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FEASIBILITY OF MOBILIZING COMMUNITY RESOURCES FOR
HIV/AIDS PATIENTS IN KALINGALINGA COMPOUND LUSAKA

BY

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DECLARATION (IV)

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

SIGNED BY-----

DATE:-----

SIGNED BY-----
Ellie

DATE:-----

STATEMENT

(V)

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

SIGNED BY

CANDIDATE

DEDICATION (VI)

Dedicated to my husband Sam Kabwe for his encouragement and support. To our daughters Katandula, Nociku and Besa. For allowing me to leave them behind and for feiting the motherly love and care that I owe them.

ABSTRACT

(vii)

The aim of the study was to determine the feasibility of mobilizing community resources for HIV/AIDS patients in Kalingalinga compound. Following the observation that there is on increase in the number of AIDS cases and that the government has adopted the strategy of community based care of all the patients with AIDS, it has put a lot of financial strain on providing care to such patients.

Observations and discussions with the people and literature review at home and abroad have revealed that the families take the burden of acring for their patients at home without expecting any help from the community members.

The Ultimate aim was to establish the feelings of the community members, towards the possibilities of mobilizing resources for HIV/AIDS patients from within the community. The information obtained could be used to establish whether a pilot project of community based health care service could be started. This could help the families and cares the burdens the face whilst caring for the patients.

The study was conducted between October 14 - 30th Septmeber, 1993 which involved a multi staged probability sampling. A random sampling of 50 household heads resident in Kalingalinga was conducted 5 of each household were selected from each section. The sample consisted of both men and women aged between 19-42 years.

The researcher administered a semi structured interview schedule to the sampled population to cover the aspects of:-

1. Knowledge that the people have concerning the providing of assistance to Aids patients in their homes.
2. The availability of resources in Kalingalinga
3. The willingness of the people to provide and organise resources for HIV/AIDS patients.

BACKGROUND INFORMATION

1.1 INTRODUCTION

The Aids pandemic is having an extra ordinary and astonishing diverse range of impacts on the lives of the people the world over. Namely, the Psychological, Social, Cultural, Economical and Political impacts.

This can be contributed to the increasing numbers of AIDS cases. 1992 reported a total of approximately 10 - 12 million infected people the world over (WHO 1992).

This prompted the World Health Organisation to find the best way of combating the effects of the AIDS epidemic on the individual, family and the community.

It was agreed that an AIDS patient should be looked after like any other patient with any illness, they need to be treated with respect, honour dignity and a non-judgemental attitude (WHO 1991). They also came up with a strategy of incorporating AIDS patients within the society through the Primary Health Care (PHC). Such that AIDS patients get the maximum benefit of care and support that the Communities are able to provide.

The resources that the communities use in providing care/support are such things as material, financial, infrastructure and manpower resources. Material and money resources could be things that people can contribute or donate. Infrastructure are such things as clinics, schools, church halls community halls and other structures made for common use.

The manpower resources are the people within the community who would volunteer to provide moral, spiritual and physical help to the side within the community. The resources can be mobilised by some key leaders from within the community such people as Church leaders, Politicians, Business-men, Teachers, Village Headmen, Community Health Workers, Traditional Birth Attendants.

Non government Organisations have been seen as the backbones of each projects. There are church groups, civic groups such as Rotary, Lions clubs. Self help projects from women and the youth. All these need to be mobilised so that patients within the community can receive the care.

Successes have been seen in other countries such as the case in Kabondo-Uganda when the Christian Community have organised themselves to provide care to AIDS patients (William Glen 1991).

In Agomanya- Ghana, the Catholic Church has organised themselves to provide care and economic support to AIDS patients (Hampton Janie 1991).

In Zambia a total of 23,984 AIDS cases have been diagnosed and notified, with 1593 deaths reported by October, 1992 (Health Reforms 1992). In response to the epidemic, they have started several projects and activities. These are such as the home based care team, who provide care and support to AIDS patient within the patients own homes. These were started in 1982 with their base at University teaching Hospital (UTH) and the one at Chikankata Mission Hospital. Home care is involved in providing medical and nursing care, counselling, material and spiritual support to AIDS patients within their own home setting with the involvement of communities. Its objectives is to provide a humane, cost effective medical and nursing care to AIDS within homes.

The voluntary agencies concerned with AIDS are the children in distress (CINDI). Which has started a project in Matero named "Kwasha Mukwenu" where women have mobilised themselves to provide care to orphaned children who have been left by parents who die from AIDS.

The Anti AIDS Clubs in schools provide a service to AIDS patients within homes. The Health Education Unit aims at providing health Education and materials on AIDS to create awareness concerning AIDS.

Therefore all groups of people should be aware of AIDS and be motivated to participate, such as the women and the youth. They are able to create or relieve the burden of caring for AIDS patients in their homes.

People are aware of AIDS from Health Education Campaign programmes that have gone on the care in peoples homes and some people have experienced the problems of nursing an AIDS patient at home. But we do not see the community actively involved in providing this care

Therefore the research would like to determine the willingness of the people to provide care and support to those that are sick with AIDS within their communities. Presently they are doing so. It is primarily a family affair.

1.2 STATEMENT OF THE PROBLEM

The impact of AIDS is putting huge pressure on the health budget and services. This is felt more where Government expenditure is low. Therefore ways and means had to be found on how to spend the limited resources. (AIDS Actin 1992).

From observations and records there are indications that the services that the patients receive from the agencies and organisations such as the home based care team, the Anti AIDS are not adequately providing an effective care to AIDS patients. This is so because the services they provide to these people/patients do not involve the communities within which the patients stays.

They do not receive adequate care from these organisations in such a way that their services are based on brief visits to the patient's home with inadequate resources. They are found in situations like these because they work in isolation. They do not involve the communities in providing the care. These organisations are not incomes generating and cannot meet the economical, material and social needs of these patients in most cases. The resources they are able to provide are limited they are dependent on donations from other organisations.

The question is, why are the communities not, involved in providing care/ support to these AIDS patients.

Health Education has been carried out people with AIDS are known and can be seen. The evidence of AIDS is so high that it has made almost everyone aware of the presence of AIDS. The mass media has talked about AIDS booklets, Videos, Drama has been distributed. People have got relatives friends with AIDS and they know the seriousness of the disease and its impact on the economical, social, spiritual and other aspects of life.

(Nkwoware 1989) Found out that 70% of AIDS patients and their relatives prefer to have their patients in hospital due to the financial stress that they have when they provide care within the patient's homes.

Therefore community involvement can reduce stress levels the patients and relatives face, it can enable them to cope better with their situation. This can be so if the people are involved in providing material, financial and support to those that are sick.

When communities are actively involved in providing care, it increases people's knowledge about AIDS and helps to change their attitude towards the patients, it also helps the people in the community to see the seriousness of the disease so that they can be able to change their sexual behaviour to health full ones.

Policies of involving communities in providing health care to AIDS patients have been laid down since 1987 and yet the people are not seen to be actively involved in providing care and support. Could it be that there are no people who can volunteer to provide the service.

Is it that people are not aware of the responsibility they have, in order to give the service. Could it be that there are no resources to provide the support to these patients.

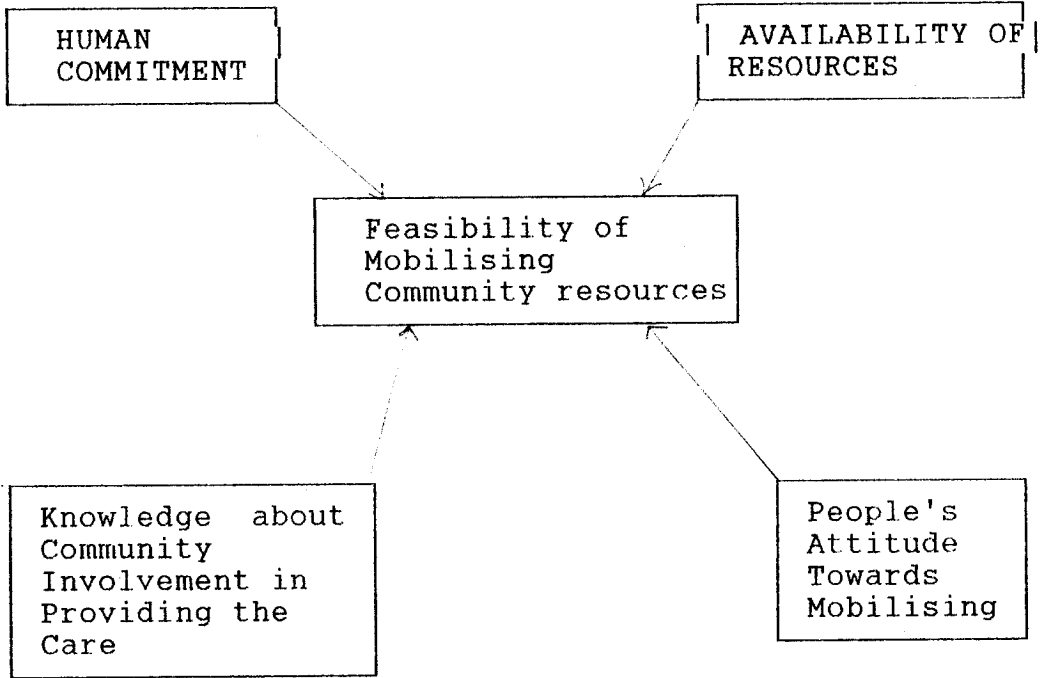
As has been seen from other communities the facilities/resources are available and involvement of communities in providing the care to AIDS patients can easily be looked after with minimum resources as long as there is adequate human commitment (Hamphon Janie 1991)

The people may start educational campaign to make others aware of the responsibility they have in providing the care. Fund raising activities, donations and other help could be procured from the people as long as they are willing to participate.

The study therefore attempts to determine the feasibility of mobilising community resources in Kalingalinga for utilisation by HIV/aids patients.

The recommendation can be made towards the possibility of starting such as project in Kalingalinga on a pilot basis and this can be replicated in other places. This can reduce the stress levels the patients and relatives face in giving nursing care at home.

VARIABLES THAT COULD DETERMINE THE FEASIBILITY OF MOBILISING COMMUNITY RESOURCES FOR HIV/AIDS PATIENTS



CHAPTER TWO

LITERATURE REVIEW

1. Introduction
2. The World Situation
3. The Africa Situation
4. Strategies for AIDS Care
5. Types of Community resources to be utilised
6. Methods of Mobilising resources
7. Some types of community programmes
8. Projects in Zambia
9. Conclusion

INTRODUCTION

The AIDS pandemic is having an impact on the social, cultural, physical, economical, psychological and political aspects of people's lives. The measure in numbers of those injected means that there will be an increase in the demand on health expenditure and facilities. This therefore means that there are limited resources needed to provide adequate care for AIDS patients.

Strategies have been set up on how adequate care can be provided to AIDS patients. Incorporating patients within the community has been adopted as the best way in which they could be cared for. Thus home based care projects have been set, with the full involvement of community members.

THE WORLD SITUATION

The World Health Organisation has estimated that at least 10-12 million people are infected with the virus that causes AIDS. Most of the people do not actually know that they are infected. Between 500,000 and 3 million of them are expected to develop AIDS by the early 1990s. This means that during the next five years there may be 5 - 10 times more AIDS cases than there has been over the last five years. The epidemic thrives on human ignorance and resistance to change.

People infected with HIV continue to be full functional members of society. They should be helped to do so as behave responsibly so as to prevent further spread of the HIV (AIDS Action 1988).

Government can work towards formation of Social Welfare assistance programmes. Recognition and funding of Community, service agencies, public education and provide resources for HIV/AIDS programme (Gillmore Norbert 1992).

THE AFRICA SITUATION

Africa has had a share of the total numbers of Aids cases. An epidemic has reached alarming proportions. The economic manifestation of AIDS will be seen in terms of health services especially if funded from their future economic growth. As most developing countries have annual per capita health expenditure on budgets of under 10 US dollars.

It is estimated that the Medical costs in Africa of treating a person with AIDS is around 20 Us dollars per year.

As the epidemic progresses . The already meagre and stretched health budgets of many countries will be quite insufficient to cope. Because up to 80% of beds in some urban hospitals in Africa are occupied by patients with HIV related illnesses. Choices have been made on how to spend the limited resources. If people with AIDS are to be cared for adequately (AIDS Action 1992).

In West Africa as other parts of the world NGO's are playing a leading role in the fight against AIDS. In Ghana for example, members of the Catholic Church are combating AIDS on several fronts. In education and prevention, in counselling and medical care and in home based care and economical support for people with AIDS and their families (Hampton Janie 1991)

STRATEGIES FOR AIDS CARE

In response to the epidemic, the World Health Organisation held meetings. The first international meeting was held in 1989 in Viena. They formed AIDS service organisations (ASO's). The Organisations provide support to individuals and communities in response to the needs created by AIDS pandemic.

Those needs arise particularly in relation to prevention, care and resources. ASO's are usually community based and non-governmental. The objectives of ASO's are solely AIDS related. They say that patients suspected or known to be HIV infected should remain intergrated with society to the maximum possible extent and be helped to assume responsibility for preventing HIV transmission to others. Exclusion of persons suspected or known to be HIV infected will be unjustified in Public Health terms and would seriously jeopardize educational and other efforts to prevent the spread of HIV (WHO 1990).

Effective Community based programmes can help increase peoples understanding of HIV/AIDS and to reduce stigma for people with AIDS.

TYPES OF RESOURCES TO BE MOBILISED

The scope of the AIDS problem calls for imparrallel involvement of all sectors, the international community societies, families and individuals who should be mobilised for public interest sustained in HIV/AIDS prevention and control (WHO Press Release 1992).

We are therefore faced with a task of involving the significant intermediaries, such as the society religious leaders, mass-media and professionals. Communities counselling communities is one of the national efforts, involving every available means of social organisational, communication and community leadership with the goal of promoting changes in sexual behaviour needed to curb the spread of HIV/AIDS. Those who could make this vision a reality include political readers, healers chiefs village headmen, counsellors church leaders volunteer organisations such as Rotary, Lions, Jaycees, artists and entertainers, women organisations, Youth movements, sports clubs and cultural associations Community Héalth Workers and Village Health Communities all can work to reduce the burden from families and individuals (Glen Williams 1991)

METHODS OF MOBILIZING RESOURCES

The rate at which the epidemic is occurring the economic, status of the nations, the limited resources in health institutions and the chronicity of the disease is putting huge pressure on health budgets and societies, especially where government expenditure is low. Up to 80% of beds in some urban hospitals in Africa are occupied by patients with AIDS and AIDS related illnesses. Therefore divices have to be to made on how to spend the limited resources if people with AIDS have to be cared for (AIDS Action 1992).

Effective community based programmes can help to increase people's understanding of HIV/AIDS and reduce stigma. Programmes of health care and support for people with AIDS can be encouraged to take initiative of that projects in which they participated are in effect their own and have the maximum impact. The principle kind of activities can include visits- counselling of individuals in homes at work in association premises in health centres, meeting discussions, group orientation training in seminars, courses, workshops, public cultural events such as dramas, shows, traditional events, festivals, cerebrations, sports competition, self help projects, local action groups with participatory planning implementation and evaluation. Health Education represents an important channel of communication with local communities (exchange No. 1, 1991).

SOME TYPES OF COMMUNITY PROGRAMMES

The Rwanda Red Cross with the Aid from the Norwegian Red Cross is helping to make sure that people with AIDS and related illnesses receive basic nursing care at home. The project has developed training materials on care for chronic illness related to AIDS, TB and Malaria. Two Rwanda Nurses, trained Red Cross volunteers (mostly teachers and Community Workers) to teach carers how to:-

1. Recognise and understand the common symptoms of chronic illnesses.
2. To keep the patient and their surrounding clean
- 3 To provide a diet that is an nutrition as possible
4. Prevent transmission of disease including HIV
- 5 Treat skin and mucus membrane infections fevers and diarrhoeas.
6. relieve pain and discomfort
- 7 care of the dying

The volunteers are supposed to be provided with AIDS information materials, dressings, soap, GV paints, pain remedies, oral rehydration salts, vaseline (AIDS Action 1988).

In response to the needs of the HIV infected persons and those who live with them and partly as a result of inadequacy of existing services a variety of community initiated care activities have been started. In general they emphasise the importance of continuation of community based care as much as possible. The focus is on the family as a whole. Taking into account the psychological, physical, economical, cultural and social dimensions of infection and disease. (WHO 1991).

St Martins clinic has shown that an innovative and successful health care programme and support for people with AIDS can be established with only limited resources. Provided there is sufficient human commitment Health Education is having a positive impact on the attitudes of people towards AIDS.

The stigma of AIDS within the family has been greatly reduced. People in Agomanya are willing to care for their family members suffering from AIDS, there has been no known case of abandonment.

One of the programmes main strength is the fact that the initiative has come from Ghanaian nationals and the programme is now by people who are well known and respected in local areas. Another key factor is the leadership role of the Catholic church, including religious and lay people at various levels.

The programme has successful integrated a range of different groups and individuals. The church, the ministry of health, non-governmental groups, community leaders and traditional healers. Although coming from different backgrounds participants all share a common purpose to care and support people with Aids and prevent Aids by improving both the education and incomes of people (Humpton Janie 1991).

The Swaziland government together with traditional healers association have began a wide range of training programmes. That covers immediate issues of infection control during traditional treatment as well as the general principles of Aids prevention care counselling of people with HIV/AIDS and families and cooperation with the existing health system (WHO No.3 1993) .

TASO is a fully fledged NGO offering counselling services, outpatients cluical care, and home care for people with AIDS and HIV infection. It offers awareness and sensitization programmes for a cross section of the community from medical personnel and political leaders, village community health workers. We in TASO want to share with the World especially our fellow Africans, our concept of counselling and support for people with Aids and support for communities that find themselves unsure of how to react to Aids. In TASO's approach to HIV counselling and care faith and religious are optional spiritual counselling available but everyone whether they are muslim, christian or atheist should feel at home in TASO (Kareena Nonel 1992).

PROJECTS IN ZAMBIA

The home based care was started in 1987 at Chikankata and U.T.H. Home based care is based on providing medical and nursing care supervision and counselling and friendly support for the HIV/AIDS persons and his family in the patients own home. with the full support of the community at least until death of the patient.

RATIONALE FOR HOME CARE

1. Decongestion of hospital wards to release limited beds for more acute curative diseases.
2. The home was thought to provide the best environment for emotional support of patients with limited life span.
3. Care by the family can be more personal and no less efficient than hospital care as long as professional support and supervision is provided.
4. Caring for patient at home has a powerful educational message to the family and the community. Knowing someone who is ill as a result of HIV infection provides the most effective motivation we know to teach changes in sexual behaviour motivation.

GENERAL OBJECTIVES OF HOME BASED CARE

To provide a humane, cost effective, medical and nursing care within the patients own home.

SPECIFIC OBJECTIVES FOR HOME BASED CARE

1. Decentralizing the project by integrating the local clinic, by offering training courses in counselling, training health workers and volunteers to offer home based care to patients in their catchment areas. Thereby making it a community based programme. Thus reducing the demand to and from home based care officers to patients all over Lusaka.
2. To arrange for specialist clinics e.g TB, Leprosy to save the patients the trouble of travelling to and from U.T.H.
3. To provide rehabilitating programmes to off set the impact. The psychological and other effects of those directly affected i.e the persons already infected with or without clinical signs of illness. Along with other sexual partners. Household members and other in their environment must be helped with their problems through counselling , education and other ways by health workers and volunteers. Visitation and counselling of people in their homes health centres and associated places should be encouraged.

Orientation and training courses, seminars. workshops, public and cultural events dramas and musical shows festivals should be utilized for Aids educations.

Self help projects local action groups participatory planning implementation and education should be encouraged (Aids Action Sept. 1989).

EXPANSION OF HOME BASED CARE

1. The use of urban clinic network, can be helpful to relieve the burden of the home care team.
2. Use of trained lay volunteers, who are willing to give few hours regularly in their locality, lay volunteers should be sought in their catchment areas of those urban clinics through personal contact through and community leaders and offering to give training to potential volunteers on Aids.
3. Integrating the Aids patients within communities might have an influence on public opinion to prevent discrimination against Aids patients (Chipipa P. 1987).

LIMITATIONS OF HOME BASED CARE

1. Morbidity rates 60-80% of Zambians live in or around urban centres. Therefore most people are engaged in gainful employment due to economic pressures.

These pressures mean that there are limits on food and housing.

2. Terminal care at home presents a particular challenge to the home care team. Caring for the terminally ill can be very distressing for families, friends and health workers.
3. Consistent adequate funding is a major issue.

THE COPPERBELT HEALTH EDUCATION UNIT

This is a non governmental organisation working within the framework of the Zambian National Aids prevention and control programme. Their main objective is to carry health education to the people through drama, publication of literature on Aids (Aids Action 1992).

THE SOCIETY FOR WOMEN AND AIDS (SWAAZ)

Their objective is to find ways through research and education. To help women cope with Aids as individuals, Mothers and carers. Often called the triple jeopardy. The bulk of the informal health care in the home is provided by women. Both in the family and in the community. In practice every country, whatever its level of economic and social development is also taken into account, women contributions to health care is overwhelmingly greater than that of men. Without informal carers. the financial burden of formal health care in every country would be vastly increased. Home care is the key factor which allows those who are ill, disabled or old to continue to live in the community. And home care is provided mainly by women the real cost of informal care is high. One calculation says that the value of women's work in the household alone much of which is looking after others if given economic value would add an estimated one third to the world's gross national product.

Women's role as primary providers of health care within the family and community is usually underestimated. Particularly by women themselves. They expect and so does everybody else, that they will as a matter of course provide a range of care in the home, the workplace and the community. This they do in their role as mothers, spouses, partners, grandmothers and sister and voluntary and trained health workers care includes attention to basic needs such as food and water, fuel for cooking and heating and maintenance of a clean and sanitary environment. They often provide home based care for the disabled convalescents and the chronically ill. contributing essential elements such as affection and compassion. (Mriphe Jeopardy Women & Aids the pans institute 1990).

THE ANTI AIDS PROJECT/CLUBS

The aims of these clubs are based on three promises which each member has to make before joining the club. And these are:-

1. I will avoid HIV/AIDS by avoiding sex before marriage and outside marriage.

2. I will help my friends and relatives to protect themselves by telling them about HIV infection and Aids disease.
3. I will help people with HIV infection as much as possible.

Each school has a patron who is usually a school teacher, who helps their students run the club. Each club develop its own organisational rules and activities. Such as offering help to people with AIDS with gardening, carrying water helping with children, taking messages and acting as examples to others. Organising Educational activities such as using examples of Aids as a bases for school projects in science, english, organising school quizzes and debates, also plays on Aids (Baker Kristine 1989).

CONCLUSION

In order to relieve the burden of Aids care from the patients and their carers, a strategy of involving communities in providing care has been seen as the most effective cost reducing care for Aids patients. It also reduces on the psychological and stigma associated with the disease as the people get aquainted to nursing these people in the communities, they learn many things about Aids.

The major community resources that could be used are human commitment, public infrastructure such as schools and church, material resources such as food stuff, linen, equipment donated and money this can possibly be done as long as the people are willing to provide support to Aids patients.

DEFINITION OF OPERATIONAL TERMS

<u>TERM</u>	<u>DEFINITION</u>
1. SUPPORT	Providing for the needs of another person
2. MOBILIZE	To organise, collection of resources for HIV/AIDS patients.
3. RESOURCES	Goods collected for HIV/AIDS patients, these are manpower, money, infrastructure, spiritual
4. VOLUNTEER	People from the community who offer to provide care to AIDS patients.
5. PATIENT	An HIV/AIDS infected person showing symptoms of illness.
6. COMMUNITY	Group of people where HIV/AIDS patients live and interact closely with others in society

ABBREVIATIONS

HIV - Infection with Human Immune deficiency Virus

AIDS - A Immune deficiency Syndrome the result of infection by the HIV

PHC - Essential health care made accessible at a cost the country can afford with practical and scientifically and socially sound.

WHO - World Health Organisation

AVAILABLE RESOURCES

HUMAN RESOURCES - To provide physical assistance such as home help, with cooking getting water generally nursing care.

(SPIRITUAL RESOURCES-Providing pastoral care, praying and MENTAL) counselling.

MONEY - Literally offering money in order for the patients to buy essentials such as food, clothing and to rent shelters.

INFRASTRUCTURE - The building in which these activities can take place such as other church halls, Community halls and in which organising for such services can take place e.g making arrangements for to door campaign deciding on who to help which time.

CHAPTER THREE

3.1 GENERAL OBJECTIVES

To determine the feasibility of mobilizing community resources for HIV/AIDS patients in Kalingalinga Compound.

3.2 SPECIFIC OBJECTIVES

1. To verify the kind of resources available in the community.
2. To assess the knowledge the people have concerning community care of HIV/AIDS patients.
3. To determine the willingness of the people to provide support and care.
4. To assess the commitment of the people to such as project.
5. To utilize the results in order to make recommendation concerning the feasibility of starting up a pilot project in Kalingalinga.

CHAPTER THREE

3.1 GENERAL OBJECTIVES

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3.2 SPECIFIC OBJECTIVES

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5. To utilize the results in order to make recommendation concerning the feasibility of starting up a pilot project in Kalingalinga.

CHAPTER 4 METHODOLOGY

4.1 RESEARCH DESIGN

A descriptive design involving the identification and exploration of a number of mutually related factors concerning the feasibility of mobilizing community resources for the care of HIV/AIDS patients. The method was one of the non international studies which involved the collection of data systematically and easied presentation of data which gave a clear picture of the prevailing situation with the people in Kalingalinga. Concerning their knowledge and attitude towards mobilization of resources for HIV/AIDS pts.

4.2 RESEARCH SETTING

Kalingalinaa compound was chosen to represent shanty compounds where the majority of the people are of low income. The setting was chosen because it was convinient to the reseacrher as regards time for data collection. The data was collected during the first and second week of October.

Kalingalinga is one of the more than 10 shanty compounds in Lusaka. It is situated between Kabulonga, Mtendere, Longacres and Chainama Golf Club. It is about 5Kms from the hospital.

Most houses are self erected and some have been up graded by the district council. It is served with a health centre, two primary schools, a community hall and church buildings belonging to various denominations there was state shop - ZCBC and many privately owned shops and a market.

4.3 STUDY POPULATION

Kalingalinga has a population of about 15,748 people out of which 7,369 are males while 7,450 are females.

The compound has about 12 sections with approximately 20 households in each section.

The population under the study were household heads resident in Kalinagalinga.

Both males and females were included in the population under study. Then ages ranged from 19 - 42 years. All the people interviewed came from a diversity of backgrounds and all over the country such as culture education, religion, educational level and income.

4.4 METHOD OF SAMPLING/SAMPLE SIZE

The sample consisted of 32 females household heads and 18 males. Who were systematically and randomly selected.

The 10 people selected for the focus group discussion were the heads of each department in the market and 5 departments in either case of men and women were randomly and systematically selected.

SELECTION APPROACH

The different samples in the study were the residents of Kalingalinga (sample 1) and the leaders at the market (sample 2)

SAMPLE 1

With the help of my research assistant and an appointed politician we were able to systematically choose the 10 sections needed by using the lottery methods where all the numbers for the sections were written down on pieces of paper and were put on a container and shaken.

Then 10 pieces of paper were picked this method ensured that all the sections had an equal chance of being selected.

This method also enabled the researcher to generalize the findings to the rest of the study population, which could not have been possible in a non-probability sampling.

The next stage involved selection of 5 (five) respondents or subjects from each of the 10 sections.

This was done using systematic sampling which is a technique of selection based on the selection of elements at equal interval starting with a randomly selected element of the population.

The sampling interval was found by using the sampling fraction as follows:-

20 = Number of houses each section

5 = Number of required respondents from each section 4

Therefore every 4th house along the line in each section was picked and the household head interviewed if he/she was there and was willing to be interviewed. If not then the next house was chosen

SAMPLE 2

Simple random sampling was used to select the 5 women and 5 men for the focus group discussion. These men and women were found selling at the market. They were about 30 people selling at the market and so every 3rd person at the market was chosen to be participant in the focus group discussion and these people came from different sections, therefore they were representative of the many sections.

The focus group discussion gave indepth information of feasibility of mobilizing community resources for HIV/AIDS patients. The subjects were able to express themselves freely as the men and women were separated, this means that they were not having any inference over what the other sex meant.

4.5 DATA COLLECTION TECHNIQUES AND TOOLS USED

Two Data collection techniques were used

1. INTERVIEW SCHEDULE

This is a data collecting technique that involved oral questioning of respondents individually. This method was chosen because the majority of the respondents were semi-literate. Thus using all interview schedule ensured that as the interviewers administered the question tool we were able to explain and clarify some questions and interpret some questions in a language that was best understood by the respondent. The questions were presented to each respondent in the same way to ensure objectivity.

The respondents were interviewed in privacy and answers were recorded there and then.

However anonymity was not possible in this case as a direct face to face interview of subjects had to be done. Nevertheless confidentiality was maintained by ensuring names. This was done to elicit personal opinions.

Advantages of this technique were:

- a) Classifications of questions was possible where it was not clear.
- b) There was a high response rate.

Disadvantages.

It was time consuming and expensive as the research could only interview few people in a day.

An assistant had to be trained and used in this data collection.

However, this did not affect the results in any way

QUESTION SEQUENCE

The interview schedule comprised of open and closed ended questions.

The schedule had four main parts. In the following order

1. Demographic background i.e. Age, Sex, Marital status etc.
2. Knowledge of the people to assist of Aids patients
3. Availability of resources
4. Willingness of the people to provide resources

FOCUS GROUP DISCUSSION (FGD)

This was an indepth discussion guide with a small number of men and women (10) to talk about feasibility of mobilizing community resources for HIV/AIDS patients in Kalingalinga.

It gave the researcher indepth information on the knowledge the people have on the need to assist aids patients in Kalingalinga, availability of resource, willingness of the people provide andmobilize resources sources of incomes and the chosen people who could be instrumental in mobilizing such resources from the community in Kalingalinga.

The men and women were interviewed separately in the local language that all could understand . An assistant was used to record responses. No limitations were encountered as groups were easy to form.

4.6 DATA COLLECTION PROCESS

The sampled households were called upon with one of the workers at the health centre who was well known to the people. The purpose of the visit was explained to thehouse owner, to make them aware of how they were selected out of al the other houses. After verbal consent was obtained, then the interview proceeded in privacy to ensure confidentiality.

4.7 ETHICAL CONSIDERATIONS

Permission was sought and obtained from the ethical committee (UTH) and from Director of Public health of Lusaka Urban District Council to conduct the study at Kalingalinga. The community leader, the counsellor was also asked for permission to carry out house to house interviews, and verbal permission was given before. administration of each tool the researcher introduce herself, the prupose of her visit and verbal consent was obtained.

For easy identification and acceptability of the researcher on assistant from the health centre and a party leader were asked to acompany allocated to the researcher.

4.8 PILOT STUDY

A pilot study was carried out in Mendere compound to test the data collection tools and the time it takes to administer each tool,

Following this exercise some open ended questions were changed to closed ended and some closed ended questions were opened.

Some questions were refrased for easy understanding of respondents and additional questions were constructed. No major changes were made on the research proposal.

4.9 LIMITATION OF THE STUDY

It was not possible to conduct the study on a large scale due to limited time in which the study could be completed and submitted to the University of Zambia sample size was small therefore generalisation of findings were limited to the study population only a limited number of tools were used, Therefore more detailed information could not be obtained using the limited tools.

CHAPTER 5

PRESENTATION AND ANALYSIS OF FINDINGS

Data were analysed with the aid of a computer using as SPSS programme. Prior to this Data were coded open questions were categorized and assigned suitable terms to bring related data together. The names of all the variables in the interview schedule were programmed and the groups to be compared and cross tabulated were identified. Frequency counts were enumerated and all percentage rounded to whole numbers

TABLE 1: DEMOGRAPHIC DATA FREQUENCIES

A. AGE GROUP	FREQUENCY	PERCENTAGE	CUMMULATIVE TOTAL PERCENTAGE
19 - 24	8	16	16
25 - 30	11	22	38
31 - 36	10	20	58
37 - 42	11	22	80
42 and above	10	20	100
TOTAL	50	100	100
B. SEX			
MALE	18	36	36
FEMALE	32	64	100
TOTAL	50	100	100
C. RELIGION			
PROTESTANT	19	38	38
CATHOLIC	27	54	92
OTHERS	4	8	100
	50	100	100

Table 1 A. Shows no marked variations in the age groups which are ranging from 8 - 11 (16-22%)

Table 1 B. Most of the respondents interviewed were female 32 (64%).

Table 1 C. The majority of the respondents are catholics 27 (54%). The protestants are 19 (38%).

TABLE 2: DEMOGRAPHIC DATA FREQUENCIES/INCOME/EDUCATIONAL LEVEL

Zambia Kwacha (K.000) A. Income per month	Frequency	Percentage	Cummulative Total Percentage
None	21	42	42
5-10	4	8	50
11-20	13	26	76
21-40	9	18	94
41 and above	3	6	100
TOTAL	50	100	100
B. Educational level			
Never been	2	4	4
Priamry	23	46	50
Secondary	19	38	88
College/Unive rsity	6	12	100
TOTAL	50	100	100

42% of the respondents have no income at all while 46% have primary school education.

TABLE 3: EDUCATION BY OCCUPATION

EDUCATIONAL LEVEL	OCCUPATION			TOTAL
	UNEMPLOYED	SELF EMPLOYED	FORMALLY EMPLOYED	
NEVER BEEN	2 (4%)		6 (12%)	8(16%)
PRIAMRY	11 (22%)	6 (12%)	7 (14%)	24(48%)
SECONDARY	7 (14%)	5 (10%)	5 (10%)	17(38%)
COLLEGE/UNI VERSITY	1 (2%)			1 (2%)
TOTAL	21 (42%)	11 (22%)	18 (36%)	50(100%)

42% of the repondents are unemployed and 36% are in various forms of formal employment. 48% are of primary Education whilst only 16 % have been to school.

TABLE 4: EDUCATIONAL LEVEL BY MONTHLY INCOME

EDUCATIONAL LEVEL	INCOME (ZK - 000)					TOTAL
	NONE	5-10	11-20	21-40	OVER 41	
NEVER BEEN	2 4%					2 4%
PRIMARY	11 22%	4 8 %	5 10%	1 2%	2 4%	23 46%
SECONDARY	7 14%		5 10%	6 12%	1 2%	19 38%
TOTAL	21 42%	4 8%	13 26%	9 18%	3 6%	50 100%

There are 21(42%) of the respondents who have no income. 13(26%) are within 11-20000 kwacha income bracket while only 6% get over 41000 kwacha

TABLE 5: KNOWLEDGE BY PEOPLE TO CARE FOR AIDS PATIENTS

KNOWLEDGE	FREQUENCY	PERCENTAGE	CUMMULATIVE PERCENTAGE
YES	42	84	84
NO	4	8	92
TOTAL	50	100	100

84% of the people are knowledgeable about the need to provide care to Aids patients in their homes

TABLE 6: KNOWLEDGE OF WHO PROVIDES CARE FOR AIDS PATIENTS IN HOMES

RESPONSE	FREQUENCY	PERCENTAGE	CUMMULATIVE PERCENTAGE
SPOUSE	18	36	36
OTHER RELATIVES	27	54	90
FRIENDS/NEIGHBOUR	2	4	94
DO NOT KNOW	3	6	100
TOTAL	50	100	100

The general view is that Aids patients are cared for by their relatives. Thus representing 54%. And those cared for by spouses were 36%.

TABLE 7: AVAILABILITY OF RESOURCES IN THE COMMUNITY

RESOURCES	FREQUENCY	PERCENTAGE	CUMMULATIVE PERCENTAGE
MONEY	8	16	16
SPIRITUAL	16	32	48
MANPOWER	24	48	96
INFRASTRUCTIVE	2	4	100
TOTAL	50	100	100

Manpower scored the highest 48% as the commonest resource, closely followed by spiritual 32% then money 16% and laslty infrastructure 4%.

TABLE 8: HOW RESOURCES CAN BE OBTAINED FROM COUMMUNITY

SEX	DONATION AL COMPAIGN	DOOR TO DOOR COMPAIGN	CHURCH OFFERING	EDUCATIN G THE PEOPLE	TOTAL
MALE	9 18%	3 6%	4 8%	2 4%	18 36%
FEMALE	21 42%	4 8%	4 8%	3 6%	32 64%
TOTAL	30 60%	7 14%	8 10%	5 10%	50 100%

Donations have been chosen as the best way of obtaining resources from the community by both the males 9 (18%) and females 21(42%).

TABLE 9: HOW EAH RESOURCE CAN BE OBTAINED

RESOURCE	METHODS OF OBTAINING				TOTAL
	DONATIONS	DOOR TO DOOR CAMPAIGN	CHURCH OFFERING	HEALTH EDUCATION	
MONEY	8 16%				8 16%
SPIRITUAL				16 32%	16 32%
MANPOWER		18 36%		6 12%	24 48%
INFRASTRUCTURE	2 4%				2 4%
TOTAL	10 20%	18 36%		22 44%	50 100%

Most of the resources were said to be obtained through educating the people to do so. spiritual resources were the highest among those that needed to be mobilized through health education 16(32%).

TABLE 10: WILLINGNESS TO PROVIDE RESOURCES/SEX/RELIGION/INCOME

A. SEX	YES	NO	TOTAL
MALE	16 32%	2 4%	18 36%
FEMALE	32 64%		
TOTAL	48 96%	2 4%	32 64%
B. RELIGION			
PROTESTANT	18 36%	1 2%	19 38%
CATHOLIC	27 54%		27 54%
OTHERS	3 6%	1 2%	4 8%
TOTAL	48 96%	2 4%	50 100%
C. INCOME			
NONE	19 38%	2 4%	21 42%
5 -10	4 8%		4 8%
11-20	13 26%		13 26%
21-40	9 18%		9 18%
41 AND ABOVE	3 9%		3 9%
TOTAL	48 96%	2 4%	50 100%

The majority of those that are using are women 32 (64%). Most respondents using are Catholics representing 27 (54%) of the respondents most of willing no income 19 (38%).

TABLE 11: WILLINGNESS TO PROVIDE RESOURCES BY AGE

AGE IN YEARS	YES	NO	TOTAL
19 -24	7 (14%)	1 (2%)	8 (16%)
25 -30	11 (22%)		11 (22%)
31 -36	9 (18%)	1 (2%)	10 (20%)
37 -42	10 (20%)		10 (20%)
43+	11 (22%)		11 (22%)
TOTAL	48 96%	2 4%	50 (100%)

Most of the age groups are well represented in the willingness to provide resources 48 (96%)

TABLE 12; INCOME AND TYPE OF RESOURCE WILLING TO PROVIDE

TYPE OF RESOURCE	INCOME (ZK-000)					TOTAL
	NONE	5 -10	11-20	21-40	41+	
MONEY		1 (2%)	1 (2%)	3 (6%)	3 (6%)	8 (16%)
SPIRITUAL	6 (12.5%)	5 (10.4%)	3 (6.25%)	2 (4.16%)		16 (33.33%)
MANPOWER	10 (20.8%)	3 (6.24%)	5 (10.4%)	4 (8.33%)		22 (45.83%)
INFRASTRUCTURE					2 (4.16%)	2 (4.16%)
TOTAL	~16 (33.3%)	9 (18.75%)	9 (18.75%)	9 (18.75%)	5 (10.4%)	48 (100%)

Out of the 48 people that are willing to provide resources have no income at all. The commonest resources that the people could offer was its human resource 10 (20.8%). The other resources and income seem to have no significant statistical variations one from the other.

TABLE 13: RELIGION BY THE TYPE OF RESOURCES WILLING TO PROVIDE

RELIGION	RESOURCES				TOTAL
	MONEY	SPIRITUAL	HUMAN	INFRASTRUCTURE	
Protestant	11 (22.9%)	1 (2.1%)	7 (14.6%)		18 (37.5%)
Catholics	7 (14.58%)	10 (28.8%)	8 (16.6%)		25 (52.1%)
Others	3 (6.3%)			2 (4.16%)	5 (10.4%)
TOTAL	17 (35.4%)	15 (21.25%)	14 (29.16%)	2 (4.16%)	48 (100%)

Out of the 48 that are willing to provide resources 17 (35.4%) from all religions backgrounds are willing to provide money and 15 (31.25%) are willing to provide the spiritual resources such as pastoral care and religious counselling.

TABLE 14: SEX/TYPE OF RESOURCES THE PEOPLE ARE WILLING TO ORGANISE

SEX	TYPES OF RESOURCES				TOTAL
	MONEY	SPIRITUAL	HUMAN	INFRASTRUCTURE	
MALE	10 (20.8%)	3 (6.25%)	8 (16.66%)	2 (4.6%)	23 (47.9%)
FEMALE	4 (8.33%)	12 (25%)	9 (18.75%)		25 (52.1%)
TOTAL	14 (29.16%)	15 (31.25%)	17 (35.4%)	2 (4.16%)	48 (100%)

Most of the males 10 (20.8%) from the 23 are willing to organise money. And the human are mostly willing to organise for spiritual resources such as pastoral care counselling and prayers. 12 (25%).

TABLE 15: MARITAL STATUSES BY TYPES OF RESOURCES THEY ARE WILLING TO ORGANISE FOR.

MARTAL STATUS	RESOURCES				TOTAL
	MONEY	SPIRITUAL	HUMAN	INFRASTRUCTURE	
SINGLE	1 (2.1%)	3 (6.25%)	7 (14.6%)		11 (22.9%)
MARRIED	6 (12.5%)	8 (16.66%)	3 (6.25%)	2 (4.16%)	19 (39.5%)
DIVORCED	1 (2.1%)	8 (16.66%)	1 (2.1%)		10 (20.8%)
WIDOWED	1	6 (2.5%)	2 (4.16%)		8 (16.66%)
SEPARATED					
TOTAL	8 (16.66%)	25 (52.1%)	13 (27.1%)	2 (4.16%)	48 (100%)

The married 19 (38%) out of all the others are most willing to organise most of the resources especially the spiritual resources 8 (16.66%).

CHAPTER 6: DISCUSSION OF FINDINGS AND ITS IMPLICATION ON HEALTH

DISCUSSION OF FINDINGS

INTRODUCTION

The study attempted to determine the feasibility of mobilizing community resources for HIV/AIDS patients in kalingalinga compound Lusaka.

Before mobilizing Community resources a number of variables that are likely to have an affect on its success were examined. And these were as follows:-

1. The community's knowledge of the need for for them to assist AIDS patients.
2. Availability of resources in relation to age, sex marital status, religion, educational level and occupation and wheter the community were willing to provide and organise resources for such patients.

The discussion will be as follows

- Demographic variables / background
- Knowledge that the community have on the need for them to assist in providing care to AIDS patients.
- Availability of community resources
- Willingness of the people to provide and mobilize resources.

6.1 DEMOGRAPHIC PROFILE OF RESPONDENTS

The study sample consisted of 50 respondents, who are residents of Kalingalinga and are heads of households.

Out of 50 (100%) 32 (64%) females and 18 (36%) males their ages ranged from 19 - 42 years (Table 1)

Their religion was as follows, Catholics 27 (54%) . 19 (38%) protestants, other religions 4 (8%). this indicates that there are two major denominational categories, but predomoinantly christians . This smilarity in their christaian faith can be taken advantage of to be used in mobilizing community resources.

6.2 KNOWLEDGE THAT THE PEOPLE HAVE CONCERNING THE NEED FOR ASSIST AIDS PATIENTS WITHIN THE COMMUNITY

The study revealed that the majority of the responsdents. Shows 42(84%) out of 50 (100%) are aware of the need to rprovide care to Aids patients within their community. This is supported by the focus group discussion which revealed that the people are very much aware of the need to provide care for the patients within their community (Table 5)

It is further supported by a study made in Uganda at St. Martins Clinic (Hampton Janie 1991) where health education is having a positive impact on the attitude of the people towards Aids as the stigma of Aids has been greatly reduced.

The awareness that has been revealed in the study could be attributed to the fact that, the national Aids prevention and conting strategy of giving health education to the people through pamphlets, radio, Television, stickers emphasizing the need for the community to provide care is also having a positive impact in Zambia.

Another interesting observation is that 6 (12%) out of 50 (100%), 27 (54%) say that the relatives and spouses provide care for AIDS patients in their homes. (Table 6)

It is further strengthened by a study done in Mazabuka Chikankata hospital (Glen William 1991) where it was revealed that the relatives and spouses provide care and whatever form of support to their relatives sick with AIDS.

It is also supported by an observation in Agomanya Ghana (Hampton Janie 1991) who revealed that the spouses and relatives are actively involved in providing care to AIDS patients homes.

This situation has been seen before because of the Kinship affiliation and closeness that the extended African families are known for . This is usually shown in situation such as a sickness or death in the family.

6.3 AVAILABILITY AND METHODS OF OBTAINING THESE RESOURCES IN THE COMMUNITY.

Rueslts from the study show that the human resources was the most readily available resource. As it shown in Table 7. That out of 50 (100%), 24(48%) support this while the least available resource was money 8 (16%). The cause for this situation could be that money is a scarce resource which cannot be easily obtained as most of the people earn very little money or nothing at all as they are unemployed. Hence the need to suggest the human resource as it is always available.

This revelation seems to be the same as that done inUganda where human resource was the most readily available resource. Therefore the feasibility of starting a community project is positive as long as there is adequate human commitment to sustain it.

The study also showed that out of the 50(100%) 21 (42%) females and 9(18%) males were willing to go on door to door campaign asking for donations and pledges of providing manpower to help them with the project and provide a resource. (Table 8)

6.4 COMMUNITY WILLINGNESS TO PROVIDE RESOURCES FOR THE THE CARE OF HIV/AIDS PATIENTS

The study shows that the majority of the respondents are willing to provide resources out of 50(100%), 48(96%) of the people are willing. The table also shows that we the 32 (66.6%) of the women included in the sample are willing and 16(33.3%) out of 18 (37.5%) of the men are also willing to provide resources. This finding is complemented by the focus group discussion finding which revealed that all the 10 participants were willing to provide whatever they can. And it is from this group that fears of lack of money to donate was expressed. It was then clarified that it is not only money which needed to be provided (Table 10)

It shows that the people indeed are willing to provide all they can helping these patients the fact that the impact of the willingness has been seen and felt by everybody as they are aware of it seem to have had an influence on their attitudes such that they feel obliged to help in whatever way possible.

Findings complement those of Uganda Kabodo (William Glen 1991) where people have started project within their communities because of the need they have felt to help one another in such difficult circumstances.

The study further revealed that all the catholic respondents are willing to provide resources. And the resources that they are willing to provide spiritual help in the form of counselling and pastoral care as shown in Table 10 (11,12,13). It is also interesting to note that the people with no income were most willing to provide physical care and support 10 (20.3%) out of 19 (39.5%) within no income.

The impression one gets from such figure is to that there is a lot of willingness among the people. It was good to note that the catholics were willing to offer spiritual care. This could be most helpful in spearheading support group information and since it means then that a good number of the people in the compound are catholics.

This is further supported by focus group discussion where they suggested the same strategy of obtaining spiritual care. This can be most helpful in spearheading the information of support groups based on catholic denomination, because it can be seen that the make half of the population belong to the same denomination.

This can be supported to what is happening in Ghana (Hampton Janie 1991) where members of the catholic church are combating Aids on several fronts in education and prevention, in counselling and medical care and community based care and support for people with AIDs and their families regardless of their religions affiliation, ethical background or political allegiance.

The study further revealed that the people with no income are willing to mobilize resources, especially human resources. This is possibly as the result of the fact that there is nothing else they can offer other than their own labour in providing home help as well as going round asking people to assist with the care of Aids patients.

This was observed in Uganda at St Martins Clinic where a successful programme of health care and support has been established with only limited resources as long as there was sufficient human commitment.

The study further reveals that all age groups are family represented within willingness to provide resources and also in mobilizing these resources.

6.5 IMPLICATION ON HEALTH

The findings of the study show that the community members in Kalingalinga are aware of the need for them to provide assistance and care to Aids patients within their communities.

Despite the awareness the people are providing the assistance that these patients need

Therefore, the health education which has caused awareness has not had an influence on the people actually provide the assistance needed.

Thus shows that awareness campaigns alone are not enough to bring about the needed change in attitude and behaviour. These education and health workers need to realize that education which brings about holding discussions with community members where people can express their views fears etc. So that the need is highlighted either for more education on Aids or home care. As the findings inducate that these people are actually willing to provide assistance, it could be that they do not know how.

Therefore education and health workers may need to carry out orientation programmes to community members, pain them in problem showing techniques they may even be some representatives who may be taken to other areas to look at some successful community programmes there.

The study further revealed that both sexes of the respondents are inclined to mobilizing human resources. This is probably due to the past experiences where people's help has been available in situations of need such as at funerals and other emergency needs people are always available.

The focus group discussion revealed that the church leaders, community health workers and other public workers can be influential in mobilizing resoucres.

This can be supported by findings in Ghana where a successful programme has been implemented by its nationals. It is successful because the community members feel committed to the plan which they themselves initiated and are implementing. Therefore commitment is the only tool that can be used in order for such a programme to succeed.

This can be supported by what is happening in Ghana (Humpton Janie 1991) where the members of the catholic church are combating Aids on several fronts, in education and prevention, in conunselling and medical care and community based care and economic support for peole with Aids and their families regardless of their religions affiliation.

CHAPTER 7.1 CONCLUSION AND RECOMMENDATIONS

7.1 CONCLUSION

The study sought to determine the feasibility of mobilizing community resources for HIV/AIDS patients. Findings from the study revealed that most people are aware of the need for them to provide assistance to AIDS patients. This information was obtained through the interview schedule and focus group discussion.

The findings also revealed that the most readily available resource was its manpower. The study also revealed that half of the population are catholics, which can make organising the community project through them easy as they are all willing to provide and mobilizing these resources. Most of the respondents are willing to provide and organise resources, age level and education, income and marital status did not seem to have any significant variation on the level of willingness to provide resources. Their main limitations were resources such as money and buildings in which activities can take place were their biggest problem. Their main limitation was that they did not pin point any one who could spearhead such as project, as the suggested people also had their own jobs to pursue. Otherwise the possibilities are there that the communities could mobilize resources for HIV/AIDS patients within Kalingalinga.

RECOMMENDATIONS

LONG TERM

TO THE MINISTRY OF HEALTH/ NATIONAL AIDS PREVENTION AND CONTROL PROGRAMME

1. They should spearhead the establishment of community based programme, through the community key leaders such as teachers, church leaders etc by training them in programme planning, implementation and evaluation by holding community workshops so that when these people are trained , they can then be able to disseminate information and train others in the community.
2. They should intensify the training of community health workers and the curriculum should be adjusted so that it suits the community based Aids care, as they will provide care of the chronically ill within the community

INTERMEDIATE

TO THE NON GOVERNMENTAL ORGANISATIONS

They should intergrate their efforts with those of the MOH and NAPCC. So that they assist in training these community and leaders, by assisting them with manpower such as health workers with , financial resources. Organisations such as the family health trust, christian, children fund and other civic and chritable organisaion such as rotary club, Lions club, Hope foundation. This will ensure that these programmes are a realistically implemented.

IMMEDIATE

The home based care unit should start involving the community members, by asking for volunteers to assist them with their work as they carry it out.

The can do this by e.g asking someone, from nearby to get them some water for bathing the patient some people can be called upon to help with offloading the needed items from the vehicle they have come with and after the session, encouraging the people to continue provide the care to these patients.

A

ACTIVITY	M O N T H																			
	JUNE				JULY				AUGUST				SEPTEMBER				OCTOBER			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1 Proposal Development				X	X	X	X													
2 Ethical Clearance									X	X	X									
3 Obtaining Permission for field work															X					
4 Pilot Study															X					
5 Main Study - Data Collection																X				
6 BeDataAnlysing																	X			
6. Data Analysis																	X			
7 Report Writing																		X		
- First Draft																			X	
- Final Draft																				X
8 Submission of Report																				X

X - Indicates 1 week.

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Date: ...10-7-93.....

TO WHOM IT MAY CONCERN


Dear Sir/Madam

This letter serves to introduce Rose Kabwe..... who is a BSc IV student at our institution.

As part of the programme each BSc IV student is expected to conduct a research study on a topic of her/his interest in health. We shall be very grateful if this student is assisted with the information she/he is looking for.

Please be assured that what ever the student obtains will be treated with strict confidentiality.

Yours faithfully


Janet K. Chime
LECTURER
for/HEAD OF POST BASIC NURSING DEPT.

UNIVERSITY TEACHING HOSPITAL

(Board of Management)

I N T E R N A L M E M O R A N D U M

TO : The Head - Post Basic Department
Attention: Ms. J. Chime

FROM: The Acting Deputy Director

DATE: 12th August, 1993

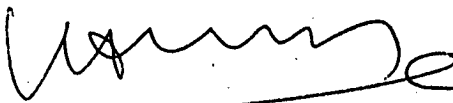
SUBJ: STUDENT'S RESEARCH PROPOSALS


I am pleased to inform you that the research proposals of the following students have been approved in the Ethical Committee:-

- Beauty M. Mulundu
- Eneless Sakala
- Nyaunde Honester
- Ms Mary Jaramba N.
- Ndubu Muliwawa
- Benard Kasawa K.
- Pascalis Shipili
- R.S. Kabwe

The University Teaching Hospital Management would very much wish to render support had it not been due to severe constrains. However, students would be free to call at this office for any possible assistance.

The delay is regretted.


DR. W.M. MWANSA



SCHOOL OF MEDICINE
UNIVERSITY OF ZAMBIA
DEPARTMENT OF POST BASE NURSING
P O BOX 50110
LUSAKA

The Director of Public Health
Public Health Department
P O BOX 30789
LUSAKA

3rd September, 1993

ufs Head of DPBN
Lusaka

Dear Sir/Madam

RE: RESEARCH STUDY

I am a final year student at the school of Medicine University of Zambia. I am required to submit a research study in the area of my interest as part of the course requirements. My research topic is: FEASIBILITY OF MOBILISING COMMUNITY RESOURCES FOR HIV/AIDS PATIENTS IN KALINGALINGA.

I would be very grateful if you would allow me to conduct interviews in Kalingalinga compound. This will enable me collect information required for the study.

Collection of data will be from 9th - 23rd Sept., 1993.

Your favourable response to my request will be greatly appreciated.

Yours faithfully

ROSE KABWE



Lusaka Urban District Council

MEMORANDUM

C. C.

The Sister-in-Charge
Kalingalinga Clinic

REFERENCE

DATE

LMN/bsm
PHD/11/2

7th September, 1993

RE: RESEARCH STUDY - FEASIBILITY OF MOBILISING COMMUNITY
RESOURCES FOR HIV/AIDS PATIENTS IN KALINGALINGA

Ms Rose Kabwe, a final year student at the School of Medicine University of Zambia is carrying-out a research study on the above subject.

Kindly avail to her any information you may have on her research topic.

Dr L M Ngenda
DEPUTY DIRECTOR
PUBLIC HEALTH SERVICES

cc. The Senior Nursing Officer
The Nursing Officer

FOUCS GROUP DISCUSSIONS FOR MARKETTERS

INSTRUCTIONS

Greetings to the group

Self introduction and purpose of discussion explained to the group stressing the importance of each persons active participation. Ensure confidentiality of information.

Request permission to take notes.

1. Who provides care to AIDS patients in the home.
2. What problems does the care providers face.
3. Are you willing to provide the support these people with AIDS.
4. If you are, what can you provide for them.
5. Is it possible to mobilize resources for AIDS patients from Kalingalinga.
6. Through whom can they be mobilized.
7. Are you willing to be one of the mobilizers.
8. What Kind of resources can be obtained from Kalingalinga compound to help such people.
9. What kind of activities can you employ to help raise money for these patients.
10. Can the procured resources be used properly.
11. Where can they be stored, things such as materials and money.

INTERVIEW SCHEDULE FOR HOUSEHOLD HEADS

Self introduction of interviewer
Purpose of interview and study clarified
No names nor address will be held in confidence
No. of interview:

SECTION A DEMOGRAPHIC DATA

FOR OFFICIAL USE

1. How old are you?

- (a) 19 - 24 years
- (b) 25 - 30 years
- (c) 31 - 36 years
- (d) 37 - 42 years
- (e) Above 42

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2. Sex

- (a) Male
- (b) Female

--

3. What is your marital status?

- (a) Single
- (b) Married
- (c) Divorced
- (d) Widowed
- (e) Separated

--

4. What is your religion?

- (a) Protestant
- (b) Catholic
- (c) Others, please specify

--

5. How far did you go in your education.

- (a) Never been
- (b) Primary
- (c) Secondary
- (d) College
- (e) University

--

6. What is your occupation?

- (a) Unemployed
- (b) Self employed
- (c) Others please specify

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7. If in employment how much money do you get at the month end?

- (a) 5 - 10,000 Kwacha
- (b) 11 - 20,000 Kwacha
- (c) 21 - 40,000 Kwacha
- (d) 41 and above

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SECTION B. KNOWLEDGE ABOUT COMMUNITY CARE

8. Who provide care to Aids patients in homes?

- (a) Spouse
- (b) Other relatives
- (c) Friends and neighbours
- (d) Do not know

--

9. Is the care they receive adequate?

- (a) Yes
- (b) No

--

10. Are the people in the community supposed to assist in providing the care?

- (a) Yes
- (b) No
- (c) Do not Know
- (d) All the time

--

11. Are the patients and relatives willing to be assisted?

- (a) Yes
- (b) No
- (c) Do not know

--

12. Do you know that you have to assist such patient?

- (a) Yes
- (b) No
- (c) Other

--

13. When can you assist them with care?

- (a) Sometimes
- (b) All the times
- (c) Other please specify

--

SECTION C AVAILABILITY OF RESOURCES

14. What resources available can be used in helping to provide the care?

- (a) Money
- (b) Spiritual
- (c) Spiritual support
- (d) Building for activities
- (e) Other please indicate

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15. What can you offer in this case

- (a) Nothing
- (b) Spiritual
- (c) Material support
- (d) Assist in house activities
- (e) Others specify

--

16. Is it possible to obtain these resources from community?

- (a) Yes
- (b) No
- (c) Do not know

--

17. What resources are available in Kalingalinga which can be mobilized?

- (a) Manpower
- (b) Money
- (c) Churches
- (d) Infrastructure
- (e) All the above

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SECTION D. WILLINGNESS OF THE PEOPLE TO PROVIDE THESE RESOURCES

18. Are you willing to provide any resources

- (a) Yes
- (b) No

--

19. How can they be obtained from other people

- (a) Donation
- (b) Door to door request
- (c) Church offering
- (d) Health Education on aids and community care
- (e) Other

20. Are you willing to be the organiser for such resources

- (a) Yes
- (b) No

21. Where can these resources be safely stored?

- (a) At the community hall
- (b) At church
- (c) In the patients home
- (d) Other specify

22. Do you know of any organisation which can help you in such a project?

- (a) The church
- (b) The NGOs
- (c) All the above
- (d) Do not know

23. Is there any community project in your compound?

- (a) Yes
- (b) No
- (c) Do not know

24. If yes is it helpful to the people in your community?

- (a) Yes
- (b) No

End of interview thank you.

INDICATORS AND CUT-OFF POINTS FOR VARIABLES

VARIABLES

INDICATOR AND CUT-OFF POINTS

	<u>DEPENDANT</u> Feasibility of Mobilising Community Resources	<u>Feasibility : 2</u> Not Feasible: 1
	<u>INDEPENDENT</u> People's attitude to Mobilisation	Positive : 2 Negative : 1
2.	Knowledge about Community Care	<u>Present : 2</u> Not present: 1
3.	Availability of resources	<u>Availabl : 2</u> Not available:1
4.	Human Commitment	<u>Willing : 2</u> Not willing:1

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