EXAMINING THE ROLE OF DECONCENTRATION DECENTRALIZATION IN COMBATING HIV/AIDS IN KALUNGU DISTRICT

A CASE STUDY OF LUKAYA TOWN COUNCIL

A Dissertation Submitted to the Institute of Ethics and Development Studies in Partial Fulfillment of the Requirements for the Award of Degree of Bachelor of Arts (Ethics and Development Studies) Of Uganda Martyrs University

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Dedication

This dissertation is dedicated to my Parents and my Supervisor.

Acknowledgement

I thank the Almighty God the provider of knowledge and wisdom for seeing me throughout my studies and for enabling me to undertake my research successfully, without His grace I wouldn't have made it.

I extend my deep appreciation to my supervisor Mr. Mubangizi Denis for the guidance and advice provided during the study that made it possible for me to successfully complete theresearch.

Special thanks go to my parents my sister and brothers and my dearest friends Kajjumba Elaine, Nabiryo Dora, Namubiru Annie and my Favorite Ssonko Raymond for the moral and financial support you gave me. Your effort was not in vain and may God bless you abundantly.

I extend my sincere gratitude for all who have made a tremendous contribution to this study, and to all the lecturers who have taught me since first yearand I appreciate your encouragement and moral support.

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May the Almighty God bless you abundantly!

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List of Abbreviations

HIV/AIDS: Acquired immune Deficiency Syndrome

KCCA: Kampala City Council Authority

NACPs: **N**ational AIDS control programs

NGOs: **N**on-governmental organizations

SPSS: Statistical Package for the Social Sciences

UNICEF: United Nations Children's Emergency Fund

WHO: World Health Organization

Abstract

The study was aimed at assessing the role of deconcentration Decentralization in combating HIV/AIDS in Kalungu District..The study objectives were; To find out the role of deconcentration in combating HIV/AIDS, To find out the extent to which deconcentration has helped in combating HIV/AIDS and To find out the solutions in improving the role of deconcentration in combating HIV/AIDS.

The study employed case study design approach using a quantitative and qualitative research paradigm to collect data from 56 (fifty six) respondents using structured questionnaires, and interviews.

The study found out that deconcentration helps in addressing the difficulties of trying to coordinate disparate HIV/AIDS activities; leads to greater accountability of health workers, improvement in Hospital/Health Sector through information asymmetry and also that it emphasizes a more rational and unified health service that caters to local preferences. Further, Deconcentration, it has helped to improve accountability, helps to shift parts of the workload, helped transparency and has improved efficiency of resource utilization and legitimacy. Improving the role of deconcentration in combating HIV/AIDS can be done through recruiting more medical personnel to fill the vacant posts by the local government and also that Health care providers have to be educated on the importance of involving beneficiaries in planning and managing health care delivery in combating HIV/AIDS.

The study was recommended that the management in conjunction with community leaders should have enlightenment to the local people about the importance of participation in health services It was also recommended that they should be appropriate technical and attitudinal training for service providers. The study also recommended that there is also a need to equip the community health centers with better equipment to treat patients

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

Chapter one serves as an introduction to the study. It follows with the background of the study, Statement of the problem, Objectives,Research Questions, Scope of the study, Significance of the study,Justification of the study as well as the Conceptual frame work the definition of key words.

1.1 Background of the Study

In the last two decades, health sector decentralization policies have been implemented on a broad scale throughout the developing world. Deconcentration, Decentralization, often in combination with health finance reform, has been touted as a key means of improving health sector performance and promoting social and economic development (World Bank 1993). Decentralization has become an increasingly popular policy mechanism in many European Health care systems. It is deeply ingrained in some parts of Europe (Nordic countries) and types of health systems (social health insurance) where recent extensions of decentralization draw on a century or more of organizational and managerial experience.

Mills and Vaughan (2010) pointed out that De-concentration signifies that the central government hands over some of its authority to the administrative local offices of the ministry responsible for health. It allows the establishment of local management with a degree of discretion to manage health-related activities without necessarily having constant reference to central government officials.

Boissoneau, (1996) argued that deconcentration and decentralization is said to be appropriate in health service delivery because of the special variation in patient preferences and the ability of the local official to identify the needs better. Decentralization has been recognized as a possible answer to some of the operational and coordination problems confronting AIDS control and prevention programs. Public health experts believe that a program of decentralization is needed to elicit a stronger multi-sectorial response to the epidemic and that it can accelerate the implementation of projects at all levels of society. The main goal of de-concentration has been to enhance equity, increase efficiency and ensure more participation and responsiveness of government to citizens

In African developing countries, on the other hand, the increasing decentralization of health care services has been mostly a response to the impetus in the promotion of primary health care by international donor organizations, such as the World' Health Organization (WHO) or UNICEF (Akin, 2001). Despite enormous progress in health globally, primary healthcare services in many can African developing countries are facing different challenges mostly in combating HIV/AIDS. Many studies have documented that decentralization could be useful in supporting and developing health services closer to citizens.

Bitarabeho (2003) pointed out that Uganda adopted a system of deconcentration decentralization to improve systems of governance and foster economic growth especially in rural areas primarily to eradicate poverty. He further argues that de-concentration has aimed at speedier and more responsive services, enhances efficiency, freedom of access to services and freedom to decide among other benefits.

In Uganda, many national AIDS control programs (NACPs) are adopting policies intended to deconcentrate decentralize the planning and implementation of HIV/AIDS prevention and service programs to regional, district, and community levels. Deconcentration is viewed as a means of mobilizing the skills, commitment, and resources of both governmental and nongovernmental organizations (NGOs) at the local level to deliver educational, counseling, medical, and support services to a variety of target groups. As families, businesses, and communities have begun to feel personally the consequences of AIDS, local organizations of all kinds have come to realize that they can and must play a role in the fight against the epidemic. They increasingly understand that like health care services, AIDS prevention and care services are by their very nature decentralized: their foundation and power is the direct face-to-face relationship between a caregiver and a client (Lazar et al., 2002).

A thorough review and appraisal of the deconcentration decentralization doctrine, theory, practice and discipline in Uganda projects a system strewn with challenges. On the basis of these challenges, a pessimist may even point out that de-concentration is a failure. However, by closely analysing the entire decentralization and deconcentration process, there are positives amidst the gloom. Karyeija and Kyohairwe (2012) in their assessment of Kampala City Council Authority (KCCA) case as an agency, observed that explicit performance indicators in terms of city cleanliness, road maintenance, and law enforcement may suggest a focus on value for money when technically evaluated. The identification challenges however should be stimuli of reforms and improvements in decentralization to

achieve its original aims and objectives for all service sectors including the health sector.

Kalungu District is a district in southern Central Uganda. It is named after the 'chief town' of the district, Kalungu, where the district headquarters are located. The district began functioning on 1 July 2010. Kalungu was selected as the district headquarters. Agriculture, livestock farming and fishing in Lake Victoria and the marshes of the Katonga River, constitute the main economic activities in Kalungu District. Faced with the need to encourage such a broad-based, multisectoral response to the threat of AIDS in the Lukaya Town Council in Kalungi Ditrict, government officials and other stakeholders are turning to the concept of deconcentration decentralization as a means of guiding and supporting the diverse activities of a large and increasing number of organizations and projects. International and bilateral donor agencies are also confronted with the questions of whether, when, and how to support efforts at decentralization.

In 2013, an estimated 1.6 million people were living with HIV, and an estimated 63,000 Ugandans died of AIDS-related illnesses. As of 2013, the estimated HIV prevalence among adults aged 15 to 49 stood at 7.4% (Uganda Ministry of Health 2010). Promising signs were shown between the years of 2005 and 2013 as the number of AIDS-related deaths in the country is reported to have decreased by an estimated 19%. Nevertheless, at the end of 2013, Uganda had 140,000 new cases of HIV infections, accounting for 7% of the world’s total increase – the third largest increase in any country. Robust treatment and prevention initiatives have been implemented in recent years, leading to improved conditions for people living with HIV. Due to the implementation of antiretroviral treatment throughout the country there has been a

gradual increase in the number of people living with HIV receiving treatment. However, as of 2013 more than 60% of adults living with HIV were still not on treatment. The fight against HIV/AIDS can also be controlled by deconcetration and decentralization mostly of the health care.

1.2 Problem Statement

The primary drivers of HIV epidemic in most places are commercial female sex work, unprotected sex between men who have sex with men, and injecting drug use. HIV epidemic in places like Kalungu District is concentrated in nature and heterogeneous in its spread. While interventions have been brought to decline in HIV epidemic at most of the places, emerging pockets and risk groups with high vulnerability warrant focused attention. Whereas deconcentration holds a serious promise for efficient, effective, responsive, accountable, sustainable but also participatory service delivery and combatting HIV, in practice, the approach is dotted with bottlenecks, obstacles, and inefficiencies. Particularly in Uganda, the institutional challenges to the philosophy, theory, and practice of deconcentration, decentralization are numerous. Decentralized health units in Uganda suffer from crippling institutional, managerial and human resource incapacity (Muriisa, 2008) to perform their mandate. In some local governments, Devas (2005) asserts that decision making processes are unsystematic, mechanisms of accountability between the technocrats and elected officials are inadequate, and there is shortage of officials with the necessary technical, managerial and financial skills. This is has been left out by many studies which has left a research gap. Therefore the research is prompted to investigate the role of deconcentration

decentralization in combating HIV/AIDS in Kalungu District as case study of Lukaya Town Council

1.3 Objectives of the Study

1.3.1 General objective

To Examine the Role of Deconcentration Decentralization in combating HIV/AIDS in Kalungu District

1.3.2 Specific objectives

i. To find out the role of deconcentration in combating HIV/AIDS
ii. To find out the extent to which deconcentration has helped in combating HIV/AIDS
iii. To find out the solutions to improve the role of deconcentration in combating HIV/AIDS

1.3.3 Research questions

i. What is the role of deconcentration in combating HIV/AIDS?
ii. What is the extent to which deconcentration has helped in combating HIV/AIDS?
iii. What are the solutions to improve the role of deconcentration in combating HIV/AIDS?

1.4 Scope of the Study

1.4.1 Content Scope

This Content is purposely to examine the role of de-concentration in combating HIV/AIDS. It will be focused on the role of deconcentration in combating HIV/AIDS, the extent to which deconcentration has helped in combating HIV/AIDS, and the solutions to improve the role of deconcentration in combating HIV/AIDS.

1.4.2 Geographical Scope

This Research operated in Lukaya Town council in Kalungu District which is bordered by Gomba District to the north, Butambala District to the northeast, Mpigi District to the east, Masaka District to the south and Bukomansimbi District to the west. The 'chief town' of the district, Kalungu, is located 21 kilometres (13 mi), by road, northeast of the city of Masaka, the largest metropolitan area in the sub-region.

1.4.3 Time scope

This research considered a period of 4 years that is 2011-2014 in order to be in position to assess the role of deconcentration decentralization in combating HIV/AIDS in Kalungu District as case study of Lukaya Town Council. This time period will also be chosen because it has enough data relevant to the topic under investigation.

1.5 Significance of the study

To the government, the study will provide information at both central and local levels both the operations of the health sector at local citing the strengths and differences in combating HIV/AIDS.

The findings of the study may also help the Leaders and top management of Lukaya Town Councils who may use the information in determining strategies of implementing decentralization and deconcentration in the district. The findings may help them know how to make and enforce policies and terms of service which are friendly and satisfying to the communities that they serve.

To Health workers, Management will ensure there is knowledge explosion in the HIV/AIDS initiatives for instance the growth of more knowledge increases the complexity and fast work in

developing up and improving a certain project so as to benefit the entire community as well as readily accessible.

To development partners, the development partners will utilize the findings to establish the ways they can improve health service in Lukaya Town Council and elsewhere in Uganda

To the University, the alumni and the continuing students as well as lecturers will enhance their knowledge on the role of decentralization in Uganda's and elsewhere in the world.

To the researcher, the study enabled to gain a more detailed insight into decentralization as well as gaining academic accreditations of bachelors Degree of Uganda Martyrs University. It will be of great importance because she will acquire research skills which can be applied to conduct research in other subjects

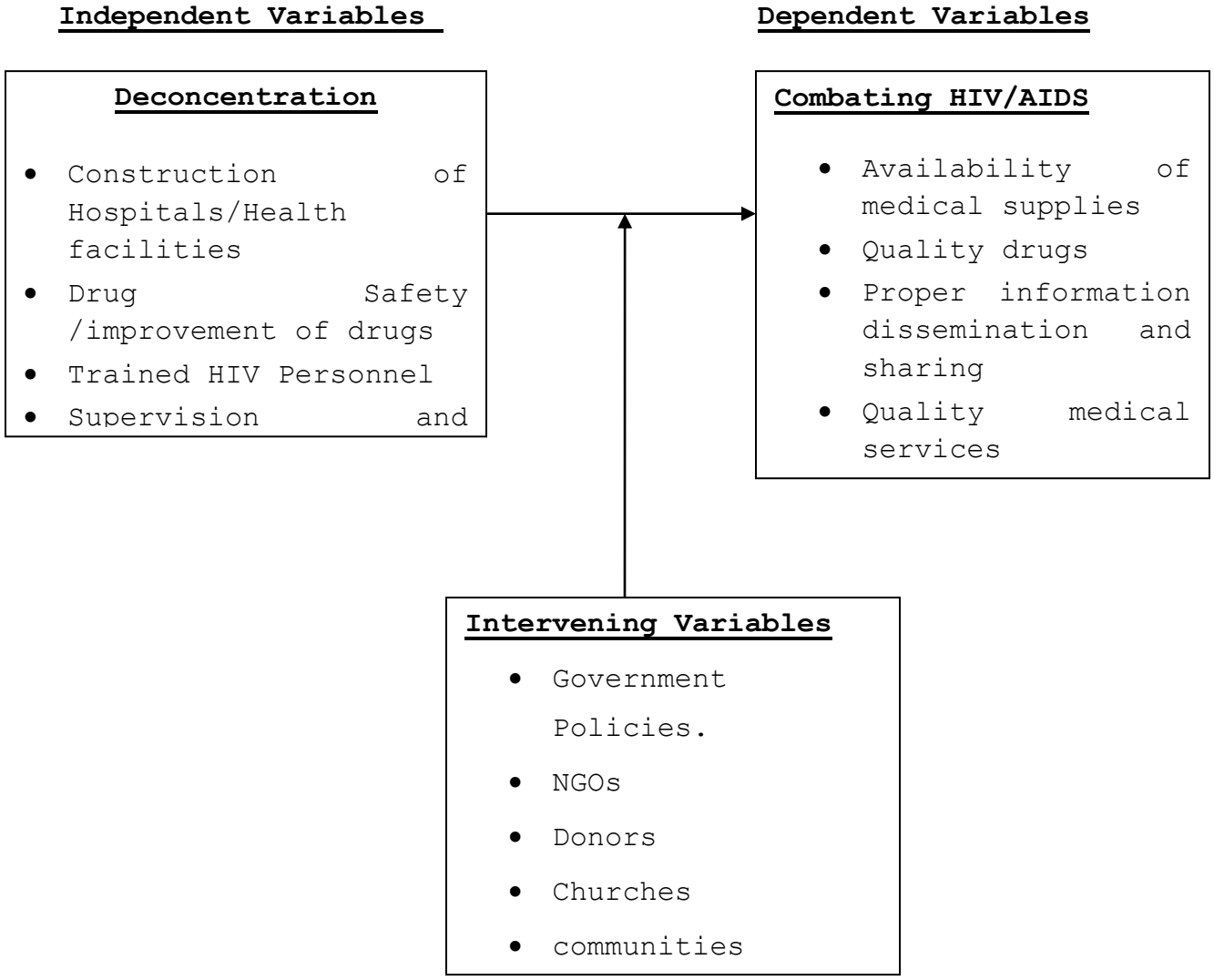
1.6 Justification of the study

Most studies in the area with households in Lukaya Town Council have focused on ways in which the public health services can be best delivered to the local people living in the area, leaving out the relationship between decentralization and Combating HIV/AIDS. This aspect calls for the need to investigate the role of decentralization on combating HIV/AIDS in Lukaya own Council

1.7 Conceptual Frame work

The conceptual framework illustrates how the decentralization relates to combating HIV/AIDS in Lukaya own Council. The independent variable is deconcetration while the dependent variable is combating HIV/AIDS in Lukaya own Council

Figure 1.1: Conceptual Framework



Source: Adopted and modified from Timothy, and Stephen Coate, (2003)

The conceptual framework describes the relationship between the independent variables and the dependent variable. In this conceptual framework, deconcetration is the independent variable while combating HIV/AIDS is the dependent variable. The conceptual frame work is modified and developed basing on Timothy, and Stephen Coate, (2003). In this study, it is assumed that deconcetration has a significant effect on combating HIV/AIDS. In the conceptual frame work, deconcetration is

operationalized into Hospital/Health Sector, Dry Safety, Trained HIV Personnel and Supervision & monitoring. Deconcentration also has a role on combating HIV/AIDS through availability of medical supplies, quality drugs, proper information dissemination and sharing and also quality services.On the other hand Government policies and regulations, NGOs, Donors, Churches and Communities are considered as the intervening variables. The study thereby examines whether the effect of deconcetration increases or decreases the fight against HIV/AIDS.

1.8 Definition of Key Terms

Deconcentration: Deconcentration is the policy of breaking up and divesting operations of large organizations in order to reduce the degree of concentration in an industry. De-concentration, refers to a transfer to lower-level central government authorities, or to other local authorities who are upwardly accountable to the central government

Decentralization; Decentralisation is usually referred to as the transfer of powers from central government to lower levels in a political-administrative and territorial hierarchy. The term de-centralisation is used to cover a broad range of transfers of the "locus of decision making" from central governments to regional, municipal or local governments

Combating; to fight or contend against HIV/AIDS; oppose vigorously

HIV/AIDS: Acquired immunodeficiency syndrome (AIDS) is a chronic, potentially life-threatening condition caused by the human immunodeficiency virus (HIV). By damaging your immune system, HIV interferes with your body's ability to fight the organisms that cause disease. HIV is a sexually transmitted infection

1.9 Conclusion

In conclusion, the long-term benefits of the deconcetration decentralization are linked to improved fight against HIV/AIDS. Therefore this study continues to investigate the role of deconcentration in combating HIV/AIDS, the extent to which deconcentration has helped in combating HIV/AIDS and find out the solutions to improving the role of deconcentration in combating HIV/AIDS as will be seen in chapter two.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Chapter two deals with reviewing the related literature on the study about the Role of Deconcentration in Combating HIV/AIDS. The study shall then focus on the major themes of the study which are; to find out the role of Deconcentration in combating HIV/AIDS, to find out the extent to which Deconcentration has helped in combating HIV/AIDS and to find out the solutions to improving the role of Deconcentration in Combating HIV/AIDS.

2.2 The Role of Deconcentration in Combating HIV/AIDS

Deconcentration has become an increasingly important component of health sector reform efforts in developing countries. A survey of developing and transitional nations in the mid-1990s indicated that out of the 75 such economies with populations greater than five million, all but 12 claim to have embarked on some type of transfer of power to local governments (Akin, 2001). Deconcentration is most commonly distinguished by the extent of control over specific types of responsibilities - administrative, political or fiscal in combating HIV/AIDS.

Deconcentration also plays an important role of addressing the difficulties of trying to coordinate disparate HIV/AIDS activities for different regions from a central location. decision-making to the local level can reduce the time required for making decisions, as well as increasing the likelihood that decisions will be made with the benefit of local knowledge of conditions

The Hospital/Health Sector has been improved as a result of Deconcentration through information asymmetry. In this case, the local governments or agencies can pursue their own agenda if central MOH is not well informed about their activities. Still, if local powerful groups (ie insurance companies and physicians) have significant investments in health care issues, they may use their influence to limit the intended objectives of de-concentration decentralization.

Deconcentration has also enabled drug safety. This also comes as allocative efficiency increases because local decision-makers have access to better information on local circumstances rather than basing on only central authorities, and they use this to tailor services and spending patterns to local needs and preferences.

Having Trained HIV Personnel is one of the potentials of Deconcentration in the health sector. It emphasizes a more rational and unified health service that caters to local preferences, improved implementation of health programs. decrease in duplication of services as the target populations are more specifically defined and also reduction of inequalities between rural and urban areas .

Deconcentration is also believed to increase the sustainability of health sector and most importantly HIV/AIDS activities through supervision and monitoring and by increasing the involvement of local communities. The economic rationales for Deconcentration decentralization, apart from the cost savings from reduced bureaucracy and faster decision-making, generally focus on the extent to which it can lead to an increase in the welfare of local populations by allowing the supply of health

services to be more in line with the services that local populations value more highly.

Additionally, by increasing community participation in health systems, Deconcentration can lead to greater accountability of health workers, thereby increasing the quality of health services and the efficiency by which they are produced. De-concentration can also improve quality of work by allowing the employees who have direct knowledge of products and services to make decisions and complete tasks. Quality can also improve through enhanced employee motivation that are implementing a certain project. Employees may do a better job because they feel a personal accountability for the outcome, even though responsibility ultimately rests with the individual who made the delegation. Motivation should also be enhanced as de-concentration enriches the worker's job by expanding the types of tasks that are involved (Arrowsmith and Sisson, 2002)

Deconcentration relieves the top executives of the burden of performing various functions. Centralisation of authority puts the whole responsibility on the shoulders of an executive and his immediate group. This reduces the time at the disposal of top executives who should concentrate on other important managerial functions. So, the only way to lessen their burden is to decentralise the decision-making power to the subordinates which means there is more efficiency in implementation of the HIV/AIDS projects

Gregersen et al., (1999) pointed out that de-concentration promotes better control and supervision regarding combating HIV/AIDS initiatives. De-concentration ensures better control and supervision as the subordinates at the lowest levels will have the authority to make independent decisions. As a result

they have thorough knowledge of every assignment under their control and are in a position to make amendments and take corrective action

2.2 The Extent to which Deconcentration has helped in Combating HIV/AIDS

With Deconcentration, administrative authority and responsibility are handed over to lower levels within central-government agencies or ministries. This arrangement shifts parts of the workload and some decision-making authority from the central administration to intermediate levels and the periphery, and gives discretion to local managers to adapt central directives to local conditions. The key feature of Deconcentration, however, is that responsibility for program implementation remains within the jurisdiction of the central office or program. Deconcentration is the most frequently applied form of decentralization

Regarding Quality drugs, the idea of this movement is to increase efficiency and citizen participation in health services and improve access to health care and drugs in rural populations (Akin, Hutchinson &Strumpf, 2005). Whilst Deconcentration Decentralization has been found to be ineffective in several instances, Foley, (2008) argues that this is due to other reforms instituted in parallel to decentralization and that decentralized health care is the most realistic method of increasing access to medicines in the developing world right now.

Regarding availability of medical supplies; De-concentration of the health care also indirectly increases access to medicines because it often coincides with the existence of community

health insurance through risk pools. The traditional communes that operated under the Cooperative Medical System in China provided risk pooling infrastructure which is simply a voluntary health insurance program (Blumenthal &Hsaio, 2005).

Proper information dissemination and sharing; Bossert et al (2000) enumerated that, de-concentration increases health sector performance, increase service delivery effectiveness, improve efficiency of resource utilization, through Proper information dissemination and sharing. improve accountability, transparency and legitimacy as well as increasing equity of services by enabling marginalized and poor groups to access health care.

Quality services; Deconcentration improves technical efficiency and effectiveness through greater cost consciousness at the local level. Additionally, the quality of service improves because the public provides input on local decision-making processes and holds local decision-makers accountable for their actions (Murindwa, 1999).

Deconcentration, encompasses the process by which the agents of central government control are relocated and geographically dispersed" (Sayer et al., 2009). it also means administrative decentralization, i.e. a transfer to lower-level central government authorities, or to other local authorities who are upwardly accountable to the central government" (Ribot 2002). It involves the transfer of administrative responsibility for specified functions to lower levels within the central government bureaucracy, generally on some spatial basis.

One of administrative decentralization which redistributes decision-making authority and financial and management responsibility among levels of the central government; there is no real transfer of authority between levels of government. It

may involve only a shift of responsibilities from federal forest service officials of the capital city to those stationed in provinces, districts, etc" (Gregersen et al., 1999).

Deconcentration is usually accomplished by giving increased managerial authority and responsibility to provincial and district-level managers for planning, allocating resources, and initiating and implementing projects aimed at combating HIV/AIDS. As project interventions become more standardized, and as experience is gained, projects can be increasingly managed by personnel at lower levels in the system. The distinguishing characteristic of deconcentration is that responsibility for the planning, funding, and implementation of these activities remains within the jurisdiction of the central government. They are centrally funded and managed programs, usually staffed by regular civil-service personnel.

Deconcentration which is often considered to be the weakest form of decentralization and is used most frequently in unitary states-- redistributes decision making authority and financial and management responsibilities among different levels of the central government. It can merely shift responsibilities from central government officials in the capital city to those working in regions, provinces or districts, or it can create strong field administration or local administrative capacity under the supervision of central government ministries

The presumed benefits of de-concentration have attracted development planners for decades, and decentralization has become an integral component of many national development plans. The seductive prospect of accelerated implementation, improved quality, increased participation, and expanded service delivery

is a powerful inducement. Many of these benefits do, in fact, result from successful programs of de-concentration.

concentration programs aimed at HIV /AIDS control that are functioning well use strengths at one level of a system to compensate for weaknesses at other levels. Central offices, as previously noted, often do a poor job at operating service-delivery programs at the periphery. They find it difficult to achieve local participation, to adapt programs to local conditions, to build local capacity, and to achieve sustainability of local programs (Gregersen et al., 1999).

The key strengths of local organizations, on the other hand, are precisely in the areas where central programs are weak: local presence, legitimacy, an established role in the community, low-cost or voluntary manpower, knowledge of the local situation, and motivation to serve their membership and the immediate community. It is this "embedding" in the community which central and regional programs lack, and which can be provided only by local organizations (Larson, 2008). In situations where "government" is suspect, these local organizations can provide a crucial interface between central programs and the general population. For AIDS prevention efforts, the ties that local organizations have to their members and to the community are the medium for exerting influence to change the sexual behavior of individuals.

2.3 Solutions to improving the role of Deconcentration in combating HIV/AIDS

Health care providers have to be educated on the importance of involving beneficiaries in planning and managing health care delivery in combating HIV/AIDS. These providers can be sensitized during training, worships and seminars organized by policy makers, NGOs, and civil society groups. This is because, the health worker is the one close to the user and until he or she sees the need to encourage local level participation; national efforts aim at doing so will be thwarted (Mills and Vaughan 2010)

Arrowsmith and Sisson, (2002) argued that community participation in health services and HIV/AIDS initiatives in the whole rural community should be made official or legal, so that when beneficiaries are denied the opportunity to partake, they will have the power to challenge the operators of the given health delivery system.

It is important to have enlightenment to the local people about the importance of participation in health services like immunization and the benefits of decentralization and de-concentration of health services. Mass education exercise should be organized by bodies like the District Assembly, NGOs and advocates of local participation to create awareness in these people. By doing so, the local people will be equipped with knowledge and ideas on the nature of participation and their roles. This will eliminate the tendencies for local people to drag or hijack the process as complained by some of the health workers at the health centers. The education will also instill in local people the zeal to take the move to participate in service delivery rather than always waiting to be brought in my health professionals (Malone, and Thomas, 2009).

Most times there is always limited health facility equipment, doctors and nurses in health centres that are need to effectively combat HIV/AIDS. So there is a need to equip the community health centres with both staff and equipment to treat patients through health services.

Alleviation of poverty among the poorest communities especially the women will help to increase effective utilization of these Health services. There should be infrastructure development in the community. This will improve the Health facility accessibility by the patients to all the HIV/AIDS programs (Arrowsmith and Sisson, 2002)

There were many unattended patients in major Health facilities so there was a need to purchase equipment and recruit more medical personnel to fill the vacant posts by the local government to boost access to the services especially for communities in rural areas (Malone, and Thomas, 2009). Worth noting the Health facility officials requested the Government to give them salary increment because of the type of the work they do and the inaccessibility of remote areas where they work from.

More effort is needed to understand the factors that will drive effective behavioral change and acceptance of HIV testing. This is vital for prevention programming targeted at the general population and specific risk groups.

There is need to have appropriate technical and attitudinal training for service providers; and opportunities for improving the quality of life - emotional, sexual, and social - of persons infected with HIV and subjected to life-long anti-retroviral treatment.

In conclusion According to the views of the scholars above it has been shown that there exists a relationship between deconcetration and decentralization in combating HIV/AIDS and the literature also reveals the big gap between deconcetration decentralization and HIV/AIDS which is still on the rise.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

Chapter three presents the methodology that will be used in the study. It covers the research design, study population, sample population, size, sampling procedures, data collection methods and their corresponding data collection instruments, data management and analysis procedures, reliability and validity and the ethical considerations.

3.1 Research Design

The study used a case study design approach considering both quantitative and qualitative approach using structured questionnaire, interviews, and document analysis. A case study was used because it provided an in-depth study of the problem with limited time scale (Amin, 2005). The case study approach is perceived as the most preferable way of obtaining holistic, in-depth insights into the role of de-concentration Decentralization in combating HIV/AIDS. Yin, (1994) argues that case study research strategies are appropriate for the investigation of how and why questions, especially when the concern is to study contemporary issues over which the research has no control (Barifaijo, Basheka and Oonyu, 2010). Case study research is also applicable when the boundary between a phenomenon under investigation and its organizational and social context is unclear. A triangulation of quantitative and qualitative research techniques will be adopted, in order to exploit the synergies offered by different methodologies. Both primary and secondary data were collected through interviews, Questionnaires and document review.

3.2 Area of Study

The study will be carried out in Lukaya Town Council in Kalungu District. This area was chosen because it had enough relevant data and information regarding the topic under investigation

3.3 Study Population

The study was conducted in Lukaya Town Council. The study considered a total population from the Local Government Administrators, Town clerks, Councilors and other local government health officials.

3.4 sample size

A total of 56 respondents was selected based on Krejcie and Morgan (1970) sampling guidelines using the probability simple random sampling method, and non-probability methods of purposive sampling criteria. Table 3.1 below shows the different population categories targeted, sample and sampling methods that will be used in the study.

Table 3.1: Sample size and selection

S/N	Category	Population	Sample size	Sampling Technique
1	Local Government Administrators	7	6	Purposive
2	Town clerks	5	4	Purposive
	Councilors	13	11	
3	Other local government Health officials	40	35	Simple random sampling
Total		65	56	

Source: Kalungu District Performance Report (2015)

The corresponding sample size for the population of 65 is 56. This is selected based on Krejcie and Morgan (1970) sampling

guidelines using the probability stratified random sampling method, and non-probability methods of purposive sampling criteria. Using proportions the sample size is obtained for the respective groups as

$$\text{Local Government Administrators} = \frac{7}{65} \times 56 = 6$$

$$\text{Town clerks} = \frac{5}{65} \times 56 = 4$$

$$\text{Councilors} = \frac{13}{65} \times 56 = 11$$

$$\text{Other local government health officials} = \frac{40}{65} \times 56 = 35$$

3.5 Sampling Techniques and Procedure

3.5.1 Purposive Sampling

Purposive sampling is whereby the samples are selected with a purpose in mind. This is in one or more specific predefined groups the research is seeking to gather information about the topic under investigation. In this study, purposive sampling technique will be used to select key respondents that is; the Local Government Administrators and Town clerks because it is best suited for selecting information rich cases for in depth study. Purposive sampling, also known as judgmental, selective or subjective sampling, is a type of non-probability sampling technique. Non-probability sampling focused on sampling techniques where the units that are investigated are based on the judgment of the researcher

3.5.2 Simple random sampling technique

Simple random sampling technique will be used to select cases of units of observation as they become available to the research because this method is unbiased, representative in nature,

dependable and each respondent has the same equal probability of participation. Simple random sampling wasused to select other local government health officials.

3.5.3 Convenience Sampling

A convenience sample is one of the main types of non-probability sampling methods. A convenience sample is made up of people who are easy to reach. With convenience sampling the subjects are selected because of their convenient accessibility and proximity to the research. It will be used because it is fast, inexpensive, easy and the subjects are readily available. Convenience sampling will also be used to sample the Councilors and other local government Health officials.

3.6 Data Collection Methods

The researcher used both primary and secondary data collection methods. Both qualitative and quantitative techniques were used to investigate the topic under investigation.

3.6.1 Questionnaire guide

A questionnaire is a formulated written set of questions that will be used to obtain information about the study objectives from the study population (Amin, 2005). The questionnaire will be used to collect quantitative data. The questionnaires will be administered to the other local government health officials because respondents can read and write the answers and also the respondents possess the information required to answer the questions and are willing to answer the questions honestly and it is less expensive for data collection. The study used a close and open ended questionnaire to collect data.

3.6.2 Interviewing guide

An interview is a conversation between two people (the interviewer and the interviewee) where questions are asked by the interviewer to obtain information from the interviewee. The interview guide will be used to collect qualitative data. The researcher will interview the local Government Administrators and Town clerks face to face to obtain in-depth information on the topic under investigation. The interview guide will be used to collect qualitative data because the information will supplement the data that will be obtained from the questionnaire and it is easy to use.

3.6.3 Documentary Review

Document analysis involves reviewing existing published and unpublished information relating to the deconcentration decentralization in combatting HIV/AIDS. During the research publications and reports from the District will be reviewed, Health facilities and other research generated documents, journals and reports. References from which data is drawn will recognized in this study. The study used a documentary review checklist to gather information objective by objective, in line with the variables of the study.

3.7 data quality controll

3.7.1 Validity

Validity refers to the extent to which questions in an instrument accurately measure the variables therein (Hair et al., 2003). In other words, Validity is the accuracy and meaningfulness of inferences, which are based on the research results (Mugenda and Mugenda, 1999). The questionnaire is subjected to expert face validity and theoretical content validity tests. A content validity index (CVI) is an indication

of the degree to which the instrument corresponds to the concept it is designed to measure. Amin's (2005) recommended minimum CVI of 0.7 which will be employed.

3.7.2 Reliability

Reliability refers to the degree to which a set of variables are consistent with what they are intended to measure (Amin, 2005). When the items on an instrument are not scored right versus wrong, Cronbach's alpha is often used to measure the internal consistency which is often the case with attitude instruments that use likert scale (Barifaijo, Basheka&Oonyu, 2010). Mugenda&Mugenda, (2003) stresses that a coefficient of 0.80 or more implies that there is a high degree of reliability of the data, and that's what the researcher adopted.

3.8 Procedure of Data Collection

An introduction letter from UMU will be issued to the relevant authorities in Lukaya Town Council introducing the researcher to the respondents. The sampled respondents who are physically located, will be identified and the questionnaires administered to them, while appointments are fixed for meeting the key respondents for face to face interviews

3.9 Data analysis

3.9.1 Quantitative data analysis

The data collected will be edited, coded and later analyzed using Statistical Package for the Social Sciences (SPSS) computer program. Quantitative data waspresented in form of descriptive statistics using frequencies and percentages for each of the variables used in the study,

3.9.2 Qualitative Data analysis

Qualitative data analysis involved identification and transcribing the qualitative findings into different themes (Mugenda and Mugenda, 1999). The themes then edited, coded and arranged in different categories to generate useful conclusions and interpretations on the research objectives which were deduced for reporting in a narrative form.

3.10 Measurements of variables (Quantitative studies)

The variables were measured by operationally defining concepts. For instance the questionnaire will be designed to ask responses about the topic under investigation. These will be channelled into observable and measureable elements to enable the development of an index of the concept. A five - (5) strongly disagree, (4) disagree, (3) not sure (2) agree, (1) strongly agree were used to measure both the independent and dependent variables. The characteristics of the respondents were measured at nominal and ordinal.

3.11 Ethical Considerations

The following were done to ensure that Ethical Considerations

The research will seek an introductory letter from the UMU which will be presented to the authorities to seek permission and consent. The data obtained from the respondents will be treated purely as academic and confidential for the safety, social and psychological well-being of the respondents.

Informed consent was sought and appropriate documentation was kept, and questionnaires were coded guarantee anonymity as no one of the respondents was named at any time during the research or in the subsequent study

The respondents will be selected for their willingness to participate without compulsion and no risks to the respondents will be identified at any stage during the research

3.12 Limitations

The research will face a time constraint in data collection, analyzing of data and in final presentation of the report. However, this problem will be overcome by ensuring that the time element is put into consideration and that all appointments agreed upon with respondents are fully met.

There will be a limitation of reliance on interview data. With the use of interviews, it will be hard to control respondent behaviour because some of the interviewees are sensitive to minor changes in interview wording. There were elements of item-nonresponse as the answering process may fail to proceed smoothly because the respondent lacks motivation or ability. Some respondents also gave responses such as; the questions are too difficult, not interesting, among others which the researcher will find somewhat unsatisfactory of the expected findings. However, the research conducted reliability and validity tests to ensure the consistence and accuracy of the tools that were used.

There will also be a difficult of probing deeper into the subject matter because some respondents might withhold some information because it is regarded as confidential. However, they be assured that any information given would treated with maximum confidentiality.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.0 Introduction

Chapter four presents the findings of the study, which were got from different respondents, and these are presented, discussed, and analyzed in this chapter four. Data collected from the questionnaires, and interview guides was analyzed Chapterresults on the background information of respondents are analyzed and interpreted. In addition still, it presents, discusses and analyses the findings in the order of the research objectives and questions as stated earlier in chapter one..

4.1 Response rate

The study administered the following instruments for the collection of the data: interviews and questionnaire.

Table 4.1showing the response rate of the respondents

Instruments administered	**Frequency (F)**	**Percentage (%)**
Questionnaires Returned	50	89.3
Questionnaires returned	0	0.0
Interviews carried out	6	10.7
Total Sample	**56**	100.0

Source: Primary data

Table 4.1 has demonstrated the distribution of the respondents according to the instruments that, (89.3%) of the targeted respondents participated by answering the questionnaires whereas (10.7%) participated by giving responses during the interview. The outcome from the table shows an effective and influential participation that depicted a successful data collection leading to compilation of a report with enough information.

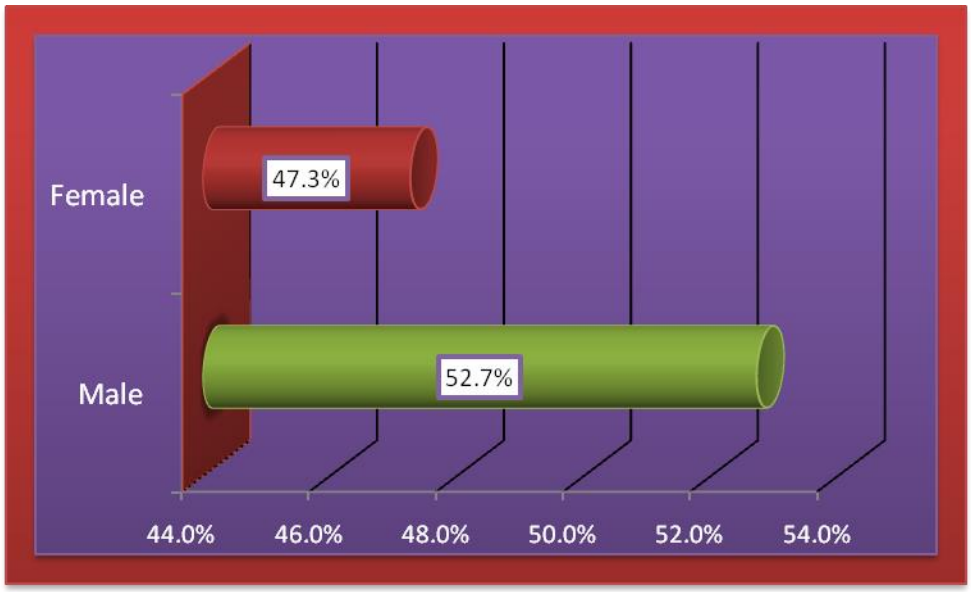
4.2 Background information of respondents

The background information of respondents was deemed necessary because the ability of the respondents to give satisfactory information on the study variables greatly depended on their background. The background information of respondents solicited data on the samples and this has been presented below and categorized into; gender, age, held, education and occupation, of the respondents.

4.1.1Gender of the respondents

The following figure presents findings about the gender of respondents and analysis follows. Data related to gender of the respondents is presented in the Bar chart below.

Bar Chart 1: Below Showing the Gender of Respondents



Source: Primary data

According to the statics bar chart one, results from the questionnaire indicate that52.7% were males and 47.3% females. Gender is an important variable in a given institution which is variably affected by any social or economic phenomenon. This implied that there was gender imbalance as observed from the percentage of men involved compared to the percentage of women involved. This also assisted the study to obtain information from distinct sides thus acquiring unbiased data. Hence the variable gender was investigated for this study and details of their respective gender as presented in the pie chart above

4.1.2Age of Respondents

The following table presents findings about age group of respondents and analysis follows.

Table 4.2showing the Age of respondents

Age of respondents		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 20 years	9	16.1%	16.1%	16.1%
	20 - 30	20	35.7%	35.7%	51.8%
	30 - 40 years	12	21.4%	21.4%	73.2%
	41 - 50 years	7	12.5%	12.5%	85.7%
	Over 50 years	8	14.3%	14.3%	100.0%
	Total	56	100.0	100.0	

Source: Primary Data 2016

Using the questionnaire method, the results Table 4.1 show that showed that the 35.7% of the respondents had 20-30 years, these were followed by 21.4% who had years ranging from 31 – 40years, then 16.1% of the respondents were below 20 years,14.3% had over 50 years whereas 12.5% of the respondents had years 41 – 50 years. This implied that the largest portion of the respondents were still at youth stages and also depicted that the most respondents were youths. This also assisted the researcher to acquire varying views from distinct age groups. This was collected by use of questionnaire method since it was easier to use and was not very costly to use..

4.1.3 Education Level of Respondents

The study also established the education level of the respondents. The findings form the questionnaireswere recorded and presented in the figure below. In this section, differences in educational attainment of the respondents are discussed.

Table 4.3 showing Education Qualification of Respondents

Status		Frequency (F)	Percent (%)	Valid Percent (%)	Cumulative Percent (%)
Valid	Certificate	9	25.5	25.5	25.5
	Diploma	17	16.4	16.4	41.8
	Degree	27	49.1	49.1	90.9
	Masters	5	9.1	9.1	100.0
	Total	**56**	**100.0**	**100.0**	

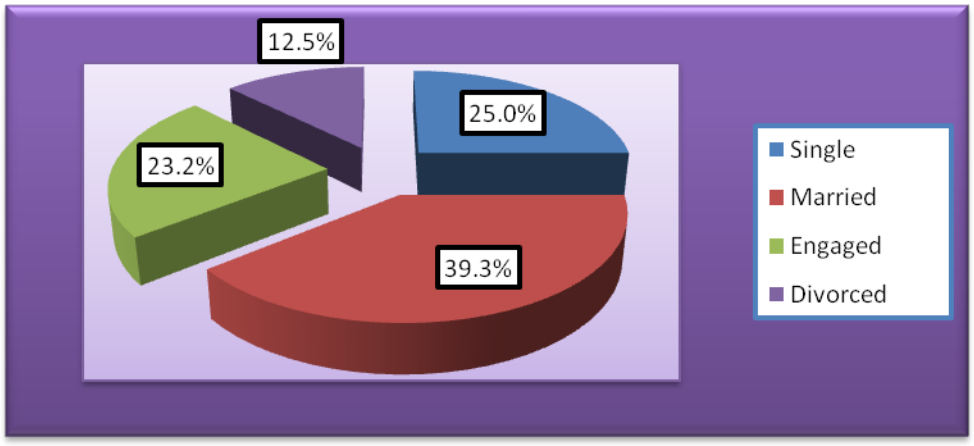
Source: Primary Data 2016

Study findings from the questionnaire revealed thatthe most respondents that is 49.1% were degree holders, these were followed by 25.5% of them who had attained a diploma only, then 16.4% of the respondents had a certificate while 9.1% were having a Masters degree. It also implied that all the respondents had attained some education implying that responding to the questionnaires was an easy task that would not take too much time. This helped the researcher to collect data and compile final report in the shortest possible time. As noted by Olaf, (2009), the educational attainment of respondents is an important indicator of their knowledge and attitude about role of deconcertation decentralization in combating HIV/AIDS

4.2.4 Marital Status of Respondents

The study also revealed the Marital Status of Respondentsin which findings were recorded as indicated in the pie chart below.

Pie Chart 1: Marital Status of Respondents



Using the findings from the questionnaires, 39.3% of the respondents were married, those were followed by 25.0% who were single, 23.2% were engaged whereas 12.5% just separated. This implied that most respondents had families with a lot of responsibilities to accomplish. Quantitative data regarding marital status of the respondents was collected using questionnaire method,

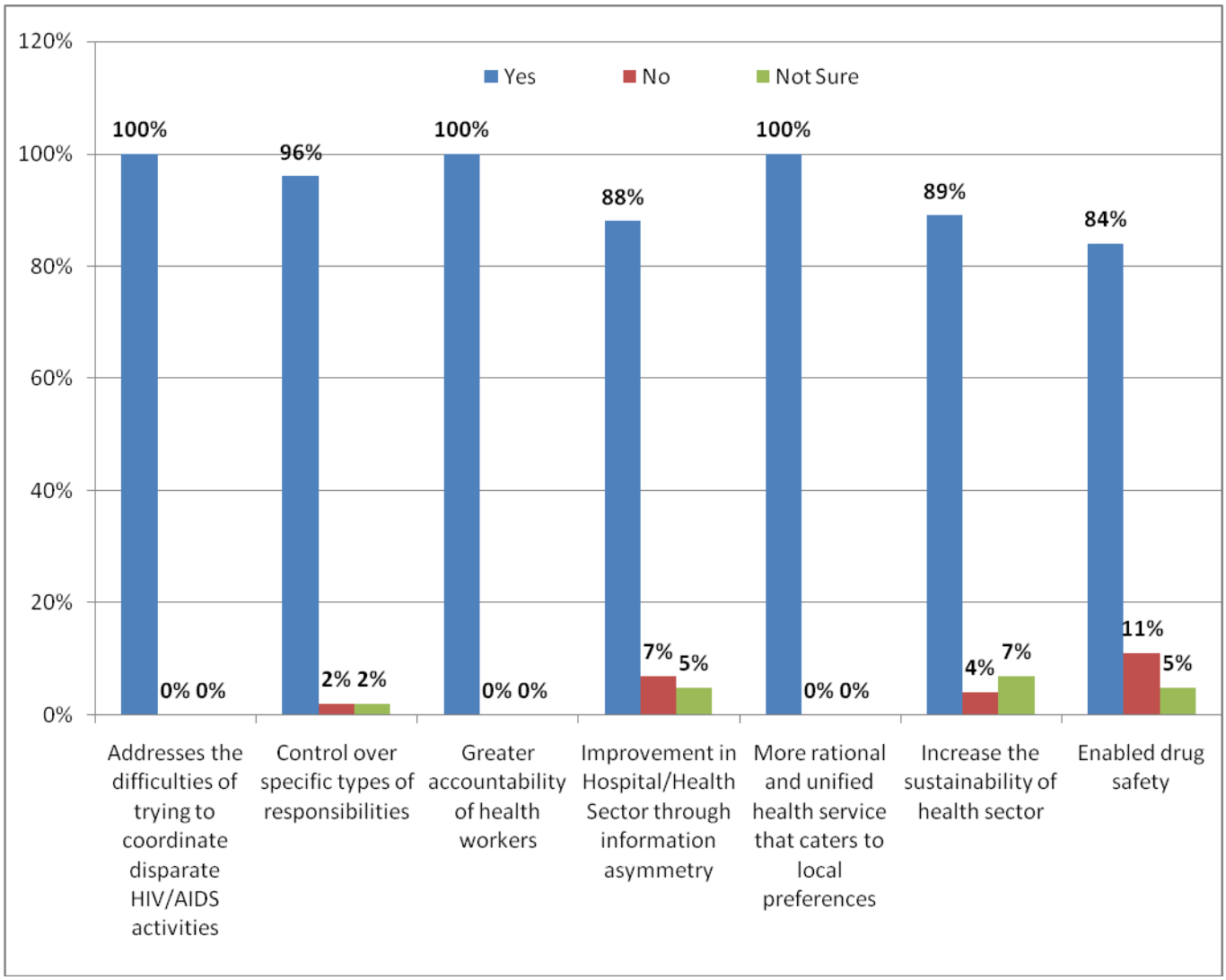
4.1.5Understand by decentralization

Asked on whether they understand decentralization, majority of the respondents noted that they understood decentralization as a process of redistributing or dispersing functions, powers, people or things away from a central location or authority. Some other respondents pointed out that a program of decentralization is needed to elicit a stronger multi-sectoral response to the epidemic such as HIV/AIDS and that it can accelerate the implementation of projects at all levels of society.

4.3 The role of deconcentration in combating HIV/AIDS

The first objective of the study was to examine the role of deconcentration in combating HIV/AIDS. The findings were presented, analysed and interpreted in percentages, and frequencies as indicated below.

Bar Chart 2showing the role of deconcentration in combating HIV/AIDS



Source: Primary data

From the findings of the study, it was also presented that the from the questionnaire findings that (100%) of the respondents agreed that deconcentration helps in addressing the difficulties

of trying to coordinate disparate HIV/AIDS activities. This was in line with the study findings, Arrowsmith and Sisson, (2002) pointed out that de-concentration also plays an important role of addressing the difficulties of trying to coordinate disparate HIV/AIDS activities for different regions from a central location. Decision-making to the local level can reduce the time required for making decisions, as well as increasing the likelihood that decisions will be made with the benefit of local knowledge of conditions.

The questionnaire findings also revealed that (92.0%) of the respondents agreed that de-concentration has control over specific types of responsibilities; administrative, political or fiscal in combating HIV/AIDS, (2.0%) of them disagreed, and (2.0%) of the respondents were not sure about this. This implied that De-concentration has become an increasingly important component of health sector reform efforts in developing countries through improving the administrative, political or fiscal responsibilities in combating HIV/AIDS These findings were in agreement with Akin, (2001) who argued that de-concentration is most commonly distinguished by the extent of control over specific types of responsibilities - administrative, political or fiscal in combating HIV/AIDS.

In relation to the findings of the study, it was indicated that the majority (100.0%) of the respondents agreed that deconcentration leads to greater accountability of health workers. In line with the interview findings one of the respondents said that;

> *Deconcentration can lead to greater accountability of health workers, thereby increasing the quality of health*

services and the efficiency by which they are produced (Interview in Lukaya: 9th April 2016)

In regards to the findings of the study, it was showed that the majority (88.0%) of the respondents agreed that de-concentration has led to improvement in Hospital/Health Sector through information asymmetry, (7.0%) disagreed, (5.0%) of the respondents were not sure whether it has led to improvement in Hospital/Health Sector through information asymmetry. This showed that if local powerful groups (ie insurance companies and physicians) have significant investments in health care issues, they may use their influence to limit the intended objectives of de-concentration decentralization. Inline with the study findings, Arrowsmith and Sisson, (2002) argued that the Hospital/Health Sector has been improved as a result of de-concentration through information asymmetry. In this case, the local governments or agencies can pursue their own agenda if central MOH is not well informed about their activities.

In addition to the above, the study findings presented that the majority (100.0%) of the respondents agreed that deconcentration emphasizes a more rational and unified health service that caters to local preferences. From the study findings, it was also indicated that the majority (89.0%) of the respondents strongly agreed that de-concentration is believed to increase the sustainability of health sector, (4.0%) of them agreed, (7%) of the respondents were not sure. This was in agreement with one of the interviewed respondents who said

Deconcentration is also believed to increase the sustainability of health sector and most importantly HIV/AIDS activities through supervision and monitoring and

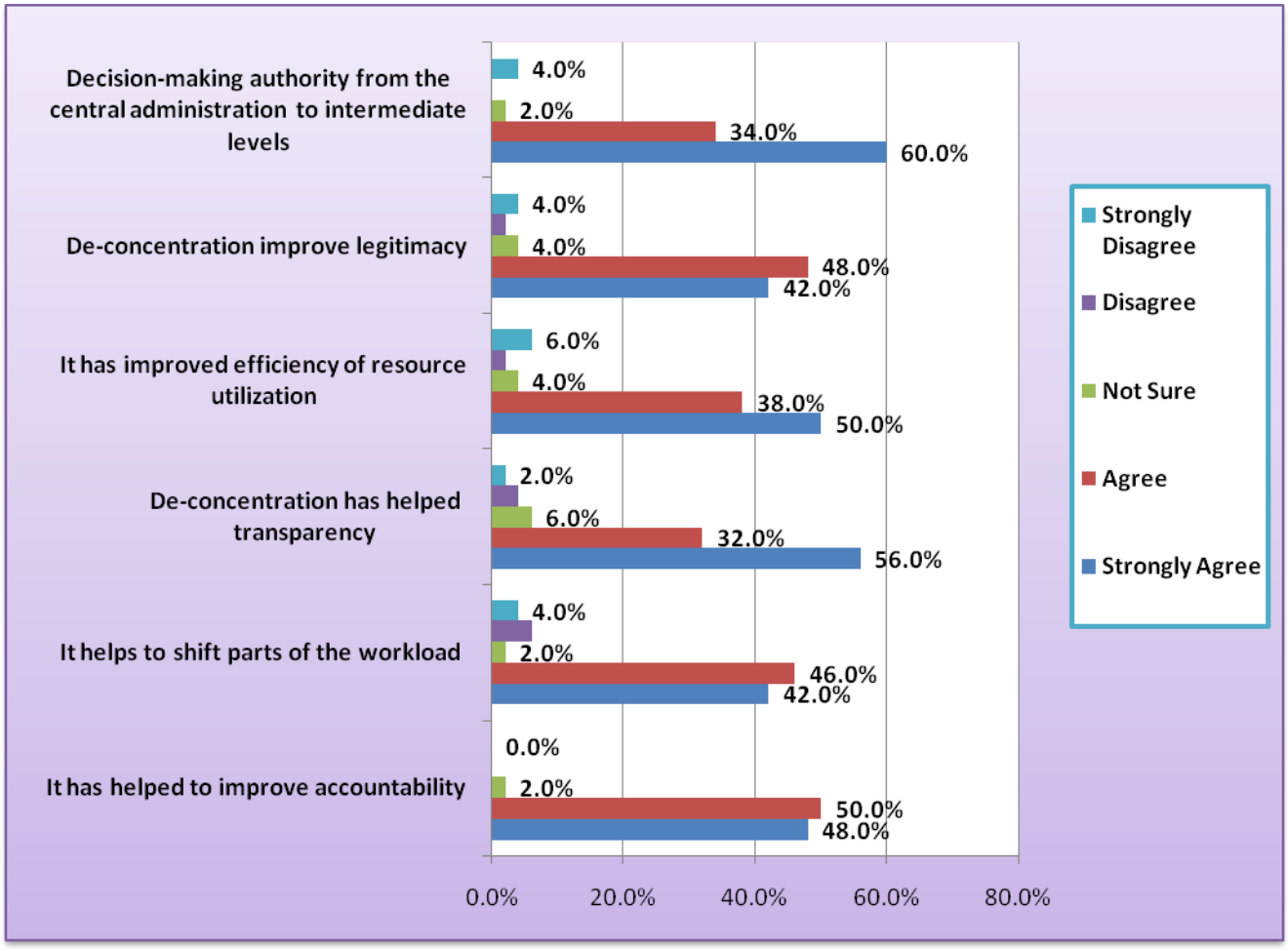
by increasing the involvement of local communities(Interview in Lukaya: 9th April 2016)

According to the findings of the study, it was indicated that the majority (84.0%) of the respondents strongly agreed that de-concentration has enabled drug safety, (11.0%) disagreed, (5.0%) of the respondents were not sure whether de-concentration has enabled drug safety. This signifies that De-concentration has also enabled drug safety. This also comes as allocative efficiency increases because local decision-makers have access to better information on local circumstances than central authorities, and they use this to tailor services and spending patterns to local needs and preferences.

4.4 The extent to which deconcentration has helped in combating HIV/AIDS

The second objective of the study was to examine the extent to which deconcentration has helped in combating HIV/AIDS. The findings were presented, analysed and interpreted in percentages, and frequencies as indicated below. They are categorized on how the respondents strongly agree, (SA), agree (A), neutral (N), disagree (D) and strongly disagree (SD), Standard Deviation (STD)

Bar Chart 3: showingThe extent to which deconcentration has helped in combating HIV/AIDS



Source: Primary data

From the study findings collected by the questionnaire, it was also indicated that the (50.0%) of the respondents agreed that de-concentration has helped to improve accountability, (48.0%) of them strongly agreed while (2.0%) of the respondents were not sure whether that was not necessary. The mean of 3.48 and standard deviation of 1.024 represented the majority (50.0%) who agreed. This implied that de-concentration can lead to greater accountability of health workers, thereby increasing the quality of health services and the efficiency by which they are produced. This was in agreement Bossert et al (2000) who

enumerated that, de-concentration increases health sector performance, increase service delivery effectiveness, improve efficiency of resource utilization and improve accountability,

In regards to the findings of the study, it was showed that the majority (46.0%) of the respondents agreed that deconcentration helps to shift parts of the workload, (42.0%) agreed, (2.0%) of the respondents were not sure about this while (6.0%) and (4.0%) disagreed and strongly disagreed. The mean of 3.34 and standard deviation of 1.135 represented the majority (46.0%) who agreed. This arrangement shifts parts of the workload and some decision-making authority from the central administration to intermediate levels and the periphery, and gives discretion to local managers to adapt central directives to local conditions (Foley, 2008).

According to the findings of the study, it was indicated that the majority (56.0%) of the respondents strongly agreed that De-concentration has helped transparency, (32.0%) agreed, (2.0%) of the respondents were not sure whether de-concentration has helped transparency while (6.0%) and (4.0%) disagreed and strongly disagreed. The mean of 3.68 and standard deviation of 0.983 represented the majority (56.0%) who strongly agreed.in line with the study findings, one of the interviewed respondents said that

> We have been able to achieve transparency and legitimacy as well as increasing equity of services by enabling marginalized and poor groups to access health care*(Interview in Lukaya: 9th April 2016)*.

In relation to the findings of the study, it was showed that (50.0%) of the respondents strongly agreed that it has improved efficiency of resource utilization, (38.0%) agreed, (4.0%) of the respondents were not sure while (2.0%) and (6.0%) disagreed

and strongly disagreed. The mean of 3.52 and standard deviation of 0.759 represented the majority (50.0%) who strongly agreed. As noted by Mills and Vaughan (2010) Deconcentration, has helped to improve accountability, helps to shift parts of the workload, helped transparency and has improved efficiency of resource utilization and legitimacy

In addition to the above, it was indicated that (48.0%) of the respondents agreed that de-concentration improve legitimacy, (42.0%) agreed, (4.0%) of the respondents were not sure about this while (2.0%) and (4.0%) disagreed and strongly disagreed. The mean of 3.18 and standard deviation of 0.854 represented the majority (48.0%) who strongly agreed. In line with the study findings, one of the respondents said that

> De-concentration increases health sector performance, increase service delivery effectiveness, improve efficiency of resource utilization, through Proper information dissemination and sharing, improve accountability, transparency and legitimacy as well as increasing equity of services by enabling marginalized and poor groups to access health care (*Interview in Lukaya: 10th April 2016)*.

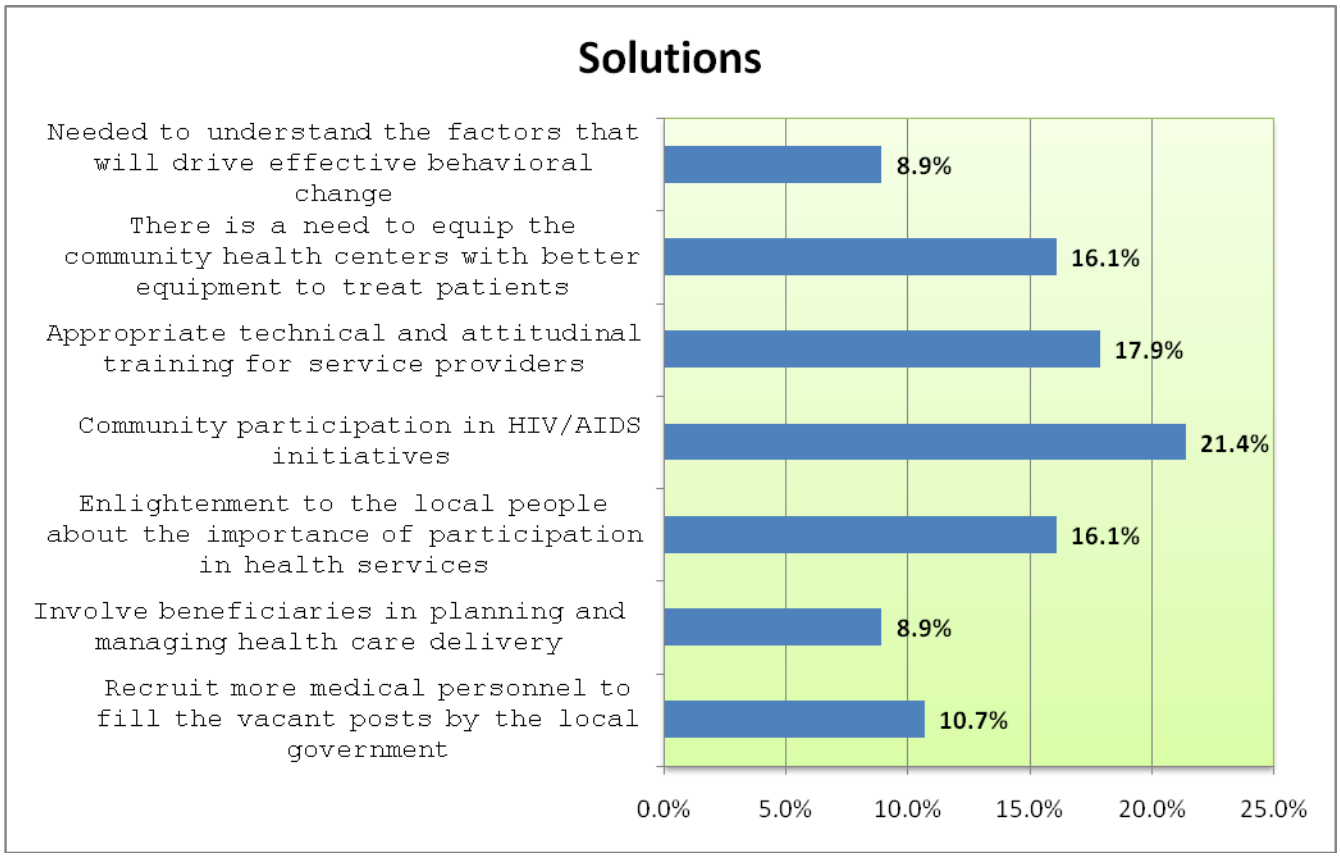
More to the above, it was also presented that the (60.0%) of the respondents strongly agreed that De-concentration helps improve some decision-making authority from the central administration to intermediate levels, (34.0%) agreed, (4.0%) strongly disagreed while the (2.0%) of the respondents were not sure whether de-concentration of the health care indirectly has increased access to medicines. The mean of 4.09 and standard deviation of 1.204 represented the majority (60.0%) who strongly agreed. This was in agreement with Blumenthal &Hsaio, (2005) who agreed that De-concentration of the health care also indirectly

increases access to medicines because it often coincides with the existence of community health insurance through risk pools.

4.5 Solutions in improving the role of deconcentration in combating HIV/AIDS

The third objective of the study was to examine the solutions in improving the role of deconcentration in combating HIV/AIDS. The findings were presented, analysed and interpreted in percentages, and frequencies as indicated below. Varies responses were gotten and indicated in the table below. They are categorized on how the respondents strongly agree, (SA), agree (A), neutral (N), disagree (D) and strongly disagree (SD), Standard Deviation (STD)

Bar Chart 4 showing the solutions in improving the role of deconcentration in combating HIV/AIDS



Source: Primary data

The findings collected from the questionnaires indicates that the most solutionn improving the role of deconcentration in combating HIV/AIDS was that there is a need to recruit more medical personnel to fill the Solutions as pointed out by (10.7%) of the respondents. In line with the study findings, one if the interviewed respondents argued that

> There were many unattended patients in major Health facilities so there was a need to purchase equipment and recruit more medical personnel to fill the vacant posts by the local government to boost access to the services especially for communities in rural areas (Interview in Lukaya On 10th April 2016)

In was also revealed that (8.9%) of the respondents argued that the Health care providers have to be educated on the importance of involving beneficiaries in planning and managing health care delivery in combating HIV/AIDS. It was also noted by (16.1%) that there is need to have enlightenment to the local people about the importance of participation in health services. This signified that it is important to have enlightenment to the local people about the importance of participation in health services like immunization and the benefits of decentralization and de-concentration of health services

The respondents (21.4%) also agreed that the community participation in HIV/AIDS initiatives in the whole rural community should be made official and that there is need to have appropriate technical and attitudinal training for service providers as noted by (17.9%).In line with the study findings, Malone, and Thomas, (2009) argued that there is need to have appropriate technical and attitudinal training for service providers; and opportunities for improving the quality of life - emotional, sexual, and social - of persons infected with HIV and subjected to life-long anti-retroviral treatment.

The respondents (16.1%) also pointed out that there is a need to equip the community health centres with better equipment to treat patients as compared to (8.9%) of respondents who needed to understand the factors that will drive effective behavioural change. One of the interviewed respondents said that

> Most times there is always limited health facility equipment, doctors and nurses in health centres that are need to effectively combat HIV/AIDS. So there is a need to equip the community health centres with both staff and equipment to treat patients through health services (Interview in Lukaya On 10th April 2016)

IN line with the study findings Malone, and Thomas, (2009), argued that there were many unattended patients in major Health facilities so there was a need to purchase equipment and recruit more medical personnel to fill the vacant posts by the local government to boost access to the services especially for communities in rural areas.

CHAPTER FIVE

SUMMARY, CONCLUSION & RECOMMENDATIONS

5.1 Introduction

The purpose of the study was to examine the role of deconcetration decentralization in combating HIV/AIDS in Kalungu district. This chapter presents the summary of the study, conclusions and recommendations of the findings. They are presented objective by objective.

5.2 Summary of the Study

5.2.1 The role of deconcentration in combating HIV/AIDS

The findings also showed that (100.0%) of respondents generally agreed that It helps in addressing the difficulties of trying to coordinate disparate HIV/AIDS activities. It was also revealed that (96%) of the respondents had control over specific types of responsibilities; administrative, political or fiscal in combating HIV/AIDS. It was also shown that deconcentration leads to greater accountability of health workers, improvement in Hospital/Health Sector through information asymmetry and also that it emphasizes a more rational and unified health service that caters to local preferences

5.2.2 The extent to which deconcentration has helped in combating HIV/AIDS

As revealed from the findings, majority of the respondents (98.0%) generally agreed that deconcentration, it has helped to improve accountability, helps to shift parts of the workload, helped transparency and has improved efficiency of resource utilization and legitimacy. The study findings also revealed that de-concentration helps improve some decision-making

authority from the central administration to intermediate levels.

5.2.3 Solutions in improving the role of deconcentration in combating HIV/AIDS

The study showed that most of the respondents agreed that there is a need to recruit more medical personnel to fill the vacant posts by the local government and also that Health care providers have to be educated on the importance of involving beneficiaries in planning and managing health care delivery in combating HIV/AIDS. It was also pointed out by the respondents that there is need to have enlightenment to the local people about the importance of participation in health services; also have appropriate technical and attitudinal training for service providers. There is also a need to equip the community health centers with better equipment to treat patients

5.4 Conclusions

Conclusively, deconcentration helps in addressing the difficulties of trying to coordinate disparate HIV/AIDS activities; leads to greater accountability of health workers, improvement in Hospital/Health Sector through information asymmetry and also that it emphasizes a more rational and unified health service that caters to local preferences. Further, Deconcentration, it has helped to improve accountability, helps to shift parts of the workload, helped transparency and has improved efficiency of resource utilization and legitimacy. Improving the role of deconcentration in combating HIV/AIDS can be done through recruiting more medical personnel to fill the vacant posts by the local government and also that Health care providers have to be educated on the

importance of involving beneficiaries in planning and managing health care delivery in combating HIV/AIDS.

5.5 Recommendations

It is recommended that there is need to have enlightenment to the local people about the importance of participation in health services

It was also recommended that they should be appropriate technical and attitudinal training for service providers.

There is also a need to equip the community health centers with better equipment to treat patients

5.6 Suggestions for Further Research

Following from this study, there are several possible avenues for future research

- The role of deconcentration on sustainability of HIV/AIDS projects
- The impact of community participation in combating HIV/AIDS.

5.7 conclusions

This chapter has showed the summaries conclusions and recommendations from the study revealing the role of deconcentration decentralization in combating HIV/AIDS in Kalungu district

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APPENDIX 1: QUESTIONNAIRES

Dear respondent,

I am called NAIKAZI **SUSAN** , a student of Uganda Martyrs University. I am carrying out a research study on the topic of **"Examining the role of deconcentration decentralization in combating HIV/AIDS in Kalungu district** A case study of **Lukaya Town Council".** This questionnaire is therefore intended to seek information on the above subject matter. The information is purely for academic purposes and all the answers will be handled with utmost confidentiality. I therefore humbly request that you complete this questionnaire correctly in the spaces provided or options given (Please, tick the appropriate answers where options are given).

Section A: Background Information

2. `Sex

a) Male ☐ b) Female ☐

1. Age Group

a) Below 20 years b) 20 – 30 years ☐ c) 31-40 years ☐

d) 41-50 years

g) Above 50 years ☐

3. Education Level

a) Certificate ☐ b) Diploma ☐

c) Degree

c) Others (Specify)…….

4. Marital Status

a) Single ☐ b) Married ☐ c) Divorced ☐

d) Separated ☐

5. How do you understand by decentralization?

……

……

Section B: The role of deconcentration in combating HIV/AIDS

5. To what extent do you agree with the following statements with regards to the role of deconcentration in combating HIV/AIDS?

	The role of deconcentration in combating HIV/AIDS	**YES**	**NO**	**NOT SURE**
a	It helps in addressing the difficulties of trying to coordinate disparate HIV/AIDS activities			
b	It has control over specific types of responsibilities - administrative, political or fiscal in combating HIV/AIDS			
c	It leads to greater accountability of health workers			
d	De-concentration has led to improvement in Hospital/Health Sector through information asymmetry			
e	It emphasizes a more rational and unified health service that caters to local preferences			
f	De-concentration is also believed to increase the sustainability of health sector			
g	De-concentration has also enabled drug safety			

SECTION C: The extent to which deconcentration has helped in combating HIV/AIDS

6. To what extent do you agree with the following statements with regards to the extent to which deconcentration has helped in combating HIV/AIDS

	The extent to which deconcentration has helped in combating HIV/AIDS	**5**	**4**	**3**	**2**	**1**
a	It has helped to improve accountability					
b	It helps to shift parts of the workload					
c	De-concentration has helped transparency					
d	It has improved efficiency of resource utilization					
e	De-concentration improve legitimacy					
f	De-concentration helps improve some decision-making authority from the central administration to intermediate levels					

SECTION D: The solutions in improving the role of deconcentration in combating HIV/AIDS

7. What solutions you give to improve the role of deconcentration in combating HIV/AIDS

	Solutions	SA	A	NS	D	SD
a						
b						
c						
d						
e						
f						
g						

Thank you for your time

APPENDIX II: INTERVIEW GUIDE

Dear Respondent,

I am called **SUSAN NAIKAZI,** a student of Uganda Martyrs University. I am carrying out a research study on the topic of **"Examining the role of deconcentration decentralization in combating HIV/AIDS in Kalungu district** using a case study of **Lukaya Town Council".** You have been selected to share with us your experience and make this study successful. The Interview. I am conducting is basically aimed at obtaining qualitative information to compliment the quantitative information which I am also collecting. Information given will be treated with utmost confidentiality.

1. What do you understand by the term decentralization?
2. What do you understand by the term deconcentralization?
3. How has deconcentration helped in combating HIV/AIDS?
4. What solutions would you give to improve the role of deconcertationiin combating HIV/AIDS?
5. What recommendations can you give with regards to this topic under investigation?

THANKS FOR YOUR TIME

Appendix III: Sample Size Determination

Note: "N" is population size and "S" is sample size.

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	246
25	24	130	97	320	175	*950*	*274*	4000	351
30	28	140	103	340	181	1000	278	4500	351
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	181	1200	291	6000	361
45	40	180	118	*400*	*196*	1300	297	7000	364
50	44	190	123	420	201	1400	302	8000	367
55	48	200	127	440	205	1500	306	9000	368
60	52	210	132	460	210	1600	310	10000	373
65	***56***	220	136	480	214	1700	313	15000	375
70	59	230	140	500	217	1800	317	20000	377
75	63	240	144	550	225	1900	320	30000	379
80	66	250	148	600	234	2000	322	40000	380
85	70	260	152	650	242	2200	327	50000	381
90	73	270	155	700	248	2400	331	75000	382
95	76	275	159	750	256	2600	335	100000	384

Source: Krejcie, R. V., & Morgan, D.W. (1970).