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Research Article

Strengthen HIV Service Delivery through Community-Led Monitoring: A Mixed-Methods Empirical Investigative Finding of Quality, Accessibility, and Human Rights in Addis Ababa, Ethiopia

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Abstract:
HIV/AIDS remains a major global public health challenge, with an estimated 40.8 million people living with HIV, 1.3 million new infections, and 630,000 annual deaths, indicating persistent gaps in testing and treatment (UNAIDS, 2024). In Ethiopia, over 603,000 people live with HIV, with Addis Ababa accounting for more than 110,000 cases and a prevalence of 3.42%, significantly higher than the national average (EPHI, 2023). Existing health monitoring systems such as HMIS largely focus on quantitative outputs and overlook client perspectives, satisfaction, and human rights concerns.
This study aimed to strengthen HIV service delivery through a community-led monitoring approach in selected ART and key population clinics in Addis Ababa. A descriptive mixed-method design was employed, including a survey of 462 clients analyzed using SPSS, alongside 12 key informant interviews and 8 focus group discussions for qualitative insights.
Findings revealed high levels of service accessibility (97.2%) and client satisfaction (98.4%). While 86% of clients reported consistent ART use, 14% experienced adherence challenges due to psychosocial factors. Notably, 53.7% of clients incurred costs for non-exempted services, particularly laboratory tests and opportunistic infection treatments. Human rights indicators were largely positive, with most clients reporting respectful care and minimal stigma, privacy violations, and waiting times. However, small proportions reported stigma (3.3%), privacy issues (~1%), and delays (2%), indicating areas needing improvement.
The study concludes that HIV services in Addis Ababa are generally accessible and client-centered, but systemic gaps—particularly service costs and minor human rights violations—remain barriers. Strengthening community-led monitoring is essential to promote equitable, stigma-free, and high-quality HIV care.

Keywords: *Community-Led Monitoring (CLM), HIV/AIDS, Addis Ababa, Key Populations, Service Delivery, Human Rights*

1. Introduction

HIV/AIDS is one a global public health critical issue of concern that has affected significant number of people, and resulted death for millions of individuals in the world. According to UNAIDS (2024), HIV/AIDS fact sheet documented and publicized that an average estimated 40.8 million people were live with HIV in globally in the year 2024. It also indicated that globally an estimated 44.1 million people were died due to HIV/AIDS starting from start of the epidemics.Furthermore, the report indicated that a world still have huge number of an average new infections estimated to reach on an average of 1.3 million people, and an average AIDS related death of individuals reached 630,000. In addition, a fact sheet has indicated that only an estimated average 31.6 million people were accessed ant-retrieval therapy by year 2024. This implied that the other significant number of HIV infected persons were have unknown HIV status, and/ or known were out of HIV treatments.

In Ethiopia the first HIV positive persons were known in 1984 in Addis Ababa and the first clinical AIDS cases were digonised in 1986 (Tully & Wood, 2010). Since then it have brought significant and disproportionate impacts over the life of the communities in a city. Currently, the epidemiological estimate has indicated that to the years (2022- 2023) a Ethiopia has 603,537 persons living with HIV and Addis Ababa constitutes an above estimated number of 110,000 PLHIVs (EPHI , 2023).

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Despite of this the HIV burden is not proportional in a country while urban areas have the highest burden holder than rural areas which have the lowest relative burden. Addis Ababa is one of the largest urban area in Ethiopia and it have the second highest HIV prevalence rate which is 3.4% next to Gambella region reached 4.8%. This prevalence rate is much higher than even the national average prevalence rate which is 0.9 (EPHI, 2023).

According to Ethiopia HIV/AIDS National Strategic Plan 2023–2027, (2023) the HIV epidemic in Ethiopia have its own demographics pattern in a country while key population groups such as female sex workers shows the highest prevalence rate 23% seconded by injecting drug users 6%. In addition in terms of gender women faced doubled effect of HIV prevalence which is nearly 1.2% , than men prevalence rate is 0.6 %. In terms of urban to rural proportion the urban women is three times more than infected than rural women which shown unique and context specific prevention and treatments intervention challenges.

According to the Second Stigma Index Survey of 2021 30% of PLHIV and key populations in Ethiopia face stigma and discrimination in healthcare settings. The study reviled that about 20% of PLHIV reported HIV testing without proper informed consent and 7% of PLHIV reported HIV status disclosure without consent in the healthcare settings. Furthermore, the study by ministry of Health (2024) rapid assessment findings on stigma, informed consent and disclosure in healthcare settings,in Ethiopia has indicated existences of challenges such as stigma, unconesneted care, and disclosure in healthcare settings and limited mechanisms to monitor availability, accessibility and quality of HIV services, stigma and human right violations in healthcare settings.

According to WHO (2022) guideline for HIV services key and priority population groups have limited access to quality HIV services by various hindering factors. The guideline mentioned those factors such as shortage in drug supply and stock-outs, poor patient treatments, and communication by the health care providers, lack of empirical data from clients views, poor actions on demand creations, insufficient clients friendly health facilities, and poor legal actions for human right violation in the health care settings. As resultant effect of those hindering factors key and priority population groups were vulnerable to new infections, poor ART treatment adherence, higher dropout and high number of lost from follow-up and treatments and ultimately unable to bring viral suppression in ART treatments. These challenges of treatments adherence, are further aggravated by inaccessibility to proper education, lack of sufficient legal and social reforms (WHO, 2022).

The participation of key and priority population groups in health care services provision monitoring were limited due to structural exclusions. The Ethiopian Ministry of health has applied a conventional health care monitoring system typically called Health Management Information System (HMIS) for long time. This system were largely captured quantitative outputs and clinical results only. It did not sufficiently, and adequately addressed and captured health care provider attitudes, largely ignores to incorporate, and document level of client satisfaction and dissatisfaction and human right violations incidences. The health management information system as a traditional system it has excluded clients issues of concerns and overlooked opportunities to solve sensitive clients issues systematically. It also ignores key and priority population engagements to the identification of unaddressed health care problems and omit their contributions for alternative solutions provision for recurrent clinical services problems.

These gap highlights the need for implementation of community led monitoring to strengthen HIV services delivery among key and priority population groups. This has highlighted the need for implementing a community participatory approach which incorporated the views and perspectives of clients as part of HIV services delivery tracking, accountability and transparency. Thus, community led monitoring approach has adopted from experiences of other developed countries implementation practices to monitor HIV services in the health care setting which aimed to realized availability, accessibility, quality and satisfaction on HIV services delivery by empowering and promoting the communities through use of empirical findings for their active engagement and advocacy.

Therefore, this study is part of the pilot program for the implementation of community led monitoring which was conducted to strengthen HIV services delivery through community led monitoring implementation in Addis Ababa. The principal aim of the study were to empower the key and priority population groups through directly engaged them on evidences based services monitoring and practices for engagement, education and advocacy to solve the problems by tracking the HIV services provision progress.

2. General Objective

To strengthen HIV service delivery empirical evidences generated through community led monitoring approach in the selected five ART and key population clinics at Addis Ababa, Ethiopia.

3. Specific Objectives

1. To assess the availability, and accessibility of HIV services within healthcare settings using community led monitoring and generate empirical evidences used for community engagement, and education in the selected five health facilitate at ART and KP clinics.

2. To assess the quality of HIV services in the selected five health facilities by generated empirical evidences through community led monitoring approach used for direct community engagement, education and advocacy in ART and KP clinics services .

3. To identify human right violation incidences by generate empirical evidences within healthcare settings through community led monitoring approach and use evidences for community engagement, education and advocacy in the selected five health facilities.

4. Contribution of the study

The study has contributed to both programmatic practice and academic knowledge. As part of programmatic purposes initially, it has provided empirical evidence on HIV services delivery through community led monitoring in Addis Ababab Ethiopia. The findings were utilized at the health facility level, sub-city and city level interventions by engagement of communities, for education and advocacy. It has contributed to opened eyes to addressed the major research gap regarding community-driven monitoring within healthcare facilities and strangeness its services delivery practices. It has highlights the experiences of people living with HIV and female sex workers, on ensuring voices of marginalized populations by ensuring the participation of the community by directly engaged them on tracking of HIV services deliver to them and in turn helps to inform service improvement efforts. In addition the findings provide operational guidance for policymakers and program managers seeking to institutionalize community led monitoring framework (CLM) within local facility level monitoring frameworks. Finally, the findings had strengthen community participation in monitoring promotes accountability, in improving the service quality, and advances equitable, client-centered HIV service delivery, thereby supporting facility level and regional and national HIV control goals.

5. Research Methods and Methodology

Research Design

The study has applied descriptive research design. This design is essential when the study aim is to describe a phenomena, and to systematically document existing and ongoing conditions (Creswell, 2018). The design is highly suitable since it enables an assessment of HIV services performances , identification of gaps, for utilization and documentation of lived clients experiences as it have happened in regular HIV services provision of the health care provider institutions. The design has selected to carryout an assessments of HIV services delivery performances with no manipulation of its variables and it helped to get clear descriptions of ongoing conditions on availability, accessibility, and quality of HIV services. Furthermore, application of this study deign helps to understand HIV services delivery practices in real world context and it has helped for HIV services improvements , modification and change in policies of health care services through provision of empirical description of phenomena.

Research Method

The study has applied mixed research method approach to assess the availability , accessibility, quality and human right protection services in the selected five health facilities ART and KP clinics. The application of a mixed method approach has helped the study to capture quantitative numerical data or descriptive statistical findings by employed measurable HIV services indicators and supplemented by qualitative insights generated from contextual understanding of clients and services provider experiences. In the study client exit interviews were conducted to collect measurable quantitative data by applied measurable indicators such as accessibility and availability of HIV services, waiting and traveling time for services, and services uptakes.

The qualitative data were generated from 12 key informant interviews and 8 focus group discussions aimed to explore client experiences, HIV service provision obstacles affecting the accessibility and quality standard of HIV services rendered. In terms of the data presentation, analysis and discussion quantitative data were analyzed by applied standard SPSS-2022 software and descriptive statistics such as mean and standard deviation were taken to know patterns and services gaps. On the other hand the qualitative data analyse were made thematically by categorizing related concepts and arranged each indicators based on the research specific objectives(Johnson & Onwuegbuzie, 2004).

The integration of qualitative and quantitative outputs were undertaken at the stage of discussion by interpretation of results of each methods to strengthen the study findings by applied data triangulation system which aimed to cross validation of each results collected from two distinct methods. According to World Health Organization WHO, (2021), application of a mixed method approach is highly advised in public health services researches like HIV services delivered to key and priority population groups because it encourages strong evidence based decision making and practices and increased reliability and validity of the findings by mixing the measurable statistical mean and standard deviation values with lived experiences of clients. The application of mixed method approach in practices of community led monitoring context enabled to generate measurable data on monitoring of HIV services delivery by incorporating clients and providers views to find breadth and depths of information. The application of mixed methods study helped to improve well -informed practices, accountability and to facilitate meaningful engagement,

education, advocacy and to preparation of agreed upon action plans for points forwards.

Study Area

This study has conducted in Addis Ababa the capital city of Ethiopia. The city is the largest of all cities by its size and served as heart for political, economic and health services transaction for a country (CSA, 2013).

It is a city that have hosts large and divers population with rapped in and out migrations including key and priorirty population groups.

According to Federal HIV/AIDS Prevention and Control Office (FHAPCO, 2015) Addis Ababa have significant number of vulnerable communities were interacted in trade, politics, social and other based relations which make Addis Ababa the target for HIV epidemic prevalence. This huge vulnerability of the community placed the city as the major focus area for HIV prevention, care and treatment interventions.

Addis Ababa has second HIV prevalence rate of 3.42 of a country and hosts more than 100,000.00 PLHIVs EPHI, & FMoH, (2023). The city have broad network of public and private health facilities provided HIV services including prevention, testing, and treating , including support and care programs for at risk and vulnerable groups. In the city though it has huge HIV services availability, there are gaps in relation with accessibility, and quality. In this study Addis Ababa city administration health bureau has selected as one of the implementer of community led monitoring approach adopted from other African countries. This study has conducted on five selected health facilities found in Addis Ababa city administration including Arada, Lideta, Yeka, and Kolfe Keranio.

These five selected health facilities were identified in Addis Ababa by their accommodation of huge number of HIV services users, and have facility based and community based HIV services delivery outlets . The study selected study sites includes Yekatit 12 Hospital medical college found in Arada sub-city, Abinet and Beleteshachew health centers were found in Lideta Sub-cities, Korea Zemachoch health facility has found Yeka woredas and Arada DIC center found in Arada sub-city.

Population of the Study

The study population includes focused on key population groups only female sex workers, served in KP clinics and 1 drop in centers, and priority population groups- persons living with HIV-served in ART clinics. The populations were drown from total number of individuals receiving ART services in ART clinics and total number of individuals drawn from KP and or Drop in center services users. The total population is 4,743 of this total number each facilities have distinct numbers. The Wr/o Beleteshachew Health Center has 923, Abint health center, 204, Arada drop-in center, 339, Yikatit 12 hospital 3,088, Korea Zemachoch Memorial Hospital, 189.

The selection of the facilities were done by applied purposive sampling techniques by considering the huge lived experiences on HIV services provision and accommodation of sufficient beneficiary available for the study purposes. The facilities have significant number of clients receiving HIV services care, treatment and support and care services. This study population has included both sex above the 15 years old. The female sex worker typically females using KP services and PLHIV from both female and male category. The inclusion of both key and priority population groups have an advantage to assess HIV services accessibility, availability, quality and lived clients experiences.

Sampel Size Detemination and Sampling Technique

Sample Size

In order to determine the sample size of the study Cochran statistical formula (1977) has applied. Since the population in each facilities have provided in various amounts and proportionate allocation of sample for each health facilities was povital (Cochran, 1977). Since the total study population is finite which is N= 4,743 the proportionate allocation on samples were made for each health facilities by using their relative number of PLHIV and FSW. According to this formula a 95% of confidences level, Z= 1.96, maximum variability p=0.5, and margin of error is 5% e=0.05

$n0=Z2 \cdot p(1-p)e2=(1.96)2 \cdot 0.5 \cdot 0.50.052 \approx 384 n0 = e2 Z2 \cdot p \cdot (1-p) = 0.052(1.96)2 \cdot 0.5 \cdot 0.5 \approx 384.$

Since the initial sample needs to be adjusted by applied finite population sampling the adjustment has made

$n = n_0 / [1 + (n_0 - 1) / N]$

$n = 384 / [1 + (383 / 4743)]$

$n \approx 355.3 = 355$

In addition, taken to consider unturned responses, incomplete data submissions, and withdrawals the increments were made in the sample size by 20% of 355 = 71. So, the final sample taken is 355+71= 426. The sample size were determined by proportionate allocation aimed to get representative coverage among the selected facilities considered their number of KP and ART services users constituted. In addition, the strong attentions were given to achieve sufficient statistical power for capturing trained of findings flow in HIV services accessibility, quality and client satisfactions. It has also assumed the sample as it were sufficient for inculcating variation in services utilization and to promote client lived experiences while keeping feasibility for data collection and management.

Facility-Level Proportionate Allocation

Table:1 facility level proportionate samples allocation

Facility Name	Reported Clients	Sample Size	Female	Male
Wr/o Balteshchew Health Center	923	83	58	25
Abinet Health Center	204	18	14	4
Arada DIC	339	30	30	0
Yikatit 12 Hospital Medical College	3,088	277	171	106
Korea Veterans Memorial Health Center	189	18	11	7
Total	4,743	**426**	284	142

Sampling Technique

This study have applied a proportionate stratified sampling to assign study samples. In the study each and every health facilities and community services sites were represented a stratum. The participant of the study identified based on proportionate allocation of the number of PLHIVs served at each facilities. In the study the application of stratified proportionate sampling technique has ensured the data representations, gender balances, and eliminate the selection bias by taking feasibility as its centred point of study sample selections in each health facilities. The application of systems random sampling approach were implemented at every K th beneficiary selection and an exit interviews were undertaken from ART and KP clinics. The daily attendance list has taken as checklist to manage K th on the course of undertaken interview sessions and till the total allocated facility sample has completed.

Sample Inclusion and Exclusion Criteria

Inclusion criteria

The study has applied inclusion criteria to screen eligible study sample population that were all confirmed HIV positives whom were on ART treatments, and adherence supports. These includes clients aged 15 and above and received HIV services in Key Population (Female Sex worker) clinics and priority population (Persons Living with HIV) clinics. The clients who were received HIV services at the selected health facilities during the data collection period, and expressed their voluntary engagement to interred into agreed upon informed consent. In addition client would not have difficulty of speaking and understanding the Amharic langue.

Exclusion Criteria

The exclusion criteria applied to exclude unfit and inappropriate study participants were services users who can not attained the interview due to injuries and on acute and chronic clinical illness. It also excluded services users who were not appointed for HIV services at the date and time of the interviews. In the study clients who were excluded by age that clients who were under the age of 15 were not participated and clients whom were not volunteered to engage in the study and clients refused to give consent and assents have excluded in section of the study population. It has also excluded clients who can not communicate and understand the local Amharic language used for the interview.

Data collection Instruments

The study has applied mixed research approach and the tools used to collect the data were drawn from both qualitative, and quantitative methods. The quantitative data has collected from sample survey of structured quantitative questionnaires in the courses of an exit interview. Whereas, the qualitative data on the other had were gathered from focus group discussions among the selected beneficiaries and key informant interviews of KP and ART services providers. The sample survey of 462 participants has enabled to generate the participants demographic features, services utilization conditions on quantifiable availability, accessibility, quality and satisfaction on HIV services. On the other had qualitative insights collected from the focus group discussion and key informant interviews has enabled to explored challenges, to assess enabling conditions on the words and perceptions of HIV services users.

Ethical Considération

In the study prior approval from regional government has taken to conduct the study. This study is considered as a pilot study by its natures on the enforcement of community led monitoring approach through using empirical findings on the HIV services provisions. Initially, the Addis Ababa city administration health bureau have made formal permission to conduct the study and at the end they were validated the study findings on the regional study finding dissemination workshop. The bureau has been facilitated conditions on identification of eligible health facilities to conduct a study in it and tom identify community based drop in centers such as key and priority population clinics.

The researcher has taken informed consents with each study participants and voluntary engagement were ensured. As part of its prior data collection process the data collectors were trained on basics of confidentiality, ethical considerations, and on culturally relevant communication approach to carryout interviews, to document and reporting of the data gathered at filed. In addition the data were anonymize to keep confidentiality and integrity. Regarding the language used for the data collection all questionnaires were interpreted into the local Amharic language to get the full understanding of questions by the interviewer, and participants. Lastly, all the collected data were securely stored, transferred and transcribed.

6. Results and discussion

The study results has presented in three major themes driven from its objectives and supportive sub-themes for elaborated presentation. The first result of the study is about the availability, and accessibility of HIV services, the second is about quality and satisfactions and the third theme is all about incidences of hum rights violation in health care settings. In each three major sub-themes the community led monitoring indicators data were generated and results were presented. These included the sample survey the total of 462 samples taken on HIV service users who were participated in responding a structured questionnaires. In addition, the qualitative insights were collected from 8 focus group discussion participants and 12 key informant interviews.

I. The Availability, and Accessibility of HIV services

1. Physical and Service Accessibility

In this part of the study has assessed and discussed the physical, and services accessibility in relation with HIV services that were easily accessible and utilizable by the services users and the qualitative and quantitative study findings have presented blow. In addition the assessment finding on accessibility and sufficiency of HIV services rendered to them in their recent facility visit has presented.

Table 2: Summary on Essay and sufficent Access to HIV services

		Frequency	Percent
Number of clients reported an easy access to HIV services in the health facility without any problems/challenges.	yes	449	97.2%
	no	13	2.8%
	Total	462	100%
Number of clients responded as they have got HIV services sufficiently in their recent facility visit.	Yes	446	96.7%
	No	14	3.0%
	Total	460	99.7%

(CLM Facility Survey, April – June 2024 Addis Ababa)

The survey of 462 participants have indicated that the majority of health care services users 449(97.2%) have reported availability and physical accessibility of HIV services and 446 (96. 7%) of the respondents agreed that as they have got HIV services sufficiently in their recent facility visit in the five selected health facilities. This survey results has implied that the clients have got HIV services without problem or challenges in the five health facilities and assured as there is no distance or physical barrier to get HIV services in the study area.This finding strongly aligned with the findings from focus group discussion participants, they were highlighted that services users lived experiences on travel from home to health facilities, and possibility of getting HIV services sought. This study finding aligned with the finding by Penchansky and Thomas, (1981),who was emphasized on the fit between the client and the health services systems and on the meaningful contributions of established and functional infrastructural adequacy of service provider organizations to provide optimal services utilization.

However, small number of services users such as 14(3%) of the respondents responded as they did not got the required HIV services sufficiently in their recent facility visits and (2.8%) identified physical accessibility challenges which highlight the presences of structural obstacles affected nearly 3% of HIV services users in the

selected five health facilities. This challenges has indicated that though it is not covered significant number and even rear cases of unavailability and inaccessibility of HIV services have the possibility to worsen the health outcome of the patients, if it is not addressed timely. The focus group discussion participants in this regard has reviled that clients who were traveled long distances were not by lack or absences of health facilities in their nearby communities and villages rather it is due to fear of stigma and discrimination and confidentiality breaches.

One of the focus group discussion participated noted that *" as he come from outside of Addis Ababa from Oromia region of Ethiopia searching better ART services in this respective health facility. He has reported that he had 10 years of ART services in his current facility and expressed his interest to get sustained treatment in it until HIV related stigma and discrimination abolished in his communities and villages*".

In the same tone key informants emphasized that those small number of clients who were traveled long distances to access HIV services which is not in the absences of the ART care providers in the their nearby community and region but, due to search of better treatments, inquiry of high quality HIV services, and to refrain themselves from possible incidences of stigma and discrimination the health care setting. In general the qualitative results has supported the survey finding by explained why client travelled long distance to get HIV services or conditions of physical and services inaccessibility as it has happened due to the prevalent stigma and discrimination in their immediate social circle and preference to get quality health services .

2. Availability of ART Services, and Adherence Managements supports

In this part of the study the ART services availability and adherence management practices assessment findings were presented with reference to consistent and uninterrupted ART treatments.

Table 3: Summary on Availability of ART services and adherence managements

		Frequency	Perecent
Number of clients reported consistent ART services utilization and have good adherence.	yes	397	86%
	no	65	14%
	Total	462	100%
Reasons for inconsistent ART services.			
Fear of drug dependency		19	4.2%
Fear of stigma and discrimination		9	2%
Issue on confidentiality breaches		2	0.5%
Contextual and personal factors		26	5.6%
Total		56	11%

(CLM Facility Survey, April – June 2024 Addis Ababa

The table above clearly illustrated that concerning on ART services availability and adherence management practices. The study shows that significant clients 397(86%) confirmed the availability of ART services in their respective health facilities and have consistent ART utilization management. This finding has suggested that the existences of effective ART services delivery and strong adherence management practices in their respective health facilities. However, small number of clients 65(14%) reported ART adherence management interruptions by various reasons 4.2% due to fear of drug dependency, 2% due to incidences of stigma and discrimination in the health care settings, 0.5% due to concerns on privacy and confidentiality breaches, and 5.6% of the clients by their own personal reasons.

This finding has strongly aligned with the previous empirical works of Mills (2006), who was found that ART services utilization and adherence management were influenced by psycho-social and contextual factors. In addition the findings from focus group discussion have strengthened this result which lighted those challenges of ART availability and adherence management caused from personal and social pressures that now and then minimize adherence with physically accessible HIV services. This indicated that the qualitative insights has contextualized the statistical survey reported data by indicated that ART adherence management were largely affected by widespread psycho-social and contextual factors which could inform an intervention on creation of enabling environments for ART adherence managements.

Availability of Essential Drugs First, Second and Third Line ART Drug Treatment

In this theme the study has answered the availability of all essential drugs depending on the clinical conditions and its subsequent follow-up services and to show the

duration of follow-up attendances versus clients clinical conditions.

Table 4: Summary for clients who have taken ART drug from their respective health center.

		Frequency	Percent
Number of clients responded for how long they have taken ART drug a one facility visit.	For 1 month	111	24.1%
	for 3 months	250	54.1%
	for 6 months	76	16.4%
	For 6 and above months	23	5.0%
	Total	460	100%

(CLM Facility Survey, April – June 2024)

Table-4 shows results of the ART drug dispensation and indicated that out of 462 clients 111(24.1%) take ART drug for one month which are services users at close follow-ups and the majority 250(54.1%) taken for two months and 76(16.4%) takes for two and thee months consecutively. These suggested that the facilities have a very good stock management and strong client case alignments as per their current viral load and CD-4 counts and their cases of vulnerability conditions for opportunistic infections. Furthermore, 440(95.2%) acknowledged the provision of costs free HIV service strengthen equitable ART services acceptability. But still 22(4.4%) of clients were payed for opportunistic infection treatments, 231(50%) for laboratory services which were not exempted as charge free, and 5(1.1) for condoms in cases of unavailability and shortage in health facilities.

In similar fashion the significant number of focus group discussion participants agreed as they have got some part HIV services and laboratories freely such as ART drug, PEP and proflaxies, condom. They also disclosed that any opportunistic infection treatments , laboratories and others than ART and HIV cases as it have provided with personal costs. The key informants asserted that as there is no policy to exempt opportunistic infection treatment services and certain laboratory services for key and priority population groups. Thus, the qualitative findings contextualized statistical data of 258(55.5%) finding on request for fees to get health cares services among key and priority population groups has happened due policy distinctions on HIV service as exempted and not exempted services which could indicated the needs for an advocacy to exempt all services for needs of supports.

Availability of Costs free HIV services

In this part of the study finding has presented the finding in relation identification of HIV services rendered with costs exempted and services that needs fees from clients to be utilized in their resepctive health facilities.

Table 5: Summary of request for fees to HIV Services

		Frequency	Percent
Number of clients requested fee by services providers for HIV services in this health center recently.	yes	22	4.7%
	no	440	95.2%
	Total	462	100%%
Number of Respondents Responded payments for HIV Services types.	For opportunistic infection drug.	12	2.7%
	For Condom were no avail and referred to get it in private clinics.	5	1.1%
	For laboratories other than exempted services	231	50%
	Total	248	53.68%

(CLM Facility Survey, April – June 2024)

The table above clearly indicated that the majority of clients that are 440(95.2%) acknowledged the provision of costs free HIV service which strengthen equitable ART services acceptability. But still 22(4.4%) of clients were payed for opportunistic infection treatments, 231(50%) for laboratory services which were not exempted as charge free, and 5(1.1) for condoms in cases of unavailability and shortage in health facilities. In similar fashion the significant number of focus group discussion participants agreed as they have got some part HIV services and laboratories freely such as ART drug, PEP and proflaxies, condom but still they were not

exempted to get charge free HIV services for all clinical cases. They have consistently disclosed that any opportunistic infection treatments , laboratories and others than ART and HIV cases have provided with personal costs. In similar fa-shine the key informants asserted that as there is no policy to exempt opportunistic infection treatment services and exempt certain laboratory services for key and priority population groups. The key informants strongly noted that this cases were happened due policy distinctions on HIV service as exempted and not exempted HIV services being provided which could indicated the needs for an advocacy to exempt all services for needs of supports.

Availability of Sufficient Clinical Staffs

In this sub-theme the availability of sufficient clinical staffs has assessed and the respondents results have funded and presented in the table below.

Table 7. Summary of Responses on Sufficient Staffing in respective health facilities

		Frequency	Percent
Number of clients responded that their respective health facility always have sufficient staffs**.**	Yes	411	88.9%
	No	49	10.6%
	Total	460	99.5%

(CLM Facility Survey, April – June 2024)

The present study survey finding as table 7 clearly indicated that out of the total study participants 88.9% were agreed that their respective health facilities have an adequate health care provider clinical staffs. The focus group discussion participants consistently agreed that HIV services were rendered bu sufficient trained and qualified human resources and they did not reported clinical staffs insufficiency as their mean challenges in securing HIV services. In contrary, 49 (10.6%) reported that human resources were insufficiently employed, and they have reported that that their respective health facility did have incomplete human resources .This result has suggested that human resources recruitment and placements needs careful follow-ups to sustain ART services availability, accessibility and quality. respective health facilities have sufficient staffs employed and working for them. In addition the key informant acknowledged the insufficiency of human resources caused by higher turn overs but, the challenges is not interrupted HIV services rendered to them.

II. Quality of HIV Services, and Level of Satisfactions

1. Satisfaction on Health Information, and Explanation

In this theme it has presented findings on quality of HIV services and level of satisfactions in health information provision and explanations and satisfaction on HIV services in the recent visits.

Table 8: Summary of Clients Satisfaction on Health Information/ Explanation**.**

		Frequency	Percent
Number of Clients Responded their Satisfaction on Health Information/Explanation.	Yes	432	93.4%
	No	27	5.9%
	Total	459	99.4%
Number of clients who were satisfied by HIV services of the health facility in their recent visit.	Yes	455	98.4%
	No	6	1.4%
	Total	460	99.8%

(CLM Facility Survey, April – June 2024)

As the survey finding above clearly illustrated that the study have founded highest level of client satisfaction which is reported by 432(93.4%) of the study participants as they were satisfied with health information and explanations and 455(98.4%) reported their overall satisfaction by HIV service in their recent facility visits. These strong client satisfaction of findings have suggested that the health facilities have maximum achievements in beneficiary centered communication within HIV services delivery and associated with quality of HIV services rendered. The focus group discussion participants in this regards consistently agreed as they have got clear communication, respectful health information provision and interviews, and supportive interaction from health care providers in their respective health care provider facilities which could increased confidences and adherence to treatments and in tern implied the good quality of HIV services.

III. Human Right Violations in Health Care Settings

A) Professional Health Care Services and Respect

In this theme is has tried to assessed the professional manner and respect from health care provider to their respective clients in the study facilities.

Table 9: Summary on staffs are always friendly and professional.

		Frequency	Percent
Number of clients responded that staffs are always respectful to clients, friendly and professional.	yes	450	97.5%
	no	12	2.5%
	Total	462	100%

(CLM Facility Survey, April – June 2024)

As the table above clearly stated that the present study have founded significant findings which is 450 (97.5%), and assured as they have got professional and friendly treatments in their respective health facilities. This has indicated that the study facilities assigned services providers that have provided services in a manner that is expressed as friendly and professional and they provided respectful, and client centred health care services. According to WHO (2021), report respectful treatment has taken as core parts of quality health services and it has associated with enhanced trust, adherence to ART, and retention in cares. In addition, the previous study conducted in Ethiopia by Abate et al, (2021) has studied and documented the higher level of respectful treatments raged from 80% to 95% .

The highest percentage in the present study is highly associated with urban contexts, and reflects the better staffs capacities built and implementation of health care right based services delivery. While 12(2.5%) reported unprofessional and unfriendly HIV treatments in their respective health facilities. This has suggested the occurrences disrespects and inhuman treatment in the care setting that needs the serious attention of actors to give immediate responses. It shows that the disrespect, and poor provider attitude even in the few cases could reduce effective health accessing habits, quality and client satisfactions and it has adversely affected health care communications.

B) Stigma and Discrimination in Health care settings

In this part of the study the human right violations in relation to incidences of stigma and discrimination in health care setting has assessed and presented as follow.

Table 10: Summary of stigma, and discrimination

		Frequency	Percent
Number of clients responding experiences in incidence of stigma and other serious actions by health care providers in the past one year.	Yes	15	3.3%
	No	445	96.3%
	Total	460	99.5%

(CLM Facility Survey, April – June 2024)

The study finding has indicated that 445 (96.3%) have no experiences of stigma, and discrimination in the study health care provider facilities in their one year lived experiences. Whereas, 15 (3.3 %) reported experiencing stigmatizing and discriminatory incidences in their respective health care provider facilities. This finding has implied that even-though the majority did not report the stigma and discrimination incidences in their respective health facilities, the small portion of stigma and discrimination in the health care setting could affected services delivery and remaining concerning issue.

According to UNAIDS, (2022) stigma and discrimination in the health care setting is reported as a big challenge for to HIV services delivery practices. Similarly, the previous empirical studies has indicated and reported that stigma, and discrimination in the the health facilities in Sub-Saharan African have founded in between 5% to 20%(Nyblade et al., 2019). When we compare this study finding with the above study finding the present stigma study findings were relatively low, which indicated positive progress in stigma reduction efforts in Addis Ababa heath facilities.

C) Experiences of Privacy violations and Confidentiality breaches

In this theme the study has founded the extent of privacy violation and confidentiality breaches as the human right violation incidences in the respective health facilities.

Table 11. Summary of privacy violations and confidentiality breaches

		Frequency	Percent
Number of Clients Who Where Experienced Violation of Privacy In This Health Center In Your Recent Visit.	Yes	4	0.9%
	No	457	98.9%
	Total	460	99.8%

(CLM Facility Survey, April – June 2024)

The study have founded significant number of clients 457(98.9%) as they have no experiences of privacy violations and no confidentiality breaches. These suggested that the strong compliance to confidentiality and privacy protocols in respective health facilities. Despite of it smaller number of clients 4(1%) reported privacy violation in their health facilities. The previous empirical study in Ethiopia by Bayisa et al. (2022), have founded that 23% confidentiality breaches in the care provider facilities. If we compare this study finding with the present study finding it is much low and but it is still significantly affect the rights and dignity of clients. Because, from the views of human rights in health care setting even a single incidences of privacy violations and confidentiality breaches attributed as violation of fundamental human rights. It has negatively affected the HIV treatments by minimized interruption to treatments. Thus, the continues adoption and implementation of strong clients compliant redress mechanisms to solve privacy and confidentiality breaches and to realized dignity and worth of clients is a key for successful health outcomes.

D) Long Waiting Time

In this theme the study have founded experiences of client who had long waiting duration for accessing HIV services and it has seen from the human rights perspective to get quality health care services within reasonable time frames.

Table 12.: Summary of long waiting Time

		Frequency	Percent
Number of clients who were responded long waiting time to get HIV services in this health facility	yes	9	2.0%
	no	449	97.3%
	Total	459	99.4%

(CLM Facility Survey, April – June 2024)

The table above clearly indicated that majority of the study participants 449(97.3%) did not experienced long waiting time. This findings has implied that the study health facilities have strong efficiency and responsive to their clients. Whereas, the few participants 9(2%) of study participants reported experiences of long waiting in their respective health facilities. The previous similar study conducted in Ethiopia by Mohammed et al., (2019), shown that long waiting times were reported 15% to 40% of the health care seeking services users. This study have founded minimal percentage of clients who had long waiting experiences which could be associated with intervention model of applying differentiated service delivery model and improved work flows managements in the selected health care facilities.

E) Left the Health Facility Without Medical Prescriptions

In this theme the study have founded the findings of identified incidences of cases that were attributed to left the health facility without medical prescriptions and the incidences were taken as a serious human right violation.

Table 13: Summary of clients lefts without medical services prescriptions

		Frequency	Percent
Number of Clients Who were Left The Health Facilities Without Medical Services Prescriptions in the past one year.	yes	4	0.8%
	no	456	98.8%
	Total	460	99.5%

(CLM Facility Survey, April – June 2024)

As the table above clearly shown that the majority of study participant have found that ,456(98.8%) of clients did not left the facility without sought medical prescriptions. The strong findings has suggested that the facilities have good stock out management, avail comprehensive HIV services and with sufficient helping staff. Whereas, 4(0.8%) have an incidences of left the health facility without medical prescriptions. The few incidences have its own clinical implications including treatment interruptions and risks of viral load multiplications and the small findings on left the health facility without medical prescriptions were associated with poor medication stock outs and services interruptions.

7. Conclusion

Overview, the study have founded that the quantitative findings which have indicated that overwhelming majority of clients 97.5% reported health care providers approaches as friendly and professional, 96.3% and did not experienced stigma and discrimination incidences, 98.9% of the respondents reported no privacy violation and

confidentiality breaches. In addition, 97.3% did not experienced long waiting time and ultimately 98.9% were not leave the health facility without medical prescriptions. These findings all together suggested that the study facilities have strong adherence to ethical and professional services and enhanced trust among clients. However, a small percentage of those interviewed study participants reported human violations types, ranging from stigmatization (3.3%), unprofessional conduct (2.5%), violations of client privacy (0.9%), and waiting times (2%). The qualitative study gave further insight and shed more light on the issue. It was found that even a single case of violation could have a significant impact on client uptake of services, especially in a highly stigmatizing illness as HIV.

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