A STUDY TO DETERMINE THE NEEDS OF HOME BASED CARE HEALTH PERSONNEL IN NDOLA URBAN CLINICS

BY

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ZRN - 1989,
ZRM - 1992

LUSAKA, ZAMBIA
I wish to extend my gratitude to my Lecturer, Mrs Jumbe for her patience and her unfailing guidance without whom, this study could not have been successful.

I wish to thank my sponsors, The Directorate of Human Resources Development for awarding me an opportunity to study for my degree in Nursing. My heartfelt gratitude goes to my close friend Lameck Lungu who encouraged me and supported me while at school.

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DECLARATION

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

Signed ..........................................................

Approved ..........................................................
STATEMENT

I hereby certify that this study is entirely the result of my own independent investigation.

The various sources I used, which I am indebted to, are clearly indicated within the text in the paper and in the references.

Signed........................................................................................................

Candidate.................................................................................................
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ABSTRACT

The purpose of the study was to determine the needs of HBC health personnel in Ndola Urban Clinics.

The review of literature on relevant study done in other countries and within Zambia revealed that there are influencing factors on the topic under-study and the factors include:- Economy of the country, distance from patient's home to the clinic, availability of transport, staffing levels, attitude of staff toward the programme, training of staff, supervision and incentives from management, community cooperation and cultural beliefs. A descriptive explanatory and non-intervention type of study was used. The study was conducted in Ndola district. The population understudy was fifty (50) health personnel, of which 40 were nurses and 10 were clinical officers. The respondents were randomly selected. Data was collected using self administered questionnaires. Data was analysed manually and findings presented in frequency tables, cross tabulations and Bargraphs.

The study revealed that HBC health personnel had no resources such as:- transport, gloves and drugs to use in the management of HIV/AIDS patients in their homes.

The health personnel were supervised by their superiors but lacked incentives and this acted as demotivating factor that lowered their morale. The study also revealed that the majority respondents 54% were not trained. The attitude of health personnel toward HBC programme was good especially those who joined the programme voluntarily.
The health personnel received cooperations and support from the community. The community provided material, psychosocial and spiritual support to HBC patients in their homes.

The study also revealed that there were cultural beliefs that affected the care rendered to the patients in their homes. Some of the cultural beliefs were that, those who suffer from AIDS were either bewitched or had, sexual intercourse with a woman who had an abortion and therefore were supposed to be taken to tradition healers for treatment. Sexual cleansing after the death of a spouse was another ritual practiced by many tribes in Zambia. This ritual promotes the spread of the virus to a partner who is not infected.
<table>
<thead>
<tr>
<th>No.</th>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>1.</td>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
</tr>
<tr>
<td>2.</td>
<td>HIV</td>
<td>Human Immune Virus</td>
</tr>
<tr>
<td>3.</td>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>4.</td>
<td>HBC</td>
<td>Home Based Care</td>
</tr>
<tr>
<td>5.</td>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>6.</td>
<td>DHMT</td>
<td>District Health Management Team</td>
</tr>
<tr>
<td>7.</td>
<td>CMAZ</td>
<td>Church Medical Association of Zambia</td>
</tr>
<tr>
<td>8.</td>
<td>ARC</td>
<td>Acquired Related Complex</td>
</tr>
</tbody>
</table>
CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

The first cases of Acquired Immuno Deficiency Syndrome (AIDS) were reported early in 1980 in America. Mann. J. (1988) describes the HIV/AIDS epidemic as volatile, dynamic and unstable in the sense that the disease is incurable and hence can not be controlled. HIV/AIDS does not recognise race, colour, creed or religious affiliation. It cuts across all boundaries and targets mankind (Mphuka’s 1997).

According to UNAIDS (1996) about 22.6 million people globally were living with HIV/AIDS; New HIV infection was 3.1 million; Death due to HIV/AIDS 6.4 million; Cumulative number of HIV infections were 29.4 million and cumulative number of AIDS was 8.4 million. As shown by the global statistics above, throughout the world today, an increasing number of people are infected by the virus that causes AIDS.

In Zambia the trend is not different from other countries as shown by global statistics, everyday an estimation of 500 persons are infected with HIV. The peak ages of new infection are in the 20 to 30 years age range for females and 30 to 40 years range for males. Zambia’s HIV sero-prevalence profile are:~ urban areas 25-32%, rural areas 8-16% (UNICEF 1996). About 36% of Zambia’s total population is HIV AIDS infected. (Mphuka’s 1997).
The AIDS pandemic is advancing rapidly. Prevention measures have failed to stop it as millions who are already infected with HIV go on to develop AIDS. It is a chronic disease, lasting months or years and a person with AIDS may have several re-admission into the hospital.

The burden on the health services is growing due to increased workload on hospital resources which have remained static (Chela, C. 1994). According to the study conducted by WHO, (1990) in Lusaka on National AIDS prevention and control programme, patients with AIDS related illnesses occupied up to 70% of hospital beds, displacing patients suffering from other diseases. The growing number of admissions of patients with AIDS related illnesses has led to health institutions, non-governmental organisations (NGOs) and mission hospitals to develop programmes which will enable people with AIDS related illnesses to be cared for in their homes, hence the emergence of Home Based Care programmes.

In 1986 the Church Medical Association of Zambia (CMAZ), an umbrella organisation of all Mission hospitals, adopted Home Based Care (HBC) as a strategy to respond to the AIDS challenge in the country. The Zambian Government in 1991 reaffirmed it's commitment to primary health care (PHC), as a strategy for delivering health care where the people are. (MOH 1994).

PHC also supports the concept of HBC and encourages community participation, so that the community can take an active role in looking after its
own sick people, with the help and guidance of health workers. Home based
care teams were formed at hospitals and clinics throughout the country to
educate the community on matters related to HIV/AIDS. Thus, in Zambia,
HBC programmes have been implemented in two ways:

1. Hospital initiated outreach programmes or vertical programmes. These
   are initiated by the hospital staff concerned about the care provided to
   hospitalised people with HIV/AIDS and the need expressed by the
   people with AIDS, then slowly integrating the programme into the
   community.

2. Community initiated programmes or horizontal programmes: These are
   started by religious individuals with small budgets and donations from
   churches. They rely on community volunteers with support from
   community based organisations, churches and health facilities. The aims
   of both vertical and horizontal home based care programmes are:

   - To enable health workers to make home visits.
   - To train volunteers, families and people with AIDS in basic nursing care and
     infection control.
   - To ensure that people receive basic nursing care as well as social and emotional
     support.
   - To mobilise other people to provide support.
   - To reach sick people who are not using health services.
   - To provide advise or money for income generation.
   - To integrate the care with HIV/AIDS education.
- To promote acceptance of people with HIV/AIDS
- To reduce pressure on Hospital-inpatient work load and thereby decongesting the medical wards (WHO 1994)

The health workers play a major role in helping the family and the community to provide care to their sick at home. They work with the community, stimulate health styles, self care and educate the community to solve both individual and community health problems. The goal of home based care health personnel is to encourage the family to prevent health problems when possible, to take care of the existing problems and educate the family to know when it is time to get help. However, the efforts of home based care health personnel are not without drawbacks and some of these include:

- The social economic status of the country which has a major taxing effect on the care rendered to people with AIDS, in their homes.
- Many home based care teams do not have transport facilities to cover long distance to reach clients home.
- Drugs and protective clothing such as gloves and aprons are inadequate and in some places they are not even there.
- The team does not have enough time to conduct home visit because the same health care providers need to render services at the health facilities where they are based.

The above mentioned factors have great influence on the impact of home based care programmes throughout the country.
The implementation of HBC programmes in Ndola is in two ways i.e:

- NGO's which cater for Nkwazi, Mushili, Chipulukusu, Ka'ngonga, Chiwala and Kaloko compounds. The rest of the townships are run by District Health Management Board and Ndola Central hospital HBC. According to CBOH/MOH (1977), Copperbelt Province has 207,088 HIV/AIDS patients and Ndola District has got 51,740 adults with HIV/AIDS.

**TABLE I**

**TOTAL NUMBER OF AIDS AND ARC CASES**

**REPORTED ALL ZAMBIA BY YEAR**

<table>
<thead>
<tr>
<th>Year</th>
<th>AIDS Cumulated Total</th>
<th>ARC Cumulated Totals</th>
<th>Cumulated Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1985</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1986</td>
<td>241</td>
<td>1,347</td>
<td>1,588</td>
</tr>
<tr>
<td>1987</td>
<td>709</td>
<td>4,741</td>
<td>5,450</td>
</tr>
<tr>
<td>1988</td>
<td>1,693</td>
<td>8,234</td>
<td>9,927</td>
</tr>
<tr>
<td>1989</td>
<td>2,803</td>
<td>11,757</td>
<td>14,565</td>
</tr>
<tr>
<td>1990</td>
<td>4,201</td>
<td>15,066</td>
<td>19,267</td>
</tr>
<tr>
<td>1991</td>
<td>5,847</td>
<td>18,684</td>
<td>24,531</td>
</tr>
<tr>
<td>1992</td>
<td>7,123</td>
<td>20,784</td>
<td>27,907</td>
</tr>
<tr>
<td>1993</td>
<td>8,304</td>
<td>22,497</td>
<td>30,801</td>
</tr>
<tr>
<td>1994</td>
<td>9,406</td>
<td>23,358</td>
<td>32,764</td>
</tr>
<tr>
<td>1995</td>
<td>12,741</td>
<td>25,973</td>
<td>38,714</td>
</tr>
<tr>
<td>1996</td>
<td>14,566</td>
<td>27,881</td>
<td>42,447</td>
</tr>
<tr>
<td>1997</td>
<td></td>
<td></td>
<td>44,000</td>
</tr>
</tbody>
</table>

Adopted from or source - MOH 1997 National AIDS, STD, TB and Leprosy Programme
TABLE 2

ZAMBIA HIV ADULT (Ages 15yrs and above) PREVALENCE ESTIMATES

BY PROVINCE 1997

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>HIV+ Adult Total</th>
<th>HIV+ Adult Urban</th>
<th>HIV+ Adult Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>100.570</td>
<td>43.299</td>
<td>57.271</td>
</tr>
<tr>
<td>Copperbelt</td>
<td>207.088</td>
<td>186.614</td>
<td>20.474</td>
</tr>
<tr>
<td>Eastern</td>
<td>91.337</td>
<td>18.407</td>
<td>72.980</td>
</tr>
<tr>
<td>Luapula</td>
<td>73.393</td>
<td>14.918</td>
<td>58.475</td>
</tr>
<tr>
<td>Lusaka</td>
<td>180.782</td>
<td>165.201</td>
<td>15.580</td>
</tr>
<tr>
<td>Northern</td>
<td>105.058</td>
<td>23.232</td>
<td>81.826</td>
</tr>
<tr>
<td>North Western</td>
<td>29.674</td>
<td>9.208</td>
<td>20.468</td>
</tr>
<tr>
<td>Southern</td>
<td>92.936</td>
<td>41.921</td>
<td>51.644</td>
</tr>
<tr>
<td>Western</td>
<td>65.516</td>
<td>10.756</td>
<td>54.700</td>
</tr>
</tbody>
</table>

FROM MOH AND CBOH 1997
1.2 STATEMENT OF A PROBLEM

Since the first cases of Acquired Immuno Deficiency syndrome (AIDS) were reported in 1981 in America, the disease has assumed pandemic proportions and has been recognised world wide (Mann, J. 1988). The Sub-Sahara Africa, Zambia included is facing a severe HIV/AIDS pandemic as the disease advances at a fast rate. In Zambia, approximately 500 people are getting infected everyday, and the multitude that get infected with HIV go on to develop AIDS in the long run. (WHO 1993).

The need to care for patients with HIV/AIDS, often over a period of time or years, is challenging the families, friends and health care systems which are already crippled with limited resources. The increasing demand for care has fallen on poorly equipped and under funded health services, making it impossible to offer quality care to affected patients. (UNAIDS 1996)

In trying to relieve the burden on health institutions or decongesting the hospitals, the Church organisations and NGOs in conjunction with hospitals spear-headed the formation of Home Based Care (HBC) programmes in the country in 1987. The emergence of HBC has considerably played a major role in augmenting the family efforts because the AIDS pandemic calls for concerted efforts from care providers and the community at large.

The World Health Organisation (WHO) defines HBC as "any form of care given to the sick people in their home". It can mean the things people might do to take care of
themselves or care given to them by the family members or health workers. Care include Physical, Psychosocial and Spiritual activities. (WHO 1993). The aim of home based care programme is to facilitate the family's caring role by strengthening the patient's capacity to take care of himself and develop a positive attitude toward life. Apart from decongesting the hospitals, home care is preferred by most people with AIDS and their families because of the following reasons:—

- It is less expensive for family members as they cut down on transport money for hospital visits;
- The family members can meet other responsibilities more easily, which can be difficult if they had to stay at the hospital to help care for the patient and take food for the patient;
- People who are very sick or dying and know that there is no cure for their disease, would rather be in their homes with family members around them, so that they are able to get attention and love whenever they need it or when need arises.

However, the whole idea of home care has turned out to be "home neglect" and a nightmare for some families due to inadequate preparation and lack of information and support. The impact of AIDS on any family is such that, it creates havoc, disruption of household routines and a complete change of future plans. The person with AIDS suffers from anxiety over the future and family, low self esteem, fear of rejection, guilt over possibilities of having infected the spouse or partner, fear of long
illness and the process of death. The family too goes through fear of contracting the
disease and the agony of watching a loved family member wasting away. the primary
care giver undergoes stress due to lack of knowledge and skill on how to nurse the
patient at home. They are anxious about the inadequate resources and materials to use
and poverty worsens as money goes to meet the health care expenses. (MOH, WHO
1994)

According to a study conducted by Woelel et. al. (1996) in Zimbabwe on community
involvement, most families lack education and resources in caring for patients with
AIDS. In many families the house hold budget was over stretched. They could not
afford basic supplies and the extra cost of the patient was a major burden. As a result
of the above mentioned scenario, the families are left with no option but to commit
their loved one to hospital care.

Most of the studies done in the past aimed at describing the complexity of the impact of
the disease (AIDS) on the individual, family and community. Other studies
concentrated on knowledge, attitude and practice of community on HBC in
management of HIV/AIDS patients. The common element in all these studies is that
the community have very little knowledge on HBC. According to a study done by
Chandi. E. (1997). 68% of the respondents had little knowledge on HBC programme
and did not participate in HBC programmes because the concept was not fully
understood by them. In view of the above findings the researcher feels its important to
conduct a study to determine the needs of HBC health personnel. The research
question that the investigator has in mind is.... Why is it that the community still
express lack of knowledge on HBC programmes despite the health system's emphasis on home care for the people with HIV/AIDS? What are the problems HBC health personnel face in information dissemination in order to get active community involvement in home based care of patients with HIV/AIDS?

There could be several variables that have effect on the needs of health personnel and therefore affect the rendering of service to the community and influence community participation in the end.

These factors include:-

- **Economy of the country.** When the economy of the country is good, resources for the care of HBC patients will be available, while on the other hand if economy of the country is poor there will be no resources for HBC health personnel to use in HBC programme.

- **Location/Distance:** If the distance between the clinic and the home of a patient who needs home care is long, then the health workers will not be able to see many patients in a day and hence there will be fewer visits in a month. If the distance is short the health personnel can see a lot of patients in a day make frequent visits in a month.

- **Transport:** If the HBC health personnel have transport, they can even visit patients who stay very far from the clinic and if they don't have transport, only those patients who stay within walking distance from the clinic will be visited.

**Staffing-levels:** If the clinic is well staffed, then it will be easy to divide staff 50
that some go to the community while others remain at the clinic to offer services. But when there is a shortage of staff, the health personnel will rarely visit the patients in the community.

- **Attitude of Staff**: If the health personnel have a positive attitude towards HBC programmes, they will participate actively but if their attitude is negative, they won't be involved in the programme;

- **Supervision**: When there is supervision from DHMT, problems faced by health workers will be solved, but when supervision lacks, health workers might feel uncared for and the programme will not succeed;

- **Training**: Trained health personnel work effectively because they will be able to apply the knowledge and skills in management of patients in their homes. The untrained may not work effectively as they may have less knowledge and skills in home management of HIV/AIDS patients:

- **Community Cooperation and Support**: If the community is not supportive and cooperative, HBC programme can not operate effectively because it requires active community participation but if it is supportive and cooperative, HBC programmes will be successful.

- **Cultural Belief**: These might hinder or promote the efforts of HBC health personnel in trying to meet the need of HIV/AIDS patients;

**Assumption**: the central theme the research study focuses on is, to determine the needs of HBC health personnel in home management of HIV/AIDS patients. The researcher assumes that the above mentioned variables have influence on the needs of HBC health personnel as shown in the problem analysis.
PROBLEM ANALYSIS

SERVICE RELATED FACTORS

- Staffing Levels
- Attitude of Staff
- Availability of Resources
- Health Policy
- Supervision
- Training

SOCIAL ECONOMIC FACTORS

- Economy of the country
- Location / Distance
- Transport

THE NEEDS OF HBC HEALTH PERSONNEL

Cultural Beliefs:
(Norms, Values, Religion)

Community
Factors

Cooperation

Social support

Acceptance
1.2 JUSTIFICATION OF THE STUDY

The study is aiming at determining the needs of the HBC health personnel in Ndola Urban Clinics. The researcher conducted the study to find out the needs or problems faced by health personnel in HBC programmes, and hopes that the findings of the study will assist the health personnel to try and find solutions so that the AIDS patients will receive quality care in their homes.

Most of the studies done in the past aimed at describing the complexity of the impact of HIV/AIDS on individual, family and community but nothing has been done to assess the needs of health personnel in management of HIV/AIDS patients in their homes. As a result of this the researcher is compelled to conduct a study in this area so that the findings of the study will assist the district health board of management in formulating policies concerning HBC programmes taking into consideration the needs of health personnel. The investigator is conducting the study as a partial fulfilment of BSc. Degree in Nursing Programme.

1.4 HYPOTHESES

1. Lack of training of staff in the Clinics has contributed to lack of active participation in Home Based Care programmes.

2. Inadequate resources for HBC programmes has contributed to negative attitude of health personnel towards HBC programmes.

3. Cultural beliefs influence community cooperation.
1.5 OBJECTIVES

GENERAL OBJECTIVE

To determine the needs of HBC health personnel

SPECIFIC OBJECTIVES

1. To find out the availability of resources at the Clinics for management of AIDS patients in the community

2. To determine the support HBC health personnel get from the District Health Management Boards

3. To identify the types of support health personnel get from the community

4. To determine the attitude of health personnel toward home care in the management of HIV/AIDS patients

5. To determine the motivation HBC health personnel get from the District Management Board

6. To determine the means of transport HBC health personnel use when conducting home visits
### OPERATIONAL DEFINITIONS

#### TERMS

**Home Based Care**

Any form of care given to HIV/AIDS patients by family members, the community and health workers, in their own homes. Care includes spiritual, physical and psychosocial activities.

**Primary Care Giver**

A member of the family identified as the person providing the actual nursing care to the patient in the home.

**Health Personnel**

Health workers involved in the provision of medical-care, nursing care, and counselling services to HIV/AIDS patients in their homes.

**Needs**

Basic requirements that HBC health personnel must have in order to deliver services to patients who need home care.
### VARIABLES AND CUT OFF POINT

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>INDICATIONS</th>
<th>CUT OFF POINT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attitude</td>
<td>Joined HBC by choice</td>
<td>Positive</td>
</tr>
<tr>
<td></td>
<td>Enjoys HBC programmes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trained HBC by</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Directive from ADMT or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In charge Does not enjoy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HBC programme</td>
<td></td>
</tr>
<tr>
<td>2. Training</td>
<td>Attended one or more</td>
<td>Received some training</td>
</tr>
<tr>
<td></td>
<td>Workshops of seminar</td>
<td></td>
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<tr>
<td></td>
<td>Never attended a seminar</td>
<td>Not received any</td>
</tr>
<tr>
<td></td>
<td>Or workshops</td>
<td>Training</td>
</tr>
<tr>
<td>3. Resources</td>
<td>Drugs, Gloves</td>
<td>Adequate</td>
</tr>
<tr>
<td></td>
<td>Drugs</td>
<td>In adequate</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>Poor</td>
</tr>
<tr>
<td>4. Community support</td>
<td>Social emotional,</td>
<td>Adequate</td>
</tr>
<tr>
<td></td>
<td>Spiritual and material</td>
<td>Inadequate</td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td>Poor</td>
</tr>
<tr>
<td></td>
<td>Spiritual support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>5. DHMT Supervision</td>
<td>Collection of HBC monthly returns</td>
<td>Inadequate</td>
</tr>
<tr>
<td></td>
<td>Meetings with supervisors, Submissions of HBC monthly returns</td>
<td>Adequate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inadequate</td>
</tr>
</tbody>
</table>
2.0 LITERATURE REVIEW

INTRODUCTION

The influence of the Human Immune Virus (HIV) and the disease which it causes are no longer marginal to us, no longer exotic, but real and its influences shall be felt for decades to come. The mainstreaming of the disease into our daily existence is not easy and the topic HIV/AIDS still creates feelings of denial, fatalism, hopelessness and despair. As the understanding of the way the virus moves, interacts with other diseases, manifests itself, how people learn to live with HIV/AIDS and how the community responds increase, then the feeling of hopelessness are converted into empowerment and ultimately positive action. Information Collection and dissemination is integral to the planning process for the future and our responses to the pandemic is dependent on the flow of reliable and sound information on HIV/AIDS. (UNICEF 1996).

The global estimation of HIV infections are, one million Children and about 22 million adults by end of 1998, of which 16 million would be from sub-Saharan Africa. It was estimated that by the end of the century, cumulative total of HIV infection may reach 30 to 40 million world wide and the number of AIDS cases will be more than 10 million. (WHO 1994).

In many countries, health institutions are inadequate to meet the existing health needs as well as the additional challenges resulting from HIV/AIDS. There is therefore need to explore alternative low cost and easily accessible
care to people affected by HIV/AIDS, without necessarily compromising the
quality of care given. (SAFAIDS 1994). Home Based Care (HBC) strategy is
one of the measures taken by the health system in providing low cost quality
care to HIV/AIDS patients. HBC programmes were initially financed by
Church Organisations, secular NGO's and other well wishers, but of late HBC
programmes have been facing declining donor support and overwhelming
increase in the number of patients, creating a big gap between service needs and
resources availability. The Zambian Government responded to the situation by
formerly endorsing HBC in the health strategy, urging the District Health
Management Boards to support HBC concept by encouraging HBC
programmes to improve efficiency, through increased integration with other
health care systems. The emphasis is put on utilization of existing primary
health care facilities located closer to the house holds and home based care must
be viewed as one of the components in the continuum of available services to
people living with AIDS between the hospital and home. (MOH:WHO 1994).

Generally in Zambia, staffing HBC programmes is a significant challenge with
frequent shortages of health personnel in health institutions. In most cases the
health workers experiences conflicting work demand because the same people
who go to see patients in their homes are the very ones who are supposed to
meet the needs of the patients who come to the clinics. Chela, C. and
Shankanga, Z. (1994) indicated that many health workers resigned from HBC
programmes due to continued exposure to overwhelming needy patients and
families, and lack of adequate resources to satisfy their needs. Other reasons for "Burn Out" include the uncomfortable long distance covered during home visiting and lack of encouragement from superior which later led to low staff morale and lack of commitment of health personnel to home based care programmes.

Most families are affected by the adverse effects of structural adjustment programmes (SAP) which has made them struggle to meet their basic needs and the extra demand imposed by a Chronically ill patient makes the situation worse. The families do not have resources and in most cases, expect the health care team to provide the resources, but it is also difficult for the health workers to provide for the needy patients because the health institutes lack resources too. (MOH 1996).

As a result of the above mentioned situation, the health care provider becomes frustrated because he/she is not able to meet the needs of the client. According to a study conducted in Monze HBC by Chela, C. (1994), the key reason for low staff morale by HBC, health personnel was a perceived lack of monetary gain and intrinsic incentives to stay within the HBC programme. The respondents stated that they did not receive adequate allowance money for the efforts they made to try and meet the needs of HIV/AIDS patients in their homes. They also stated that the administrators never gave them support and encouragement for HBC programmes. (MOH WHO 1994).
In Kenya, general complaints of HBC staff were that, they received insufficient vertical communication from their superiors; lack of job orientation from administrators; their roles in HBC programmes were not clearly defined; lack of consistency in supervision and unsupportive administrators. (Smart, R. and Fincham, R. 1993). According to Hampton, J. (1994), in some countries, HBC health personnel are provided with incentives to motivate them so that they can meet the needs of HIV/AIDS patients. Agomanya HBC team in Ghana is an example where HBC health workers are given bicycles for transport and other resources such as medicine and food supplements for HIV/AIDS patients. Although the health personnel are paid by Ministry of Health, they also get some allowances from the HBC programme funds e.g. lunch allowance (Hampton, J. 1994).

In Uganda, Taso HBC meet the needs of the increasing number of AIDS patients in their homes. The team educates families and community on home care. It also provides care which comprise of Medical treatment and nursing care. It also offers training to its members to empower them with many skills especially counselling skills to help HIV/AIDS patients.

Taso believes that counsellor stress and burn out indicates the need for in-built support systems as well as guidelines for minimum standards for training or supervision of counsellors. It aims at adequate training to provide quality care to patients. Taso team is able to conduct many home visits in a week because
it has a vehicle for transport. It generates its own funds in addition to the allocation it gets from the Ministry of Health and from this income, Taso is able to pay its workers. (WHO TASO 1994).

In Malawi, HBC programmes have incorporated all workers in the health care system so that their efforts can be combined to meet the needs of HIV/AIDS patients in their homes. The burden of AIDS patients is not thrown to health institutions alone but to the community and other government sectors e.g. Agriculture (Jackson, H. 1996). The above mentioned strategy was supported by O’Bre’ene, E. and Pfeifer, G. (1997), who stated that there is need to mobilize adequate resources to facilitate the role of the primary care givers in HBC, who are faced with a challenge to keep people with AIDS as health as possible, with sufficient resources. The health personnel undergo some training and know how best they can teach people the basic principles of caring for terminally ill patients. Proper counselling is given to the Primary care providers and patients so that they know what to do and how to give and seek emotional and practical support from the community and health personnel.

In Zambia the trained health workers who are working with HBC projects run by NGOs are given a lot of support in terms of food supplyments, basic medications and nursing aids to meet the needs of HIV AIDS patients in their homes.
These resources are donated by well wishers. The health workers also attend workshops and seminars to improve their knowledge on home management of AIDS patients and also to enhance their counselling skills. (Chella, C. and Shankanga, Z. (1994).

Chikankata home based care in Zambia is one of the successful HBC in the country. It trains Health workers in home management of AIDS patients and equips them with counselling skills for them to work effectively in the community. It owns a vehicle and it receives resources from donors. Chikankata HBC have implemented an integrated approach in AIDS management. The concept of integrated AIDS management incorporates Pastoral care along side with Medical and nursing care, counselling and education. When a patient dies one or more members of the HBC team provides pre-burial counselling to the family and attends the funeral if possible.

Attending funerals demonstrates that support and care do not end with the death of the patient and that the team has an ongoing concern for the welfare of the family and the community. The members of HBC team who are drawn from various disciplines also provides each other with spiritual support and this has been a major sources of encouragement among themselves despite hardships, enabling them to cope with the inadequancies from hospital management and emotional stress arising from working in the field of AIDS (Campbell, D. and William, G. (1995).
However, many African countries, Zambia included are experiencing difficult times because of the effects of structural adjustment programmes, making it impossible for the health sector to provide adequate resources to its health institutions and motivate its employees. The limited resources at the health centres/clinics and in the community have made it difficult for health personnel to meet the needs of HIV/AIDS patients in their homes (WHO GPA 1994). Chela, C. and Shankanga, Z. (1994) stated that "there is need to meet the needs of the HBC health personnel by hospital administrators in the health system, so that they can in turn motivate the community to take up the responsibility of caring for their AIDS patients in their homes." This supports the principle which stresses that it is important to meet the needs of the health care provider so that she can meet the needs of the patients in home care. When there is dissatisfaction on the part of health worker, it will be reflected in the attitude towards HBC programmes. It may manifest itself in lack of commitment to the programme or signs of burn out may be seen. The key element to successful HBC is the positive motivated staff who have the ability to motivate the patients and families into thinking in terms of quality of life.

The management of AIDS patients in the community calls for concerted efforts from community, social welfare departments, churches and health institutions, so that holistic care is provided. (Rossie, M. and Reyer, R. 1995).

Since most of the patients are religious, the spiritual aspect of the patient's life must not be overlooked. The most effective approach to HBC is
interdisciplinary collaboration. All government sectors must be involved to provide resources to meet the needs of a patient in his own home environment. The overwhelming feelings of guilt and anxiety experienced by an infected individual, can have devastating effects on patients and families unless handled effectively. According to Kneisi, C. and Pleufer, W. (1993), Spiritural distress and loneliness, fatigue, low self-esteem, sexual integrity and home management are the six key psychosocial issues which need to be seriously considered when caring for HIV/AIDS patients. The HBC health personnel must consider key factors in the delivery of care to patients. Holistic intervention must consider totality of the individual with HIV/AIDS, that is Body, Soul and Mind. The HBC health worker must spearhead the provision of holistic type of care by involving other people from different fields such as Psychologists, Social workers etc. With or without resources and motivation, the challenge to the HBC health personnel is to intensify their efforts to continue arming the people with information and knowledge so that they can no longer be perceived as vulnerable but empowered and look at life positively. The Ministry of Health should critically look at measures that will motivate health personnel and aim at equipping the health centres with resources that will meet the needs of the community they serve. (Mataka, E. 1996).
CHAPTER THREE

3.0 METHODOLOGY

3.1 RESEARCH DESIGN
The purpose of the study was to determine the needs of home based care health personnel in Ndola Urban clinics. The study used a descriptive survey approach to get the accurate description of the needs of HBC health personnel. The term survey is often applied to research that is broadly description or explanatory. Treece and Treece (1977) defines survey as a non experimental type of research in which the researcher investigates the community or group. This may be done by asking questions, interviewing, observing what people are doing and focus group discussions. The descriptive research design was preferred by the researcher because it provided data about the current situation within a relative short period of time and it enables the description of variables. Quantitative method was used to measure the measurable variables. Several variables were identified in this study both dependent and independent variables. The independent variables were put under five groups:

- **Demographic variables** - Age, sex and marital status.
- **Social economic variables** - economy of the country. Transport and location distance.
- **Community variables** - Community co-operation, social support and acceptance.
- **Service variables** - Attitude of staff, availability of resources, supervision, remuneration, training, and staffing levels.
- **Cultural beliefs** - Values, norms and religion.

### 3.2 STUDY SETTING

The study was conducted in Ndola Urban Clinics because all the sixteen (16) clinics have been directed to incorporate HBC programmes in the delivery of health care to the community, through primary health care strategy. It was easy to assess the needs of health personnel with regards to HBC programmes because every member of staff is involved in the programme.

Ndola District is ranked second in the number of HIV/AIDS patients, while the leading one being Kitwe with 54,794 patients according to MOH/CBOH (1997). Copperbelt has the highest number of HIV/AIDS patients in the country. It has a total of 207,088 adults who are HIV positive and 51,740 are from Ndola District. The various clinics where the study was conducted are: Prisons, Kawama, Chifubu, Twapia, Lubuto, Kabushi, Masala, Kaloko, Ndeke, and Kaniki.

### 3.3 STUDY POPULATION

The study population included Nurses, Doctors, and Clinical Officers in Ndola.
Urban clinics because these are the people involved in HBC programmes in their catchment areas.

3.4 SAMPLING METHOD/SAMPLE SELECTION

Probability sampling specifically the simple random sampling method was used. The sample frame for all the ten clinics was 119 i.e. Prisons (8), Kawama (10), Chifubu (14), Twapia (15), Lubuto (15), Kabushi (7), Masala (20), Kaloko (12), Kaniki (8), Ndeke (10). However for better representation stratification was done according to each clinic. Therefore, from each clinic a numbered sampling frame was prepared. The numbering of health personnel for each clinic was as follows:

For Prisons clinic was from 01 to 08; Kawama 01 to 10; Chifubu 01 to 14; Twapia 01 to 15; Lubuto 01 to 15; Kabushi 01 to 07; Masala 01 to 20; Kaloko 01 to 12; Kaniki 01 to 08; and Ndeke 01 to 10. Only 5 were selected from each clinic.

The lottery technique was used in each case to ensure random selection, where the number for each unit of the population was placed in ten different containers, mixed well and the luck number drawn, that constituted the sample and picked numbers were matched with the sampling frame to locate the names (Bless and Achola 1982). Therefore, from each clinic only five lucky numbers were picked from the ten different clinics bringing the total number of all randomly selected health personnel to 50. This simple random sampling method was chosen because each element of the population had the same
3.5 **SAMPLE SIZE**

The sample size was Fifty respondents. Five health personnel were interviewed from each clinic. This number was considered reasonable, taking into account the limited resources such as time and money.

3.6 **DATA COLLECTION TECHNIQUES AND TOOLS**

**QUESTIONNAIRE**

These comprised of open-ended and closed ended questions. The questionnaires were self administered given out by the researcher to the respondents. The questionnaire method was found suitable because it permits anonymity and may result in more honest responses. Furthermore, since it would be used on the literate sample, the questionnaire could be left with the respondents to be collected later. To control for anticipated limitation of low response rate and ambiguity, the questions in the questionnaire were simple and straightforward. The instrument were checked and corrected after pre-testing to ensure validity and reliability.

3.7 **ETHICAL CONSIDERATION**

The right of privacy was observed by obtaining direct consent for participation from the respondents and measures were taken to ensure that informed consent
and confidentiality requirements were met in this study. The respondents were informed of the purpose and the benefit of the study, so doing co-operation was assured. To ensure anonymity the researcher omitted the names of the respondents. The researcher got permission from the Director of Health at Ndola District Health Management Board and from the In-charge at the clinics. A feed back would be given to respondents after analysis of data and interpretation of findings.

3.8 PILOT STUDY

The pilot study was conducted at Chipulukusu clinic among the health personnel involved in HBC programme. This clinic was excluded from the main study. The main aim of the pilot study was to appreciate the trial of the data collection tool. to yield valid reliable data and suitability for phrasing and sequencing the questions. The pilot study was therefore helpful to detect flaws or gaps in the content of the data and hence necessary corrections were made.
4.0 DATA ANALYSIS

Data was sorted out according to the tools that were used. To ensure quality control, the questionnaires were checked for mistakes and corrections were made immediately after collecting data. The data from open-ended questions were categorized and coded. Data from closed ended questions was analysed manually using a calculator and then presented in the form of frequency tables, cross tabulation and percentages. Bar graphs were also used to present data. Only meaningful data was used for the interpretation of the findings.

4.1 PRESENTATION OF FINDINGS

The objectives of the study was to determine the needs of HBC health personnel in Ndola Urban clinics. The data collected was presented in tabular form which made it easier to summarize findings. Results presented in this chapter were obtained from fifty (50) respondents (health personnel) involved in HBC programmes.
<table>
<thead>
<tr>
<th>TABLE 1 DEMOGRAPHIC INFORMATION OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 – 30</td>
<td>5</td>
<td>10%</td>
</tr>
<tr>
<td>31 – 40</td>
<td>24</td>
<td>48%</td>
</tr>
<tr>
<td>41 – 50</td>
<td>21</td>
<td>42%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td>Married</td>
<td>34</td>
<td>68%</td>
</tr>
<tr>
<td>Divorced</td>
<td>7</td>
<td>14%</td>
</tr>
<tr>
<td>Widowed</td>
<td>6</td>
<td>12%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Majority of the respondents 80% (40) were females, within the age of 31-40 years and 68% (34) were married.
<table>
<thead>
<tr>
<th>Qualification</th>
<th>Frequency</th>
<th>Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZEN</td>
<td>10</td>
<td>20%</td>
</tr>
<tr>
<td>ZEM</td>
<td>20</td>
<td>40%</td>
</tr>
<tr>
<td>ZRN</td>
<td>7</td>
<td>14%</td>
</tr>
<tr>
<td>ZRM</td>
<td>5</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical Officer</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

Majority of the respondents 40% (20) were Zambia Enrolled Midwives. (ZEM)
TABLE 3: CULTURAL BELIEFS THAT AFFECTED THE GIVING OF CARE TO HIV/AIDS IN THE COMMUNITY

<table>
<thead>
<tr>
<th>Cultural Beliefs</th>
<th>Frequency</th>
<th>Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>15</td>
<td>30%</td>
</tr>
<tr>
<td>No</td>
<td>35</td>
<td>70%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Majority of the respondents 46.7% stated that the ritual of sexual cleansing after the death of a spouse affected the delivery of care to HIV/AIDS patients.

TABLE 4: TYPE OF CULTURAL BELIEFS

<table>
<thead>
<tr>
<th>Type of cultural beliefs</th>
<th>Frequency</th>
<th>Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual intercourse after a woman</td>
<td>3</td>
<td>20%</td>
</tr>
<tr>
<td>Woman has borted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual cleansing after a death of a</td>
<td>7</td>
<td>46.7%</td>
</tr>
<tr>
<td>Death of the spouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witchcraft</td>
<td>5</td>
<td>33.3%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15</td>
<td>100%</td>
</tr>
</tbody>
</table>
**TABLE 5: SUPERVISION FROM DHMT**

<table>
<thead>
<tr>
<th>Supervision from DHMT</th>
<th>Frequency</th>
<th>Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>32</td>
<td>64%</td>
</tr>
<tr>
<td>No</td>
<td>18</td>
<td>36%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Majority of the respondents 64% (32) stated that they were supervised by DHMT.

**TABLE 6: INCENTIVE FROM DHMT**

<table>
<thead>
<tr>
<th>Incentives from DHMT</th>
<th>Frequency</th>
<th>Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>No</td>
<td>46</td>
<td>92%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Majority of the respondents 92% (46) stated that they did not receive any incentives from DHMT for carrying out HBC programmes.
TABLE 7  NUMBER OF PATIENTS

<table>
<thead>
<tr>
<th>Number of patients</th>
<th>Frequency</th>
<th>Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 – 50</td>
<td>31</td>
<td>62%</td>
</tr>
<tr>
<td>51 – 100</td>
<td>14</td>
<td>28%</td>
</tr>
<tr>
<td>Above 100</td>
<td>5</td>
<td>10%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Majority of the respondents 62% (31) stated that the number of patients in their catchment ranged between 10 – 50 patients.

TABLE 8  NUMBER OF WORKSHOPS ATTENDED

<table>
<thead>
<tr>
<th>Number of workshops attended</th>
<th>Frequency</th>
<th>Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three or more</td>
<td>6</td>
<td>12%</td>
</tr>
<tr>
<td>Two</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>One</td>
<td>18</td>
<td>36%</td>
</tr>
<tr>
<td>None</td>
<td>22</td>
<td>44%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Majority of the respondents 44% (22) never had a chance of attending any workshops on HBC programmes.
Table 9: Availability of Resources in relation to attitude of personnel towards HBC programme

<table>
<thead>
<tr>
<th>Availability of resources</th>
<th>Attitude of personnel towards HBC Programme</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive</td>
<td>Negative</td>
</tr>
<tr>
<td>Yes</td>
<td>5 (10%)</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>30 (60%)</td>
<td>15 (30%)</td>
</tr>
<tr>
<td>Total</td>
<td>35 (70%)</td>
<td>15 (30%)</td>
</tr>
</tbody>
</table>

The majority of respondents 90% (45) stated that resources were not available, but most of them 60% (30) had a positive attitude toward HBC programme.

Table 10: SUPPLY OF GLOVES

<table>
<thead>
<tr>
<th>Supply of Gloves</th>
<th>Frequency</th>
<th>Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Good</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td>Poor</td>
<td>40</td>
<td>80%</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Majority of respondents 80% (40) stated that the supply of Gloves was poor
Table 11: SUPPLY OF DRUGS

<table>
<thead>
<tr>
<th>Supply of drugs</th>
<th>Frequency</th>
<th>Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Good</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td>Poor</td>
<td>41</td>
<td>82%</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Majority of respondents 82% (41) stated that the supply of drugs was poor.

Table 12: TRAINING IN RELATION TO HOME VISIT

<table>
<thead>
<tr>
<th>Training</th>
<th>Home Visit</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>18(36%)</td>
<td>5(10%)</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>5(10%)</td>
<td>22(44%)</td>
</tr>
<tr>
<td>Total</td>
<td>23(46%)</td>
<td>27(54%)</td>
</tr>
</tbody>
</table>

Majority of the respondents 54% (27) who did not conduct home visits 44% (22) were not trained.
Table 13: Training in relation to Attitude of personnel towards HBC programme

<table>
<thead>
<tr>
<th>Training</th>
<th>Attitude Positive</th>
<th>Attitude Negative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20 (40% )</td>
<td>3 (6% )</td>
<td>23 (46% )</td>
</tr>
<tr>
<td>No</td>
<td>17 (34% )</td>
<td>10 (20% )</td>
<td>27 (54% )</td>
</tr>
<tr>
<td>Total</td>
<td>37 (74% )</td>
<td>13 (26% )</td>
<td>50 (100% )</td>
</tr>
</tbody>
</table>

Majority of the respondents 74\% (37) who had a positive attitude toward HBC programme 40\% (20) received some training.

Table 14: Manner of joining HBC in Relation to Attitude of health personnel Towards the HBC programme

<table>
<thead>
<tr>
<th>Manner of joining HBC</th>
<th>Attitude of personnel toward HBC programme</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Attitude Positive</td>
<td>Attitude Negative</td>
</tr>
<tr>
<td>By choice</td>
<td>33 (66% )</td>
<td>2 (41% )</td>
</tr>
<tr>
<td>By Directive</td>
<td>5 (10% )</td>
<td>10 (20% )</td>
</tr>
<tr>
<td>Total</td>
<td>38 (76% )</td>
<td>12 (24% )</td>
</tr>
</tbody>
</table>

Majority 70\% (35) who joined HBC programme by choice, 66\% (33) had a positive attitude toward the programme.
<table>
<thead>
<tr>
<th>Community Cooperation</th>
<th>Tradition Beliefs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>15 (30%)</td>
<td>31 (62%)</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>4 (81%)</td>
</tr>
<tr>
<td>Total</td>
<td>15 (30%)</td>
<td>35 (70%)</td>
</tr>
</tbody>
</table>

Majority respondents 92% (46) stated that they received community cooperation. Most of them 62% (31) stated that there were no traditional beliefs that affected the delivery of care.
The majority of the respondents 76% (38) stated that they received social emotional support from the community while 48% (24) received both social emotional and spiritual support.
Fig. 2 Means of transport used when conducting Home Visits

Majority of the respondents 82% (41) stated that they had no transport to use when conducting home visit. They walked when visiting clients in their homes.
Fig. 3: Reasons for conducting Home visit

Majority of the respondents 64% (32) stated that the reasons for conducting home visits was to make follow up of clients.
DISCUSSION OF FINDINGS

SOCIAL DEMOGRAPHIC DATA

The study sought to determine the needs of HBC health personnel in Ndola Urban clinics. Out of the fifty respondents, 40% (20) were Zambia enrolled midwives (ZEM), 20% (10) were Zambia enrolled nurses (ZEN), 16% (8) were clinical officers; 14% (7) were Zambia Registered nurses (ZRN) and 10% (5) were Zambia Registered midwives (ZRM). 20% (10) were males while 80% (40) were females. The mean age of the respondents was 35 years and majority of the respondents 48% (24) were in the age range of 31 - 40 years as shown in Table 1.

CULTURAL BELIEFS

Majority of the respondents 70% stated that there were no cultural beliefs that affected the delivery of care to patients in their homes, but 30% stated that they encountered some cultural beliefs that affected their delivery of home care. Some of the cultural beliefs were that, those who suffer from AIDS were either bewitched or had sexual intercourse with a woman who had an abortion, and therefore were supposed to be taken to traditional healers for treatment. Sexual cleansing after the death of the spouse was another ritual practiced by many tribes in Zambia. This ritual promotes the spread of the virus to a partner who is not infected and it should be discouraged.

This is in agreement with one of the hypothesis which states that cultural beliefs influence the community cooperation. The community does not accept anything that goes against its
beliefs. This indicates that there is still need to educate the community on what is HIV/AIDS, mode of transmission, incubation period and its prevention, so that these beliefs can be ironed out.

COMMUNITY SUPPORT

All the respondents 100% stated that HBC patients received community support in various forms. Seventy six percent of the support was social-emotional support, sixty four percent was spiritual support twelve percent was material support and eight percent of the support was in the form of food.

This implies that HBC health personnel worked hand-in-hand with the community in meeting the needs of HBC patients. They received community cooperation. These findings are in agreement with Rossi, M. and Reyer, R. (1995) who stated that the management of HIV/AIDS patients in the community calls for concerted efforts from community, social Welfare departments, churches and health institutions so that holistic care is provided. Kneisi, C. and Pleufer, W. (1993) also advocated for helistic intervention which considers the totality of an individual with HIV/AIDS, that is body mind and spirit.

SERVICE RELATED FACTORS

The study revealed that most of the respondents 64% received supervision from District health management team and that the type of supervision was through the submission of monthly returns. These findings are consistent with TASO-WHO (1994) who stated that TASO visited its health workers monthly to evaluate the programme and give support to its support.
Furthermore the study revealed that majority of the respondents 92% did not receive any incentives from the District health management team for carrying out HBC programmes. This could be a demotivating factor to the health personnel because they feel they are sacrificing for the programme and not remunerated for the extra efforts they make. They are overworked because they attend to patients at the clinic as well as in the community.

Chela, C. and Shankanga, Z. (1994) had similar finding in their study on cost and impact of HBC programmes, they stated that there were problems of low staff morale and lack of commitment of health workers due to lack of incentives to motivate them resulting in burn out.

The majority respondents 62% stated that the number of patients who needed home care in their catchment area ranged from 10 - 50. Patients from these findings one can postulate that the health personnel have to work extra hard to meet the needs of the increasing number of patients in the community. It requires them to divide their time carefully so that they do not devote most of their time in the community and abandon their responsibilities at the clinic or devote most of their time to their responsibilities at clinic and abandon the patients in the community. There is need to strike a balance.

The study also revealed that resources for HBC programme were not available. 80% of the respondents stated that the supply of gloves was poor and this increases the risk of infection to the primary care giver. Drugs are also in short supply as shown in Table 9. 82% of respondents stated that the supply of drugs was poor. The above mentioned situation could frustrate the health personnel because they are not able to meet the needs of the needy patients. These findings are consistent with those of Chela, C. and Shankanga, Z. (1994) who
stated that general burn out signs of health personnel in HBC programmes have continued due to exposure to overwhelming needy patients and families; inadequate resources to satisfy their needs; conflicting work demand, i.e. at the clinic and in the community and the amount of uncomfortable travel involved with home visits.

However, despite the above findings, the study also indicated that the health personnel had a positive attitude toward HBC programmes, especially those who were trained. As indicated in Table 11 70% of the respondents who had a positive attitude toward the programme, 60% stated that resources were not available for the programme. In this particular study the finding could imply that availability of resources does not influence the attitude of health personnel. Therefore these findings disapprove the hypothesis which states that inadequate resources for HBC programmes contributed to the negative attitude of health personnel toward HBC programmes.

This suggests that there could be other factors that affect the attitude of health personnel such as, the manner of joining HBC programme, as shown in Table 14. The majority of the respondents, 70% who joined HBC programmes by choice, 66% had a positive attitude, but 24% of those who joined HBC by directive, 20% had a negative attitude. This implies that health personnel must not be forced into joining the programmes but should do it voluntarily.

Training also has some influence on conducting of home visits. Table 12 shows that majority of the respondents, 70% of those who did not conduct home visits, 60% were not trained. This supports the hypothesis which states that lack of training of health personnel contributes to lack of active participation in HBC programmes. From these findings one would suggest that there is need to train health personnel in order for them to participate actively in the programme.
Similar findings were amplified by WHO TASO (1994) who stated that training of staff on HBC programmes makes the programmes successful. The TASO health personnel under go some training before they start their operations in the programme and this equips them with knowledge and skills.

The study also revealed that transport facilities were not provided to health workers for home visits. As shown in figure 2, 82% of the respondents stated that they had no transport to use when conducting home visits, instead they walked to client's homes. This could mean that few patients would be visited in a week or month. There is need to provide transport facilities for health workers.

These findings are in agreement with Campbell (1995) who evaluate Agomanya HBC in Ghana. His findings were that every HBC team had a transport either in form of a bicycle, motor bike or vehicle. This enabled the teams to visit many HBC patients in a week.

Furthermore, the study revealed that the health personnel knew that they had an obligation to see clients in their homes regardless of the availability of transport. Figure 3 shows that, 64% of the respondents stated that they conducted home visits to make follow ups of clients. These findings were supported by study done by Chela, C. and Shankanga Z. (1994) which revealed that the health personnel for Chikankata HBC made follow up to monitor patients health and when the patient died one member of HBC team would attend the funeral to give moral support to the family.
IMPLICATIONS TO THE HEALTH CARE SYSTEM

The study revealed that there is still need to promote information, education and communication to health workers and community on the concept, the importance of HBC and its operations in order to offer quality services to chronically ill patients in their homes. Health policy makers should consider ways of motivating the HBC health personnel for effective operation of the programme. The health personnel must be provided with resources to enable them meet the needs of patients and be rewarded for the extra efforts to ensure that the programme succeeds. Provision of transport must be given the first priority.

Effective establishment of HBC programmes denotes that roles of health personnel and other health workers should expand because they are also expected to work in the community as well. This implies that there is need to train the health personnel in special skills such as counselling and advocacy, to speak for those subjected to injustice. Training schools such as schools of nursing are challenged to incorporate counselling at an early stage in order to meet the needs of families with HIV/AIDS patients.

CONCLUSION

The study sought to determine the needs of HBC health personnel and the findings suggest that, most of the health personnel had positive attitude towards the programme but they lacked motivation from the DHMT. They have no transport to use when conducting home visits, resources are inadequate, and quite a number of health personnel need training in the operations of HBC programmes. Majority of the respondents conducted home visits despite inadequate resources to meet the needs of patients in their homes.
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 to include other districts in this particular province or in other provinces.

2. The Zambian government should consider increasing budgetary allocation to the health sector in order to continue training psychosocial counsellors which is a needed service as the number of people with HIV/AIDS increases. The increase in the monthly allocation to the District health management board will also mean increase in the provision of resources and incentives to HBC personnel.

3. The District health management Board should consider training of health personnel as a priority to meet the overwhelming needs of patients in their homes. Support of already trained health personnel should be done so that they feel cared for by their superiors.

LIMITATION OF THE STUDY

The major limitation of the study was limited resources such as funds and the time framework in which the research project was to be completed.
REFERENCES


21. WHO. Framework of guiding principles for HIV AIDS. Coordinations at country level. MASERU.


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

SELF ADMINISTRATION QUESTIONNAIRE
ON THE NEEDS OF HOME BASED HEALTH PERSONNEL.

DATE: ____________
TIME: ____________
PLACE: _______________________

QUESTIONNAIRE No: __________

INSTRUCTIONS TO INTERVIEWEE.
1. Please do not write your name on this questionnaire.
2. Kindly tick [ ] the appropriate answer or write the appropriate response in the space provided _______.
3. Answer all the questions in this questionnaire.
4. Information given will be held in confidence and no other person will have access to the papers, but only be utilised for the purpose of the study.
1. What is your sex?
   1. Male [ ]
   2. Female [ ]

2. How old are you?

3. What is your marital status?
   1. Single [ ]
   2. Married [ ]
   3. Divorced [ ]
   4. Widowed [ ]

4. What is your qualification?
   1. ZEN [ ]
   2. ZEM [ ]
   3. ZRN [ ]
   4. ZRM [ ]
   5. Clinical Officer [ ]
   6. Doctor [ ]

5. What religion do you belong to?
   1. Christian [ ]
   2. Islam [ ]
   3. Buddhist [ ]

6. How did you join Home Based Care (HBC) programme?
   1. By choice [ ]
   2. Directive from DHM [ ]
   3 Others, specify ____________________________

7. Do you enjoy HBC programmes?
   1. Yes [ ]
   2. No [ ]

8. State reasons for your answer to question 7.

______________________________
9. How long have you been involved in the programmes?
   1. 1 - 2 years [ ]
   2. 3 - 4 years [ ]
   3. 5 - 6 years [ ]

10. Did you receive any training in HBC?
    1. Yes [ ]
    2. No [ ]

11. If the answer to question 10 is Yes, state the type of training.
    
    
12. How many workshops have you attended in HBC?
    1. Three or more [ ]
    2. Two [ ]
    3. One [ ]
    4. None [ ]

13. Did you get any supervision from DHMT in activities?
    1. Yes [ ]
    2. No [ ]

14. Do you get any incentives for carrying out HBC activities?
    1. Yes [ ]
    2. No [ ]

15. If your answer to question 14 is Yes, state the type of incentives.
    
    
16. Do you conduct home visits?
    1. Yes [ ]
    2. No [ ]

-3-
17. State reasons for your answer to question 16


18. What means of transport do you use when conducting home visits?
   1. Foot [ ]
   2. Bicycle [ ]
   3. Vehicle [ ]

19. How many patients in your catchment area need home care?
   1. 10 - 50 [ ]
   2. 51 - 100 [ ]
   3. Above 100 [ ]

20. Do you have enough resources for HBC programmes?
   1. Yes [ ]
   2. No [ ]

21. If the answer to question 20 is No, why do you think resources are not enough?


22. What is the supply of drugs like?
    1. Very good [ ]
    2. Good [ ]
    3. Poor [ ]

23. What is the supply of gloves like?
    1. Very Good [ ]
    2. Good [ ]
    3. Poor [ ]
24. Do you get extra renumerations from DHMT for carrying out HBC activities?
   1. Yes [ ]
   2. No [ ]

25. Does the community cooperate with you in home care?
   1. Yes [ ]
   2. No [ ]

26. If your answer to question 25 is No, why do you think it does not cooperate with you?

27. What type of support do you get from the community?
   1. Social - emotional support [ ]
   2. Spiritual support [ ]
   3. Material support [ ]
   4. None [ ]
   5. Others [ ]

28. Are there any cultural beliefs that affect the care you give to HIV/AIDS patients?
   1. Yes [ ]
   2. No [ ]

29. If your answer to question 29 is Yes, state the type of cultural beliefs.

Thank you very much for answering the Questionnaire.
THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

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

8th July, 1998

Dear Sir/Madam,

This is to introduce, MONICA MAPENI, a Fourth Year BSC (Nursing) Student in the Department of Post Basic Nursing, School of Medicine, University of Zambia. The student is undertaking a Research Study in partial fulfilment of the above mentioned degree.

The Research Programme for study is: TO DETERMINE THE NEEDS OF HOME BASED CARE HEALTH PERSONNEL IN N'DOLA URBAN CLINICS

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

Yours faithfully

Lydia Jumbe
COURSE CO-ORDINATOR
DEPARTMENT OF POST BASIC NURSING
The Executive Director,  
Ndola District Health Board of Management,  
P.O. Box  
NDOLA.

Dear Sir/Madam,

PERMISSION TO UNDERTAKE A RESEARCH STUDY

I am a fourth year student, pursuing a degree in Nursing course at the University of Zambia.

As part of the course requirement, I have to undertake a research study. I am therefore asking for permission to undertake a study in Ndola Urban Clinics. The title of my study is "DETERMINING THE NEEDS OF HOME BASED CARE HEALTH PERSONNEL".

It is hoped that the research findings will be useful for improving the quality of care given to patients in their homes.

Thanking you in anticipation.

Yours faithfully,

MONICA MAPENZI (MISS)

cc. Head PBN, School of Medicine