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A STUDY TO DETERMINE THE NURSING CARE NEEDS OF FAMILIES WITH CHILDREN ORPHANED BY HIV/AIDS IN LUSAKA URBAN

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST-BASIC NURSING

A STUDY TO DETERMINE THE NURSING CARE NEEDS OF FAMILIES WITH CHILDREN ORPHANED BY HIV/AIDS IN LUSAKA URBAN

A Research Study, submitted to the Department of Post-Basic Nursing, School of Medicine, in partial fulfilment of the requirements of the Bachelor of Science Degree in Nursing.

Nursing Research (NR420) by Mavis M Chinkumbi (ZRN Lusaka 1986; ZRM Ndola 1991) Lusaka, Zambia. October, 1996.

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DECLARATION

I hereby declare that the work presented in this study for the degree of Bachelor of Science in Nursing has not been prescribed either wholly or in part for any other degree; and is not being currently submitted for any other degree,

Signed: ..... Date: 5/12/96

(candidate)

Signed: .....

(supervising lecturer)

STATEMENT

I hereby certify that this study is entirely the result of my own independent investigation. The various persons and sources to which I am indebted are gratefully and clearly acknowledged in the text and in the references.

Signed: .....

(candidate)

DEDICATION

This study is dedicated to my beloved husband John S Kachimba for his increasing encouragement and support, to my children Mwika and Joshua who always wondered why mummy had to go to school; the fond memories of my late father Mr H A Chinkumbi and finally my sisters for their friendship, understanding and support as I managed my rigorous schedule.

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I wish to take this opportunity to express my sincere thanks to my sponsors, the Directorate of Manpower Development and Training with the Ministry of Health for awarding me a scholarship.

I thank Mrs P Ndele my supervising lecturer for her patient guidance and the constructive criticisms without whom this research would not have been a success. I extend my appreciation to Bathsheba Ngandu, Nomsa Mataka and Maiuna Ginwalla at the UNICEF Library also Mr Mwelwa (CHIN) for their special assistance with the different literature.

Special thanks to Mr Munsanje, family Health Trust who granted me permission to access the families under study and also grateful to Mtendere Community for their co-operation.

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Lastly thank you to all who made the study a success.

Thanks and God bless.

ABSTRACT

The main aim of the study was to determine the nursing care needs of families with children orphaned by the HIV/AIDS in Lusaka urban.

Data was collected from orphan carers or guardians caring for those orphaned children whether the child or children lost both parents or a single parent i.e. double or single orphan respectively.

A structured interview schedule was constructed and used to collect data. A survey method was used and the study was explorative in nature. Data was collected between the 31st of August and 16th September from the orphan carers, guardians or single parents.

The study revealed that the majority of orphan carers appreciate counselling services; having been exposed to the service appreciate counselling as the most crucial aspect in the nursing needs of those families with health education ranking next and offering treatment ranked lowest as they considered this activities as sorely restricted to a health centre environment. Some respondents revealed lack of knowledge as regards nurses role.

The majority of respondents are knowledgeable about HIV/AIDS and reacted positively towards its prevention. However a few could not express their knowledge on prevention.

The above findings support the two hypothesis of study which states that;

- the literacy levels of HIV/AIDS by orphan carers will determine the knowledge of nursing care needs of the family.

- reactions of orphan carers towards HIV/AIDS will determine the nursing care needs of the family.

Much of the information obtained makes the study important particularly to Community Health Nursing. Therefore suggested readings are indicated in the bibliography. It is hoped that the findings will provide insight into the area of counselling and health education to help up-grade the quality of family health care.

LIST OF ABBREVIATIONS

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immuno Defficiency Syndrome
UNICEF	United National International Children Emergency Fund
PHC	Primary Health Care
M.O.H.	Ministry of Health
DHMT	District Health Management Team
U.T.H.	University Teaching Hospital
MCH	Maternal and Child Health
CINDI	Children in Distress
FHT	Family Health Trust
SAFAIDS	South Africa AIDS Information Dissemination Service Bulletin P-3
N.G.O.	Non Governmental Organisation

1.0 INTRODUCTION

The HIV/AIDS pandemic has had far reaching implications on many population groups world over. In the developing countries children have not been spared by the pandemic. In Africa, particularly increasing numbers of children are getting infected with HIV infection and being orphaned, and experience stresses from the effects of HIV/AIDS.

The sub-Sahara African region alone currently accounts approximately 60% of the estimated 11 million people world wide. The rapid increase may be at least 26 million people infected most in the developing countries by the year 2000.[1]

In Zambia, at least 250,000 of Zambians out of 8.1 million citizens are infected with the virus. The patients with AIDS related illness occupy up to 70% of the hospital beds. The reported cases of AIDS reveal that out of nearly 30,000 cases, close to 15,000 are youths between 18 and 35 years of age and females are infected more than males.[2]

Across the developing world, the children left behind as their parents die form the infection are emerging as a new phenomenon of the AIDS pandemic. In Africa alone they may be an many as 2 million children without one or both parents as a result of the epidemic [3], also emerging is the child headed household in which the eldest orphan becomes the parent as no relation is agreeable to care for them. Nearly one of every three children born may be infected. The majority however are uninfected and survive their parents as orphans.[4]

The prevailing and progressively lowering of the economic performance of the country has declined the families income in real terms and therefore aggravated

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[1] Berkelys (1993) AIDS in the developing world Clinical Infection Disease 17, Supp 12 S329-36
[2] WHO (1990) National Aids Prevention and Control Programme Lusaka - Zambia
[3] Kelso BJ (1994) Orphans of the storm UNICEF Document No 2998 - Zambia
[4] Ibid

the status of the children in the poorest household. Consequently due to economic crisis and possibly lack of adult leadership, the orphans have turned to the streets in order to make a living. The streets are their fixed habitual abode and a source of livelihood.

The children who are relocated in extended families have turned into labourers in some homes as well as business houses. Those who work do all sorts of jobs such as selling goods as vendors, collecting scrape and discarded left overs as well as begging. they augment the total household income of their carers usually at the expense of their psychological well being.

The poorer communities may be in double jeopardy with regard to caring for the orphans. Firstly they may be least able to take necessary measures to avoid HIV infection, so that the absolute numbers of orphans will, continue to rise. Secondly these communities are less able to provide support to children, particularly nutrition and healthy support due to the limited resources. The problems mainly are those with food shortages resulting in ill health and malnutrition, loss of access to the essential health facility, lack of adequate clothing, blankets and education.

Widows, widowers, relatives and significant others that take on the responsibilities of caring for the orphans into their homes share many of these children's needs and problems. The needs of orphans include physical needs, education, health care, emotional and psychological support. Nurses in the community health centres should be able to play a major role in the support of these families by looking at the health needs and together with the families elicit the nursing care needs and render care in accordance with those identified.

The health problems, the availability and accessibility of medical and hospital resources and the knowledge and attitudes of individuals or family will determine in some measure the "mix" of nursing skills required by a particular family at a particular time. Regardless of the type of problem, the area and

extent of nursing practice required can be analysed by the same elements in nursing practice. These include physical care, therapeutic measure, education and family counselling.[5]

The plight of families with HIV/AIDS orphaned children should be looked into even from the nursing point of view.

The differences in the pattern of nursing needs required in households with children orphaned by HIV/AIDS may differ as widely within the medical and social circumstances in which they are found.

[5] Freeman Ruth Band Heintich Janet (1981) Community Health Nursing Practice. W.B. Saunders Company London.

1.1 STATEMENT OF THE PROBLEM

The problem of increased orphans in areas of sub-Sahara Africa badly affected by the HIV/AIDS epidemic has received increased attention. A number of studies have been done to predict the future impact of the HIV epidemic or orphans.[6]

In Zambia, at least 80,000 children have lost one or both parents [7] and officials expect the number to rise. In the past, the extended families provided care to these orphans. To day this is not possible as the numbers or orphans continued to increase. A study of the "Situation Analysis of Orphans of HIV/AIDS Survival Assistance" by the Social Policy Research Group of 1993, reported that 40% of the Zambian households have one or more orphan under their care and that the majority are largely in the urban areas.[8]

With the growing awareness of distress that bereaved children or families with children orphaned by HIV/AIDS face, it should be generally considered important by our health sector to come up with solutions to some problems these families experience. Will the traditional extended family's system be sufficiently elastic to absorb orphans of AIDS and care for them as if they were their own? What are their problems even as carers of orphaned children? The fact that AIDS may claim lives of both parents and guardians is an indication to the fast growing population of orphan numbers. Therefore the extended families may actually be headed by vary young adults or too old grand parents.

Most of the developing countries are undergoing economic restructuring, Zambia inclusive. The economic constraints in most governments cannot cope

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[6] Foster a et al (1995) Orphan Prevalence and Extended Family Care in peri urban community of Zimbabwe

[7] Rutayuga J.B (1992) Assistance to AIDS orphans whithin the family kinship system and local institutions.(a programme for East Africa). AIDS education and prevention Suppl:57-68.

[8] Mulenga C (1993) Orphans, Widows and Widowers in Zambia (a situation analysis & options for HIV/AIDS Survival assistance). Institute of African Studies - UNZA: Lusaka

with the drain of resources caused by the effects of AIDS especially the orphaning of children. Usually during the times of economic troubles a disproportionate share of suffering will be born by the most vulnerable, among whom are orphans who are least equipped to combat the effects of poverty. Also there is a cut down on the allocations of resources given to the health sector.[9] Evidently with the prevailing economic situation, Zambia cannot adequately meet the needs of the orphans.

The circumstances in which the orphans find themselves prejudice their safety, health and moral welfare. The children may fall prey to exploitation by criminals, may be engaged in drug abuse and trafficking and may be forced to live on the street and live on scrap food. The young girls may engage in unhealthy practices like promiscuity that may endanger their lives predisposing them to the HIV infection.

In view of the above family health circumstances that the orphans find themselves, the nursing care needs are obvious as the families may have health related problems with which they are unable to cope with. The problems include threats to health and the need for intelligent action for health promotion. The families should be knowledgeable in order for them to maintain health on their behalf.

The National Health Policies and Strategies states that. "Primary Health Care (PHC) will be a vehicle through which health shall be delivered to the people. The Zambian government is committed to provide its people with equity of access to cost effective quality health care as close to the family as possible." [10] The health care delivery system should consist of a large variety of interrelated elements that contribute to health in homes, schools, work place and communities through the health and other related sectors.

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[9] UNICEF - Document 19 No 2704 - Lusaka

[10] Mumbuwa E et al 1994 Assessment of current government health care delivery services in Lusaka Urban. The Social Recovery Project study seriel No. 17 - Lusaka.

Nurses have a role to play in the various setting to ensure that the masses are equipped with the knowledge that they need to promote good health in their own environments. It is important to create awareness on the available resources for the various groups of people in the community and how to access them.

To maintain health, the individual or family must be able to deal with the problems of participating in preventive curative and rehabilitative measures to make social adjustments that are required by the health situation.

Individuals and families should make wise decisions in relation to seeking and using health services to contribute in whatever way they can towards maintaining the health of others. The capacity to deal with the situation, to cope is central to the health competence of the family.

The contribution of nursing to the health care of orphans of HIV/AIDS is to strengthen and supplement the capacity of these individuals and their families. The families encounters stress of illness as in these who are actually infected with the HIV infection or an opportunity to prevent disease and promote health. The nurse comes in contact with those families from the health centres and can access these families through the home based care providers. The nurses should explore the various avenues of gaining access to these families.

The nursing needs are paramount in situations where the nurse encounters an orphan inflicted with disease and needs the services of the nurse as she applies the therapeutic measures. Other related problems that may occur due to economic hardship may need intervention by the nurse. These may include health education on matters relating to nutrition, counselling to reach the emotional and psychological aspects of the individual and families.

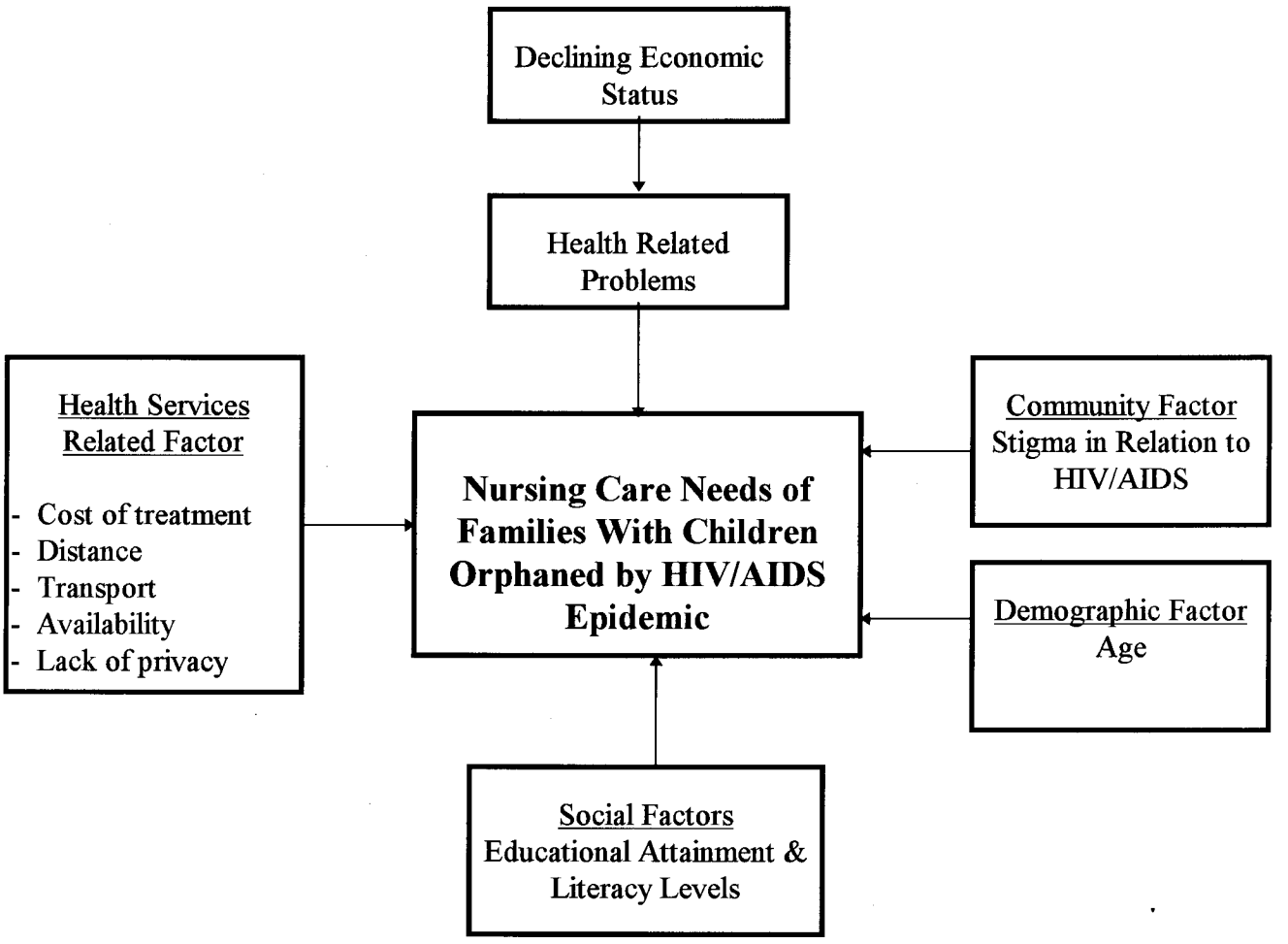
Orphaned children may be young and not able to reason well as they strive to meet their health needs. The nursing services are needed in order to offer adequate information that will help promote health.

The literacy levels of the care givers will determine to some extent the accessibility to the nursing services. The care givers also have to be knowledgeable for them to seek the right kind of assistance and so should also be aware of the services available to them.

The families economic status will influence the need to seek for the nursing services. Individuals and families may be aware of the services available but will not be able to access them due to economic constraints. The stigma that is attached to HIV/AIDS will hinder a family from coming up with felt needs of the family, most of which will require a nurses intervention.

Orphaned children need emotional, physical, psychological and social support. These needs will vary with every child, age group, sex, social and economic background. The nursing needs of these families will also differ in various settings i.e. the non institutional extended family system, foster parents and adoption, day care centres and those under support of older siblings and peer groups. There is therefore need to identify most crucial situation and so the necessity of innovatively utilising existing resources and systems as much as possible.

PROBLEM ANALYSIS DIAGRAM



1.2 PURPOSE AND SIGNIFICANCE OF THE STUDY

Purpose

To determine the nursing care needs of families who have been exposed to HIV/AIDS and its consequences in particular the orphaning of children.

Significance

The results of the study will be useful to the nurses especially those working in the community, to make necessary adjustment in their approach as they render care to families with orphaned children, targeting the felt needs. The nurses will apply appropriate techniques to curb against any emotional and psychological effects of its family members.

The results will benefit both the health care givers and health systems whether governmental or non governmental and the consumers of health.

Appropriate recommendation to the Nursing Council and the schools of nursing to give a theoretical base and practical experience to nurses as regards the needed services to render in order to support the deserving families and meet their needs.

The total well being will contribute to their personal and national development.

1.3 OBJECTIVES OF STUDY

Introduction

The issue of orphans in our communities still exist under the shadow of the extended family role to absorb orphans. As the data on families with orphaned children become available at national level and awareness of the increasing numbers about these families within the communities, concern as regards to the nurses role in the situation such as this arose initiating a need for documentation of the nursing care dimed necessary to render to such families.

General Objectives

To determine the nursing care needs of families with children orphaned by HIV/AIDS in Lusaka Urban.

Specific Objectives

1. To determine the knowledge of orphan carers concerning HIV/AIDS.

2. To determine the reaction of orphan carers towards HIV/AIDS.

3. To determine the family interrelations.

4. To elicit the nursing care dimmed necessary to render in a home with children orphaned by HIV/AIDS.

5. To share the findings with the nursing care providers and teachers of nurses in order to improve the nursing approach towards families with children orphaned by HIV/AIDS.

1.4 THE HYPOTHESIS

1. Literacy levels of HIV/AIDS by orphan carers will determine the knowledge of nursing care needs of the family.

2. Family interrelations are dependent on the size of the family and religious affiliations.

3. Reactions of orphan carers towards HIV/AIDS will determine the nursing care needs of the family.

4. The availability of the nursing service will determine the extent to which the services are sought.

5. Counselling service requirement is dependant on the extent to which family members are exposed to the service.

1.5 OPERATIONAL DEFINITION

1. Family Nursing Need is present when:-

   - the family has health problems with which they are unable to cope; and

   - there is reasonable likelihood that nursing will make a difference in the family and ability to cope.

2. Coping is dealing with problems associated with health care and social adjustment with reasonable success.

3. Orphan a child who has lost a mother or father or both and usually below the age of 18 years.

4. Orphan carer, a widow or widower or any other extended family member playing the role of a guardian.

2.0 LITERATURE REVIEW

INTRODUCTION

During literature review, little or no information was found relating to the nursing care needs of families with orphaned children. However generally needs of the orphaned children and their carers have been discussed. The nursing care needs discussed in many texts and journals are these relating to the specific medical conditions and the nursing care that was necessary to meet the specific problems encountered with these conditions.

Caterinicchio M J (1995) states that, the health care systems of the future must be driven by the needs of the patients and families. Nurses must make decisions and take action that are crucial in ensuring that this becomes a reality. Re-defining nursing care needs according to patients needs and that of the family, provides an organising framework to examine across all levels of nursing, the dimensions of practice most likely to meet patient and family needs to contribute to optimal outcomes as well as enhance the linkages between practice, education and research. [11]

The epidemic of HIV/AIDS has advanced tremendously and nothing that has been done in the field of prevention has succeeded. In the communities, HIV/AIDS has become a part of everyday life. The need to care over a period of years is challenging families, friends and the health systems (WHO 1994).[12]

Protecting human well being while adjusting to the harsh economic and social realities has been on the UNICEF's major concerns and has been termed "Adjustment with a human face."[13] As such, the delivery of health services to

[11] Catennichio M J (1995) Redefining Nursing According to patient and family needs
[12] W.H.O. (1994) National AIDS Prevention and Control Programme - Lusaka
[13] UNICEF Report (1986)

people living with orphans is inclusive of the family characteristics, the significant others and the communities where they live.

The literature reviewed is that which has relevance to the study, and will be discussed under the following headings.

1. AIDS and family life.
2. The health care delivery facilities
3. Family health care
4. Counselling as a family nursing need.

2.1. AIDS AND FAMILY LIFE

In the mid 1994, the World Health Organisation (WHO) estimated that there were over 3 million adolescents and adults with aids in the world. By the year 2000, there will be at least 40 million persons in the world infected with HIV including 2.3 million children.[14]

The numbers of AIDS orphans is already beginning to affect family life in the places where the virus is most rampant. In orphanages in Portau Prince Haiti, over half of the children below 18 Months are HIV infected.[15] UNICEF calculates that in 10 countries of east and Central Africa, if present HIV infection trends continue, up to 5.5 million children under the age of 15 will be orphaned by the year 2000.[16]

In Rakai in Southern Uganda, a recent "save the children fund" survey puts at over 24,500 the number of parentless children.[17] Grandmothers who would normally count upon their children now care for grandchildren. Young widows now raise not only their own children but those of their late husbands co-wives facing dubious health and survival prospects of their own. The youngsters are themselves prime targets for HIV infection. Their life style often placed them on the wrong side of any law designed to protect the health and well being of the minors.

Emotionally vulnerable and economically deprived, the children are easily drawn into selling sexual favours. 7% of street boys aged between 6 and 14 in Khartoom are infected with HIV. In Sao Paulo Brazil, 9% of children tested in state institutions were HIV positive.[18]

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[14] Gevberding J.L. (1994) Managing occupational exposures to HIV Willian and William, Baltimore
[15] UNICEF (1990) Children and AIDS (an impeding calamity)
[16] Hunters (1990) orphans and widows fo AIDS epidemic in sub-sahara Africa, Pergamon Press Oxford
[17] Hunters (1990) orphans and widows fo AIDS epidemic in sub-sahara Africa, Pergamon Press Oxford
[18] Hunters (1990) orphans and widows fo AIDS epidemic in sub-sahara Africa, Pergamon Press Oxford

Zambia is at the heart of Africa's AIDS belt, with an estimated 500 new cases of HIV infection per day and estimated adult HIV prevalence rate of 10-15% in rural and 25-30% in urban areas.[19] The National AIDS Control Programme in the M.O.H. puts the number of orphans at around 200,000 - 250,000 in 1995 increasing to 550,000 - 600,000 by the year 2000. The orphan numbers have been enumerated in several studies in Zambia. The sample sizes vary as do the definitional criteria, although most have a cut off point at the age of 18.

[19] M.O.H. Document (1994) The current HIV/AIDS situation and future demographic impact

The needs assessment indicated food security, health education and protection are the major issues at material level. In response to educational status in urban areas estimation put the proportion of orphans in school going age who are not enrolled at 32%, compared to around 25% of non orphans. In rural areas, the situation is more severe with 68% of orphans not enrolled in school compared to 48% on non orphans. School drop out contribute to a high number of street children estimated to 70,000 [21].

Hospital initiative home based care have failed to go beyond the medical attention of the patient to look at the psychological and emotional stresses in the family. Care is virtually non existent beyond the death of the patient. Anecdotal evidence suggest that extended families are still managing to cope with the burden of orphans with the caring function remaining with the mothers and mothers relations.

In the urban setting coping strategies of AIDS affected households are mainly informal sector marketing. Typically selling salaula (2nd hand clothes) charcoal, cooking oil, kapenta and various seasonal food stuffs and fruits. In rural areas the coping strategies are more related to farming activities and beer brewing. Marketing is of less importance.

Intra-communication support appears to be extremely limited and what help there is comes from institutions such as churches, government, public welfare association schemes and department of social welfare, small NGO's and some home based care programmes. even so a Ndola survey of orphan households revealed that in 86.4% of cases there was no support from the community NGO or government.[22]

[21] St Francis Hospital (1993) HIV/AIDS Activities unpublished report - Katete
[22] Catholic Diocess of Ndola (1995) AIDS department Preview of Orphans & their Educational Status

The NGO's attempted to provide support to orphans and widows through various means such as Kwasha Mukwenu project where women care takers visit and monitor progress of orphans in their catchment areas.

The government capacity is reduced and needs straightening along with NGO's. The scale of the orphan problem is so large that the interventions must be low cost and community centres to be combined with awareness raising of community leaders and health workers as to the nature of the orphan problem and potential problems.

It is apparent that for the health personnel, the community nurse out there needs to do a lot more to meet the health needs of these families. The nurse in the community has a significant role to play as the home health care needs of families with orphaned children are multifaceted in nature and extend beyond the physical health to include the emotional and psychological well being.

It is essential for the nurse to explore the difficult areas in which families are unable to cope and offer the needed care to individual families. If the nurses in the community are to contribute to the equivalent evolution of health care systems, they must continue to be visible within the system, nurturing informed choice and decision making in their communities.

2.2 HEALTH CARE DELIVERY FACILITIES

The health care delivery system should consist of a large variety of interrelated elements that contribute to health in homes, schools, work place and communities through the health and other related sectors. It includes self care.

Since independence, Zambia has gone a long way in improving its health facilities [23]. Between 1964 and 1981 in a number of hospitals and health centres beds have doubled. Health care in Lusaka is provided by the government, private sector, parastatal, private companies and traditional healers. Under the government sector there are three hospitals. U.T.H. is a national referral hospital. There are 22 government health centres and 4 first aid posts. The health centres are divided into 8 administrative zones. 10 of the centres have maternity facilities and the remaining centres do not. The catchment population range between 20,000 0 128,994 (DHMT 1993).

The Alma-Ata-Declaration of 1978 states that Primary Health Care was to attain health for all the world's people by the year 2000. The Lusaka Urban Technical Task Force was in 1992 tasked to deliver an urban PHC system for the country starting with the city of Lusaka. A master plan was developed and the health care delivery system status was one such area identified. PHC applies the same principles in both rural and urban populations. However the urban situation has certain special features e.g. increased population, high concentration, reduced accessibility to health facilities and service. The urban population tends to show more diversity than the rural. In Zambia Roeddle et al 1992, recognised that the present PHC model is oriented to rural areas and a model for urban PHC needs to be developed with appropriate

[23] M.O.H. 91992) National Health Policies and Strategies - Lusaka

policy support and organisation structure[24]. Thus the need for advocacy for the focus of public health resources in urban areas to the poor among whom orphans are victims.

Case studies carried out in UTH paediatric shows that 95% of the children admitted had first seen a traditional healer or had been offered treatment by the grandmother[25]. In this view a lot of our families in the communities attempt to provide care within their homes which could indicate the need for home health services. The other reasons could be attributed to the accessibility of health services. This involves mobile services, transport, money for attendance also the feeling about the fees and what transpires if not able to pay for the service.

An assessment of the government health care services in Lusaka urban revealed that, the health centres are adequate although there is a critical shortage of doctors. The health services provided are mainly curative, MCH, Diagnostic, on daily a basis and the rest on specified days. There was little outreach activities going on in the communities though 2/3 of health care providers claimed provided outreach activities. More than one half of the responding providers were either never visited by professional supervisors or only visited irregularly.[26]

In view of the above situation, it is evident that much is desired in the health sector circles in order to improve the delivery care system especially in the urban areas. Compounded with the cycle of poverty as a long term problem nurses can, and being the most easily accessible health personnel go a long way in trying to alleviate any untoward effects that the health delivery system has on our communities. The nurse must be able to ascertain these difficult situations and be able to

[24] Roddel et al (1993) Better Health in Lusaka (a challenge to urban PHC and UTH) Lusaka
[25] Proff A Khan et all (1987) Traditional Healing Practices in disease of childhood - Zambia
[26] Mumbwa E et al 91994) Assessment of Current goverment and health care delivery services in Lusaka urban. The Social Recovery Project study serial No. 17 - Zambia

advice and health education. It is vital that the nursing needs be met within the families capacities optimally.

The policy formulation will be much dependant on the needs and resources which must be identified in light of the prevailing conditions, financial commitment, government priorities and ambitions. The most politically salient needs which should be addressed by health policies are those which are associated with client vulnerability i.e. food production, poverty issues specifically addressing the women and family environment, education and the equitability and accessibility of the health services.

2.3 COUNSELLING AS A FAMILY NURSING NEED

The family is the basic unit of society. It serves as needs of procreation, child rearing and protection of its family members and mutual help. Traditional families everywhere are under strain, weakened by the effects of HIV/AIDS and urbanisation associated with industrialisation. Whether or not they can care for a family member who has HIV infection will depend on the strength of both individual family members and the strength of the family as a whole. In view of the demands which these conditions make on the family, the stigma associated with them and the fatal nature of the disease, some families will find it extremely difficult or impossible to cope.

Lippmann SB et al (1993) stated that "the presence of HIV spectrum illness stimulates a powerful emotional reaction from a patient's family and friends. Sadness, anxiety, helplessness and anger are also common. Health care staff should address and maximise interpersonal comfort. Stigmatisation and isolation are major stressors. Bereavement is complicated by fear, shame, dependency and hopelessness. Therefore a task in counselling is crucial to maintain the integrity and supportiveness of the patients social unit by encouraging open communication between those involved and by educating about AIDS.

Counselling, a process of dialogue and mutual interaction is aimed at facilitating problem solving, understanding and motivation. In counselling, the psychosocial needs of individuals and families are taken into account together with and in the same way as medical, financial and legal needs.

Counselling is designed to provide support in times of crisis, to promote change when required, to propose realistic action in the context of different situation and to assist in accepting of information on health and

well being and adopting to its implications. It is provided in a context in which there is recognition of a broad range of medical, social, economical and personal or family needs involved. The needs will vary according to family circumstances, community support available, health as well as social services to which they have access, whether or not they have HIV infection or have worries about HIV infection and want to prevent it.

Families who have lost parents as a result of HIV/AIDS go through a process of blow, recoil, withdrawal and acceptance. If they pass through successfully they are likely to continue to support one another expressing love, acceptance, handling the various and often predicament and loss.

Family members may be provided according to what they have been through with new insights into themselves and their relationships. Families and individual members will often show remarkable abilities to cope and may adapt in un-expected ways. Families who do not progress beyond some point in this process will tend to ignore or reject the infected member, as occurs in infants born infected from HIV/AIDS suffer frequent diarrhoea infections. They fail to thrive and development is delayed.

Special issues on counselling involve breast feeding which is recommended to continue as evidence suggest that the risk of HIV transmission by breast milk is slight. The risk is out weighted by the benefits of breast feeding. Counselling on immunisation, the benefits also far outweighs the risks of these cases.

School children infected with HIV/AIDS should be prevented against catching respiratory or other childhood infections. The guardians should be taught the need to protect the child from other

infections. Immunisations due during school going periods should be encouraged. Sometimes the HIV infected child may suffer discrimination and other children may make fun of the child. This provides formidable challenge to the nurse to counsel the respective individuals and provide consistent support whilst recognising that the actions of other children are very powerful and difficult to overcome.

As families struggle with the reactions of anger, depression and guilt, a critical task of the nurse is to help the family understand the strength of an the reasons for irrational out bursts that accompany infection, illness and loss of a loved one. Their ability to withstand them will need continuous support. Thus the future of orphaned children and their carers, the maintenance and the standards of living become matters of intense concern.

Nurses should have the skills to counsel families and individuals. The nurse should conduct home visits to people who are too disturbed with the events and so respond promptly to the emotional and psychological matters that arise. The nurse observes the availability of the service by conducting home visits. In addition, she/he should be able to offer information, guidance, suggestions and make contacts with the formal and informal sources of support for maximum benefit of the orphans and their carers.

2.4 FAMILY HEALTH CARE

Professional personnel concerned with today's health delivery system are seeking improved methods of providing health care to the masses while attempting to keep this care personal and individualised. Nurses play a key role in delivering this individualised health care and have an advantage in all health care settings as they are with individuals and their families for a greater amount of time than other professionals. One method being developed for improved health service, is the emphasis on the entire family unit rather than just one individual member because the health of one family member affects the entire family.

As nurses we believe that this trend to emphasise the entire family unit is a realistic and reasonable one. It is one that emphasises the dignity and personality of the family and the individuals. It is a realistic approach of helping people to help themselves as they can avail themselves to the resources and strengths drawn from their nuclear or other type of family.

In any family situation, its is important for the nurse involved in the family to know the individual family and their life styles and needs, their particular ways of coping with stress as these families are unique in their responses and manner of coping with stressful situations. The reactions depend on many things including previous experiences with illness and death, modes of coping with crises and the special meaning the parent has to the family.

Community nurses can be important assets in helping the family when the parent dies as they face the many adjustments that death will bring. The nurses can also assess the response of the community to the illness that caused the death and may take an opportunity to offer respective health education. Teachers, friends, extended family members and

others overwhelmed by the death may react with over protection and over solicitousness or by withdrawal and detachment. The nurse has a vital role to play in such situations.

The community members may need guidance in understanding the illness HIV/AIDS and in giving appropriate help to the family. School personnel may also need guidance in understanding the children reaction and knowing how best to help the child who returns to school as most orphans do not have a chance of continuing education.

Family and individual assessment is also important in trying to elicit the health problems in the family. A Clinical Nursing Tool by Dorothy Smiths (1968) is helpful in beginning to collect data and assess the families. The information collected should include the general information about the family. This includes the guardian or parent, siblings or orphans, living arrangements, family life, financial religion and previous health experiences. There is need to collect information specific to the orphaned children, information related to illness and also the physical assessment of the children. This may include all the systems where necessary and feasible.

With regard to the assessment of the families with orphaned children, it is possible to determine any areas in which the families and individuals are not coping. Continuous assessment may enable the nurse to be skilled in assessing changing grief reactions and the coping patterns of the family. Some behaviours seen in the parent or guardian may puzzle and frustrate the nurse unless they understand the importance of the coping patterns of the family or individual. Confidentiality must be maintained.

Coping behaviour has been descried as "all of the mechanisms utilised by an individual to meet a significant threat to his psychological stability and enable him to function effectively."

The community health nurse stands challenged to meet the nursing needs of families with children orphaned by HIV/AIDS. The HIV/AIDS has had its own implications on family life bringing about health related problems with which families are failing to cope. In view of the limited resources and adequate health facility, the nurse should take up the challenge to meet the family health needs in the cheapest and quickest way possible by offering the identified care within the family circles. Offering counselling services is an element of nursing practice.

3.0 METHODOLOGY

3.1 RESEARCH DESIGN

The survey approach was found suitable for the study. This approach is a non experimental type of research in which the researcher investigates a community or a group of people.[27] The study design is explorative in nature which is aimed at determining the nursing care needs of families with children orphaned by HIV/AIDS in Lusaka urban, Zambia.

The design has been chosen to enable the researcher to systematically collect an accurate account of family nursing needs as they are presented.

[27] Treece E W & Treece J W (1977) Elements of Nursing Research Mosby Comp - St Louis

3.2 RESEARCH SETTING

The study is to be conducted in Lusaka urban. Lusaka has a mixed population of high, medium and low income groups. It has a total population of about 1.5 million.[28] The researcher decided to look at one zone area due to limited time and resources available to conduct the study. Mtendere was chosen. The study is to be carried out in this community as there are groups in the community e.g. the churches, CINDI, FHT looking after families with orphaned children. This will enable the researcher to identify these families and access them easily. The families are aware and used to these groups or non governmental organisation offering them both material and psychological support. It will facilitate clearing of any suspicion from them and gain co-operation when dealing with them.

[28] Central Statistics 1990

3.3 SAMPLE: SELECTION AND APPROACH

A letter asking for permission to conduct a study was sent to the directors of Family Health Trust. Permission to conduct study was granted. Permission form the individuals in the sample was obtained verbally on the day of the interview.

The sampling frame was made available from Family Health Trust. The individuals selected in the sample were approached at their own homes by the researcher, and asked if they were willing to participate in the study.

The sample included men and women between the age of 18 and 50 years who were orphan carers. A sample of 60 respondents was randomly selected from Mtendere's section A through to D. The interviews were conducted to both male and female during the month of August.

The sampling technique was a simple random sample. This method allowed all subject in the frame an equal and non zero chance of being included in the study. The sample was chosen by the use of random number table. A list of family name was obtained from Family Health Trust register. The 160 names obtained were each assigned to two digit number. 60 two digit numbers were picked randomly from the random number table. The families who's names were bearing these numbers were chosen for the study.

A simple random sample was chosen for the study. It was appropriate since a register of clients was available. It is not possible to have a representative sample due to the time factor in which the study was to be submitted.

3.3 DATA COLLECTION TECHNIQUE

In order to elicit necessary data and information two research strategies were employed.

a) Involves secondary "desk" research which is based on the review of literature.

b) Involves undertaking field research.

A structured interview schedule was used for this category of respondents. They were interviewed by use of an interview schedule with both closed and open ended questions. The questions were presented in the same manner to all the respondents to ensure objectivity.

This method has been preferred because:-

i) Some clients are illiterate, hence not available to comprehend and give responses to the questions;

ii) Depth of respondents could be assured since the researcher will pursue any question of special interest;

iii) Questions are clarified during the interview; and

iv) A higher proportion of responses will be obtained from respondents.

Data Collection

Data was collected between the 31st day of July and 10th of August 1996.

3.4 ETHICAL CONSIDERATION

Direct consent for participation was obtained verbally from participants and confidentiality assured. Permission was sought from the AIDS Ethical and Research Committee in order to conduct the study in the community of Lusaka in a designated area however no ethical issues were noted. Also permission sought from the Director of Family Health Trust - CINDI, programme.

3.5 PILOT STUDY

The pilot study was conducted on the community household subjects mainly carers of children orphaned by the HIV/AIDS in Lusaka Teaching Hospital vicinity and Garden Compound outside the area ear marked for the study sample.

Ten family households were included. The carers of these families to be excluded in the study. The aim of the pilot study was to appraise the potential of data collecting tool, yielding valid and reliable data also sequence of questions.

4.0 PRESENTATION OF FINDINGS AND ANALYSIS OF DATA

4.1 INTRODUCTION

Coding of data was done manually, the analysis of data was done by computer software SPSS.

The findings have been presented in percentage and the raw figure bar and pie charts.

The variables will be tested using cross tabulations and the presentation of findings done in table form.

Table 2: Age and Sex Distribution of the Respondents.

Age	Females	Males	No. of Respondents	Percentage
15 - 19	2	0	2	3.3
20 - 24	5	1	6	10
25 - 29	13	2	15	25.0
30 - 34	5	5	10	16.7
35 - 39	12	9	21	35
40 - 49	1	2	3	5
50+	3	0	3	5
Total	41 (68.3%)	19 (31.7%)	60	100

The female respondents were more than the males i.e. 68.3% and 31.7% respectively. The majority of respondents fell between 25-29 age group. The older category had three (5%) respondents and all females.

FIGURE 1: SEX DISTRIBUTION

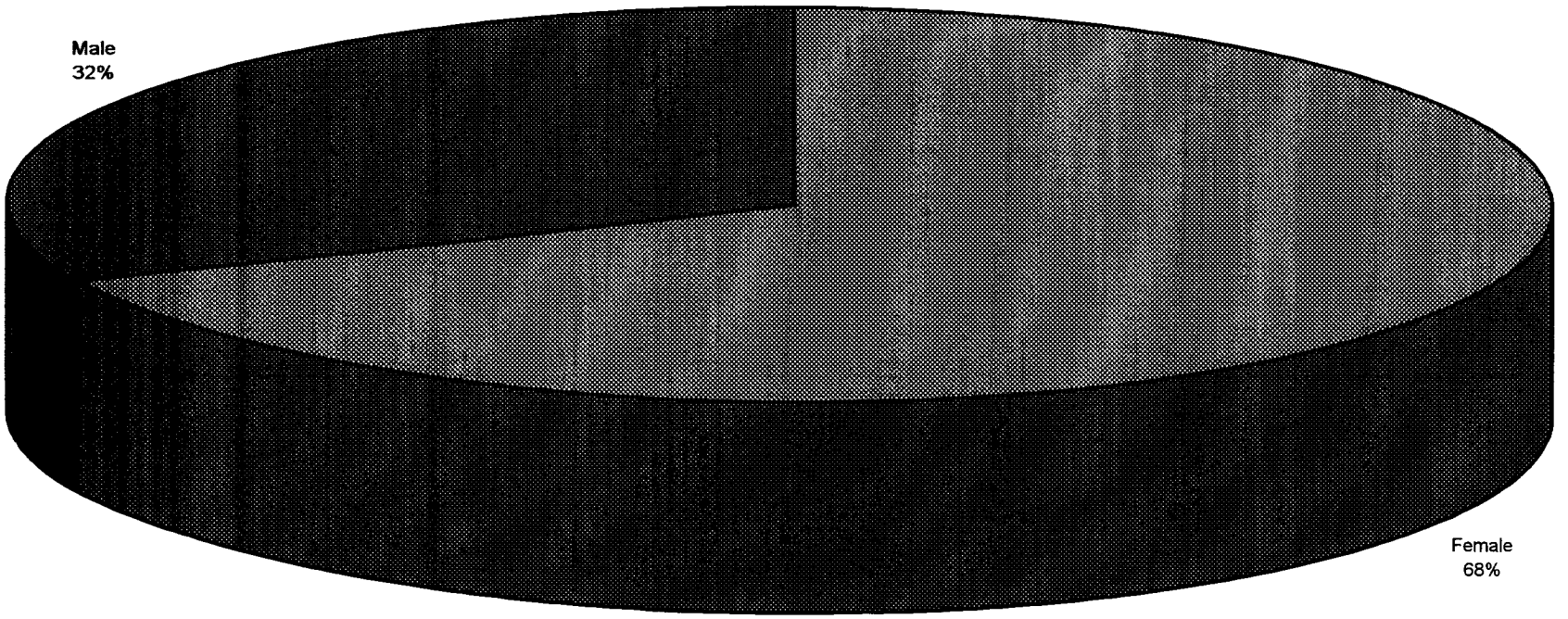


FIGURE 2: AGE DISTRIBUTION

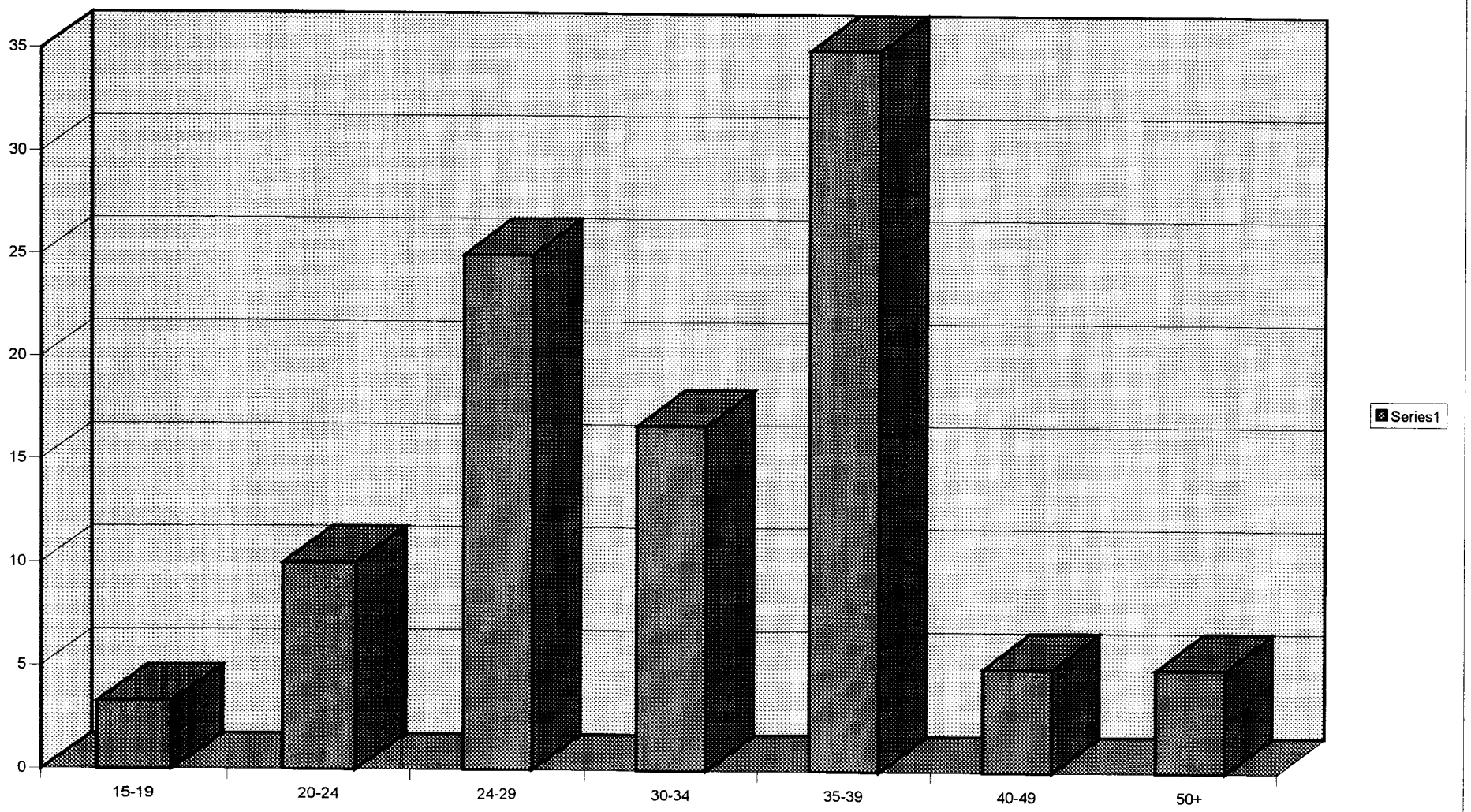


Table 3: Sex and Marital Status Distribution of Respondents

Marital Status	Females	Males	No. of Respondents	Percentage
Married	20	10	30	50
Single	5	7	12	20
Separated	1	0	1	1.7
Divorced	1	0	1	1.7
Widowed/er	14	2	16	26.7
Total	41 (68.3%)	19 (31.7%)	60	100

The majority of respondents were married (50%); however the number of those widowed was also high (26.7%) and single guardians were 12 (20%).

Table 4: The Educational Level of Respondents

Level	No. of Respondents	Percentage
University	1	1.7
College	2	3.3
Secondary	13	21.7
Primary	33	55.0
None	11	18.3
Total	60	100

The majority of respondents have primary education (55%) whilst the number of those without education is quite high 18.3%.

FIGURE 3: MARITAL STATUS

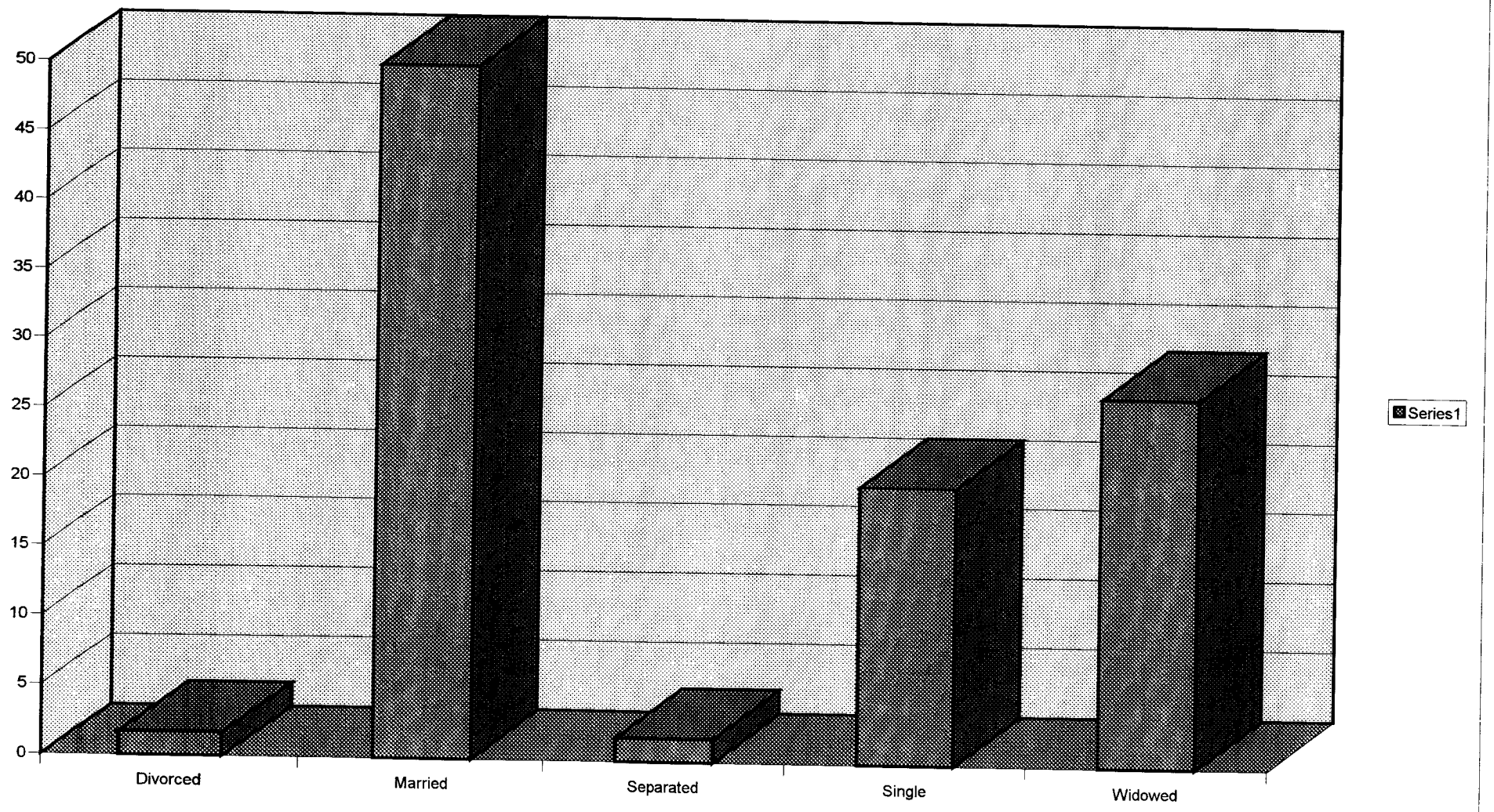


Table 5: Occupation and Monthly Income Distribution of Respondents

Occupation	50,000 and below	51,000 - 100,000	101,000 - 150,000	Above 150,000	No monthly income	No. of Respon-dents	%
Self employed	22	1	2	6	0	31	51.7
Unemployed but skilled	1	2	2	0	12	17	28.3
Servant	0	0	0	1	0	1	1.7
Other	4	5	0	2	0	11	18.3
Total	27	8	4	9	12	60	100

The majority of respondents are self employed (51.7%) with a monthly income of upto K50,000. The majority of the unemployed (28%) have no income although they are skilled.

Table 6: Number of Persons in Household and Meals Per Day Distribution

Group Category	Average No. of meals per day	No. of respondents	Percentage
1 - 5	3	15	25
6 - 10	2	40	66.7
11 - 15	2	4	6.7
16+	1	1	1.7
Total		60	100

The majority of respondents (66.7%) are at least between 6 - 10 occupants and have only two (2) meals per day. The next category (25%) with a family between 1-5 have three (3) meals per day.

FIGURE 4: MONTHLY INCOME

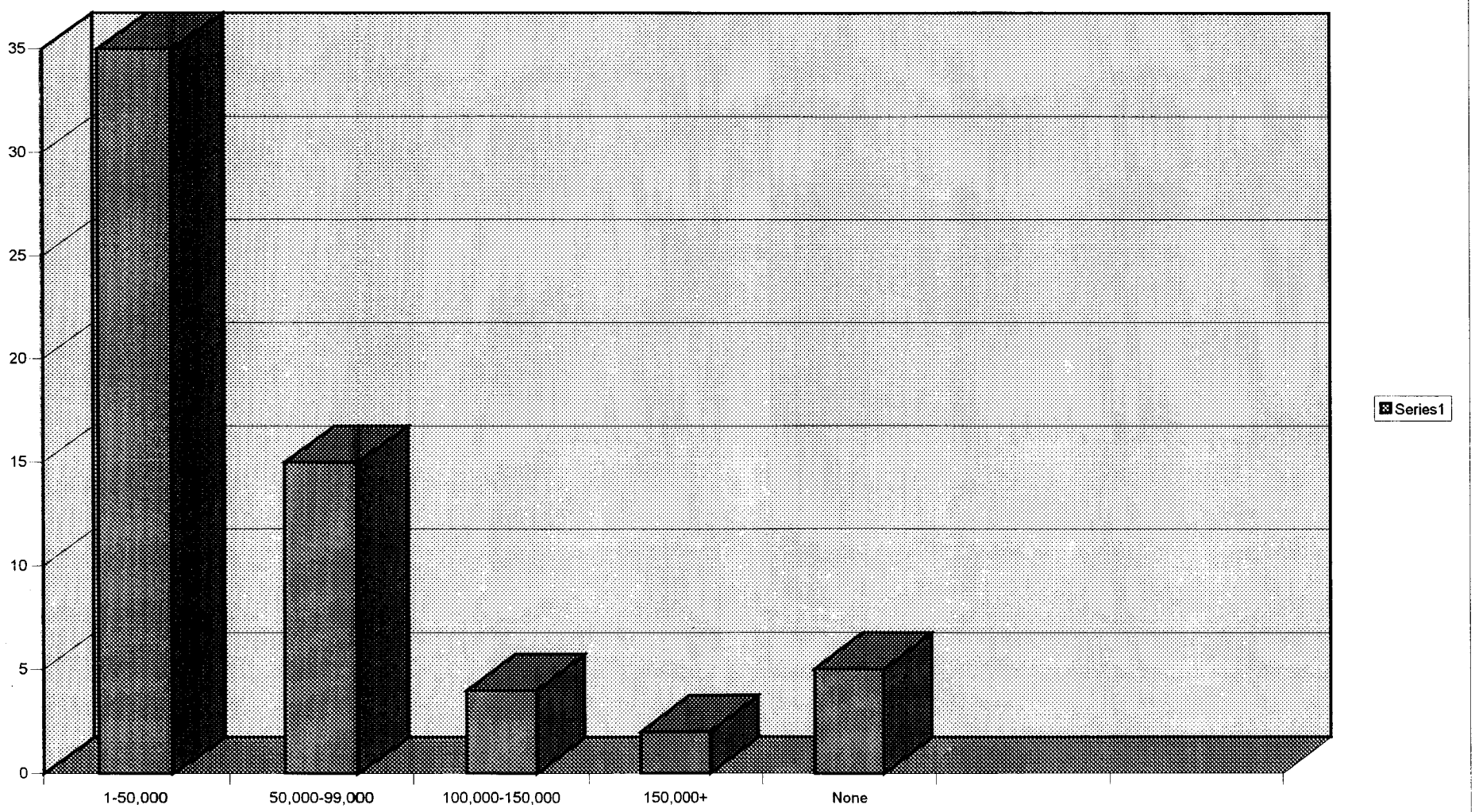


Table 7: Religion and Family relations/interactions Distribution

Interactions	Christian	Moslem	Other	No. of Respondents	Percentage
Poor	15	1	0	16	26.7
Fairly well	*12*	*1*	*1*	*14*	*23.3*
Satisfactory	11	0	1	12	20.0
Very well	18	0	2	18	30.0
Total	56	2	2	60	100

The majority of respondents (30%) from the Christian faith interacted very well with their families. The next highest category from the same faith (26.7%) have poor family interactions.

Table 8: Education and Knowledge of HIV Infection Distribution

Educational Level	Positive (Yes)	Negative (No)	No. of Respondents	Percentage
University	1	0	1	1.7
College	3	0	2	3.3
Secondary	13	0	13	21.7
Primary	27	6	33	55
None	10	1	11	18.3
Total	53 (88.3%)	7 (11.7%)	60	100

The majority of respondents (88.3%) irrespective of the educational level are knowledgeable about HIV/AIDS.

FIGURE 5: RELIGION DISTRIBUTION

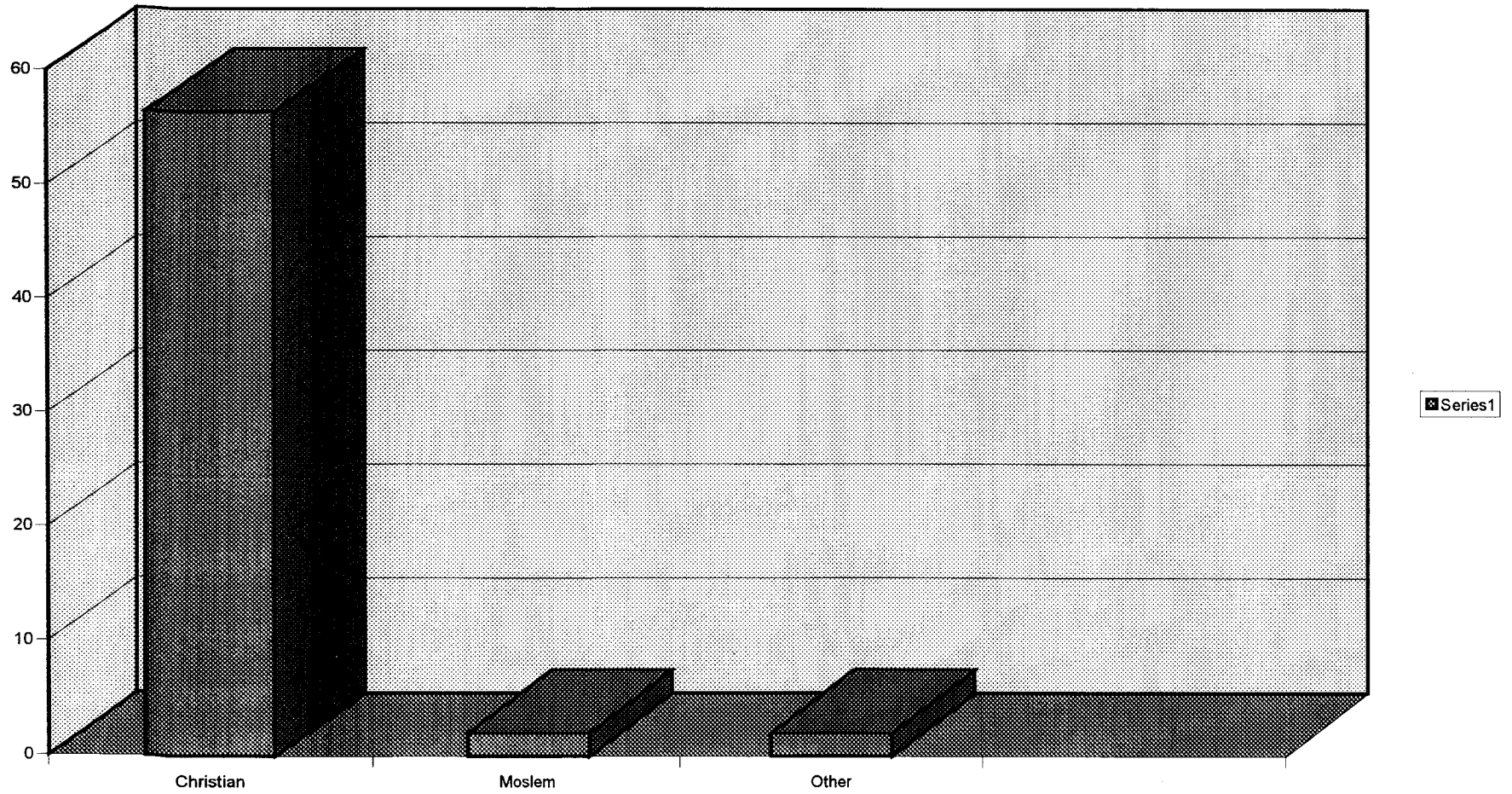


Table 9: Age in Relation to Knowledge of HIV/AIDS Distribution

Age Group	Positive (Yes)	Negative (No)	No. of Respondents	Percentage
15 - 19	2	0	2	3.3
20 - 24	6	0	6	10.0
25 - 29	13	2	15	25
30 - 34	10	0	10	16.7
35 - 39	21	0	21	35.0
40 - 49	1	2	3	5
50+	0	3	3	5
Total	53	7	60	100

The majority of respondents (35%) between 35 - 39 age group are knowledgeable about HIV/AIDS, followed by 25 - 29 age group with 25%.

Table 10: Education and Rating of Services Rendered at Health Centre

Educational Level	Adequate	Inadequate	Not Known	No. of Respondents	Percentage
University	0	1	0	1	1.7
College	0	2	0	2	3.3
Secondary	4	9	0	13	21.7
Primary	14	17	2	33	55
None	4	7	0	11	18.3
Total	22 (36.7%)	36 (60%)	2 (3.3%)	60	100

The majority of respondents (55%) with primary education stated that services were adequate.

Table 11: Education in Relation to Intervention if suspect Family Member of Having HIV infection.

Educational Level	Offer home care	Resort to Hospital	Take to raditional Healer	Not Known	No. of Respondents	%
University	0	1	0	0	1	1.7
College	0	2	0	0	2	3.3
Secondary	0	12	1	0	13	21.7
Primary	4	20	6	3	33	55
None	1	5	3	2	11	18.3
Total	5 (8.3%)	40 (66.7%)	10 (16.7%)	5(8.3%)	60	100

The majority of respondents (66.7%) irrespective of educational level opted for hospital intervention.

Table 12: Distribution Frequency of Precautions to be taken to ensure family members do not acquire HIV infection.

Precautions	Frequency	Percentage (%)
Advocate for use of condoms in child bearing age group	9	15
Seek for family counselling	18	30
Ensure assistance	6	10
Ensure one sexual partner	3	5
Educating family about HIV through health workers	12	20
The use of prayer	2	3.3
Not known	10	10.7
Total	60	100

The majority of respondents (30%) states counselling as the best measure followed by 20% who identified education through health workers as a precaution to take.

FIGURE 8: REACTION TO HIV/AIDS

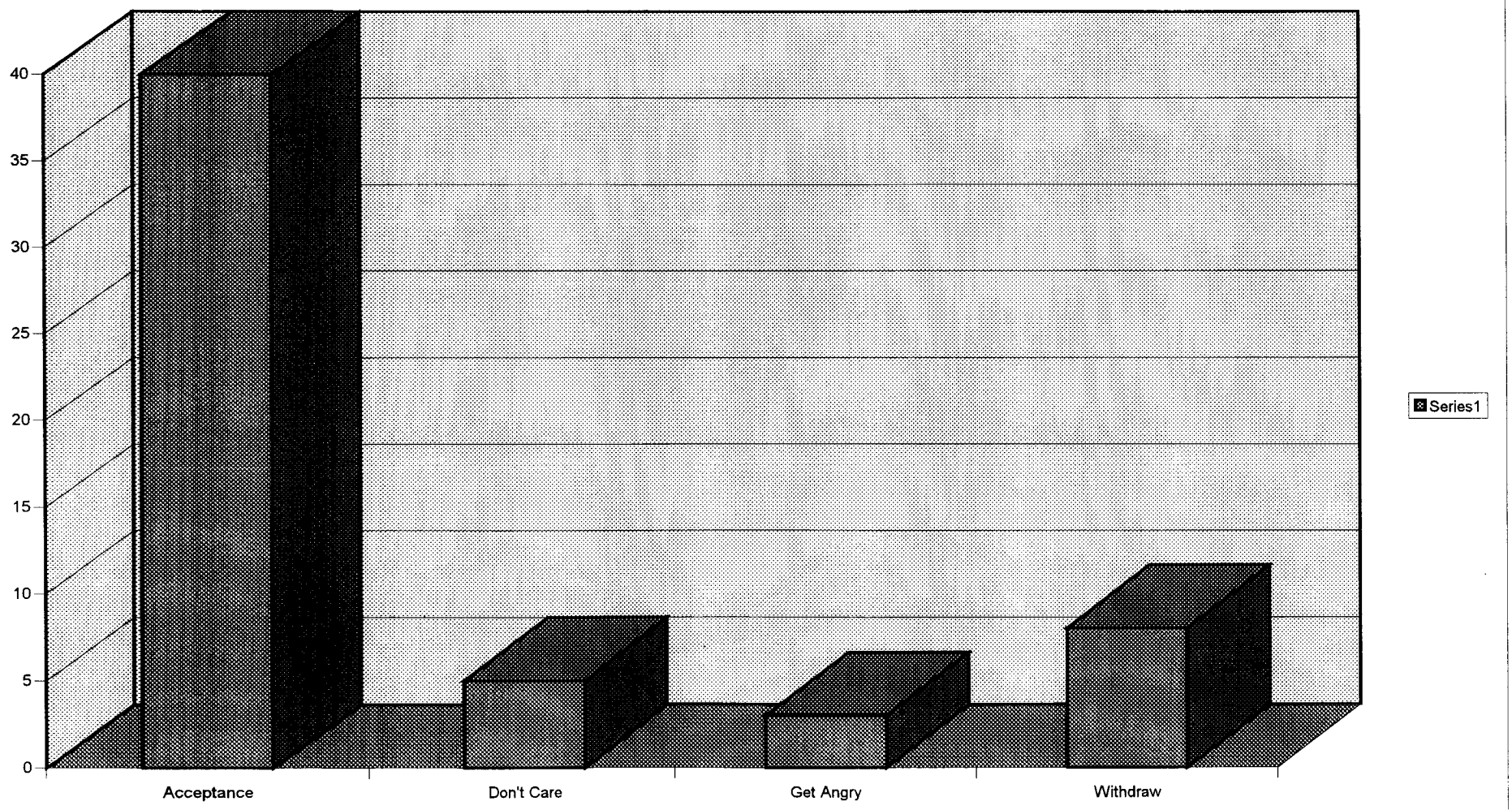
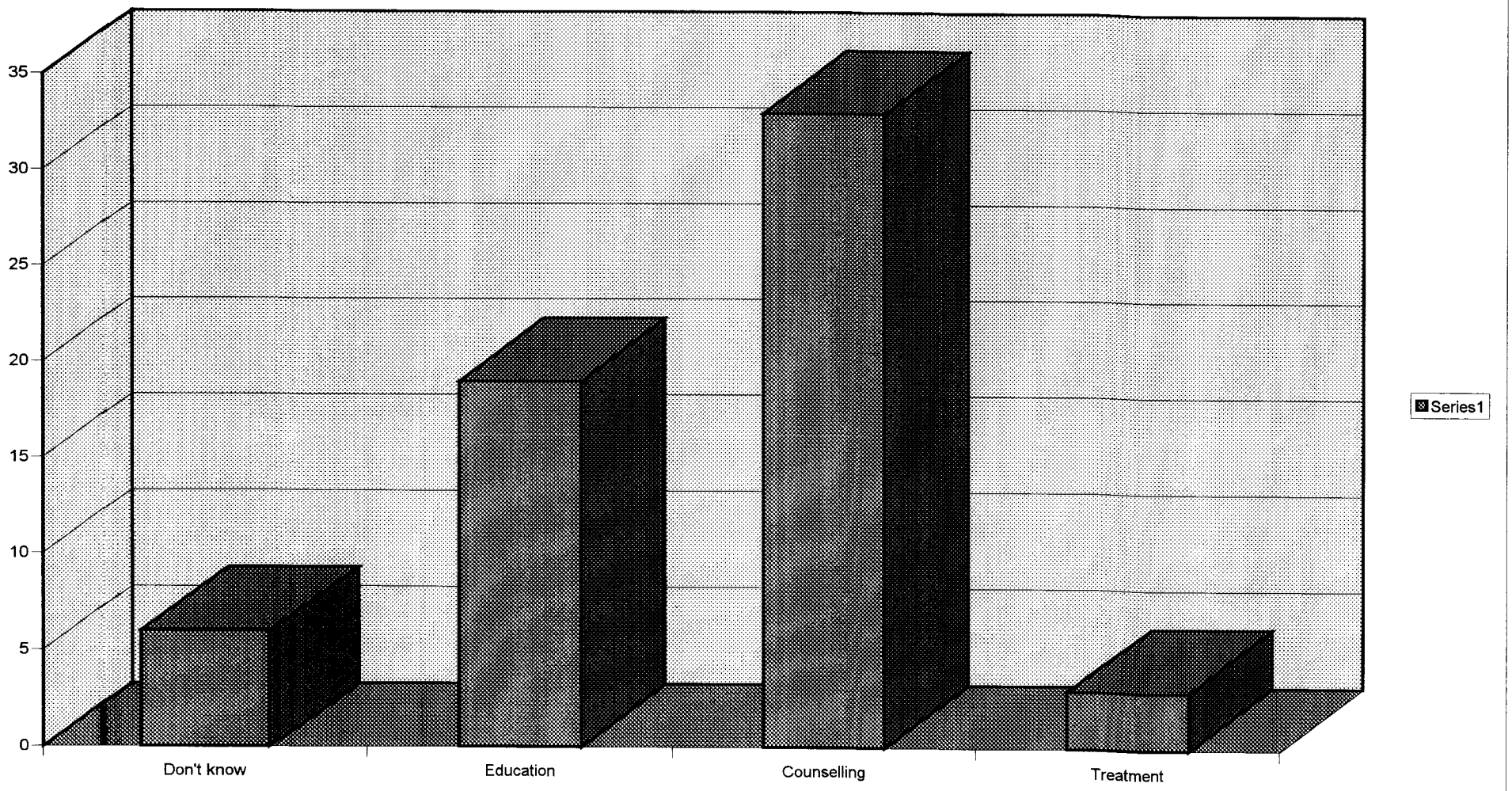


FIGURE 9: NURSING CARE NEEDS CONSIDERED

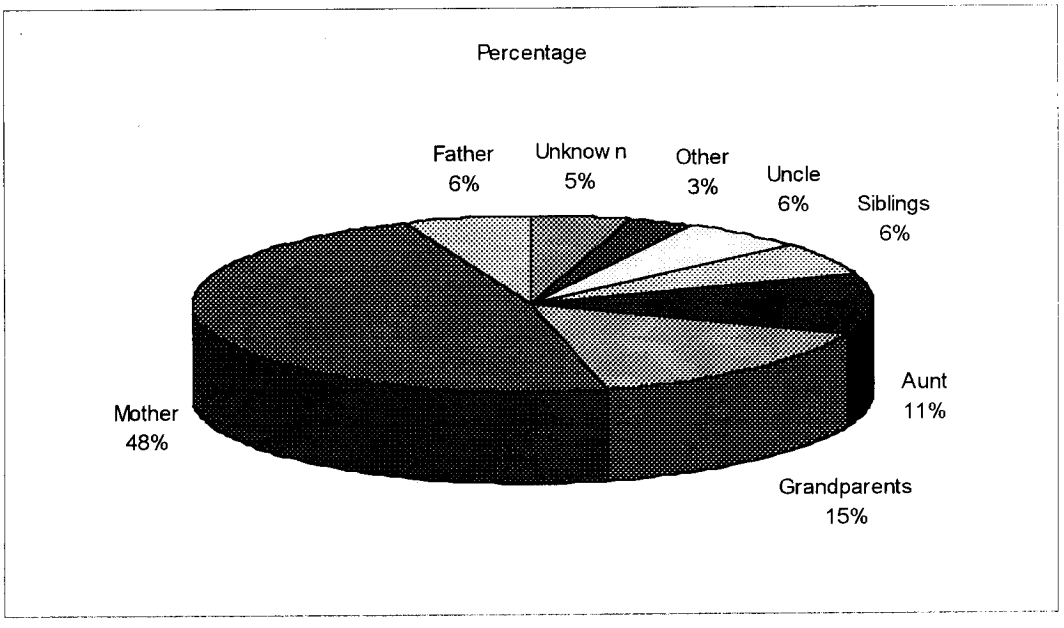


5.0 DISCUSSION OF FINDINGS

Age and Sex Distribution of Findings

The highest frequency of respondents were the female, 68.3% which supports the statement that, "the majority of the orphan carer today are either mothers or the female relatives of the widows."[29]

A peri-urban (Libala and Chilenje) enumeration survey of 95 families containing 300 orphans found that nearly half of the carers of orphans are mothers, a figure similar to that in Katete, 45%. Surviving fathers unlike surviving mothers are unlikely to be care givers 6.3%. In none of the cases are the carers outside the extended families.



The burden of caring for orphans is falling on the mothers in almost half of the households.

Source: Regiment Parish (1995) Libala, Chilenje, Lusaka.

[29] CINDI Project (1991) Enumeration & Needs Assessment survey for orphans - Matero East, Lusaka.

The males usually remarry easily and almost always do not favour keeping children from the previous marriage. The children are not tolerated by step mothers either. It is likely then, that the orphans are relocated amongst extended family members and usually those on maternal side.

It is significant to note that the woman in the society are the sole carers of most families even in the absence of a marriage. Also in old age women still continue to play their role as carers.

Employment Status and Family Income

According to the Southern African Magazine (1992), [30] the donor community had pushed the Zambian authorities too fast and beyond their capacities to sustain the Structural Adjustment Programme. Inflation reduced the living standards of people and led them to changing their diet from rich and expensive protein foods to cassava and maize meal. The informal sector experienced a decline in income as a result of the contraction of the formal sector. The retrenchment in the civil service further reduced the numbers of the employed hence exacerbating the unemployment problem.

The above situation support my findings that the majority of respondents 51.7% are self employed inclusive of both male and female and not in formal employment. Thier jobs vary, though mostly it's selling of perishable goods and other types of groceries. Though self employed, the income per month is below in most cases (36.6%) below K50,000. hence the majority of respondents would be in the lower social economic group. The majority of the unemployed (28%) have no income although they are skilled. This indicates a lack of employment opportunities. This situation adds on to a large category of people within the lower social economic group.

[30] Southern Africa (1992) The Structural Adjustment Programme in Zambia (Sapphio - Harare P1-29)

The low income versus the high cost of living as is presently the case in Zambia, threatens and impairs the coping mechanisms of extended families especially where added responsibilities are borne. [31]

Number of Persons in the Household and Meals Affordable per day

The enumeration survey of Matero in 1991 of needs and assessment survey for orphans revealed that orphans are not discriminated against when meals are served.[32] Of the 396 households, 60% of families eat three meals per day together, 17% eat two meals per day together while 8% eat one meal per day together.

The total population of the household members of this study in the 60 families was 425 members, with an average of 7.08 members per household. Of these the highest group category of between 6-10 occupants, 40 (66.7%) had only two meals per day, a trend which seemingly has deteriorated from 3 meals per day in 1991 as per the survey in Matero. The large size families could be indicative of functional role of the extended family system or the population growth rate 5.9% (urban growth rate 1980 - 1990 - Lusaka) due to high birth rates.[33] Mulnutrition could be evidenced in children above 5 years old and also adults due to the reduced number of meals in 24 hours.

Education Status

The educational level of the orphan carer ranged from never been to school to University level. The highest frequency 33 (55%) had been to primary school 11(18.3%) had never been to school, while 13(21.7%) had been to secondary school and 2(3.3%) college and 1(1.7%) had been to University. See table 8.

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[31] CINDI Project (1991) - An Enumeration and needs Assessment Survey for orphans - Matero East Lusaka, Zambia

[32] CINDI Project (1991) - An Enumeration and needs Assessment Survey for orphans - Matero East Lusaka, Zambia

[33] De Bunca Rocian 1994 Study to identify individuals and Organisations concerned with children in need - Lusaka

A survey done by CINDI project in Matero East Zambia (1991) showed that the age group 7-10 years, more non orphans 75% are in school while 68% of orphans are in school. There are not drop outs in orphans while 7% of non orphans have droped out of school. A higher precentage of orphans 32% have never been to school as opposed to non orphans 19% who have never been to school The disadvantage is hard on orphans who may start school late because of lack of vaccancies as they are moved in families, lack of educational support due to loss of parents. The age groups 11-15 and 16-20 had similar pictures with main reasons being lack of support, drop outs due to the psychological and emotional impact of parental loss lack of spiritual and parental support and self pity which leads to regression and thus poor academic performance.[34]

Orphans who may later be orphan carers themselves need to be educated like any other children need education. A lack of education during the time they are young will lead to a high frequency of non fully educated carers in adulthood as is evidenced in my study with the majority attaining only primary education level.

The importance of education in any society is of great importance for both personal and national development. The future of our country will not depend on the presence of new generations but also the total development of various aspects of life, education being one of them.

It is a step ahead that people are trying to gain education where they could, but it is a chellenge for one who has not gone far in education and not earning a reasonable income to afford to take on an orphaned child and ensure the child attains further education. It is a challenge that we have illiterate people and those who are losing the little they had acquired by dropping out of school.

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Religion and Family Interractions

Mtendere community is a religious community with 56 (93.3%) families being members of various churches of christian faith and only 2(3.3%) moslems and 2(3.3%) other spiritual believers.

The church groups are known for building community relationships that have offered urgent and on-going support to individuals and families in times of need. This has been demonstrated by the church featuring in community support for the orphans.

Mtendere has shown heterogeity in age, sex, education and socio-economic status. From such a heterogenous community one may forsee the complexity of the orphan issue in terms of their placement and care.

As regards family relations, the majority of christian faith 18(30%) have very good family relations as they claim to live according to what they belive in. However, poor family relations ranked next and was still under the christian faith. This is indicative of the varied problems encountered in homes that can lead to poor relations. This can range from overcrowding in homes, ill health, misconceptions and generally a lack of knowledge in how families must care for each other especially in added responsibilities.

Religion has a way of strengthening family ties though the choice to place orphans with relations is a Zambian practice which with wealthy families is a way of strengthening family ties and have an unconditional pleasure to do. For poor families it becomes a duty and a burden with limited expectations as to how far it can be born despite being of the christian faith.

Knowledge of HIV Infection

Educational level today does not necessarily influence the knowledge of HIV infection. Of the total respondents 88.3% had knowledge of HIV infection irrespective of the educational status. Much has been done in the area of dissemination of information though little seems to be done in the field of prevention.

High levels of knowledge about AIDS have veen found in sub sahara African countries [35]. One study in Uganda, showed that 98% of respondents know how AIDS is transmitted and that it has no cure. The Kwala district, 92% of the secondary school students correctly answered questions regarding importance aspects of AIDS as early as 1989.[36]

In Zambia, a survey conducted by the Copperbelt Health Education project in 1990 to assess the knowledge and attitude beliefs also practice on AIDS of lecturers, instructors, teachers in the tertiary education institutions in the Copperbelt revealed that 83% of respondents know about AIDS, the cause and the route of transmission. Thus spread of information has seemingly been the responsibility of all who had access to the information in the schools as students or work places down to the communties in which they live. Due to its implications a lot of community members have taken interest and learnt about the infection.

It is evident that HIV/AIDS has affected almost every family in most of our communities and because of its nature and the lack of a cure, a lot are aware of what to look for and how to convince themselves that what they are seeing is a clear picture of what they have seen and heard before.

[35] Webb Douglas (1996) SAF AIDS NEWS Volume 4 No1.
[36]

AIDS has touched a lot of lives and a radical change in life style becomes necessary when all of a sudden, care giving is needed. Families are not prepared, and thus there is a deficit in competence resulting in insecurity, embarrasssing situations and over work. Although the majority are knowledgeable they need the emotional and psychological support and concrete health and social services early in the stages after loss of loved one from HIV/AIDS.

Reactions to HIV/AIDS

The reactions of the majority of respondents towards the HIV/AIDS is positive 43(71.7%). The health worker or community nurse should take advantage and intervene appropriatly as the community is interrested in finding solutions to the problems encountered. For the minority who withdraw (15%) and do not care (10%) efforts should be driven towards making them realise the improtance of being aware of HIV/AIDS and its consequences, thus the need for Health Education.

Precautions to take to ensure family members do not acquire HIV/AIDS.

The highest frequency of respondents 18(30%) advocated for counselling service. Family counselling service was the most favoured response. This can be attributed to the fact that the families targeted are those who have had previous exposure to the service. However, the majority made it clear that counselling was a better way of approach as it allows the family or client to being sensitized and know that their input is of outmost importance as solutions to problems can be sought within affordable means.

The community is still looking at the health sector to intervene in any way appropriate because the disease has overwhelmed the entire population and answers are hoped to be realised from the health sector. The nurse then is also challenged to come up with remedial interventions to curb against the further

spread of the disease and the loss of lives in many households. Families with orphaned children are a target group as the existing pattern of orphan care in extended families and their distribution, can give rise to problems in adjusting to new social life and thus psychological health intervention is needed.

Crisis intervention, vocational guidance and counselling about problems associated or concerning the disease would be made available and offered to the clients. As the clients seem to be un accustomed to talking about their psychological problems an empathic and information seeking attitude on the part of the health care staff is essential.

The health visitor or nurse will work in searching for health needs and promoting client awareness and actions in response to professionaly guided identified needs. These could be those identified by clients, easily seen, opened up by the health provider and suspect or hidden needs.

Primary care practitioners should interract with the clients or patients for the purpose of helping them resolve health problems by clarifying issues and or presenting different options, and the community nurse should be in the forefront.

Nursing Care Needs of Families with Children Orphaned with HIV/AIDS

Nursing has tended to focus on health needs of individuals rather then the life style implication of health for families and the natural support system they provide. In efforts to find the nursing care needs of the family with children orphaned by HIV/AIDS, the majority of respondents 32(53.3%) are in favour of counselling as a need for such a family and ranked next by the health education (31.7%).

The delivery of home health services that are accessible and cost effective is contingent on understanding the characteristics and the needs of the aggregate

who need the service. The community health nurse's work involves the provision of home health services.

Counselling is paramount on issues relating to HIV/AIDS. A big number of respondents did agree that the nurse is their easiest contact in the health sector and so should be skilled with the ability to recognise the need targeting the counselling service and if able counsel clients as the situation necessitates it.

Trained counsellors are few and the nursing profession should include "counselling" in the curriculum in order to equip the nurse with the needed skill. The responses of the presence of HIV spectrum should be addressed in order to strengthen coping skills and maximise interpersonal comfort.

Bereavement is complicated by fear, shame, dependency and hopelessness. Therefore a task in counselling is to maintain the integrity and supportiveness of the family social unit by encouraging communication between those involved and by educating about AIDS which the next highest category respondents alluded to.

Nurses, being professionals should acquire the skill of counselling early during their training if they are to help families who have been afflicted by the scourge of HIV/AIDS.

5.1 IMPLICATIONS OF THE HEALTH SYSTEM

With evidence of increased awareness of HIV/AIDS and its consequences, the public looks forward to seeing action in real terms on part of health care providers as regards the specific interventions. Also the majority of communities are aware that health support systems are few and though trying to manage the communities are not succeeding due to the increased population, lowered economic status and a lack of resources.

The findings of the study spell out an intensified need for the majority of government and non governmental workers e.g. nurses who are in constant interactions with the communities to be equipped with the necessary skill to promote health in homes afflicted by HIV/AIDS.

Because of its overwhelming nature, the health system through which many clients pass should forge ahead and empower the nurses by providing them the needed skill and knowledge to promote health. The government should be committed to provide the needed financial support to boost the health sector instead of leaving it all to the community and NGOs. The health systems should be planned in such as way that the needs of the community are targeted.

5.2 NURSING IMPLICATIONS

The nursing schools are challenged to incorporate counselling at an early stage in order to meet the health needs of aggregates of these families.

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

This study reveals that the nursing needs of families with children orphaned by HIV/AIDS are varied ranging from offering counselling service, health education and offering treatment in times of illness. However for the majority, counselling service have been emphasised especially that the HIV scourge has overwhelmed a lot of families and will continue to do so as there is no treatment and efforts to prevent it seem futile.

The study has also revealed that those who have been exposed to the HIV/AIDS and its consequences are knowledgeable about the HIV/AIDS and are aware of the preventive measures put in place. Thus it is evident too that most people are reacting positively towards any measures to curb against HIV/AIDS and agree that people should face reality and work together to curb against HIV/AIDS consequences.

6.2 RECOMMENDATIONS

1. The Zambian government should consider increasing budgetary allocation to the health sector in order to continue the training of psychosocial counsellors nurses inclusive which is evidently a needed service.

2. The schools of nursing should enco-operate "counselling" as a basic nurse training need in the curriculum in order to equip the graduate nurse with needed skills to intervene in all circles of client health care including emotional and psychological care.

3. Refresher courses should be given to the trained counsellor in health centres and appropriate offices opened up in different communities.

4. Support of the already trained counsellors should be done so that the counsellor feels that he or she is part of the team, and so further training could be offered when the potential has been identified in the individual.

5. There is need for a larger study to be carried out at National level.

6.3 LIMITATION OF THE STUDY

1. Period was short for the research study.

2. The sample was small to be generalised.

3. No available literature review done in Zambia on nursing care needs of orphaned children.

6.4 BIBLIOGRAPHY

1. Africa Health — Volume 18 No 4 May 1996

2. Berk R A et al — Health Care Needs of persons with HIV/AIDS in various settings. Western Journal of Nursing Research 19(6): 647-71, 1995 December.

3. Cater K F et al — Health Needs of Homeless Clients Accessing Nursing Care at a free clinic Journal of Community Health Nursing 11(3): 139-47, 1994.

4. Caterinicchio M J — Redefining Nursing According to Patient and Family Needs AACN Clinical Issue 6(1):153-6 Feb.1995.

5. Fylkessness K et al — An Update on the Current HIV/AIDS Situation and Future Demographic Impact - 1995 Lusaka.

6. Gerberding J L — Managing Occupational Exposures to HIV William and William 1994 - Baltimore

7. Glick D F — The Relationship Between demographic characteristics and nursing problems in home health care. Public Health Nursing Journal 11(4): 259-67 1994

8. Harwarth A et al — Social consequences of AIDS in 49 Zambian Families - (Paper presented at the VII International Conference of AIDS) 1991 Florence, Italy.

9. Harwarth A — Counselling and HIV/AIDS in Zambia. National Aids Prevention and Control Programme 1992 - Zambia

10. Hunter S — Orphans and Widows of AIDS Epidemic in Sub-Sahara Africa - 1990. Pergamon Press - Oxford.

11. Kelso BJ — Orphans of the Storm 1994 UNICEF Document No 2998 - Lusaka

12. Lippman S B et al — AIDS and the family implications for Counselling
AIDS care 5(1):71-8 1993

13. Needham Dale — Aids Orphans in Africa - Catherine's story 1996 - Lusaka

14. Social Policy Research Group — Orphans, Widows and Widowers in Zambia
A situation analysis and options for HIV/AIDS survival assistance UNZA - 1993 Zambia

15. Ungvarski P J and Hurley P M — Nursing Research in HIV/AIDS Home Care
Home Health Care Nursing 13(4): 9-13 1995

16. UNICEF — Putting Children First
Zambia National Programme of Action for children 1995

17. Webb Douglas — A situation analysis of children in Especially difficult circumstances
UNICEF - 1995 Zambia

18. WHO — Global Programme on AIDS: AIDS Home-Care hand book 1992

19. WHO — AIDS: Images of the Epidemic 1992

20. Yelding David — Caring for Someone With AIDS (A clear practice guide for people coping with AIDS including where to go for information and support) British Library Cataloguing in Publication date Paston Press London, Norfolk 1990

APPENDIX I

LETTER REQUESTING FOR PERMISSION

30th July, 1996.

The Director
F amily Health Trust,
LUSAKA.

u.f.s. The Head, Post Basic Nursing

Dear Sir,

re: PERMISSION TO COLLECT INFORMATION FROM THE FAMILIES WITH CHILDREN ORPHANED BY HIV/AIDS INFECTION

I am a 4th year student at the department of Post Basic Nursing undergoing a Bacheler of Science degree in Nursing.

In partial fulfilment of the requirement of the programme, I am required to carry out a research project. My topic of study is "A Study to Determine the Nursing Care Needs of Families with Children Orphaned by HIV/AIDS in Lusaka Urban".

I hereby request for permission to carry out interviews with the families under your care with Children Orphaned by HIV/AIDS between the 31st July to 10th of August, 1996.

Your assistance will be greatly appreciated.

Yours faithfully,

Mavis M. Chinkumbi

APPENDIX II

QUESTIONNAIRE FOR ORPHAN CARERS

UNIVERSITY OF ZAMBIA

DEPARTMENT OF POST-BASIC NURSING

QUESTIONNAIRE FOR ORPHAN CARERS

STUDY TITLE: A STUDY TO DETERMINE THE NURSING CARE NEEDS OF FAMILIES WITH CHILDREN ORPHANED BY HIV/AIDS IN LUSAKA URBAN

QUESTIONNAIRE FOR CARERS OF CHILDREN ORPHANED BY THE HIV/AIDS IN LUSAKA URBAN.

QUESTIONNAIRE

NO. ----------

For Official Use Only

INTRODUCTION

1. Please read the instructions and answer all questions.

2. Either tick [ ] the appropriate answer or write your comment in the space provided.

3. Note that the information provided on this paper is not to be shares between or amongst colleagues; all information will be held in confidence.

4. You need not mention your name in the questionnaire.

SECTION A - DEMOGRAPHIC DATA

Please tick [ ] in the box or write in the blank space provided.

1. Sex of respondent
   a) Male
   b) Female

2. Age of respondent at last birth day. _____

3. Marital status
   a) Married
   b) Single
   c) Divorced
   d) Widowed
   e) Separated

4. What is your religion?
   a) Christian
   b) Moslem
   c) Buddhist
   d) Other, specify

5. What level of education did you attain?
   a) Primary
   b) Secondary
   c) College
   d) University
   f) Never been to school

6. What is your occupation?

a) Self employed
b) Not employed
c) Farmer
d) Servant
e) Other, specify

_____

7. Where do you live?
a) Low density
b) Medium density
c) High density
d) Other specify

_____

8. Who is the head of the household?
a) Father
b) Mother
c) Brother
d) Sister
e) Other specify

_____

9. What is your monthly income?
a) K50,000 and below
b) K50,000 to K99,000
c) Between K100,000 and K150,000
d) Above K150,000
e) Other specify

_____

10. How many are you in your household?

_____

11. How many rooms does your house have?

_____

12. What is your source of water?
a) Well
b) Stream
c) Tap
d) Borehole

13. What type of toilet do you use?
a) Flush
b) Pit
c) Bush
d) Others specify

SECTION B - COPING AREAS

14. How well do family members relate to each other?
    a) Fairly well
    b) Very well
    c) Satisfactory
    d) Badly

15. Do you have food at all times?
    a) Yes
    b) No

16. If No, where do you get help from?
    a) Neighbours
    b) Relatives
    c) Church
    d) Others specify

    _____

17. What do family members do In the event of illness or sickness in the family?
    a) Go to hospital
    b) Go to traditional healers
    c) Go to private hospital
    d) Use home remedies
    e) Other specify

    _____

18. What type of medical conditions make you seek help?

    _____

    _____

19. How often do family members seek help on health related problems?
    a) Always
    b) Sometimes
    c) Never

SECTION C - ACCESSIBILITY TO HEALTH SERVICES

20. Are you near a health centre?
    a) Yes
    b) No

21. Are you able to afford the fees at your health centre?
    a) Yes
    b) No

22. If No what would you prefer to pay for the health services?

    _____

23. How would you rate the services rendered by your health centre?
    a) Adequate

b) Inadequate
c) Not useful
d) Other specify

_____

24. What nursing care do you receive at the health centre?

_____

SECTION D - KNOWLEDGE

25. Do you know about HIV/AIDS?
a) Yes
b) No

26. How many orphans are there in the family?

_____

27. What would you do if you suspected a family member of having HIV/AIDS?

_____

28. What precautions would you take to ensure other members of the family do not contract the HIV infection?

_____

29. What nursing care would you consider necessary to render to a family who have lost a parent due to HIV/AIDS infection?

_____

30. How do you react when people talk about HIV/AIDS?
a) Don't care
b) Get angry
c) Acceptance
d) Withdraw

END OF QUESTIONNAIRE