CONSTRAINTS AND POSSIBLE SOLUTIONS OF IMPLEMENTING HOME BASED CARE PROGRAMME BY THE CATHOLIC CHURCH IN KABWE, ZAMBIA

BY

MWABA KAUNDA

A DISSERTATION SUBMITTED TO THE UNIVERSITY OF ZAMBIA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF EDUCATION IN ADULT EDUCATION

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DEDICATION

I dedicate this thesis to my late mother, Bertha Mwelwa Chibwe Kaunda. You were a kind, loving and strong woman. I still shed tears when I recall how you suffered. Only time heals. May your soul rest in Eternal Peace. I also dedicate this work to my father Wellington Kaunda and my aunt Catherine Kaunda Chibwe for their financial and emotional support as well as my supervisor, Wanga Weluzani Chakanika, for encouraging me when I was almost giving up on school.

Lastly, I dedicate this work to my sisters Mwewa, Mulala , Chanshi and Kabwe for giving me strength and spiritual support when I encountered challenges during the programme. My brothers, Wellington and Mwenya. My source of joy, nieces Mwelwa, Hope and Faith, nephews James, Lwendo and Chileshe and not forgetting grandmother Diana.

I thank God for the wisdom, grace and strength.

AUTHOR'S DECLARATION

I, Mwaba Kaunda, do solemnly declare that this thesis represents my own work and that it has never been submitted for a degree at any other University. All the works of other people which have been cited have been acknowledged.

Signature: …… Date: ……...…..……..…...……

Supervisor's Signature: …… Date: ……..……

CERTIFICATE OF APPROVAL

This dissertation by **Mwaba Kaunda** is approved as fulfilling part of the requirements for the award of the degree of Master of Education in Adult Education of the University of Zambia.

EXAMINERS

Examiner's Signature: ……..... Date: ……...……...

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ABSTRACT

The purpose of the study was to investigate constraints and possible solutions of implementing Home Based Care programmes by the Catholic Church in Kabwe District. The objectives were to; investigate stakeholders perceived benefits of the Home Based Care programme in Kabwe, establish the constraints faced by stakeholders in the implementation of the Home Based Care programme in Kabwe; and establish stakeholders suggested solutions to the constraints faced in the implementation of Home Based Care programme in Kabwe.

The study was qualitative and employed a case study design. A sample comprising 100 (1 director, 9 coordinators and 90 caregivers) was drawn from three home based care centres. The participants were randomly and purposefully selected for the study. Purposive sampling was used to select the director and coordinators while caregivers were selected using simple random sampling. Information was obtained from participants using interview guides and focus group discussions. Qualitative data were coded and analysed using themes.

The findings of the study revealed that the home based care programme had benefits such as the provision of monetary support to orphans and vulnerable children, health care to the sick and sensitizing people on HIV/AIDS and other illnesses. Lack of finances, infrastructure and proper training among caregivers were some of the constraints.

Arising from the findings, the study made the following recommendations:

Firstly, the Ministry of Health should conduct regular short meetings with caregivers and coordinators so that they gain knowledge and skills. Secondly, the Ministry of Community Development and Social Welfare should partner with Home Based Care centres in Kabwe in order to help the vulnerable children. Lastly, the Ministry of Health should help Don Bosco, Lukanga and Ngungu centres with health materials to sustain the programme.

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LIST OF ACRONYMS AND ABBREVATIONS

HBC:	Home Based Care
OVCs:	Orphans and Vulnerable Children
WHO:	World Health Organisation
NGOs:	Non-Governmental Organisations
FBOs:	Faith Based Organisations
CBOs:	Community Based Organisations
AIDS:	Acquired Immune Deficiency Syndrome
HIV:	Human Immunodeficiency Virus
PLWHA:	People Living with HIV and AIDS
FAWEZA	Forum for African Women Educationalist in Zambia

CHAPTER ONE

INTRODUCTION

1.1 Overview

This chapter presents background information on the constraints and possible solutions of implementing Home Based Care programme by the Catholic Church in Kabwe District. It further presents the statement of the problem, purpose of the study, research objectives, research questions, theoretical framework, operational definitions and a summary of the chapter.

1.2 Background

The background of the study provides an overview of the rationale for the choice of the topic and time inquiry in the dissertation. The primary purpose of the section is to establish the context for the problem that the researcher plans to investigate (Zulu, 2015:1). Kasonde-Ngandu (2013:13) views background as a brief overview of the problem the researcher aspires to tackle. It is the setting or position of the study as it helps to clarify what has brought about the need for the study. Thus this section highlights the background to the study.

According to the World Health Organisation (2002), home based care(HBC) is the provision of basic nursing care needs by formal and informal caregivers to people in their own homes. The service is available to people who have mental, physical, emotional and social needs. World Health Organisation (2001:53) defines(HBC) as "the provision of health care services by formal and informal care givers in the patient's home in order to promote, restore, and maintain a person's maximum level of comfort, function and health including care towards a dignified death." The strength of this approach is embedded in the dignity and privacy it gives to the patient and his/her family to be cared for in comfort of the patient's home. Among people, the many who qualify for this service are those who are living with HIV/AIDS, physically frail persons and terminally ill.

Members of Roman Catholic religious' order in Europe first delivered home care in the late seventeenth century. Home based care was perceived as a means of alleviating overburdened and under-resourced hospitals while providing better and more holistic care to chronically ill and HIV/AIDS patients. Groups of home based care were often from

NGOs and Churches would visit the patients in their communities, providing them with palliative, spiritual care and educate the patient's families on how to care for persons who are chronically ill and those living with HIV/AIDS. Home based care was meant to support mechanism for the hospital system and the PLWHA's and their families, a way to empower communities to respond to the impact of HIV/AIDS themselves by supporting them through the process.

Home based care in North America and Europe started when it became clear that hospital care was expensive and that families and other cares found it hard to cope on their own with the demanding nature of caring for people living with HIV/AIDS (PLWA) (Spier & Edwards, 1990). In the USA, the committee on a National Strategy for AIDS (1986:101) concluded that:

> *"If the care of these patients is to be both comprehensive and cost effective, it must be conducted as much as possible in the community with hospitalization only when necessary. The various requirements for the care of patients with asymptomatic HIV infection, ARC or AIDS (i.e. community –based care, out- patient care, and hospitalization) should be carefully coordinated*."

Mweemba (2012) states that the history and evolution of caregiving in Zambia recognises the wider policy and structural Health reform process from the late 1970s to 1990s. The Alma Ata Declaration of 1978 provided the impetus and direction of the Zambian government to make primary health care the key channel for the delivery of health services. Management Boards for all major Hospitals Community participation was already a key feature of the Zambian health system as demonstrated by 30% of the rural facilities being developed on self-help basis and the existing policies at that time of free medical services.

The first Home based care programme in Africa for people living with HIV/AIDS first started in Uganda and Zambia in late 1980 (Williams, 1990). In 1987, medical workers in Zambia made first attempts to reach those dying of AIDS in their homes. This hospital-based home care model, pioneered by the Salvation Army in the southern province of Zambia to care for tuberculosis (TB) and Leprosy patients, was extended to People Living with HIV&AIDS (PLHIV/AIDS) (Iliffe, 2006) due to insufficient hospital bed spaces for

the growing number of AIDS patients (Myslik, et al. 1997). The Family Health Trust (FHT) and the Ndola Catholic Diocese have two distinct origins. The Family Health Trust HBC project (FHTHBC) was started in 1987 by a British Professor who was working in one of the clinics in Lusaka. The project was initiated to respond to the increasing number of HIV/AIDS and Kaposi's Sakoma patients who could not afford institutional care. On the contrary, the Ndola Catholic Diocese HBC programme started in 1991 as a Catholic Church group that visited and treated sick church members or their friends and family members at home. Between 1988 and 1990, the Catholic Church and Chikankata Hospital, of the Salvation Army established large home based care programmes. About 30 Mission hospitals were providing Hospital Based care to PLHIV/AIDS by 1993. In addition, clinical health workers were supplemented and in some cases even replaced by trained lay people based in the community.

In 1996, the Church Medical Association of Zambia (CMAZ), an umbrella organization of all Mission Hospitals adopted home based care as a strategy to respond to the AIDS challenge in the country. The University Teaching Hospital (UTH) Home Based Care programme started in October 1987. Lungu (1996) cited by Kaunda (1997), found out that the total number of referrals to UTH Home care unit in 1994 was 3,368 and in 1995, the number increased to 4,887. It, therefore, indicated a 26% rise in demand for Home care service within that one year. Patients were referred to Home Care for education, counseling and continuity of supervising care in homes.

In 1987, nearly 90% of AIDS patients preferred to be cared for at home to in hospital. In the light of this, the hospital arranged for teams of health workers to visit their homes. The programme aimed to assess AIDS patients at home for physical, psychological, social and spiritual needs. Counselling and education about HIV/AIDS education were started within the patients' families and communities. A key factor was to encourage acceptance of AIDS patient and deal with the myths surrounding it. Rosenburg (2005) mentions that in Africa most home based care programmes are provided by non-governmental organisations (NGOs) and faith based organisations (FBOs). These provide services unavailable in health care institutions. Muwaniki (2010) postulates that encouragement of home based care in the era of HIV/AIDS was intended to reduce economic and human resource pressure which health care systems especially faced.

In most African countries there are now well-developed home based care programmes and systems, although access to these programmes is still not universal (Uys and Cameron, 2003).

Due to the increasing numbers of patients who were bedridden, the need for HBC increased and many national and international organizations started related activities, mostly targeting PLWHA only. Since the scope of HBC services was not clearly defined, patients with PLWHIV/AIDS were discharged from hospitals without any proper referral system for ensuring a continuum of care. Thus there was a need to train HBC providers who would be responsible for training and support.

The World Health Organisation (WHO, 2000) states that between 70% and 90% illness takes place within the care home. Research evidence shows that most people would rather be cared for at home and that effective care improves the quality of life for ill people and their families. HBC is one of the best ways for most people to receive quality care. HBC was perceived as a means of alleviating the strain of overburdened and under - resourced hospitals while providing better and more holistic care to chronically ill and HIV/AIDS patients. Groups of home based caregivers, often from Non-Governmental Organisations and churches would visit patients' in their communities to provide them with palliative and spiritual care and to educate the patient's families on how to care for persons who are chronically ill and those living with HIV/AIDS. HBC's main purposes are to improve people's access to information and education in order to help them protect themselves against various diseases and sensitizing the community about HIV/AIDS related issues.

Like the rest of Sub-Saharan Africa, Zambia is in a seemingly never ending struggle with HIV/AIDS and various diseases such as cancer, stroke to mention but a few. Home Based Care in Kabwe is central to the fight against chronic long term illness.

1.3 Statement of the problem

Ellis and Levy (2008) mention that a research problem is a general issue, concern or controversy to be addressed. The statement of the problem should briefly address the question at the same time. The statement of the problem is used to centre and focus the researcher at the beginning, keep the researcher in track during the effort of research and it can be used to validate that the effort delivered an outcome that solves the problem. It is, therefore, very important for the researcher to ensure that this aspect is well defined as

it helps him/her in identifying the variables to be investigated in the study. Kasonde-Ngandu (2013) states that the statement of a problem refers to an issue or concern that puzzles the researcher.

The Catholic Church has been providing home based care for the community. It caters for the health needs of the diocese, particularly HIV/AIDS and cares for the needy and sick people within the territory of the diocese and the remote parts where no one goes to provide medical care. Despite the rich programme offered by the Catholic Church in the provision of HBC in Kabwe, it is not known what constraints are faced and their possible solutions.

1.5 Purpose of the study

Ndhlovu (2012:17) says that, "the purpose of the study is the general statement which reflects the intention of one's research''. Chuma et al. (2006) suggest that the purpose of the study means stating clearly what one wants to find out about the problem which affects a certain community or the nation at large. The purpose of the study, therefore, was to investigate the constraints and their possible solutions of the Home Based Care programmes by the Catholic Church in Kabwe District.

1.6 Research objectives

Kombo and Tromp (2006:38) define research objective as a specific statement relating to the defined aim of the study. Objectives are intentions usually stated in measurable terms.

1.6.1 General Research Objective

The general objective of the study was to investigate the constraints and their possible solutions of the Home Based Care programme by the Catholic Church in Kabwe District of Zambia.

1.6.2 Specific Objectives

The specific objectives of the study were to:

i. investigate stakeholders' perceived benefits of the Home Based Care programme by the Catholic Church in Kabwe;
ii. establish the constraints faced by stakeholders' in the implementation of Home Based Care programme by the Catholic Church in Kabwe; and

iii. establish stakeholders suggested solutions to the constraints faced in the implementation of the Home Based Care programme by the Catholic Church in Kabwe.

1.7 Research Questions

A research question is an issue that the researcher seeks to answer which is related to the research objective. The research question guides the research process by addressing variables of the study (Kombo, et al 2011:48).

1.7.1 General Research Question

What are the constraints and possible solutions of implementing Home Based Care programme by the Catholic Church in Kabwe District?

1.7.2 Specific Questions

This study responded to the following three questions:

i. What were the stakeholders' perceived benefits of implementing Home Based Care programme by the Catholic Church in Kabwe district?
ii. What constraints were faced by stakeholders' in the implementation of the Home Based Care programme by the Catholic Church in Kabwe District?
iii. What were the stakeholders' suggested solutions to the constraints faced in the implementation of the Home Based Care programme by the Catholic Church in Kabwe District?

1.8 Significance of the Study

Significance of the study means the importance of the results of the study to the society or government and other agencies (Ndhlovu, 2012:20). Ngoma (2006:22) defines significance of the study as the main reason to show why the study is important. The findings of the study might influence decision makers in the running of the programme to improve the delivery of home - based care services. It is also hoped that the findings of the study may be useful to the Department of Community Development and Catholic Church in that they may make informed decisions on the management of Home Based Care programme. It may also contribute to the growing body of knowledge on the subject.

1.9 Delimitation of the study

Delimitation is about a geographical area where the study is essential (Kombo, 2011). Delimitation is the actual site where the researcher collected data and is in control. According to Heppner & Heppner (2004), cited by Nawa (2015:22), delimitation are parameters that a researcher chooses to place in the study. The study was conducted in Central Province, which is one of the ten provinces in Zambia. It is geographically located in the central part of the country. The province covers an area of approximately 94, 394 square kilometres, tagged as the 4th largest after Northern, Western and North Western Provinces. The provincial capital is Kabwe and the province is divided into 7 districts which are Mkushi, Mumbwa, Chibombo, Chisamba, Kapiri Mposhi and Serenje (Central Statistical Office, 2015). This study was confined to Lukanga, Ngungu and Don Bosco Centres in Kabwe District that have very active home based care programmes.

1.10 Theoretical Framework

A theoretical framework is a theory that guides the researchers' work. Kombo and Tromp (2006) argue that it is a reasoned set of prepositions which are derived from and supported by data of evidence. Imenda (2014:189) cited by Phiri (2015:8) reported that, a theoretical framework is the application of a theory or set of concepts drawn from one and same theory, to offer an explanation of an event, or shed some light on a particular phenomenon or research problem. This study was guided by Health Belief Model (HBM).

To explain why early screening programmes for health conditions such as tuberculosis were unsuccessful, social psychologists in the 1950's constructed the Health Belief Model (HBM) (Hochbaum, 1958, Rosenstock, 1974). The HBM is a theoretical framework which is commonly used in health education and health promotion. However, since its inception, the HBM also explained individual's seeking of medical treatment /advice and compliance with actions related to symptoms and diagnosis (Janz and Beck, Stretcher and Rosenstock, 1997). The model asserts that an individual will take preventive action if he or she believes that: i) He or she is at risk for developing a health condition; ii) the health condition will have severe negative impact; iii) there exists a preventive health behaviour that could be beneficial in either reducing the risk or the seriousness of the health condition and iv) the benefits of this preventive health behaviour outweigh the barriers or consequences of the preventive health behaviour. The model also accounts for the influence of various social

demographic variables such as sex, race, social economic status and insurance status which work to regulate individuals' assessments of health conditions and preventive behaviours (Rosenstock, 1974).

The HBM has the following four major constructs:

a) Perceived susceptibility and seriousness or threat of health condition- It refers to the subjective perception of risk of developing the health condition. It ranges from an individuals' belief that he or she is at no risk of acquiring the health condition to the belief that he or she is extremely vulnerable to getting the health condition. Perceived threat comprehends beliefs regarding troubles the health condition could generate in the individual's life and also emotional responses when an individual think about developing the health condition. It can be measured in terms of whether the individual believes the health condition could affect her financial security (McClenahan et al, 2007) and how anxious or stressed he or she would feel if he or she had the health condition (Werner, 2003).
b) Perceived benefits of preventive health behaviour – This construct embraces aspects of how effective and beneficial the individual believes the preventive health behaviour to be in reducing her risk of developing the health condition. It includes statements such as, "I have a lot to gain by doing (preventive health behaviour'' or "completing preventive health behaviour could save my life".
c) Perceived barriers to preventive health behaviour – This construct of HBC encompasses the negative qualities or costs of preventive health behaviour. Aspects that are considered here are whether the preventive health behaviour is expensive, embarrassing, tedious, painful or distressing. These features are characteristics which would trigger avoidance. Another possible barrier to preventive health behaviour is the availability of alternative actions that have similar functions. To assess the construct previous measures, include responses to "It is embarrassing for me to do or preventive health behaviour can be painful'' (McClenahan et al, 2007).
d) Cues to action – These are described as triggers. The inclusion of cues to action as a construct in the health belief model is to account for prompting moment "to set the process in motion". This construct involves various items such as media campaigns, newspaper articles and advice from others, family members or friend's illness.

To explain why early screening programmes for health conditions such as tuberculosis were unsuccessful, social psychologists in the 1950" s constructed the Health Belief Model. The HBM is related to the current topic as there is element of home based care programme which deals with health related issues such as HIV/AIDS. The main aim of the Health Belief Model in this case is to help the stakeholders to pay particular attention to home based care programme in order to curb the constraints and stimulate effectiveness in implementing health promotion programme.

1.11 Definition of terms

Home Based Care - This is treatment, care and support given to People Living with HIV/AIDS/ other diseases in their homes by family members, friends, neighbours, trained caregivers or community members who belong to community based organisations offering HBC.

Caregiver - A member of the community providing care and support to People Living with HIV/AIDS and chronically ill patients.

Community - A group of people sharing the same culture and living together in the same geographical area.

Community Home Based Care Volunteer- A community member who provides home based care and support to People Living with HIV/AIDS/other diseases in a community.

Knowledge - The Information People Living with HIV/AIDS /other diseases have about home based care services or whether they are aware of HBC services in their communities and who offers them.

Constraint – Something that limits someone's freedom of action.

Programme - A time bound plan that details the hearing situation, what learners are expected to know, how they are to learn it, the participants and facilitators' roles as well as the place, facilities and resources.

Education – it is a system of planned and organised inculcation of morally, physically and intellectually accepted experiences, skills, knowledge and competences from generation to generation

1.11 Organisation of Dissertation

Chapter 1 provides the background of Home based care programme, It gives the statement of the problem, purpose of the study, objectives of the study, research questions, significance of the study, delimitation, definition of terms, organisation of the dissertation and summary of the chapter. Chapter 2 provides a review of literature from outside Africa, within Africa and Zambia. it also highlights the identified gaps. Chapter 3 presents the methodology that was used for this study. It comprises the research design, population, sample and sampling procedure, data collection procedure, research instruments, data analysis, limitations of the study, ethical considerations and a summary. Chapter 4 presented the findings of the study. Chapter 5 discusses the findings of the study, theoretical framework and reviewed literature have been used. Chapter 6 provides the conclusion to the study as well as recommendations made.

1.12 Summary of Chapter One

Presented the background to the study, the statement of the problem, purpose of the study, research objectives, research questions, significance of the study, delimitation of the study and theoretical framework.it also presented operational definitions used in the study. The next chapter reviews the literature relevant to the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

In the view of Kombo and Tromp (2006:62) the literature means the works the researcher consulted in order to understand and investigate the research problem. A literature review therefore is an account of what has been published on a topic by accredited scholars. The cardinal point is that literature review brings out issues that address the research objectives. This chapter reviews the relevant literature and to achieve this, it used research objectives as subheadings. By way of reminder, the objectives were: to investigate stakeholders' perceived benefits of implementing in Kabwe Home Based Care programme; to establish the constraints faced by stakeholders in the implementation of Home Based Care programme in Kabwe; and to establish stakeholders suggested solutions to the constraints faced in the implementation of Home Based Care programme in Kabwe.

2.2 Stakeholders perceived benefits of home based care programme by the Catholic Church in Kabwe

UNAIDS (2004) conducted a study in Mumbai, India and Bangalore, India which investigated perceptions and discriminations of HIV and AIDS related stigmatisation and discrimination across societies of the country. The study revealed that there were responses of ostracism and rejection. The predominant effect at individual level was fear and withdrawal, leading to secrecy about social isolation which also led to difficulties in accessing community care and support services. This study looked at perceptions and discriminations of HIV and AIDS in India while the current study is looking at constraints and their possible solutions of home based care programme by the Catholic Church in Kabwe District in Zambia

UNAIDS (2007) states that, the practice of HBC for HIV/AIDS patients can be characterised into almost seven different but related activities. These consist of the actual provision of care, education, supplies and equipment, staffing, financing and sustainability, monitoring and evaluation.

According to Hornby (2000), a benefit is an advantage that something gives you; a helpful and useful effect that something has. National Home Based Care Policy Guidelines (2002) in Kenya under the Ministry of Health outline the following benefits of home based care:

i. the provision of medication;
ii. physical and emotional care, or will the care and support;
iii. counseling;
iv. the provision of food or food supplements;
v. the provision of material items such as bedding and soap;
vi. the cost of transport for the ill person; and
vii. help with housework and other instrumental activities of daily living. Giving families cash allowances so that they can access services as they see fit.

Thus far, most home based care services have been established through unsystematic, needs based efforts (Uys & Cameron, 2003). Home based care organisations recognise the importance of providing home based cares with adequate training. These training should include General basic nursing care, Training primary caregivers in home based care, Counselling services of patients and families and Assessments of basic needs (food, shelter and clothes).

Wesunga (2015) conducted a study on the components, practices and benefits of home based care of HIV/AIDS patients in Kenya. The study design employed a cross- section survey carried out in Butula Local Community. It had a sample size of 370 respondents in which a questionnaire was used to collect data. The study revealed the key components of HBC which included counselling (38%), nutrition (30%), social support systems (30%) and nursing (15%). Furthermore, benefits of incorporated nursing of patients in familiar environment (41%), affordability (31%) and good support from family members (14%). Those patients who were registered did benefit from free food and free medication. The study by Wesunga is different from ours because it is a cross- sectional study design and has a sample of 370 participants while the current study used a case study design with a sample of 100 participants. In addition, this study has produced an extensive base of the knowledge about stakeholders' perceived benefits of home based care programme.

Another study was conducted by Kaleeba et al. (1997) on "The AIDS Support Organisation" (TASO) in Uganda. The results revealed that individuals and families were able to live positively with HIV and AIDS, through counselling, medical care and material support to their families. This study (TASO) brought a change in people's attitude, knowledge and lifestyle on HIV and AIDS support to patients suffering from the disease. To meet the needs of AIDS care to existing health services at district level in general, there is need for specialised service. This study was conducted in Uganda and focused mainly on AIDS patients while the current study is focusing on home based care programme in 3 centres in Kabwe District in Zambia.

A study by Tanzania Commission for AIDS (2015) showed that HBC benefited the patient and family as well as the community at large. Through this programme, the financial expenses of caring for patients away from the family were reduced. At family level, HBC helped to hold the families together with the objective of caring for the patient as well as accepting the patients' condition. In addition, there was reduction in the cost of care which enables the family to attend to other tasks whilst caring for the patient.

Matsela (2008) conducted a study on the social costs and benefits of community home based caregivers in Roma valley in Lesotho. Oral interviews were used in data collection. The findings revealed mixed feelings of costs and benefits from this unique health care system on the caregivers, the care recipients and the relatives of the care recipients. Despite the caregivers being happy contributing to their society, their services presented some costs to them and their family. The challenges highlighted included dispute with their families due to non- numerated work they do. The study by Matsela used interviews only while this study used interviews and focus group discussions as data collection strategies. The findings of this study therefore were likely to reflect a higher level of reliability.

A similar research was carried out by Simwanza (2009) on the benefits of home based care utilisation and client satisfaction a case study of PLWHA in rural Choma. The study was a non- interventional, cross- sectional and descriptive study. The findings included general satisfaction with the care in which 58.2% were very satisfied and 2.5% were unsatisfied with way caregivers treated clients. In spiritual support area, 68.4% of the clients said they were not satisfied with the Holy Communion given to them while 31. 6% were satisfied. This study focused mainly on PLWHA in rural Choma while the current study targeted

caregivers, coordinators and the director of the home based care programme in Kabwe Urban District.

2.3 Constraints faced by stakeholders in the implementation of home based care programme by the Catholic Church in Kabwe

In South Africa, Muwaniki (2010) conducted a study on the challenges faced by Phutanang Home Based Care in providing care and training in Mankweng Township in the Limpopo Province. The study was purely qualitative and took a single case study design. Data was collected through fieldwork and document analysis. Multiple data collection consisting of an open ended interview was used in fieldwork, focus group interview and data matrix was used in the analysis of data. The findings were that Phutanang Home Based Care faced challenges such as lack of funds, stigmatisation, lack of sanitary facilities and lack of infrastructure. The present study is different from the one conducted by Muwanika (2010) because it was conducted in one centre in South Africa while the current study focused on three centres in Kabwe District in Zambia.

Rweuzara (2012) also conducted a study on Home Based care services as strategies to support Anti-Retroviral Adherence: The case of Musoma Municipal in Mara region. The objectives of the study were to: explore the role of home based care service providers in supporting ART adherence; determine the perceptions of health care providers towards Home Based care services; determine the perceptions of clients enrolled in ART towards HBC services and describe challenges faced by HBC providers in rendering services to their clients.

Rwezaura's (2012) study and the current study diverge on two points. The first being that Rwezauras' study was conducted in Tanzania while this study was conducted in Zambia. The second difference was on some of the objectives. The point of convergence is on the fourth objective of Rwezaura study which was describing the challenges HBC providers face in rendering services to their clients. Some of the challenges facing HBC providers were reported as being: inadequate motivation, lack of transport allowances, lack of material support such as food aid and lack of resources to help them conduct their supportive supervision activities due to lack of bicycles.

The government of Botswana initiated a comprehensive Community Home Based Care (CHBC) programme in some communities in which HIV clients or patients were cared for at home with the assistance of CHBC and family caregivers. The problems encountered were the impact of caregiving on older women and young girls, poverty, isolation, stigma and lack of knowledge and the need for psychological support.

Qalinge (2011) conducted a study in which the main aim was to assess and explore experiences of and challenges facing caregivers in the rural North West province of South Africa. Qualitative method was used in the study. Data was collected using focus group discussion from caregivers and non-probability sampling was used in selecting the respondents. The study highlighted the following challenges: inadequate government and community support networks, inadequate supervision by health workers, lack of psychological support, impact of poverty in caregiving leading to lack of income and lack of training. This study was conducted in South Africa and the current study was based in Kabwe, Zambia.

Studies done by Adebayo et al (2004) in Nigeria and McCreary et al (2004) in Swaziland both highlighted the problem of poor funding and that was mainly left to the NGOs to manage the programme. However, the NGOs frequently lacked infrastructure and capacity to carry out home based care activities.

Nsutebu et al. (2001) investigated the low coverage of home based care programmes in Africa and used two home based care projects as case study's. The very limited involvement of governments in the provision of home based care services appeared to be one of the main reasons behind the low coverage of home based care in Africa. It was discovered that in the past the government provided drug kits to HBC projects through the World Health Organisation. Since the introduction of health reforms, the support ceased. In addition, majority financial resources in the Ndola HBC were provided by foreign donors, such as the Norwegian Agency for International Development (NORAD). Food supplements, financial and material support were usually from World Food Programme, European and American NGOs. Nsutebu et al. (2001) is in agreement with the current study on various issues. They shared the view that the government should create an enabling environment for the HBC programmes, material and financial support be made available by the foreign donors. The two studies were conducted in Zambia. The point of

divergence is that this study was conducted in Lusaka and Ndola while the current study was carried out in Kabwe District.

Mukubesa (2005) conducted a study on the role of HIV/AIDS Home Based Care in promoting positive Sexual Behaviours among Adolescents in Kabwe Urban. Data was collected using two structured questionnaires. The study established that family counselling was not covered in depth as the main focus was on the primary mode of HIV/AIDS transmission which was through sexual intercourse. The various ways of transmission such as through blood and use of sharp instruments were not focused on very much. This study used structured questionnaires when collecting data while this study used semi structured interview guide and focus group discussion in data collection.

Kaunda (1997) conducted a study on home care for people with AIDS in Lusaka. The study adopted a cross- sectional descriptive study which aimed at collecting and presenting data about primary caregivers and their symptom management. The sample consisted of caregivers in six zones of Lusaka District. A semi- structured questionnaire was used, semi- structured interview schedule and check list were used to collect relevant information from respondents. The findings showed that over 60% of Home Based Caregivers had problems in coping and caring for people with AIDS. This was due to the absence of government policy and guidelines on Home care and lack funding or allocation especially for home based caregivers. This study employed a cross- sectional descriptive study design while the current study adopted a case study. This study also looked at all caregivers in six zones of Lusaka District while the current study sampled caregivers from only three centres out of ten home based care programme in Kabwe District.

2.4 Stakeholders suggested solutions to the constraints faced in the implementation of home based care programme by the Catholic Church in Kabwe

There are various constraints that can hinder the implementation of a home based care programme. Matsela (2008) conducted a study on the social costs and benefits of community home based caregivers in Roma valley Lesotho. This study made the following recommendations: There should be a policy in place that governs community Home Based Care system under the Ministry of Health and Social Welfare, provision of food packages to the patients and their families; there should be a strong firm attempt to integrate men in Community Home Based Care since gender inequality appeared to be one of the

controversies and lastly; the government of Lesotho should allocate some budget for Community Home Base Care programme. This study was conducted in Lesotho and the recommendations are relevant to the current study.

Simwanza (2009) also conducted a study which sought to investigate the benefits of home based care utilisation and client satisfaction in Choma. A non-interventional, cross-sectional and descriptive study was used. The recommendations made were that government should consider rendering support to home based care activities. This could be in the form of formulation of a specific policy that is home based care directed. In addition, he indicated that efforts must be made to provide proper budget lines, as well as supplement the efforts of the care providers. The point of divergence was on the research design as this study used non-intervention, cross- sectional and descriptive study while the current has used a case study.

Chela and Siankanga (1991) in their paper discussed Zambia's experience with HBC of PLWHA. The dual explained that experiences from Chikankata and Katete suggested that stigmatisation by the community of the sick individual cared at home was rarely a problem for the individuals involved. Most care programmes are able to supply foods or other materials for a clients or patients in a home, but it is important to achieve a balance between what the client or patient needs and what the client or patient wants. They also stated that transport was a problem for all programmes. The paper also revealed that the majority clients or patients were religious. Therefore, the spiritual aspect of home care should be emphasised. Their study is different from our study because it was conducted countrywide and its' focus was on PLWHA while the current study focused on only one district, Kabwe.

2.5 Summary of Chapter

The chapter looked at home based care as a concept and other related issues. The chapter which follows discusses the methodology that was employed in the stud.

CHAPTER THREE

METHODOLOGY

3.1 Overview

Chapter two presented literature related to the study. This chapter discusses the research methodology that was used in this study. Gupta and Gupta (2011:1) define methodology as all those methods\techniques that are used in conducting a research. Research methodology on the other hand refers to "… techniques used to structure a study, gather and analyse information in a systematic way" (Polit and Beck 2004: 731). Methodology is defined as the activity or business of choosing, reflecting upon, evaluating and justifying the methods you use in data collection (Wellington, 2002:12). Thus, in relation to this study, the research method has been described and various aspects of methodology summarised under separate subheadings of research design, population, sample size, sampling procedures, data collection procedure, data collection instruments, data analysis, limitations of the study and ethical considerations.

3.2 Research design

A research design is viewed as a programme to guide the researcher in collecting, analysing and interpreting observed facts (Bless and Achola, 1988). Macmillan and Schumacher (1997) also describe a research design as a plan and structure of the investigation which is used to obtain evidence to respond to research objectives. It may also mean a specification of most adequate operations to be performed in order to test specific hypotheses under given conditions. A research design is important as it determines research results and findings. This study adopted a case study design. Gerring (2005:131) defines a case study as a research strategy, an empirical inquiry aimed at investigating a phenomenon within its natural context. Kruger (2000) in White (2005:68) explains that "the term case study has to do with the fact that a limited number of unit's analysis (often only one), such as individual, a group or an institution, are studied intensively". The intent of employing a case study approach was to be able to describe the unit in detail, in context and holistically.

3.3 Target population

Dube (2010:70) points out that a universe population is "… a well-defined or specified set of people or group of things, households, firms, services, elements or events which are being investigated". Castillo (2009) shares the same view and says that population is the entire group of individuals or objects to which researchers are interested in generalising the conclusions. Borg and Gail (1979) view population as all the members of a hypothetical set of people, events or objects to which generalisations of the results of a research study could be made. In this study, the target population included all coordinators, caregivers and director of the programme.

3.4 Sample and Sampling Procedures

3.4.1 Sample Size

A sample as viewed by Moore and Mcbee (1989) is a subject of the entire population from which information will be gathered. White (2005:252) defines a sample as 'a group of subjects from a larger population'. According to Leedy and Ormrod (2005:133), the particular entities which qualitative researchers select comprise their sample, and the process of choosing them is called sampling. Therefore, sampling involves a process of selecting persons from a target population of interest so that the sample may fairly generalise the results back to the population from which the sample was chosen. The important thing in sampling is to identify an appropriate sample from which to acquire data. In this study, 100 participants (respondnts) were selected for the study. The participants were categorised as follows: 1 director of Home Based Care programme, 9 coordinators and 90 caregivers from the three selected centres.

3.4.2 Sampling Procedures

Sampling techniques are procedures adopted by researchers in coming up with a study sample. Borg and Gall (1979) mention that, sampling is the selection of units to represent the entire set from which units were selected. The aim of sampling procedure is to produce a group that is representative of the population in order to make accurate generalisations about the population (Calsan,2007). For this study, purposive and simple random samplings techniques were used to select the sample.

Saunders (2003) defines purposive sampling as a non- probability sampling technique in which the researchers' judgement is used to choose some appropriate characteristics required of the sample members. Purposive sampling was used to select the director and 9 coordinators. The researcher used purposive because in this method, the researcher was targeting a group of people believed to be reliable for the study.

Simple random sampling is a method that is used to select for relatively small and clearly defined population. For this study, a sample of 90 caregivers who are part of Home Based Care (HBC) programme were selected using simple random sampling to participate in focus group discussions. This was done by getting a list of caregivers in each centre and writing their names on pieces of paper. The ruffle draw was conducted to come up with the care givers who were sampled. Since this study was conducted in HBC centres, the caregivers were distributed as follows: Lukanga 30, Ngungu 30 and Don Bosco 30.

3.5 Data Collection Procedure

Data collection is a process of gathering information from the respondents aimed at proving or refuting some facts. Data collection is important in research as it allows for dissemination of accurate information and development of meaningful programmes. This process explains how the researcher entered the field. Creswell (2009) states that data collection procedure answers the who, when and how of the research proposal or project. Firstly, the participants were briefed about the nature of the study. This was followed by seeking informed consent from the participants. The researcher then started collecting data by interviewing the director of HBC programme and coordinators. Interviews were used to investigate stakeholders perceived benefits of the HBC programme and constraints faced by stakeholders in the implementation of Home Based Care programme. Secondly, focus group discussions were held with caregivers to establish stakeholders' suggested solutions to the constraints faced in the implementation of the Home Based Programme in Kabwe. The data collection was undertaken over a period of one month.

3.6 Data Collection Instruments

Research instruments refer to the tools or techniques that the researcher uses in data collection. Kumar (1999:148) says 'data collection may involve administering a questionnaire, conducting an interview or a focus group discussion or observing what is

going on among the subjects of the study. In this study, the collection of data relied on the use of the following: focus group discussion guides and interview guides.

3.6.1 Focus Group Discussion Guide

A Focus group discussion guide is a tool for collecting data that involves a special type of group in terms of its purpose, size, composition and procedures (Kasonde- Ngandu, 2013). Wimmer and Dominic (1987:151) say, "Focus groups or group interviewing is a research strategy for understanding audience/ consumer attitudes and behaviour. From 6 to 12 people are interviewed simultaneously with the moderator leading the respondents in a relatively free discussion about a focal topic". All interviewed group comprised of caregivers participants in home based care programme. For this study, three focus group discussions composed of 10 members were conducted at each centre. Focus group discussions were chosen because they could help source for more information quickly and are useful for identifying and exploring issues so as to obtain in depth information on concepts, perceptions and ideas of the group.

3.6.2 Interview Guide

According to Chilisa and Preece (2005), interview refers to a conversation or interaction between the researcher and a research respondent. Interviews are a two-way method which allows an exchange of ideas and information. Interviews are unique in that they involve the collection of data through direct verbal interaction between the interviewee and interviewer. In an interview guide, a list of general topics and questions is used by an interviewer to conduct a semi -structured interview. During interviews, the responses to the questions were written down or recorded using a phone by the researcher as interviewees were giving their views. Interview guides were used to get information from Coordinators and the Director.

3.7 Data Analysis

Data analysis is categorizing, ordering and summarising the raw data and describing them in meaningful terms. There are many analysis methods that can be used. At present, research studies generally use either narrative or statistical or both. The type of analysis methods depends on the research design and the method by which they were collected or measured (Moore and Mc Cabe, 1989). Cohen et al. (2007) state that qualitative data

analysis is a four step process that involves; identifying the main themes, classifying responses under the main themes and integrating themes and responses into text to the report. Merriam and Simpson (1995:224) define qualitative data as "… data that is not transferable to numbers and not comparable by statistical procedures. In this study, qualitative data was analysed by coding and classifying the themes that emerged from common responses. Themes are patterns across data sets that are important to the description of a phenomenon and are associated with specific research questions. The themes become the categories for analysis (Saldana, 2009).

3.8 Limitations of the study

No research project is without limitations. Limitations are the challenges the research anticipates to face or faces during the study. Kombo and Tromp (2006) mention that the research should therefore state the ways in which the challenges faced are to be overcome. The major limitation encountered in this study was that the data collected would not be necessarily generalised to the wider population because only 3 centres were sampled out of 10 centres. It is possible that the issues that would be identified might not be reflective of a broader range of all participants in other centres.

3.9 Ethical Considerations

Ethics in respect of research refers to a set of standards that guide researchers on how they should interact with the researched and how the research problems could be conceived and formulated. Kombo and Tromp (2006) mention that ethical and issues are concerned with regard to privacy, confidentiality, harm, deception and informed consent. In this case, ethical consideration has to do with protection of respondents and anonymity. The researched were assured that the findings of the research would be used for academic purpose only and that confidentiality would be maintained and names of subjects would be withheld. The necessary ethical procedure was followed in this study. Firstly, permission was obtained from the University of Zambia before embarking on the research. Secondly, permission was sought from the coordinators of the HBC programme. From individual respondents, consent was sought in person for their willingness to participate in the study. It was explained to them that they were free to withdraw from the study at any time and that their participation was voluntary. It was made clear that the information to be

collected was purely for academic purposes and no one was requested to disclose his or her identity.

3.10 Summary of the Chapter

This chapter has discussed the methodology that was employed in the study. A case study design was used in order for the researcher to gain knowledge about the HBC programme. Qualitative methods were used to collect data. Focus Group Discussion guides and interview guides were used in data collection. A sample size of 100 participants was drawn from the universe population. Data collection procedures, data collection instruments, data analysis, limitation of the study and ethical considerations have also been outlined.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Overview

The previous chapter discussed the methodology which was adopted for the study. This chapter presents the findings on constraints and their possible solutions of the Home Based Care programme by the Catholic Church in Kabwe District. The findings are presented according to the research questions. These were:

(i) What were the stakeholders' perceived benefits of implementing home based care programme by Catholic Church in Kabwe District?

(ii) What were the constraints faced by stakeholders' in the implementation of home based care programme by the Catholic Church in Kabwe District? And

(iii) What were the stakeholders' suggested solutions to the constraints faced in the implementation of the home based care programme by the Catholic Church in Kabwe District?

4.2: Participants Bio Data

Figure 1: Participants Sex

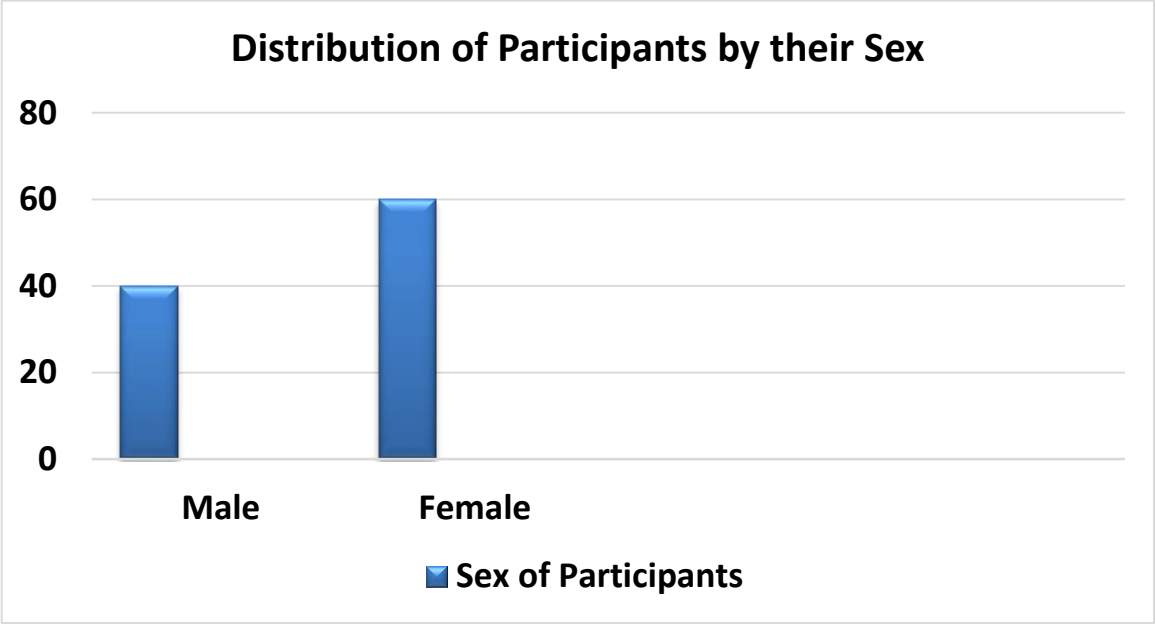

Figure 1: above shows that 60 (60%) were female and 40 (40%) were male bringing the sum total of all participants (director, coordinators and caregivers) to 100. They were more females due to the passion they have for the sick.

Figure 2: Distribution of Participants by the number of years worked in Home Based Care centres

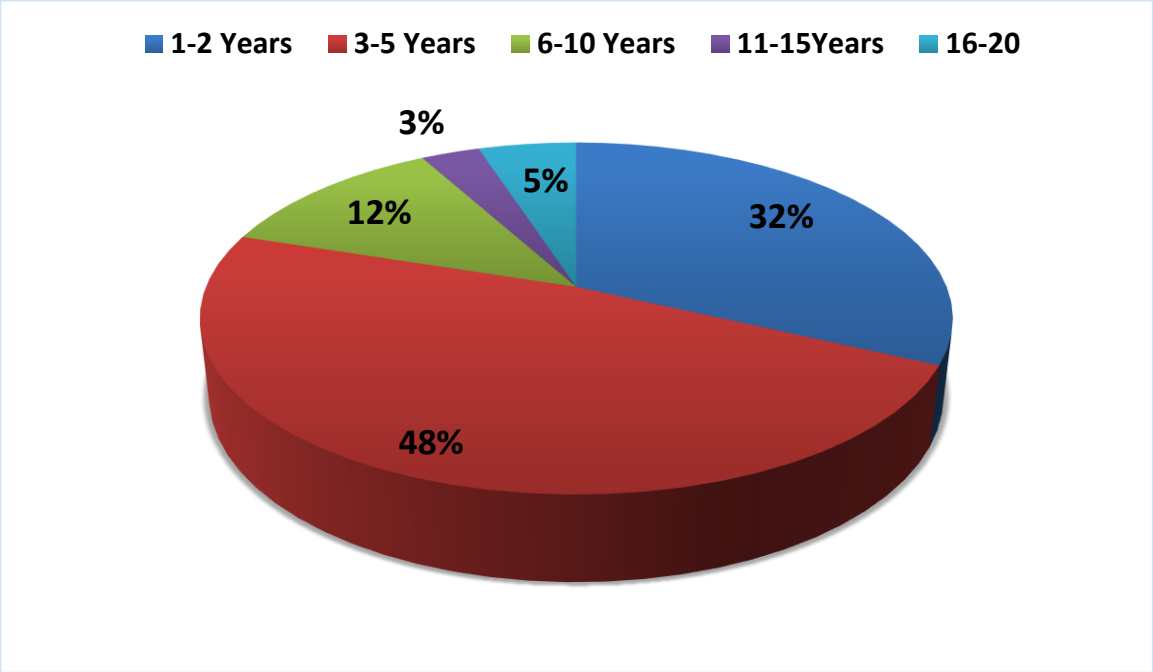

Figure 2: above shows the distribution of participants by the number of years they had worked in the HBC programme. Those who served between 1- 2 years were 32(32%), 3-5 years were 48 (48%), 6-10 years were 12 (12%), 11- 15 years were 3 (3%) and 16-20 years were 5(5%). Respondents who spent more years in home based care programme proved to be useful when it came to suggested solutions meant to improve the HBC programme.

4.3 Research Question 1: What were the stakeholders' perceived benefits of implementing Home Based Care programme by the Catholic Church in Kabwe?

The first research question sought to investigate stakeholders' perceived benefits of the Home Based Care programme. To answer this question, interviews were conducted with the Director and coordinators. Later, focus group discussions with the caregivers were conducted. The interviews and the focus group discussions were recorded and transcribed. This was done for the purpose of triangulating the information given by the director of the programme, coordinators and caregivers. The findings presented below give two sets of data from interviews and focus group discussions.

(a) Findings from coordinators

Eight (8) out of nine (9) coordinators stated that Home Based Care centres benefited the community while one (1) indicated that HBCs did not benefit the community. Some of the benefits mentioned by Coordinators during interviews were as follows:

(i) The provision of educational support to orphans and vulnerable children

The provision of education supports to orphans and vulnerable children (OVC) is one of the benefits which coordinators mentioned. This provision of educational support gives OVCs an opportunity to acquire skills and Knowledge which can enable them survive in the community. One of the coordinators said, *"We provide educational support to OVCs such as paying school fees and buying school uniforms for them''.* Another participant said*, "Balafwa abalwele abesa namalwele ayapusana ukubakoselekesha, nokubapelako ifyakulya." (*Meaning they help sick people with various things and are assisted by providing them with food*).*

(ii) Sensitisation of people about HIV/AIDS and other illnesses.

Some of the coordinators mentioned that the community was also sensitised about HIV/AIDS and other illnesses. The provision of information and sensitisation of the community about different diseases especially HIV/AIDS proved to be a great service provided by the HBC programmes although there were other sources from which the community could get information such as radio and TV adverts. With such sources, members of the community were not accorded the opportunity to ask questions about how some diseases can be prevented or are acquired. In contrast, caregivers visited people in their communities who in turn sought information about various aspects of the illnesses. For example, one coordinator said, *"Through quick sensitisation, we were able to quickly identify and help people who were chronically ill with HIV/AIDS, TB, CANCER, and DIABATES*".

However, one coordinator stated that Home Based Care programmes had no benefits to the community. This coordinator said, *"HBC is not beneficial and as effective as it used to be when it was introduced. Some caregivers reveal the information to the public about those patients who are positive.''*

Another coordinator, however, mentioned that despite the benefits, there was still discrimination of orphans and vulnerable children in HBCs. The coordinator said:

> "*Stigmatisation is still an issue in most centres. Some people fail to request for services offered by the centres even if they are in desperate need hence, die silently. This is because they fear to be stigmatised by some caregivers who are neighbours and church members and are not confidential".*

(b) Findings from focus group discussions with caregivers.

The majority of caregivers who participated in the focus group discussions indicated that HBC had benefits while a few participants (respondents) mentioned that they did not see any benefits. The following were the benefits discussed by Caregivers:

(i) Provision of health care to the sick people

The caregivers mentioned that HBCs benefitted the community because they provided health care to the sick. One of the caregivers from one parish said, *"We care persons with disabilities and mental illness. Chronically ill and HIV/AIDS patients are also provided with psychosocial counselling and food".*

Another caregiver said: "*We network with the health centres to reduce stigma and discrimination against the sick. In addition, we go in communities to sensitize people on the negative effects of stigma and discrimination".*

From the focus group discussions, most of the caregivers stated that stigmatisation seemed to be a problem of the past. Home based care programmes were also considered a useful component of society and a lot of people were interested in their activities. One caregiver said:

> "*We do not focus on HIV/AIDS only but also address a whole range of community needs and as a result, the community does not perceive us to be affected by HIV but see us as partners in development".*

As earlier stated, there were a few caregivers who participated in focus group discussions, who still mentioned that HBCs did not benefit the community. They mentioned that there

was discrimination of orphans and vulnerable Children. One of them stated that in most cases, vulnerable children were down trodden. The caregiver said:

> *"The coordinators of HBC sometimes segregate in choosing OVCs. In most cases, they include or rather shortlist the names of their children who are not even vulnerable. The OVCs are sometimes discriminated and looked down upon by even caregivers."*

One participant (respondent) in the focus group discussion said," *Nomba abantu balaibwelamo pantu abakuntanshi balalya impiya elo balasala pakupela abalanda"* (meaning Some people are put off as the leaders' misuse the funds and discriminate when distributing to the needy.)

(c) Findings from the director of programme

The director was interviewed on the benefits of Home Based Care programmes and he said*:*

> *"HBCs have a lot of benefits for the community. Orphans and vulnerable children are taken care of by paying school fees for them. Sick people suffering from HIV/AIDs are given help in form of food to ensure that their health is improved. The home based care that is given is holistic and based on gospel value."*

Many participants (respondents) stated that they were benefits of the HBCs to the community while a few saw no benefits at all.

(d) Summary of the findings of research question one

The first research question sought to answer the views of coordinators, caregivers and director on the benefits offered by the home based care programme. The study established that the programme had a lot of benefits. These benefits included the provision of education to orphans and vulnerable children, provision of health care to sick people and the sensitization of people about HIV/AIDS, TB, cancer, diabetes and stroke. On the other hand, others indicated that there were no benefits derived from HBC centres in the sense that they were not as effective as they used to be in the past because they did not uphold the aspect of confidentiality.

4.4 Research Question 2: What were the constraints faced by stakeholders' in the implementation of the Home Based Care programme in Kabwe?

The second research question sought to establish the constraints faced by stakeholders in the implementation of Home Based Care Programme. To answer this question, interviews were conducted with the director, coordinators and focus group discussions with caregivers. The findings presented below give two sets of data from interviews and focus group discussions.

(a) Findings from coordinators and caregivers.

All the nine (9) coordinators who were interviewed said that they had encountered constraints in the management of Home based Care programme in Kabwe District. Caregivers who participated in the focus group discussions also indicated that they had faced constraints in the running of the programme.

(i) Findings from coordinators

All the coordinators from various centres revealed major constraints encountered in the running of the programme. The participants indicated that lack of financial support was a serious problem affecting the HBC programme at the centres. One of the respondents said:

> "*There is not much to give out due to lack of funding and there are no local donors." Furthermore, there is lack of infrastructure''.*

Another respondent stated that, there was no adequate accommodation space for offices, lack of proper furniture, stationary and accommodation facilities. He also mentioned that lack of transport such as bicycles and allowances for supporting staff was also a big challenge.

(ii) Findings from caregivers

The majority of caregivers who participated in the focus group discussions mentioned that they had encountered constraints. One of the constraints that came out prominently had to do with inadequate funding. Funding was cited as a major constraint. One of the respondents revealed that, HBCs were no longer receiving financial support from donors to finance programmes such as the paying of school fees for vulnerable children.

Other caregivers mentioned that there was lack of training amongst them which meant that most of them were illiterate or had low levels of education. One participant said*, "We need continuous in-service training in form of workshops and seminars so that we know how to work"*. They stated that it was a challenge to work when one was not trained. Some of them also stated that their lack of writing and language skills was a hindrance to their operations and hence the need for skills development.

It was also revealed in the study that the other constraint faced by caregivers was lack of proper infrastructure in the centres making their operations difficult. This lack of infrastructure resulted in not having psychosocial counselling in the centres. Additionally, centres had few chairs which were only offered to men. These chairs mostly came from caregiver's homes. As a result, some caregivers especially women, sat on reed mats.

One participant in the focus group discussion also mentioned that time keeping was a challenge. She said, *"Most of the times, some of the people report late for meetings*", an observation which was clearly noticed as well. Another participant complained of lack of time keeping by coordinators. He said *"Time keeping by the coordinators is poor and that applies to the director of the programme too".*

Another participant in the focus group discussion also mentioned the lack of health materials such as drugs, gloves, soap and washing detergents, cotton wool and bedpans to use during visitation as a challenge. She explained that the lack of these materials was making work difficult.

Another participant in the focus group discussion mentioned transport as a challenge. She said, *"Ubwafya twakwata bumbi nimumyendele pantu inchinga twakwata shinono elo shimbi shalifwa".* (Meaning transport is another constraint as most bicycles which are used to move around are few while some are none functional).

(iii) Findings from the director

The Director of programme mentioned that HBCs had no money to run effectively as the Global Fund which was the major funder had withdrawn funding making poor children who had benefitted from the same stop going to school. He said:

> *''Parents can't afford to pay school fees due to the poor economy. The donor agencies are not generous enough as they used to be. Another challenge is that of poor infrastructure and there is also no proper coordination between the coordinators and caregivers".*

4.5 Suggested solutions to address the constraints faced by the stakeholders' in the implementation of home based care programme in Kabwe

The following were some of the measures being taken to address the constraints faced by HBCs. The information presented below was from caregivers, coordinators and the Director.

(i) Findings from coordinators

The coordinators reported that since there was no longer donor support, the HBCs had formed Savings and Loan Association (SLAs) which would give loans to members to enable them to start or conduct business in order to sustain their families Money came from caregivers and from the community being served. Another coordinator also said:

> "We have started some *income generating activities such as farming and chicken rearing so that we generate income. We also ask local and international organisations for support in form of clothing and money."*

(ii) Findings from the director

The director indicated that, they were workshops and seminars conducted for the coordinators and caregivers to keep them abreast with latest information on HBC programmes in the centres. Furthermore, he mentioned that the centres had ventured into fundraising activities such as fundraising walks, farming and chicken rearing in order to raise some money.

4.6 Summary of findings from research question two

Research question two sought to find out the constraints faced by stakeholders in the implementation of home based care programme. The constraints included lack of funding, lack of infrastructure, lack of training, inadequate health materials and failure to keep time. These constraints were addressed by measures such as conducting workshops and seminars to train caregivers and coordinators. Lastly, HBC centres were asking local and international organisations to offer support in form of money.

4.7 Research Question 3: What were the stakeholders' suggested solutions to the constraints faced in the implementation of the home based care programme in Kabwe?

The third research question sought to establish what the stakeholders' suggested as solutions to the constraints faced in the implementation of the Home Based programme in Kabwe. Interviews and focus group discussions with the coordinators, caregivers and director were conducted. The interviews and focus group discussions were recorded and transcribed.

(i) Findings from coordinators

The responses which emerged from the coordinators were that the director of HBC should engage Ministry of Community Development and Social Welfare and other agencies such as UNICEF to help in paying school fees of orphans and vulnerable children. *One participant pointed out that, "inform the community about the need to be self- reliant for instance come up with long term projects."*

(ii) Findings from caregivers

Caregivers suggested possible solutions to the constraints faced at home based care centres. They mentioned that the lack of health materials could be overcome by involving key stakeholders from the Ministry of Health who would help to avail some medicines to these centres.

One caregiver said:

> *"There is need to invite local and international donors to help in the management of the centres if a solution to the funding crisis is to be found. In addition, there is need to come up with long term projects*

such as the construction of houses and guest houses which can raise funds''.

Another one said that in order to empower youths, they should equip them with life skills such as carpentry, bricklaying and cookery.

With regard to the problem of training, some caregivers stated that coordinators and the director of programme should conduct workshops and seminars in order to impart knowledge and new skills in caregivers. Other caregivers mentioned that OVCs in higher learning institutions who were in need of funding should be referred to the Ministry of Community Development and Social Welfare and Forum for African Women Educationalists in Zambia (FAWEZA) for support since HBC centres were having challenges sponsoring them.

(iii) Findings from the Director

The Director of the Home Based Care programme suggested the following solutions: Firstly, he proposed that if all the staff in all the HBC centres should be trained in project management, project proposal writings and start income generating activities. The other suggested solution was to ask nurses, doctors and medical persons to volunteer and train the locals in best health care practice.

4.8 Summary of findings from research question 3

Research question three sought to establish the stakeholders suggested solutions to the constraints faced in the implementation of the home based care programme in Kabwe. Some of the suggestions included need to invite local and international donors to help in the management of the centres if a solution to the funding crisis I to be found, the OVCs in higher learning institutions that were in need of funding should be referred to the Ministry of Community Development and Social Welfare and Forum for African Women Educationalists in Zambia (FAWEZA) for support since HBC centres were having challenges sponsoring them, to conduct fundraising ventures to sustain the projects, engaging the government (Ministry of Health) to provide needed materials and also train the locals in health care practice.

4.9 Summary of chapter Four

Chapter four of this study presented findings on the constraints and their possible solutions of Home Based Care programme by the Catholic Church in Kabwe District. The respondents included coordinators, caregivers and director of the programme. The findings were that home based care benefits the community by providing educational support to orphans and vulnerable children and provision of health support to the sick people. Nevertheless, others indicated that HBC programmes had no benefits due to the discrimination against some orphans. The constraints faced in the implementation of programmes were lack of funding, lack of infrastructure and no health materials such as drugs, cotton wool and gloves when treating HIV/AIDS patients and those who were chronically ill.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Overview

The previous chapter presented findings of the study. This chapter discusses the findings on the constraints and their possible solutions of Home Based Care Programme by the Catholic Church in Kabwe District. According to David and Sutton (2004: 338) cited by Zulu (2015), the discussion chapter is a segment that brings together the main research findings, key elements of literature and focuses on answering the original research problem, comparing the research findings with previous research. The discussion was guided by research objectives which were to:

(i) investigate stakeholders' perceived benefits of implementing Home Based Care programme by Catholic Church in Kabwe;
(ii) establish the constraints faced by stakeholders' in implementation of Home Based Care programme by Catholic Church in Kabwe; and
(iii) establish stakeholders' suggested solutions to the constraints faced in the implementation of Home Based Care programme by Catholic Church in Kabwe.

5.2 Objective 1: Stakeholders' perceived benefits of implementing the Home Based Care programme by the Catholic Church in Kabwe

The study revealed that the Home based Care programme benefited the community even though there were a few participants in the study who did not agree. One of the benefits of the Home based programme which was mentioned by the participants in the study was the sensitisation of people about HIV/AIDS and other illnesses. In addition to what has been mentioned, the majority of caregivers who participated in focus group discussions also mentioned that Home Based Care centres benefited the community as they provided health care to the sick. The findings in our study agree with one of the construct of the Health Belief Model (Hochbaum, 1958) on perceived benefits of preventive health behaviour. The construct embraces aspects of how effective and beneficial the individual believes to be in reducing the risk of developing the health condition. Statements such as, "I have a lot to gain by doing" (preventive health behaviour) and "completing preventive health behaviour could save my life" (McClenaham et al., 2007).

Additionally, the findings discussed above are in agreement with the National Home Based Care Policy Guideline (2002) in Kenya, under the Ministry of Health which outlined the benefits of home based care which included: the provision of medication, physical and emotional care and support, counselling and the provision of food and supplements. The findings of our study further tie with the findings by Kaleeba et al. (1997) which revealed that individuals and families were able to live positively with HIV/AIDS through counselling, medical care and material support from HBC centres.

The other benefit which was revealed by the study was the provision of education support to orphans and vulnerable children. Coordinators and caregivers indicated that the provision of educational support to orphans and vulnerable children gave these orphans an opportunity to acquire skills and knowledge. The provision of educational support to these needy children meant that the HBC centres in Kabwe were fulfilling the purpose for which they were established and were in line with what Vidal (2001) stated that faith based organisations should be engaged in a wide variety of activities beyond worship, most of which provide services and immediate benefits to needy individuals and families. One lesson that can be drawn from these findings is that the HBC programme in Kabwe was fulfilling the purpose for which it was created.

Despite home based care programme having benefits, a few participants in the study said that they saw no benefits because there was discrimination in the choosing of OVCs and caregivers had no confidentiality. This finding is similar to the findings of UNAIDS (2004) in a study conducted in Mumbai, India and Bangalore, India. The study revealed that there were aspects of ostracism and rejection of OVCs. Furthermore, the predominant effect at the individual level was fear and withdrawal, leading to secrecy about social isolation which also led to difficulties in accessing community care and support.

The views expressed by the few people who did not see the benefits of HBC centres should be taken seriously as it is an indication that something was not being done correctly. Further, it is a weakness because what this means is that there are still stakeholders who do not appreciate the benefits of the programme and may frustrate programmes planned for.

5.3 Objective 2: Constraints faced by stakeholders in implementation of the Home Based Care programme by the Catholic Church in Kabwe

The study sought to establish the constraints faced by stakeholders in the implementation of the Home Based Care programme by the Catholic Church in Kabwe. The study findings revealed that all the coordinators (9) had faced constraints in the implementation of the home based care programme. It was also revealed in the study that even caregivers who participated in focus group discussions had encountered a number of challenges. One of the challenges faced by coordinators and caregivers in the implementation of the HBC programme was lack of funding from donors and government. Home based centres did not have money to buy furniture, food for patients and meet the daily expenses. This challenge is also common to other HBC centres outside Zambia. For example, Muwaniki's (2010), in his study also reported that Phutanang Home Based Care in South Africa faced challenges such as lack of funds and lack of infrastructure. A study conducted by Rwezaura (2012) in Tanzania also mentioned that HBC providers encountered challenges such as inadequate motivation due to lack of transport allowance, lack of material support and resources to enable them conduct their supportive supervision activities.

The constraint of lack of funding was also noted by Kaunda (1997) who mentioned that over 60% of Home Based Caregivers had problems in coping and caring for people with AIDS. This was due to absence of government policy and guidelines on Home care and lack of funding or allocation especially for home based caregivers.

A number of lessons can be drawn from the findings discussed above. Firstly, the absence of funding for these programmes meant that HBC centres could not carry out all the planned for activities such as paying school fees for OVCs and also caring for the sick. Secondly, the operations of coordinators and caregivers were affected since they needed transport to take them in the communities as they sensitised people.

The study also revealed that caregivers were not trained for the work they were doing. Qalinge's (2011) in his study also revealed a challenge of lack of training among workers in addition to other challenges such as inadequate government and community support networks, inadequate supervision by health workers, lack of psychological support and impact of poverty in caregiving leading to lack of income. This state of affairs is very worrying. The implication of this finding is that many caregivers did not know how to

work because they are not trained. It is no wonder people were complaining about confidentiality because these caregivers were not competent to carry out the tasks they were meant to do.

The other constraints faced was the lack of health materials such as drugs, gloves, soap and washing detergents, cotton wool and bedpans to use during visitation for the programme to operate well. The absence of these materials led to the cancellation of these programmes. The very limited involvement of governments in the provision of home based care services appear to be one of the main reasons behind the low coverage of home based care in Africa.

Although the HBC Programme experienced various constraints, participants in the study said that certain measures had been put in place to try and lessen the constraints. Workshops and seminars were conducted with coordinators and caregivers to help them be abreast with latest information regarding the running of HBC centres.

5.4 Objective 3: Stakeholders suggested solutions to the constraints faced in the implementation of Home Care programme by the Catholic Church in Kabwe

Objective three discussed participants suggested solutions to the constraints faced in the implementation of Home Based Care programme by the Catholic Church in Kabwe. Possible solutions: One of the solutions suggested by participants in the study was that the Ministry of Community Development and Social Welfare as well as the Ministry of Health should partner with other stakeholders and assist HBC centres to continue providing educational and health support to needy people. While this can be done, it is important to remember that the government also has schools and hospitals which they are struggling to support;

The formation of Savings and Loan Associations (SLAs) to assist members get loans at an interest for purposes of starting a business is a good one. By giving out loans to members of the community, HBC centres may save some money from the interests levied on the loans. This money can then be channelled to the implementation of the programme;

Furthermore, participants made a preposition to the effect that all coordinators and caregivers must be well trained in the management of HBC programme. This strategy would lead to the improvement in the management of HBC programmes. It is a well-

known fact that a well-trained human resource yields results. On the contrary, if people are not well trained, they fail to carry out tasks effectively. By training these key stakeholders, it is hoped that HBC centres will be effective and efficient.

The Other is time keeping which was also suggested as a solution be taken seriously. All activities done should be time bound and with proper keeping of time, all programmes can be achieved. The above solutions are supported by Matsela (2008) who made the observation: that there should be a policy in place which would guide the government of community Home Based Care system under the Ministry of Health and Social Welfare. Provision of food packages to patients and their families, and that the government of Lesotho should allocate some budget for Community Home Based Care programme. In the same vain, Simwanza (2009) suggested that the government should consider rendering support to Home based care activities and this could be in form of a specific policy that is home based care directed. In addition, he indicated that efforts must be made to provide proper budget lines, as well as supplement the efforts of the care providers. Nsutebu et al. (2001) is also in agreement with the suggested solutions as he shared the view that the government should create enabling environment for HBC programmes, materials and financial support made available by the foreign donors.

5.5 Summary of Chapter Five

This chapter discussed findings of constraints and possible solutions of the home based care programme by the Catholic Church in Kabwe District. It has indicated that Home Based Care centres were benefitting the community by providing educational support to OVCs, provision of health care to the sick people and the sensitisation of people about HIV/AIDS and other illnesses. However, not all stakeholders saw these benefits. Home Based Care centres were encountering a number of challenges such as lack of resources for their smooth operations and lack of training. Some of the suggested solutions include the training of caregivers and engaging in fundraising ventures to raise money which would help in effectively running the centres.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Overview

The previous chapter discussed the findings of the study. This chapter presents the conclusions and recommendations of the study.

6.2 Conclusions

The objectives of this study were to: i) investigate stakeholders perceived benefits of home based care programme by the Catholic Church in Kabwe, ii) establish the constraints faced by stakeholders in the implementation of Home Based Care Programme by the Catholic Church in Kabwe and iii) establish stakeholders suggested solutions faced to the constraints faced in the implementation of Home Based Care programme by the Catholic Church in Kabwe. The study was conducted in three centres namely Don Bosco, Lukanga and Ngungu centres in Kabwe District. A case study was used in the study of which focus group discussion and interview guide was used to collect data. The sample was 100 which consisted of 1 director, 9 coordinators and 90 caregivers. Purposive sampling was used to select the director and coordinators while caregivers were selected using simple random sampling.

Many conclusions can be drawn from the study regarding Constraints and Possible Solutions of implementing Home Based Care Programme by the Catholic Church in Kabwe District. Using the research objectives, the following were the conclusions of the study:

The first objective attempted to investigate stakeholders' perceived benefits of Home Based Care programme by the Catholic Church in Kabwe. The findings revealed that all categories of participants, namely; director, coordinators and caregivers confirmed that the programme was beneficial to the community. Home Based Care Centres were perceived as benefiting the communities in Kabwe. Some of the perceived benefits of HBC centres included the provision of education support to OVCs, provision of health care to the sick people and the sensitisation of people about HIV/AIDS and other illness. In as much as many participants in the study appreciated these benefits, there were some who did not see any benefits meaning that there was something which was not being done correctly.

The second objective sought to determine the constraints stakeholders faced in the implementation of Home Based Care programme. Stakeholders such as coordinators and caregivers encountered constraints in the management of the Home Based Care programme in Kabwe District. Some of the constraints faced in the implementation of the programme included lack of finances to effective run the centres, lack of training among caregivers, making it difficult for them to work, lack of or no proper infrastructure at the centres, lack of health materials such as drugs, gloves, soap, washing detergents, cotton wool and bed pans to use during visitations. Other constraints faced included lack of transport to enable the caregivers move around and late coming of both coordinators and caregivers.

The third objective and research question sought to establish stakeholders suggested solutions to the constraints faced in the implementation of the Home Based Care programme. Stakeholders suggested a number of solutions to the constraints faced in the implementation of the Home Based Care programme. Among the suggested solutions were that the government, through the Ministry of Community Development and Social Welfare as well as Ministry of Health should partner with other stakeholders to enable HBC provide educational support and health care to the needy, formed Savings and Loan Associations (SLAs) which would give loans to members to enable them start or conduct business to sustain their families ,solicit for donor support from both local and international donors in material and monetary form, the participants made proposition to the effect that all the caregivers and coordinators must be well trained in the management of the HBC programme. This strategy would lead to the improvement in the management of HBC programme and refer orphans and vulnerable children in higher learning institutions in need of financial report to the Ministry of Community Development and Social Welfare.

6.3 Recommendations

Arising from the findings, the study made the following recommendations:

a) The Ministry of Health should conduct regular short trainings and meetings with caregivers and coordinators so that they gain knowledge and skills;
b) The Ministry of Community Development and Social Welfare should partner with Home Based Care centres in Kabwe in order to help these vulnerable children; and
c) The Ministry of Health should help these centres with the same materials since they are also supplementing government efforts in providing health care to the public.

6.4 Suggestions for Future Research

Home Based Care is a diverse area of study. This study concentrated on the constraints and their possible solutions by the Catholic Church in Kabwe District from the point of view of coordinators and caregivers. This study did not take care of the views of the beneficiaries of the HBC programmes. It would be interesting to get their views regarding the constraints and possible solutions as well. This is because they are major stakeholders in these programmes.

6.5 Summary of the Chapter

Chapter six presented the conclusions and recommendations of the study. The conclusions were drawn from the research objectives of the study while recommendations were based on the findings and discussion of the study. It was revealed that majority of the participants said home based care benefited the community. On the other hand, it was concluded that inadequate funding was one of the major challenges encountered in the implementation of the programme. Chapter has also highlighted several propositions.

REFERENCES

Adebayo, L.L., Irinoye, O.O., Oladuyin, M.A. and Fakande, I. (2004). "Community Home Based Care (CHBC): example from Living Hope Care and Support Organisation in Usun State, Nigeria*". Journal of Nursing and Midwifery*, 6 (1): 49- 55.

Bless, R. and Achola, P. (1988). *Fundamentals of Social Research: African Perspective*. Cape Town: Junta. Research

Borg, W.R. and Gail, M. (1979). *Educational: An Introduction to Research*. London: Longman.

Buch , E. (1974). *Second Class Citizens*. London: Continuum.

Burns, R. B. (1991). *An* Introduction *to Research Methods*. London: GAGE.

Burns, R. B. (2000). *An Introduction to Research Methods*. New York: GAGE.

Cameron, S., Coetzee, L. and Ngindi, N. (2009). *Legal Aspects of Palliative Care*. Pretoria: Hospice Palliative Care Association of South Africa.

Castillo, J. J. (2009). *Research Population*. http//www.experiment-resources.com/research.

Central Statistics Office. (2015). *Census of Population, Housing and Agriculture*: Central Provinces Analytical Report, Vol.1. Lusaka: Government Printers.

Chela, C.M. and Siankanga, Z.C. (1991). *Chikankata AIDS Care and Prevention Department*. Mazabuka: Ministry of Health/WHO.

Chilisa, B. and Preece, H. (2005). *Research Methods for Adult Education in Africa*. Hamburg: UNESCO, Institute for Education.

Chuma, P. C. (2006). *Methods and Techniques in Adult Learning*. Lusaka: ZAOU.

Churches Health Association of Zambia (2013). Lusaka*: SMART WEB SOLUTIONS. Design*: *Qualitative, Quantitative Mixed Methods Approaches*. New York: SAGE Publications Ltd.

Cohen, C., Manion, L. and Morrison, K. (2007). *Research Methods in Education* (6th ed). New York: Routledge.

Creswell, J. W. (2003). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches (*2nd ed.). London: Sage Publishers.

Creswell, J. W. (2009). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches (*3rd ed.). New Delhi: Sage Publishers.

Defilipi, K. (2005). "Integrated Community – based care: Striving towards balancing quality

with coverage in South Africa." *Indian Journal of palliative care* 11(1): 34-47.

Dube, O. (2010). *Research Methodology*. Lusaka: ZAOU.

Durlak, J. A. and Dupre, E. P. (2008). "Implementation Masters: A Review of Research on the influence of Implementation on Programme Outcomes and Factors Affecting Implementation". *American Journal of Community Psychology*, Vol. 41(3): 327-350.

Ellis, T. J. and Levy, Y. (2008). "Framework of problem- based research: A guide for novice researchers on development of research - worthy problem". *Informing Science: International Journal of an Emerging Transdiscipline, 11,* 17-33.

Gerring, J. (2005). *A Case Study Research*. New York. Cambridge University.

Gupta, D. and Gupta, M. (2011*). Research Methodology*. New Delhi. PHI Learning Private.

Heppner, P. P. and Heppner, M. J. (2004). *Writing and Publishing your Thesis Dissertation and Research: A Guide for Students in the helping Professions.* California: Brooks/ Core- Thomson Learning.

Hochbaum, G. M. (1958). *Public Participation in Medical Screening Programs: A Social Service Publication Study Public Health Service Publication* No.572. Washington DC: Government Printing Office

Hornby, A.S. (2000). *Oxford Advanced Learner's Dictionary* (8th ed.). Oxford: Oxford University Press.

Hornby, A.S. (2010). *Oxford Advanced Learner's Dictionary* (8th ed.). Oxford: Oxford University Press.

Iliffe, J. (2006). *The African AIDS Epidemic*. Ohio: University press

Imenda, S. (2014). "Is There a Conceptual Difference Between a Theoretical and Conceptual Frameworks?" *Journal of Social Sciences*, v. 38 (2): 185- 195.

Janz, N. K. and Becker, M.H. (1984). The Health Belief Model: A decade later. *Health Education Quarterly*, 11(1) 1-47.

Kaunda, V. H. (1997). *Home Care for People with AIDS in Lusaka*. Lusaka: UNZA press.

Kaleeba, N., Kalibala, S., Kasejje, M., Anderson, S. Van Praag, E. (1997). "Participatory Evaluation of Counselling: Medical and Social Services." *The AIDS Support Organisation (TASO) Uganda. AIDS Care*. 9 (1) 13-26.

Kasonde – Ngandu, S. (2013).Writing a Research Proposal in Educational Research. Lusaka: UNZA Press.

Kombo, D. K. and Tromp, D.L.A. (2011). *Proposal and Thesis Writing: An Introduction*. Nairobi: Pauline Publishers.

Kombo, D. K. and Tromp, D.L.A. (2006). *Proposal Writing and Thesis Writing: An Introduction*. Nairobi: Pauline Publishers.

Kumar, R. (1999. *Research Methodology: A step by step Guide for Beginners*. Thousand Orks, CA: Sage Publishers.

Leedy, P. D. and Ormrod, J.K. (2001). *Education Practical Research: Planning and Design* (7th ed.). New Jersey: Prentice Hall Inc.

Leedy, P. D. (2005). *Education Practical Research: Planning Design.* (8th ed.). New Jersey: Pearson.

Lindsey, E. (2002). *Community based care in resource limited settings: Framework for action.* Geneva: World Health Organisation.

Louden, M. (1999*). South Coast Hospices Community based HIV/AIDS home based care model. HIV/AIDS Best Practice Services.* Pretoria: Department of Health.

Lungu, F.F. (1996). (Unpublished). Home Based Care Project. Report for January – December 1995.Lusaka. Family Health Trust.

Macmillan, J. H. and Schumacher, S. (1997). *Education and Economics Crisis: The Case of Mozambique and Zambia*. Stockholm: SIDA.

Matsela, M. (2008). *Social Costs and Benefits of Community Home- Based Health Delivery Systems in Lesotho: The Case of Roma Valley*. Unpublished. Roma: National University of Lesotho.

McCreary, L.L., Mkhonta, N.R., Popovch, J. M., Dresden, E. M., and Mndebele, E.T. (2004). "Family care giving: Home based care in rural Swaziland". *Africa Journal of Nursing and Midwifery*, 6 (1) 18- 24.

Merriam, S. B. and Simpson, E. L. (1984). *A Guide to Research*. Malabar: Kruger Publishing Company.

Moore, D.S. and Mc Cabe, G.P. (1989*). Introduction to the Practice of Statistics*. New York. Freeman and Company.

Muhammad, N. and Gigonyo, J. (2005). *Operational Challenges Home Based Care for PLWHA Community Multi- Country HIV/AIDS programs for Sub- Saharan Africa: Working Paper Series No.88*. Africa region: ACT Africa.

Mukubesa, S. B. A. (2005). *The Role of HIV/AIDS Home Based Care in Promoting Positive Sexual Behaviours among Adolescents in Kabwe Urban*. Lusaka. UNZA press.

Muwaniki, C. (2010*). Challenges faced by Phutanang Home Based Care in providing care and training in Mankweng Township in the Limpopo Province*. Limpopo: University of Limpopo.

Mwansa, D. (2005). *Introduction to Research Part II Qualitative Research* (1st ed.). Introduction. Lusaka: ZAOU.

Mweemba, D. (2012). *Decentralisation of Care: A Community Home Based Care Perspective*. Netherlands: Tilburg University.

Myslik, W. D. and Freeman, A., and Slawski, J. (1997). "Implications of AIDS for South African Population age Profile*". Southern African Journal of Gerontology,* vol 6 (2): 3-8.

National Home- Based Care Policy Guidelines. (2002). Nairobi: Ministry of Health.

Nawa, N. (2015). *An Evaluation of the Programme at Lusaka Central Prison in Zambia*. Lusaka: UNZA Press.

Ndhlovu, D. (2012). *EPS 301 Research Methods in Special Education*. Lusaka. UNZA Press.

Ngoma, P. S. (2006). *Introduction to Research Part I Quantitative (1st ed.). Nature and Purpose of Research*. Lusaka: ZAOU.

Nsutebu, E.F., Walley, J. D, Mataka, E. and Fikansa, C. (2001). "Scaling - up HIVAIDS and TB home based, Lessons from Zambia": *Health Policy and Planning,* Vol .16(3): 240-247.

Patton, M.J. (2002). *Qualitative Research and Evaluation Method*. Thousand Oaks California: Sage Publishers Ltd.

Peil, R. et al. (1982). *'Lifelong Cooperation Education*'. Michigan: University of Michigan.

Phiri, D. (2015). *Students' Perceptions of Instructional Techniques Used by Tutors in University Zambia Extension Education in Lusaka District*. Lusaka: UNZA Press

Polit, D. and Beck, T. (2004*). Essentials of Nursing Appraisal and Utilization*. Philadelphia: Lippincott.

Qalinge, L. (2011). *Assess and Explore the Experiences and Challenges Facing the Volunteer Caregivers in the Rural North West Province of South Africa. Pretoria.* University of South Africa.

Rosenstock, I. M. (1974). Historical Origins of the Belief Model. *Health Education Monographs* 2,328-335.

Rwezaura, P. K. (2012). Home *Based Care Services as Strategy to Support Anti-Retroviral Adherence: The Case of Musoma Municipal.* Mara region. Muhambili University of Health and Allied Sciences.

Saldana, J. (2009). *The Coding Manual for Qualitative Researchers*. Thousand Oaks California: Sage Publishers Ltd.

Saunders, S. (2003). *Research Methods for Business Studies*. London: Prentice Hall.

Simwanza, G. L. (2009). Benefits of Home Based Care Utilisation and Client Satisfaction: A Case Study of PLWHA in Rural Choma. Lusaka. UNZA press.

Singleton, R. et al. (1988). *Approaches to Social Research*. New York: Oxford University Press.

Spier, A. and Edwards, E. (1990*). Facing AIDS: A Strategy Manual.* McGregor: SYNCOM Publishing.

Stefanou, R. (2009). *Success in marketing. (1st* ed.*). Marketing Research*. London: John Murray(Publishers) Ltd.

Stretcher, V. and Rosenstock, I. M. (1997). *The Health Belief Model: Health Behaviour and Health Education Theory, Research and Practice*. (2nded.). San Francisco: Jossey Bass.

Training Package for Community Care Givers. (2002). WHO.

United Nations Programme on HIV/AIDS (UNAIDS). (2007). Reducing HIV Stigma and Discrimination: a critical part of national AIDS Programmes. Retrieved from http:// data. aids org/ pub report/2016 at 22:40hrs on 02-08-2016.

UNAIDS. (2004). Report on Global AIDS Epidemic 4th global report. Geneva: Switzerland.

Uys, L. R. and Cameron, S. (2003). Home based HIV/AIDS Care. Cape Town: Oxford University press.

Vanpraag, E. Rowland, S. Gottlieb, M. et al. (2007*). Implementing a continuum of care for HIV: lessons learned from Tanzania,* ftguonline.orglftgu 232/index.php/ftgu/article/view 2027/405 Accessed August 2012.

Vidal, C. A. (2001). *Faith-Based Organisations in Community Development. Washington*: The Urban Institute.

Wellington, J. (2000). *Educational Research*. London: Citizens Continuum.

Werner, P. (2003). "Factors influencing intentions to seek cognitive status examination: a study based on the Health Belief Model*." International Journal of Geriatric Psychiatry* 18, 787-794.

Wesunga, B. (2015). "Components, Practices, and Benefits of Home Based Care of HIV and AIDS Patients in Kenya: Butula Local Community's in Perspective. *"African Journal of Educational and Social Sciences*. Vol. 2, No. 1.

White, C. J. (2005). *Research: A Practical Guide*. Pretoria: Ithuthuko Investments Publishers.

Wimmer, R. D. and Dominic, J.R. (1987). *Mass Media Research; An Introduction.* 2nd Ed. Delhi: Sage Publication.

World Health Organisation. (2002). Primary *Health Care. Health for all series* 1. Geneva: WHO.

World Health Organisation. (2001). *Community Home Based Care in Resource- Limited Settings. A framework for Action*. Geneva: WHO.

World Health Organisation. (2000). *Fact Sheets in HIV/ AIDS for nurses and midwives.* Geneva: WHO.

Zulu, N. (2015). *An Analysis of the Implementation Process of the Community- based Therapeutic Care Programme in Lusaka District*. Lusaka: UNZA Press.

APPENDICES

APPENDIX 1: INTERVIEW GUIDE FOR FOCUS GROUP DISCUSSION

Introduction

Dear respondent,

I am Mwaba Kaunda a student at the University of Zambia pursuing a Master of Education in Adult Education. I am conducting a research to find out the constraints and their possible solutions to the Home Based Care programme by the Catholic Church in Kabwe District. You all have been sampled to participate in this focus group discussion. Be as free and truthful as you respond to the questions possible solutions to the Home Based Care programme by the Catholic Church in Kabwe District. You all have been sampled to participate in this focus group discussion. Be as free and truthful as you respond to the questions.

1. How long have you been participating in home based care programme?
2. Are you're a caregiver in this Home Based Care Centre?
3. What do you know about Home Based Organisations?
4. What are the benefits of Home Based Care centres if any?
5. What constraints have you encountered if any in the implementation of Home Based Care Programmes?
6. Are there any measures that have been put in place to overcome the constraints you have mentioned?
7. In your opinion, what do you think are the solutions to the constraints encountered?

Thank you

Name: Kaunda Mwaba (0977 883865)

Address: University of Zambia

Department of Adult and Extension Studies

Box 32370

Lusaka

APPENDIX 2: SEMI STRUCTURED INTERVIEW GUIDE FOR COORDINATORS

Introduction

Dear respondent,

I am Mwaba Kaunda a student at the University of Zambia pursuing a Master of Education in Adult Education. I am conducting a research to find out the constraints and their possible solutions to the Home Based Care programme by the Catholic Church in Kabwe District.

I wish to assure you that the information you provide will be used for academic work.

You have been purposefully selected to take part in this study. Be as free and truthful as you respond to the question.

Date of interview: _____ Sex: _____

1. How long have you been participating in home based care programme?
2. Does the Home Based Care programme benefit the community?
3. In your view, what are the benefits of the Home Based Care programme to the community?
4. Explain why you think the Home Based Care programmes has no benefit.(For those who saw no benefits)
5. Are there any constraints you have encountered in the implementation of the Home Based Care centres?
6. What constraints have you encountered. (For those who agreed).
7. What measures have been put in place to overcome the overcome the constraints?
8. In your opinion, what do you think are the solutions to the constraints encountered?

APPENDIX 3: INTERVIEW GUIDE FOR THE DIRECTOR

Introduction

Dear respondent,

I am Mwaba Kaunda a student at the University of Zambia pursuing a Master of Education in Adult Education. I am conducting a research to find out the constraints and their possible solutions to the Home Based Care programme by the Catholic Church in Kabwe District.

I wish to assure you that the information provided will be used for academic work.

1. How long have you been participating in home based care programme?

2. How does home based care benefit the community?

3. Are there any constraints you have encountered in the running of home based care?

4. Are there any measures that have been put place to overcome the constraints?

5. In your own opinion, what do you think are the solutions to the constraints encountered?

End

Thank you.

Name: Kaunda Mwaba (0977 883865)

APPENDIX 4: RESEARCH BUDGET LINE

Running costs	**ZMW**
Printing documents k1.00 x 90 pages per copy	K720.00
Internet browsing	K400.00
Traveling costs: Kabwe to Lusaka	K1000.00
Reams of paper 5x 29	K145.00
Editing and proof reading	K2000.00
Binding 6 copies at k300 10% contingent fund	K1800.00 K1000.00
Grand Total	**K8065.00**

APPENIDIX 5: RESEARCH TIME SCHEDULE 2015

ACTIVITY	APRIL	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Identification of area of the problem									
Formulation of the research topic									
Literature review									
Development of research instrument									
Data collection									

RESEARCH TIME SCHEDULE 2016

	JAN	FEB	MAR	APRIL	MAY	JUN	JUL	AUG	SEP	OCT
Data collection										
Data analysis										
Report preparation										
Report production										

APPENDIX 6: INFORMED CONSENT FORM

THE UNIVERSITY OF ZAMBIA

SCHOOL OF EDUCATION

DEPARTMENT OF ADULT EDUCATION AND EXTENSION STUDIES

INTRODUCTION

My name is Mwaba Kaunda I am a University of Zambia Student who is currently pursuing the Degree of Master of Education in Adult Education. I am conducting a research study on constraints and possible solutions of implementing home based care programme by the Catholic Church in Kabwe District.

You have been purposively selected for this study for this study. I am kindly requesting you to participate freely and honestly. The information that will obtained from interview guide and focus group discussion will be used for academic purposes.

INFORMED CONSENT

My participant in this study is voluntary. However, I am not assured at the end of my participation. All traces of information gathered from me during this study will be destroyed after the study. I am also assured of anonymity and confidentiality. Should feel uncomfortable with participating in this study, I am free to withdraw.

Declaration

I have read and understood the content above. Therefore, I agree/not agree to participate in the study.

Signature: …….. Date: ……..

APPENDIX 7: PERMISSION LETTER FROM DRGS

THE UNIVERSITY OF ZAMBIA
SCHOOL OF EDUCATION

Telephone: 291381
Telegram: UNZA, LUSAKA
Telex: UNZALU ZA 44370

PO Box 32379
Lusaka, Zambia
Fax: +260-1-292702

Date 3/05/16

TO WHOM IT MAY CONCERN

Dear Sir/Madam

RE: FIELD WORK FOR MASTERS/ PhD STUDENTS

The bearer of this letter Mr./Ms. KAUNDA MWABA Computer number 513801961 is a duly registered student at the University of Zambia, School of Education.

He/She is taking a Masters/PhD programme in Education. The programme has a fieldwork component which he/she has to complete.

We shall greatly appreciate if the necessary assistance is rendered to him/her/.

Yours faithfully

THE UNIVERSITY OF ZAMBIA
ASSISTANT DEAN (PG)
03 MAY 2016
SCHOOL OF EDUCATION
P.O. BOX 32379, LUSAKA

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