THE STUDY TO DETERMINE KNOWLEDGE, ATTITUDE AND PRACTICE OF COMMUNITY TOWARDS HBC SERVICES FOR HIV/AIDS PATIENTS IN KITWE

BY

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A STUDY TO DETERMINE THE KNOWLEDGE, ATTITUDE, AND PRACTICE OF COMMUNITY TOWARDS HOME-BASED CARE SERVICES FOR HIV/AIDS PATIENTS IN KITWE URBAN DISTRICT

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DECLARATION

I hereby declare that the work presented in this study for the bachelor of science in Nursing Degree has not been presented wholly or in part for any other degree nor is it being currently submitted for any other degree.

Signed: [Signature]

CANDIDATE

Approved: [Signature]

SUPERVISING LECTURER

UNIVERSITY OF ZAMBIA
DEPT. OF POST
BASIC NURSING
SCHOOL OF MEDICINE

1998-02-26
I hereby certify that this study is entirely the results of my own independent investigations. The various sources of information to which I am indebted are clearly indicated in the paper and in the references.

Signed: [Signature]
DEDICATION

I dedicate this study to my parents, especially my mother Mrs. Rita Chandi for her encouragement and support throughout my life and especially during the years of study.

To my dear wife, Lillian Chandi, for her loving and unti ring support and understanding; To my daughter, Della; sons Milambo and Muuka, who were denied daddy's company and care at tender ages. To my brother Eugene and sisters Eunice and Chipo for the support during my year of study: To my Sister-in-law Mrs. Della Bumba for the faith and encouragement during the years of study and lastly to all my relatives and friends to many to mention.
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ABSTRACT

The purpose of this study was to determine the knowledge, attitude and practice of community towards Home-Based Care Services of HIV/AIDS patient in Kitwe Urban.

Review of literature on relevant studies done throughout the world revealed that there are a number of influencing factors such as; age of the care provider, poverty, cultural background, stigma, health education of level, community, participation, support from relatives, education level of community, resources and supervision of care provider. A descriptive, explanatory and non-intervention type of study was used. The research was conducted in Urban Kitwe District.

The population understudy was fifty (50) members of community; twenty five (25) from Chimwemwe and twenty five (25) from Kapoto township. The respondents were randomly selected.

Data was collected using a structured interview schedule. Data was analyzed manually and findings presented in frequency tables and cross tabulations.

The study revealed that most of the respondents had basic primary school education, their knowledge level on HBC for HIV/AIDS patient was poor/low.
It was also revealed that most of the respondents had no formal training on HBC. This contributed to the misconception about the programme and the poor quality of care.

The attitude of the community toward the PWAs and the programme was negative, mainly because of inadequate information on the programme.

Regarding practice, the study found that most respondents described the Care as pathetic. Reason being that of not having enough supervisors, inadequate material and financial support.

However the study came up with positive finding; Most respondent were willing to take part in HBC after extensive training and with adequate support from the concerned authority.
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<td>WHO</td>
<td>World Health Organization</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>HIV</td>
<td>Human Immune Virus</td>
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<td>AIDS</td>
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CHAPTER ONE

1.0. INTRODUCTION

1.1. BACKGROUND INFORMATION

By 30th June 1996, the World Health Organization (WHO) estimated that 21.4 million people were living with Human Immune Virus or Acquired Immune Deficiency Syndrome (AIDS). The cumulative cases of AIDS in adults and children which were reported by countries to WHO stood at 1,393,649. This showed an increase of approximately 19% (UNAIDS 1996).

In most countries there are now significant numbers of people living with HIV-related illness. The burden on health services is growing. In 1992 developing countries spent a total of US$ 340 million on health care for people living with AIDS (PWAs) up to a third of national budgets (AIDS ACTION 1995).

One study carried in Zambia, reported that up to half of all patient-day in medical wards of central hospitals were accounted for by people with HIV related illness.

This has led health Institutions, Non-Governmental Organizations (NGOs) and mission hospitals, developing programmes to enable people with chronic illness to be
cared for at home—Home Based Care (HBC) or Community Home Based Care (CHBC).

Home Based Care programmes started in the mid 1990s by Non governmental sector in response to the AIDS health crises.

In Zambia, in 1986, the Church Medical Association of Zambia (CMAZ), an umbrella organization of all mission hospitals adopted the HBC as a strategy to respond to the AIDS challenge in the country. A second programme was established at the University Teaching Hospital (UTH) in Lusaka.

In Kitwe Home-Based Care programmes started later in the 1990s in Lwangwa township by the catholic organization (Catholic Diocese of Ndola). By the end of 1992, there forty seven (47) registered Home-Based Care programmes in Zambia, most started by hospital staff with external funding. These programmes, together managed to reach over 9,000 PWAs to provide clinical treatment, emotional, social and pastoral support and in most cases, domestic supplies such as soap and blankets (MOH/WHO 1994).
The Home-Based Care programmes in Zambia have been implemented in two ways:-

- Hospital-Initiated Out research programmes, or Vertical programmes.

These are initiated by hospital staff concerned about the quality of care provided to hospitalized PWAs and the need exposed by PWAs. Then slowly integrating into the community.

- Horizontal Programmes or Community-Initiated Programmes. These are started by religious staff with donations or small budgets from churches. These rely on community volunteers with support from the community-based organization, church and health facilities.

Which ever way or model is used in the programmes it should aim at:-

- Ensuring that people receive basic nursing care as well as social and emotional support.
- Enabling health workers to make home visits.
- Train volunteers, families and people with HIV in basic nursing care and infection control.
- Mobilizing other people to provide support.
- Reaching sick people who are not using health services.
- providing advice or money for income generation.
- Integrating care with HIV education.
- Promoting acceptance of PWAs.
- Reducing pressure on hospital in-patient facilities.

Further more, HBC programmes aims at empowering the community with knowledge on Home-Based Care Services and HIV/AIDS, and consequently motivate them to care for the PWAs in their homes. But studies have shown that provision of care is not easy. At the most HBC can become "home neglect" (AIDS ACTION 1995). This has been compounded by inadequate information about HBC services, pressure on economically poor families, health worker inability to make frequent visits and inadequate training and equipment given to volunteers. Neglect or level of community involvement is attributed to the fear about HIV or belief that the patient or relative will die soon.

In Kitwe, HBC programmes have placed more emphasis on delivery of care. Little has been done in integrating care with HIV education and mobilizing the community in the provision of care.
According to available statistics, Kitwe Home-Based Care programmes recorded a greater problem in sustaining commitment from part-time staff or health volunteers, primarily because they joined for monetary gain and to a lesser degree, stress related obligations "born out". With the current projection that 90% of the country's 25,000 hospital beds will be occupied by PWAs by the year 2010 (MOH/WHO 1994), a need exists to strengthen community and family involvement in the Home-Based Care Services.

1.2. STATEMENT OF THE PROBLEM

Although the constantly growing HIV/AIDS care needs have already overwhelmed the coping capacity of urban health systems in hard hit countries, demand for care will increasingly fall on poorly equipped and under funded rural services, household and individuals (UNAIDS 1996). Already 80% of hospital beds in infectious disease hospital in Abidjan and Ivory Coast are occupied by people with HIV/AIDS (UNAIDS 1996).

Zambia has an estimated 500 new cases or HIV infections per day and adult prevalence is 10-15% in rural areas and 20-25% in urban areas. The infection rate in urban area is expected to peak up to 28% (UNAIDS 1996).
This evident from most urban hospitals recording high number of HIV/AIDS patients in their day wards. Kitwe Central Hospital has not been spared by this problem.

In trying to allocate the congestion at the Institution the church organization in conjunction with the hospital Administration spear-headed the formation of Home Based Care units in the urban areas. The emergence of HBC programmes has considerably played a role in augmenting in family effort because the AIDS pandemic calls for concerted effort from care providers.

While community participation has been sort in HBC, a study conducted in Zimbabwe on community involvement in provision of care for the PWAs revealed that some families who opted to care for their loved ones at home, made an inordinated sacrifice in order to provide care they, they for went education, and ward opportunities at the same time their house budgets was stretched to cover basic items, particularly food (Woeld et al 1996).

In Zambia, Lusaka HBC programme recorded 37.5% staff resignation in a couple of years. General "born out" symptoms were reported by many home visit workers. The
continued exposure to overwhelmingly mar needy patients and families, lack of adequate resources to satisfy their needs, conflicting work demands and the amount of uncomfortable travel involved with Home-Based Care reported as factors.

Most families cannot afford basic supplies and the extra cost of the patient were major burdens on the families. As a result the families were left with no option but to commit their loved ones to hospital care.

Care providers at family level do not have adequate experience, training and knowledge in caring for the chronically ill patients. Most of them reported lack of information/explanation about their patients. This placed them at risk of contracting diseases.

Another problem which has kept the community away from care is the daunting task of cooking, washing and comforting the PWAs. This means considerable time as about 50-90% is spent on the patient. This limits the activities care givers, it reduce the time for economically productive activities as most patient need care for a long period of time-months or years.
This trend has made nursing staff to continue playing a prominent role in HBC, by doing much of counselling, information dissemination and providing professional care. As the number of PWAs increase, the demand on them will increase, they will be unable to cope with the needs of the community.

Further more, community based support services for PWAs is generally unavailable, at the best inconsistent and underfunded. This has contributed to the patient/client neglect, which is seen in most patients admitted to hospital. This lack of support has increased patient turn over in medical wards and consequently increased the death rate among PWAs.

In Zambia there has been no published study targeted on assessing the knowledge, attitude, and practice of community towards Home-Based Services. However, a study carried out by Mwiinga on Response of HIV/AIDS patient and relatives to HBC in Lusaka, revealed that there was a gap in the knowledge, attitude and practice in HBC for PWA. In view of the situation, the research question to be addressed is how much knowledge does community has towards HBC services in PWAs community attitude and practice will also be assessed. This will be done by rating scale.
However, there exists assumption on factors that are deemed to influence community knowledge, attitude and practice towards HBC services for people with HIV/AIDS.

- Lack of support from relatives.
  Despite the presence of relatives nearby, many studies revealed that this did not increase the support. Even relatives living nearby "frequently visited" only visited half the times. This was attributed to the harsh economic situation brought about by the structural adjacement programme (SAP).

- Many people lacked knowledge or understanding the role of HBC, the programme is viewed as that one which supports other members of the family clothes, supporting children at school, building better houses and feeding the whole family.

- Poor quality of home care as compared to those hospital set up. This arises because volunteers are not committed and poor or inadequate training such development has forced HIV/AIDS patient seek hospital care.

- Fear
  Care of terminally ill patient may be frightening experience. Care givers may be afraid of what will happen as illness, perhaps advances even be afraid of death of loved ones. Fear also comes when the care providers lack adequate strength or ability to meet patient needs.
- Poverty

This has greatly affected community's level of participation. Lack of much needed resources has made caring for the PWAs a nightmare for most families. Most families in the community are prepared to assist but their financial stand is the draw back.

- Health Education

There is no programme aimed at educating the community on the Home Based Care. This has contributed to the poor attitude towards the programme.

- Lack of supervision

Most programmes have few members of part-time staff or volunteers. This makes it difficulty to monitor activities of primary care givers in homes.

- Lack of Resources

Home-Based Care programmes are poorly funded making caring of the PWAs very poor. Families lack adequate materials resources in their homes. This development has contributed to the poor quality of PWAs in the community.

- Age

More adults are likely to take part in HBC programmes. It is expected that as one advances in age the more caring he/she will become.
The purpose of this study is to establish the knowledge, attitude and practice of the community towards HBC services and the data obtained from the study will provide relevant authority, policy makers at national level, regional and district level information to formulate strategies and implement appropriate HBC services in Zambia.

The researcher hopes that the information will enhance community participation in care programmes at grass root, thereby improving the quality of the life of the PWAs.
DIAGRAMMATIC PRESENTATION OF THE RELATIONSHIP BETWEEN VARIABLES

- Community Participation in Care for PWAs
- Health Education on Care for PWAs
  - Educational Level of Respondents
  - Frequent Supervision

- Stigmatization
  - Support from Relatives
    - Cultural Background
  - Resources
    - Poverty

- Knowledge, Attitude and Practice of Community towards HBC Services of HIV/AIDS Patients
CHAPTER TWO

2.0. OBJECTIVES AND HYPOTHESES

2.1. GENERAL OBJECTIVE

- To determine the knowledge, attitude and practice of community towards HBC services for PWAs.

2.2. SPECIFIC OBJECTIVES

- To assess community’s level of knowledge in relation to HBC
- To determine community’s attitude towards HBC services.
- To identify the kind of care that the community offers to the HIV/AIDS clients in their home setting.
- To establish the extent to which other factors such as education level, stigmatization, availability of resources, poverty, community participation, support from relatives, health education, supervision and cultural background influence the knowledge, attitude and practice of community towards HBC.
- To make recommendations to policy makers, relevant Non-Governmental Organizations.

2.3. HYPOTHESIS

- The knowledge, attitude and practice of community has an influence on the HBC services for HIV/AIDS patients.
- The community views of HIV/AIDS has an effect on the quality of care rendered.
CHAPTER THREE

3.0. LITERATURE REVIEW

The literature related to the research topic, the knowledge, attitude and practice of community towards Home Based Care services will be reviewed and discussed in this chapter.

I will be systematically and orderly discussed under the following headings.
- Global situation
- Regional situation.
- The Zambian perspective
- The knowledge of community toward HBC
- The attitude of community toward HBC
- The practice of the community toward HBC.

3.1. INTRODUCTION

From the dawn of the human life history, the community has been at the heart of human development. It has been the first emotional and social support mechanism provider. Members experienced their first teacher and first health provider in the community is the family, providing shelter a system of mutual solidarity and support.
The greatest challenge for the public health today is to seek ways to empower families to do well what they can do best. Families cannot do the job alone, a positive relationship between families and health sector is essential.

Communities now need all the outside help they can get to reinforce the role of a family to plan for and provide care for their HIV/AIDS victims. In short, community is the natural frame work for matter concerning health.

1. GLOBAL SITUATION

The Human Immune Deficiency Virus (HIV) infection and Acquired Immune Deficiency Syndrome (AIDS) continue to be a major health problem world wide and will be so for many years as many more cases are reported each day.

By mid July 1996, UNAIDS (1996) said an estimated 21.8 million adults and children world wide were living with HIV/AIDS, of whom 20.4 million (94%) were in developing world. Close to 19 million adults and children (86% of world population) were living with HIV/AIDS in the sub Saharan Africa and in South West Asia, of the adults 12.2 million (58%) were males and 8.8 million (42%) females.
The global cumulative number of HIV infection among adult has more than doubled since the beginning of the decade, from 10 million in 1990 to 25.5 million by mid of 1996 of which 14.9 million were men (58%) and 10.5 million women (42%). (UNAID 1996).

The HIV infection has no cure, it is therefore important to develop practical strategies to prevent the scage of HIV transmission. For the already infected, the infection develops into AIDS which is a chronic debilitating illness. Therefore a mechanism of support need to be developed or established the Home-Based Care. The support system should draw resources from the community and health institution.

The support system will call for concerted effort world wide as AIDS pandemic spreads.

The Nursing Times (1990) predicted that in United Kingdom alone, there would be enough AIDS cases to fill every surgical and medical bed in hospital by the end of the century. So more AIDS patients will be nursed in their own homes as such individuals and communities will assume responsibility for matter of health.
Miller (1986) reported on the plight of HIV/AIDS patient in the United Kingdom. He demonstrated that the social economic stress associated with HIV/AIDS is more than just a disease, it has become a major political and cultural issue. He further outlined the vast majority of AIDS patients fended for themselves or dependent on charity for continued care. There was no systematic approach to care for those patients at home.

2. REGIONAL SITUATION

Most of the epidemiological evidence indicates that the extensive spread of HIV in the region began in the mid to late 1970s. Adult prevalence rate range from approximately 1 per 1000 (0.1%) in the Comoros to move that 18% in Botswana.

By mid 1996, 13.3 million adults were living with HIV in the Sub-Saharan Africa, representing about 60% of the worlds total. These were basically from three broadly defined geographic areas. The Central/Eastern Africa which is Cameroon, Ethiopia, Kenya, Rwanda, Sudan, Uganda and Zaire (Congo K.) with 37% of HIV current status, the Southern Africa is Botswana, Malawi,

Studies done in seven Sub-Saharan Africa region revealed that more than 10% of women attending Ante-Natal Clinic in Urban areas were infected with HIV (UNAIDS 1996). Infection was found to be ranging from Teen years and peaking before 25 years. This represents women in the reproductive age.

Furthermore, WHO (1996) estimates that 3 million HIV infected infants born in the world with HIV infection since the beginning of the pandemic, over 90% have been born in Africa.

This ever constantly growing number of HIV/AIDS patients in the region has overwhelming the coping capacity of urban health system in hard hit countries. This demand for care fall on poorly equipped and under funded rural services, households and individuals.
Already 80% of hospital bed in an infectious disease ward in Abijan, Cote d’Ivoire, and 50% in a hospital in Kampala, Uganda are occupied by people with HIV disease (XI AIDS Conference 1996).

In most countries in the region, faced with significant number of people with HIV/AIDS (PWAs) health services (Government) NGOs and mission hospital have developed programmes to enable people with chronic illness be cared for at home—Home Based Care. These programmes main aim was to reduce cost and demand on the in-patient facilities, saving money was not their prime aim. Development of Home Based Care came up after many studies showed that many people preferred to be nursed at home, with adequate resources and support.

In Zimbabwe, Kerkhoven (1994) reported that the mounting morbidity and mortality from HIV infection came with increasing burden of care on the health services and inevitably on the community and family. This lead to development of Home Based care services. By 199 Zimbabwe had 65 home care schemes.
These were facing increase in referred or registration of patient as fast as they became established. Community had to organize themselves to meet the demand, but their efforts fell too short-insufficient. This was due to the heavy burden terminally ill patient exert on the household in terms of labour, finance, psycho social stress in the household that already struggling to survive the harsh economic climate.

AIDS Care (1995), further highlighted problems the Zimbabwean programmes faced. The vertical programmes that exclusively targeted HIV/AIDS patients tended to include chronically or terminally ill patient. This was due to the pressure from the service community who felt stigmatized by visits from an identified HIV/AIDS team. Further more, many studies in the Sub-Saharan region have revealed that for many patients home care may mean "home neglect". Patient may die without benefits of basic medication, adequate and appropriate food, proper nursing care and basic physical comfort. They (patients) may spend extended period alone while other households are busy elsewhere.
Uganda, probably the first country in the Sub-Saharan region to come out in open over the HIV/AIDS status of its citizen to date is still faced with a daunting task of caring for its PWAs. According to Williams (1996), this daunting task is faced by many Christian communities because all members are volunteers and the amount of time they have for community work is limited. Most of them have full-time jobs and many have families to support. They have inadequate funds and materials for the enormous needs for the people they are trying to help or serve (PWAs).

He further reports that, Uganda despite being the oldest in AIDS campaign, it is still faced with the AIDS stigma. Many patients with AIDS feel rejected, making it difficult to cope with the condition. The source of rejection is always the result of judgement and censure on moral ground or because of fear of contracting the disease. Usually this occurs because members of the family, friends and neighbours do not know how to cope with a person who is dying.

THE ZAMBIAN PERSPECTIVE

Zambia is a landlocked country in Central Africa with a population of 7,818,447. Out of which 3,975,083 (50%)
are female and 3,843,334 (49.2%) are males. Fifty eight percent of the total population is in the rural area (CSO 1990).

Fylkenese (1995) states that Zambia is the heart of African AIDS belt, stretching from Uganda and Kenya southward to (eastern) southern Africa, the sero-surveillance data from Ante natal clinic from 1994 shows a great diversity in the spread of HIV across the country ranging from 16-31.9%.

By December 1996, the country had reported 14,566 cases of AIDS and 27,881 were reported as AIDS related complex (ARC) (MOH-NASTLP 1996).

In addition, the economic of the country has been beset by a severe recession resulting in increased unemployment lower income and decline health and social services. The combination of these factors and the estimated 500 new HIV infection per day has over burdened the health services. The burden of providing care for the PWAs today is almost exclusively falling on hospital where 90% of the total HIV/AIDS care cost are expended.
In Zambia, up to 60% of in patients admission on medical wards in major hospital and 70% of tuberculosis admission are HIV positive patient (WHO-MOH 1994). This is because, community based support service for PWAs are generally unavailable or, at best inconsistent and under funded. The pressure on hospitals represents a prohibitive drain on resources, resulting in declining and often neglect care of PWAs. This trend is expected to worsen with the increase in number of HIV/AIDS cases as projected by WHO.

Community based support services can be an effective complement or even alternative to hospital services for PWAs. It support and builds on the strengths of the family and community while providing services often not available within hospital such as emotional spiritual and social support.

Home-based care programmes providing services within a community also provides a unique opportunity to reduce the fear and stigma associated with HIV/AIDS.
Jackson (1996) stated that, while claims by UNAIDS show the success of home based care programmes, SAFAIDS is unaware of any home care studies in different countries in Africa that report high level of coverage based on reasonable assessment of underling need or that report having a sustainable resources to meet existing needs adequate over time. She said on the contrary studies increasingly suggest major underlying difficulties around both cost and the quality of the programmes. The widely reported and extolled home care in the region, that of Salvation Army at Chikankata Hospital is running into increasingly difficulties now, the enormous real cost per home visit is beginning to be felt, let alone the cost of expanding services on the original basis to meet the growing needs.

So unless the models of home and community care services radically change to genuine community rootedness and ownership backed by external support, rather than expanding current models that are at present, generally opposite, they have little hope of expanding coverage and improving quality of care in the face of the rapid escalating needs.
THE KNOWLEDGE OF COMMUNITY

An evaluation report of home-based care under CMAZ revealed that although marital achievement has been recorded in home-based care, in line with AIDS awareness and care, inadequate knowledge about HIV/AIDS among the community and home based care providers is still evident. Knowledge lack has contributed to the inadequate integration of HIV/AIDS prevention and care activities in other health activities and involvement of some key sectors (Agriculture, community development and social sector) for HBC (Macwangi 1993).

Lack of knowledge can be further be highlighted by the many programmes recording a high turnover of client enlisting for food hand out. Up to date many people in Zambia still believe that HBC programme is there to provide food supplement to poor people in the community.

In Kitwe, one coordinator, explained how alot of impoverished families enlisted under their care when the programme was established, similar view were expressed by many programmes in Zambia.
Piet Reyer (1996) reports that when many hospitals decided to run home-based programmes (to decongest the in patient), it sent PWAs home, informing the community in one way or another that hospital had decided that care had to come from the family. The community did not understand what was going on (sick were cared by hospital). This led to most care failing, because not adequate information was given and care givers (in the community) were not taught how to go about caring.

**ATTITUDE OF COMMUNITY**

Attitudes are developed from what a person knows, therefore inadequate knowledge and misconception can lead to development of wrong or negative attitudes toward a particular situation or concept. Mwiinga (1991) in her study found that many families preferred that the patients remain in hospital, thereby registering a negative response to home-based care. She attributed such attitude to lack of knowledge about illness, role disillusionment, high cost in procurement of drugs be it traditional or otherwise.

Misconceptions about the HBC services have been registered by many programmes. Many volunteers joined the programme with the hope of financial benefits. Realising that these were to render free to the PWAs, many dropped out.

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In Kitwe, some townships with high number of HIV infected people has only a handful of care providers-increasing the levels of "born out".

THE PRACTICE OF COMMUNITY

The community involvement in the delivery of care varies considerable from one which renders care to the PWAs to that which isolates itself from HIV infected people.

In Lesotho, according to Ntsekhe (96), the major problem faced with PWAs is lack of support. The condition is so stigmatized people with HIV are isolated.

The provision of care to individual affected with HIV including those with AIDS remains a major challenge to health care systems world wide. The HIV/AIDS pandemic has intensified competition of scarce resources and in many parts of the world, especially in countries here basic health care remains inadequate, has stretched health care facilities to the limits.
In Zambia a study by WHO/MOH (1994) reveal that despite the presence of relatives within walking distance of PWAs, this did not ensure increased support to more than half of the PWAs and even relatives living nearby "frequently visited" only half the PWAs.

One can deduce from this data that there is gradual disintegration of family structure resulting from economic hardships that Zambia is currently facing.
DEFINITION OF TERMS

1. Home Based Care: Any form of care given to the sick people in their home. Care includes physical, psychological and spiritual.

2. Knowledge: What care givers know about Home Based Care.

3. Attitude: A mental view, opinion or disposition towards a particular concept.

4. Practice: Putain action a skill learnt in a particular profession.

5. Community: Group of people, individuals living in an area, having common beliefs or belonging to the same organization.

6. Care Giver: A member of the community providing actual nursing care to the patient at home.

7. Volunteer: A member of the community trained to provide nursing care for HIV/AIDS patient. She renders free services to the chronically ill.
CHAPTER FOUR

4.0. METHODOLOGY

4.1. RESEARCH DESIGN

The purpose of this study was to determine the knowledge, attitude and practice of community towards HBC services for people with HIV/AIDS. A descriptive explanatory and non-intervention type of study was used. A combination of these methods of research would be more effective in finding out the nature of the problem more accurately and possible influencing factors.

The study only describes and explains the phenomena and the subjects were in their own natural setting. The variable that were investigated in this study were:-

4.2. VARIABLES

a). Dependent Variables

Knowledge, attitude and practice of the community towards HBC services of HIV/AIDS.

b). Independent Variable

i). Educational level of the community.

ii). Poverty.

iii). Community participation.

iv). Stigmatization.

v). Support from relatives.
vi). Support and supervision from health promoters.

vii). Availability of resources.

viii). Health education.

VARIABLES, INDICATORS AND CUT OFF POINTS

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>INDICATORS</th>
<th>CUT OFF POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>Knowledgeable</td>
<td>2 - 4</td>
</tr>
<tr>
<td></td>
<td>Not knowledgeable</td>
<td>0 - 1</td>
</tr>
<tr>
<td>Attitude</td>
<td>Positive</td>
<td>2 - 4</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>0 - 1</td>
</tr>
<tr>
<td>Practice</td>
<td>Good</td>
<td>2 - 4</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>0 - 1</td>
</tr>
</tbody>
</table>

CRITERIA FOR INDICATORS AND CUT OFF POINTS KNOWLEDGE

1. KNOWLEDGE

a). Knowledge - The respondent should:
   i). Have alot of information on HBC.
   ii). Be able to explain what HBC is.
   iii). Have read materials on HBC.
   iv). Have received informal information on .

b). Not Knowledgeable - The respondent should only meet 0-1 point of the criteria.
2. ATTITUDE

a). **Positive attitude** - The respondent should:
   i). Have participated in home based care programme.
   ii). Have knowledge on services in the community.
   iii). Be able to nurse the HIV/AIDS patient at home.
   iv). Be able to offer support to the sick in the community.

b). **Negative Attitude** - The respondent should only meet 0-1 point of the criteria.

3. Practice

a). **Good practice** - The respondent should be able to:
   i). Have received formal training in HBC.
   ii). Be willing to take up training in HBC.
   iii). Have adequate resources to care for PWAs in the community.
   iv). Know that its everyone’s responsibility to care for the HIV/AIDS patient.

b). **Poor practice** - The respondents should only meet 0-1 points of the criteria.
4.3. **RESEARCH SETTING**

The study was conducted in Kitwe District, one of the six (6) Districts on the Copperbelt Province. The researcher chose to carry out the study in Kitwe because no much research has been conducted in HBC. Furthermore, it was easy to communicate with respondents and health care providers considering the time in which the study was to be completed. It was also convenient because the researcher is familiar with the province and the town under study. The researcher was able to communicate in the local language without any difficult. Copperbelt province is one of the nine provinces in Zambia. It has six districts, Namely Kitwe, Ndola, Kalulushi, Chingola, Mufulira and Chililabombwe. It shares boundaries with North Western province on the west. Southern province on the south, Luapula province on the east and the Democratic Republic of Congo on the north. The province has a population of 1,632,336 of which 775,929 are females and 847,407 are males (CSO 1990).
KITWE DISTRICT

Kitwe district is located in the centre of Copperbelt province. It is purely a mining town, with a population of 396,574 of which 189,195 are females and 207,379 are males. The district has twelve (12) townships, of which seven (7) have well established HBC programmes. The researcher randomly selected the two (2) townships running HBC programmes, namely Chimwemwe and Kapoto, using the lottery method.

Chimwemwe township is located on the Northern part of the city. It is the largest township, sharing boundaries with Buchitownship on the south, Kwacha on the east, Race Course and Kamatipa on north and Mindolo on the west. Chimwemwe has a population of 50,000 people. Despite the large population, the township has only one (1) health centre and one (1) nutrition post.

Kapoto township on the other hand lies on the eastern part of the city centre. It has one of the ungraded township in Kitwe unlike, Chimwemwe, this township is not serviced by the city council authorities. It is a completely run down infrastructure. most houses are made of burnt bricks. It is a small township compared
to Chimwemwe but has a population of 25,000. The
township is serviced by one (1) health centre
constructed in 1992 on self help basis with assistance
from Italy.

4.4. STUDY POPULATION

The study population included all members of the
community in Kapoto and Chimwemwe townships. A lottery
method was used to draw a sample.

4.5. SAMPLE SIZE

The researcher used a sample of fifty (50) from a total
population of 75,000 in habitants of Chimwemwe and
Kapoto townships combined. Twenty five (25) subjects
were drawn from Chimwemwe and twenty five (25) from
Kapoto.

4.6. SAMPLING METHOD

Sampling involves selection of a number of units from
a different study population (Varkevisier 1991). In
this study two samples were drawn using the sampling
method. Simple random sampling method was used to
sample the fifty (50) units drawn from two townships.
This technique ensures that all units in the population
have equal chances of being involved in the sample.
4.7. DATA COLLECTION TECHNIQUE

One method of data collection techniques was used.
- Structured interview schedule.

STRUCTURED INTERVIEW

It is quantitative method in which the question and wording are fixed and identical for all respondents. The instrument comprises of a series of questions that were both open and closed ended. The responses were filled in by the interviewer. This method was used because of the following reasons:-

- The method is assumed to be the most efficient way of gathering data. It is accurate since it allows the interviewer to probe more and clear misunderstandings of questions during the interview.
- It was most appropriate because the subjects in the study were mostly illiterate.

However, the instruments has some draw backs:-

- The presence of the interviewer may lead to the interviewee not giving precise and accurate answers especially in close ended questions.
- There was need to train research assistant to assist in data collection. Therefore ensuring a uniform understanding and recording of responses could have been a problem.
These problems were addressed by ensuring that the interviewer created good rapport with respondents. Furthermore the interviewer introduced themselves and assumed the respondents that information given will be held in confidence. The researcher ensured that the question were simple and clearly stated to minimize problems of misunderstanding.

4.8. DATA COLLECTION

Data was collected in the second week of September 1997. It was collected by filling in the structured interview schedule. The researcher carried out the interview in the subjects' own home setting from Monday to Friday.

The interview schedule was serially numbered, each was checked for completeness immediately after collection and data was entered on the data master sheet to avoid losses and mixing up data.

4.9. PILOT STUDY

The pilot study was done at Chimwemwe health centre in order to find out the completeness and suitability of data collection tool. Corrections and adjustment were then made accordingly.
4.10. LIMITATIONS OF THE STUDY

- It was difficult to get the required sample in time owing to the stipulated working schedule for the health volunteer who had to accompany me and the assistant in the community.
- It was difficult to obtain adequate amount of literature done in Kitwe on HBC - Not much has been documented.
- Time was limited so the study was to be completed with the academic year.
- Money was not adequate to cover all necessary expenses.

4.11. ETHICAL CONSIDERATION

- Letter asking for permission to conduct the study was sent to the coordinator of Home Based-Care activities (Catholic diocese) in Kitwe.
- Permission to carry out the study was granted in writing by the coordinator.
- Consent was got from the respondents before they were interviewed. Anonymity of all the respondents was maintained. This was explained to the respondent before the interview.
CHAPTER FIVE

DATA ANALYSIS AND PRESENTATION OF FINDINGS

INTRODUCTION

In this chapter, the analyzed data will be presented in form of frequency tables, cross tabulations and numerical description will be given for each table. Data was analyzed manually.

A total of fifty (50) members of the community were randomly selected and interviewed from Chimwemwe and Kapoto townships in Kitwe Urban. Twenty five (25) were randomly selected from Chimwemwe and another twenty five (25) were selected from Kapoto townships.

5.0. DATA ANALYSIS

The data which was collected from respondents was analyzed in October 1997. Data was first edited for completeness and transferred on the data master sheet to avoid losses and mixing up data. Responses to open end questions were categorised and coded.

Frequencies were made by simple tallying. Questions to certain variables were cross tabulated to show relationship between particular variables.
5.1. PRESENTATION OF FINDINGS

The findings of the study are presented in frequency tables cross tabulations. The tables are presented in order of question presented in interview schedule.

SOCIAL DEMOGRAPHIC DATA

TABLE 1: AGE DISTRIBUTION OF RESPONDENTS

<table>
<thead>
<tr>
<th>AGE RANGE IN YEARS</th>
<th>RESPONDENTS IN CHIMWEMWE</th>
<th>RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-29</td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td>30-34</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td>35-39</td>
<td>6</td>
<td>5</td>
<td>11</td>
<td>22%</td>
</tr>
<tr>
<td>40 AND ABOVE</td>
<td>9</td>
<td>14</td>
<td>23</td>
<td>46%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that majority 23 (46%) respondents were 40 years and above.

TABLE 2: MARITAL STATUS OF RESPONDENTS

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>RESPONDENTS IN CHIMWEMWE</th>
<th>RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>10%</td>
</tr>
<tr>
<td>Married</td>
<td>13</td>
<td>8</td>
<td>21</td>
<td>42%</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>14%</td>
</tr>
<tr>
<td>Widowed</td>
<td>7</td>
<td>9</td>
<td>16</td>
<td>32%</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that majority 21 (42%) of the respondents were married.
TABLE 3: EDUCATIONAL LEVEL OF RESPONDENTS

<table>
<thead>
<tr>
<th>EDUCATIONAL LEVEL</th>
<th>RESPONDENTS IN CHIMWEMWE</th>
<th>RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>11</td>
<td>17</td>
<td>25</td>
<td>56%</td>
</tr>
<tr>
<td>Secondary</td>
<td>13</td>
<td>6</td>
<td>19</td>
<td>38%</td>
</tr>
<tr>
<td>College</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td>None</td>
<td>Nil</td>
<td>Nil</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that majority 28% (56%) respondents had primary school education. Those with secondary education were 19 (38%).

TABLE 4: EMPLOYMENT STATUS OF RESPONDENTS

<table>
<thead>
<tr>
<th>EMPLOYMENT STATUS</th>
<th>RESPONDENTS IN CHIMWEMWE</th>
<th>RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>14%</td>
</tr>
<tr>
<td>Informal</td>
<td>16</td>
<td>19</td>
<td>35</td>
<td>70%</td>
</tr>
<tr>
<td>Others</td>
<td>5</td>
<td>3</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that most 35 (70%) respondents are in informal employment.
### TABLE 5: FAMILY INCOME OF RESPONDENTS

<table>
<thead>
<tr>
<th>FAMILY INCOME RANGE (THOUSANDS)</th>
<th>RESPONDENTS IN CHIMWEMWE</th>
<th>RESPONDENTS IN KAPOTO</th>
<th>TOTALS</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>K20, - K50,</td>
<td>9</td>
<td>7</td>
<td>16</td>
<td>32%</td>
</tr>
<tr>
<td>K51, - K100,</td>
<td>7</td>
<td>9</td>
<td>16</td>
<td>32%</td>
</tr>
<tr>
<td>ABOVE K100,</td>
<td>9</td>
<td>9</td>
<td>18</td>
<td>36%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that a proportional number of 18 (36%) of respondents got income of one hundred thousand and above while 16 (32%) had income between K20, - K100.

### TABLE 6: RELIGIOUS AFFILIATION OF RESPONDENTS

<table>
<thead>
<tr>
<th>RELIGIOUS AFFILIATION</th>
<th>RESPONDENTS IN CHIMWEMWE</th>
<th>RESPONDENTS IN KAPOTO</th>
<th>TOTALS</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>9</td>
<td>8</td>
<td>17</td>
<td>34%</td>
</tr>
<tr>
<td>UCZ</td>
<td>5</td>
<td>7</td>
<td>12</td>
<td>24%</td>
</tr>
<tr>
<td>W/Tower</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Pentecostal</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Others</td>
<td>6</td>
<td>7</td>
<td>13</td>
<td>25%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that majority 17 (3%) of respondents belonged to the Catholic Church, with UCZ 12 (24%) and others 13 (26%).
TABLE 7: LENGTH OF STAY OF RESPONDENTS

<table>
<thead>
<tr>
<th>LENGTH OF STAY, RANGE (YEARS)</th>
<th>RESPONDENTS IN CHIMWEMWE</th>
<th>RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 4 yrs</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td>5yrs-9 yrs</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>18%</td>
</tr>
<tr>
<td>Above 10 yrs</td>
<td>20</td>
<td>18</td>
<td>38</td>
<td>76%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that majority 38 (76%) of the respondents had lived in the respective townships for more than ten (10) years.

TABLE 8: RESPONDENTS INFORMAL KNOWLEDGE ON HOME-BASED CARE

<table>
<thead>
<tr>
<th>INFORMAL KNOWLEDGE ON HBC</th>
<th>NUMBER OF RESPONDENTS IN CHIMWEMWE</th>
<th>NUMBER OF RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>22 (44%)</td>
<td>23 (46%)</td>
<td>45</td>
<td>90%</td>
</tr>
<tr>
<td>No</td>
<td>3 (6%)</td>
<td>2 (4%)</td>
<td>5</td>
<td>10%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>25 (50%)</td>
<td>25 (50%)</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table shows that majority 45 (90%) had informal information on home-based care.
### TABLE 9: RESPONDENTS’ LEVEL OF KNOWLEDGE ON HOME BASED CARE

<table>
<thead>
<tr>
<th>LEVEL OF KNOWLEDGE</th>
<th>NUMBER OF RESPONDENTS IN CHIWEMWE</th>
<th>NUMBER OF RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot</td>
<td>10</td>
<td>6</td>
<td>16</td>
<td>32%</td>
</tr>
<tr>
<td>Little</td>
<td>15</td>
<td>19</td>
<td>34</td>
<td>68%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that most 34 (68%) of the respondents had little knowledge on home based care.

### TABLE 10: RESPONDENTS HAVING READ MATERIALS ON HOME BASED CARE

<table>
<thead>
<tr>
<th>READ MATERIALS ON HBC</th>
<th>NUMBER OF RESPONDENTS IN CHIWEMWE</th>
<th>NUMBER OF RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>18%</td>
</tr>
<tr>
<td>No</td>
<td>22</td>
<td>19</td>
<td>41</td>
<td>82%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table shows that most 41 (82%) respondents have never read any material on home-based care.
TABLE 11: HAVING READ MATERIALS ON HOME BASED CARE

<table>
<thead>
<tr>
<th>INVOLVED IN HBC PROGRAMME</th>
<th>NUMBER OF RESPONDENTS IN CHIMWEMWE</th>
<th>NUMBER OF RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5</td>
<td>6</td>
<td>11</td>
<td>22%</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>19</td>
<td>39</td>
<td>78%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table show that very few 11 (22%) respondents were involved in home based care programme in the two townships.

TABLE 12: RESPONDENTS’ CHOICE ON WHERE TO NURSE HIV/AIDS PATIENTS

<table>
<thead>
<tr>
<th>WHERE TO NURSE HIV/AIDS PATIENTS</th>
<th>NUMBER OF RESPONDENTS IN CHIMWEMWE</th>
<th>NUMBER OF RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>13</td>
<td>11</td>
<td>24</td>
<td>48%</td>
</tr>
<tr>
<td>Hospice</td>
<td>6</td>
<td>5</td>
<td>11</td>
<td>22%</td>
</tr>
<tr>
<td>Home</td>
<td>5</td>
<td>7</td>
<td>12</td>
<td>24%</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that 24 (48%) respondents want HIV/AIDS patient to be nursed in the hospital.
**TABLE 13: RESPONDENTS' VIEWS ON HIV/AIDS PATIENTS**

<table>
<thead>
<tr>
<th>COMMUNITY’S ATTITUDE TOWARD HIV/AIDS PATIENT</th>
<th>NUMBER OF RESPONDENTS IN CHIMWEMWE</th>
<th>NUMBER OF RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>6</td>
<td>8</td>
<td>14</td>
<td>28%</td>
</tr>
<tr>
<td>Negative</td>
<td>19</td>
<td>17</td>
<td>36</td>
<td>72%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that most 36 (72%) respondents had a negative attitude toward HIV/AIDS patient.

**TABLE 14: RESPONDENTS' TYPE OF CARE FOR HIV/AIDS PATIENTS**

<table>
<thead>
<tr>
<th>TYPE OF CARE FOR HIV/AIDS PATIENTS</th>
<th>NUMBER OF RESPONDENTS IN CHIMWEMWE</th>
<th>NUMBER OF RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Good</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>7</td>
<td>4</td>
<td>11</td>
<td>22%</td>
</tr>
<tr>
<td>Poor</td>
<td>18</td>
<td>19</td>
<td>37</td>
<td>74%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that majority 37% (74%) of respondents described the care of HIV/AIDS patients as poor.
### TABLE 15: RESPONDENTS' FORMAL TRAINING IN HOME-BASED CARE

<table>
<thead>
<tr>
<th>FORMAL TRAINING IN HBC</th>
<th>NUMBER OF RESPONDENTS IN CHIMWEMWE</th>
<th>NUMBER OF RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5</td>
<td>6</td>
<td>11</td>
<td>22%</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>19</td>
<td>39</td>
<td>78%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that most 39 (78%) respondents had no formal training in home based care.

### TABLE 16: RESPONDENTS' WILLING TO BE TRAINED IN HOME-BASED CARE

<table>
<thead>
<tr>
<th>WILLING TO BE TRAINED IN HBC</th>
<th>RESPONDENTS IN CHIMWEMWE</th>
<th>NUMBER OF RESPONDENTS IN KAPOTO</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>17</td>
<td>15</td>
<td>32</td>
<td>64%</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>10</td>
<td>18</td>
<td>26%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table shows that majority 15 (32%) of respondents were willing to be trained in home based care.
### TABLE 17: RESPONDENTS' EDUCATIONAL LEVEL IN RELATION TO KNOWLEDGE ON HOME-BASED CARE FOR HIV/AIDS PATIENTS

<table>
<thead>
<tr>
<th>EDUCATIONAL LEVEL</th>
<th>KNOWLEDGE ON HBC FOR HIV/AIDS PATIENTS</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIGH (6%)</td>
<td>LOW (46%)</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>4 (8%)</td>
<td>23 (46%)</td>
<td>27</td>
</tr>
<tr>
<td>Secondary</td>
<td>10 (20%)</td>
<td>10 (20%)</td>
<td>20</td>
</tr>
<tr>
<td>College</td>
<td>2 (4%)</td>
<td>1 (2%)</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>16 (32%)</td>
<td>34 (68%)</td>
<td>50</td>
</tr>
</tbody>
</table>

Table shows that 27 (54%) of the respondents had basic primary school education, and 34 (68%) had low knowledge on home based care for HIV/AIDS patients.

### TABLE 18: RESPONDENTS’ KNOWLEDGE IN RELATION TO PARTICIPATION IN HOME-BASED CARE PROGRAMME

<table>
<thead>
<tr>
<th>LEVEL OF KNOWLEDGE</th>
<th>PARTICIPATION IN HBC RESPONDENTS PROGRAMME</th>
<th>TOTAL</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES (14%)</td>
<td>NO (18%)</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>7 (14%)</td>
<td>9 (18%)</td>
<td>16</td>
</tr>
<tr>
<td>Low</td>
<td>4 (8%)</td>
<td>30 (60%)</td>
<td>34</td>
</tr>
<tr>
<td>TOTAL</td>
<td>11 (22%)</td>
<td>39 (78%)</td>
<td>50</td>
</tr>
</tbody>
</table>

The table shows that majority 34 (68%) of respondents had low knowledge on home based care and 39 (78%) had not participated in home-based care programme.
TABLE 19: RESPONDENTS’ LEVEL OF EDUCATION IN RELATION TO QUALITY CARE HBC.

<table>
<thead>
<tr>
<th>EDUCATIONAL LEVEL</th>
<th>QUALITY OF CARE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VERY GOOD</td>
<td>SATISFACTORY</td>
</tr>
<tr>
<td>Primary</td>
<td>0 (0%)</td>
<td>6 (12%)</td>
</tr>
<tr>
<td>Secondary</td>
<td>2 (4%)</td>
<td>7 (14%)</td>
</tr>
<tr>
<td>College</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Total</td>
<td>2 (4%)</td>
<td>14 (28%)</td>
</tr>
</tbody>
</table>

The table shows that most 27 (54%) of the respondents have only primary education and 34 (78%) said that the care of HIV/AIDS patient was poor.

TABLE 20: RESPONDENTS’ LEVEL OF KNOWLEDGE IN RELATION TO THE QUALITY OF CARE.

<table>
<thead>
<tr>
<th>LEVEL OF KNOWLEDGE</th>
<th>QUALITY OF CARE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VERY GOOD</td>
<td>SATISFACTORY</td>
</tr>
<tr>
<td>High</td>
<td>3 (6%)</td>
<td>6 (12%)</td>
</tr>
<tr>
<td>Low</td>
<td>0 (0%)</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Total</td>
<td>3 (6%)</td>
<td>14 (22%)</td>
</tr>
</tbody>
</table>

The table shows that majority 33% (66%) of respondents had low knowledge on home-based care and 36 (72%) described the care as poor.
TABLE 21: RESPONDENTS’ FAMILY INCOME IN RELATION TO QUALITY OF CARE (HBC).

<table>
<thead>
<tr>
<th>FAMILY INCOME</th>
<th>QUALITY OF CARE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VERY GOOD</td>
<td>SATISFACTORY</td>
</tr>
<tr>
<td>K20,000 - K50,000</td>
<td>0</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>K51,000 - K99,000</td>
<td>0</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>K100,000 and above</td>
<td>1 (2%)</td>
<td>9 (18%)</td>
</tr>
<tr>
<td>Total</td>
<td>1 (2%)</td>
<td>13 (26%)</td>
</tr>
</tbody>
</table>

The table shows that a proportional number 19 (38%) of respondents family income was K100,000.00 and above and 6 (72%) said that the quality of care for HIV/AIDS patient was poor.

---

TABLE 22: RESPONDENTS FORMAL TRAINING IN RELATION TO AVAILABILITY OF HEALTH VOLUNTEERS

<table>
<thead>
<tr>
<th>TRAINED IN HBC</th>
<th>AVAILABILITY OF HEALTH VOLUNTEERS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AVAILABLE</td>
<td>NOT AVAILABLE</td>
</tr>
<tr>
<td>Yes</td>
<td>11 (22%)</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>9 (18%)</td>
<td>30 (60%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20 (40%)</td>
<td>30 (60%)</td>
</tr>
</tbody>
</table>

The table shows that 11 (22%) respondents had training in home based care and 30 (60%) said that in most cases the health volunteers were not available when needed.
TABLE 23: RESPONDENT ATTITUDE TOWARDS HIV/AIDS PATIENTS IN RELATION TO THEIR AGE

<table>
<thead>
<tr>
<th>ATTITUDE TOWARDS HIV/AIDS PATIENTS</th>
<th>AGE RANGE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25-29</td>
<td>30-34</td>
</tr>
<tr>
<td>Positive</td>
<td>3 (6%)</td>
<td>0</td>
</tr>
<tr>
<td>Negative</td>
<td>7 (14%)</td>
<td>6 (12%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>10 (20%)</td>
<td>6 (12%)</td>
</tr>
</tbody>
</table>

The table shows that 36 (72%) respondents had a negative attitude towards HIV/AIDS patients and 23 (46%) were 40 years and above.

TABLE 24: RESPONDENTS AGE IN RELATION TO WILLINGNESS TO TRAIN IN HOME BASED CARE

<table>
<thead>
<tr>
<th>AGE RANGE</th>
<th>WILLINGNESS TO TRAIN IN HOME BASED CARE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>25 - 29</td>
<td>5 (10%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>30 - 34</td>
<td>9 (18%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>35 - 39</td>
<td>16 (32%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>40 and above</td>
<td>5 (10%)</td>
<td>7 (14%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>35 (70%)</td>
<td>15 (30%)</td>
</tr>
</tbody>
</table>

The table shows that most 18 (36%) respondents were between 35-39 years and 35 (70%) were willing to be trained in home based care.
TABLE 25: RESPONDENTS EDUCATIONAL LEVEL IN RELATION TO WILLINGNESS TO PARTICIPATE IN HOME BASED PROGRAMMES.

<table>
<thead>
<tr>
<th>EDUCATIONAL</th>
<th>WILLINGNESS TO PARTICIPATE IN</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Primary</td>
<td>12 (24%)</td>
<td>16 (32%)</td>
</tr>
<tr>
<td>Secondary</td>
<td>14 (28%)</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>College</td>
<td>3 (6%)</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>29 (58%)</td>
<td>21 (42%)</td>
</tr>
</tbody>
</table>

The table shows that 28 (56%) of respondents had basic primary school education and 29 (58%) were willing to be trained in home based care.

TABLE 26: RESPONDENTS, ATTITUDE TOWARDS HIV/AIDS PATIENTS IN RELATION TO LEVEL OF KNOWLEDGE

<table>
<thead>
<tr>
<th>ATTITUDE OF RESPONDENT</th>
<th>LEVEL OF KNOWLEDGE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIGH</td>
<td>LOW</td>
</tr>
<tr>
<td>Positive</td>
<td>11 (22%)</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Negative</td>
<td>4 (8%)</td>
<td>30 (60%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15 (30%)</td>
<td>35 (70%)</td>
</tr>
</tbody>
</table>

The table shows that most 34 (68%) respondents has a negative attitude and 35 (70%) had low knowledge on HBC.
CHAPTER SIX

6.0. DISCUSSION OF FINDINGS

In this chapter, the findings of the research study aimed at determining the knowledge, attitude and practice of community towards home-based care services of HIV/AIDS patient in Kitwe Urban will be discussed and appropriate nursing implications made. From the findings the researcher will draw up some relevant recommendations. The sample consisted of twenty five (25) members of the community from Chimwemwe and the other twenty five (25) from Kapoto townships.

SOCIAL-DEMOGRAPHIC DATA

The age range of the respondents was from twenty five (25) years to forty years and above. The majority (46%) were forty years and above. Twenty one (42%) were married (Table 2).

The educational level of the two communities was low, (48%) had only basic primary school education, making it difficult for them to comprehend most information on HBC because most literature is written in English.
In the study most families (36%) monthly income was above one hundred thousand kwacha (K100,000.00) per month, though it highly depended on how well business is conducted that month.

**KNOWLEDGE OF THE COMMUNITY**

Findings from the study reveal that most respondents (68%) had little knowledge on for HIV/AIDS patients. This was attributed to the non availability of educational materials. Only (18%) respondents acknowledged having had read some materials on HBC.

The study further revealed that 46% of the respondents who had primary education also lacked knowledge on HBC.

Many respondents linked the lack of knowledge to lack of interest, inability to read and general non availability of literature on HBC.

These findings are in line with a study done on cost and impact of HBC for people with HIV/AIDS in Zambia (MOH/WHO 1994).

Macwangi (1993) also confirmed the findings when she stated that "although marked achievement has been recorded in HBC, inadequate knowledge about HIV/AIDS among community and I providers is still evident".
Other findings from this study are that most respondents (60%) did not participate in HBC programmes because they had little knowledge on the programme, ultimately the low knowledge is reflected in the poor quality of care rendered to PWAs. The study reveals that even those who had participated in the programme equally lacked adequate knowledge on the programme—some expected monetary gain. As a result many programmes are registering a high resignation rate (MOH/WHO 1994).

Further more, the concept of HBC was not fully understood by many respondents as they could not explain what it was and the activities carried out by the unit. This was mainly because most of the information available to them was based on "hear say". (46%).

From these findings one can assume that respondents felt there was need for more information for them to work better. However, it is worth noting that the majority respondents (90%) had heard of Home Based Care programme (Table 8) even though they did not know what went on. Another positive indicator is that the respondents wanted more information on HBC.
ATTITUDE OF COMMUNITY

In the study only 22% of respondents were involved in HBC programme. Since attitude dependent on knowledge, even the amount of involvement in the programme will depend on it. This low level of participation was attributed to the lack of information and incentives and above all the enormous task of caring for PWAs. These findings were supported by a study done in Monze on care provider by (WHO/MOH 1994) which revealed that most volunteer staff, aside from household activities, maintained family gardens and sold perishable, gardens goods at the market. Most of these activities suffered greatly when they went on home visits. Even the part-time nurses/counsellors were found not to be fully involved in HBC programme, due to pressure of work in the hospital.

The study also found that the more one advances in age the less likely he is likely to have a positive attitude towards PWAs as most respondents (32%) aged 40 years and above recorded a negative attitude. This development reflects certain level of disintegration in the family system in Zambian culture, where looking after sick family members was once considered as an
"honor" and privilege by the community. This study paints a gloomy picture in the care of HIV/AIDS patient as the HIV infection mostly affects the productive ages leaving the aged and the young to care for the sick. These sentiments were shared by UNAIDS (1996).

Furthermore, the study revealed that most of the respondents (48%) preferred to nurse HIV/AIDS patient in the hospital were care was adequate (medical people know better to care for the PWAs) as the community was scared to care for the PWAs in the home setting because of the perceived high chances of contracting HIV/AIDS infection. Those who tried to help gave up because the task was demanding.

Mwiinga (1991) had similar findings in her study on HIV/AIDS patient and family towards HBC in Lusaka, she registered a negative response to home care which was attributed to lack of knowledge.

This study also evaluated the effect attitude had on the quality of services offered the programme. It was found that the negative attitude (70%) affected the respondents view of the services offered by the care providers (54%).
Other findings were that despite family members being aware of the HIV/AIDS status of their members only a few offered to help. The negative attitude could also be a result of the poor socio-economic situation the country is passing through. People would like to help but they do not have the means. (UNAIDS 1994).

The findings from the study also show that those who received support, it was mainly moral and spiritual support. From these findings one can postulate that the HIV/AIDS stigma has greatly affected people's attitude in rendering care for the PWAs as can be seen from Dr. Ktskhe (1996) who said "lack of support for HIV/AIDS patient is largely blamed on the stigma the disease possesses, people with AIDS are isolated".

**PRACTICE OF THE COMMUNITY.**

The study revealed that only 22% of respondents had formal training in HBC. The small number of respondents trained in HBC affected the amount of supervision in the community. 60% of the respondents revealed that health volunteers were not available when needed.

One can assume that the low number of trained volunteers in the two townships (Chimwemwe and Kapoto) is responsible for the poor quality of care.
This is expressed by the care givers in Lusaka (Kaunda July 1996). She reported that UTH Home-Based Care team was only able to visit patients once in a week and care rendered during the visit was described as inadequate.

Further findings were that 30% respondents with family income ranging between K50,000 K100,000.00, described the care for HIV/AIDS patient in the home as poor, unlike those getting K100,000 who said it was good, implying that quality care is highly dependant on availability of adequate material and financial support.

Similar findings were amplified by WHO/MOH (1994) when they said that PWAs were considered as people in need, because they did not get enough food, clothing and bedding. Example, even soap which is critical for maintenance of hygiene and sanitation was not affordable by most families with HIV/AIDS patient due to financial constraints. Most families, according to the report did not have enough food and financial support.

Good practice in any programme is dependant on adequate training of care providers in the community. This would elicit good attitude towards the HIV/AIDS
patient and consequently improve the quality of care. This would help reverse the trend which considers home care at its worst home "neglect". This is because most families do not have enough information and the means to care for the sick. Hospital care is most preferred by respondents (48%) because it is perceived "better". This development has increased the turnover of HIV/AIDS patient in day wards in hospitals.

Similar views are prevalent both in Urban and Rural areas as WHO/MOH (1994) also reports that most people interviewed in Mungula Village in Monze, preferred hospital care to home care. "At hospital the disease is known better and necessary treatment and help will be given".

For the quality of care to improve or enhanced most respondents were of the view that, training for volunteers should be extensive, allowing them to dispense common drug like aspirin and the period of training be extended from two weeks to a month. The respondent also felt that adequate transport, protective materials and incentives would motivate people in joining the programme.
Other suggestion were that, for the programme to improve, more volunteers should be trained to meet the ever increasing number of PWAs and the programme should be adequately funded and more community based than it is at present.

In trying to assess the influence of community's age on willingness to participate, the study revealed that the age range of 35-39 is more likely to participate in the HBC (32%).

However, it is worth noting that most respondents (58%) were willing to be trained in HBC, of whom 28% had secondary school education.

These findings were supported by WHO/MOH (1994) report which stated that most members of the community were willing to nurse PWAs at home with adequate support from the HBC unit.

This is a good indication because most PWAs prefer to be nursed at home where "they are more free, can ask for anything they need".
6.1. NURSING IMPLICATIONS

The study revealed that Home-Based Care seem not to be well integrated in the community. The community lacked basic knowledge on HBC. This is attributed to most respondents having only basic primary education making it difficult for them to read and comprehend most literature as it was in English. This gap in knowledge has contributed to the low level of participation by the community. Only 11 (22%) of respondents had formal knowledge on HBC.

These are important finding needing immediate/prompt attention considering the high rate of HIV infection in the country. This implies that there is great need to provide more formal training, short and frequent refresher courses to community.

Further more, the health information Unit should map up a vigorous campaign to enlighten the people that is a community based programme needing support.

The attitude of the community towards HIV/AIDS is poor. This implies that there is need to change the people’s attitude towards PWAs. This can only happen when the community is provided with enough information and education on HBC.

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The community should be encouraged and supported by various organs involved in through provision of information, on how to care for HIV/AIDS patient in the community, teaching aids such as posters, pamphlets and supporting medical staff should show interest in the role of community is playing in the management of PWAs. Immediate there is an effective information, education and communication system the community will be able to care for the loved ones in their homes.

In evaluating the practice of respondent in relation to the care of PWAs the study revealed that the care for HIV/AIDS patient was poor reason for the poor quality ranged from. Lack of adequate supervision, shortage of necessary material, not knowing how to care for PWAs and inadequate finances.

This was because only few respondents were trained in HBC and the socio-economic situation that the country was going through made it difficult for people to have access to the resources needed in the care.

This implies that there is need to work out better strategies to ensure that supplies are available to care givers. The programme should enroll more volunteers so as to increase the number of supervisors in the community. This study shows that the majority
respondent showed willingness to participate in the volunteer programme. Therefore the concerned authority should put in place measures that will enhance full participation from respondents.

6.2. CONCLUSION

This study was aimed at determining the knowledge, attitude and practice of community towards the HBC services for HIV/AIDS patient in Kitwe urban.

Data was collected using a structured interview schedule. The sample consisted of 50 members of the community, twenty five (25) from Chimwemwe and twenty five (25) from Kapoto township.

The study concluded that most respondent had no formal knowledge on HBC for HIV/AIDS patient, hence the misconception in the knowledge of HIV/AIDS patient. The attitude was also affected by the lack of knowledge. With regards to practice, most respondents revealed that the quality of care was poor and this was attributed to inadequate materials, lack of support and supervision. Poor financial support to most families contributed to the poor quality of the services.
However, most respondents showed willingness to participate in HBC on condition that they undergo an extensive training programme.

6.3. RECOMMENDATIONS

Based on this study, the following recommendations were made:-

1. Efforts should be made by other researchers to replicate this study, on a larger scale so as to include other HBC programmes in the province.

2. Stimulate community based participatory approach to HBC within existing health, religious and social services a community level in order to meet need in a cost effective way with less dependence on hospital initiated team of visitor and greater reliance on community based care programme.

3. Facilitate community capacity to support families caring for the chronically and terminally ill by developing activities and counselling strategies that focus on the community and family care as well as chronically ill, including PWAs.

4. Train more volunteers and health care providers; including community health worker on HBC and how to involve families in care and emotional support.
5. Improve supervising system and give incentives for HBC staff and volunteers.

6. Intensify information education and communication system (IEC) on HBC so as to eliate positive attitude from the community.
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10. Macwangi (1993) The extent to which the HBC Concept has been put into practice, - Abstract


15. Nkowane A (1990) *Determinants of relatives Capacity to Cope and effects on rejection or acceptance of HIV/AIDS patients in our urban communities in Zambia* - UNZA


ANNEX 1

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF POST BASIC NURSING

STRUCTURED QUESTIONNAIRE FOR THE COMMUNITY TO DETERMINE THE KNOWLEDGE, ATTITUDE AND PRACTICE OF THE COMMUNITY TOWARDS HBC SERVICES FOR HIV/AIDS PATIENTS

DATE OF INTERVIEW __________________________

PLACE OF INTERVIEW _________________________

NAME OF INTERVIEWER _______________________

NUMBER OF QUESTIONNAIRE ___________________

INSTRUCTIONS

1. Introduce yourself to the respondent.

2. Explain purpose of the interview to the respondent.

3. Tell the respondents how he/she was selected.

4. Tell the respondent that responses will be treated confidentially.

5. Do not write the name of respondent.
1. How old were you on your last birthday?
   a). 25 - 29 years
   b). 30 - 34 years
   c). 35 - 39 years
   d). 40 years and above

2. What is your marital status?
   a). Single
   b). Married
   c). Divorced
   d). Widowed
   e). Separated

3. What is your educational level?
   a). primary
   b). Secondary school
   c). College
   d). None
4. What do you do for your living?
   a). Formally employed
   b). Self employed
   c). Others specify
   d). None

5. What is your salary per month?
   a). K20,000 - K40,000
   b). K50,000 - K90,000
   c). K100,000 and above

6. Which church do you go to?
   a). Catholic
   b). UCZ
   c). Watch Tower/Jehovah's Witness
   d). Pentecostal
   e). Others (Specify)

7. For how long have you been living in the township?
   a). Less than 2 years
   b). 2 - 5 years
   c). Above 5 years
8. How you received any information informal on Home Based Care?
   a). Yes
   b). No
   c). No response

9. How much information do you know about Home-Based Care?
   a). A lot
   b). Little
   c). No Response

10. Where did you hear first about Home-Based Care?
    a). Radio
    b). Television
    c). Friends
    d). Newspapers
    e). Others (Specify)

11. Have you ever read any materials on HBC?
    a). Yes
    b). No
    c). No response
12. For your response to question 11, give reasons for the answer.

______________________________

______________________________

______________________________

13. In your own words, what do you understand by HBC?

______________________________

______________________________

______________________________

SECTION C: ATTITUDE

14. What do you think of the HBC services for HIV/AIDS patient in the community?

a). Good

b). Poor

c). Not sure

15. Have you ever participated in a HBC programme?

a). Yes

b). No
16. If the answer to question 15 is Yes, what role did you play?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

17. If the answer is No, give reason for your non participation.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

18. Where would you like HIV/AIDS patients to be nursed?
   a). Hospital
   b). Special units / Hypices
   c). Home
   d). Others (Specify) ______________________

19. For your response to question 18, give reason for your choice.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

20. How does your community view HIV/AIDS patients?
   a). Positive
   b). Negative
   c). Others (Specify) __________________________
21. Have you had a member of your family or friend suffering from HIV/AIDS?
   a). Yes
   b). No
   c). Not sure

22. If Yes, what role did you play?

23. Did you receive any support from the community members?
   a). Yes
   b). No

24. If Yes, what kind of support did you get?

25. If the answer is No, why do you think the community did not help?
SECTION D: PRACTICE

26. Have you received any formal training in HBC?
   a). Yes
   b). No
   c). No response

27. If Yes, how long was your training?

28. If the answer to Question 26 is NO, would you like to go for a course in HBC?
   a). Yes
   b). No

29. If the answer to Question 28 is No, support your response.

30. Do you have HIV/AIDS patient in your community on HBC?
   a). Yes
   b). No
31. If the answer is Yes, how would you describe the care?
   a). Very good
   b). Satisfactory
   c). Poor
   d). Other (Specify)

32. Who do you think should be involved in care of HIV/AIDS?

33. How accessible are health promoters (volunteers) in your community?
   a). Always available
   b). Not available

34. How can the Home-Based Care services be improved in your community?

END OF INTERVIEW
THANK YOU VERY MUCH
THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

Telephone: 252641
211440 (UTH) 254824 (Pre-Clinical) Ridgeway Campus
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-250753

P.O. Box 50110
Lusaka, Zambia

Your Ref: 
Our Ref:

1st April, 1997

Dear Sir/Madam,

This is to introduce Eustace Chandi; a fourth year BscN Student in the School of Medicine, Department of Post Basic Nursing. This student is carrying out a Research in partial fulfillment of the Degree requirement. The research topic is KNOWLEDGE ATTITUDE AND PRACTICE OF COMMUNITY TOWARDS HOME-BASED CARE SERVICES FOR HIV/AIDS PATIENTS IN KITWE URBAN.

We shall be most greatfull if you could access the student to information on this subject, clients or interviews and any other assistance the student may require.

Yours faithfully,

[Signature]

Patricia M. Ndele (Mrs)
ACTING HEAD/RESEARCH LECTURER
THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

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P.O. Box 50110
Lusaka, Zambia

Your Ref:
Our Ref:

27th August, 1997

The Coordinator,
Kitwe Home Based Care Unit
Box 20969
KITWE

ufst. Mrs. Ndele
Research Coordinator

Dear Madam,

RE: RESEARCH STUDY

I am a fourth year student at the University of Zambia in the Department of Post Basic Nursing, School of Medicine, currently pursuing a Degree in Nursing.

I am required to conduct a research study in partial fulfillment of the Bachelor of Science Degree in Nursing. My research topic is "Knowledge, Attitude and Practic of Community Towards Home Based Care Services for HIV/AIDS Patient". I hope that the findings of this study will be useful enhancing Community Involvement Home Care programmes in the district.

I hope to carry out this study in Kitwe's Chimwemwe and Kapoto townships from the 8th to 13th September, 1997.

I would be very grateful if you would kindly allow me to conduct this study in your townships.

Yours faithfully,

EUSTACE CHANDI
STUDENT PBN.
Our Ref: KCH/101/1/31

18th November, 1997.

The Dean of Students,
University of Zambia,
LUSAKA.

Dear Sir,

RE: EUSTACE CHANDI.

Eustace had carried out a community based research project on Home based Care in Kitwe's Ipusukilo and Chimwemwe compounds respectively this research will enable us as well to answer most of the problems being faced in our community.

We commend him for his desire to research in Community Based Home Care programme.

Thank you.

Yours faithfully,
KITWE CENTRAL HOSPITAL

PKB/acm