THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
POST BASIC NURSING

A STUDY TO DETERMINE THE KNOWLEDGE, ATTITUDE AND PRACTICE OF CARE GIVERS TOWARDS HIV/AIDS PATIENTS IN CHOMA URBAN DISTRICT

BY

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TABLE OF CONTENTS

CHAPTER 4

CHAPTER 5

CHAPTER 6

ANNEXES

LIST OF TABLES

DECLARATION

I hereby declare that the work presented in this study for the Bachelor of Science degree in Nursing has not been presented wholly or in part for any other degree nor is being submitted for any other degree.

Signed: ______________________
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DEDICATION

This study is affectionately dedicated to my beloved children Namasiku, Gift and Glory who were denied daddy's company and care at a very tender age.

To my wife and Honourable brother Mabenga for their encouragement and support. Lastly to all my relatives and friends too many to mention.

STATEMENT

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 dearly indicated in the paper and references.

Signed: ____________

ABSTRACT

The purpose of this study was to determine the knowledge, attitude and practice of care givers towards HIV / AIDS in Choma Urban District..

The review of literature done in other countries and within Zambia revealed that there are influencing factors on the topic understudy and these factors include: - Stigma, age of care givers, past experiences, lack of community involvement, educational level, traditional beliefs and culture, marital status and inadequate resources.

A descriptive, explanatory and non - intervention type of study was used.

The population under study was fifty (50) caregivers (men and women). The respondents were randomly selected. Data was collected using a structured interview schedule, analysed manually and findings were presented in frequency tables and cross tabulations.

The study revealed that the majority of the caregivers were females aged 40 years and above.

It was also revealed that most of the respondents had only primary education, but despite this, their level of knowledge about HIV/AIDS was good. Most of the respondents complained of inadequate resources to meet the basic needs of the family and this attributed to the negative attitude and poor practice towards the HIV/AIDS patients.

The study recommended that there is need to train more caregivers in the community. A system should be put in place to supervise and monitor work of caregivers by the Home Based Care Team. The Home Based Care support should not only be focussed on the patient but to include the family and community at large.

LIST OF ABBREVIATIONS USED

1.	AIDS	-	Acquired Immune Deficiency Syndrome
2.	CBoH	-	Central Board of Health
3.	CSO	-	Central Statistical Office
4.	DHMT	-	District Health Management Team
5.	HBC	-	Home Based Care
6.	HIV	-	Human Immuno Deficiency Virus
7.	MOH	-	Ministry of Health
8.	NGOs	-	Non-Governmental Organizations
9.	PWA	-	Patients with AIDS
10.	STI	-	Sexually Transmitted Infection
11.	UNAIDS	-	Joint United Nations Programme on AIDS
12.	UNICEF	-	United Nations International Children's Emergency Fund
13.	WHO	-	World Health Organization

CHAPTER 1

1.0. INTRODUCTION

1.1. BACKGROUND INFORMATION

The HIV/AIDS epidemic has become a serious health and developmental problem in many countries around the world. The joint United Nations programme on AIDS (UNAIDS, 1999) estimates the number of HIV infection worldwide at about 33.4 million by the end of 1998, of which 22.5 million were found in Sub-Sahara Africa. Another 13.4 million persons have already died from the disease since the beginning of the epidemic, mostly in Africa. It is also reported that about 590,000 infants now become infected each year, about 90% of who are African children (WHO, 1999).

Zambia has an area of 752,614 square kilometres. According to the last census, which was done in 1990, the population of the country was 7.82 million (Central Statistical Office, 1996). This number is projected to be 11.8 million by the year 2000. Southern province is one of the nine provinces found in Zambia. The province has 10 districts and Choma district shares boundaries with at least 5 of other districts. These are: - Monze to the North, Kalomo to the South, Namwala to the North -Western side, Gwembe on the east and Sinazongwe on the Southern Eastern border.

It is reported that there is a high prevalence of HIV infection in Zambia. Between 14% and 16% of the total adult population is said to be HIV positive. The prevalence is much higher along the line of rail (27%) than in the rural areas (10%). It is further reported that in 19993 alone 40, 000 – 50, 000 of deaths were recorded in the hospitals throughout the country (Bourne et al, 1996). Ministry of Health (1994) estimates that 500 people are infected with HIV/AIDS everyday in Zambia. However, these published figures are not an accurate picture prevailing on the ground due to the poor system of reporting, for example, some figures from those in private practice are not published.

The acquired immuno deficiency syndrome was first reported in New York and California in 1981, in previously healthy male homosexuals who presented with opportunistic infections mostly Kaposis sarcoma (Fosters, 1995). In Zambia, the first case of HIV/AIDS was reported in 1984 (Mann, 1996).

Human Immuno Deficiency Virus (HIV) is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). HIV destroys the biological ability of the human body to fight off opportunistic infections such as tuberculosis. A person can be infected with HIV for a long time without showing any symptoms of the disease. Nonetheless, during this period before a person develops symptoms, he can transmit the infection through sexual contact to others who are not infected. An infected woman can also transmit the disease to her infant during pregnancy or delivery. HIV can also be spread by transfusion of contaminated blood and by sharing needles used for injections . AIDS is defined in terms of how much deterioration of the immune system has taken place as seen by the presence of opportunistic infections. AIDS is commonly manifested as a chronic illness in individuals infected with the virus. These people are more likely to be taken care of within their homes after they are discharged from the hospital. To ensure effective care, relatives and family members must be able to provide psychological and emotional support to the HIV/AIDS patient.

"An integrated approach to the care of patients with HIV/AIDS, through the strengthening of primary health care rather than through the vertical approach, would appear to be a more effective means of providing care of patients with HIV/AIDS" (Fosters, 1995). One of the most practical alternatives, which the government and the Ministry of Health have adopted as it cannot manage the increasing load of patients with HIV/AIDS in the hospitals is community participation (involvement of the family and relatives). "The role of the extended family among many cultural groups in Africa, and the willingness in many instances to care for family members at home, points to home care as a valuable alternative to hospitalisation" (Nkowane, 1991).

The Ministry of Health spearheaded various strategies to contain and limit the spread of STI / HIV infections through National AIDS STI and Leprosy programme. The care has been extended to the family through the Home based Care concept which deals with the care of HIV/AIDS patients in their homes. Home-based care programme started in the mid 1990s by Non Governmental Organizations (NGOs) in response to the HIV/AIDS crisis. Chikankata Home-Based Care is one of the first programmes to be initiated in Zambia. It is located in Mazabuka District, Southern province.

The home-based care programme generally aims at: -

- Ensuring provision of cost effective complement to hospital care.
- Train volunteers and people with HIV in basic nursing care and infection control.
- It offers an opportunity to relieve overcrowded hospitals by reaching the HIV patients once discharged from the hospitals.
- It provides advise on how the community can generate income to help the families with HIV/AIDS.
- It promotes the acceptance of patient with HIV/AIDS.
- It empowers care services and HIV/AIDS and consequently motivates them to care for AIDS patients in their homes.
  (WHO, 1994)

1.2. STATEMENT OF THE PROBLEM

Acquired immuno deficiency syndrome is a relatively new disease in the tropics and has created an urgent public health problem throughout the world. It is almost a decade and half since the HIV/AIDS epidemic was discovered in the world. Since the first cases were reported the epidemic has evolved into a serious global health problem with serious impact on households especially in developing countries. The epidemiology of HIV/AIDS infection is well understood and the cases of disease that are being seen now represent infections that occurred 5-10 years ago. UNAIDS (1999) reported that a total number of 16.3 million people died of HIV/AIDS since the beginning of the epidemic; out of this number adults accounts for 12.7 million, children below 15 years 3.6 million and women 6.2 million.

Coping with the HIV/AIDS illness imposes a number of constraints on the carers and this is a challenge, which has to be addressed in this new decade. However, there exists factors that may influence the caregiver's knowledge, attitude and practices towards patients with HIV/AIDS. Socio-economic status may greatly affect the caregiver's level of participation. Lack of much needed resources has made caring for patients with HIV difficult for most families. Most of the families cannot afford to meet the basic needs required in a home because of the economic hardships, which have been brought by the Structural Adjustment Programme (SAP) and the increased inflation in the country.

Care of the terminally ill patients may be intimidating to those taking care of HIV/AIDS patients. This could be due to the fact that there is often a long period of decline, amounting to months or even years with periods of relatively good health interspersed with bouts of serious illness. Many of the symptoms of HIV/AIDS are difficult or distressing to manage such as frequent diarrhoea. The caregivers may not have the resources to manage such a condition; they may not have the knowledge as to what to do in such instances.

Many people lack knowledge or understanding of their role as care givers as a result, knowledge deficit may affect their attitude and practice towards the care of a patient with HIV/AIDS. When caregivers are given the opportunity to learn about the care of HIV/AIDS patients in the homes most of them adopt a more loving attitude that may uplift the patients morale. "The positive attitude by carers as a result of knowledge gained about care of HIV/AIDS patients would be a very good stepping stone towards improving quality of care and attitudes" (Mwiinga, A;, 1995).

The HIV/AIDS still carries a degree of stigma even where it is common; this means that both patients and family members may find it difficulty to talk about their problems with neighbours or even friends for fear of being discriminated agaisnt. "It is interesting and noteworthy that stigma with HIV/AIDS is rife as evidenced by denial to having a spouse suffering from AIDS". Mwiinga, M, et al (1994). This is really common especially when a man discovers that the wife is HIV positive, he will divorce the wife. Ktskshe,

(1996) stated that "lack of support for patient with AIDS is largely blamed on the stigma the disease possesses, people with AIDS are isolated".

Lack of support from relatives is another factor, which can influence the attitude and practice of carers towards HIV/AIDS patients. Extended family ties nowadays are not as strong as they were in the past especially in the urban areas because of economic hardships faced by many households as a result of loss of employment due to privatisation of companies and retrenchments. Extended families are expected to provide support to the family in terms of financial and material resources as the extended family is known to be an entity with the social responsibility of caring for its members. The increasing number of women with the disease is an urgent issue that require prompt attention as care of the sick continues to be regarded as the responsibility of women serving as the major caregivers. Women also are the immediate nurturers of orphaned children many of whom are survivors of HIV/AIDS affected households. "There are already about 520,000 orphans in Zambia as a result of HIV/AIDS and the number is expanding rapidly due to the epidemic" (MOH/CBoH, 1999).

Age is another factor that may influence the attitudes and practices of caregivers towards the HIV/AIDS patients. It is believed that more adults are likely to take an active role in the care of patients than the younger ones. "It is expected that as one advances in age the more caring he will become". Chandi. M (1997).

Past experiences with HIV/AIDS relatives have made people more knowledgeable about the disease. However, this past experience could have a negative or positive attitude towards the patient. But sometimes carers are not prepared to go through what they experienced the last time they nursed a HIV/AIDS patient hence may develop a negative attitude.

Community involvement may also influence the attitudes and practices of carers towards HIV/AIDS patient. In addition to family members, other members of a patient's community may be able to provide assistance. Women organizations, church groups and others may be able to provide practical assistance. Communities may be in the position to start income generating projects to sustain those individuals who are able to work on part time basis. The Aids Service Organization, TASO in Uganda has successfully started such a project in Kampala. (Okware, 1989). This is further supported by Lopez, P. D (1985) who reported that community mobilization has worked well in countries like Uganda, Tanzania and Democratic Republic of Congo through health education and awareness campaigns aimed at motivating family and community members.

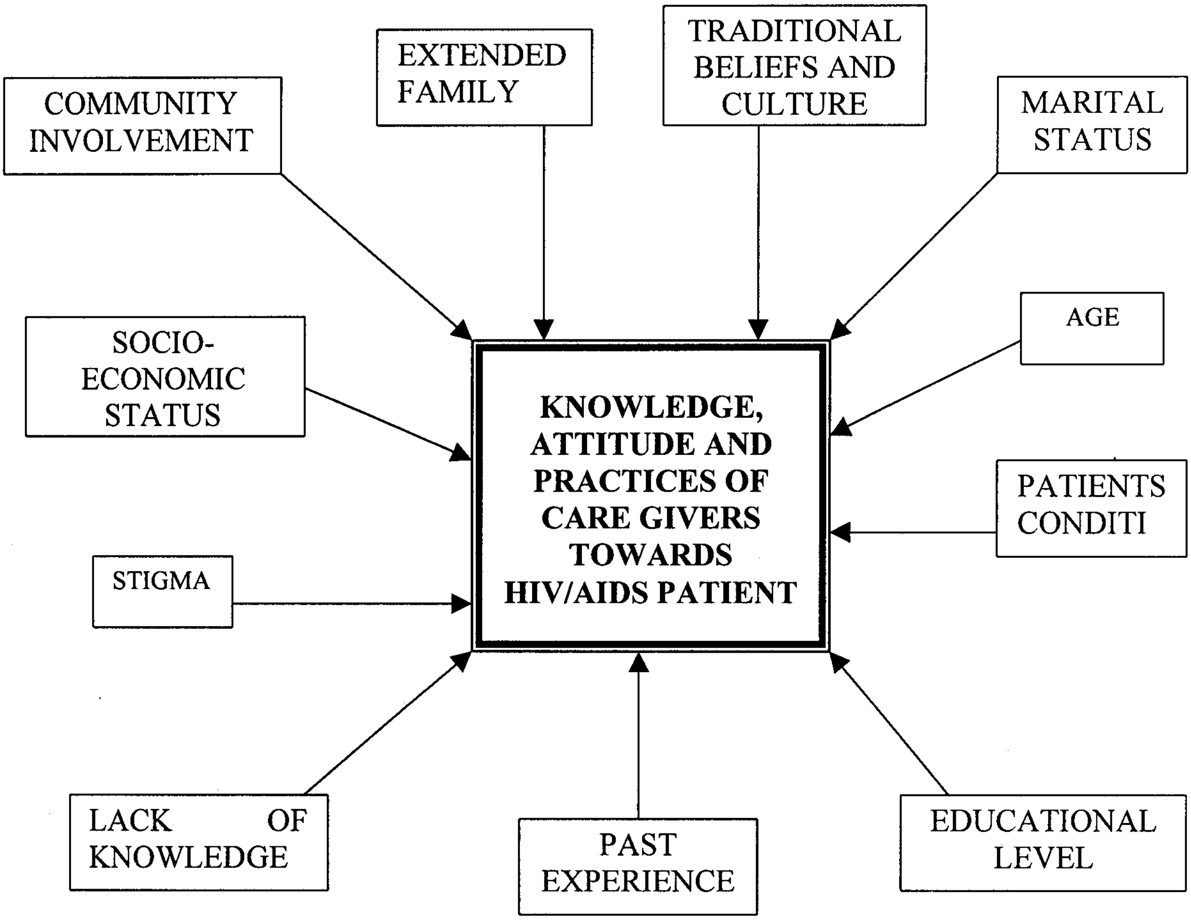
The presence of HIV / AIDS patient in a home entails a major reallocation of labour away from usual tasks towards the care of the sick individual. This means considerable time is spent looking after the patient reducing time for economically productive activities, as most of the terminally ill patients need a long period of care.

Educational level can affect the attitudes and practices of carers towards HIV/AIDS patient as well. If one is educated, it means that he will understand the disease and probably would have had a lot of exposures on the nature of illness. Education is an added advantage to the caregivers as they would be able to understand the nature of the illness; this would in turn help them improve on the care given to the patients infected with HIV/AIDS.

Traditional beliefs and culture may affect attitude and practices of care givers as some people believe that to suffer from any chronic illness such as tuberculosis, and HIV/AIDS could be due to a curse from the Almighty God and this in turn would hinder the provision of quality care due to the misconception of the disease and the caregivers would reluctantly give good care to such patients.

Marital status may also influence the attitude and practices of carers as it is believed that if one is married it is expected that one is going to be responsible and hence take good care of the patient with HIV/AIDS as opposed to someone who is not married, as he will not have the time to take care of the HIV/AIDS patients in the homes.

A DIAGRAM OF ANALYSIS OF FACTORS INFLUENCING THE CARER'S KNOWLEDGE ATTITUDE AND PRACTICES TOWARDS HIV/AIDS PATIENTS



1.3. JUSTIFICATION FOR THE STUDY

The Acquired Immuno Deficiency syndrome (AIDS) is a disease that is posing a major threat to humanity. The epidemic posses a great challenge to health care systems and the community to cope with this added burden of HIV/AIDS patients. Because of this reason, many governments and Ministries of Health are now recognising that the current health care system will not cope with the increasing number of patients. One of the most practical solutions to this problem is the involvement of the family and relatives in the care of these patients infected with AIDS. Zambia, recognizing the cultural practices as many African countries do, family members and extended family members play a major role in the care of the sick in the homes. The involvement of the relatives in the care of individuals infected with the disease is crucial because of the chronic nature of the illness. This study will provide information on the knowledge, attitude and practices the caregivers of HIV/AIDS patients have, as this is likely to determine how they are coping with the demands of looking after their HIV/AIDS infected patients. This information will be of importance to relevant authorities involved in the care of HIV/AIDS patients such as the Home Based Care which consists of volunteers trained in psycho-social counselling and Kara Counselling Trust Unit which has just established itself in Choma District. The study results will also be of benefit to the policy makers so that effective measures can be put in place in order to provide effective care to the HIV/AIDS patients through carers.

1.4. OBJECTIVES OF THE STUDY

General Objective

The main objective of this study was to determine the knowledge, attitude and practices of caregivers towards HIV/AIDS patients in their homes.

Specific Objectives

1. To determine the knowledge of carers on HIV/AIDS.
2. To assess the factors influencing the carer's knowledge, attitude and practices towards HIV/AIDS patients.
3. To assess the kind of care the caregivers offer to HIV/AIDS clients in their home setting.
4. To make recommendations to relevant authorities, non-governmental organizations and policy makers, which would assist in providing quality care of HIV/AIDS patient in their homes.

1.5. STUDY HYPOTHESIS

1. Carers with adequate knowledge have positive attitudes towards the care of HIV/AIDS patients.
2. The attitude of caregivers will be positive towards close relatives with HIV/AIDS than distant relatives.

1.6. OPERATIONAL DEFINITION OF TERMS

1.	**COMMUNITY:**	Group of people the HIV/AIDS patient interacts with in society.
2.	**KNOWLEDGE:**	Amount of insight people have on nature of a disease.
3.	**PATIENT:**	A person diagnosed as having HIV/AIDS related infection.
4.	**PRACTICE:**	Performance or execution of care towards HIV/AIDS relative.
5).	**CARE GIVER:**	This extends to any person living or not living with the patient but administers care to the patient.

1.7. VARIABLES

The dependent variables for the study are: -
Knowledge, Attitudes and Practices.

The independent variables have been identified and these include: -

Age, Gender, Marital status, Traditional beliefs and Culture, Lack of Knowledge and Community participation.

An independent variable is a variable that is assumed to cause changes in the problem under study.

A dependent variable is a variable, which depends on the independent variable.

TABLE 1: VARIABLES AND CUT OFF POINTS

VARIABLE	INDICATOR / CATEGORY	CUT OFF POINTS
Knowledge about HIV/AIDS	Very Good	Responses to question with score 5 and above
	Good	Response to question with score 3-4
	Inadequate	Responses to question with score 2 and below
Attitude	Positive	The patient is accepted by the care givers
	Negative	The patient is not accepted by the care givers
Practice	Good	Ability to take care of the patient
	Poor	Unable to take care of the patient
Social status	Good	Care givers can afford to provide the necessary needs such as food, toiletries
	Poor	Unable to provide the basic needs required to care for the patient.
Extended family ties	Present (Strong)	They are willing to help
	Absent (Weak)	They are not willing to help
Traditional beliefs and culture	Yes	They adhere to traditional beliefs and culture regarding HIV/AIDS
	No	They do not adhere to traditional beliefs and culture regarding HIV/AIDS
Community involvement or co-operation	Yes	They are willing to help HIV/AIDS patient
	No	They are not willing to help HIV/AIDS pstients

CHAPTER 2

2.0. LITERATURE REVIEW

2.1. INTRODUCTION

The family constitutes the basic unit of society and inevitably demands special attention. In all societies and cultures, the family plays a vital role in the development of individuals. Promotion of family health is a basic concern of every government. The family can be regarded as a national strength in many places and should be included as a valuable member of community based home care. Without the family's support, patients cannot be adequately cared for at home. With the family's support home care becomes a viable alternative to hospitalisation. Most of the countries including well developed countries emphasize the role of the family or community in caring for HIV/AIDS patients as the family acts as the first emotional and social support providers.

2.2. GLOBAL

The outbreak of HIV/AIDS since the 1980s has posed a global threat to family health. The Human Immune Deficiency Virus (HIV) infection continues to be a serious global health problem and will be so for many years as many more cases are reported each day. According to UNAIDS (1999), the global cumulative number of HIV infection among adult population has more than doubled since the beginning of the decade, from 10 million in 1990 to 33.6 million in 1999, of which 14.8 million are women and 1.2 million among children. It is also stated that a total of 2.6 million died of HIV/AIDS by 1999 of which adults accounts for 2.1 million, women 14.8 million and children less than 15 years 470,000.

In a study entitled "costs of care in the developing and developed world", Scitovsk, A and Over, M (1998), revealed that home care was an integral part of the services needed by HIV/AIDS infected people. They further found out that using a mix of home services, clinic visits and hospitalisation could lower financial costs of HIV/AIDS care in developed countries.

2.3. REGIONAL

Most of the data available indicate that extensive spread of the AIDS/HIV in the region started in the late 1970s and early 1980s. UNAIDS (1999), estimated that Sub-Sahara countries continue to bear the brunt of HIV/AIDS with close to 70% of the global total population which is HIV positive. It further states that life expectancy in Southern Africa, rose from 44 years in the early 1950s to 59 years between 2005 and 2010 because of the pandemic.

On 5th June 1993 representatives from community based AIDS prevention and care programmes in five Subsaharan African countries (Kenya, Tanzania, Uganda, Zambia and Zimbabwe) met in Berlin just prior to the IXth International Conference on AIDS. They spoke about their programmes strengths, shortcomings and hopes for the future. The discussion focussed on strategies to strengthen community based AIDS prevention and care in Africa. Some of the recommendations which were passed at the meeting includes; augmentation of health education efforts and produce materials in local languages, building on already existing resources in the community such as traditional healers, women and the voluntary spirit of community members and strengthening community outreach and involvement especially at the grassroot/family level (Berlin Report, 1993).

A study on assessment of community's attitude towards HIV/AIDS and home based care in Kenya conducted by Olenja J (1999), revealed that due to inadequate information about the disease and care expectations; people were ambivalent towards the sick and in some instances out right rejection prevailed. This formed the basis for their preference for institutional based care as opposed to home based care. This was further compounded by the economic status of the household/family. Sheer poverty mitigates against providing adequate home-based care in as much as families may be willing to do so. It also confirms that one may perhaps be too taken in by the romanticized idea of unswerving community support. This may further relegate the burden to the primary unit, the family and especially the woman who ultimately carry the load with limited resources. This emphasizes the need to initially share the issue with the community in order to work out the mechanisms that will lessen the burden of, and facilitate home care. Training in the care of AIDS patients is crucial yet lacking at the family and community level. Very few caregivers had appropriate training and were worried about their lack of knowledge and yet they had to care for patients. It was evident that they lacked a framework that would provide the capacity to facilitate home care. Such a framework would bridge the gap between the noble concept of home-based care and the realities of home based care.

2.4. ZAMBIAN

Zambia is one of the six most affected countries in Sub-saharan Africa. HIV prevalence is reported to be doubling every one to three years (John Hopkins, 1991). Zambia has an area of 752,614 square kilometres. According to the last census, which was done in 1990, the population of the country was 7.82 million (CSO, 1996), but this number is projected to be 11.8 million by the year 2000. According to MOH (1994) estimates 500 people are infected with AIDS/HIV everyday. It is further documented that there are 520,000 orphans as a result of AIDS and the number is expanding rapidly to the epidemic.

The Zambian government has acknowledged and recognized HIV/AIDS as a major social and medical problem. The response of the Zambian Government to HIV/AIDS scourge has been affected by the scarcity of resources because the scourge has coincided with a period of economic difficulties characterized by high foreign debt and poor economic performance. As a result even the educational and awareness campaigns have been carried out largely with support of donor agencies and non-governmental organizations (WHO, 1997).

In 1992, CSO conducted a demographic health survey across Zambia and interviewed 7000 women and one of the questions asked was "what do you suggest is the most important thing the government should do for people who have AIDS/HIV?". In response 61.6% mentioned provision of medical treatment; only 3.2% thought that the government should help relatives to provide care, but there was a difference between urban and rural women with 4.6% of urban women mentioning this, but only 1.7% of rural women. About 10% thought the government should "Isolate, quarantine or jail" AIDS sufferers; 10.4%, answered this way. This seems to indicate a high degree of stigma as well as a widespread perception that AIDS is a problem of "other people". In the same study the women were asked another question. "If your relative is suffering with AIDS, who would you prefer to care for him or her?". The preferred caretaker was relatives/friends, at 61.9% followed by government at 23%. From this study we can say community involvement in the delivery of care varies considerably from one, which renders care to the patients with AIDS, to that which isolates itself from HIV infected people.

There are many problems faced by households or families trying to care for a relative with AIDS/HIV. A study of 50 AIDS patients and their families was conducted in 1990 at UTH, Lusaka by Nkowane and the study title was "Determinants of relatives capacity to cope and effects on rejection or acceptance by HIV/AIDS patients in an urban community in Zambia". She found out that there were many social and psychological pressures on relatives who provide care even when the economic means were available. The study also revealed that relatives of patients with persistent diarrhoea who lived in houses with no running water or toilets were reluctant to have the patient discharged. Nkowane further observed that nurses provide only limited care, with relatives providing most of the care while the patient is hospitalised.

In a study conducted by Mwiinga M. (1991) on the response of HIV/AIDS patients and their families to home care in Lusaka urban, showed a positive response to home care among patients for the following reasons: - desire for constant family attention, choice of food, relaxed home atmosphere, opportunity to seek other forms of treatment outside hospital and cost effectiveness. The study recommended that efforts to make home care acceptable by both patients and care givers should be enhanced and future studies should concern themselves with the concerns and information needs of primary care givers involved in home care of AIDS patients.

Given the nature of HIV/AIDS and the understanding that social and environmental variables play a significant role in the spread of HIV in a community, it is important that efforts should include a strong community component. One vehicle of community participation is through the primary health care concept, WHO (1981). Home-based care programmes providing services within a community provides a unique opportunity to reduce the fear and stigma associated with HIV/AIDS. Zambia now has a number of mature home-based care (HBC) programmes that are known worldwide and have served as models for programmes in other countries. It's clear that they provide a service, which is valued by the patients and families alike. Donor agencies have also tended to view HBC as the solution to the problem of caring for increased number of HIV/AIDS patients. A good example of one established home based care is the one based at Chikankata Mission Hospital run by the Salvation Army in Mazabuka District, Southern province (Foster S (1995).

2.5. CONCLUSION

From the literature outlined in this study one is able to deduce that most of the patients would rather be nursed in their homes where they would be relaxed, choice of food given and seek other alternative treatment such as traditional healers. On the other hand most of the relatives are reluctant to nurse the HIV/AIDS patients in their homes due to economic hardships which most families are faced with, since looking after a terminal ill patient requires a lot of resources to meet the demands. It has also been pointed out that some patients would rather be nursed in hospitals than homes due to fear of the social stigma about the disease by the society.

CHAPTER 3

3.0. RESEARCH METHODOLOGY

3.1. RESEARCH DESIGN

The purpose of the study was to determine knowledge, attitude and practices of caregivers towards HIV/AIDS patients in Choma District. The researcher conducted a descriptive study, which involves a systematic collection and presentation of data to give a clear picture of a particular situation understudy and its more effective in finding out the nature of the more accurately and possible influencing factors. The study was aimed at getting caregivers opinions on the care of HIV/AIDS patients nursed in their own homes. The design is suitable because it will be less expensive and does not require a lot of time in which to complete the survey.

3.2. RESEARCH SETTING

The study was conducted in Choma urban in the southern province of Zambia. This was chosen because of limitation of time and since no funding available to conduct the study. Furthermore, it was easy to conduct the study because the researcher was able to communicate with the clients in the native language (Tonga) without any difficult.

Choma District is located in the Southern province of Zambia 225 kilometres South of Lusaka on the main road to Livingstone. The District is the centre of Southern province and it covers about 7300 square kilometres of land with most of it lying about 1.3 metres above sea level. The District is found on flat land, which forms a plateau, and the valley is in the east in Gwembe, to southern east is Sinazongwe. Southern province has ten (10) districts and Choma district share boundaries with at least 5 of these districts; these are Monze to the North, Kalomo to the South, Namwala to the Northwestern side, Gwembe on the east and Sinazongwe on the Southern Eastern border. According to the District Health Management Team (DHMT) Demographic Survey (1997), the population estimates of Choma District was 207, 544 where approximately 51,690 people live in Choma urban and the population density is at 23-persons/square kilometre. The majority of the people live in rural area and there are about 155,854. The district is served by 2 general hospitals, Choma and Macha Mission Hospitals. The District is mostly engaged in agricultural activities. Most of the farmers grow crops like groundnuts, sweet potatoes, maize and beans.

The District has a home based care team comprising of trained counsellors who visits the clients in conjunction with the newly opened Kara Counselling Trust. The researcher was with this team during conduction of the study.

3.3. STUDY POPULATION

The study population consisted of 50 caregivers both men and women looking after HIV/AIDS patients in their own homes.

3.4. SAMPLE SIZE

The study comprised of fifty (50) caregivers (men and women) caring for HIV/AIDS patients in Choma.

3.5. SAMPLING METHOD

Sampling involves selection of a number of units from a different study population (Varkevisier, 1991). In this study simple random sampling method was used to select a sample of fifty (50) respondents in Choma urban.

This technique ensures that all units in the population have equal chances of being involved in the study.

One of the limitations of this type of sampling is that if the population is large randomisation is time consuming.

3.6. DATA COLLECTION TECHNIQUE AND TOOLS

A semi-structured interview was conducted, as some of the respondents were not able to write and read. A semi-structured interview may be required to ask a number of specific questions, but beyond these the interviewers are free to probe as they choose. The advantages of this method are: -

- The interview procedure may serve time for the interviewee because he does not have to go through the process of returning the instrument.
- Generally an interview can be used to elicit information from a broader group of individuals.
- It offers an opportunity to appraise the validity of the report, because the interviewer is present to observe what is taking place.
- It's accurate since it allows the interviewer to probe more and clear misunderstandings of questions during the interview.
- If the interviewee doesn't understand one of the questions during the interview, he may ask to have it repeated. The interviewer on the other hand may ask, "Why don't you understand it?" By recording the item the researcher can make the question more meaningful to other interviewees (Treece and Treece, 1986).

On the other hand, the instrument has some disadvantages, which include: -

- The presence of the interviewer may lead the interviewee not giving precise and accurate answers especially in close-ended questions.
- In a large research project, the director will need to use interviewers and suitable persons may not be readily available. A training programme of course adds to the expense of the project.
- It is difficult to make a comparison of one interviewers data with another interviewers data unless a rigid procedure is followed at times.

3.7. <u>DATA COLLECTION</u>

Data was collected in the third and fourth week of July 2000. It was collected by filling in the structured interview schedule. The researcher was in the team of the home-based care members during their home visits to the clients. The data collected was checked for completeness and entered on the data master sheet to avoid misplacement or loss of data.

3.8. PILOT STUDY

The pilot study was done in Choma town centre in order to find out the completeness and suitability of data collection tool. Corrections and adjustments were then made to the instrument accordingly. All participants in the pilot study were excluded from the main study to avoid bias. According to Treece, Jr. (1996) a pilot study is a small preliminary investigation of the same general character as the major study. It is designed to acquaint the researcher with the problems to be corrected in preparation for the large research project. The main purpose of the pilot study is to make improvements in the research project and to detect problems that must be solved before the major research is attempted.

3.9. ETHICAL CONSIDERATIONS

- Before data collection, a letter asking for permission to conduct the study was written to the Director of Kara Counselling Home Based Care.
- Before the interview verbal permission was sought from the respondents.
- The respondents were informed of the purpose of the study so as to win their maximum support and cooperation.
- The respondents were assured of privacy and anonymity maintained by not writing the respondents names on the interview schedule.

CHAPTER 4

4.0. DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1. INTRODUCTION

In this chapter, the analysed data will be presented in form of frequency tables, cross tabulations and numerical description will be given for each table. Data was analysed manually. A total of fifty (50) respondents were randomly selected and interviewed from Choma Urban District.

4.2. DATA ANALYSIS

The data, which was collected from respondents was analysed in September and October 2000. Data was first edited for completeness and transferred on the data sheet to avoid losses and mixing up data. Responses to open ended questions were categorised, coded and entered on the data master sheet.

Questions to certain variables were cross-tabulated to show relationship between particular variables.

4.3. PRESENTATION OF FINDINGS

The findings of the study are presented in frequency tables and cross tabulations. The tables are presented in order of questions presented in interview schedule. It was found suitable to use tables because they summarize results in meaningful way enabling the reader to understand the author's intention in the study.

TABLE 2: DEMOGRAPHIC DATA FREQUENCIES

AGE GROUP OF RESPONDENTS	FREQUENCY	PERCENTAGE (%)
15 – 24 Years	1	2
25 – 34 Years	6	12
35 – 44 Years	17	34
45 and above	26	52
TOTAL	**50**	**100**
SEX		
Male	17	34
Female	33	66
TOTAL	**50**	**100**
MARITAL STATUS		
Single	3	6
Married	27	54
Divorced	6	12
Widow	8	16
Widower	-	-
Separated	6	12
TOTAL	**50**	**100**
RELIOUS AFFILIATION		
Christian	44	88
Moslem	-	-
Hindu	-	-
Non	6	12
Others	-	-
TOTAL	**50**	**100**

EDUCATIONAL LEVEL	FREQUENCY	PERCENTAGE (%)
No education	4	8
Primary	21	42
Secondary	16	32
College	9	18
TOTAL	**50**	**100**
NUMBER OF ROOMS IN A HOME		
1 – 2	-	-
3 – 4	14	28
5 – 6	19	38
7 – 8	8	16
9 and above	9	18
TOTAL	**50**	**100**
RESPONDENTS' NUMBER OF DEPENDANTS		
1 – 2	1	2
3 – 4	14	28
5 – 6	11	22
7 – 8	15	30
9 and above	9	18
TOTAL	**50**	**100**
OCCUPATIONAL STATUS		
Formally employed	9	18
Self employed	14	28
Part time employed	1	2
Unemployed	17	34
Others		
TOTAL	**50**	**100**

The demographic table shows that majority of the respondents were aged 45 years and above 26 (52%), most of whom were females 33 (66%). Most of the respondents were married 27 (54%). 44 (88%) of whom were Christians with 6 (12%) not belonging to any religion. 21 (42%) of the respondents had primary education, 16 (32%) had been to secondary school, 9 (18%) to college and 4 (8%) had no education. The table also shows that majority of the respondents were unemployed 17 (34%), 14 (28%) self employed, 9 (18%) formally employed and 1 (2%) part time employee.

TABLE 3: RESPONDENTS' RENSPONSES TO WHETHER THEY HAVE HEARD ABOUT AIDS / HIV OR NOT

WHETHER THEY HAVE HEARD ABOUT AIDS / HIV	FREQUENCY	PERCENTAGE (%)
Yes	50	100
No	-	-
TOTAL	**50**	**100**

The table shows that all the respondents 50 (100%) had heard about HIV / AIDS.

TABLE 4: RESPONDENTS SOURCE OF INFORMATION ABOUT AIDS/HIV

SOURCE OF INFORMATION	FREQUENCY	PERCENTAGE (%)
Friend	13	26
Health Care Provider	26	52
Magazine	3	6
Radio	6	12
Others	2	4
TOTAL	**50**	**100**

The table shows that majority of respondents 26 (52%) source of information was from Health Care Providers, 13 (26%) from friends and only 6 (12%) from the radio.

TABLE 5: RESPONDENTS' LEVEL OF KNOWLEDGE ON CAUSES OF HIV/AIDS.

LEVEL OF KNOWLEDGE	FREQUENCY	PERCENTAGE (%)
Very good	21	42
Good	22	44
Inadequate	7	14
TOTAL	**50**	**100**

The table shows that majority of the respondent's knowledge was good 22 (44%) with only 7 (14%) with inadequate knowledge.

TABLE 6: RESPONDENTS' LEVEL OF KNOWLEDGE ON PREVENTION OF HIV/AIDS

LEVEL OF KNOWLEDGE	FREQUENCY	PERCENTAGE (%)
Very good	20	40
Good	23	46
Inadequate	7	14
TOTAL	**50**	**100**

The Table shows that most of the respondents had very good knowledge about the prevention of HIV/Aids 20 (40%), 23 (46%) good, with only 7 (14%) with inadequate knowledge.

TABLE 7: RESPONDENTS HAVING NURSED AN HIV/AIDS PATIENT BEFORE

NURSED A HIV/AIDS PATIENT BEFORE	FREQUENCY	PERCENTAGE (%)
Yes	18	36
No	32	64
TOTAL	**50**	**100**

The table shows that majority of the respondents 32 (64%) have not nursed a patient with HIV/AIDS.

TABLE 8: RESPONDENTS RELATIONSHIP WITH THE PATIENT

RESPONDENTS RELATIONSHIP WITH THE PATIENT	FREQUENCY	PERCENTAGE (%)
Husband / wife	4	8
Son / daughter	4	8
Brother / sister	17	34
Uncle / Auntie	4	8
Nephew / Niece	7	14
Grand parent / grand child	2	4
Cousin	10	**20**
Friend	2	4
TOTAL	**50**	**100**

The table shows that majority of the patients were nursed by a sibling (brother/sister) 17 (34%) and cousins 10 (20%).

TABLE 9: RESPONDENTS CHOICE ON WHERE TO NURSE HIV/AIDS PATIENT

RESPONDENTS CHOICE	FREQUENCY	PERCENTAGE (%)
Home	23	46
Hospital	16	32
Hospice	11	22
TOTAL	**50**	**100**

The table shows that majority of the respondents 23 (46%) preferred the HIV/AIDS patient to be nursed at home, 16 (32%) at the hospital and only 11 (22%) at the hospice.

TABLE 10: RESPONDENTS SEX IN RELATION TO AGE GROUP

SEX	AGE GROUPS IN YEARS				TOTAL
	15 - 24	**25 – 34**	**35 – 44**	**45 AND ABOVE**	
Male	-	3 (6%)	7 (14%)	7 (14%)	17 (34%)
Female	1 (2%)	4 (8%)	10 (20%)	18 (36%)	33 (66%)
TOTAL	**1 (2%)**	**7 (14%)**	**17 (34%)**	**25 (50%)**	**50 (100%)**

The table shows that majority of the respondents were females 33 (66%) out of which 18 (36%) were 45 years and above.

TABLE 11: SEX OF RESPONDENTS IN RELATION TO MARRITAL STATUS

SEX	MARITAL STATUS					TOTAL
	Single	**Married**	**Divorced**	**Widow**	**Separated**	
Male	-	15 (30%)	-	-	2 (4%)	17 (34%)
Female	3 (6%)	13 (26%)	6 (12%)	7 (14%)	4 (8%)	33 (66%)
TOTAL	**3 (6%)**	**28 (56%)**	**6 (12%)**	**7 (14%)**	**6 (12%)**	**50 (100)**

The table shows that majority of the respondents were women 33 (66%). Most of the respondents were married 13 (26%) females and males 15 (30%).

TABLE 12: RESPONDENTS LEVEL OF EDUCATION IN RELATION TO SEX

LEVEL OF EDUCATION	SEX		TOTAL
	MALE	FEMALE	
No education	1 (2%)	3 (6%)	4 (8%)
Primary	5 (10%)	16 (32%)	21 (42%)
Secondary	5 (10%)	11 (22%)	16 (32%)
College	6 (12%)	3 (6%)	9 (18%)
TOTAL	**17 (34%)**	**33 (66%)**	**50 (100%)**

The table shows that among 33 (66%) females, 16 (32%) had primary education, 11 (22%) secondary education and 3 (6%) with no education. Whilst among men 6 (12%) had college education, 5 (10%) had primary education and only 1 (2%) had no education.

TABLE 13: RESPONDENTS LEVEL OF KNOWLEDGE IN RELATIONTO SEX

LEVEL OF KNOWLEDGE	SEX		TOTAL
	FEMALE	MALE	
Very good	10 (20%)	11 (22%)	21 (42%)
Good	15 (30%)	6 (12%)	21 (42%)
Inadequate	8 (16%)	-	8 (16%)
TOTAL	**33 (66%)**	**17 (34%)**	**50 (100%)**

The table shows that majority of respondents had very good and good knowledge 21 (42%) respectively for both sexes while only 8 (16%) among the females had inadequate knowledge.

TABLE 14: RESPONDENTS LEVEL OF KNOWLEDGE IN RELATION TO AGE GROUP

LEVEL OF KNOWLEDGE	AGE OF RESPONDENTS				TOTAL
	15 - 24	25 – 34	35 – 44	45 AND ABOVE	
Very good	-	5 (10%)	6 (12%)	10 (20%)	21 (42%)
Good	1 (2%)	1 (2%)	10 (20%)	10 (20%)	22 (44%)
Inadequate	-	-	2 (4%)	5 (10%)	7 (14%)
TOTAL	**1 (2%)**	**6 (12%)**	**18 (36%)**	**25 (50%)**	**50 (100%)**

The table shows that majority of respondents 43 (86%) knowledge was very good and good respectively in all age groups, those with inadequate knowledge were 7 (14%) and were aged 35 – 45 years and above.

TABLE 15: RESPONDENTS ATTITUDES TOWARDS HIV/AIDS PATIENT IN RELATION TO AGE

ATTITUDE	AGE GROUPS				TOTAL
	15 - 24	25 – 34	35 – 44	45 AND ABOVE	
Good	-	3 (6%)	5 (10%)	12 (24%)	20 (40%)
Poor	1 (2%)	3 (6%)	13 (26%)	13 (26%)	30 (60%)
TOTAL	**1 (2%)**	**6 (12%)**	**18 (36%)**	**25 (50%)**	**50 (100%)**

The table shows that majority of the respondents 30 (60%) in all age groups had poor attitude towards HIV/AIDS patients.

TABLE 16: RESPONDENTS LEVEL OF KNOWLEDGE IN RELATION TO ATTITUDE TOWARDS HIV/AIDS PATIENT

LEVEL OF KNOWLEDGE	ATTITUDE		TOTAL
	POSITIVE (GOOD)	NEGATIVE (POOR)	
Very Good	11 (22%)	10 (20%)	21 (42%)
Good	13 (26%)	9 (18%)	22 (44%)
Inadequate	5 (10%)	2 (4%)	7 (14%)
TOTAL	**29 (58%)**	**21 (42%)**	**50 (100%)**

The table shows that majority of respondents 13 (26%) with good knowledge had a positive attitude, 10 (20%) had negative attitude towards HIV/AIDS patient.

TABLE 17: LEVEL OF KNOWLEDGE IN RELATION TO PRACTICE TOWARDS HIV/AIDS PATIENT

LEVEL OF KNOWLEDGE	PRACTICE		TOTAL
	GOOD	POOR	
Very Good	13 (26%)	11 (22%)	24 (48%)
Good	10 (20%)	9 (18%)	19 (38%)
Inadequate	3 (6%)	4 (8%)	7 (14%)
TOTAL	**26 (52%)**	**24 (48%)**	**50 (100%)**

The table shows that majority 13 (26%) with very good knowledge had good practice while 4 (8%) with inadequate knowledge had poor practice.

TABLE 18: **NUMBER OF TIMES RESPONDENTS HAVE BEEN VISITED BY HOME BASED CARE TEAM**

VISIT BY HBC TEAM	FREQUENCY OF VISITS					TOTAL
	ONCE A WEEK	TWICE PER MONTH	REGULARLY	NONE	OTHERS	
Yes	1 (2%)	7 (14%)	31 (62%)	-	8 (16%)	47 (94%)
No	-	-	-	3 (6%0	-	3 (6%)
TOTAL	**1 (2%)**	**7 (14%)**	**31 (62%)**	**3 (6%)**	**8 (16%)**	**50 (100%)**

The table shows that majority of the respondents have been visited by Home Based care team regularly 31 (62%) while only 3 (6%) have not been visited.

TABLE 19: **RESPONDENTS ABILITY TO PROVIDE BASIC NEEDS IN RELATION TO AGE**

BASIC NEEDS	AGE GROUPS				TOTAL
	15 - 24	25 – 34	35 – 44	45 AND ABOVE	
Yes	-	2 (4%)	3 (6%)	8 (16%)	13 (26%)
No	1 (2%)	4 (8%)	15 (30%)	17 (34%)	37 (74%)
TOTAL	**1 (2%)**	**6 (12%)**	**18 (36%)**	**25 (50%)**	**50 (100%)**

The table shows that majority of the respondents were unable to provide basic needs 37 (74%), out of which 17 (34%) were aged 45 years and above.

TABLE 20: AVAILABILITY OF COMMUNITY SUPPORT IN RELATION TO RESPONDENTS ABILITY TO PROVIDE BASIC NEEDS

COMMUNITY SUPPORT	ABILITY TO PROVIDE BASIC NEEDS		TOTAL
	YES	NO	
Yes	6 (12%)	12 (24%)	18 (36%)
No	7 (14%)	25 (50%)	32 (64%)
TOTAL	**13 (26%)**	**37 (74%)**	**50 (100%)**

The table shows that majority of the respondents had no support from the community 32 (64%), those who had community support 18 (36%) only 6 (12%) were able to provide basic needs.

TABLE 21: RESPONDENTS PREFERRED SUPPORT GROUP IN RELATION TO AGE GROUP

PREFERRED SUPPORT GROUP	AGE IN YEARS				TOTAL
	15 - 24	25 – 34	35 – 44	45 AND ABOVE	
Community	-	1 (2%)	1 (2%)	2 (4%)	4 (8%)
NGOs	-	3 (6%)	10 (20%)	13 (26%)	26 (52%)
Government	1 (2%)	2 (4%)	7 (14%)	10 (20%)	20 (40%)
TOTAL	**1 (2%)**	**6 (12%)**	**18 (36%)**	**25 (50%)**	**50 (100%)**

The table shows that majority of the respondents 26 (52%) preferred NGOs, 20 (40%) Government and only 4 (8%) preferred community support.

CHAPTER 5

5.0. DISCUSSION OF THE FINDINGS

In this chapter, the findings of the research study will be discussed. The aim of the study was to determine the knowledge, attitude and practice of caregivers towards HIV/AIDS patients in Choma Urban District.

5.1. DEMOGRAPHIC DATA

The age range of the respondents was from twenty five (25) years to forty-five (45) years and above. The majority 26 (52%) were aged 45 years and above, this is so because many youths have migrated to big towns such as Lusaka in search of employment (Table 2 page 21). Most of the respondents were females 33 (66%) out of which 27 (57%) were married. The high number of female caregivers could be attributed to the culture, which prevails in the Zambian society where care of the family members is considered to be a woman's responsibility. This has also been found in other studies conducted in Zambia. Chela C. M (1994), noted that, "community participation and resource mobilization are mainly done by women, hence they form the key carers for those infected with HIV/AIDS in the community". The number of married respondents (both males and females) was high because of the strong belief attributed to the institution of marriage. In an African perspective if one is not married he/she is considered an outcast and society would not give him the respect he/she deserves.

The study also revealed that majority of the respondents were Christians 44(88%) with only 6 (12%) not belonging to any religious denomination. This increased number of Christians is due to the fact that historically Christianity has been introduced into our communities since colonization and also the country has been declared a Christian nation by the Republic President (Dr. F. J. T. Chiluba) in 1991.

Other findings from the demographic data showed that most of the respondents had not gone beyond primary education 21 (42%). This is because many parents may not afford to send their children beyond the primary level of education because of high school fees, also considering that Choma is a rural area, most of these families rely on subsistence farming so such parents would rather send their children to help in the fields than send them to school. Furthermore, most families don't see the benefit of sending their children beyond secondary education as most of those who have gone beyond secondary level are just roaming the streets since there are no jobs.

The study also found that as a source of income many of these care givers were engaged in income generating activities such as brewing beer (local wine), backyard gardening, petty trading at home popularly known as "Tuntenba" and also selling vegetables at the market. However, it must be noted that these efforts are undertaken to increase family income in order to meet the basic needs.

5.2. KNOWLEDGE

The results form the study revealed that majority of the respondents 43 (86%) level of knowledge was high on HIV/AIDS while 7 (14%) had inadequate knowledge (Table 5 page 24). These findings show that much has been done in the area of dissemination of information on HIV/AIDS. Macwani M et al (1994) had similar findings in a study conducted in Kaoma and Lusaka where women were asked on HIV/AIDS transmission, majority of the respondents (73%) had good knowledge with only 27% who indicated that they did not know how HIV/AIDS was transmitted. The study also revealed that nearly all women 96% knew that HIV/AIDS cannot be cured.

Other findings of the study shows that most of the respondents 26 (52%) source of information was a health care provider (Table 4 page 23). These results indicate that Health Care Providers are in the forefront in health education on sensitisation about HIV/AIDS. The health education campaigns are disseminated through various means such as print and electronic media, radio, health education at health centres and drama. These are the many ways messages have spread everywhere.

The study also showed that majority of those in the reproductive age group (15 years to 34 years) had very good and good knowledge on HIV/AIDS. These results confirms that the reproductive age group frequents the clinics and hospitals and hence get health education on HIV/AIDS than the old ones who are through with child bearing, so they don't frequently come to the health centres unless when they are ill.

5.3. ATTITUDES

Attitudes of carers depend on knowledge, which they have on HIV/AIDS, thus even the quality of care rendered will depend on it. This study revealed that majority of the respondents with good knowledge 13 (36%) had a positive attitude while 10 (20%) had negative attitude towards HIV/AIDS patients (Table 15, page 28).

The study results also showed that out of 50 respondents 18 (36%) had nursed a patient with AIDS/HIV before and the majority of the respondents relationship with the patient with HIV/AIDS was a sibling 17 (34%) and cousin 10 (20%) (Table 7 page 24). These results shows that care givers were more willing to nurse their close relatives (nuclear members) than distant relatives. However, care givers nursing patients with HIV/AIDS patients complained that it was difficult to nurse patients with HIV/AIDS since it increased the household work, reduced care for other family members disturbing formal work and reduced time to go and search for money. These sentiments are also acknowledged by Chela C. M (1994), when he said "caring for patients with AIDS leads to increased chores and reduced care for other family members". Another study conducted in Uganda West Region by Mann (1996) revealed that the care of people with AIDS by extended family members was declining because of poverty, stigma and other responsibilities.

The study further revealed that majority of the respondents 23 (46%) preferred to nurse patients with AIDS at home (Table 8 page 25). This finding is consistent with the prevailing reality in Zambian society and most African cultures where the family takes a lead in the care of the sick. In a home, the environment is conducive for recovery since the patient will be free, relaxed, receive love, care, psychological, emotional and material support from relatives and other members of community.

The other finding of the study revealed that most of the respondents 37 (74%) were not able to provide the basic needs of the patients (Table 18 page 30). Out of this number majority were aged 45 years and above 17 (34%) and this is because most of the elderly have no means of getting income since most of them were out of employment and are also disadvantaged by their age. The study results also showed that those who received support from the community 6 (12%) (Table 19 page 30) was mainly psychological. These results points out that most families are willing to help but are handicapped by poor socio-economic situation caused by the harsh effects of the economic reform process of the Structural Adjustment Programme. These sentiments are also echoed by UNAIDS (1994) which reports, "people would like to help but they do not have the means".

5.4 . **PRACTICE**

The study revealed that out of a total number of respondents with good practice 26 (52%), 13 (26%) had very good knowledge with only 3 (6%) with inadequate knowledge (Table 16 page 29). In line with these findings, the hypothesis which states that "carers with adequate knowledge have positive attitude towards HIV/AIDS patients", has been accepted. Carers of patients with AIDS in the community need to have adequate knowledge about HIV/AIDS in order to have good practice and this would bring about positive attitude and improve the quality of care towards HIV/AIDS patients. The community needs to be encouraged and supported in the management of HIV/AIDS by the concerned parties such as NGOs. Furthermore, the role played by the community should be appreciated by medical staff and all stakeholders so as to give them encouragement should appreciate the role played by the community.

The study results also revealed that the practice of the respondents in relation to care of patients with HIV/AIDS was poor and reasons for this poor quality could be due to inadequate resources, not knowing how to care for patients with AIDS, stigma associated with the disease such as fear of contracting the disease and misconceptions attached to the disease.

Other findings from the study revealed that the Home Based Care team visited most of the respondents regularly 31 (62%) with only 3 (6%) reported to have not been visited (Table 18 page 30). These findings explains why majority of the respondents' choice of support group was NGOs (Table 20 page 30). This could be because of the support, which NGOs such as Kara Counselling Trust was providing i.e. transporting very ill patients to the hospital.

The study also revealed that only 20 (40%) of the respondents acknowledged support from the Government, perhaps it was difficult to separate the support from Government and NGOs since the two institutions collaborate in some areas for example patients who are on home based care programme are not made to pay any hospital fees.

5.5. IMPLICATIONS ON HEALTH SYSTEM

HIV infection ultimately develops into AIDS, which is a chronic debilitating illness whose prognosis is death. One of the most practical alternatives realised in the care of HIV/AIDS patients is the decentralization of care to the family, relatives and community. This concept of decentralizing care has helped to decongest the few health institutions and has proved to be cost effective to the Government.

Involvement of caregivers in the community is inconsistent with one of the principles of Primary Health Care that emphasises the right and duty of individuals and communities to assume responsibility for matters related to their own health.

The attitude of the community towards HIV/AIDS is poor. People know about HIV/AIDS but behaviour change has not taken place, therefore there is need to change people's attitude towards patients with HIV/AIDS by providing continuous education about HIV/AIDS.

Health care systems should be innovative and adapt to new demands as a result of changing trends in management of HIV/AIDS, if they are to offer care that will be able to make a difference. For example, medical staff and NGOs should appreciate the decentralization of care to the community.

CHAPTER 6

6.0. CONCLUSION

This study was aimed at determining the knowledge, attitude and practice of caregivers towards HIV/AIDS patients in Choma Urban District.

Data was collected using a structured interview schedule. The sample size consisted of 50 caregivers of P.W.A. The study revealed that most of the respondents were aged 45 years and above with females contributing the largest number.

The study also revealed that majority of the respondents had primary education due to the socio-economic situation that the country was going through which made it difficult for many families to send their children to secondary school. The findings of the study showed that most of the respondents had good knowledge about HIV/AIDS.

The attitudes and practice was generally poor in all the age groups and this affected the quality of care rendered to the patients with AIDS.

However, the study revealed that most of the respondents preferred to nurse the patients in their own homes, which is a positive indicator that the disease is being accepted slowly considering the stigma, associated with the disease.

6.1. RECOMMENDATIONS

1. The home-based care support should not only be focussed on the patient but to the family and community at large.
2. More caregivers should be trained in the community as these people are near the family and are able to understand the problems of the local people.
3. There should be a system in place to supervise and monitor work of caregivers by H.B.C Team.

4. The hospital should work hand in hand with the newly established Kara Counselling Trust so that they give priority to meeting the overwhelming needs of patients affected with HIV/AIDS.
5. All those involved in the provision of care such as NGOs and medical staff should intensify the education and communication system to those caring for HIV/AIDS patients so that they develop positive attitude.
6. Another study should be conducted on a large scale so that the results can be generalized.

6.2. LIMITATION OF THE STUDY

- It was difficult to obtain adequate information about what has been done in the District since nothing much has been documented.
- Limitation of time as the study had to be completed within the academic year.
- Money was a constraint since the study was not funded according to the proposed budget.

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REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH
25 - APR 2000
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15th March 2000

Dear Sir/Madam,

This is to introduce FABIAN MABENGA, 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 ~~Programm~~ topic for study is A STUDY TO DETERMINE KNOWLEDGE, ALTITUDE & PRACTICES OF RELATIVES (Next of kin) CARING FOR HIV/AIDS PATIENTS IN CHOMA DISTRICT

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

C.M. Ngoma (Mrs.)
COURSE CO-ORDINATOR
SCHOOL OF MEDICINE
DEPARTMENT OF POST BASIC NURSING

KARA COUNSELLING AND TRAINING TRUST

"Positive and Fully Alive"

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18th July 2000

Mr. Fabian Mabenga
UNZA
P.O. Box 50110
LUSAKA

Dear Mr. Mabenga

PERMISSION TO CARRY OUT RESEARCH

With reference to your letter, we are very happy to assist you in your research concerning the knowledge, attitudes and practice of relatives caring for HIV/AIDS patients. We have a very active Home Based Care going in Choma so our volunteers will be willing to introduce you to their clients having explained your study. I would ask you treat any confidential material given you with the utmost respect as you are working in a very sensitive area.

We look forward to seeing your finished document when you have completed it as I am sure it would help us in our work with the volunteers and the families.

Yours sincerely

Sr Philippa O'Sullivan

Sister Philippa O'Sullivan
Manager

KARA COUNSELLING
P.O. BOX 630461
CHOMA ZAMBIA

AN INTERVIEW SCHEDULE FOR THE CARE GIVERS OF HIV / AIDS

Date of interview................................

Place of interview..............................

Name of interviewer............................

Number of Respondent.........................

INSTRUCTIONS FOR THE INTERVIEWER

1. Introduce yourself to the respondent.
2. Explain purpose of the interview.
3. Tell the respondents how she/he was selected.
4. Explain assurance of confidentiality.
5. Do not write the name of the respondent.

SECTION A: **DEMOGRAPHIC DATA**

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1. How old were you on your last birthday?

   a). 15 – 24 years

   b). 25 – 34 years

   c). 35-44 years

   d). 45 years and above.

2. What is your sex?

   a). Male.

   b). Female.

3. What is your marital status?

   a). Single

   b). Married

   c). Divorced

   d). Widow

   e). Widower

   f). Separated

4. What is your religion?

   a). Christian.

   b). Moslem

   c). Hindu.

   d). Non

   e). Others, Specify__________________

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5. What is your highest educational attainment?

a). No education

b). Primary.

c). Secondary

d). College

e). University

6. Where do you live?

Name of Compound___________________

7. How many rooms has your house?

a). 1

b). 2

c). 3

d). 4

e). More than 4

8. How many dependants do you have?

a). 1 - 2

b) 3 – 4

c). 5 – 6

d). 7 – 8

e). 9 and above

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9. What is your occupational status?

   a). Formally employed
   b). Self employed
   c). Part time employed
   d). Unemployed
   e). Others (Specify) ________________

SECTION B **KNOWLEDGE**

10. Have you ever heard about AIDS / HIV?

    a). Yes
    b). No

11. If the answer is yes to question 10,
    What was your source of information?

    a). Friend
    b). Health Care Provider
    c). Magazine
    d). Radio
    e). Others (Specify) _____________

12. What causes AIDS / HIV?

    ____

13. How can AIDS / HIV be prevented?

    ____

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SECTION C **PRACTICES**

14. Have you nursed a patient with HIV/AIDS before?

a). Yes

b). No

15. If the answer is yes to question 14, explain.

____

16. Do you believe in any traditional beliefs and culture of your society?

a). Yes

b). No

17. Explain your answer to question 16.

____

____

SECTION D **ATTITUDE**

18. What is your relationship with the patient?

a). Wife / Husband

b). Son / Daughter

c). Auntie / Uncle

d). Brother / Sister

e). Nephew / Niece

f). Cousin

g). Grand parent / Son

h). Friend

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19. How are family meals shared?

a). The adults eat together

b). The children eat alone

c). The patient eats alone

d). The patient eats with adults

20. Explain your answer to question 19.

____

____

21. Where do you think an HIV / AIDS patient should be nursed?

a). Home

b). Hospital

c). Hospice

d). Others (Specify) ____________

22. Give reasons for your answer to question 21.

____

____

SECTION E **COMMUNITY SUPPORT**

23. Does the Home Based Care Team visit you?

a). Yes

b). No

24. If the answer to question 23 is yes, how often do they visit your home?

    a). Once a week

    b). Twice a month

    c). Regularly

    d). Others (Specify) _______________

25. Does the Home based Care Team give you any support?

    a). Yes

    b). No

26. If the answer to question 25 is yes, what type of support do they give you?

    a). Food

    b). Clothing

    c). Medicine

    d). Morale

    e). Others (Specify)_______________

27. Does the community support you?

    a). Yes

    b). No

28. If the answer is yes to question 27 what kind of support do you get from the community?

    ____

    ____

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29. Who in the community supports you?

a). Neighbour

b). Church

c). Friends

d). Relatives

e). Others (Specify) ______________

SECTION F **SOCIO SUPPORT**

30. Do you get any support from your extended family members?

a). Yes

b). No

31. If the answer is yes to question 30, what type of support do they give you?

a). Money

b). Material

c). Food

d). Moral support

e). Others (Specify) ______________

32. Are you able to provide the basic needs to the patient?

a). Yes

b). No

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33. If the answer is no to question 32, how do you meet the demands of the patient?

____

____

34. Which organization would you think can support your relatives.

____

____

THANK YOU FOR ANSWERING THE QUESTIONNAIRE