the recent campaigning from donors and governments funding HIV/AIDS programmes in Nigeria for improved programme integration as a strategy to ensure that HIV treatment become sustainable in the long term. The implementation of integration strategies in hospitals has the potential to improve access to HIV/AIDS service by improving the anonymity of HIV-positive clients seeking medical attention for the HIV and AIDS associated illnesses – contributing to reduction in HIV-associated stigma. It may also contribute to improvements in quality of non-HIV medical services by leveraging on the vast funding and resources being channelled to HIV/AIDS treatment and eliminate the need for parallel systems and the strain it places on already poor health resources (manpower, infrastructure, equipment and so on).

As discussions continue at policy and implementation levels about the appropriateness of standalone or integrated HIV/AIDS treatment models especially at this point in the evolution of the Nigerian HIV/AIDS response, it should prove worthwhile to have an understanding of the perceptions of beneficiaries and direct providers of HIV/AIDS treatment services.

It is expected that this knowledge should contribute to guide the design of the programmes in hospitals especially bearing in mind the need to keep the programmes sustainable and to ensure the best possible client outcomes.

2. CHAPTER 2 – LITERATURE REVIEW

2.1. Introduction

In the review of literature, an analysis of the characteristics of the integrated HIV/AIDS clinic model is investigated. The chapter begins with an attempt to look into the origins and scope of the current demands for the integration of HIV/AIDS programmes in general and of HIV/AIDS treatment services into the mainstream hospital service delivery profiles in particular. It goes on to explore literature on the characteristics of integrated HIV/AIDS clinics and elucidates current thinking about the benefits and challenges of integrating HIV and AIDS treatment in general hospital settings.

This chapter details findings from previous studies investigating the perceptions of health care workers and their clients along three main themes; one, HIV-related stigma directed at the clients, two – the ease of providing and accessing services and lastly; the outcomes of accessing HIV/AIDS treatment services in an integrated clinic.

These three themes feature quite predominantly in the review of studies reporting on the determinants of patient's choices of hospitals to use and patient's satisfaction which are linked to client adherence to Anti-retroviral Treatment and retention in care (Bankwar, Bhagat, Lodha and Pal, 2011; Bangsberg, Dickenson, Essex, Gilbert, et al, 2003).

Stigma and discrimination have been identified as major determinants for the uptake of HIV and AIDS diagnostic and treatment services (Belachew, Haile, Lulseged and Maedot, 2007) and deeply affects the lives of people with HIV/AIDS. Fear of being identified as a Person Living with HIV or AIDS may discourage a one from getting tested, from accessing medical services and medications, and from disclosing their HIV status to family and friends.

Cunningham, Ryan, Sarkisian, Sayles and Silver (2007) and Appleby, Burge, Devlin et.al (2010), established a strong link between patient's choice of hospitals and their appreciation of the quality of services and outcomes of treatment while several others studies including Chue (2006), Akpala, Onwujekwe, and Uzochukwu (2004), Lunnen, Ogles, & Pappas, (2008) and Pekarik and Wolff (1996) documented the link between treatment outcomes and patient satisfaction. Similar relationships were established by Godley, Fiedler and Funk (1998), Lambert, Salzer and Bickman (1998) and Rey, Plapp and Simpson (1999) as quoted in Dore, M.M. (2010).

Flores and Ngui (2006) refer to a series of studies which conclude that…

> … "Patient satisfaction with care and ease of using health care services are important quality and access-to-care indicators and key measures for monitoring and evaluating the performance of health care systems. Satisfaction with care influences several health behaviours, including changing providers, adhering to treatment, changing health care plans, avoiding physician visits and filing lawsuits. Satisfaction with care can vary according to practice characteristics, service organization, and site of care."

This literature review presents opposing views on the three themes from various studies focussed on integrated HIV and AIDS care and treatment service delivery and is presented to demonstrate the different perspectives to the integration of these services from both service providers and HIV-infected clients utilizing these services.

2.2. Characteristics of the integrated HIV/AIDS clinic model

Donor-supported health programmes in Nigeria have mostly followed a vertical approach to their implementation because this tended to be operationally easier to manage and monitor. This is quite understandable, given to that most of these programmes are funding and time-bound and there is a need to demonstrate how effective the interventions have been (in the short-term at least), in other to attract funds for future interventions. The HIV/AIDS response programmes have inadvertently followed a similar direction especially as the programme was initially captioned as an "emergency response" (PEPFAR, 2003)

Lately however, there has been an increasingly call for these programmes to contribute directly to overall health system improvements especially given the weakened status of the health sector in these environments. The "integrated approach" to programme implementation is now being promoted as the way to do this (Levine and Oomman, 2009). In 2007, the Director General of the World Health Organization proposed that...

> …"We are all concerned about the need for more coordination, coherence and cohesion, for less duplication and less waste…. We need a comprehensive, integrated approach to service delivery. We need to fight fragmentation…"

The WHO HIV/MNCH Technical Working Group (2008) defines integration as "the organization, coordination, and management of multiple activities and resources to ensure the delivery of more efficient and coherent services in relation to cost, output, impact, and use (i.e. acceptability)".

The recent rapid scale up of HIV treatment means that HIV has effectively become the first large-scale chronic care programme in many resource-limited settings. Increasingly also, the role of primary health centers as well as clinics and hospitals in managing both HIV and non-communicable diseases has been noted and interest is growing in various models for integrating both types of health services (UNAIDS, 2011)

At the point of service this integration refers to a clinic that provides continuous care services to a wide range of people, including those living with HIV and those with non-communicable diseases. Tools and approaches are shared, and a multidisciplinary team of health workers provide services to everyone (Ford, Gupta, Jassens, van Damme, and Zachariah et al., 2007).

While much has been documented about the need for integration of HIV/AIDS programmes, it seems that there is a significant variation within hospital settings, of the effort to integrate HIV/AIDS services. Church and Mayhew (2009) observed a range in this regard from those facilities in which HIV/AIDS services are provided in specialized units within the same hospitals (facility-level integration) to those in which these services are provided along with a range of other non-HIV services by the same clinicians or general service unit (provider-level integration). Despite these differences in the service models, Kuku (2006) insists that there is no one perfect model and whether the clinics are stand alone, integrated, mixed or mobile – the biggest consideration should be that which is most accessible for the targeted clients.

Chiko, Chipukuma, Giganti et al (2010), observed three important modifications that were required for the functional integration of HIV and non-HIV out-patient services. These modifications included: one - the amalgamation of space and patient flow; two - the standardization of medical records and three - the introduction of generalized services targeted non-specifically to all clients e.g. routine provider initiated testing and counselling (PITC). On a similar note, Adamchack, S., Aradhya, K. and Wilcher, R. (2010), proffer ten essential steps for strengthening integrated service relevant among which is the need to organize services by having a good appreciation about how clients move through the health facility, making most use of available space (and other resources)

using a triage system to reduce potential bottlenecks in client flow and making efforts to reduce client waiting time and patients costs.

2.3. Risks and Opportunities for HIV-related stigma and discrimination

The integrated clinic model has also been advocated for on the grounds that it led to a reduced opportunity for clients to feel stigmatized. Diaby, Ekpini, Kuassi et al (2004) documented feedback from clients who had defaulted from PMTCT care services at a standalone facility in which one of the clients commented that;

> "… even the location bothers me, because everyone who comes to the clinic knows what goes on [at the programme]. As soon as a pregnant woman is seen coming here, it's known right away that she is HIV-positive".

Intrahealth (2009) quotes another client as saying;

> "Before integration, there was a lot of discrimination because there was only one HIV office, and patients had to wait in line outside and everyone knew you had HIV. Now with integration, you can go to any office and receive the services you need."

Chiko, Chipukuma, Giganti et al (2010) reported mixed feedback from clients who had responded to questions about the risk of stigma before and after the integration of their clinic. Some of the HIV-positive clients felt that the integration had provided some anonymity to them, while others felt that they were now more exposed to stigma as the non-HIV clients could now more readily identify them. They also reported that after the integration, a larger proportion of the non-HIV clients were obviously more comfortable with the improved service conditions and anonymity. Clients reported feeling that clinic staffs were more pleasant, maybe as an outcome of the trainings they had received about minimizing stigma in the hospital setting prior to the integration of HIV/AIDS services. Health care workers interviewed were inclined to agree with the first group. Their study observed that after the integration of HIV and non-HIV clinics at two sites in Zambia that health care workers felt better about the opportunity of working together with no divisions, helping more HIV-infected people test and enrol for treatment and contributing to a reduction in the exposure of their clients to HIV-related stigma.

Amoran (2011) reported that a majority (97.9%) of health care workers had confirmed their ethical and legal commitment to providing services to PLHIV and only 1.7% had given confidential information to patient's family members or relatives without the consent of the patient. In support, only 2.1% of the same health workers expressed a belief that other patients would be reluctant to attend hospitals where lots of AIDS patients are being managed.

With regards to stigma in health settings generally, Aghamolaei, Hasani, Tavafian and Zare (2009), observed that most healthcare providers showed positive attitudes towards patients with HIV and noted that most of the health workers believed that caring, educating, counseling, and treatment of patients with HIV resulted in quality of life improvements.

The Health Policy Initiative (2008) compiled a list of best practices in the provision of non-stigmatizing and non-discriminating clinical care based on analysis of in-depth interviews with clinic staff from client-preferred sites and PLHIV focus groups in Cambodia, Thailand, and Viet Nam. Key among this in maintaining the confidentiality of HIV-positive clients utilizing clinic services were recommendations to ensure that client's medical files, clothes, and beds are not labeled to avoid unnecessary disclosure of HIV status. They also recommended the avoidance of separate care wards for PLHIV as a way to reduce stigma. This was despite the preference expressed by several PLHIV groups.

2.4. Ease of providing and accessing services in an integrated clinic

One dimension to the benefits of integrating HIV treatments services is the increased opportunities for decentralization of HIV/AIDS care and treatment services to lower level health facilities like Primary Health Centres (PHC) with potentials to lead to an make services more available to the populace and lead to an increase in client uptake, client retention (and hence an improvement in clinical outcomes) as observed by Reuter (2006). In support of this observation, Baird, Baptista, Gloyd and Gimbel et al. (2010) observed the capacity of the integrated clinic model in primary health centres "to test more patients for HIV, place more patients on ART more quickly and efficiently, reduce loss-to-follow-up, and achieve greater geographic HIV care coverage" when compared to the vertical model.

It is important to note also that the integration of HIV treatment services creates opportunities to utilize hospital resources more efficiently. In support of this view Baird and co also documented

how resources for HIV-related services (which are significant at this time because of the huge investments currently channelled to HIV mitigation efforts) have been used to rehabilitate hospital infrastructure, including laboratories and pharmacies, strengthen supervision, fill workforce gaps, and improve patient flow between services and facilities in ways that can benefit all programs as opposed to being used to set-up stand alone HIV treatment facilities.

Therefore, rather than leading to declines in other primary health care services (because the same resources are used competitively to provide these services along with HIV services) Ford, Gupta, Jassens, van Damme and Zachariah et al. (2007), Butley, Chao and Degroot et al. (2008), Cohan, Gomez and Feakins et al. (2008), Binagwaho, Leslie, Price and Welsh (2009) as well as El-Sadr and Howard (2010) all reported that integration had contributed to increases in non-HIV services as more a standardized quality of care (including regular check-ups, weight measurement and blood pressure checks) previously only available to HIV-positive clients through stand-alone clinics was now more readily available to general hospital client population because of integration. The reports by Chiko, Chipukuma, Giganti et al. (2010) and Dehne, Greener, Maier, Obure et al. (2011) both concur with this trend by concluding that integration will lead to less fragmented services, higher levels of continuity of care, better referral systems and possibly reductions in patient/community-level costs resulting from fewer visits to facilities, greater proximity of services and reduced delays in accessing treatment.

It is important to note that even clients who had not actually experienced the integrated model – were positively disposed to this model because it eliminated the costs of completing their referrals for unavailable HCT services. Askew, Ayisi, Gathitu, Homan, Liambila, Mwangi, et al. (2008), noted from a study comparing sites integrating Family Planning and HCT services with standalone sites, that majority of the clients from these standalone sites reported an improvement in the ease of accessing services at integrated sites and considered this the preferred model.

In spite these very positive findings, Bedelu, Ford, Hilderbrand and Reuter (2006), Heunis, Meulemans, van Ruesburg and Wouters (2008) and Reuter (2005), have noted that the scale-up of the integrated HIV clinic model would face significant impediments due to the human resources limitations that typically characterise resource-constrained settings. Agreeing with this view, Levine and Oomman (2009) conclude that without significant investment in hiring and training of more health workers, the quality of care could decline and workload would increase. This potentially

would jeopardise hospital services. Also in support Chiko, Chipukuma, Giganti et al (2010) documented that integration of HIV and non-HIV outpatient services in clinics could lead to an overall increase in client-waiting times which could become a source of dissatisfaction to hospital clients. Disagreeing with this view, Bedelu, Ford, Hilderbrand and Reuter (2006) conclude that **service integration** had in helped to spread the workload among all staff and also recommend **decentralization** (taking HIV treatment services to more hospitals) to spread the load among different clinics and **task shifting** to allow lay counsellors to test, nurses to initiate ARVs, pharmacists' assistants to manage drug supply, adherence counsellors to support the system and proactively clients and community groups to actively engage in service provision. In their study, all these interventions had contributed to the near-doubling in service users even with no increase in the population of the nursing staff.

It has also been suggested that hospital workers could be more proactive in addressing the challenges experienced by hospital clients in the course of accessing hospital services generally (whether in standalone or in integrated clinics) as clients are more likely to default from care when they perceive the services or the staff negatively. These notions of negativity cover a spectrum of perceived issues ranging from long waiting-times to abusive speech and stigmatizing behaviour from health care workers (Diaby, Lin, Matia, Painter and Sibailly, 2004). Campbell, Gregson, Madanhire, Nyamukapa and Scott (2011) have noted that patients and nurses do not always agree on constituted 'good hospital services'. They observed that nurses tended to under estimate the effect of long waiting times and frequent hospital visits and also tended to expect general obedience from patients as interpretation of clients willingness to adhere to treatment instructions. Both parties were however inclined to agree on such issues as acceptance (treating HIV-positive patients like all other patients), confidentiality, kindness and understanding on the part of nurse as favourable factors for ensuring greater ease of access to services.

2.5. Service Delivery Outcomes of integrating HIV/AIDS services in clinics

The integration of HIV/AIDS services is not taken only at face value, but there is evidence that it may lead to improvements in service delivery outcomes. Bedelu, Ford, Hilderbrand and Reuter (2006) and Reuter (2006) in reporting their work in Lusikisiki, documented the potentials for an effective integration of HIV/AIDS care and treatment services. Their study shows how integrated rural clinics had ensured a faster and sustained uptake of HIV-positive clients accessing treatment

services and a much lower rate of client drop-out compared with larger specialized HIV/AIDS treatment hospitals. They linked this observation to the fact that the integrated clinics offered a multiple range of services and HIV/AIDS clinic services being integrated into general consultation. Anaya, Asch, Bowman, et al. (2009) noted similarly, that patients who visited Integrated HIV Care (IHC) clinics were more likely to achieve viral suppression.

Proponents of the integrated HIV clinic model also talk of the potential for improvements in the quality of care provided to the patients. Askew, Ayisi, Gathitu, Homan, Liambila, Mwangi, *et al*. (2008) suggests that quality of care was observably better in integrated clinics when compared to standalone facilities (probably because the clinicians were also spending more time interacting with their clients). In an ante-natal setting, Butley, Chao, Degroot et al. (2008), reported an improvement in the uptake of non-HIV services (testing for syphilis) when ANC was integrated with HIV services just as Cohan, Gomez, Feakins et al. (2008) documented a significant increase in HIV testing among pregnant women attending ANC when provide-initiated opt-out testing was adopted as part of the routine ANC services. Integration led to similar positive outcomes among TB patients (El-Sadr and Howard, 2010) and also among diabetics in chronic care (Ford and Gupta et al., 2007).

Integration may also have a positive influence on health care workers and hospital operations. Lifson, Bekele, Cirera, Faltamo, et al. (2009), in their report of the mid-term evaluation of the integrated management of adolescent and adult illness in Ethiopia, concluded that the integration of HIV and AIDS services at health facilities has been beneficial to both HIV-positive clients and hospital workers. They observed significant improvements in hospital utilization and increased access of clients to quality HIV services. Hospital workers felt that they were better trained and motivated by what they perceived to be an increase in their credibility as clinical care providers in the eyes of the community. This led to an improvement in the confidence levels of health workers and a better efficiency of use of personnel and hospital resources (Intrahealth, 2009).

Noting that the factors contributing to improving client outcomes and health worker perception about the competence and capacity, Coetzee, Friedland and Harries (2007) suggested that the increase in trainings opportunities and the upgrading of the clinic environment was by far more responsible for the observed improvements in client's health outcomes and health worker motivation than merely co-locating HIV and non-HIV clients but agreed that that HIV funds could be applied more strategically to improve other health programmes.

On the downside of all of these benefits of HIV clinic integration, Askew, Ayisi, Gathitu, Homan, Liambila, Mwangi, *et al*. (2008) observed that even though health care workers in the integrated clinics were pleased with potential for better client outcomes – they were worried about increases in work load and clients waiting time and advocated for an increase in number of health care workers support the integrated clinics. Asiimwe, Kibombo and Matsiko (2005) observed similar reservations from health workers who felt there was not enough time and staff to provide family planning services and anti-retroviral treatment at the same time. Chiko, Chipukuma, Giganti et al (2010) also note this perceived increase in workload from health workers even when in fact, there had been no significant change in their workload.

Also some PLWHA interviewed by Hausler, Jackson, Kigozi et al. (2010) preferred to be seen by the same clinicians expressing a desire to build trusting relationship (over time) with their clinicians as one way to deal with the psychological impact of being diagnosed with HIV. They concluded that the inability of integrated clinics to guarantee this for their PLWHA clients could contribute to client defaulting and poor treatment outcomes. Countering this notion however, Buve, Kalibala and McIntyre (2003), believe that the demands of HIV and AIDS care and treatment had contributed to a renewed focus on client services issues like patient counselling, privacy and had led to a more comprehensive approach to health service delivery which addressed the physical, social and psychological well-being of the patient. This potentially contributes to a more client-friendly environment and improved patient participation in treatment decision-making that could be equally beneficially to non-HIV clients if treatment services are integrated in hospital settings.

2.6. Summary

The three themes being reached have been identified to greatly impact the long-term opportunities for hospitals providing HIV (and other chronic disease) services to enroll and retain new clients. The retention of HIV+ clients on appropriate treatment and their continuous adherence with the treatment plans have been identified as key to achieving the goals of anti-retroviral treatment. Reduction of opportunities for HIV-related stigma and improvements in the ease of accessing and providing HIV treatment services as well as in the outcomes of treatment all contribute favorably to client retention and adherence.

When HIV-related stigma and discrimination occur in hospital settings, it poses a hindrance to patients seeking diagnostic and treatment services for HIV and AIDS. In studies evaluating the opportunities and impact of stigma in integrated HIV clinics, clients reported mixed feedback on their perception of the risks and incidence of stigma in the process of accessing services. Some studies documented favorable perceptions about integration of HIV treatment services in general hospital settings because it was associated with a higher degree of anonymity which helped to reduce opportunities for stigma while others documented that clients had reported felling more exposed to stigma and discrimination because they could now be easily identified by others who were not HIV-positive.

Also on a positive note is the report of clients who felt that health workers were more pleasant and understanding of their needs because they had trained and better prepared to deal with PLHIV within an integrated clinic system.

Health workers tended to agree with the first group of clients that integration provided greater anonymity for all patients (as opposed to the standalone HIV treatment clinic model) and reduced the risks for HIV-related stigma. They noted that more patients were accessing HIV services as proof that integration had led to reduction of stigma within the clinic. The importance of maintaining confidentiality was however identified as a key strategy for reducing the risk of stigma and discrimination in an integrated HIV clinic.

Regarding the ease of accessing and providing services, it was noted that the integration of HIV and AIDS services created opportunities to decentralize these services, bring them closer to clients in smaller, more rural communities that were far from the current treatment facilities. This potentially reduces transport costs and also the frequency of referrals and hospital visits for both HIV and non-HIV related services (as both services could now be provided within the same settings at little extra costs).

Researchers noted documented the capacity of Primary Health Centers operating the integrated HIV clinic model, to enroll more HIV+ clients and provide ART to more people, faster and more qualitatively (because less people were loss to follow-up). They noted that integrated had also led to improvement in the uptake and quality of other non-HIV treatment services (ante-natal, TB treatment and other chronic diseases).

Clients had reported benefitting from a wider range of medical review and check-up services due to the integration of standards of care.

It was however noted that the rapid increases in client population was often not matched with a commensurate increase in staff strength and capacity. This typically led to an increase in workload faced by the health care workers and subsequently led to increase in client waiting times – potentially jeopardizing all the other successes from the integration process. Clients had identified the longer waiting times as a major disadvantage of integrated clinics though many of the health workers had not identified with this challenge.

Upon review of the outcomes of service delivery from the perspectives of clients, some of the studies reported integrated HIV clinics were more likely to enroll and retain more patients on anti-retroviral treatment over time and that the patients utilizing these clinics were also more likely to achieve viral suppression (considered one of the main goals of HIV/AIDS treatment). Quality of care was also reportedly better when compared with standalone clinics because the integrated clinics offered a wide range of HIV and non-HIV related services and because the clinicians generally spent more time with the patients addressing HIV and non-HIV related clinical complaints. Evidence from some clinics that had recently integrated HIV services into the antenatal services also showed that the uptake of both HIV and non-HIV related services had increased when integration happened and this lead to a more qualitative service profile.

There were however some studies had documented that both HIV and non-HIV clients were likely to be discouraged and potentially default more from their treatment because of the increases in client waiting time associated with integrating HIV services into general services and the fact that more clinicians tended to be involved in the service delivery and clients were more likely to be seen by a different doctor or nurse at each visit.

On the side of the health workers, some of the works documented that health workers felt that the integrated clinics were better because HIV and non-HIV staff and services tended to be complimentary and generally represented a more efficient use of staff, space and materials. Also health workers had reported feeling better trained, more competent and more motivated because they were able to offered services to all their clients (whether HIV-positive or not). There was however some reported discomfort with the increase in workload especially where attempts had not been made to plan ahead to this.

All the works reviewed show that on each theme, perceptions from clients and health workers remain largely opposing with regards the effects of integration of HIV and AIDS services into general hospital services. These themes will be researched along the lines of the reasons deduced by the studies that have so far been reviewed.

3. CHAPTER 3 - STUDY DESIGN AND METHODOLOGY

3.1. Study Design and Location

Quantitative research will be conducted using surveys to assess the perceptions of health care workers and HIV-positive clients at the Kogi State Specialist Hospital in North-Central Nigeria, about the integrated model of HIV/AIDS clinic service delivery being practiced in the hospital.

The facility is a tertiary-level health institution owned by the Kogi State Government that had been receiving support from the USAID/Management Sciences for Health (MSH) partnership for the provision of comprehensive HIV/AIDS care and treatment service since February 2008. The facility also provides TB DOTS service through a collaboration facilitated by MSH with the Kogi State Government's TB and Leprosy Control Programme. Despite the fact that there are three separate entities funding different programmes in the hospital, the hospital management has adopted the integrated clinic model to deliver out-patient services to its clients needing care and treatment for HIV and AIDS, TB and other acute and chronic medical conditions.

In this facility, the integration of HIV/AIDS clinics with the general out-patient services remains a work-in-progress. At this time however, PLHIV clients are given appointments according to their treatment schedules to attend clinics on two weekdays. Other clients are seen also on the same day. HIV-positive clients sit together with other clients in the waiting area and have to go through a nurse-triage station from where they go in for consultations with the doctors. Any doctors can see any patient as all have been trained to provide HIV/AIDS care and treatment services. The ANC unit operates by a similar arrangement. Provider-Initiated Testing and Counselling for HIV is offered routinely to all patients.

3.2. Study Population

There were two target populations for this study. The first group comprised of about 40 health care workers (clinicians and non-clinicians) engaged in the provision of HIV/AIDS care and treatment services at the ante-natal clinic and out-patient departments of the hospital. No sampling was done as the study aimed to get feedback from all the health workers in these units. All respondents were adults.

The second group comprised of about 1500 HIV-positive clients enrolled to receive HIV/AIDS care and treatment services at the same units in this facility. A total of 32 willing clients were selected at random during clinic visits to represent this population of hospital clients. All respondents were adults.

3.3. Questionnaire Construction

Two separate set of questionnaires was prepared – one for each group. The two sets of questionnaires focussed on three main constructs for evaluation; one – the perceptions of clients and health care workers in the clinic about opportunities for HIV-related stigma directed at the clients, two – their perceptions about the ease of accessing/providing services and lastly; their perceptions about the outcomes of accessing HIV/AIDS treatment services in an integrated clinic of this nature.

For the group comprised of Health Care Workers, a close-ended self-administered questionnaire was used to assess this group. The questionnaire comprised of fourteen Likert scale-type questions on the three identified study themes and a final open-ended question to get recommendations of the health care workers about the opportunities of improvements in service delivery. In the design of the questionnaire, questions 1-6 focussed on the first study theme of HIV-related stigma directed at the clients, while questions 7, 8, 9, 10, 11 and 13 related to the second theme of "these ease of providing services" and last theme on outcomes of accessing HIV/AIDS treatment services in an integrated clinic was probed in questions 12, 14 and 15.

Due to variations in literacy levels among the second study population (clients accessing HIV/AIDS treatment services), a researcher administered close-ended questionnaire was used to assess group. The questionnaire contained fifteen Likert Scale-type questions around the three themes of the study. Questions 1-5 raised queries related to the perceptions of the clients about their exposure to HIV-related stigma in the process of accessing treatment, while questions 6-9 probed their perceptions about ease of accessing treatment services. Lastly, questions 10-14 focussed on the client's perceptions about the outcome of the services they had received. Similar to the first questionnaire, a final open-ended question is added to get the recommendations of the patients about the opportunities of improvements in service delivery.

In both questionnaires, following a statement of opinion on the theme being assessed, respondents are given the option to either; agree strongly, agree, neutral, disagree or disagree strongly. This

choice of electives is made to make allowance for the expression of variations in emotions about a particular statement. A deliberate attempt was made to ensure that the questions investigating the main themes of the questionnaire had similar contents for the two study population and where variations existed it was only a matter of perspectives. This similarity was made to allow easy comparisons in the perceptions of the two study populations on the same subject matter and questions.

The table below depicts the contents of the questionnaires in this comparative format;

Health Care Workers Questionnaire (with corresponding statement number in bracket)	***Clients Questionnaire (with corresponding statement number in bracket)***
Theme 1: Perceptions about risks and opportunities for HIV-related stigma targeted at HIV-positive Clients	
I believe that people living with HIV should be seen in the same clinics as other patients - if the clinic space can accommodate this arrangement(1)	I believe that people living with HIV should be seen in the same clinics as other patients - if the clinic space can accommodate this arrangement(1)
People living with HIV should be seen by the same doctors/nurses that see other patients - if the Doctors/nurses have the skills to attend to them (2)	People living with HIV should be seen by the same doctors/nurses that see other patients - if the Doctors/nurses have the skills to attend to them (2)
I'd prefer that we set-up a separate clinic for HIV-positive clients only(3)	I'd prefer that we set-up a separate clinic for HIV-positive clients only(3)
I believe that visitors and other clients can readily identify those of our clients who are HIV-positive in our clinic (4)	I believe that visitors and other clients can readily identify those clients who are HIV-positive in the clinic (4)
I believe that clients have a right to know those who are HIV-positive in the clinic (5)	Health workers address me in a way that makes other people to know that I am HIV-positive (5)
I believe that our clinic arrangement increases our clients exposure to HIV-related stigma (6)	**(No corresponding statement as this is already inferred from answers to previous statement).*

Theme 2: Perceptions about the ease of accessing/providing services	
I am satisfied with the amount of time our clients spend in the waiting area (7)	I am satisfied with the amount of time I spend in the clinic's waiting area (6)
I believe that we are now providing more services to our clients since we started the integrated clinic. (8)	**(No corresponding statement as clients cannot assess any increase in content of services)*
All the patients get their weight and B.P checked regularly in the clinic (9)	The nurses regularly check my weight and Blood Pressure before I go on to see the doctor (7)
I have enough time to attend to the clients well (10)	The doctors take enough time to attend to me (8)
I like the combined sitting arrangements for all clients (HIV-positive and other) in the waiting area (11)	I like the combined sitting arrangements for all clients (HIV-positive and other) in the waiting area (9)
I am comfortable with the work load that I have to deal with in running a combined clinic (13)	**(No corresponding statement as this is specific for health care workers)*
Theme 3: Perceptions about outcomes of accessing HIV/AIDS treatment services in an integrated clinic	
I believe that the general quality of our services (for all clients) has improved because of the demands of providing HIV/AIDS treatment services according to strict guidelines. (12)	**(No corresponding statement as clients cannot comment on the improved linked to strict guidelines)*
**(No corresponding statement as this is specific for HIV-positive Clients)*	I have gotten better since I started receiving treatment in this clinic (10)
**(No corresponding statement as this is specific for HIV-positive Clients)*	I will like to continue receiving treatment in this hospital (11)
**(No corresponding statement as this is specific for HIV-positive)*	My answer to the last question is influenced by the fact that the hospital uses a combined clinic

	arrangement (12)
I will recommend this hospital to somebody seeking treatment for HIV and AIDS	I will recommend this hospital to somebody seeking treatment for HIV and AIDS
I have family members receiving treatment for HIV or AIDS in this hospital	I have family members receiving treatment for HIV or AIDS in this hospital
What would you recommend for this clinic to provide better services – Open-ended question.	

Table 1 – Comparative Structuring of the two sets of questionnaires used in the study

3.4. Data Collection

A total of 36 questionnaires were distributed to all the Health Care Workers (nurses, doctors and hospital counsellors) in both the General Out-Patient Department (GOPD) and the Ante-natal Clinic (ANC) during small group meetings with the hospital staff. Twenty-eight questionnaires were eventually retrieved out of which 2 were voided due to incomplete filling.

Researcher administered close-ended Likert Scale-type questionnaires were administered to 32 randomly selected and willing clients attending twice-weekly clinics over a one month period (Eight clinic days). The lengthened period of questionnaire administration was to ensure that the clinic services are not hampered by the survey exercise and to preserve the confidentiality of client's participation in the study as only four clients were selected from a pool of daily clients averaging about 60 per clinic day. The questions where explained in more details to those clients who did not seem to understand the questions the way they were structured. Clients who did not want to participate in the study after explanation of the survey protocols were given the option to opt-out. In all, a total of five clients opted-out of the process and five randomly selected respondents were recruited to replace them.

3.5. Data Entry and Cleaning

Questionnaires were retrieved and organized separately for each group of respondents and were subsequently numbered serially to maintain the identity of each individual questionnaire. Data from the questionnaires was keyed directly into a data editor sheet of SPSS to form a database. Entry

made in the database was double checked for consistency and was corrected to ensure high quality data.

3.6. Statistical Analysis and Packages

The Statistical Package for the Social Sciences (SPSS) version 17.0 was used in analysing the data. SPSS is among the most widely used programs for statistical analysis in social science**.** Frequency tables and other measures of central tendency analysis and some charts were generated directly using this package. Microsoft Excel was used to generate some of the other charts.

3.7. Analysis of Data

The primary objective of the analysis was to capture the frequency of response options of health care workers and HIV-positive clients to questions about the perceptions regarding the integration of HIV and AIDS care and treatment services into the general out-patient services of a state-owned tertiary health facility especially along three main threes; the opportunities for HIV-related stigma directed at the clients, the ease of accessing/providing services, and the outcomes of accessing HIV/AIDS treatment services in an integrated clinic of this nature.

3.8. Ethical Considerations

One major ethical issue that was addressed with the hospital administrators was the possibility of misrepresentation of hospital services and operations. Consultative meetings were held with the hospital management team to explain the extent and potential benefits of the study. Formal approval from the Hospital Management Team and the Hospital Ethics Committee was sought and received before the survey was commenced. Due consideration was given to the small possibility of interrupting hospital services in the course of conducting the surveys.

Responder anonymity for the health workers was maintained as respondents were not required to identify themselves on the questionnaire; however other bio-demographical information like sex, age and service unit will be required to assess potential differences between respondents along these variables.

The confidentiality of patients who agreed to participate in the structured interviews was maintained as only the consulting clinician was responsible for conducting administering the questionnaires at the end of the clinical consultation. Due efforts was put-in to ensure the

randomness of respondent selection and clients were given the option to opt out of the survey especially if they were uncomfortable with additional time spent in the consulting room or any other aspect of the study.

Clients were also given the details of a trained HIV/AIDS treatment counsellor to reach (at no fees) if they felt any emotional discomfort after providing answers to the survey questions and were encouraged to decline to any questions which aroused significant discomfort during the interview process. They were re-assured of the option to opt-out at anytime during the interview process.

None of the respondents opted-out of the study after giving consent during the interview process and at the time of compiling this study report, none of the respondents had reached the counsellor with concerns about their participation in the survey.

4. CHAPTER 4 – RESULTS

4.1. Introduction

This chapter presents the findings from the study based on the responses of survey respondents to two sets of group-specific questionnaires analysed using SPSS.17.0 and Microsoft Excel 2003. The first part show the demographic characteristics of survey respondents from both study population while the second part focuses responses to key statements on perceptions about the operations, benefits, challenges and otherwise of providing or accessing HIV and AIDS care and treatment services in an integrated clinic set-up.

4.2. Demographic Characteristics

Thirty consenting and randomly selected persons living with HIV attending the Out-Patient Clinic in the facility provided responses to the client-specific questionnaire. All respondents were adults had been attending the clinic for at least 12 calendar months (with reference to the month of survey – December 2011). Respondents were evenly distributed by sex (15 male and 15 female). A total of five clients (four male and one female) had initially opted-out of the survey by declining permission to be provide responses to the researcher-administered questionnaire. A similar number of sex-specific replacements were made for those clients who had opted-out.

For the other study population, twenty-six health care workers (nurses, doctors and hospital counsellors) responded correctly to provider-specific questionnaires from a total of 36 who received the questionnaires. All were adult workers engaged by the hospital and were providing services to clients attending the integrated out-patient clinics. Of these respondents, 15 were female and 11 were male.

4.3. Response from HIV+ Hospital Clients and Health Care Workers in the Integrated Clinics

The responses from both study populations are analyzed and presented comparatively based on three identified constructs of the study. Frequency distributions tables and histograms are used to illustrate the differences and similarities between the perceptions of HIV-positive hospital clients receiving treatment in an integrated clinic and those of the health care workers who provide these

services to them – about the risks, benefits and opportunities in operating this model for HIV/AIDS treatment service delivery.

4.3.1. Perceptions about risks and opportunities for HIV-related stigma targeted at HIV-positive Clients

Health care workers and HIV-positive clients in the clinics provided responses to the same five statements around this theme and one additional statement specific for the health care workers expressing the extent of their agreement or otherwise about the statements. Their responses are presented in a mostly comparative manner where similar queries have been posed to the two groups of respondents and following the sequence of the statements. Where this comparison is not possible because there is no immediately comparable statement posed to the other group, the findings from one group are presented alone.

i. *"I believe that people living with HIV should be seen in the same clinics as other patients - if the clinic space can accommodate this arrangement"*- 93.3% of the clients and 88.5% of the health care workers agreed on this statement, with 70% and 65.4% respectively expressing very strong agreement. About 3.3% of HIV-positive clients and 7.7% of the hospital workers did not agree with the statement (none expressed strong emotions) while a very similar 3.3% of clients and 3.8% of health workers were neutral on this. In all, there appears to be a quite uniform perception from both study populations about this statement.

Question 1 - I believe that people living with HIV should be seen in the same clinics as other patients (if the clinic space can accommodate this arrangement)

		Clients		Health Care Workers	
		Frequency	Percent	Frequency	Percent
Valid	Strongly Agree	21	70.0	17	65.4
	Agree	7	23.3	6	23.1
	Neutral	1	3.3	1	3.8
	Disagree	1	3.3	2	7.7
	Strongly Disagree	0	0	0	0
	Total	30	100.0	26	100.0

Question 1 - I believe that people living with HIV should be seen in the same clinics as other patients (if the clinic space can accommodate this arrangement)					
		Clients		Health Care Workers	
		Frequency	Percent	Frequency	Percent
Valid	Strongly Agree	21	70.0	17	65.4
	Agree	7	23.3	6	23.1
	Neutral	1	3.3	1	3.8
	Disagree	1	3.3	2	7.7
	Strongly Disagree	0	0	0	0

Table 2 – Frequency Table for clients and health workers response to statement 1

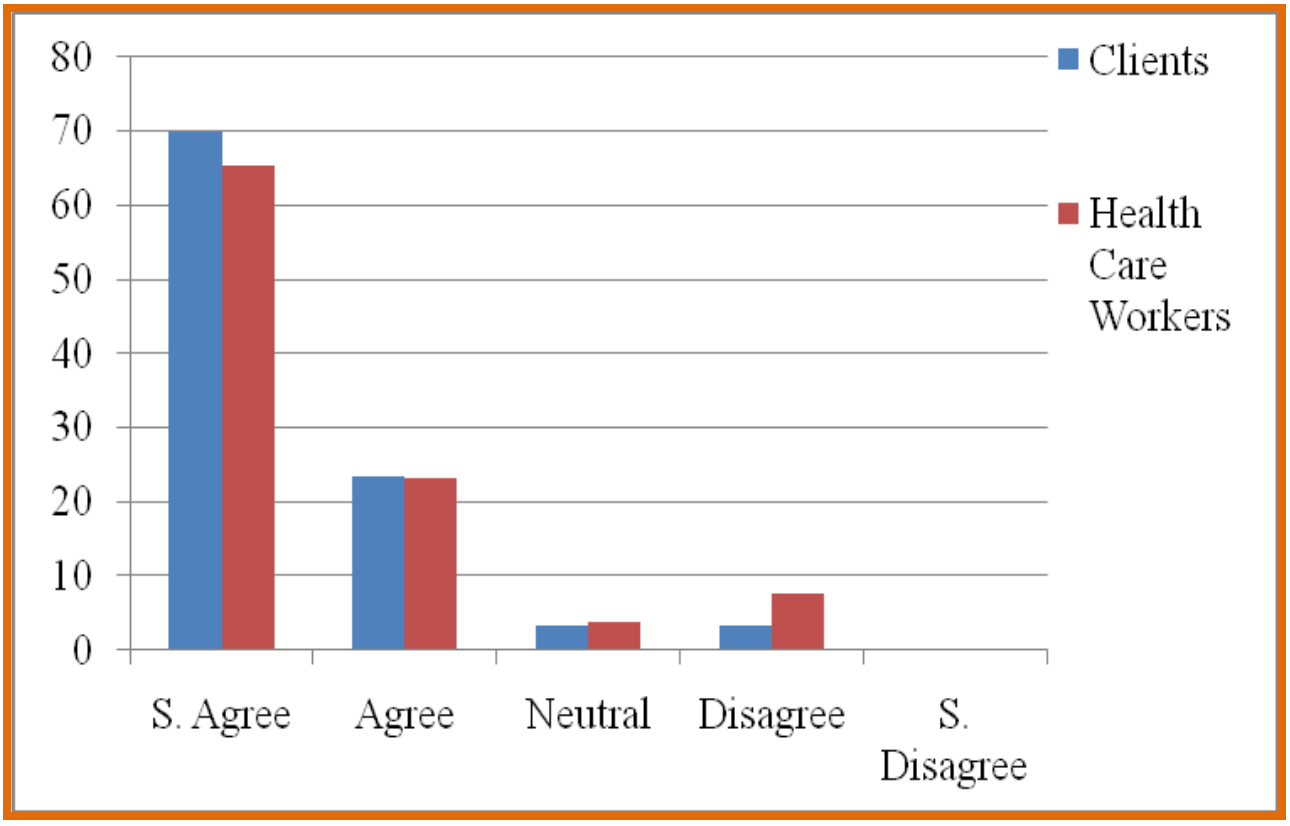


Figure 2 – Histogram showing frequency percentages for clients and health workers response to statement 1

ii. *"People living with HIV should be seen by the same doctors/nurses that see other patients - if the Doctors/nurses have the skills to attend to them".* In response to this statement, 70%

of the clients and 57.7% of the health care workers strongly agreed while 23.4% of clients and 30.8% of health workers just "agreed". Conversely, 2 of the thirty respondents among the client population disagreed with the statement (with 1 disagreeing strongly). Comparatively, 3 of the twenty-six health worker respondents disagreed and again, one disagreed strongly. Responses from both study groups were similar.

Question 2 - People living with HIV should be seen by the same doctors/nurses that see other patients - if the Doctors/nurses have the skills to attend to them					
		Clients		Health Care Workers	
		Frequency	Percent	Frequency	Percent
Valid	Strongly Agree	21	70.0	15	57.7
	Agree	7	23.4	8	30.8
	Neutral	0	0	0	0
	Disagree	1	3.3	2	7.7
	Strongly Disagree	1	3.3	1	3.8
	Total	30	100.0	26	100.0

Table 3 – Frequency Table for clients and health workers response to statement 2

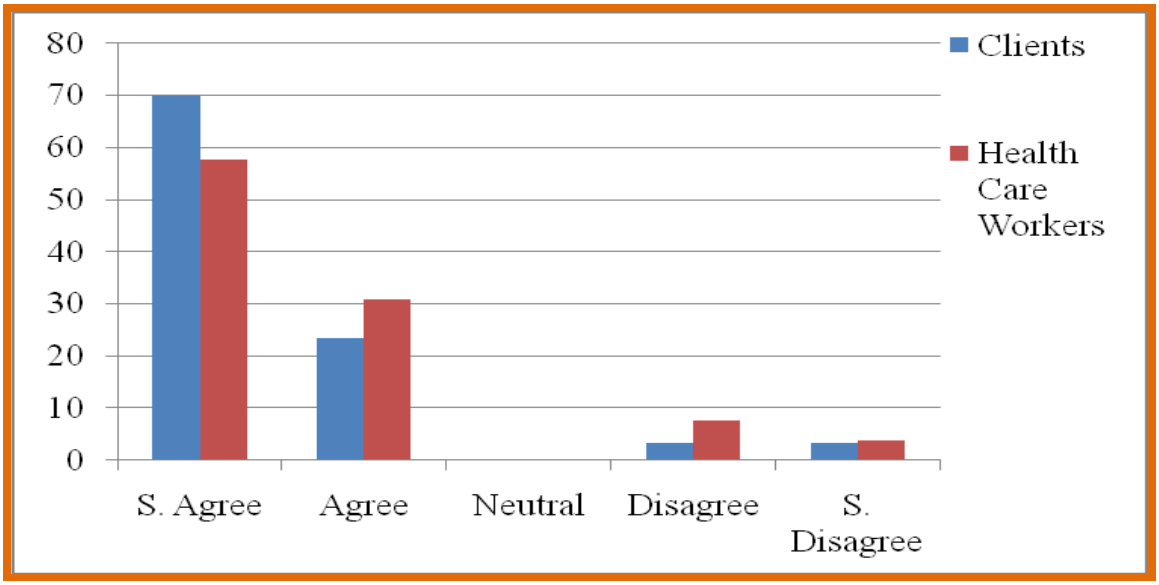


Figure 3 – Histogram showing frequency percentages for clients and health workers response to statement 2

iii. *"I'd prefer that we set-up a separate clinic for HIV-positive clients only"* – Respondents from both study population responded to the same statement assessing the degree of their comfort with operations of the currently integrated clinic and have an opportunity to propose an alternative service delivery model. There was a degree of polarization among the study populations, with 20% of clients and 30.8% of health workers in agreement. Though majority of the clients (70%) and health workers (65.4%) disagreed, as much as 10% of the clients did not seem to care (neutral). Ten clients and health workers each expressed strong emotions in disagreement.

Question 3 - I'd prefer that we set-up a separate clinic for HIV-positive clients only					
		Clients		Health Care Workers	
		Frequency	Percent	Frequency	Percent
Valid	Strongly Agree	2	6.7	2	7.7
	Agree	4	13.3	6	23.1
	Neutral	3	10.0	1	3.8
	Disagree	11	36.7	7	26.9
	Strongly Disagree	10	33.3	10	38.5
	Total	30	100.0	26	100.0

Table 4 – Frequency Table for clients and health workers response to statement 3

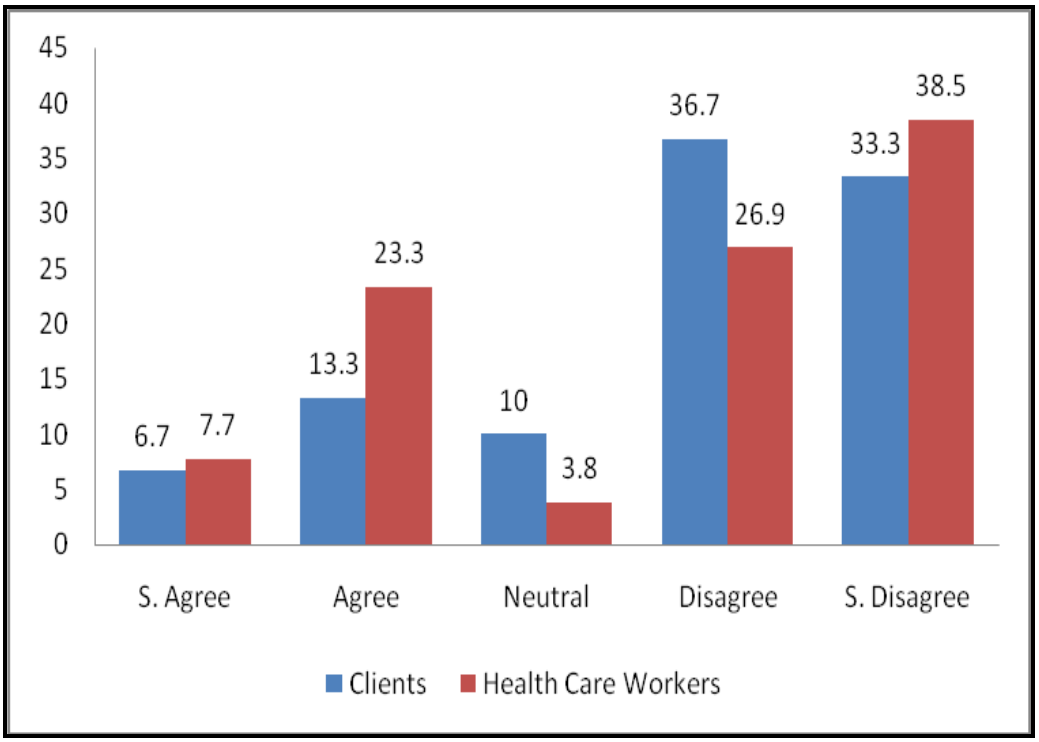


Figure 4 – Histogram showing frequency percentages for clients and health workers response to statement 3

iv. *"I believe that visitors and other clients can readily identify those clients who are HIV-positive in the clinic".* Here, both clients and health workers provide their responses to the same exact question about the possibility of non-hospital personnel easily identifying HIV-positive clients in the clinic (a situation that will be undesirable in view of the hospital management's desire to minimize the risk of client's exposure to HIV-related stigma). In response to this, 66.7% of the clients and 76.9% of the health workers did not agree with the proposition (30% and 19.2% respectively – strongly disagreed).

Question 4 - I believe that visitors and other clients can readily identify those clients who are HIV-positive in the clinic					
		Clients		Health Care Workers	
		Frequency	Percent	Frequency	Percent
Valid	Strongly Agree	5	16.7	1	3.8
	Agree	4	13.3	4	15.4

	Neutral	1	3.3	1	3.8
	Disagree	11	36.7	15	57.7
	Strongly Disagree	9	30.0	5	19.2
	Total	30	100	26	100

Table 5 – Frequency Table for clients and health workers response to statement 4

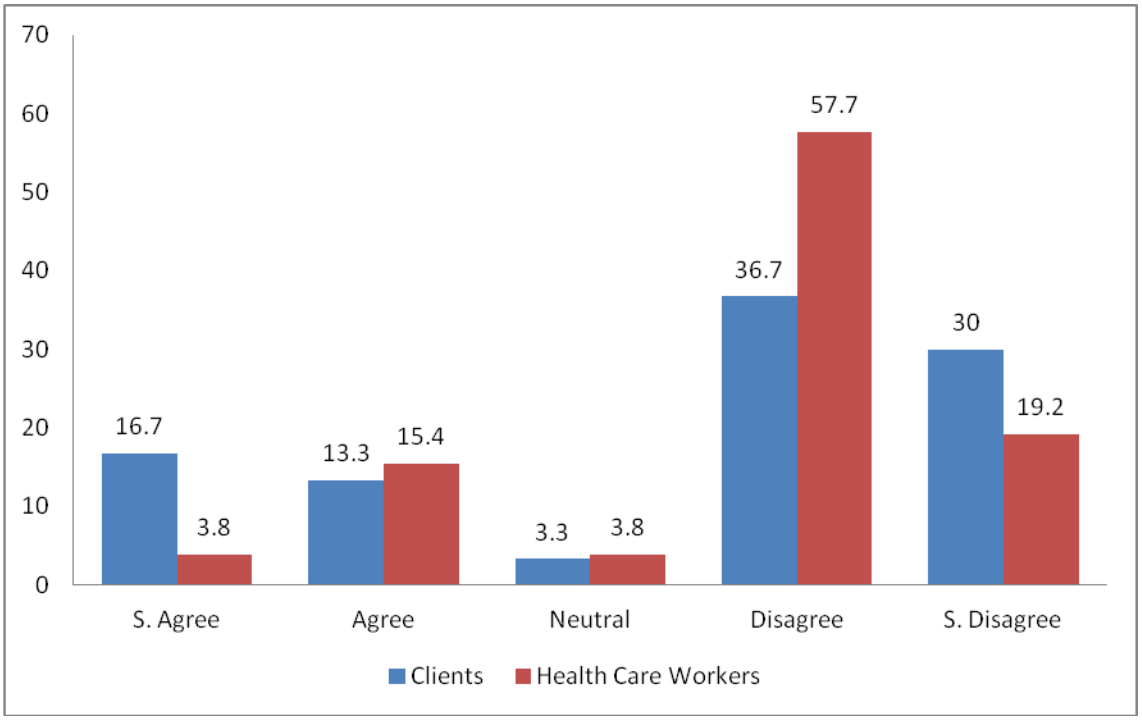


Figure 5 – Histogram showing frequency percentages for clients and health workers response to statement 4

v. *"Health workers address me in a way that makes other people to know that I am HIV-positive /I believe that visitors and hospital clients have a right to know those clients who are HIV-positive in the clinic".*

These two dissimilar but related statements assess the construct from two different perspectives. The client questionnaire statement probes about the perceptions of clients about the way health workers communicate with them in the clinic especially with regards the risk of suffering HIV-related stigma and rather than apply the same statement in the health worker questionnaire (in which case respondents are more likely to relate conflictingly with the statement due to their professional training). Instead the questionnaire for health works looks at the same issue from the

direction of "what the health workers would prefer" and hence their response may not be linked with the admission of guilt to a professional misconduct.

Statement 5 - Health workers address me in a way that makes other people to know that I am HIV-positive I believe that visitors clients have a right to know those clients who are HIV+ in the clinic					
		Clients		Health Care Workers	
		Frequency	Percent	Frequency	Percent
Valid	Strongly Agree	2	6.7	2	7.7
	Agree	0	0	0	0
	Neutral	0	0	1	3.8
	Disagree	11	36.7	13	50.0
	Strongly Disagree	17	56.7	10	38.5
	Total	30	100.0	26	100.0

Table 6 – Frequency Table for clients and health workers response to statement 5

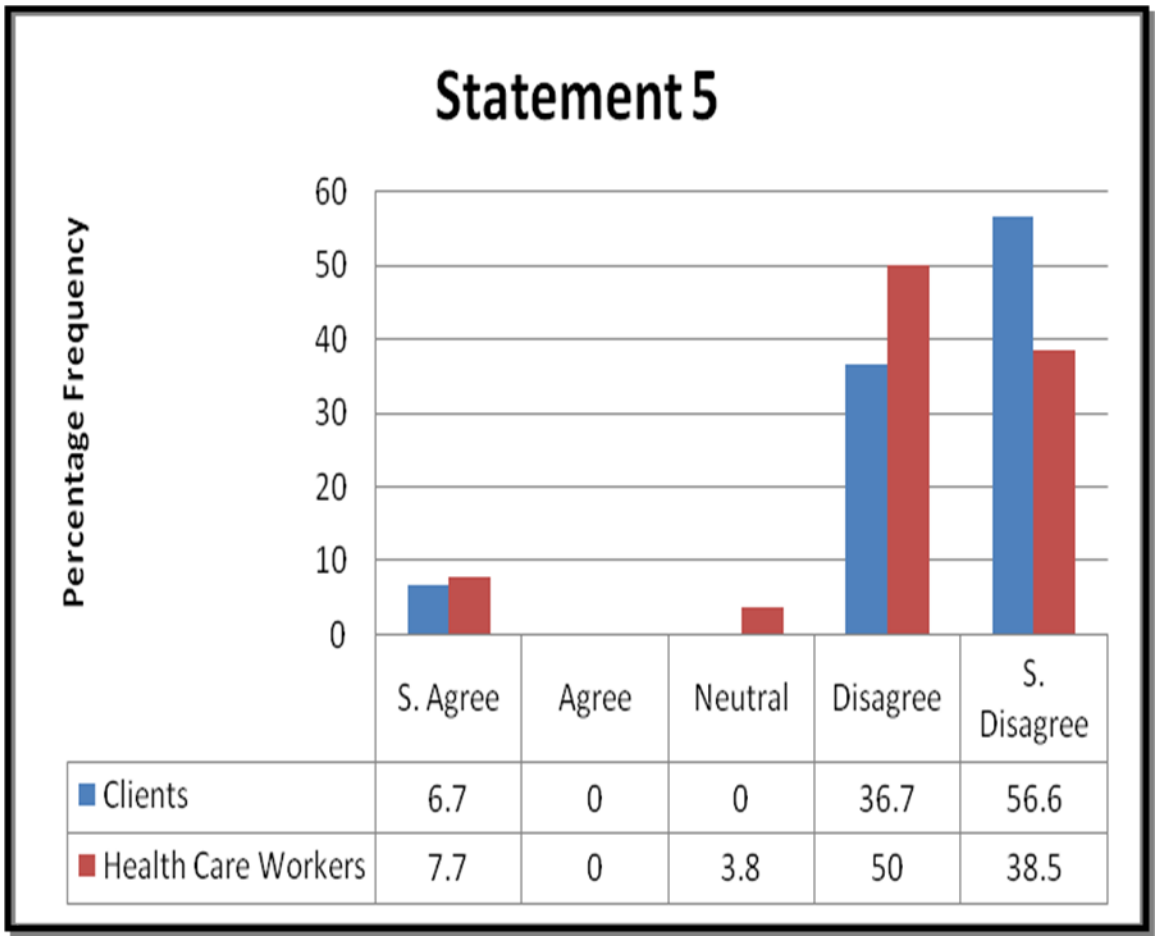


Figure 6 – Histogram showing frequency percentages for clients and health workers response to statement 5

vi. *"I believe that our clinic arrangement increase our client's exposure to HIV-related stigma".* This statement bares a significant similarity to question 4 on both questionnaires and seems to probe the construct from the same perspective, however, there is an element of the expression of "confidence about the quality" service delivery that relates more to the health workers that determines the uniqueness of this statement to this particular group of respondents and hence the this statement is not posed to the client study group.

Almost 57.7% of the respondents agree to this statement compared to more than one-third (34.6%) who disagreed. This is quite a contrast to the 76.9% of the health workers who opined that non-hospital personnel (visitors and other hospital clients) could not readily identify HIV+ clients in the integrated clinic arrangement.

Question 6 - I believe that our clinic arrangement increase our client's exposure to HIV-related stigma					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	11.5	11.5	11.5
	Agree	12	46.2	46.2	57.7
	Neutral	2	7.7	7.7	65.4
	Disagree	8	30.8	30.8	96.2
	Strongly Disagree	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Table 7 – Frequency Table for health workers response to statement 6

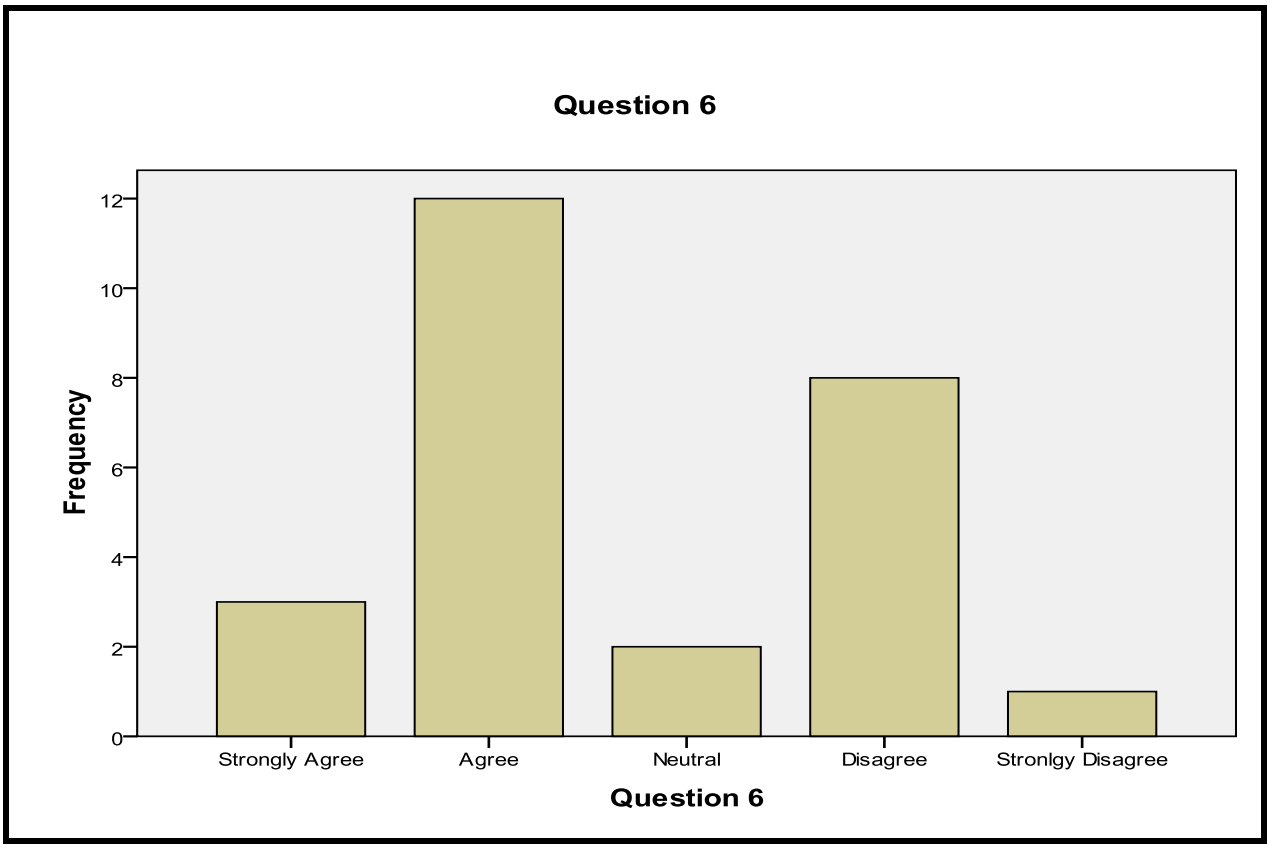


Figure 7 – Bar Chart depicting the frequency for health workers response to statement 6

4.3.2. Perceptions of health workers and HIV+ clients about the ease of providing and accessing HIV/AIDS treatment services

In probing this construct, respondent's perceptions about the ease of providing and accessing HIV and AIDS treatment services in the integrated clinic are sought. Both groups of respondents provide response to four similar statements which will be evaluated comparatively between the groups; In addition, there are two health-provider "specific" statements about the scope of the service delivery opportunities provided by the integrated clinic and the associated workload of providing these services. The data on these two statements are provided separately.

i. *"I am satisfied with the amount of time I/Our clients spend in the waiting area"* – This statement appears as number seven on the health provider survey questionnaire and as number six on the clients survey questionnaire and is basically the same statement from the varying perspectives. It is included to assess the component of "waiting time" which relates very strongly to the assessment of the main theme. In response to this statement, majority of the clients (86.6%) and the health workers (69.2%) maintain that they are satisfied with the waiting time (about a third of this proportions express strong agreement), while 6.7% and 15.4% of the clients and the health workers respectively disagree. The rest of the respondents in both groups were undecided.

ii.

Statement - *"I am satisfied with the amount of time I/Our clients spend in the waiting area"*

		Clients		Health Care Workers	
		Frequency	Percent	Frequency	Percent
Valid	Strongly Agree	7	23.3	4	15.4
	Agree	19	63.3	14	53.8
	Neutral	2	6.7	4	15.4
	Disagree	2	6.7	4	15.4
	Strongly Disagree	0	0	0	0
	Total	30	100.0	26	100.0

Table 8 – Frequency Table for clients and health workers responses to statement

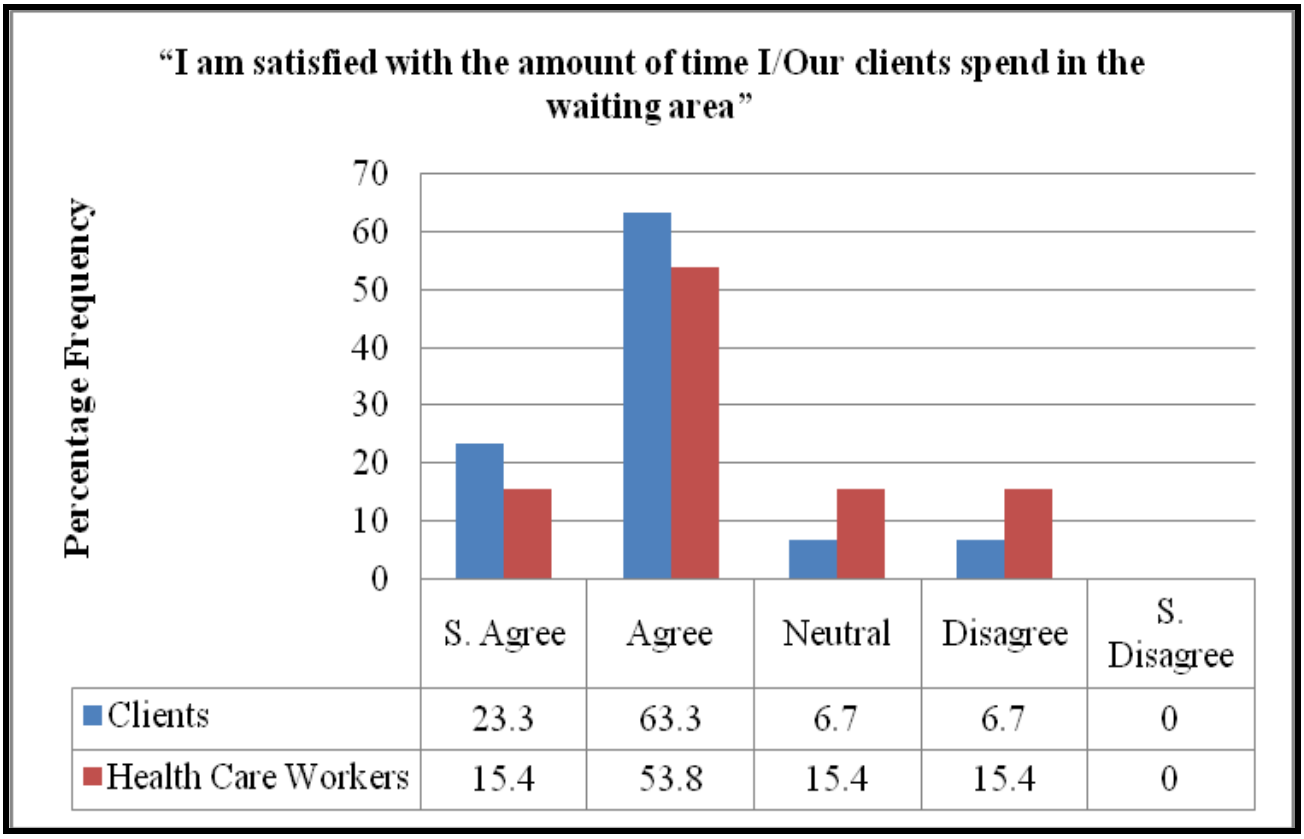


Figure 8 – Histogram for clients and health workers response to statement

iii. "All the patients get their weights and Blood Pressure checked regularly in the clinic (the nurse regularly check my weight and my Blood Pressure before I go to see the doctor)." –

A major important element for assessing the ease of accessing/providing services occurs within the context of the range of services that are offered within the timeline available to clinicians and their clients for consultation. Routine patient weight and blood pressure measurements are promoted in this hospital as routine pre-consultation services to be provided by triage nurses at the out-patient department. In a busy clinic overwhelmed by manpower shortages and high patient flow – these services are quite likely to be forgone in a bid to reduce the waiting times of clients scheduled for consultations with clinicians.

Both groups of survey participants provided responses to the same statement (based on perspective), corresponding to statement number nine on the health provider survey questionnaire and statement number seven on the client survey questionnaire. Their responses show that 90% of clients and 80.8% of the health workers affirm it to be true that these services are provided quite routinely.

Statement - All the patients get their weights and Blood Pressure checked regularly in the clinic (the nurse regularly check my weight and my Blood Pressure before I go to see the doctor)					
		Clients		Health Care Workers	
		Frequency	Percent	Frequency	Percent
Valid	Strongly Agree	9	30.0	10	38.5
	Agree	18	60.0	11	42.3
	Neutral	1	3.3	2	7.7
	Disagree	2	6.7	2	7.7
	Strongly Disagree	0	0	1	3.8
	Total	30	100.0	26	100.0

Table 9 – Frequency Table for clients and health workers response to the statement

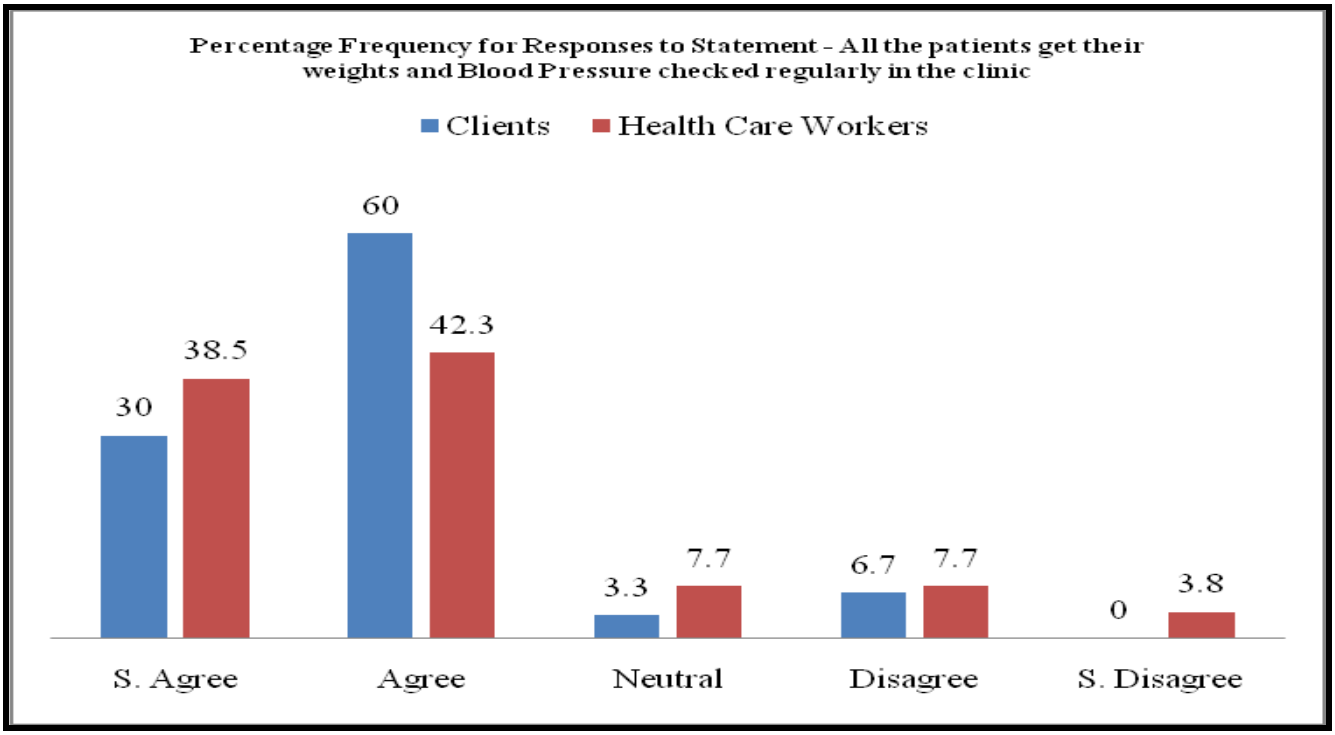


Table 9 – Histogram for clients and health workers response to the statement

iv. "I have enough time to attend to the clients well/The doctors take enough time to attend to me"

In this section, clients and health care workers are requested to state their perceptions about the amount of time typically available in the clinic for client-clinician interaction. Respondents from both study populations agree (83.6% of clients and 92.3% of health workers) that enough time is

allowed for client-clinician interaction suggesting that client load pressure in the clinic does not limit the consultation experience of clients and their health care providers.

Statement - "I have enough time to attend to the clients well/The doctors take enough time to attend to me"					
		Clients		Health Care Workers	
		Frequency	Percent	Frequency	Percent
Valid	Strongly Agree	16	53.3	11	42.3
	Agree	10	33.3	13	50.0
	Neutral	2	6.7	1	3.8
	Disagree	2	6.7	1	3.8
	Disagree Strongly	0	0	0	0
	Total	30	100.0	26	100.0

Table 10 – Frequency Table for clients and health workers response to the statement

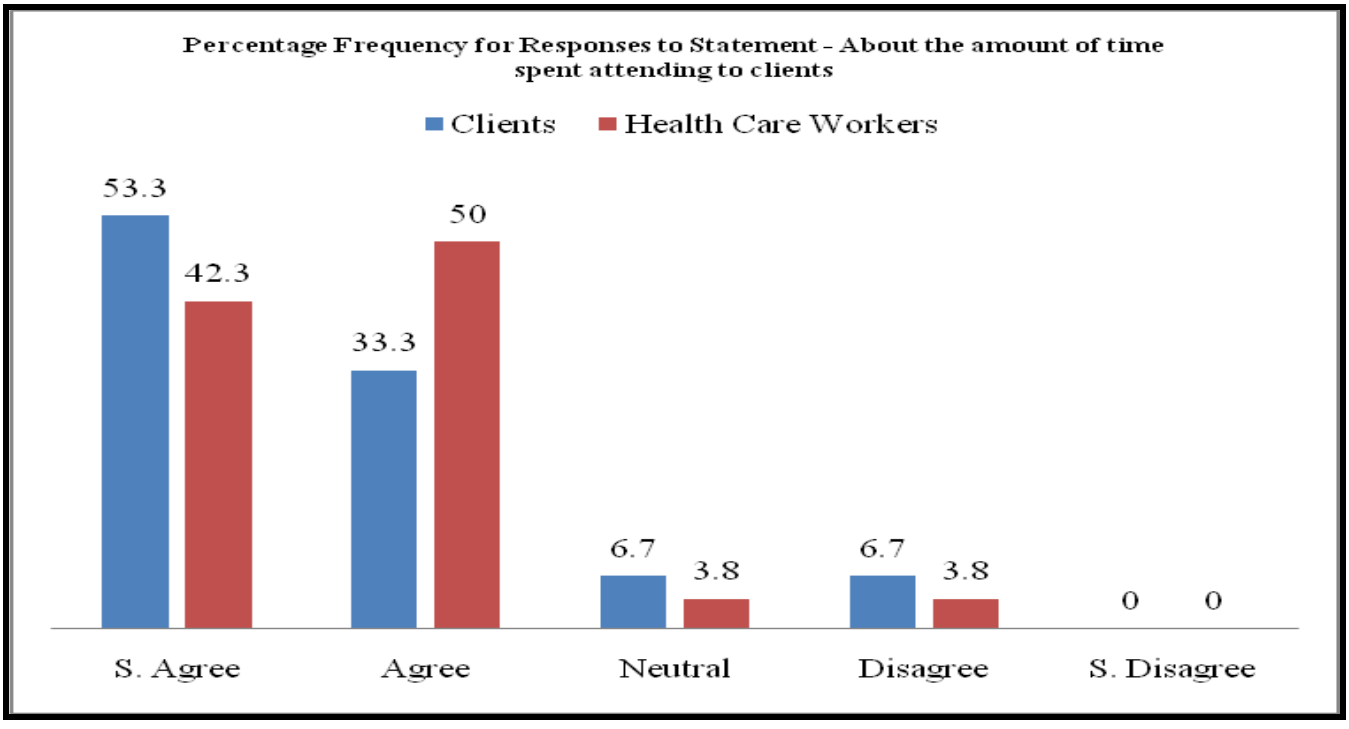


Table 10 – Histogram depicting clients and health workers response to the statement

v. *I like the combined sitting arrangement for all clients (HIV-positive and others) in the waiting area*

In this section, respondents give feedback on the "combined sitting arrangement" for all clients in the clinic waiting area. This combined arrangement requires all hospital clients, irrespective of their

HIV status (known or unknown, HIV-positive or not) to sit according together in the waiting area making allowances for separate sitting for usual hospital triage reasons or as part of the infection control protocols for managing clients with possibly infective and communicable infections.

In all, 90% of clients and 96.2% of the health care workers like this combined sitting arrangement.

Statement - "I like the combined sitting arrangement for all clients (HIV-positive and others) in the waiting area"					
		Clients		Health Care Workers	
		Frequency	Percent	Frequency	Percent
Valid	Strongly Agree	15	50.0	14	53.8
	Agree	12	40.0	11	42.3
	Neutral	1	3.3	0	0
	Disagree	0	0	0	0
	Strongly Disagree	2	6.7	1	3.8
	Total	30	100.0	26	100.0

Table 11 – Frequency Table for clients and health workers response to the statement

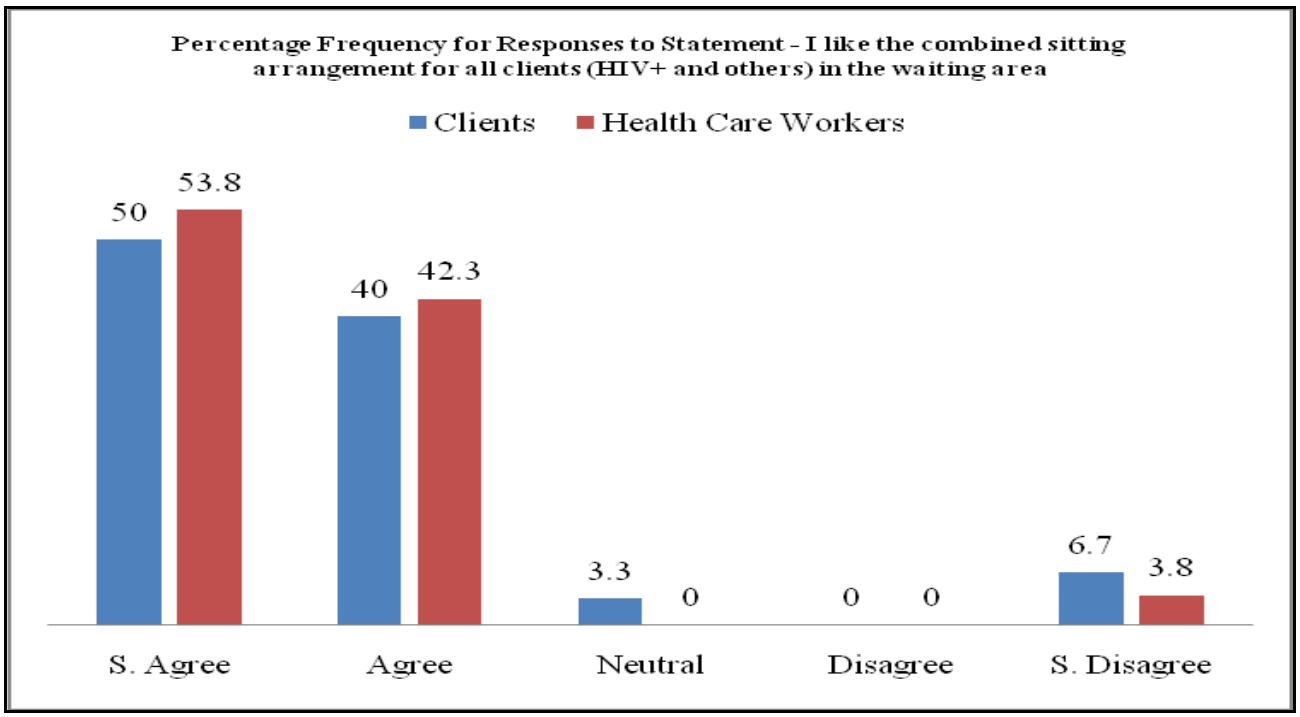


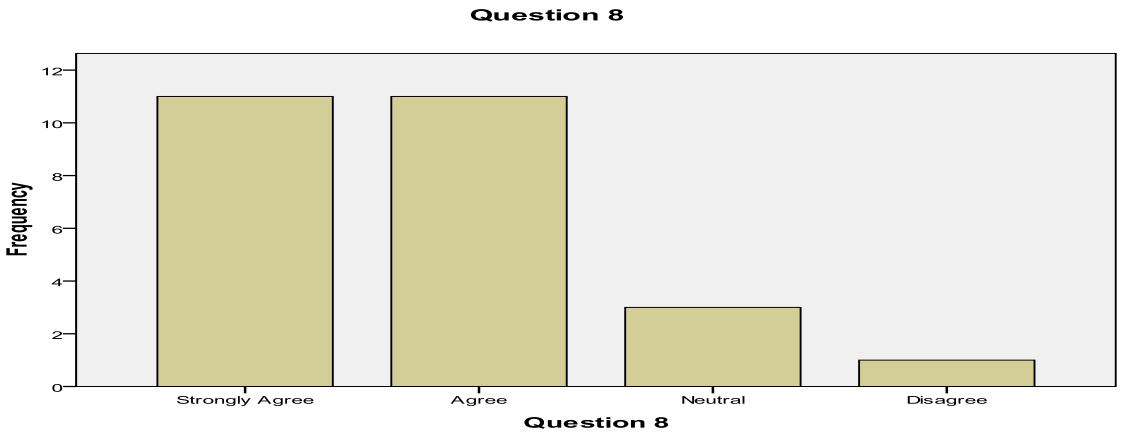
Table 11 – Histogram depicting clients and health workers response to the statement

vi. *I believe that we are now providing more services to our clients since we started the integrated clinic* – This statement was presented only to the health worker survey group and probes their impression about the notion that a wider range of hospital services are now available on offer in because of the integration of HIV and AIDS care and treatment services into general clinic services. This statement forms the first part of an attempt to query the possibility that health care workers may relate to a perception that work load has increased and has done so possibly because more services are now demanded of the clinicians in the integrated clinics.

In response to this statement - most of the health care workers 22 of the 26 respondents (representing 84.6%) agreed, while 3 (representing 11.5%) expressed neutral views. One respondent disagreed with the notion.

Statement 8 on Health Care Provider survey Questionnaire

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	11	42.3	42.3	42.3
	Agree	11	42.3	42.3	84.6
	Neutral	3	11.5	11.5	96.2
	Disagree	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

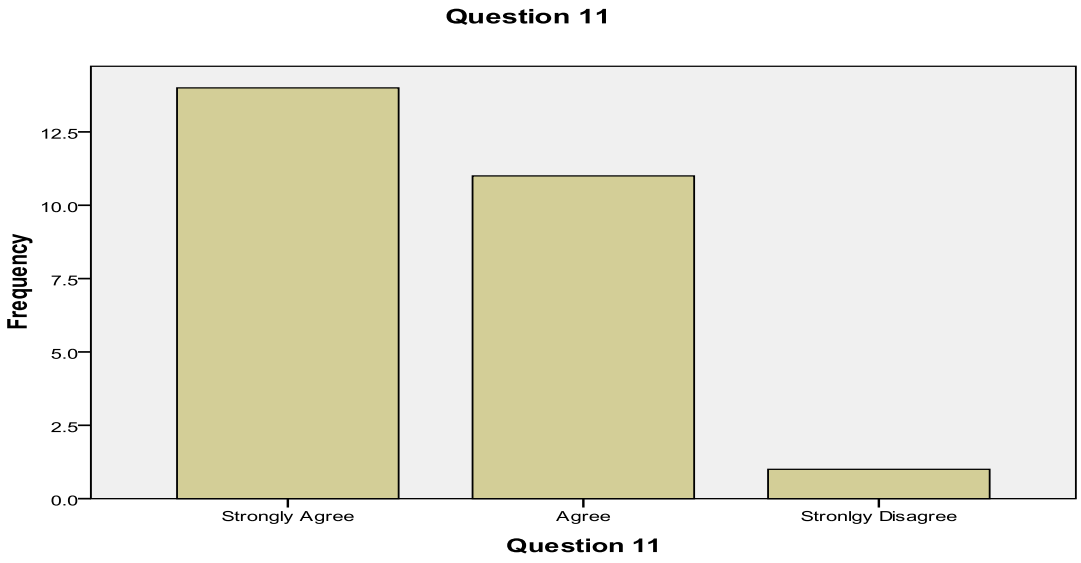


vii. *I am comfortable with the work load that I have to deal with in running a combined clinic*

This question is related to the previous one about the increase in the range of services offered in the clinic is this statement which appears as statement 11 on the health worker survey questionnaire about the level of comfort of service providers with the work load facing them in the integrated clinics. Almost all of the health workers who responded to the questionnaire agreed with statement – only one expressed a contrary view – albeit strongly.

Statement 11 on Health Care Provider survey Questionnaire

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	14	53.8	53.8	53.8
	Agree	11	42.3	42.3	96.2
	Strongly Disagree	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

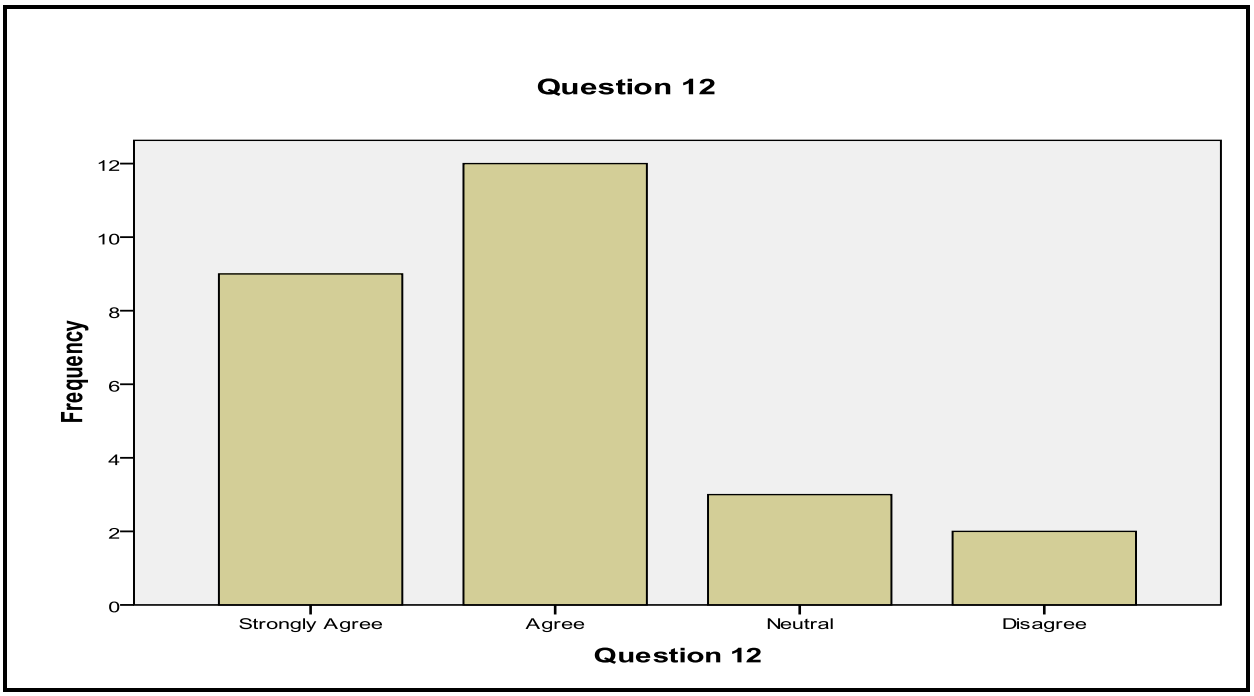


4.3.3. Perceptions of health workers and HIV-positive clients about the outcomes of service delivery

i. Provider Survey Questionnaire (Statement) Number 12 – "*I believe that the general quality of our services (for all clients) has improved because of the demands of providing HIV/AIDS treatment services according to strict guidelines"*. This statement was presented only to the health care workers and probes the perceptions of the health workers improvement in the quality of services offered and how it relates to the strict guidelines and monitoring required for HIV/AIDS treatment service delivery. While people agree strongly and 12 just agree – 3 respondents are undecided and 2 disagree with this notion.

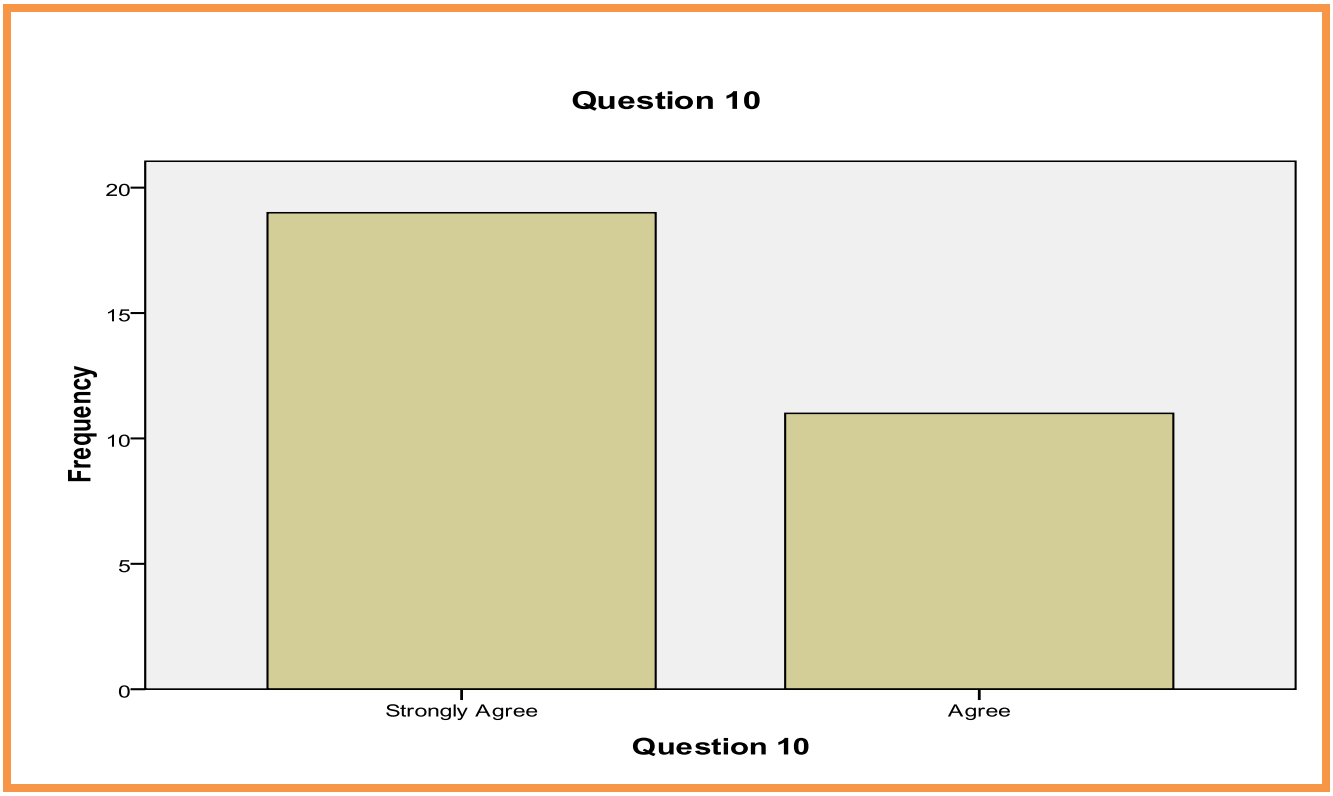
Question 12

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	9	34.6	34.6	34.6
	Agree	12	46.2	46.2	80.8
	Neutral	3	11.5	11.5	92.3
	Disagree	2	7.7	7.7	100.0
	Total	26	100.0	100.0	



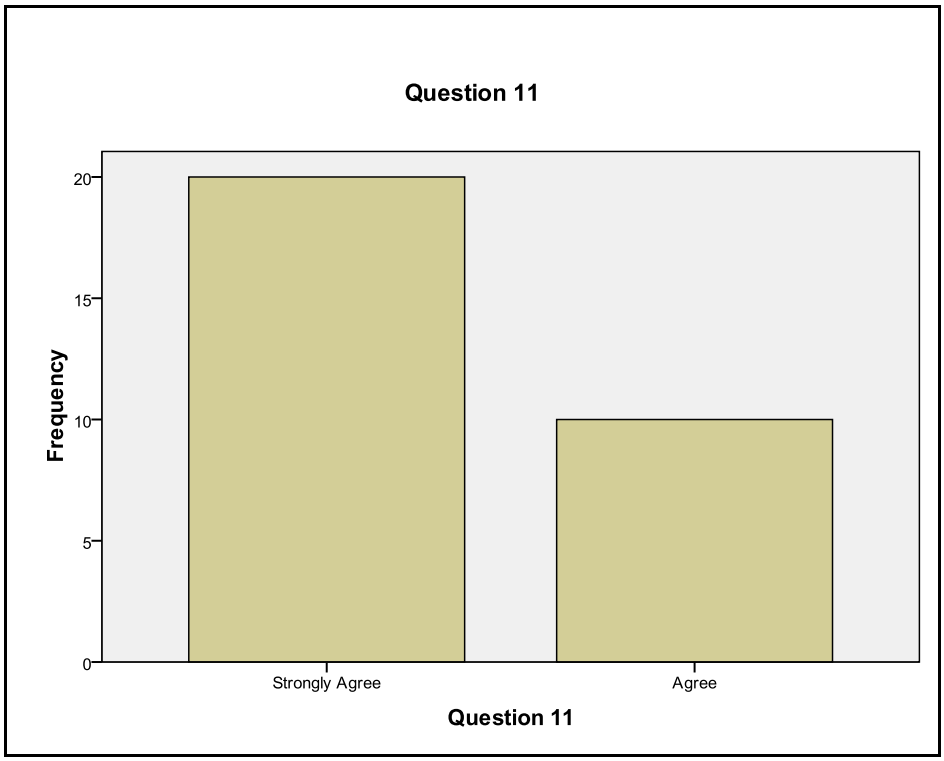
ii. Client Survey Questionnaire (Statement) Number 10 – "*I have gotten better since I started receiving treatment in this clinic".* This statement was presented to the clients only. All reported an improvement in their health since commencing treatment at the clinic with 63.3% agreeing strongly.

Question 10					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	19	63.3	63.3	63.3
	Agree	11	36.7	36.7	100.0
	Total	30	100.0	100.0	



iii. Client Survey Questionnaire (Statement) Number 11 – "*I will like to continue receiving treatment in this hospital".* Again focused on the client group only, all the respondents would like to continue receiving treatment in this facility – with 66.7% agreeing strongly.

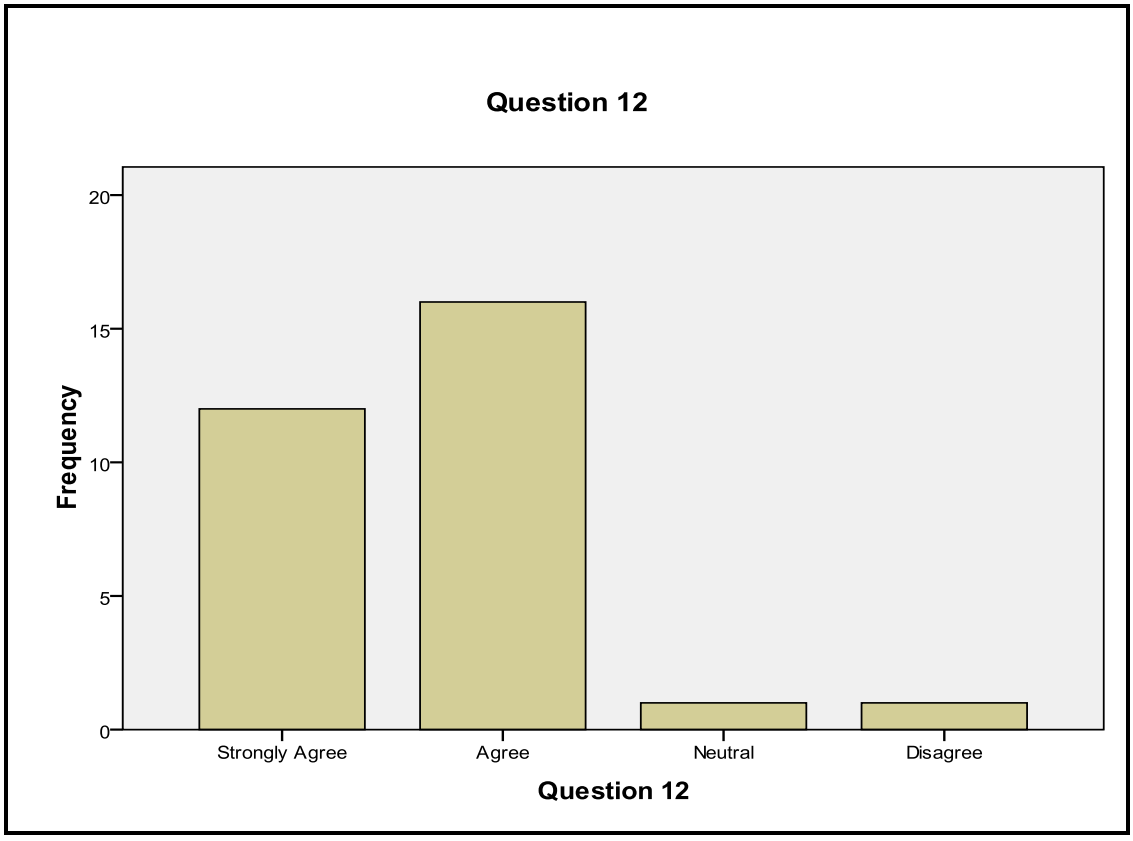
Question 11					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	20	66.7	66.7	66.7
	Agree	10	33.3	33.3	100.0
	Total	30	100.0	100.0	



iv. Client Survey Questionnaire (Statement) Number 12 – "*My answer to the last question is influenced by the fact that the hospital uses a combined clinic arrangement".*

Here – respondents are required to give feedback on whether their response to the statement about continuing treatment in the facility is influenced by the integrated arrangement of the clinic. It is noted that though all the respondents agreed that they would prefer to continue receiving treatment in the facility, one respondent from the thirty respondents did not relate this positive response to the combined sitting arrangement in the clinic and another was undecided about the notion. The rest of the respondents agreed with the notion with 40% of all respondents (12 people agreeing strongly.

Question 12					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	12	40.0	40.0	40.0
	Agree	16	53.3	53.3	93.3
	Neutral	1	3.3	3.3	96.7
	Disagree	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

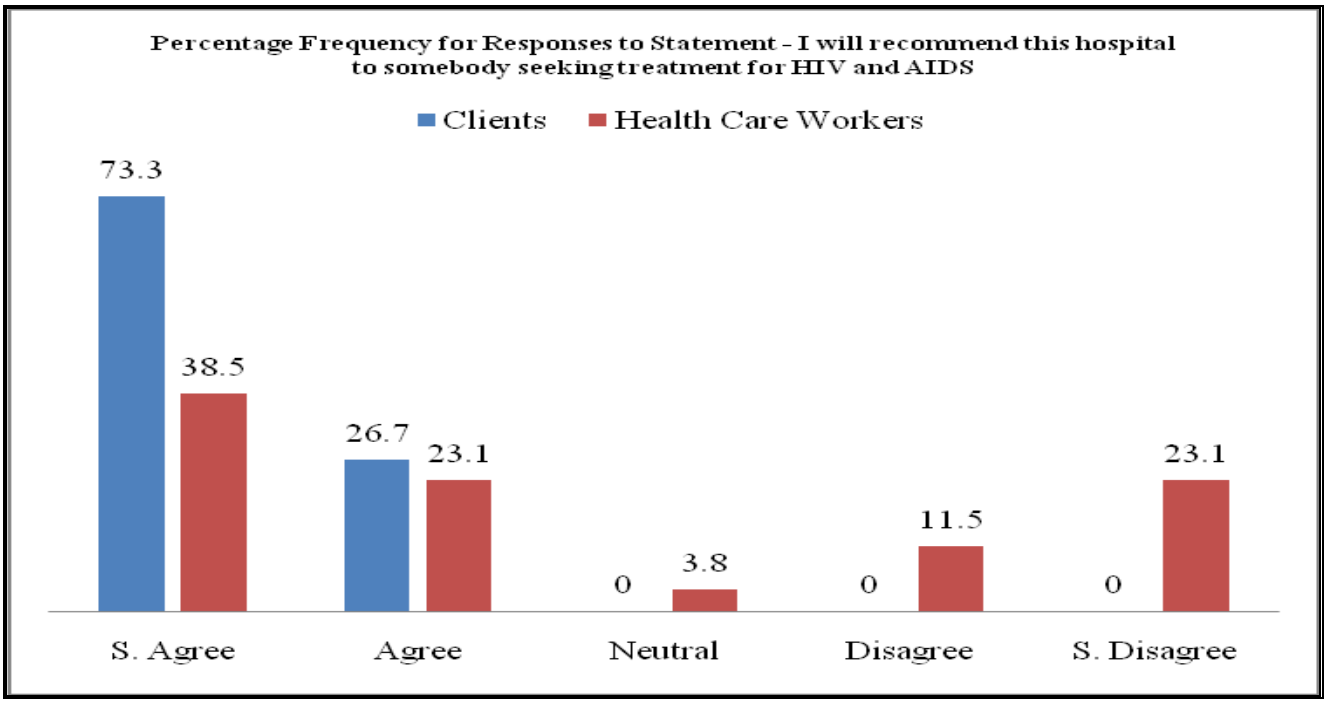


v. *"I will recommend this hospital to somebody seeking treatment for HIV and AIDS"*. In response to the statement about recommending to others seeking treatment for HIV and AIDS, respondents from both study population are required to express the degree to which they are confident that this facility can meet the treatment needs of others. This relates to the amount of confidence they have based their personal evaluation of the capacity of clinicians in this facility using the integrated clinic model to provide qualitative care and treatment services. To this extent, the survey reveals

that practically all the clients and almost two-thirds (61.6%) of the health workers will recommend this facility (73.3% of clients and 38.5% of health workers agree strongly) and a third of the health workers (34.6%) will not recommend this facility. This contrasts quite notably with the response of the health care workers about the general operations of hospital affairs and the integrated clinic and suggests that a significant proportion of the health workers may have other un-disclosed reasons for not recommending this facility to others seeking treatment for HIV and AIDS.

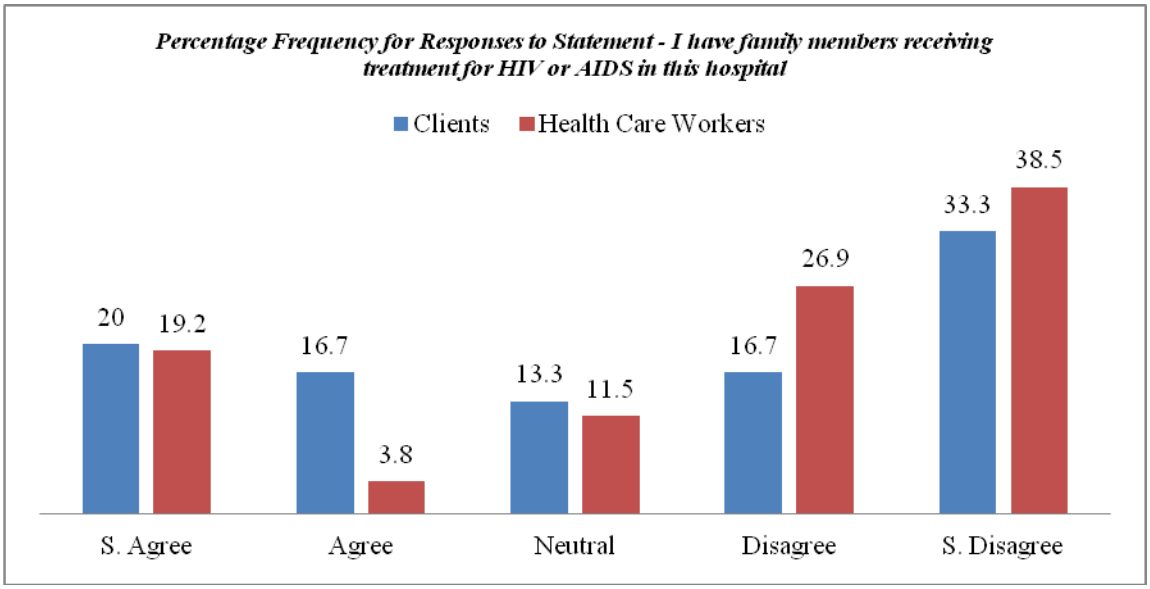
Statement - *I will recommend this hospital to somebody seeking treatment for HIV and AIDS"*

		Clients		Health Care Workers	
		Frequency	Percent	Frequency	Percent
Valid	Strongly Agree	22	73.3	10	38.5
	Agree	8	26.7	6	23.1
	Neutral	0	0	1	3.8
	Disagree	0	0	3	11.5
	Strongly Disagree	0	0	6	23.1
	Total	30	100.0	26	100.0



vi. *"I have family members receiving treatment for HIV or AIDS in this hospital"*. This statement seeks to know is the clients and health workers have family members (nuclear or extended) who are also receiving treatment in the hospital and to an extent expresses their confidence in the services offered in this facility. More than a third of the clients (36.7%) of clients have family members in the clinic compared with 23% of the health workers, while 50% of the clients and 65.4% of the health workers do not. Four out of the thirty respondents and three out of the 26 respondents from the client and health worker survey groups expressed neutral opinions to this last statement indicating an unwillingness to comment on this.

Statement – "*I have family members receiving treatment for HIV or AIDS in this hospital"*					
		Clients		Health Care Workers	
		Frequency	Percent	Frequency	Percent
Valid	Strongly Agree	6	20.0	5	19.2
	Agree	5	16.7	1	3.8
	Neutral	4	13.3	3	11.5
	Disagree	5	16.7	7	26.9
	Strongly Disagree	10	33.3	10	38.5
	Total	30	100.0	26	100.0



5. CHAPTER 5 – DISCUSSION OF RESULTS, CONCLUSIONS AND RECOMMENDATIONS

5.1. Discussion of Results

The results are discussed along the lines of the three main themes of the study. An analysis of the perception of health workers and clients about **the risks and opportunities for HIV-related stigma in the clinic** shows that 88.5% of the health care workers and 93.3% of the clients agreed that PLHIV should be seen in the same clinic and by the same doctors and nurses who also attended to other clients in the clinic. This agrees with favourable perceptions of health care workers and HIV+ clients about stigma in an integrated clinic setting as observed by Amoran (2011), who noted that only 2.1% of health workers had expressed the belief that other patients would be reluctant to receive treatment in the same settings as PLHIV, Health Policy Initiative (2008), which recommended the avoidance of separate care wards for PLHIV as a way to reduce stigma and Aghamolaei, Hasani, Tavafian and Zare (2009) who observed that most healthcare providers showed positive attitudes towards patients with HIV.

Regarding the issue of anonymity, about three-quarters of the health care workers and two-thirds of the clients disagreed with the notion that visitors and other clients (non-medical personnel) could easily identify PLHIV in the clinic, hence supporting the view that integration provided anonymity as was concluded by Diaby, Ekpini, Kuassi et al (2004) and Intrahealth (2009). Despite this, 57.7% of the health workers believed that the integrated clinic arrangement had increased the exposure of clients to HIV-related stigma (as opposed to 34.6% who disagreed). Similar mixed feedback was reported by Chiko, Chipukuma, Giganti et al (2010). Only 7.7% of the health care workers agreed that visitors and other clients had a right to know those who were HIV+ in the clinic (compared to 88.5% who disagreed) and 6.7% of the clients reported that health workers addressed them in a manner that revealed their HIV-positive status to other hospital clients (as opposed to 93.4% who disagreed).

The finding suggests overall as regards the risks and opportunities for HIV-related stigma, that the integrated clinic setting was a relatively safe environment for PLHIV to access clinical services (alongside other clients accessing non-HIV related services). Health workers and clients are willing to utilize this model and mostly agree the potential to improve client anonymity and possibly the

risk of HIV-related stigma, though health workers were still quite sceptical about the potential of integration alone to decrease stigma directed at HIV-positive clients.

Regarding the **ease of providing or accessing HIV and AIDS treatment services** in the integrated clinic, 69.2% of health workers and 86.6% of the clients who responded expressed their satisfaction with client waiting times, just as 92.3% of health workers and 83.6% of clients that adequate time was spent in actual consultation with clinicians. As proof of this, 80% of the health workers and 90% of the clients confirmed that weight and blood pressure measurement were taken routinely while all (100%) of the health workers expressed their comfort with the workload associated with running the combined clinic. All these contrast with findings by Levine and Oomman (2009) that quality of care could decline and workload increase because of man-power challenges associated with integration just as Chiko, Chipukuma, Giganti et al (2010), suggested an associate increase in waiting time (a potential source of dissatisfaction to clients). It is possible that this facility had already successfully addressed these secondary man-power gaps that could arise from integration of HIV and AIDS treatment services.

With respect to the range of services offered, 22 of the 26 (84.6%) health workers agreed that they were providing more services since the onset of the integration process agreeing with Chiko, Chipukuma, Giganti et al., 2010 and Dehne, Greener, Maier, Obure et al., 2011. This suggests that there are opportunities here to ensure less fragmented services, higher levels of continuity of care, better referral systems and possibly reductions in patient/community-level costs resulting from fewer visits to facilities and proximity of services. Askew, Ayisi, Gathitu, Homan, Liambila, Mwangi, et al. (2008) also expressed similar views.

Overall feedback on the ease of implementing the integrated clinic model shows that 96.1% of the health workers and 90% of the clients concluded that they liked the combined sitting arrangement in the waiting area.

The evaluation of the **outcome of services** agrees with all the findings from the studies already cited above as 80.8% of health workers confirmed an improvement in services (mainly because of the strict protocol guiding the provision of HIV and AIDS treatment services). This finding is particularly in agreement with the findings of Anaya, Asch, Bowman, et al. (2009), Askew, Ayisi, Gathitu, Homan, Liambila, Mwangi, *et al*. (2008) and Lifson, Bekele, Cirera, Faltamo, et al. (2009).

The analysis also shows that all the clients interviewed reported that they had gotten better since starting treatment in the clinic and that they would like to continue receiving treatment in this hospital with two-thirds of them agreeing strongly, thus agreeing with Bedelu, Ford, Hilderbrand and Reuter (2006) and Reuter (2006) who noted integrated clinics could provide effective health services to PLHIV. It is noteworthy that 93.3% of the client respondents linked their preference for continuing treatment in this clinic to the combined clinic arrangement. All of the clients preferred to be seen by the same clinicians (similar to the report of Hausler, Jackson, Kigozi et al.,2010) and about two-thirds of the health workers agreed that they would recommend the hospital to somebody seeking treatment services for HIV and AIDS (34.6% of the health workers would not). This suggests that more than a third of the health workers would not be comfortable to refer people to access treatment in their hospital. The reasons for this could be subject of future studies.

More than a third of the clients already had their family members receiving treatment in the hospital while only 23% of the health workers had confirming opportunities did indeed exist to reduce cost of family-care through the provision of comprehensive health services within the integrated HIV clinic setting.

5.2. Conclusions

The main conclusion from this study is that the integrated HIV clinic model presents a workable alternative to standalone HIV and AIDS treatment clinics and can contribute to the reduction in HIV-related stigma targeted at PLHIV in the course of accessing treatment services. In essence, these clinics aim to eliminate the needs for specialized hospital service delivery systems for people living with HIV seeking treatment. The model ensures that people living with HIV/AIDS accessing treatment services can utilize the same clinics and be seen by the same clinicians that see other hospital clients. This integration has the potential to improve the efficiency of utilization of hospital resources (space, manpower, time etc) and may contribute to overall improvements in the health system, if well managed.

Health workers and HIV-positive clients are quite comfortable with the practice of PLHIV receiving treatment in the same environment (and using the same staff) as other hospital clients and the integrated HIV/AIDS clinics provide a degree of patient anonymity that is favourable to stigma reduction.

The integrated HIV/AIDS clinic model does not necessarily pose an unbearable burden on health workers providing the services and on the clients accessing the services and offers opportunities for more services to be offered to a wider range of clients with significant improvements in quality of services to clients. Integrating HIV and AIDS care and treatment service delivery with that for other public health services, hospitals can rapidly increase the uptake of clients and access to services for both HIV treatment and the other public health concerns (Antenatal service, TB-DOTS treatment, syphilis diagnosis and treatment and many other chronically managed illnesses). It offers opportunities for family members and relatives to access comprehensive health services for HIV and non-HIV related medical concerns.

One major challenge of operating an integrated HIV/AIDS clinic include the fact that some clients may feel more exposed to HIV-related stigma in an environment where all hospital clients are seated together. This presents quite a paradox as these clinics are actually promoted on the merit of the capacity for reduced stigma opportunities because PLHIV can access hospital services with other clients and not be too readily identified at least by those who are not part of the clinical team.

Another challenge is the potential for the rapidly increasing client population (for both HIV and non-HIV services) not to overwhelm the manpower available to support these services. The evidence on increased efficiency of utilization of hospital resources should be monitored to the point where more resources (for instance personnel and additional space) will need to be mobilized to maintain the efficiency of service delivery. This subsequently addresses the other possible challenge of increased client waiting time and the possibility of clients being rushed through the clinical consultations and hence getting poorer quality of services.

The capacity building inputs for the effective roll-out of HIV and AIDS treatment services offer health workers increased opportunities to receive training and mentoring that will improve their overall service delivery competencies and proficiency and helps them to re-identify with the humanistic aspects of patient client as they get better understanding of negative impacts of stigma and discrimination in the health system and develop the skills to better prevent this.

The study also showed that quality of care (for HIV-positive clients) is not compromised as a result of the integration and may actually improve because feel less stigmatized and are hence more likely to remain adherent to their treatment plans. There is also evidence from the study that the quality of

non-HIV services may also improve because of similar uptake issues related to reduction in costs of referrals and the need for repeat hospital visits.

The ease of integrating HIV and AIDS treatment into already existing medical services delivery structures and clinics, including those provided or utilized by organizations as part of the health benefits provided to its workers presents ample opportunities for including this on work place treatment HIV and AIDS programme. The models eliminates the need for separate medical services to delivery work place HIV/AIDS treatment and creates opportunities for businesses that desire to support such services for their staffs, families and communities.

5.3. Recommendations

Several recommendations are drawn from the findings of this study about the perceptions of health workers and HIV-positive clients in integrated HIV/AIDS clinics. Overall, it is important to remember that the choice of whether or not to integrate HIV/AIDS treatment service into general patient service delivery systems should be guided by the over-riding needs and concerns of the hospital clients. The integrated clients are endorsed on the grounds that they allow a more efficient application of hospital resources, offer HIV+ clients a relatively stigma-free environment to access treatment services and allow health workers to improve their competencies without jeopardizing the quality of care offered by the clinic; however some challenges will need to be mitigated for these clinics to fully deliver on all of these potentials.

- Firstly is that the design and operations of the clinics should be spacious and comfortable enough to allow clients to seat with other clients without becoming too aware that HIV+ clients and other clients were utilizing the same space. Clients and health workers agree that there would not really be a need to separate hospital clients based on their HIV status, if the clinic arrangement was adequate to accommodate such arrangement. Hence the amalgamation of space and client flow is one key expectation of this integration process. A neat, spacious and well ventilated clinic accommodation will ensure that clients are not at unnecessary risks of transmitting communicable diseases to others (especially those who are immuno-suppressed and hence easily vulnerable to infections). Another component of the adequacy of the clinic arrangement is to ensure that all doctors and nurses have the skills and competences to attend to both HIV+ and other clients at least within the expectation of that level of medical care and arrange referrals to other clinics purely on medical grounds.

- The second recommendation is related again to the adequacy of the clinic arrangement but focuses more on the need to preserve the anonymity of hospital clients and reduce opportunities for HIV-related stigma (in fact all forms of stigma). A well managed integrated clinic will ensure the HIV-positive clients are not so easily identifiable by non-medical persons and that medical personnel maintain a high degree of confidentiality regarding client information to preserve the anonymity of their clients as they move through the various units. Specific capacity building of all staff to better understand the dynamics of disease-related stigma and its negative impact on the medical outcomes of the clients will have to prioritise. Communication between health workers and their clients should be done in such a manner that preserves the anonymity of the client's diagnosis. Hospital patients (and visitors) do not need to know what diseases other patients are treated for – this point was well stressed by both health care workers and HIV-positive hospital clients who responded to the survey. In an environment of reduced stigma, HIV-positive clients are quite comfortable to receive treatment and remain in care for longer periods.

- Thirdly, it is important develop strategies to address emerging challenges that may arise from the successful roll-out of integrated HIV/AIDS clinic services. Chief among this is the expected rapidly increased client load due to improving utilization of both HIV and non-HIV related services. The clinics will do well to maintain an adequate quantity of manpower to ensure that hospital workers do not become overwhelmed with the rapidly increasing client load. This also averts the potential challenge of increasing client waiting times which could lead to frustration on the part of the clients and greatly diminish the overall client-clinician interaction because both the clients and the clinicians are in a hurry to clear the busy clinic. Where this is not immediately possible because manpower may not be so readily available to deploy or due to space constraints that may not allow more staff to be deployed, hospitals will have develop their own strategise to ensure the smooth running of the clinic and prevent over-crowding. Some of these strategizes may include the assignment of lower cadre staff to higher level responsibilities for which they can be trained to perform (task-shifting) and the use a client appointment system. The use of a triage system to sort clients (for instance by severity or nature of illness) also helps to ensure that clients receive appropriate levels of attention and care without spending unnecessarily long periods in waiting or in consultation.

The integrated clinics become quite attractive because they offer resource-constrained families and communities the opportunity to access more comprehensive health services for HIV and non-HIV related medical concerns and reduces costs of referrals and repeat visits; however serious considerations must be made to ensure that clients continue to access services with relative ease and health workers are not negatively affected by the work schedules and work load.

- A fourth recommendation from the study has to do with the consistency of the services delivered. An integrated clinic benefits from having generalized set of services targeted non-specifically to all clients (like the Provider Initiated Testing and Counselling services that is offered in this facility). On the clients – all clients attending the clinic should be seen to benefit equally from a basis set of services that are mutually beneficial to all and as such do not allow any one group of patients to because easily identifiable. For instance, the medical monitoring of clients on HAART requires them to be weighed routinely at their clinic visits as this information is also used to track their response to treatment. If only this group of patients were weighed consistently, other patients attending the clinic will soon come to identify those clients who received this "special" treatment as being "different" or the HAART patients themselves may begin to nurse this belief and subsequently decline to be weighed in the clinic in future. Such services are better off generalized to all clients and hence ensure that no group of clients is likely to feel different from the others because of this.

  Additionally, it is important to ensure that all clients (whether HIV-positive or not) enjoy the same degree of strict audio-visual privacy during their clinic consultations and that adequate time is spent interacting with the patients and buttressing their positive perceptions about the quality of services provided to them in the clinic. Clients who have very positive perceptions of the services offered in the clinic are more likely to remain in care and even recommend the same clinic to others.

Conclusion

The increasing availability and efficacy of HIV/AIDS treatment services offers the unique opportunity to provide HIV and AIDS care and treatment services within the context of other chronically managed illness. It has also meant that more previously sick people have regained their health and are able to continue with their lives. The massive testing campaigns and the

promotion of Provider Initiated Testing and Counselling (PITC) has lead to an increase in the number of people becoming aware of their HIV status. Unlike in the past when most people developed full blown AIDS before being diagnosed, most of the people diagnosed more recently are asymptomatic or in the early stages of the infection and hence are not easily physically identifiable. The fact that majority of those living with HIV today are in fact healthy and ARVs are now easier to prescribe, dispense and use further eliminates the need for separate clinics to deliver these services and buttresses the need instead for more integration of these services into general patient clinic by applying the integrated clinic model. It's potential to improve the efficiency of utilization of scarce health resources particularly in resource-constrained environments, cannot be over-emphasised.

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Appendix I – Questionnaire 1

Kogi State Specialist Hospital: Client Survey

In this hospital, people living with HIV receive care and treatment services in the same settings as all other clients. The management desires that the same nurses and doctors provide services for all groups of clients. Please provide answers to the following questions to help us access how this clinic has met this objective.

Sex: ***Clinic/Unit:***

Date of enrollment into the clinic:

Questions/Statement

1. I believe that people living with HIV should be seen in the same clinics as other patients (if the clinic space can accommodate this arrangement)
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree
2. People living with HIV should be seen by the same doctors/nurses that see other patients (if the Doctors/nurses have the skills to attend to them)
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

3. I'd prefer that we set-up a separate clinic for HIV-positive clients only
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

4. I believe that visitors and other clients can readily identify those clients who are HIV-positive in the clinic
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

5. Health workers address me in a way that makes other people to know that I am HIV-positive
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

6. I am satisfied with the amount of time I spend in the clinic's waiting area
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

7. The nurses regularly check my weight and Blood Pressure before I go on to see the doctor
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

8. The doctors take enough time to attend to me
    - Strongly agree

- Agree
- Neutral
- Disagree
- Strongly disagree

9. I like the combined sitting arrangements for all clients in the waiting area
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

10. I have gotten better since I started receiving treatment in this clinic
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

11. I will like to continue receiving treatment in this hospital
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

12. My answer to the last question is influenced by the fact that the hospital uses a combined clinic arrangement
    - Strongly agree
    - Agree
    - Neutral
    - Disagree

- Strongly disagree

13. I will recommend this hospital to somebody else seeking treatment for HIV and AIDS?
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

14. I have other family members receiving treatment for HIV or AIDS in this hospital?
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

15. What do you recommend for this clinic to provide better services:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Appendix I – Questionnaire 2

Kogi State Specialist Hospital: Health Provider Survey

In this hospital, people living with HIV receive care and treatment services in the same settings as all other clients. The management desires that the same nurses and doctors provide services for all groups of clients. Please provide answers to the following questions to help us access how this clinic has met this objective.

Sex ***Age***

Clinic/Unit

Questions/Statement

1. I believe that people living with HIV should be seen in the same clinics as other patients (if the clinic space can accommodate this arrangement)
    - Strongly agree
    - Agree

- Neutral
- Disagree
- Strongly disagree

2. I believe that people living with HIV should be seen by the same doctors/nurses that see other patients (if the doctors/nurses have the skills to attend to them)
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

3. I'd prefer that we set-up a separate clinic for HIV-positive clients only
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

4. I believe that visitors and other clients can readily identify those of our clients who are HIV-positive in our clinic
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree
5. I believe that clients have a right to know those clients who are HIV-positive in the clinic.
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

6. I believe that our clinic arrangement increase our client's exposure to HIV-related stigma
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

7. I am satisfied with the amount of time our clients spend in the waiting area
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

8. I believe that we are now providing more services to our clients since we started the integrated clinic.
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

9. All the patients get their weight and B.P checked regularly in the clinic
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

10. I have enough time to attend to the clients well
    - Strongly agree
    - Agree
    - Neutral

- Disagree
- Strongly disagree

11. I like the combined sitting arrangements for all clients (HIV-positive and other) in the waiting area
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

12. I believe that the general quality of our services (for all clients) has improved because of the demands of providing HIV/AIDS treatment services according to strict guidelines.
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree
13. I am comfortable with the work load that I have to deal with in running a combined clinic
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree
14. I will recommend this hospital to somebody seeking treatment for HIV and AIDS
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree
15. I have family members receiving treatment for HIV or AIDS in this hospital
    - Strongly agree
    - Agree

- Neutral
- Disagree
- Strongly disagree

16. What do you recommend for this clinic to provide better services: _

Appendix 2 – Letters of Permission A – Request for Permission

Africa Centre for HIV/AIDS Management,

University of Stellenbosch,

Stellenbosch, South Africa.

14th July 2011

The Chairman, Medical Advisory Committee,

Kogi State Specialist Hospital,

Lokoja, Kogi State

Dear Sir,

APPLICATION FOR PERMISSION TO CONDUCT A QUESTIONNAIRE-BASED SURVEY IN KOGI STATE SPECIALIST HOSPITAL

In partial fulfilments of the requirements of the Master of Philosophy Degree in HIV/AIDS Management from the Africa Centre of HIV/AIDS Management at Stellenbosch University, I am carrying out a study a study with the above title.

The study will see to address the following research question - ***What are the perceptions of health care workers and HIV+ve clients of HIV/AIDS Care and Treatment Centres in Kogi State, North-Central Nigeria, about the integrated model of HIV/AIDS service delivery?***

The study objectives are as follows-

1. To establish the characteristics of the integrated HIV/AIDS clinic model
2. To assess the perceptions of the health care workers about the integrated HIV/AIDS clinic model
3. To assess the perceptions of the HIV+ve hospital clients about the integrated HIV/AIDS clinic model
4. To proffer some recommendations for the improvement of HIV/AIDS clinic service delivery.

I write to formally request your permission for the conduct of a questionnaire-based survey over the period of one-month in the Out-patient departments of GOPD and ANC in support of the study.

Thank you in anticipation of a favourable response.

Yours Faithfully,

Dr. Akpu Murphy,

MPhil 15883949

Appendix 2 – Letters of Permission B (Approval from Hospital Medical Advisory Committee)

KOGI STATE SPECIALIST HOSPITAL

P. M. B. 1146, LOKOJA.

Dr. P. H. O. Amodu
Sole Administrator

Our Ref: KSSH/MSH/T/VOL.I/T

Your Ref:

Date:

26th July 2011

Dr. Murphy Akpu,
Africa Center for HIV/AIDS Management,
University of Stellenbosch,
South Africa.

Dear Sir,

RE: APPLICATION FOR PERMISSION TO CONDUCT A QUESTIONNAIRE-BASED SURVEY IN KOGI STATE SPECIALIST HOSPITAL

I write with regards to your letter dated; 14th July 2011.

I am happy to inform you that the Ethics Committee of Kogi State Specialist Hospital has met to discuss your study proposal and have granted their approval for you to proceed with the study on: *The perceptions of health care workers and HIV+ve patients of HIV/AIDS Care and Treatment Centers in Kogi State, North-Central Nigeria, about the integrated model of HIV/AIDS service delivery.*

We understand that this study is a requirement for the award of the MPhil degree in HIV/AIDS Management from the University of Stellenbosch and we will be happy to support you in this regard. The hospital management expects your feedback on the results of this study in appreciation of the potential to improve out work.

Goodluck.

Yours Sincerely,

Dr. B.F Ehalaiye,
Chairman, Medical Advisory Committee
Kogi State Specialist Hospital

Appendix 2 – Letters of Permission C – Approval from Hospital Ethics Committee

KOGI STATE SPECIALIST HOSPITAL

P. M. B. 1146, LOKOJA.

Dr. P. H. O. Amodu
Sole Administrator

Our Ref .....

Your Ref .....

16/08/2011.

Date .....

Dr Akpu Murphy.
African Centre for HIV/ AID Management.
University of Stellenbosch,
Stellenbosch, South African.

Dear Sir,

RE: PERCEPTIONS OF CARE GIVERS AND CLIENTS ABOUT THE INTEGRATED MODEL OF HIV/ AIDS SERVICE DELIVERY IN KOGI STATE: ETHNICAL CLEARANCE.

The ethical committee having received studied and considered your proposal dated 14th of July, 2011, is pleased to inform you that approval has been granted for your research.

We wish you the best in your under takings.

Yours faithfully,

Dr Akpojaro Ikpen
Chairman,
Ethics and Research Committee.

Mrs. Rhoda Yunusa
Acting Secretary
Ethics and Research Committee.