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**“AN EXPLORATION OF THE EFFECTIVENESS OF COMMUNITY HOME-BASED
CARE PROGRAMMES IN MITIGATING THE EFFECTS OF HIV AND AIDS IN RURAL
AREAS IN ZIMBABWE. THE CASE OF SHURUGWI DISTRICT”**

By

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A dissertation submitted in fulfilment of the requirement for the degree of

Master of Social Work/ Department of Social Work /Social Development

Faculty of Social Sciences and Humanities

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Date: October 2014

DECLARATION

I Vongai Patience Mangwiro declare that this research project entitled “**An exploration of the effectiveness of Community Home-based Care programmes in mitigating the effects of HIV and AIDS in Shurugwi District in Zimbabwe**”. It has not been submitted anywhere before for any degree purposes or examination in any other university.



Signature ----- Date-----

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Vongai P. Mangwiro

DEDICATION

This dissertation is dedicated to my late mother Elmeda Maodza.



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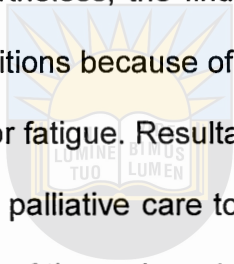
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ABSTRACT

The aim of the dissertation was to explore the effectiveness of Community Home-based Care programmes in mitigating the effects of HIV and AIDs in rural areas in Zimbabwe in Shurugwi. Triangulation method was used to collect and analyze data from one hundred and sixty four respondents using survey questionnaires and in-depth-interviews. Theoretically, the study was underpinned by the Basic Needs Approach which supports that every human being needs food, shelter and health in order for one to have a meaningful life. The findings of the study showed that CHBC programmes are effective in improving the conditions of the patients and also in mitigating the effects of HIV and AIDS in societies. Nevertheless, the findings show that patients still suffer in the long-run to improve their conditions because of lack of resources and food, shortage of funds and CHBC kits, and donor fatigue. Resultantly, this gives a double burden to all the caregivers when they provide palliative care to patients. Conclusively, more should be done to improve the conditions of the patients because they still face problems in the fight against HIV and AIDS.



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ANCRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti Retro-viral Treatment
ARV	Anti Retro- Viral
BNA	Basic Needs Approach
CHBO	Community Home-Based Organization
CHBC	Community Home-Based Care
FBO	Faith Based Organization
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
IGA	Income Generating Activity
IMF	International Monetary Fund
MDG	Millennium Development Goal
MASO	Midlands Aids Services Organization
MOCHW	Ministry of Child Health and Welfare
NGO	Non –Governmental Organization
OVC	Orphans Vulnerable Children

PLWHA	People Living With HIV/AIDS
UNAIDS	Joint United Nations Programme
UNDP	United Nations Development Programme
UNICEF	United Nations International Children
	Emergency Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WFP	World Food Programme
ZHDR	Zimbabwe Human Development Report



CHAPTER ONE

GENERAL INTRODUCTION OF THE STUDY

1.1 Introduction

This chapter presents the overview of the study. It provides the background of the study, explains the statement of the problem, significance of the study, the aim, objectives and the research questions of the research study. Definitions of concepts are provided so as to enhance a proper understanding of CHBC related programmes and concepts as used in the context of the study. The chapter outline of the research study is also presented here.

1.2 Background of the study

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have become the most serious problem in the public health internationally. Statistically, according to UNAIDS (2012: 8) at hand are 34.2 million people living with HIV and AIDS in the world and Southern Africa remains the greatest affected sub-continent which has the highest HIV prevalence rates in the world. Evidence holds that about 15 percent of the people are living with HIV and AIDS in Zimbabwe (UNAIDS, 2012). The devastating impacts of HIV and AIDS in the world have affected the people to a great extent which steered the formation of Community home-based care programmes (CHBC). This was as a result of lack of funds and resources that have led to a failure in containing and supplying the special needs of millions of patients, resulting in the adoption of CHBC. CHBC programmes have become a mitigating tool in extenuating the effects of HIV and AIDS, reducing patients suffering and pain so that they can have a better social functioning. However according to Marhal et al (2004:5) the

rationale behind the current expansion of CHBC programmes in low and middle income countries partly reflects a pragmatic response to the lack of human resources that are required to provide HIV care for diagnosed persons and that currently poses a major barrier to the successful roll-out of ART programmes. Regardless of developments in the availability of antiretroviral therapy, a lot of problems continue in the delivery of palliative care for people living with HIV and AIDS (Peter Piot, Thomas and Quinn, 2013). Such challenges include donor fatigue, lack of resources, lack of funds, shortage of food, lack of public support and inadequate government support, to mention a few. These challenges therefore obstruct the programme to fully undertake their desired goal even if the programmes have been implemented to help people. CHBC programmes can however be successful if people are sophisticated all the time on HIV and AIDS, in order to progress the patient's well-being by tackling the above mentioned challenges which pose as a barrier to more effective programmes.

Moreover CHBC programmes are guided by objectives which include the following: to provide holistic care for physical, emotional, spiritual and socio-cultural needs of the patient and the family through care teams, to organize sufficient resources for home-based care together with community leaders and stakeholders and to guarantee that care players provide for the needs and rights of diseased and affected children, to mention a few (National CHBC Standard for Zimbabwe, 2004:7). These objectives will help measure how effective the programmes are in improving the conditions of the patients by linking what has been done with the objectives of the programmes. Moreover, these objectives pave a way on how to run CHBC programmes effectively and it is the duty of each government and NGOs to take responsibility in helping the

people to overcome this deadly disease. McElrath (2002:2) stresses that CHBC programmes have been established in most high prevalence communities as part of the community-based responses to the HIV epidemic particularly in the face of limited health care resources. Therefore the research, seeks to identify and explore the effectiveness of Community Home-Based Care programmes in improving the beneficiaries health and possibly make recommendations which can convey ways and policies that can improve the patients and the running of programmes to work effectively. It is also the scope to give the statement of the problem, the purpose of the study, give the outline of the study, and define the concepts of the study and present also the objectives and significance of the study.

1.3 Statement of the problem

HIV and AIDS pandemic has caused mammoth woe in the world as every continent has been heavily hit by the pandemic. It has caused a lot deaths, pain, suffering and food insecurity in many places. The epidemic has become one of the topical areas internationally that has overwhelmed the people and Zimbabwe is one of the countries that cannot be excluded although findings show that it was the leading country in Southern Africa to have decreased HIV and AIDS dominance. CHBC programmes have played an enormous role in combating the effects of HIV and AIDS but still patients, caregivers and the programme lack the basic needs and the resources that are needed for them to improve well. As a result, CHBC programmes are not capable to set up and effectively supply services to their clients due to inadequate resources, such as overhead funds, CHBC kits and informative material (Mohammad and Gikonyo, 2005). Despite the support and efforts of the government, NGOs and donors the beneficiaries

of CHBC programmes continue to struggle to improve well thereby thwarting the effectiveness of the programmes. Even though significant commitment has so far been established to convey inclusive CHBC programmes, their success is habitually mired by fragile connections with other HIV services. Top-down benefactor strategies and absence of feasible and reliable finance strategies symbolize a challenging menace to these programmes in the extended duration (Wringe, Cataldo, Stevenson and Fakoya, 2009:22). This may result in patients' ill health deterioration and some patients could die. Subsequently, this overwhelms the government and other philanthropic organizations as they try to ameliorate the conditions of HIV and AIDS patients in Zimbabwe as there will be insufficient resources and services because assessment of patients environment and needs are not done.

Mohammad and Gikonyo (2005) contend that CHBC area is facing a number of challenges and restrictions which not merely undesirably disturb their capacity to do their events, nevertheless also ensure the possibility to aggravate insufficiency and present masculinity disparities in the midst of pretentious families and societies. Despite, CHBC programmes being implemented the effects of HIV and AIDS over the years in Zimbabwe have not reduced the death rates. This could be attributed to the weakness inherent in the strategies used in CHBC programmes. In light of all this, this study, therefore, seeks to explore the effectiveness of CHBC programmes in mitigating the effects of HIV and AIDS and in improving the conditions of CHBC beneficiaries and to make constructive recommendations that would optimistically alleviate impacts of HIV and AIDS.

1.4 Research aim and objectives of the Study

The main aim of this study is to identify and explore the effectiveness of CHBC programmes in mitigating the effects of HIV and AIDS in rural areas in Zimbabwe and see how they have achieved to improve patients conditions and modify the effects of the pandemic. Measuring the effectiveness of CHBC programmes helps to explore the gaps, challenges and problems that HIV and AIDS patients', relatives and family members faces in many societies while they try to improve the conditions of the patients. The study is guided by the following subsidiary goals:

- To identify the needs of HIV and AIDS patients, family members and the caregivers under CHBC programmes.
- To explore the services that Community Home-Based Care programmes offer to patients in rural areas.
- To investigate the challenges faced by HIV and AIDS clients, family members and caregivers.
- To examine the perceptions of clients, family members and caregivers on the effectiveness of CHBC programmes.

1.5 Research questions

The following research questions are postulated to guide the study:

- What are the needs of HIV and AIDS patients, family members and caregivers in improving their health?
- What are the services that Community Home-Based Care programmes offer to HIV and AIDS clients in rural areas?

- What are the challenges faced by HIV and AIDS clients, family members and caregivers in Shurugwi?
- What are the perceptions of HIV and AIDS patients, family members and caregivers on the effectiveness of CHBC programmes?

1.6 Significance of the study

This study will recognise the challenges and needs of the patients and the caregivers so that the government and its partners will continue to provide training for caregivers and provide enough resources for clients. The results of this project will aid the government and other organizations in reformulating policies which will reduce death rates, improve the conditions of ART clients, and those with other chronic illnesses and caregivers' needs. In addition, exploring the effectiveness of CHBC programmes will expose the challenges that CHBC faces in the administration of the programmes so that the government, donors, NGOs and the community will support them with necessary resources. This study will also help widen the scope of the literature in exploring the effectiveness of CHBC.

1.7 Scope of the study

The research examines the most mitigating tool CHBC programmes in extenuating the effects of HIV and AIDs in rural areas in improving the conditions of HIV and AIDs patients and other debilitating sicknesses. The study focuses on the beneficiaries of CHBC, family members of the patients, caregivers who provide care and visits to patients and lastly the NGOs/ government professionals who work with HIV and AIDs patients. The case study of Shurugwi rural in Zimbabwe was used.

1.8 Definition of concepts

The following terms are defined as used in the study: CHBC, caregiver and effectiveness.

1.8.1 Community Home-based care (CHBC)

The Malawi Community Home Based Care policy and Guidelines (2005:3) define Community Home-Based Care as the care provided to chronically or terminally ill patients such as those with HIV and AIDS, TB and cancer; clients affected by the illness of their relatives and friends; vulnerable and at risk groups in their homes supported by family and community members using available resources and support from the formal health worker. It is also the care provided to the terminally or chronically ill patients in their homes or their familiar communities and care is primarily provided in the home by family members and communal helpers through provision from social and health care specialists. Such care includes physical, psychosocial, palliative, spiritual care, and other services such as medical specialist care and supervision of infections, counselling, food and nutritional supplementation (World Health Organisation, 1993).

Many definitions for CHBC are given by many authors but the last definition is more relevant to this research study because it gives a broad notion of what CHBC is and further clarifies that CHBC is the most important mitigating tool in the battle against HIV and AIDS by providing care to HIV and AIDS patients in conducive home environment by their loved ones. The last definition conveys a better understanding of the services patients receive from the programme and the people who provide the care like caregivers, social workers and psychologist.

1.8.2 Caregiver

Akintola, (2004) defines a caregiver as a person who provides care to people living with HIV and AIDS and these are usually domestic members who help as 'primary caregivers and through communal members who are employed and educated to deliver services as volunteer caregivers. A caregiver is also a community member identified by the community and trained in Community Home Based Care to render direct patient care to chronically/terminally ill persons and other vulnerable persons in their homes (Malawi Community Home Based Care policy and Guidelines, 2005:6).

Building from the definition given above the Malawi CHBC policy Guidelines definition provides a better understanding that people are from the community, trained and that caregivers are primary caregivers; (these are friends, family or relatives of the patients and secondary caregivers; (volunteers from around societies) because these are the people who live in the same villages or areas with the patients and some are related to them and it is easy to build a relationship with someone whom you see all the time so that they can have a sense of belonging.

1.8.3 Effectiveness

The concept effectiveness according to (Elton, 2009) means producing a definite or anticipated result after employing something and it is measured against set goals of NGOs that include empowerment of the poor, advocating for the poor, response to disaster and bringing societal change. "It is also defined as the extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance" (Svobodo, 2003:2). Elton's definition is

more relevant to this study because it gives an insight that if any organisation wants to achieve something there is need to measure its goals, objectives with what has been done in order to see the grey areas that need further attention in order to improve the programme. Therefore the effectiveness of the CHBC programmes can be measured against the extent to which the intended goals specified in the operation are accomplished; this also helps in attracting more donors and other organisations and more resources will be available.

1.9 Chapter Outline

This section of the dissertation is a presentation of the layout of the chapters.

Chapter One: General Introduction of the study

This chapter focuses on the introduction of the research study emphasising the background of the research topic, the problem statement and the research questions; the aim and objectives of the study were clearly explained. The significance and definition of concepts of the study were clarified as well in this chapter.

Chapter Two: Literature review

This chapter review related literature on the effectiveness of Community Home Based Care programmes, theoretical frameworks and amplification on the gaps which the research proposes to fill.

Chapter Three: Research Methodology

The research methodology is highlighted in detail in this chapter. This chapter elucidates and justifies the design, sampling, sampling strategy, population and the data collection methods used in the research.

Chapter Four: Presentations and discussion of findings

This chapter focuses on the data analysis, presentation and discussion of the findings.

Chapter Five: Summary, conclusions and recommendations

This chapter provides conclusions drawn from the findings, makes recommendations. The chapter also discusses the implications of the findings to social work practice and provides suggestions for further studies.

1.10 Conclusion

CHBC programmes have become a vital mitigating tool in extenuating the effects of HIV and AIDS in many African societies hence it is very important to research on this topic because CHBC programmes have increased in many societies but HIV and AIDs patients and their family members still face a lot of challenges and problems. People all over the world are still being infected and affected by the pandemic every day. This is very questionable why the beneficiaries still struggle whereas there many CHBC programmes and donors are supporting the programme. However effectiveness of CHBC programmes cannot be delivered without accurate monetary provision for transference, expenditures and logistics therefore these also poses as a challenge in trying to improve the running of the programme. That is why this study seeks to explore the services provided to HIV and AIDS patients in communities especially in rural areas so that CHBC programmes may provide better service to the beneficiaries while solving

the above mentioned challenges. The following chapter provides a deeper meaning on the key words of the research explains the theoretical framework and gives a broad view on the study given by other scholars.



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CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter emphasizes on collected evaluations related to the area under study. According to the Liberty University (2011:2), "literature review is a critical analysis of a portion of the published body of knowledge available through the use of summary, classification, and comparison of previous research studies, reviews of literature, and journal articles". Most researchers review literature because it helps them to bring out the definite problem. The chapter defines the concept of community home-based care programmes in implementing comparable CHBC projects on a broader scope of Africa and locally in Zimbabwe. CHBC programmes have spread all over the world including the Africa continent which is the most affected with the pandemic.

In this chapter literature by other scholars is used to explore the gaps in CHBC programmes and make recommendations. The literature reviewed helps the researcher define the problem to evade oversimplification and presents new methods of solving the problem. This is why the researcher seeks to explore how effective CHBC programmes are in mitigating the effects of HIV and AIDS patients in Zimbabwe in Shurugwi rural. This chapter also presents a framework which explains the reasons and rationale of CHBC programmes in diverse societal backgrounds.

2. 2 Theoretical Framework

A theory is a set of interconnected ideas, demarcations, and suggestions that elucidates or predicts events or situations by stipulating relations among variables. The research study will be guided by the Basic needs approach.

2.2.1 The Basic needs approach (BNA)

The basic needs approach originated in the 1940s from an article by Albert Maslow in the Psychology Review of March 1943 (Emmerij, 2010). Maslow's hierarchy of needs is a philosophy of inspiration and behaviour developed by the psychologist Abraham H Maslow (1908-1970). Maslow's hierarchy elucidates the behaviour of humans in relation to basic provisions for subsistence and development. These supplies, or essentials, are organised conferring to their prominence for existence and their influence to encourage the individual.



The utmost important psychological necessities, such as food, water, or oxygen, establish the lowermost level of the need pyramid. The psychological needs should be fulfilled earlier than the other higher needs become important to individuals. Needs at the upper levels of the hierarchy are more focused on, just before the mental being and further to emotional security and development. According to Maslow (1943:3) these needs have less power to motivate persons, and they are more influenced by formal education and life experiences. The subsequent hierarchy of needs is habitually represented as a pyramid, by means of mental being prerequisites set at the base of the pyramid and desires for self-actualization positioned at the uppermost.

2.2.2 The hierarchy

- **Physiological needs:** They are the basic necessities every human being needs for survival and these include food, water, shelter, oxygen and sleep. If these basic needs are not met then human beings will put an effort to nourishing them and will pay no attention to the higher level of the hierarchy.
- **Safety needs:** As soon as the person's basic bodily needs are met the need for safety arises and these consist of the need for a sense of safety and certainty in the world. Safety becomes the second priority after an individual satisfies his or her physiological needs. Malsow believed that insufficient satisfaction of these needs might explain the possessed behavior and other sensitive problems in some people.
- **Love and belonging needs:** While the individual's biological and safety needs are met the need for love and belongingness emerge. The needs include the desire for an intimate relationship with another person as well as the need to fit to a certain group and to feel recognized. Maslow highlighted that these needs encompass both giving and receiving love.
- **Esteem needs:** These needs contain both self-esteem and reverence for other. Self-confidence is the sense that one is treasured, educated and self-determining. The esteem of others involves people respecting and raising the value of that person. Once the person has satisfied his or her basic needs, concerns about worthiness emerge. The motivation behind the esteem needs

is that the individual conforms to the society's standards and has a meaningful life.

- **Self-actualization needs:** These needs are related to apprehending the full potential one has. So when the needs arise the individual tries to accomplish what he or she is supposed to do in life, evolving his or her talents or skills to the full extent.

2.2.3 The development of BNA linked to Human development

The approach later propagated out of the work of ILO of the World Employment Programme in the 1970s. The International Labour Organization (ILO) supplemented and expanded the former notion of occupation and strategies to deal with it by linking straight to the conditions and the needs of the unindustrialized countries (World Economic and Social Survey, 2010). The idea then rose of planning a development strategy that had its key objective meeting the basic needs, including the poorest 20% of the population which includes also HIV, and AIDS and other debilitating sickness. The ILO's assisted in laying the groundwork for the basic needs approach in human development. According to the UN Intellectual History Project (2009) the ILO World Employment Conference in 1976 deliberated the basic needs strategy and decided on various follow-up activities for both individual countries and the international community. Emmerij (2010) content that as a dynamic strategy for development, the basic needs approach highlighted safeguarding that the underprivileged groups of every country have a duty to accomplish a minimum standard of living within a defined time horizon. Moreover the strategy suggested that every country provide care to two features of

basic needs: one safeguarding the delivery of certain minimum necessities of a family for private consumption (sufficient food, shelter and clothing) the other making sure that necessary services were provided by the community at large (safe drinking water, sanitation, public transport, health and education). Furthermore participation and human rights were encompassed in the description of basic needs. Meeting the basic needs was presented as universal, pertinent to all the countries, an uncommon and new story for the time and one recurrent in the human development approach. In recent times, though, the Millennium Development Goals agenda recovered the idea of the basic needs by recognizing the objectives and creating indicators to follow up on the contentment of the needs in the area of health, education and employment. Even though the theory, has been debated by other authors regarding Maslow's postulation that the lower needs should be fulfilled before a person can attain their potential and self-actualize. It however brings an insight that basic needs are very crucial for one to survive well and have a better social functioning especially when it comes to HIV and AIDS patients.

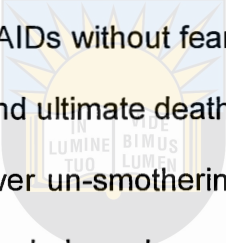
2.2.4 Application of the Basic Needs Approach to the study

The approach is relevant to this study because it encourages the family and relatives of HIV and AIDS patients to help meet the basic needs of patients under CHBC programmes in order to improve their conditions well. Furthermore the basic needs approach gives an insight that the community at large should work hand in hand with other organizations to provide palliative care to their patients in mandate to extenuate the impacts of HIV and AIDs. The basic needs approach is relevant to this study also because it supports and provides a better platform of CHBC needs for HIV and AIDS

patients and these are explained below according to the National Guideline of CHBC policies of 2002.

2.2.4.1 Psychological Needs

Psychological needs are very important as care is provided to patients. According to the National Home-Based Care Programme and Service Guidelines, 2002 the family of people living with HIV and AIDS needs a lot of provision, reassurance and approval from the community members. As a result that they may be stirred and inspired to care for their relatives living with HIV and AIDS without fear of being isolated. They should be sufficiently ready for the worsening and ultimate death of their loved ones. More so they should be conscious on how to deliver un-smothering love and support. They should also get supervision on how to deliver help and see others who are facing the same in assisting PLWHAs.



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This offers the household membership a common sense of courage and a determination to continue. Building from the above scholar, psychological needs are vital to the patients and the family members of the patients in order for them to improve very well hence the BNA gives the insight that basic needs are needed in the daily lives of the patients and without these needs life becomes hard and challenging for the patients and their families. Nevertheless the physical needs of the family members are less than those that are needed by HIV and AIDS patients. The family members need to be educated on STD/HIV and AIDS and demonstrations on how to care for patients as anticipated. Since the burden of looking after someone who is very ill or dying is continuous and heavy therefore the family may need help with household, farm or other

chores. Some of the psychological needs of HIV and AIDs patients which are needed to help them to cope include love, encouragement, warmth, appreciation and reassurance. Furthermore counselling and psychological needs can also be met by religious groups, volunteers, and other associated support groups; these can inspire faith so that PLWHA can carry on with their activities as long as promising. They can also preserve confidentiality and unconditional recognition and love and offer supportive counselling to live positively. This notion supports the basic needs in a way that every individual needs the support of others and self in order to reach the stage of self-actualization like Maslow explains in order to have a better life.

2.2.4.2 Needs of PLWHAs

HIV and AIDs patients have their needs which must be met in order to enhance the quality and length of their lives. These needs include physical, spiritual, social and psychological needs in terms of drugs for treatment, clinical care which includes medicines and consistent checks-ups. Moreover other basic needs of patients required are clothing housing, food, fuel, water, education and income. HIV and AIDs also need nursing care which includes care to toilet needs, observation of vital signs, care of wounds, persona and security. Nourishing needs includes delivery of a reasonable and locally balanced diet, physical therapy, exercise and massage. Facts, education, and communication (IEC), include up-to-date, precise material on HIV and AIDS and safer sexual behaviour.

2.2.4.3 Spiritual /Pastoral Needs

As human beings sometimes we tend to lose hope in life especially when we are sick and we can only get that hope back through spiritual needs that we get from friends,

relatives, pastors and from other church members. According to the National Guideline of CHBC policies (2002) reinforcement of present trust and assisting HIV and AIDS people in spiritual development increases the spiritual facet of life. This plays a major role in inspiring HIV and AID patients to have a positive understanding of life and to forgive others and self for any fallacies and blames. Therefore PLWHIV will be able to admit forgiveness by others, also forgive others, have comfort that God accepts and loves them. They will also be able accept support from religious groups and have freedom to allow religious groups to offer support, have free will of worship according to faith.



2.2.4.4 Needs of Orphans

The BNA supports that even orphans' needs approval from people around them and this will help them to have a sense of belonging. The basic needs are also important in the lives of orphans and these include food, shelter, clothing, education love and legal interventions in case of property inheritance and safeguard from abuse.

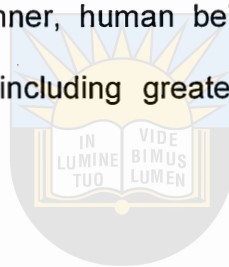
2.2.4.5 Social needs

PLWHAs have a number of social needs so that they can enjoy their lives without being discriminated by other people in the community. These needs include taking part in clubs or social groups, should be respected by other, and should delight in political rallies, church and spiritual gatherings. Moreover they should also have a chance to partake in income-generating activities, have a right to own, inherit, and bequeath property and confidentiality concerning their conditions. In a sharp contrast Maslow's hierarchy of needs and the needs for CHBC emphasises how important basic needs are

for human survival especially for those who are sick like HIV and AIDS patients. Hence HIV and AIDS patients and other debilitating sickness of patients under CHBC require much support and care. The basic needs should therefore provide a better environment for the patients to realize that they are worth to the people surrounding them and this will motivate and encourage them to take action and participate in matters concerning themselves. Moreover the transcendence needs is one of Maslow's ideals that go further than the need for self-actualisation. The transcendence incorporates a complex determination and apprehension for the moral of the community relatively than personal well-being of needs. Hence every community member needs to take part in supporting, caring and in the fight against this disease with the overall support from NGOs/ government so that patients may fulfill their dreams in life.

The basic needs approach is applicable to many settings which include also health and social welfare settings, providing a set of hypothetical guidelines for accepting the concerns of people suffering from physical illness, disabilities, or other life problems which include HIV and AIDS patients and other debilitating sicknesses. In addition to the above settings, the model is commonly functional in educational and career counseling, in which it is used to help clients' select suitable goals for their lives. Hence the BNA encourages and motivates all the people including the HIV and AIDS patients to attain self- actualisation with the help of the family, relatives and other organisations. CHBC organisations should take note of the needs written the National CHBC Programme and Service Guideline in order to improve the patients' health well. Maslow's theory, through its affirmative prominence, remains significant, mainly in everyday settings such as counseling, industrial management, and health care. Therefore the BNA further

explains that for CHBC programme to be successful there is need for assessment of the beneficiaries' environment and evaluations of the programme to measure if the programmes are helping to reduce the effects of HIV and AIDS and improve the patients' conditions well. Hence this approach emphatically suggests that the government/NGOS and the community should take the responsibility of providing sustainable basic needs, support and care in order for CHBC programmes to be more effective in extenuating the effects of HIV and AIDS. When basic psychological needs are satisfied in a constructive manner, human beings are expected to experience optimal developmental outcomes, including greater potential for caring, pro-social behavior.



2.3 Reviewed literature

The literature review covers : the objectives of CHBC; history and welfare of CHBC in Zimbabwe; the operations and services offered by CHBC in Zimbabwe; HIV and AIDS prevalence in Zimbabwe; the challenges faced by caregivers, HIV and AIDS patients and their families; the needs of caregivers, HIV and AIDS patients and their families; and the effectiveness of CHBC programmes.

2.3.1 Community Home-Based Care

Many definitions are given by different authors explaining what CHBC is. According to the Gaborne Declaration on CHBC (2001) CHBC is the care provided to HIV and AIDS patients in their own environment by their family members and supported by trained caregivers, skilled welfare officers and communities to meet their physical and health needs, spiritual, material and psychological needs. It is defined also as the care given

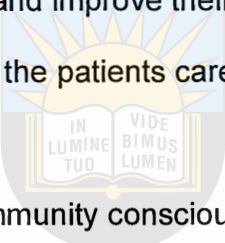
to ill people in their homes. Such care includes physical, psychosocial, palliative and spiritual activities (UNAIDS, 2002). Wide-ranging CHBC continues to be well-defined as every method of care provided to sick people in their homes, but frequently recognizes the starring role of a 'service provider', who is a community member skilled in basic nursing, teaching and counseling skills (Littrell *et al.* 2007). The researcher also defines it as care and support given to all the sick people in societies so that they can have a meaningful life. Emphatically CHBC programmes focus on providing care to all the patients in communities using the strength of families and relatives with the support also from skilled organizations which is of greater importance. Constructing on these scholars, it can be seen that palliative care is the backbone of CHBC programmes in extenuating the impacts of HIV and AIDS and in improving the conditions of the patients.



2.4 The objectives of CHBC programmes

The broad objective of CHBC programmes is to develop and implement a comprehensive CHBC activity that meets physical, psychological and spiritual needs of HIV and AIDS patients and their families (Ministry of Health Botswana, 1996). This means that CHBC programmes seek to restore the social functioning of patients in many societies by helping them to accept their situations and continue with their lives with hope that they may live positively or die with dignity. Palliative care to PLWHA and their family's needs are a wide range of services that embrace not merely clinical care directing on diagnosis and treatment, but also understanding and harmonizing services that address nourishing, psychosocial, and daily living needs and reinforce prevention wherever opportunities arise (National Home-Based Care Programme and Service

Guidelines, 2002). This broad approach to HIV care is redirected in the existing strategic plans of almost every National AIDS Programme and is actually supported by community and non-governmental health programmes and institutions. Each service in this comprehensive approach strengthens and is connected to the other amenities. For example, adherence to prescriptions increases if patients are capable to handle their HIV status, do not feel stigmatised, and feel supported. The specific objectives of CHBC are explained below as to what the programmes seek to achieve in extenuating the effects of HIV and AIDS patients and improve their conditions:

- 
- To enable the permanence of the patients care from health facility to home and community
 - To encourage family and community consciousness of HIV and AIDs prevention and care
 - To empower the PLWHA, the family, and the community with the understanding wanted to safeguard long-term care and maintenance.
 - To increase the acceptability of PLWHAs by the family/community, in future decreasing the stigma linked with AIDS.
 - To rationalize the patient/client transfer from the institutions into the community and from the community to suitable health and social services.
 - To aid quality community care for the diseased and affected.
 - To organize the resources required for sustainability of the service

The objectives above clearly explain the role of the society, NGOs and government in the fight against HIV and AIDS so as to reduce the spread of the pandemic and improve the conditions of the patients. However evidence on the ground shows that HIV and

AIDS patients struggle each day in many societies in order to improve because of lack of resources that are needed and the services provided are not sustainable enough to meet the demands of the growing numbers of people infected every day. According to Mr Bartos "He conversely asked why people carry on to die from AIDS related disease. Is the clinic too far? Is the patient tired to continue on treatment? Are ARVs scarce? Is discrimination making people shy to access treatment"? This got many people thinking as Mr Bartos surely observed the pertinent issues surrounding HIV (Herald Business, 2014:8). Some of the pertinent issues surrounding HIV and AIDs may include the lack of basic needs like food, clothing, which are not provided by the programme itself and lack of good health facilities especially in rural areas and lack of resources and shortage of funds which may hinder the successfulness of CHBC programmes. Hence this research study seeks to explore the effectiveness of CHBC programmes in Shurugwi rural so as to see how the programmes have achieved and not achieved in mitigating the effects of HIV and AIDS and in improving the conditions of HIV and AIDs.

2.5 History and welfare of CHBC in Zimbabwe

CHBC programmes were established soon after independence from British rule in 1980 and its main focus at that time was on people that were psychologically challenged or critically ill with diseases such as TB, cancer and hypertension. Zimbabwe in those early years experienced most hasty developments in health, nutrition and population (HNP). Hospitals were not jammed, and consequently could keep in-patients for longer periods of time and medication was available that time for all illnesses including common contagious diseases. By that time the critically ill patients were discharged from hospital and clinics to be cared for in their homes. The pertinent health institutions

would consign a community nurse to monitor and guide on basic tending care and offer psychosocial support. Moreover during that period, many families were capable to provide also for a relative who was discharged for home care. According to the International Federation of Red Cross and Red Crescent Societies (2004) the first HIV infection reported was branded by fear and discrimination in Zimbabwe in 1985. In the same year the Minister of Health and Child Welfare (MOHCW) established the National AIDs Coordination Programme (NACP) to manage the national response to the epidemic. The period was branded by a denationalisation and moralisation of the disease that caused high levels of stigma and discrimination in society. Regardless of this climate, Auxilla Chimusoro was the first person to freely publicise her HIV status in Zimbabwe in 1989. She later developed the first support groups in Masvingo before she died in 1998. She also started more than 50 support groups in both rural and urban areas throughout Zimbabwe.

Optimistically, these support groups delivered the first units to be involved in CHBC. According to the National Policy on HIV and AIDS for Zimbabwe (1999) when HIV first began in Zimbabwe, the government was gentle to accept the extent of the problem and take appropriate action. The government in 1999 confirmed a six-month long nation alternative in respect to the HIV epidemic and reorganized the activities for NACP and AIDs and TB unit and developed and launched a National AIDS Policy (NAP). The role for NAC was to manage all the national HIV and AIDs related activities and other interventions, as well as the monitoring and evaluations. The government presented the National AIDs Trust Fund to enable the work of NAC to gather the AIDs levy 3% tax on all taxable earnings. Moreover the levy was to fund HIV prevention efforts and care

services through centralized structures. The National AIDs Policy acknowledged that CHBC as an supplementary of the health system was to be fully established and reinforced as a necessary constituent of the continuum care for HIV and AIDs patients and their families. According to the Zimbabwe Red Cross Society (ZRSC) (2004) CHBC programmes in Zimbabwe were later started as the Integrated AIDs Project (IAP). The IAP began in 1988 with an emphasis on prevention. As the number of infected people increased the ZRSC started a CHBC programme in 1992. The focus for the IAP during that period was in three ways: the prevention of transmission of STIs and HIV and AIDs, care and support for PLWHIV and their goal was to decrease the occurrence of HIV and AIDS and its consequences among vulnerable groups in Zimbabwe through information broadcasting, admission to care and provision. There are 22 CHBC projects in the eight provinces in Zimbabwe. The volunteers from various communities are trained as care facilitators by the Zimbabwe Red Cross Society and the volunteers provide care to PWLHIV in a number of ways.

This includes providing hygiene education for infections supervision and dissemination of key health and nutrition information. They also help to moderate the stigma and discrimination related to HIV and AIDs. Evidence holds that the fundamental weakness of the programme which was recognised was preceding to the current crisis that the clients of CHBC repeatedly lacked the basic needs such as food, shelter and clothing. In order to meet these needs the ZRCS began to issue food to the CHBC clients. Nevertheless, due to financial limitations, delivery was unreliable and was often incompetent to meet the growing needs of the patients. The ZRCS lately appealed for food to be supplied to CHBC clients and their household members in order to diminish

the effect of the drought and the country's political crisis on these particularly vulnerable people. CHBC programme assist 10,000 chronically ill patients in their homes and has listed 35,000 OVCs. Hence it is of uttermost important to explore the effectiveness and find out how far the programme has managed to improve the lives of PLWHIV since the programme started until up to date.

2.6 The operations and services offered by CHBC in Zimbabwe

In the world the role of CHBC programmes is to provide care and support to the patients and their families in order to improve their conditions and have a better social functioning. They provide services such as, palliative care, psychosocial and spiritual support, counseling, conduct home visits and food security services to mention a few, with the aim of supporting and sustaining the patients to have a better social functioning and as well as preparing them for an honourable death. In most countries, it is a tradition that family members are the role players in providing care to their loved ones whether sick or not.

This reduces the burden of hospitals in providing long-term care of clients and that is why in Africa most CHBC programmes have been established in communities because of many economic reasons. In Zimbabwe CHBC programmes were a main approach to a flabbergasted public health system. Through the dwindling economy joined with the rising number of people living with HIV and AIDS the government accepted that the health system unaided could not manage with the influence of the epidemic (MOCHW, 2010). Below are the care services provided by the CHBC programmes to clients and

how they operate to improve clients' ill-health and extenuate the effects of HIV and AIDS.

2.6.1 Caregiver Service Provision

These are services provided by the caregivers to the patients. The services include psychosocial and spiritual support, hygiene education, and nursing care, monitoring drug compliance, referrals to health institutions, helping with domestic work, and escorting them to health centers. Psychosocial support is a continuum of care and support which influences both the individual and the social environment in which people live (ARC study pack, 2009). Psychosocial support also includes care of the emotional and social needs of people. This includes maintenance and provision provided by caregivers, family members, friends, neighbors, teachers, health workers, and community members on a day-to-day life.

It is also a constant fostering relationship that connects empathetic, unconditional love, tolerance and acceptance, and encompasses care and support accessible, by specialised psychological and social services. Evidence holds that clients mostly received psychosocial support from family and the church than the neighbors and the community at large. The low involvement of the neighbours maybe associated with stigma and discrimination. It is widely agreed that CHBC is one element of the continuum care which is considered particularly important in poor countries (WHO, 2004; Population Council, 2004; FHI, 2007). Referral services are therapeutic services organized by the general practitioners and delivered outside the physician's office other

than hospital. These referrals are done so as to link clients with other services that can help also.

2.6.2. HIV Testing and Counseling

“Counselling is a dialogue between a client and a care provider aimed at enabling the client to cope with stress and to make personal decisions related to HIV and AIDS”. The counselling process includes the evaluation of personal risk of HIV transmission and the facilitation of preventive behaviour. This is done by establishing a helping relationship with the patients and having conversations that have a purpose. The counselor listens attentively to the client, gives correct and appropriate information while helping the clients to tell their story. Moreover they help clients recognise, and build their strength, develop a positive attitude and make informed decisions. Empirically they are insufficient testing and counseling service centers in rural areas. Testing and counseling services were also recognised as significant in most NGOs and health institutions providing ART.

Access to voluntary and provider initiated counseling and testing (VCT and PITC) has improved significantly in recent years. However, counseling is not provided for a long period of time to make sure that clients have accepted their situation. As a result, some of the patients and relatives cannot cope with the traumatic and burden of taking care of the patients without being strengthened and motivated to be there for their loved ones. This researcher therefore brings to light that counseling should be provided to patients, family members and the caregivers so as to enhance their coping mechanism for long periods of time.

2.6.3 Nutrition support

Nutrition support is the process of providing food to people, which is essential for health and growth especially to HIV and AIDS patients with the aim of improving their conditions. Food distribution is one of the methods that have been used by many governments, including Zimbabwe to assist the patients and other communities. Nutrition is vital in CHBC programming because people living with HIV and AIDS require nutritious food which helps them progress in their health and have a better life. In Zimbabwe food is distributed by the following distributors like CARE International, Red Cross Society, Roman Catholic Church and many others. According to Matshalaga (2006), nutrition security safeguards satisfactory supply of nutrition comes in different ways which embraces delivery of agricultural inputs and production process, training in and establishment of inputs and the production process, training in and establishment of nutritional gardens and distribution of supplementary feeding.

Objectively nutritional support is a life threatening situation for effective CHBC programme. In 'Africa food shortage is a problem because of poverty and droughts'. Previous research in the area by Matshalaga (2006:25) shows that programmes with food distribution have also reported significant improvement in status of CHBC patients with some graduating from being bed-ridden to being active productive individuals. However many people still lack access to sufficient quantities of nutritious food, which causes challenges of disturbing the medication taken by clients in resource limited settings. Moreover persistent droughts have bargained the nutritive position of PLWHA and chronically ill people on the treatment in Zimbabwe.

2.6.4 Access to treatment:

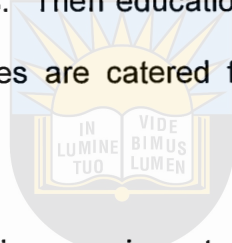
This is a process of issuing out treatment vouchers in form of money to clients for treatment and reviews given by different donors to assist the sick clients in the community. The delivery of access to treatment services is a fundamental part the programme because it helps people who cannot afford to pay for their medication, reducing the burden of family and relatives. According to Matshalaga (2006) earlier research in the area right to treatment services were mainly in form of ARVs, prevention of mother to child and treatment of opportunistic infections and sexually transmitted infections and treatment vouchers. The government hospitals, Mission hospitals and other NGOs provide such access to treatment.

However, observations by this researcher show that in most areas in Zimbabwe ARVs are no longer a hindrance to the improvement of the clients' health but shortage of food, money for reviews and the withdrawal of the donors make it hard for the patients and their families to cope with the situation. Observation on the ground by the researcher shows there is lack of funds to cater for all the people who are affected and those who suffer from other chronic sickness. This result in limiting the number of patients who receive the vouchers for treatment, leaving out others especially those who suffer from chronic illness like cancer.

2.6.5 Other common CHBC services

There are also other CHBC services offered to the affected people which include the integration of OVC support through education aid, material support (of building materials, bicycles uniforms, foot wear, blankets to mention a few) . Spiritual support

was also frequently between organizations and churches, improving water and sanitation , health and hygiene education, HIV and AIDs awareness campaigns , supply and renewal of CHBC kits and financial support for projects and funerals. These are very important in CHBC programming as they help improve the conditions of the beneficiaries and the community at large to be sustainable in fighting this epidemic. However funds continue to be a problem in CHBC programmes because it seems that health kits are not enough to cater for all the people, income generating projects breakdown because of lack of funds. Then education assistance for OVCs is another problem because a few beneficiaries are catered for leaving others still vulnerable without help by Matshalaga (2006).



Optimistically the CHBC programme is a very important programme that has contributed to a greater extent in the fight against HIV and AIDS and in improving the lives of the patients. Without the establishment of this programme into communities it could have been hard and harsh for the health institutions to run and control the situation of the pandemic. Even though, CHBC programmes empower communities by promoting autonomy and functional independence lack of resources makes it difficult for the programme to improve the clients' ill-health. The home is a favorable environment where the patients can die well but pessimistically, this causes so many challenges like psychosocial distress to both the patients and the relatives especially when there is lack of basic needs and resources to care for the patients.

2.7 HIV and AIDS prevalence in Zimbabwe

Globally the number of people newly infected by the pandemic is decreasing; this shows a greater improvement in adjusting the spread of the epidemic. The African region is one of the regions that have been affected, also affecting the development of the economic. HIV and AIDS has demoralized the lives of many people making it very difficult for all the countries to cope with the situation. Zimbabwe is one of the countries that have experienced the severest conditions of HIV and AIDS increase in the world. The politics and the social climate over the last few years made it challenging for the government and other stakeholders to respond to the crisis. More so, the country faced a number of severe crises in the past years like the exceptional growth in inflation, a severe cholera epidemic, high rates of unemployment, political violence, and a near total collapse of the public health system.

Zimbabwe was the first country in southern Africa to have reduced HIV and AIDS prevalence. The prevalence of the epidemic figure rose histrionically in the first half of the 1990s, peaking at 26.5 percent in 1997. Moreover according to the UNGASS Report (2007), the HIV and AIDS prevalence at first increased, climaxing at 26.5% in 2001 and from 2003 it declined to 23.2%, then in 2005 it declined again to 19.4% and in 2007 the prevalence fell to 15.7%. Then subsequently, HIV occurrence is thought to have deteriorated, by making Zimbabwe the first country to eyewitness such a drift. Agreeing to the government statistics, the adult rate was 23.7 percent in 2001; it then cut down to 14.3 percent in 2010 showing a decrease in the amount of people being affected by this disease. Moreover consuming the EPP and Spectrum software HIV incidence in the adult population in Zimbabwe was expected to be 23.7% in 2001, and

dropped to 18.4% in 2005, and 13.1 % in 2011 (UNAIDS 05.26E, 2010). There is devastating evidence from Zimbabwe (*Zimbabwe Human Development Report 2003*) females are predominantly vulnerable and exposed to HIV infection. Infection rates are very high in women than in men, with up to five times higher infection rates among young women than their counterparts. This figure therefore, points out that Zimbabwe has managed to decrease the rate of infection among its population through CHBC programmes which is a mitigating tool in improving the conditions of the clients. Although CHBC programmes have contributed to the decrease in the HIV and AIDS new infections, objectively the clients surviving under the programme still die and face a lot of challenges in the long run. Jackson and Lee (2002), contend that HIV and AIDS epidemic has expanded to all corners of the globe and no country and sector has not been affected and this is the reason why it is referred to as the epicenter of the epidemic.

Tangibly it is true because many people have died and lost their loved ones due to this pandemic. According to the UNAIDS Report on the global report on AIDS epidemic (2012), Sub-Saharan Africa continues to be the greatest severely affected where one in every twenty adults (4.9%) lives with HIV and AIDS and accounting for 69% lives with AIDS also globally. Even if the national prevalence of HIV infection is approximately 25 times higher in sub-Saharan Africa than in Asia, virtually 5 million people are living with HIV in South, South-East and East Asia joined. There are also other regions most deeply affected other than sub-Saharan Africa, which include Caribbean, Eastern Europe and Central Asia, where 1.0% of adults were living with HIV in 2011. Globally, 34.2 million (31.4 million–35.9 million) of people were living with HIV at the end of 2011. They is

also an estimated 0.8% of adults aged 15-49 years worldwide who are living with HIV, while the illness of the widespread continues to differ extensively among countries and regions. This however explains how devastating and distracting the pandemic is but it also shows a great improvement worldwide statistically. Therefore, this research should be conducted to see how effective the CHBC programmes are improving the conditions of patients even though the HIV and AIDS prevalence is decreasing.

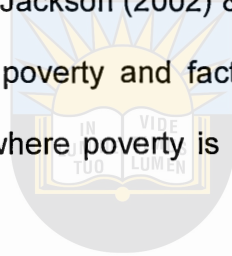
2.8 The challenges faced by caregivers, HIV and AIDS patients and their families

The challenges facing caregivers, patients and their families are examined here.

2.8.1 Caregivers

A caregiver is a trained person, often a volunteer, who works with communities and families to share information about health practices, provide some simple treatments and refers sick people to clinics /medical centers for other necessary treatments (National Community Home-based care Standard, 2004). Caregiving is done by family members and secondary caregivers who are registered and receive training to perform the duty of providing care to people living with HIV and AIDS in communities. Caregiving regularly involves responsiveness to the physical, mental, social, and psychological needs and well-being of both the caregivers and the elderly persons wanting care. The duty of caregivers is to provide psychosocial support, social support, spiritual support, counseling, education on ART adherence, nutrition education, conduct home visits, supervising the primary caregivers in providing enough care for the patients. They also report and give feedback to NGOs, National Aids Council and other organizations they will be working with. The caregivers face a lot of challenges in the

process of improving the conditions of the patients affecting their well-being making it difficult to perform their duties well. Some of the challenges include lack of health kits, lack of educational information tools, food, lack of knowledge and skills in caregiving. Kangethe (2006) asserts that severe poverty alleviation factors need to be put in place to retrieve the diminishing work environment of the caregivers and to make surviving adaptable. Lindsey et al (2003), argue that even if caregivers receive training they experience poverty, social isolation, stigma, psychological distress, and lack basic care giving education. In sharp construct, Jackson (2002) & UNAIDS (2005), say many areas of social development succumb to poverty and factors associated with it, one such conspicuous area is in caregiving, where poverty is largely the result of the impact of HIV and AIDS.



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A survey by Hope Worldwide NGO, South Africa, found that lack of food was the most pressing need besetting the caregiving process, the situation being exacerbated by the fact that the sick person may not desire what is available, but the body may demand that he be given special meals (UNAIDS, 1999). This has been found to destructively compromise the quality of caregiving in many African countries including Zimbabwe also. Africa's farming has progressively continued to deteriorate since the start of the HIV and AIDS epidemic. This is because HIV and AIDS has eroded the working capacities and productivity of communities, thereby threatening the food requirements of those living with the viruses (BBC world news broadcast, 2005). As the pandemic takes a heavy toll on the lives of breadwinners, more families are affected by shortages of food and other basic needs. This however results in burdening the primary caregivers who take care of the patients without enough resources. Furthermore

poverty affects the caregivers of many clients but, ironically, no part of the food basket is set aside to help the caregiver, who may be just as vulnerable economically as the client (Kang'ethe, 2006). The authors above clearly explain that the work of caregivers is mostly affected by poverty because they lack the basic needs for them to survive and hence they are supposed to help the patients to improve even if they lack also. This becomes a double burden and will affect the social functioning of both lives. This no doubt affects the work of the caregiver and renders him/her ineffective (Kang'ethe, 2004; NAB, 2004). Through the new campaign, GROOTS Zimbabwe CHBC has been very active in facilitating training of caregivers in income generating projects (IGPs), such as piggery, poultry, peanut butter making, and gardening.

Caregivers who have gone through GROOTS Zimbabwe nurturing, mentorship, and empowerment programmes are now producing food for their own consumption, for the community, and to donate to orphans and elderly members of the community, thereby ensuring improved nutritional standards for CHBC patients. However, most IGPs break down because of lack of funds to continue running the project thereby worsening the situation of improving their own lives and the patients. The Zimbabwean care programmes, due to lack of resources, fail to conduct refresher courses to equip these caregivers to continue providing good care to patients (Phorano, Ngwenya & Nthomang, (2005); UNAIDS,(2001a). Kang'ethe (2006, 2013a) also contend, that their services are a panacea amidst dwindling economic resources; lack of requisite skills and knowledge to handle HIV and AIDS has presented an arduous and an uphill task. Besides inadequate or unavailability of training, Kang'ethe (2010a) indicates that aging usually make it difficult for some caregivers especially the elderly to understand the dynamism

of sickness, as they sometimes cannot adequately know if the clients are getting worse and effect the requisite referral. The researchers agree with the above authors that caregivers' lives are affected while providing care to the patients in the communities. In some African communities most caregivers lack basic needs for survival, they do not have jobs or any form of employment to sustain them and lack knowledge of what is happening around the world in order for them to keep on helping the clients with relevant and up to date information. It is very important that caregivers continue to receive relevant information, training and sustenance in order to provide a better quality of palliative care to patients. However gaps still remain in terms of quality of the programmes and as a result this will affect the success of programmes.

In sharp contrast many organisations however lack funds in order to keep on training caregivers as a result of other donors terminating. This can result as a drawback in caregiving as caregivers are left with the burden to care for the patients and themselves at the same time without enough resources. Moreover the work of caregivers might affect the social functioning of their own families also as they would spend most of their time caring for other people instead of their own families. Akintola (2004) argues that the burden of caring for PLWHA, as both 'primary care givers' and secondary caregivers, is disproportionately provided by women. Men rarely assist with care giving. The reason behind women performing all these duties is linked to the traditions of many societies especially in African countries where women are seen as domestic workers and bearers of children. Objectively, men forget that women have the same equal rights with them so they should also contribute more in caregiving rather than being stereotypical towards women. Empirically it shows that although some men participate

in caregiving they always have higher positions of being the supervisors making it unfair to the women who do the rest of the work. In Zimbabwe a few men are caregivers but they hold higher positions than women in caregiving which is better than not taking part at all. Children, especially girls, are missing out on their education because of their increased caretaking responsibilities at home. According to Lindsey et al (2003), young girls often missed school and they were sexually and physically abused, sexually exploited and depressed. This shows that even if children are taken as caregivers in some cases where there are no older people to care for the sick parents children are left vulnerable to many circumstances which include the above mentioned. This will result in affecting the children physically, emotionally and psychologically and the child will also have a low self-esteem because of missing school.

Children are seen as the future generation of tomorrow so children need to be taken care of so that they can have a better future. The study discusses these challenges in the hope of impacting on policy enhancement and thereby refining the future operationalization of the programme, and the quality of the services. According to Irish AID Health Development Network and Southern Africa AIDS Information Dissemination Services (2008) most CHBC programmes and services have fallen short in terms of the quality and effectiveness of their service provision. There is lack of standards and quality assurance for CHBC services.

2.8.2 Poverty associated with CHBC programmes

Globally poverty has affected a lot of people due to unemployment, droughts, poor weather and many other reasons which include the pandemic hitting heavily on people.

“Poverty is the main barrier in providing quality care to HIV and AIDS patients in the home” (Shaibu, 2006: 92). Poverty steals the happiness of humans, it destroys freedom and makes someone qualities impossible and others enormously difficult (Suharko, 2007). Poverty is defined as absence of basic human needs encountered by certain people like food, shelter, clothing and water. This however explains how overwhelming poverty can be especially to patients when they are lacking the resources they need to recover as it becomes a double problem to them. Evidence holds that in Zimbabwe, poverty started progressing in the 1990s and all the regions were affected and the rural areas were more affected than urban areas to (Irish AID Health Development Network and Southern Africa AIDS Information Dissemination Services, 2008).

Pessimistically, as a result to funding limits, delivery was unreliable and was habitually not capable to supply the increasing needs of the patients. According to UNFPA (2007), the HIV epidemic, the emerging TB and HIV co-infection, severe droughts which are closely linked with food shortages and poverty, have significantly impacted on progress with regard to population and developmental issues in many countries. The ailment of the individual, health or poverty related, becomes a double problem where others in the community take up the responsibility of caring for those in need even if these persons themselves experience difficulties; this became evident from the findings of an ethnographic study on home-based healthcare (Van Zyl, 2010). Moreover Ngwenya and Kgathi (2006), Phorano et al. (2005), Shaibu (2006) and Stegling (2000), maintain that when patients are referred home to receive CHBC services without adequate assessment of their domestic environment, caregivers often find themselves struggling to accommodate patients in a home lacking adequate shelter, food, safe

water, proper sanitation, and clothing. This poverty contributes to poor nutrition, causing caregivers to have to struggle to accommodate patients in a home lacking basic necessities (Mohammad and Gikonyo, 2005). According to the United Nations Food Agency (2011) over one million Zimbabweans face starvation today. Empirically the 2011 Zimbabwe Vulnerability Assessment Committee (ZimVAC) estimates that just over 1million Zimbabweans are unable to meet their food requirements in the current lean season of 2012 due to the late green harvest. Evidence holds that there are 1.6million orphans in Zimbabwe living under poverty according to WFP (2012). The authors above explain how poverty has heavily hit on people including children thereby worsening the present situation of the pandemic as patients lack the basic needs like food and access to good health facilities, hence affecting the conditions of the patients and also their families. This however, becomes a stumbling block to a successful CHBC programme.

Despite, the wealth of natural resources some African countries have the pandemic and poverty has affected to a greater extent the lives of HIV and AIDS patients and their families. Thus poverty is prodigious in disturbing all the people hence policy makers should enhance the basic needs of HIV and AIDS patients and other chronic patients in order to improve their conditions. Poignantly the political crisis in Zimbabwe has contributed in affecting the food security. Consequently the undesirable consequence of HIV and AIDS on this area is of great concern. HIV and AIDS pose serious threats not only to nutrition, but also to food security in general. Basilwizi (2010) argues that, the project has left a legacy of increased vulnerability, impoverishment amongst the displaced communities due to entitlements losses. This means that HIV and AIDS

patients, family members and caregivers under CHBC programmes although they have been introduced to community projects they are not sustainable enough to provide for the patients. It is because of lack of funds, resources such as water, seeds to mention a few to keep on running the projects well. Poverty has become the most devastating problem in Africa in trying to mitigate the impact of HIV and AIDS. This poses a challenge in trying to improve the conditions of clients' health and reduce the increase of poverty levels. Shortage of food has led to poverty of caregivers and low-quality care of patients in general. These challenges also contribute to the reason why the researcher wants to conduct the study so that better ways can be advocated to help all the orphaned children, patients and their families under the CHBC programmes to have a better life. It is myopic to suggest that it is essential to change the approach to meet the basic needs of clients especially food by the government, NGOs and the community at large so that CHBC programmes can improve the conditions of patients well.

2.8.3 Lack of funds

The international donors have played a vital role in CHBC in the fight against the epidemic optimistically. They have made it possible, especially in Africa, to reduce the spread of the pandemic by donating funds, resources and also their time. Conversely, many donors who have been supporting CHBC programmes in Africa have become weary of donating funds and also because of the economic meltdown that swept and affected many countries who were sources of funding (www.doctorswithoutborders 2013). CHBC programmes presently receive inadequate financial sustenance to cater for programme activities. Finances have become the most challenging resource for most CHBC programmes in the world because clients require a large amount of funds

to be taken care of. Without finances the work of CHBC programmes will be impossible to be achieved. Kiley and Hovorka (2006) note that problems in creating active organisations among HIV service providers were commonly endorsed to lack of time and money for developing cooperative partnerships. As well as for travelling to meet representatives from diverse organizations and lack of awareness about other services providers in the area. In spite of the increased accessibility of bilateral and international funding for HBC programmes over the past decade, there are frequent reports of disappointment among programme managers in relation to the influence of donors in defining programme activities and the suggestions of these relationships for the effectiveness and sustainability of their activities (Wringe et al. 2009). Shifting trends in donor policies towards HBC programmes has also served to undermine the effectiveness of the activities that are being delivered on the ground (Wringe et al. 2009).

The African countries have been affected by the pandemic more than in any other countries in other continents because they are still developing hence this affects the funding of most CHBC programmes. According to the NAC Annual Report (2009) the GoZ raised funds from tax income from all segments through the NATF to alleviate the effect of HIV and AIDS. Moreover supplementary resources were made accessible through the Expanded Support Programme from the following: the development partners CIDA, DFID, Norwegian Aid, Irish Aid and SIDA. CHBC programmes were also given 65% of the total amount of US\$31 million which was dedicated for care and treatment for the period 2010 to 2011. Furthermore many other funds came from different donors in support of the HIV and AIDS programmes like the International

partners, Programme of Support, Global Fund and many others. These funds donated by the above donors were for supporting the OVC education, healthcare, birth registration and access to HIV and AIDS prevention, treatment and care and support services in order to assist the affected families and infected clients in the fight against the spread and re-infections of the disease again and also improve their social functioning. Surprisingly, the funds are not enough to cater for all the beneficiaries. Although they have still maintained their funding to projects such as male circumcision in Africa and other developing countries, other sources of funding have dwindled increasingly (Kang'ethe and Gutsa, 2013). Observably, funding has been negatively affected by the bad political climate from some countries. For example, in the orchestrated campaign to vilify the western world, the government of Zimbabwe has not cooperated with the donors but has instead tarnished their names and actions, convincing the Zimbabweans that donors want to extend their imperialism and colonisation back again to African countries.

Evidence indicates that the government has been aggressive to foreign non-governmental organisations (NGOs), to the extent where they threatened to pass a law that would give the government the power to inhibit with how NGOs are run. Since that time it has been difficult for the NGOs to function steadily. Furthermore the Governor of Masvingo expelled twenty-nine NGOs in 2008 because they had failed to register with his office. This has prompted an announced withdrawal of such donors. Pessimistically, although the donors donated still the funds could not tally with the amount of people who needed assistance led to the selection of a few beneficiaries benefiting and leaving the others without any form of help and worsening their situation. Perhaps emphasis on

indigenisation of economies is critical, topical and timely. Countries need to harness, tap the indigenous resources using their indigenous knowledge systems (Kang'ethe, 2011). According to UNICEF (2007), the approximately 2 million orphaned children in Zimbabwe due to HIV and AIDS and 142 000 children are HIV-positive (UNGASS, 2007). Resources continue to be a problem even if the government and the donor partners have introduced an OVC Plan of Action. The increase of orphans and vulnerable children has led to the available funding not meeting all the children's necessities. Observation on the ground shows that orphans still lack school fees although some funds were donated for OVCs hence this is another challenge that many rural and urban areas in Zimbabwe face. As a result this will affect the lives of these orphans without education as the funds only benefit a few beneficiaries while leaving the others behind.



CHBC programmes for this reason are forced to reduce the number of beneficiaries due to the scaling down of donors and also as a result of few funds. According to MAP (2004), reduced donor support is presently destabilizing the efficiency of CHBC programmes as organizations either scale down or reach out to clients with very inadequate services. In the case of donors terminating the programmes this is a drawback in mitigating the effects of HIV and AIDS. The Zimbabwe Country Report (2011) asserts that there is need to extend the tax base by guaranteeing that the informal sector subsidizes the AIDS levy. This is why the researcher seeks to investigate the effectiveness of CHBC programmes in mitigating the impacts of HIV and AIDS. To this end the researcher therefore recommends that the government and its partners should substitute indigenization and local funding to replace donor funding than

to depend solely on the donors while the programmes are lagging behind. This will cause more harm to the patients because HIV and AIDS is still there and there is no cure yet and it is still spreading each day.

2.8.4 Lack of non –monetary resources

Resources are the most important equipment in overcoming the challenges of HIV and AIDS globally in CHBC programmes. Lack of these resources in Zimbabwe and other African countries like food, caregiver's kits, transport and educational materials is another disadvantage in trying to improve the health of the patients. Pessimistically, when patients are referred home to receive CHBC services without adequate assessment of their domestic environment, caregivers often find themselves struggling to accommodate patients in a home lacking adequate shelter, food, safe water, proper sanitation, and clothing (Ngwenya and Kgathi, 2006; Phorano et al. 2005; Shaibu 2006; Stegling, 2000: 27).

However critics argue that, several CHBC services in southern Africa have been established through unmethodically, needs-based efforts and debate that more emphasis must be placed on taking more formal, systematized, and programmatic approach in inaugurating these programmes (Ogden et al. 2004). However, Mohammad and Gikonyo (2005) assert that CHBC area is facing a number of challenges and restrictions which not only unpleasantly affect their ability to carry out their activities, but also have the potential to aggravate poverty and prevailing gender disparities amongst affected families and communities. According to MOCHW (2010), there is a lack of a national strategy or policy addressing food and nutrition insecurity in

vulnerable households of people living with HIV and AIDS. This shows that the service providers are not receiving enough or continuous training because of shortage of resources and funds to train them more. Inconsistent supply of CHBC kits and other supplies also cause challenges that hinder the effectiveness of programmes and affect the improvements of patients. According to MOCHW (2010), human resources is another challenge as staff shortages were mainly due to high staff turnover which were further worsened by the fact that posts continued to be frozen in the public health sector between 2010 and 2011 in Zimbabwe. This led to high workloads for the health sector making it difficult for them to provide services to a large amount of people that are sick with less human resources. Establishing on the above scholars, resources are very important in order to achieve the goal of the programmes. On the other hand if these resources are inaccessible it poses a challenge in improving the conditions of patients and extenuating the impacts of HIV and AIDS.

2.8.5 Poor referrals of patients

In some African countries patients are poorly referred to other organisations or institutions for help because there is lack of health institutions that are near especially in rural areas (Farmer et al., 2001). This makes it very difficult to advance and sustain a medical referral system that is steady. According to NAB (2004) professional counseling and debriefing need to be strengthened in the care giving area. It is imperative that the family members who provide care for the clients receive counseling because they face traumatic, stressful and unbearable situations when caring for HIV and AIDs patients. The counseling provided for short periods leaves the families incompetently ready to face the depressions and pains that go with the care they

provide to their relatives. Mbata and Seloilwe, (2000) contend that referral systems of many health facilities lie mainly with CHBC programmes. This however explains that the referral systems are very poor, it becomes stressful for the patients without any form of support because they are not clear and they complicate patients' lives considering that they also fear the stigma and discrimination associated with the disease. Thus the researcher seeks to explore the effectiveness of CHBC programmes and suggest ways in which referrals can be clear and successful and remove the burden from the shoulders of caregivers.

2.8.6 Lack of evaluation of programmes

Evaluation of CHBC programmes is another challenge faced by some African countries due to lack of resources (WHO, UNAIDS & UNICEF, 2011). It is very important but it is rarely done because of various problems like lack of funds and transport to conduct it. According MOHCW (2010), there do also exist certain challenges in choosing suitable measures and methods in piloting the assessment. Pertinent results may consist of policy, strategy, sustainability, accessibility and efficacy of education and training and assimilation of end-of-life into health systems. According to the Health Partners International, Impact Assessment of Expanded Support Programme, Zimbabwe (2011), the current modes of delivery have been necessary because of the unstable political and economic environment in Zimbabwe over the past few years. While they have proved to be effective and relatively efficient in generating short-term value, they have not been able to satisfactorily build the local capacity necessary for long term success. Lavery et al. (2010) suggest that guidelines are required to deal with the role of communities for the evaluation of new technologies in global health for meaningful

community engagement for the future. As well as quality assurance and observations and assessment needs to be resourced properly, both to withstand programme achievements and also to guarantee satisfactory levels of programme administration and culpability. This shows that evaluations of programmes are lagging behind thereby contributing to the ineffectiveness of CHBC programmes. Observations made by this researcher show that most programmes lack evaluation of the programmes especially when the donors have terminated the projects.

This is as a result of lack of funds for the running organizations to continue evaluating and monitoring the evolvement of CHBC programmes in the absence of the donors. In tandem evaluation of CHBC programmes has a multifaceted cause which includes lack of funds and challenges in choosing an appropriate method of evaluating these programmes which makes it difficult to come up with effective programmes. To this end if more evaluations are done, this would help CHBC programmes to have efficient and effective ways of improving the conditions of patients and the way of running the programmes as well.

2.8.7 Stigma and Discrimination from the society

Globally people have been educated about HIV and AIDS and discrimination but because of different backgrounds, values, beliefs and religions it is still difficult to stop this act. According to Kangethe and Mangwiro (2013) stigma is largely informed by facts such as backgrounds, values, beliefs and norms that different societies hold making it difficult for people to adjust to new changes with ease. According to Avert, (2008) AIDs related stigma refers to the prejudice and discrimination

in reducing the effects of HIV and AIDS. Due to poverty most caregivers, HIV and AIDS patients and their family members fail to provide food for patients and even for themselves. This poverty has hit all the people especially in focused at PLWHIV and the groups and communities that are associated with it. It can result in PLWHIV being rejected from the society, avoided, discriminated against or even physically hurt. Looking at the white people they are able to accept change easily than us blacks as a result of being traditional and religious. Pindani (2008) contends that what is surprising is that even up to now other churches and their members still consider that HIV and AIDs is retribution from God as a result of immoral behaviour.

It is as a result of lack of knowledge and ignorance on the subject: of HIV and AIDS, some churches condemn their fellow members. These stigma impersonated by religion can be influential. Hence people often avoid working with or supporting HIV and AIDS people since they are recognised as sinners who deserve to become ill. According to the stigma, discrimination and attitudes to HIV and AIDs (2008), spiritual preconceptions, varied with fallacies about HIV and AIDs have become a precarious and impulsive mix that sends many people to death. On the contrary, in Ecuador and Zambia some PLWHIV have testified personal experience of stigma and discrimination for their visible participation in providing services or working with an NGO providing HBC services (Cornu and Attawell, 2003). To this end, due to the panorama of HIV related stigma, many clients are hesitant to reveal their HIV status, now and then building a stumbling block to effective CHBC delivery (Health & Development Networks, SAFAIDS, 2008). As a result this becomes a challenge to CHBC programmes to fully provide better services without the support of the public. One of the objectives of CHBC

is to address stigma, stigmatization and discrimination in Botswana, Zimbabwe and South Africa have been a lagged out process (Kang'ethe, 2013b). Discrimination however still remains a problem as other community members or family members do not want to associate with the patients and their families as the above authors emphasize that discrimination is taking long to be dealt with. "As a result of stigma and discrimination many people in societies fear to disclose their status while creating a barrier to delivering better services. Many needy households refuse government food baskets because once you receive food baskets everyone will know that you are an AIDs patient in the community" (Jacques and Stegling, 2004, 181).

Despite a high level of awareness, observations on the ground show that HIV and ADIs remain vastly stigmatized in Zimbabwe. PLWHIV are habitually seen as having done something wrong and discrimination is commonly directed to both them and their families. This result of stigma and discrimination by other people towards PLWHA forces the patients to hide their medications from their family members and relatives with the fear of being discriminated against. This can affect the patients emotionally without support from family and friends and may cause more harm to patients' ill-health. "It is important to note that HIV and AIDS stigma can be experienced not only by people living with HIV and AIDS but also by people who are suspected to be living with HIV and AIDS ..." (POLICY Project, 2003b: 4). Nevertheless, information dissemination on stigma against HIV and AIDS patients is taking too long to take root in order to tackle the spate of stigma in developing countries. Because of the fact that countries are experiencing stigma at different levels, it is important that those that are behind such as South Africa borrow a leaf from those that have moves some miles ahead in tackling the

menace (Kangethe & Mangwiro, 2013). Therefore it is myopic to suggest that the government should enforce policies on stigma and discrimination and ensure more education on this subject in order to reduce this stigma and discrimination among societies.

2.9 The needs of HIV and AIDs patients, family members and caregivers

A need is something that is essential to the survival of a human being which includes nutritional food, water, air, shelter and protection. Hence every person needs all the above necessities in order to have a better life. According to National Home-Based Care Programme and Service Guidelines, (2002) families and caregivers have their own needs also in order to help out the patients; these include physical, psychological and social/spiritual needs and they are essential to uphold family unity and well-being. For the reason that caring for someone who is very ill or dying is persistent and heavy, hence family members need help from relatives, friends and from caregivers to cope well.

The needs of HIV and AIDS patients, family members and caregivers include the following food, CHBC kits, transport, funds, clothing and other resources, to mention a few. To start with, funds are the most important asset for human existence and without money you cannot afford to provide for your living. CHBC programmes, caregivers, patients and family members lack enough funds for transport to go for reviews and also money to buy nutritious food that is needed by HIV and AIDS patients. Findings confirm that with shortages and at times outstanding government funding various CHBC organizations are required to raise money on their own and this turns out to be a barrier

for patients to improve well as most caregivers would spend most of their time fund raising instead of taking care of the patients. This explains why many CHBC programmes are fundamentally continued by many volunteers who work very hard because funds are insufficient to employ or hire paid workers. Emphatically some CHBC establishments stress that with better and increased finances, the value of their programmes might progress prominently. It is myopic to suggest that the government/NGOs should take the responsibility and help the community members in raising and providing the required funds in order for CHBC programmes to be successful Africa as a result of unreliable rainfall, inflation and a crisis in politics which also includes Zimbabwe as one of the most affected by this poverty.

When patients are referred home to receive CHBC services without adequate assessment of their domestic environment, caregivers often find themselves struggling to accommodate patients in a home lacking adequate shelter, food, safe water, proper sanitation, and clothing (Ngwenya and Kgathi, 2006; Phorano et al. 2005; Shaibu 2006; Stegling 2000: 18). Hence this becomes a drawback in improving the conditions of the patients without food which is needed to strengthen and support them as they take their pills. Observations on the ground show that even if community projects have been started as a way of increasing the food security they are not sustainable enough to provide for patients for long period due to lack of funds and to continue with the projects. Surprisingly, the patients continue to suffer and struggle to improve without food and the situation at hand makes the work of caregivers unbearable and stressful to handle. This all brings us to the question of how sustainable community-based interventions are. This researcher therefore proposes that there is need to formulate

policies concerning food security so that they become sustainable in order to provide all the basic needs of patients and caregivers in order to mitigate the effects of HIV and AIDS and the programmes to be effective and efficient.

2.10 The effectiveness of CHBC programmes

The effectiveness of CHBC can be seen in the services that are provided by the programmes if they are meeting the demands and needs of the patients. Subjectively, the challenges and needs of HIV and AIDS patients contribute to the reason why CHBC programmes are not effective enough because patients, caregivers and their families suffer the consequences of limited resources, funds and other resources needed to improve the patients' health conditions. Wringe et al (2009) contend that, regardless of the progressive governmental and commercial climate that has helped to place broad HBC programmes directly on HIV programmes, the evolving proof proposes that existing strategies increase HBC attention have given insufficient attention to addressing the challenges that have been acknowledged by those instigating small-scale but routine programmes.

Additionally, the postulation that comprehensive HBC programmes embody also a low-cost or sustainable approaches for providing variety of services needed by PLHIV has not been established by experiences on the ground. The researcher is agreement with Wringe et al that CHBC programmes were established to complement the hospitals but in the absence of enough resources to use which poses as a challenge to fully implement and achieve the goal of improving the patients' conditions and reduce the impacts of HIV and AIDS. The programme hence lacks a plan that sustains the patients

for a long period of time even though projects have been introduced in many communities, their success is hindered by funds to keep on running these projects. Furthermore Wringe et al (2009) argue that assessments remain imperative designed for providing the effectiveness of HBC interventions, and well-publicized affirmative outcomes that have started to develop are unlikely to play a key role in safeguarding supplementary finances for increasing their coverage. In sharp contrast Walt (2005) also notes that, epidemiological evaluations of CHW programmes are of inadequate importance to the policymakers, except that they are supplemented by added policy analyses that recognize the reasons that make one programme more operational than another, that evaluate the degree to which programmes can be carried across settings or that identify the reasons wanted to withstand these programmes over time.

Even though some efforts to cost HBC involvement in Zimbabwe, Rwanda and Uganda (Jaffar et al. 2009), there has been little work on discovering the relative costs or cost-effectiveness of diverse HBC policies across settings. Constructing from the above scholars, it can be seen that evaluation of CHBC programmes can be one tool that can lead to better services and to its end effectiveness can be achieved but because of many challenges that includes lack of funds it becomes impossible to successfully implement without enough resources. Even if substantial commitment has so far been shown in providing a wide range of CHBC programmes, their achievements are regularly hindered by weak connections with other HIV services. Top-down donor policies and a shortage of viable and stable funding strategies symbolize a difficult risk to these programmes in the long run (Wringe, Cataldo, Stevenson and Fakoya, 2009). In a Kenyan study, Waterman *et al.* (2006:37) examined the contextual factors that

facilitated or hindered the process of implementing effective and sustainable HBC programmes, and noted that local organizations have a tendency to 'change activities at a whim' in response to what donors will fund. This becomes a drawback in enhancing a better social functioning of patients and the successfulness of CHBC programmes. According to MOWCH (2010) overall, the implementers questioned as part of this project confirmed a good understanding of these strategies and principles.

Conversely, they revealed that as they try to follow the guidelines written in their operations, shortage of sufficient resources remains constriction over and over again. The researcher however suggests that the government/NGOs should put more attention to resources so as to overcome the challenges faced which hinders the successfulness of the programmes. To some extent we can say that CHBC programmes have managed to reduce the number of people being infected each day and has managed to distribute or provide enough drugs for patients but they are not effective as a result due to the above mentioned setbacks like funds and resources.

2.11 Conclusion

It is a fact that there has been little analysis in the literature on the effectiveness of CHBC programmes in some African countries due to certain challenges faced by these different countries. On the other hand, it is not a new subject because many researches have been done on the cost analyses of drugs and on cost effectiveness. More so the literature that exists supports that the cost effectiveness of providing drugs to people was effective and it has improved the situation than before when ARVs and other drugs were insufficient. Although there is a reduction in the number of people being infected

and dying with this disease still CHBC programmes need monitoring and evaluation in order to measure if the programme is managing to achieve its goals. This also helps to see the grey areas that still need more attention in improving the illness of HIV and AIDs patients and in mitigating the effects of HIV and AIDs. This determination suggests that the concept addresses some core issues related to welfare of people infected and affected by the pandemic which cannot be dismissed. The number of beneficiaries rises everyday this; means that there is no doubt that this triplicates the problems that the government/ NGOs are faced with in providing care and support to HIV and AIDs patients.



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CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The key aim of this research study was to explore the effectiveness of Community Home-Based Care programmes in mitigating the effects of HIV and AIDS in Shurugwi rural in Zimbabwe. The research investigated how effective these programmes are as they try to improve the conditions of HIV and AIDS patients and other chronic diseases in rural areas as a way of improving, preventing and reducing the spread of the pandemic. This chapter has outlined the research methodology that was used that is the research design, research paradigm, data collection methods and as well as validity and reliability and the limitation of the study. The chapter also enclosed how the data was analysed and the ethical issues that were deliberated when the research was conducted. This chapter presented a summary of Shurugwi rural and the wards that the research was conducted in also.

3.2 Study site

The research was conducted in Shurugwi rural which is situated in Midlands Province, southern Zimbabwe. The aforementioned is located 33km away from the headquarters of Gweru which is 350km away from Harare. Shurugwi district is a central place rich with gold and chrome mining. Its primary town is also called Shurugwi. Shurugwi District incorporates considerably some parts of the rural areas of Nhema and Chivi. The region has seen a renaissance of quarrying events after the detection of platinum at Unki which lies a few kilometers just after the Wolfshall Pass (Boterekwa). Shurugwi district is generally populated by the Karanga tribal people who form a wide range of the

inhabitants. Nevertheless present are additional minorities like Ndebele speaking people in the Rockford small scale consumption farmhouses and the Dlodlo areas. The district is dominated by the Great Dyke which splits it in the middle. The area falls under region three in the farming area and the other areas are made of poor soils which support subsistence agriculture. The researcher has chosen this area because of its experiences of illiteracy and poverty. The area also has been seriously affected by HIV and AIDS.

3.2.1 The overview of Dosert and Tongogara wards

The Dosert ward is found in the northern side of Shurugwi going to Bulawayo while the Tongogara ward is in the western side of Shurugwi district going to Masvingo town. The Tongogara ward has two wards, 13 and 12, which consist of seven villages Nehanda, Poshai, Mukumba, Gamaza, Musengezi, Matinyenya and Mteliso. While Dosert is ward 21 and has two villages which are village 1 Dosert and village 8 Dosert because these are the new resettlement farms and plots. There are twelve NGOs functioning in the district. These consist of Africare, Care International, World Food Programme, Zimbabwe Red Cross, National Aids Council, DEAP and SDARMP.

They are in the field of poverty mitigation, HIV and AIDs awareness campaigns, health and sanitation. The Tongogara ward that is 13 and 12 has a total population 7,878 people (Madebwe and Madebwe, 2005). There are five primary and four secondary schools some owned by the government and the other two are private schools. Moreover there are four clinics in both wards owned by the council. The people in Tongogara ward are subsistence farmers, which means that they only produce food enough to feed their families. Ward 21 Dosert consists of 3 611 people living there. The

ward has 2 primary schools that are Kazhambe and Zhaugwe. In attendance they is one secondary school known as Dorset. Moreover ward 21 has two health facilities that are Dorset and Zhaugwe. The district lies in agro-ecological region 3 that receives an average rainfall of between 650-800mm. It is characterized by a number of land uses including residential (settlement), agricultural, mining, industrial and forest areas with the major human activities in the rural areas being subsistence to intensive cropping, animal farming, cattle and goats forming the backbone of the community's wealth (Madebwe and Madebwe, 2005).



3.3 Methodology

3.4. Research design

A research needs a plan or strategy. According to Creswell (2009), a research design is a strategy and method for a research area, the verdict commencing a comprehensive statement to in-depth procedures of data collection and analysis. The research design has provided a plan that may have stipulated how the research was performed in a way, that permits the research questions to be responded to. The study used the mixed method; that is the use of both qualitative and quantitative methods. Triangulation is defined as the mixing of information or methods so that different perspectives or opinions bring up light upon the subject (Olsen, 2004). The determination is to increase the reliability and accuracy of the results. The purpose is often indefinite contexts to attain verification of findings through divergence of different standpoints. The researcher used a methodological triangulation of gathering data and using these two methods has provided a good understanding of the inquiry problem than both method

can alone. The qualitative method has covered the gaps left by the quantitative and also vice-versa. Qualitative approach stood to gather the facts consuming in-depth - interviews. According to Cooper (2008), qualitative interviews put an effort to recognize the world from the participants' opinions and to explain the significance of people's practices to discover their lives proceeding to methodical descriptions. This method allows the researchers to study designated subjects in-depth and try to fathom the groups of data that develop from facts. The quantitative method was also used to collect the data using survey questionnaires. And it collects numerical data in response to the research questions.

Therefore, these methods of research include the research method, design, population, sample, and sampling instrument, data collection and analysis methods. These methods allowed the researcher to gain attentiveness of peoples' attitude, value system and concerns regarding the research topic. The methods for this study concentrated on real-world situations of HIV and AIDS patients under CHBC programs in Shurugwi rural.

3.5 Population under study

According to Bless and Higson (2000, 84) as cited by Alpaslan et al (2010:15), "a population is defined as the entire group of persons or set of objects and events the researcher wants to study and the results can be generalized". In this research study, the populations under the study were the HIV and AIDS patients, key informants (CHBC officers from NGOs and the government CHBC coordinators), primary and secondary caregivers of Community Home-Based Care programmes in Shurugwi rural. According Madebwe and Madebwe, (2005) the population of Shurugwi rural is 11 489 in Tongogara and Dosert wards where the research was conducted and 147 are patients

on ART who are HIV and AIDS. These were the potential participants where information was drawn in order to generalize the result of the study.

3.6 Sample

According to David and Sutton (2004, 149), "a sample is the total number of sampling units, or cases selected from the sampling frame". The researcher chose a sampling method that was appropriate to the research study. The sample size for the quantitative was 150 people (100 HIV and AIDS patients and 50 primary caregivers) and for qualitative it was 14 people (10 secondary caregivers and 4 key informants (CHBC officers from NGOs and CHBC coordinators from government) from CHBC programmes in Shurugwi. This means that the total sample was 164 participants.

3.7 Sampling technique

The study used two types of sampling methods, probability and non-probability sampling techniques. In the probability sampling technique, the respondents or sample was nominated by means of a random procedure, by a random number generator thus every one person outstanding in the population had the similar possibility of being designated for the sample. In this study, the starting point was random by decisively selecting a beneficiary and the optimal afterward was a consistent interval; that is, every 6th person that followed was carefully chosen. The study also used non-probability sampling technique and this was purposive sampling where the population may or may not be accurately represented (Campbell, 2004). The judgmental sampling was used to select the sample and the type of sampling was established completely on the decision of the researcher. The participants were purposefully selected to obtain rich data

enough to make conclusions. In this study, these two techniques were used to select the HIV and AIDS patients, caregivers, family members and key informants (CHBC officers from NGOs and the government CHBC coordinators) who participated in the research study. The survey questionnaires and in-depth interviews are the best method of data collection for this study as they enabled quick comparisons and address the aims, objectives and prompt questions. The tools helped to measure the effectiveness of CHBC programmes on the services provided to patients

3.8 Data Collection methods and administration

The questionnaires and the interview schedule guide were the two instruments used to collect data from the respondents and participants. The first stage of the research conducted a survey by distributing 150 questionnaires. The second stage comprised in-depth interviews with the other 14 participants.

3.8.1 Questionnaires

The survey questionnaire is the means of compiling evidence of a specific population by selecting some of its members, generally through a method of homogeneous questions. The survey questionnaires tool was used to collect data from HIV and AIDS patients and the primary caregivers. The questionnaire used in this study had mixed question types which were the open-ended and closed-ended questions. According to De Vos (2005), an open-ended question allows respondents to respond in several ways they want, while a closed ended question involves that respondents select from a restricted - number of prearranged answers. The questionnaire that was used consisted of five sections, which include:

- Section A: Background and biographical information.
- Section B: The needs of HIV and AIDS patients, family members and caregivers.
- Section C: The services that are provided to the beneficiaries of CHBC programmes.
- Section D: The challenges faced by the beneficiaries of CHBC programmes.
- Section E: The perceptions of HIV and AIDS patients, family members and caregivers on the effectiveness of CHBC programmes.

3.8.2 Interview schedule guide

Face-to-face in-depth interviews were conducted with fourteen participants who deliver palliative care to HIV and AIDS patients and other debilitating sicknesses. An interview schedule guide was adopted to safeguard consistency in the information obtained from the participants. This used a flexible, discovery-oriented technique, which allowed the interviewer to genuinely discover the respondent's emotional state and viewpoints on the effectiveness of CHBC programmes. The questions asked of participants were the same and were premeditated to circumvent collecting unrelated information. The secondary caregivers and the key informants (CHBC officers' from NGOs and the government CHBC coordinators) were interviewed individually in a conducive environment of their homes and offices. The participants also signed an informed consent form. The interview took an average of thirty-five minutes and a recording instrument was used to capture the data provided by the participants. The information given by the participants was changed to rewritten transcripts. Qualitative interview is an outstanding tool to use in planning and evaluating extension programmes.

3.9 Data Analysis

Data analysis is a method of collecting, modeling, and altering data with the goal of emphasising valuable data, signifying conclusions, and supporting conclusion making (Wellman.et.al, 2005). The research study analysed the data using both quantitative and qualitative methods. For quantitative data, the researcher presented the data using frequency tables and graphs while qualitative data was presented according to key themes that emerged during the interviews. The quantitative analysis was used to apply prevailing data to inaugurate the effectiveness of CHBC programmes in improving the conditions of HIV and AIDS patients. The Statistical Package for Social Sciences (SPSS) was used to enter the data in the computer.

Qualitative data analysis was used also to analyse data as the data required an approach which is appropriate to analyse texts, visuals or narrative, such as content analysis or discourse analysis. The information was analysed and interpreted according to the data collected using thematic content analysis technique method. The information collected was summarised in any procedure of content by manipulating numerous features of the content as there is certainly no usual method for qualitative analysis but it does not mean it is not systematic. In thematic content analysis, the task of the researcher was to categorise a restricted number of themes which sufficiently replicate their written data. Creswell (2009) considers that the method of data analysis and explanation can best be obtainable by arrangement for recording data, data collection and preliminary analyses, managing or organising data reading and writing notes, producing classifications, subjects, and arrangements, coding data. The following steps were used to analyse the data.

➤ **Planning for reading data**

The researcher recorded the data in a systematic way that was applicable to the setting and participants. The researcher made sure that the essential tools for recording and writing down notes were in place before the interview started. In this study, a recording instrument was used to capture the information from the participants as the interview progressed; no other equipment has been used.

➤ **Organising data**

The first step from the site is to organise the data. Then the process arises at an early stage in the examination progression, and the researcher organised the data into files folders. Besides organizing files the researcher converts their files to appropriate text, for example a word, sentences, an entire story for analysis either by hand or by computer Creswell (1998), cited on De Vos et al (2005:). After conducting the individual interviews with the participants the information obtained was organized and documented for the purpose of record keeping.

➤ **Reading and writing memos**

In this study the research took the notes that had been made according to the themes explored during the interviews.

➤ **Generating categories, themes and patterns**

The systematic procedure stresses an intensified consciousness of the data, a focused consideration to the data, and openness to the delicate, implicit connotations of social life. Pinpointing outstanding themes, recurrent concepts or language, and designs of belief that associates people and surroundings together is the most knowledgeably

challenging stage of data analysis and one can participate the entire effort. The development of category generation encompasses observing consistencies in the surroundings or people selected for study, Creswell (1998), cited on De Vos et al (2005). The researcher represented the profiles of the participants in a table manner.

➤ **Coding data**

Zhang and Wildenmuth (2009) clarify that the aim of qualitative content analysis is to categorize the key themes or categories contained by a body of content and deliver a rich explanation of the social realism produced by those themes and categories. The progression comprises of interpretation through written data, classifying themes in the data, coding those themes, and then deducing the arrangement and content of the themes. The researcher examined the data collected from many participants and acknowledged themes (and labelled them as codes or categories) as they emerged probing the data. As the similar themes constantly progressed the researcher gathered the data together. The researcher then applied selected coding patterns to those categories and themes, and assiduously and methodically marked passages in the data by means of the codes.

➤ **Searching for alternative explanation**

As the researcher revealed the categories and patterns in the data she then engaged in analytically challenging the very patterns that appeared so definite. Then the researcher went on to research for other, probable elucidations for these data and the connections among them. Another description constantly exists, the researcher must research for uniqueness and define it and formerly validate why the explanation

presented is the most conceivable of all (Marshall and Rossman, 1999). In this study, the researcher deduced responses of the participants and linked them to what the literature review recommends in Chapter 2. Data alteration is a key to thematic analysis so the researcher guaranteed that all the information was analytically combined together through cross- check-up with the objectives and formulated themes.

➤ **Writing the report**

The information collected was summarized in any form of content by calculating various characteristics of the content as there is no standard procedure for qualitative analysis but it does not mean it is not systematic. The final step was to lay the prearranged interpretation together. This is a transcribed explanation of the phenomenon one studied, most possibly (but then not inevitably) by means of thematic categories starting the analysis as titles. Furthermore in the last stage of the spiral, the researcher presents the data, packaging anything that was found in the writing, tabular or figure form De Vos et al (2005). In this study the researcher used the table to interpret and present the answers given by all the participants using tables.

3.10 Ethical considerations

The researcher has worked with the caregivers during the attachment period therefore the caregivers will assist the researcher to work with patients well. The study was for academic purposes and the researcher complied to the reality that HIV and AIDS is still a sensitive issue and participants were taken care of appropriately by respecting their confidentiality when working with them. Moreover the, researcher made use of the ethical guidelines to conduct research to ensure a high ethical standard ethics by

respecting the people's privacy. Ethics are the principles and guidelines that help us to uphold the things we value. The following ethical considerations were applied.

- **Informed consent**

According to Armiger (2011), it means that a person gives his consent meaningfully, willingly, perceptively, in a vibrant clear way. The respondents have the right to autonomy and are protected also and individuals are more important than scientific and social interests. Research participants have the freedom to choose how much information about themselves they will reveal and under what circumstances. The researcher explained the objectives of the research study to the participants as a way of upholding consent so that they would understand what the research intends to find out.

- **Anonymity and confidentiality**

Oliver and Gregory (2003), define confidentiality as an ordinarily observed analogous to the standard of privacy. The researcher guaranteed the respondents of confidentiality that what they discussed was not going to be disclosed without their consent. The idea of confidentiality (and anonymity) was likewise consistently elevated and debated with research participants previous to their partaking in the research. Therefore no name was asked in the interviews and it was explained to the participants that psydo-names were going to be used. The participants were also informed that no one was going to access the information.

- **Voluntary participation**

The researcher did not force the respondents to participate when they did not want. It was the subject's decision to participate voluntarily, rather than the result of pressures

such as unwarranted inducement. All the participants in the study were issued consent letters to sign and confirm that they were willing to participate. The research aims and objectives were also explained appropriately to the participants during the inauguration of data collection.

- **Avoidance of harm**

Avoidance of harm means that the participants should not be harmed physically or psychologically in the research process. Hence the researcher was careful not to harm the respondents by not saying something insensitive to them or in a rough way in the process of conducting the research.



3.11 Limitation of the Study.

'There were a few problems' encountered in the field work and they are as follows:

- This research was associated with a very sensitive issue of people who are sick so some of the patients did not want to disclose the information required by the researcher. To overcome this challenge the researcher explained to the respondents the principle of anonymity reassuring them that their responses were to be handled with privacy and confidentiality.
- The study was limited by focusing only on two wards in Shurugwi rural so the results obtained may not be pertinent to other wards in Shurugwi rural. The researcher only concentrated on these two wards because there are 23 wards and these two have been affected to a greater extent than the other wards.

- The researcher managed to do her research under Midlands Aids Service Organisation in order to collect data because the organisation is the one that have full control of the programme.

3.12 Reliability and Validity

Reliability is the constancy or uniformity of the extent. According to Gravetter and Forzano (2003), Monetto (et al) (2002), cited in De Vos (et.al) (2005), reliability refers to a evaluating tool's capacity to produce reliable statistical outcomes every time it is applied. At that time if the results of the study can be repeated in a similar method, formerly the research tool is reflected to be reliable. In result, reliability has to do with the extent of casual error in the measurement the more consistent the measure, the less random error in it. According to Carole and Almut (2008), validity is commonly well-defined as the degree to which an instrument measures what it signifies to measure. It is concerned with whether the instrument measures the concept it seeks to measure and whether this perception is measured accurately. It can be seen that validity means the correct correlation between data and conclusion, but what is more problematic is the achievement of such an accurate relationship. Validity is measured imperative because the objective of the research should be an archetypal of what the researcher intends to explore and reliability concerns about the consistency and permanence of data.

3.13 Conclusion

This chapter focused on the methods that were used in gathering the data. It explained and clarified the mixed method that was used which included the research instruments

that were used, how data was collected, the scope and limitations of the study, reliability and validity and how the data was to be analysed. The following chapter is going to focus on the findings, conclusions and recommendations of the study.



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CHAPTER FOUR

PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1 Introduction

This chapter focuses on the presentation and discussion of the data that was collected from the field. The data was collected from Tongogara and Dosert wards in Shurugwi rural from the caregivers, HIV and AIDS patients and the key informants (CHBC officers from NGOs). In this chapter the data is presented in three sections; the first comprises of the results of quantitative analysis which are accessible in descriptive statistics. The second section comprises of the qualitative results of the interviews which are presented according to the themes that emerged during the discussions and field notes. The last section is the discussion of the findings of the study.

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4.2 Presentation of quantitative findings

The quantitative survey used was meant to provide detailed biographical information of beneficiaries, on how CHBC services are improving the conditions of HIV and AIDS patients and mitigating the effects of HIV and AIDS in rural areas. The results are presented below.

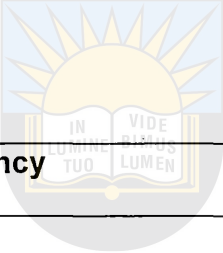
4.2.1 Biographical Information

HIV and AIDS patients and the primary caregivers were the respondents to the questionnaires in this study. The outcomes of the study revealed that 66% females responded. Thirty-four percent respondents were males. The reason why there are many females is that most women stay in rural areas, especially those that are not

educated. Therefore regarding the age respondents, Table 4.2 shows the percentage and frequency of the respondents.

As table 4.1 below illustrates, the group between the ages of 35 and above formed the largest component of the respondents in this study with 72%. This group is followed by respondents aged 26 to 35 years with 17%. The least group are those aged 18 to 25 years with 11%. On the other hand, in terms of the marital status, Fig 4.3 points out that the respondents formed three groups.

Table 4.1: Age of the respondents



Age	Frequency	Percentage
18-25yrs	15	11
26-35yrs	23	17
35 and above	98	72
Total	137	100

Fig 4.1 shows the results regarding the marital status of the respondents. Out of 137 respondents 62% were married people and followed by 21% who indicated that they were single. The figure highlights the least percentage (17%) who were separated.

The educational qualifications levels in the study consist of no education at all, primary, secondary, and tertiary education. The respondents were disseminated in four levels as designated in Fig 4.2

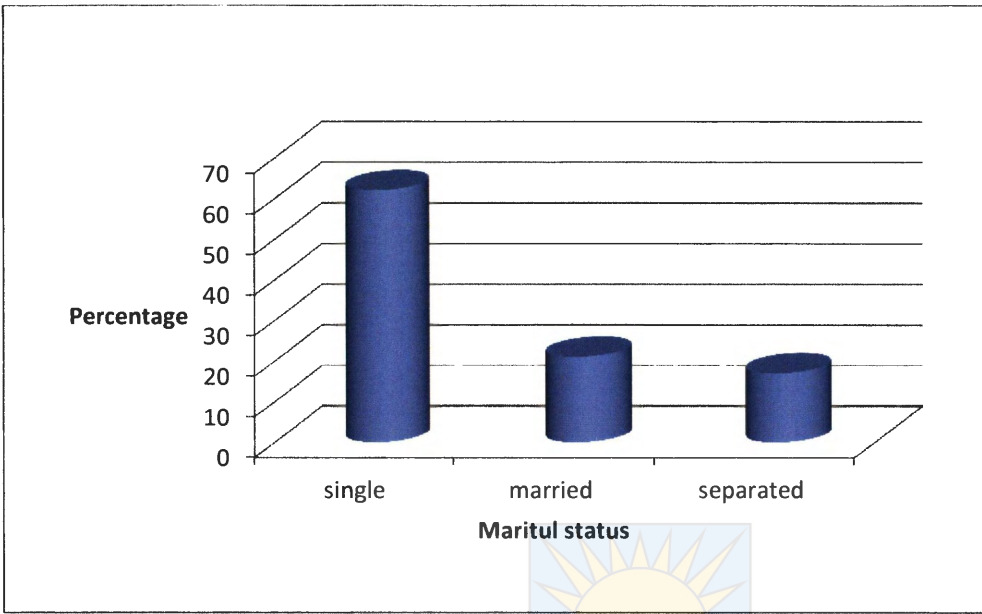


Fig 4.1: Marital status of the respondents

The Fig 4.2 below shows that when the respondents were asked about their educational qualifications the majority of the respondents (47 %) had secondary education; that is matriculation certificate and some went for secondary but did not finish school. Forty-five percent of the respondents indicated that they had primary education, that is grade seven certificates. Those who responded to no education were 4% meaning, that they did not go to school and the least number (3%) of respondents had some tertiary education qualifications.

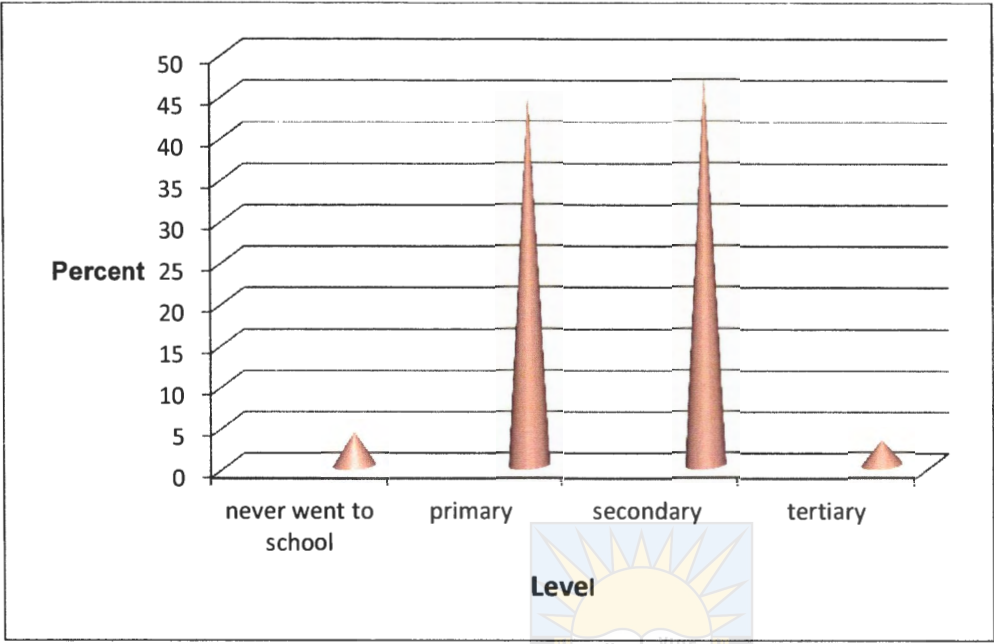


Fig 4.2: Educational qualifications of respondents

4.2.2 The needs of HIV and AIDS patients under CHBC programmes

As indicated in Fig 4.3 the largest number (86%) of respondents explained that they experience food shortages followed by the 65% respondents who showed that health kits were a shortage. About 51% recipients mentioned that they needed treatment vouchers for medication and 39% respondents indicated that transport was another need. Four percent was the least number of beneficiaries who showed that they needed school fees for orphans.

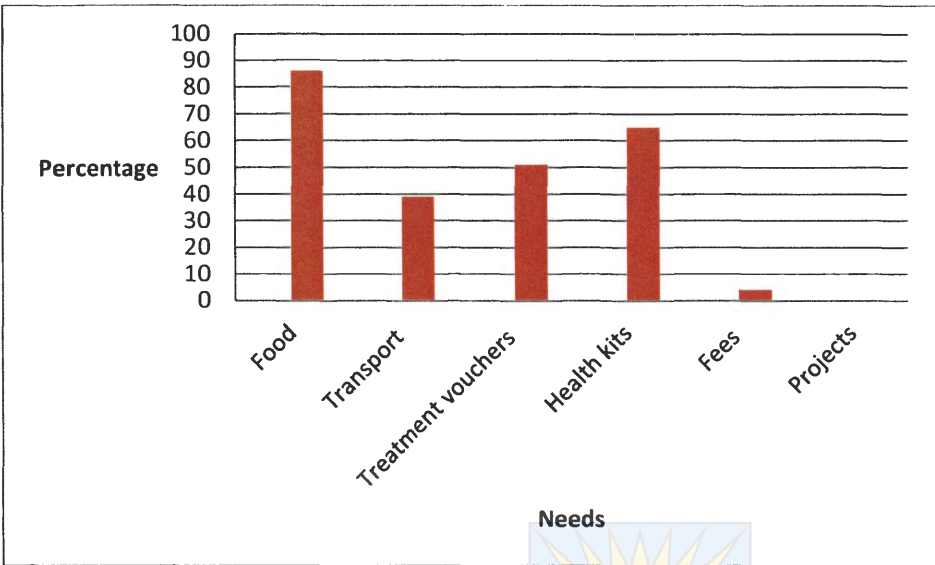


Fig 4.3: Needs of HIV and AIDS patients

As for the meals, the respondents were asked to explain the number of meals they eat per-day. Their responses are shown in Fig 4.4. The table indicates that the majority (86%) of beneficiaries eats three meals and above per day. The figure further indicates that 13% respondents eat two meals only per day. Lastly one percent explained that they eat only one meal per-day.

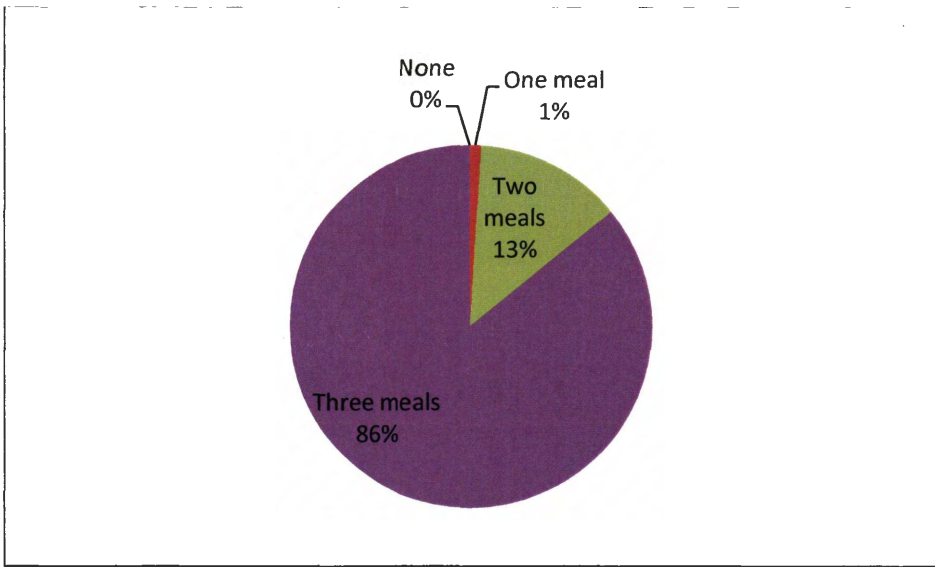


Fig 4.4: Meals eaten by patients per-day

Fig 4.5 below shows how respondents encounter food shortages in their families during the course of the year. The figure indicates that out of 137 beneficiaries who responded, most beneficiaries (42%) respondents revealed that they encounter food shortages any time of the month. This was followed by those who showed that they encounter food shortages before harvest (29% respondents). In addition sixteen percent of the respondents encounter food shortages at other times and the smallest number of (7%) respondents mentioned that they experience food shortages before the month ends.

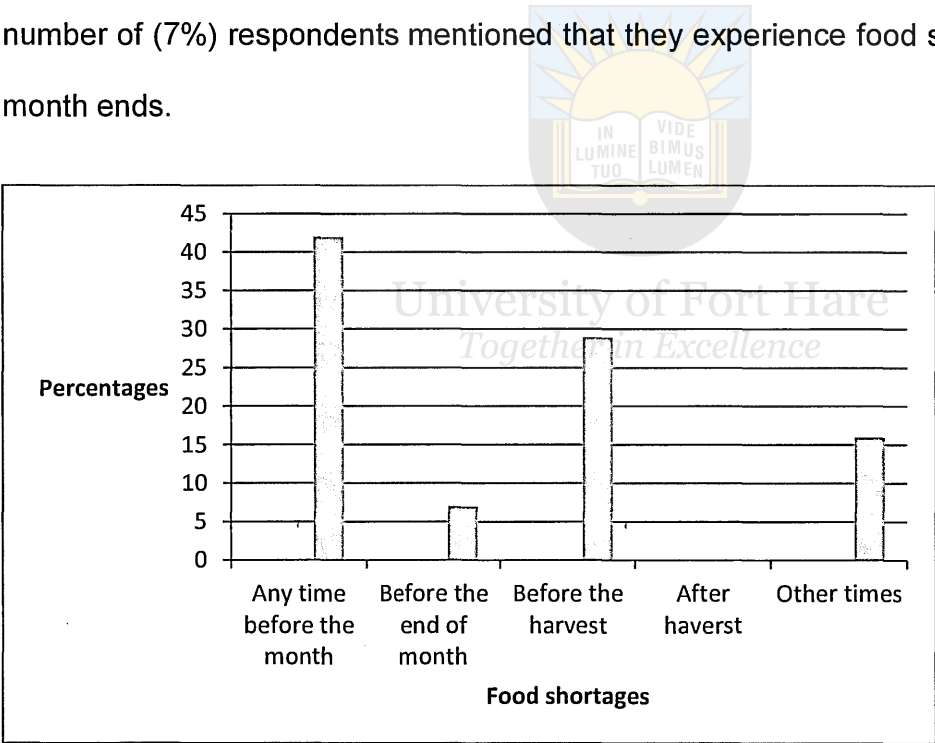


Fig 4.5: Food shortages during the course of the year

The Zimbabwean country tries by all means to eliminate poverty and make people to be responsible enough by providing for their needs. In light of this, one of the objectives of the study was to find whether the government /NGOs are helping the beneficiaries to sustain themselves in order to improve their conditions. The results show the

percentages of the respondents on Fig 4.6. Out of 137 respondents; 58% lack agricultural inputs, 38% mentioned that food shortage is affected by late rainfall and followed by 28% who explained that food shortage was due to high temperatures. The study also exposed that 23% respondents indicated that shortage of food was due to the death of the main provider and 16% respondents mentioned that lack of food was as a result of loss of livestock due to drought. About 13% beneficiaries revealed that food shortage was caused by lack of water sources /reservoirs. Eight percent respondents showed that food shortage was caused by poor harvest due to pest and diseases and then (5%) agreed that food shortage was as a result of loss of livestock due to pest and diseases. The least, 2% of the recipients, mentioned that food shortage was as a result of lack of money and unemployment. The table indicates that food shortages in Shurugwi rural are a result of the above mentioned challenges or barriers to a successful practice of subsistence farming and lack of agricultural skills as well.

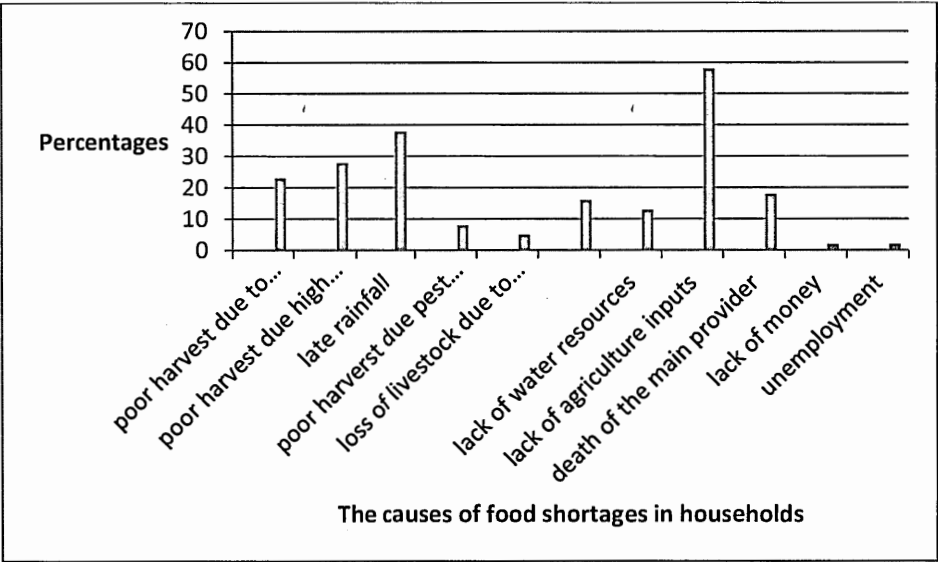


Fig 4.6: Food shortages in households

4.2.3 Possible solutions to improve food security among CHBC beneficiaries

One of the objectives of the study was to explore how the government/NGOs and the beneficiaries overcome the food shortages in order for the patients to have enough food in their household. The respondents were therefore asked to explain how they overcome food shortages in their household. Fig 4.7 indicates the percentages of how respondents adjust in order to avoid shortage of food. Sixty-four percent of respondents overcome food shortages by doing petty jobs like ploughing for other people. Fifty percent of respondents mentioned that they focus on garden projects because they are subsistence farmers and 25% revealed that they rely on food aid and borrow from friends and relatives. Ten percent agreed that they sell their crops and 7% respondents showed that they sell their livestock and the least respondents (2%) mentioned that they borrow food from shops for future payments.

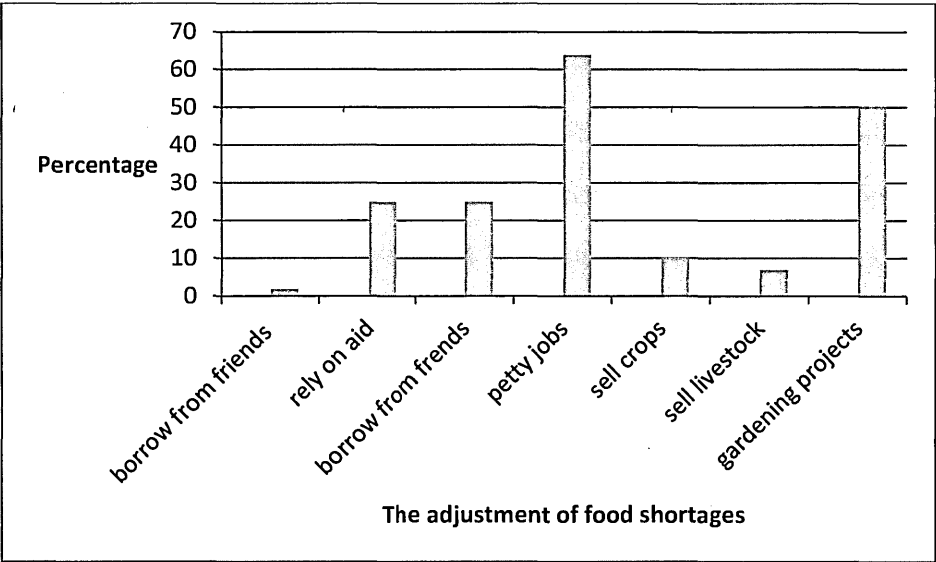


Fig 4.7: Possible solutions to food shortages

Most of the respondents (68%) indicated that they receive education on hygiene, 64% receive referrals services to other health centers and 58% showed that they receive psychosocial support from the secondary caregivers. Fifty percent indicated that they received spiritual care and nursing care from caregivers, relatives, and friends and from other church members. Forty percent recipients of CHBC agreed that they received help on monitoring drug compliance and 6% respondents that they sometimes receive food baskets. The other 6 % showed that they received drugs also like pain killers, CHBC kits and treatment vouchers to go to clinics or hospitals.

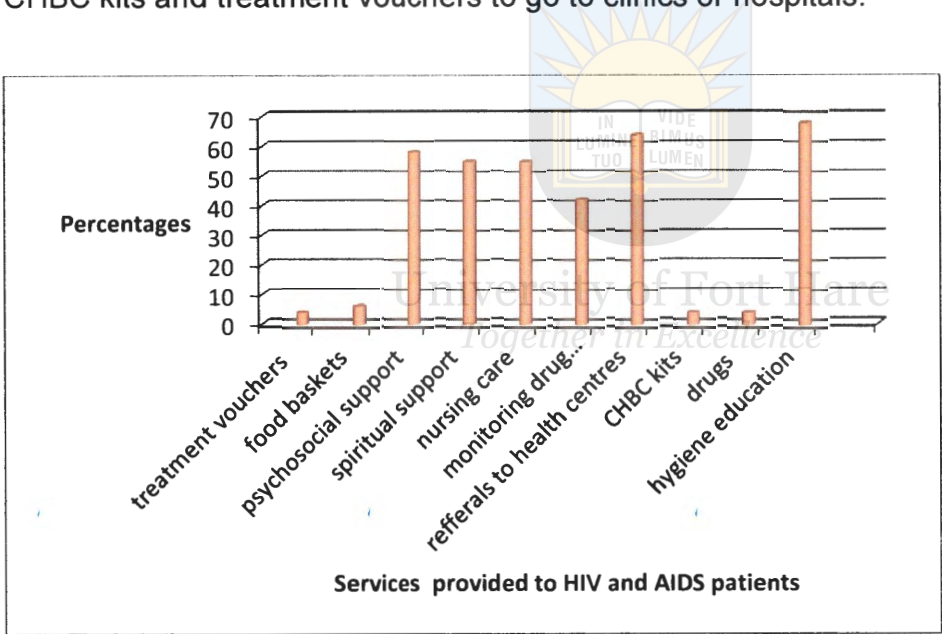


Fig 4.8: The services provided to HIV and AIDS patients

About 60% of the respondents indicated that the programme does not give them enough resources like food, drugs, CHBC kits, money, transport cost. The least beneficiaries (40%) agreed that the programme was trying its best to help them because most of the patients are now better and they can work for themselves. Fig 4.8 shows the percentages of the total number of the beneficiaries who were asked if the

services were improving their condition very well from the time they started to receive the services up to date. These were their responses; 62% of the people agreed that the services were better, followed by 34% who indicated that the services were fair and 3% showed that they was no change even if there are receiving the services. Then the least 1% indicated that things were worse.

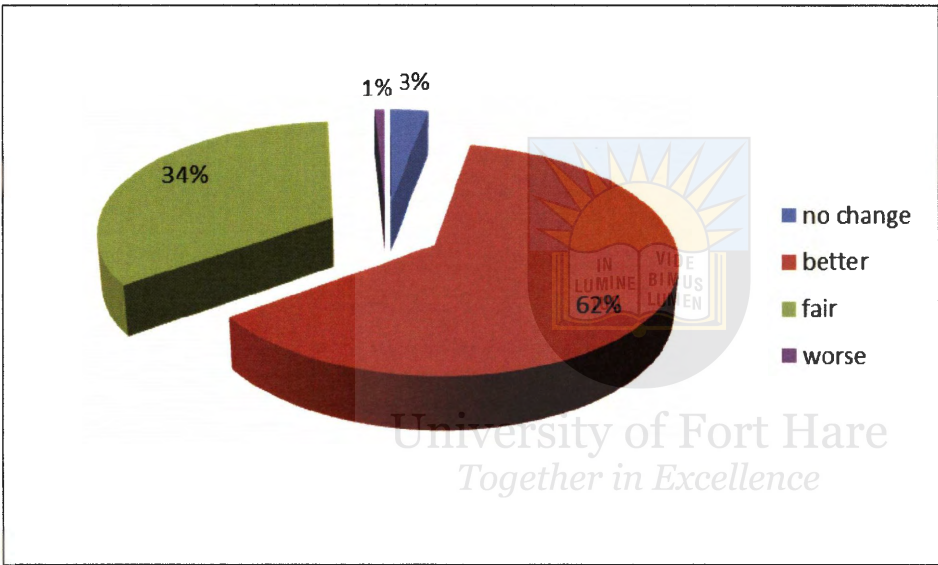


Fig 4.9: Perceptions of beneficiaries on the services they are receiving

4.2.4 Challenges underpinning CHBC beneficiaries

Fig 4.10 shows the responses that were given by the caregivers and the patients about the challenges they are facing. One hundred and thirty-seven responded and the following are the results. Majority of the respondents (74%) indicated that the main problem affecting them in their household was food shortages, followed by 72% respondents who agreed that CHBC kits are not enough. About 53% respondents mentioned that lack of funds is another challenge and 52% respondents explained that

lack of resources is another problem. The figure further shows that the least (40%) acknowledged that lack of transport is another problem they face.

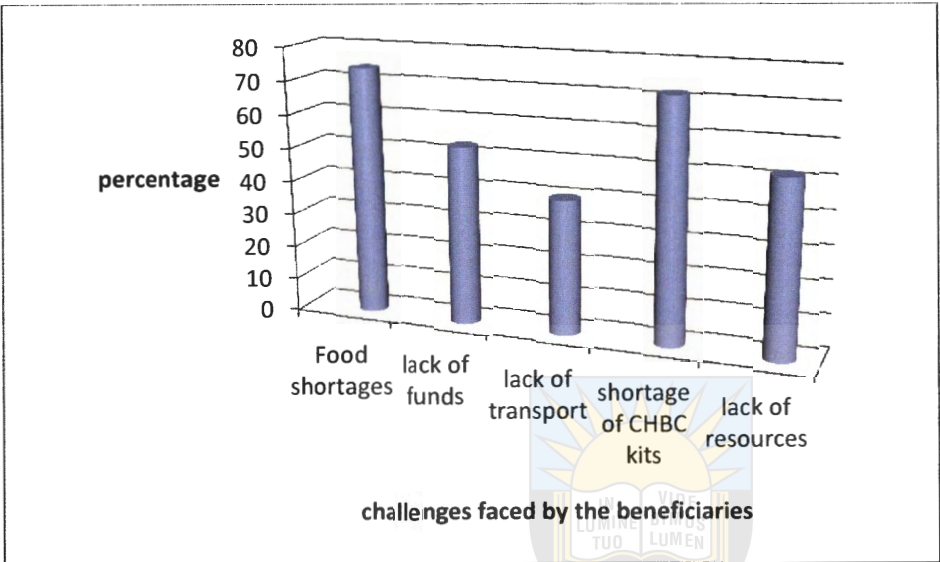


Fig 4.10: Challenges faced by patients and the primary caregivers

The caregivers and HIV and AIDS patients were however asked how they overcome the challenges mentioned above and how CHBC programmes intervene when they face such challenges. The results are shown on fig 4.11. Twenty percent of respondents mentioned that if they face problems of food and others mentioned above they do some petty jobs for other people and they are given food or money. This is followed by 20% who indicated that they receive advice from church members on how they can improve their conditions. Moreover 13% respondents agreed that they receive help from their relatives and friends when they are in need. The least number of (4%) respondents revealed that sometimes they sell their garden products.

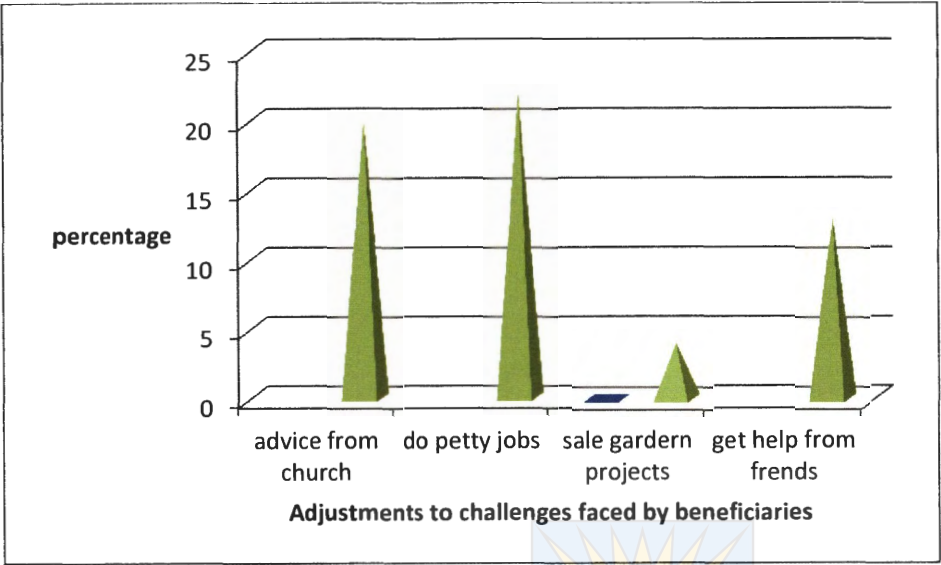


Fig 4.11: Adjustments to challenges faced by beneficiaries’

Moreover the caregivers and HIV and AIDS patients were also asked about the problems that needed external interventions and where they get help. Fig 4.12 shows the results given by the respondents (137) who were administered the questionnaires. Thirty-six percent of respondents agreed that they got help from CHBC programmes when they wanted money, pain killers and transport. About 28% respondents mentioned that they got help from the clinic of pain killers, cotton and other drugs. Twenty-eight percent also showed that they received help of money and food from their village headmen. Furthermore 23% respondents revealed that they got help from NGOs like TASO, Oxfam, Red Cross, Lutheran church, Cadec, MASO to mention a few when they needed food, money, seeds and fertilizers. Twenty-one percent respondents showed that they also got help from their ward or community counselors when they wanted money and food. Then 7% said they received help from their relatives, 4% respondents received help from the District Administrator and the least number (1%)

indicated that they got help from social welfare of school fees for orphans and birth certificates.

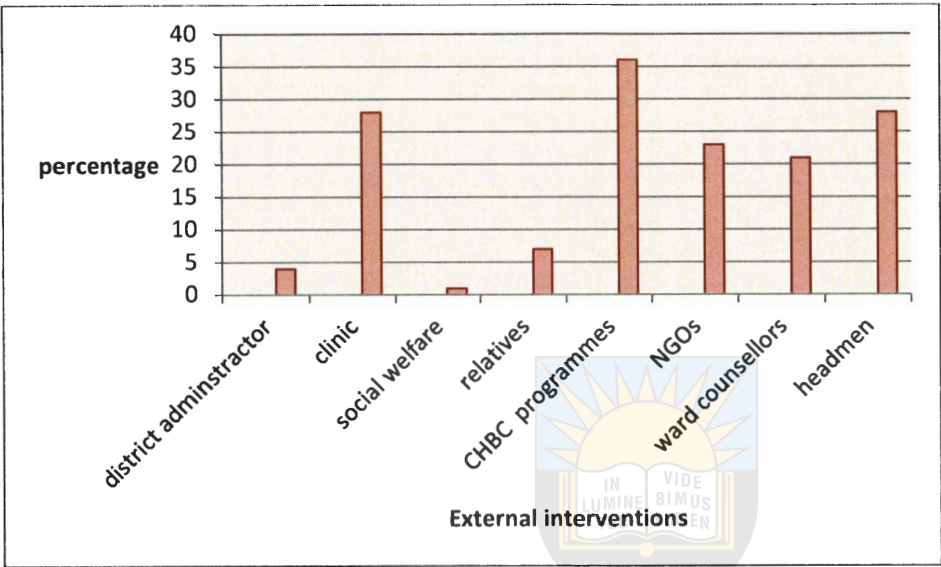


Fig 4.12: External interventions from other organizations

More so Fig 4.13 explains what the beneficiaries want the government and NGOs to help them with in order to improve well and have a better social functioning. About 26% respondents explained that they want the government and NGOs to help them with food especially to come up with a donor that issues or helps patients with food. This was followed by 18% respondents who indicated that they need more education on HIV and AIDs so that they can understand more about the pandemic. Twelve percent of the beneficiaries suggested that it would be good for the government and NGOs to help them with a certain amount of money to help themselves to cover other expenses. Nine percent of respondents showed that they need help of more projects, skills and raise funds for their needs. Three percent of respondents mentioned that caregivers should

be paid money because they work very hard and they are committed to their work and 2% respondents explained that they need help of school fees for children and orphans.

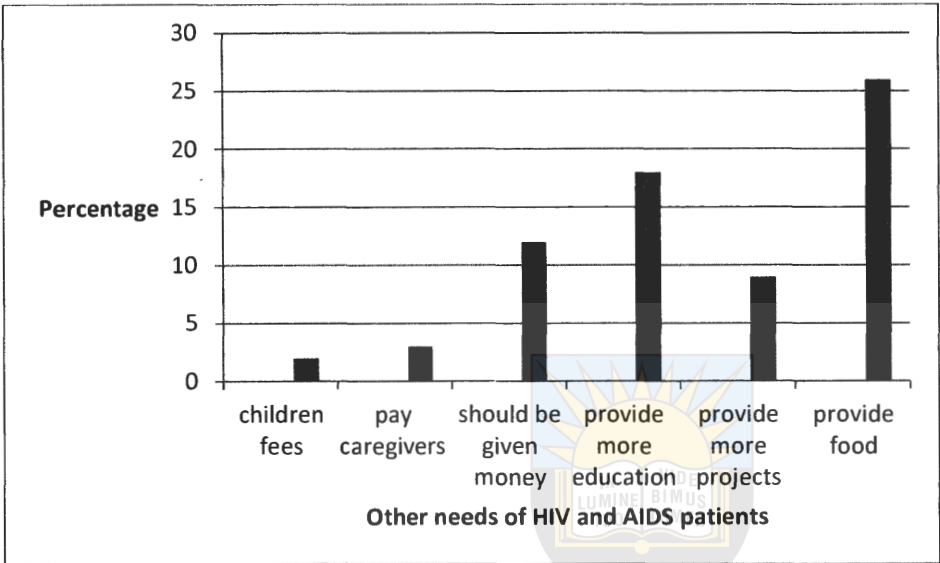


Fig 4.13: Other needs of primary caregivers and HIV and AIDs

4.2.5 The perceptions of HIV and AIDS patients and primary caregivers

The beneficiaries were also asked about their perception on the effectiveness of CHBC programmes and table 4.2 shows the frequency and percentages results of 127 respondents who responded to this question. Most respondents (62%) agreed that CHBC programmes are effective because they have managed to reduce the effects of HIV and AIDs and most patients have improved and there are a few bed ridden clients now. Eleven percent respondents indicated that the programme is not effective because there are a lot of challenges and problems that are faced by HIV and AIDs patients and other debilitating sicknesses that have been mentioned above. The least (27%) of respondents revealed that the programme should continue because people

are still infected every day, people need more education and more funds so as to overcome the challenges related to the pandemic.

Table 4.2: Perceptions of HIV and AIDs and primary caregivers

Perceptions	Frequency	Percentage
Effective	79	62%
Programme should continue	14	27%
Not effective	34	11%
Total	127	100

Fig 4.14 shows the results of the perceptions on the effectiveness of CHBC programmes if the programme is improving the conditions of HIV and AIDs patients in Shurugwi rural. The largest number, (40%), respondents indicated that that the pogramme was excellent in improving the conditions of HIV and AIDs patients because most patients can help themselves by going to the fields to work. This was followed by 30% of beneficiaries who showed that CHBC programmes were fair and 24% respondents who mentioned that the programme was good in providing the services and in improving their conditions. The least, one percent, indicated that the programme was bad because patients lack the basic needs required for them to recover well.

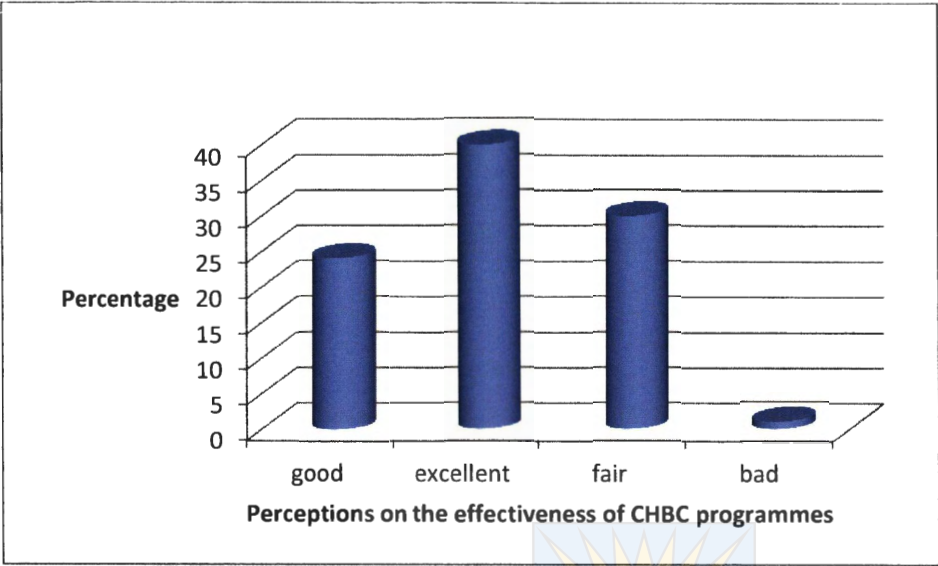


Fig 4.14: Perception on the improvements of patients

Fig 4.15 illustrates the recommendations on what the government/NGOs should do to enhance the improvements of HIV and AIDS patients and other debilitating sicknesses and to diminish the effects of HIV and AIDS. The beneficiaries of CHBC programmes suggested the following needs: 34% of beneficiaries suggested that they needed more food and more drugs to be available at clinics and hospitals all the time. Fifteen percent of respondents revealed that they need more projects and indicated that the government should help them with money. About 11% of respondents agreed that they need more CHBC kits to ease the work of secondary caregivers and 10% showed that more clinics should be built in rural areas. The least number (2%) of the respondents indicated that the government /NGOs should provide transport, increase the number of caregivers and should provide counseling to patients more often.

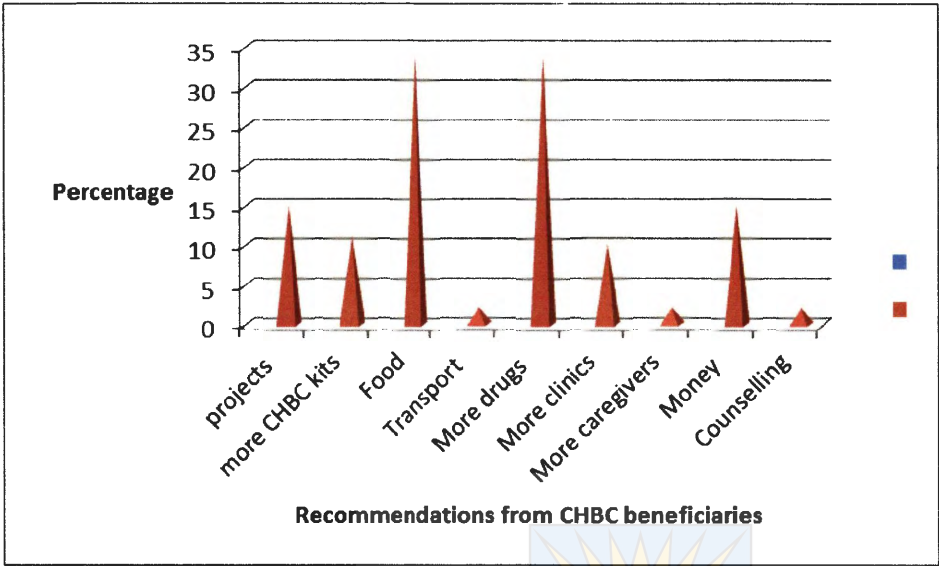


Fig 4.15: Recommendations from CHBC beneficiaries

4.3 Presentation of Qualitative data

The research study aimed at exploring the effectiveness of CHBC programmes to see how far it has achieved since the programme started until up to date. The qualitative part of this study sought to supplement the quantitative data in exploring the effectiveness of CHBC programmes. This was done using in-depth interviews to capture the exact words, feelings, perceptions, attitude and experiences of the beneficiaries of CHBC programmes. The interviews sought also to examine the services that are provided to HIV and AIDS patients and if they are improving the condition of patients and to determine whether they are sustainable enough to extenuate the effects of HIV and AIDS. Ten secondary caregivers and four key informants from NGOs (CHBC officers) and from the government (CHBC coordinators) were interviewed and the responses led to the following results which are presented according to the themes that emerged.

4.3.1 The needs of HIV and AIDS patients

The qualitative results shows that all the caregivers (10) have been providing care to patients for more than five years and each provides care to more than eight patients. The two key informants reported that they have been monitoring the patients for more than five years. Eight caregivers had a client-patient relationship and two other caregivers responded that they were related to the patients. There was an awe-inspiring agreement by the participants that the needs of the patients are lack of CHBC kits, gloves, cotton, soaps, shortage of pain killers, and lack of transport cost, lack of school fees for orphans, lack of food and other resources like books to learn more about the pandemic. Furthermore six participants indicated that the resources they were given to help the patients were not enough and they struggle to care for patients because CHBC programmes do not supply the resources all the time.

One female interviewee said that:

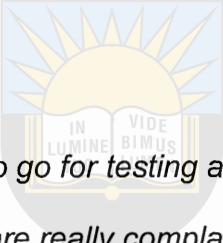
Sometimes we have to use our own resources when we are helping the patients and other times we seek help from the chiefs, counselors and headmen in the community and it's a good thing that they are supporting us.

The other six participants revealed that the resources were fine and if they had problems they would visit the clinic for further help. Moreover nine participants agreed that their needs as caregivers and as field officers were not met all the time because of lack of resources. In addition three other participants agreed that their needs were met as they also received some money, uniforms, bicycles, soaps, jiks and health kits.

4.3.2 The services provided to HIV and AIDS patients

The participants were asked about the services that are provided to the beneficiaries by CHBC programmes. All the fourteen participants mentioned that the services provided to HIV and AIDS include psychosocial support, spiritual support, nursing care, monitoring drug compliance, treatment vouchers, hygiene education, counseling, prevention condoms, food baskets, and referrals to health centres. Seven participants indicated that most patients have improved very well than before and there are one or two bedridden clients here and there.

One female participant reported that:



People are now open enough to go for testing and they come and seek help when things are hard but they are really complaining that they really need food and other resources to use like CHBC kits, cotton and food.

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Additionally five other participants explained that there are still a number of bedridden clients who really need help who suffer from other chronic diseases and the pandemic as well. When asked if the services were improving the patient's conditions six participants stated that the patients were improving but it was not easy to nurse the clients without enough resources. Six other participants' patients further revealed that the services were not improving the conditions of patients well. All the twelve participants mentioned that the services provided to patients are not sustainable enough and they are not meeting the needs of patients because most donors come for a short period then they leave and this makes their work unbearable. Conversely, the participants continue to work without the donors, because they do not have a donor for 2014 but they still submit reports to CHBC programmes every month.

One male interviewee said that:

We were told to continue supporting and visiting the patients in the community but we do not have a donor supporting 2014 which means there are no funds. We just try our best to help people because it's our duty and we volunteered on our own

Moreover they also continue to visits patients at their homes to see how they are doing because the patients in many communities get confused and sometimes lose hope when they hear that there is no donor.

4.3.3 The challenges faced by the HIV and AIDS patients and caregivers

Five participants indicated that they struggle to take care of the patients without all the necessities that are needed to support the patients to improve well. The other two CHBC officers agreed also that it is hard for them as well to monitor the progress of the patients knowing that they are not receiving anything and they hear people complain when they conduct home visits. In addition the other five participants agreed that they are able to cope even if they do not have enough resources. Furthermore eight participants agreed that patients complain that they need food, CHBC kits, gloves, cotton, soaps and money for transport to go for reviews and other essentials or even money to cater for their needs. Then the other four participants indicated that the other patients have adapted well and they make use of their garden projects and other petty jobs in order to survive.

One female participant revealed that:

We wish the programme could provide all the resources we need to look after the patients because it's not easy to help them especially when they do not have also. A lot of patients do not have any jobs or even their relatives so it's hard for them to support their sick relatives as well.

All the ten participants agreed that they use their own resources sometimes to help and they seek help also from the NGOs, Social welfare, clinics, chiefs, counselors, headmen, relatives, and friends of the patients and from the CHBC programmes as well. The two field officers also mentioned that sometimes they use other resources of other departments like the OVCs and the behavior changes. Furthermore seven caregivers and the field officers had an overwhelming agreement that they are not affected by taking care of clients because they volunteered for themselves and they are now used to the conditions of helping people.

Three participants explained that it was very difficult for them to take care of the patients especially those that they are related to because they expect a lot from them as caregivers. The participants had an awesome agreement that most of the patients face food shortages in their households to feed themselves. They mentioned that there is no donor that stands for HIV and AIDS to provide food for them but food is distributed to all the people in the community by NGOs and government. Seven participants mentioned that there is lack of pain killers most of the time although they sometimes get them at the clinics. Then the other three participants said that they collect pills sometimes for their patients if they have cards at the clinics and the clinic helps them a lot. The participants agreed that they got help from MASO with school fees for orphans, from social welfare with birth certificates for orphans and from Oxfam they got food. ADDRA

also helped the poor with food, Lutheran church, Red Cross (gardens) and from Christian care they got seeds, fertilizers for their gardens and from the government they also got seeds and fertilizers. One male participant said:

We just wish they could have a certain donor that stands to provide food to all the patients because these people really struggle when it comes to food.

4.3.4 The perceptions of secondary caregivers and Field officers

The participants were asked about their perception on CHBC programmes and six participants agreed that CHBC programmes are providing better services to patients in the community. Because they have managed to improve the conditions of HIV and AIDS patients' conditions and reduce deaths rates. They also agreed that it has been a great improvement compared to past years when patients could die without even taking medication due to lack of drugs, fear of discrimination from community members and family. One male field officer revealed:

I think we can't really complain that they have not done anything because patients are now better even if resources are few we struggle as caregivers to help the patients even with those few resources to make a difference.

Then eight participants agreed that the programme was trying the best but it is not effective to its best. The reason being that they are not meeting all the needs of the patients and the work of caregivers becomes hard without more knowledge and the resources that are needed to help HIV and AIDS patients to improve. Eight participants also mentioned that the programme needs to put more effort because there is shortage of resources. This includes machines to check for CD4 count, machines for X-rays and

the health facilities are also a few. The participants proposed what the government /NGOs should do to improve patients' conditions which includes that the NGO /government should provide food to all HIV and AIDS patients. Moreover the NGO /government should build more health facilities in rural areas, supply machines for CD4 count and X-rays in the available clinics in rural areas. They should introduce them to more projects like poultry, sewing, pottery, stone carving, village lending and savings so that these projects can sustain them for a long period. More so should provide transport cost for emergency cases, give every HIV and AIDS patients some money for other cost, pay caregivers because they work very hard, find a donor that provides food to HIV and AIDS patients only and supply enough CHBC kits. One male participant mentioned that:

We need more projects and skills rather than focusing on garden projects only because there is lack of water reservoirs and we do not have enough garden inputs to use.

Moreover six participants also agreed that the government and NGOs should provide transport cost for the patients because sometimes they are referred to far away hospitals. They should also build more clinics, increase the number of caregivers and nurses to ease their work. Furthermore there five participates agreed that medication should be available all the time at clinics and organize more workshops to educate both caregivers and HIV and AIDs patients so that they can be empowered more to take part in matters concerning their positive lives.

4.4 Discussion of findings

Effectiveness of CHBC is one phenomenon that is very important; looking at the extent to which HIV and AIDS has overwhelmed every society. The programme has therefore provided the platform for enhancing the lives of the affected and infected to have a better social functioning. However, it lacks the most very important aspects of the basic needs of the individual to fully obtain self –actualisation. Those who are affected and infected depend solely on the help of the government/NGOs in order to improve well. However if the government/ NGOs do not take full responsibility of HIV and AIDS patients they are prone to many circumstances that include dying and more opportunistic infections.

The study was steered by one model the Basic Needs Approach (BNA) which elucidates the behaviour of humans in relation to elementary requirements for subsistence and development. These provisions, or desires, are prearranged deliberating to their eminence of continued existence and their control to inspire the human being. The BNA proposes that every human being should have all the basic needs that one needs for survival in order to fulfill life. Therefore food, water, or oxygen are very crucial because they create the lowermost level of the necessity of the hierarchy. Hence the hierarchy should be followed stage by stage for one to fulfill his or her existence. This means that if basic human needs are not met patients' conditions are affected to a greater extent which will lead to more deaths and more infections and the effects of HIV and AIDs will increase. The main important aspect is that CHBC programmes are there to moderate the effects of HIV and AIDs and improve the conditions of the patients in order for them to have a better social functioning. However

if CHBC programmes do not meet and fulfill their main goal one cannot say the programmes are effective at the end of the day. Reliability and validity of many questions come into play in relation to the objectives of the research study linking it also to the objectives and the goal of CHBC programmes. Firstly the first objective sought to explore the needs of HIV and AIDs patients and the biographical information of primary caregivers and HIV and AIDs patients. The results of the study show that 66% women responded more than men in this research study because more women live in rural areas than men. This also shows that more women are affected to a greater extent than men in many societies. Moreover the needs of the patients show that food is the most important need for HIV and AIDS patients in the society followed by health kits, transport cost, treatment vouchers for medication and school fees for orphans.

The study therefore shows a greater need of resources in order to improve the conditions of patients well. Furthermore literature is in support of the results which contend that when patients are referred home to receive CHBC services without adequate assessment of their domestic environment, caregivers often find themselves struggling to accommodate patients in a home lacking adequate shelter, food, safe water, proper sanitation, and clothing (Ngwenya and Kgathi 2006; Phorano et al. 2005; Shaibu 2006; Stegling 2000:). On the other hand the National Guideline (2002) asserts that families and caregivers have physical, psychological, and social/spiritual needs that must be met in order to maintain family solidarity and well-being. Because the burden of caring for someone who is very ill or dying is constant and heavy, the family may also need help with household, farm, or other chores. This means that not only HIV and AIDS patients lack the basic needs but also the family and the caregivers that provide

the nursing care to the patients. Contrasting from the above authors and the results of the study, resources are lacking in many countries in many societies since the CHBC programme started due to various challenges that include poor rains, lack of funds, lack of agricultural inputs and donor fatigue. Empirically the 2011 Zimbabwe Vulnerability Assessment Committee (ZimVAC) estimates that just over one million Zimbabweans are unable to meet their food requirements in the current lean season of 2012 due to the late green harvest. This is corroborated by the findings of this study which show that most patients still lack food and other resources in the long run.

The research also brought to light that most projects that are implemented in many rural areas are not sustainable enough to help HIV and AIDS patients to overcome food shortages in their households. Because gardening projects are the only projects effected to equip families to increase food in their families. It is argued that, poverty alleviation projects have left a legacy of increased vulnerability and impoverishment amongst the displaced communities due to entitlements losses (Basilwizi, 2010). It is because most projects lack enough funds to make them last for a long time and due to other natural disasters and also due to dependency on donor aid.

Moreover as the study indicated, many people in rural areas are not educated; as a result of lack of funds this also affects their living standards. As subsistence farmers they are supposed to be knowledgeable enough to equip themselves for the better with good agricultural skills. According to MOCHW (2010), there is lack of a national strategy or policy addressing food and nutrition insecurity in vulnerable households with PLHIV. This shows that the service providers are not receiving enough or continuous

trainings because of shortage of resources and funds to train them more. The issue is that the government /NGOs are not reaching the poor of the poorest looking at food shortages or poverty of many HIV and AIDs patients. They struggle to find food where as we see NGOs / government distribute food especially in Shurugwi. Furthermore many donors come to issue food to all the people in the community affected by food shortages without considering those who are less privileged like HIV and AIDs patients and other debilitating sicknesses. Most of the strategies used to fight food shortages do not leave people empowered to do it for themselves especially in rural areas because they concentrate more on gardening which is affected by lack of agricultural inputs and poor rains.

Moreover the donors' supporting the programme sometimes leave or terminate before the beneficiaries are stable enough to stand by themselves this becomes a barrier also to the implementation of successful CHBC programmes. Therefore it is vital to note that the needs of HIV and AIDS are very important in order to improve their conditions well. The study shows that there are many services provided to patients by CHBC programmes which equip the caregivers and the patients to take care of themselves and to take care of the patients in order to enhance their social functioning. These services include nursing care, spiritual support, psychosocial support, monitoring drug compliance, referral to health centers and hygiene education. Evidence from the study showed that 60% of the respondents agreed that the programme was not providing better services because of lack of food, drugs, CHBC kits, money and transport cost. The programme does not have the resources but provides knowledge on how to take care of patients. According to Irish AID Health Development Network and Southern

They are grateful that most community members understand and they get help from many individuals and organizations of resources and funds. This includes headmen, counselors, District Administrator, chiefs, NGOs such as Midlands Aids Service Organization, Red Cross, Lutheran church, Oxfam, the government, National Aids Council, and many others. Nevertheless they cannot provide better services and a conducive environment for patients in a resource lacking environment. Wringe et al contend that, despite the positive political and economic climate that has served to place comprehensive HBC programmes squarely on the HIV policy agenda, the emerging evidence suggests that current plans to expand HBC coverage have given insufficient attention to addressing the challenges that have been documented by those implementing small-scale but routine programmes.

However they should take note of the broad objective of CHBC programmes which seek to develop and implement a comprehensive CHBC activity that meets physical, psychological and spiritual needs of HIV and AIDS patients and their families (Ministry of Health Botswana, 1996). Additionally the last objective of the study however, shows the results of the study on the perceptions of the beneficiaries on the programme. The findings show that the programme is effective to a greater extent because it has managed to improve the conditions of patients. And there are also a few bedridden clients and most of the clients can work for themselves. However CHBC programmes are not always effective because of lack of resources, funds and lack of evaluations of programmes which hinders the effectiveness of CHBC programmes and causes many problems in the long run. The results of the study are supported by evidence that, despite some efforts to cost HBC interventions in Zimbabwe, Rwanda and Uganda

there has been little work on exploring the relative costs or cost-effectiveness of different HBC strategies across settings (Jaffar *et al.* 2009). This means that most CHBC programmes are not addressing the challenges faced by most people in the community but put much emphasis on the cost analysis instead of various strategies used in the programme. It is therefore difficult for beneficiaries under CHBC programmes especially those in rural areas to support themselves because they are not educated enough, lack skills on agriculture and they are unemployed.

Nevertheless another objective of CHBC programme explains that the NGOs/ government seek to mobilize the resources necessary for sustainability of the service. But still they are failing to meet and supply the needs of the beneficiaries under CHBC programmes. This explains the reasons for the suggestion that the government /NGOs should help them with the following resources; build more clinics, provide more drugs at the available clinics and hospitals, introduce them to more projects, pay caregivers, provide a stipend for the patients, transport cost, food to patients, more education on HIV and AIDS, equip the patients and their families with more skills on farming techniques and adequately assess the needs of patients.

4.5 Conclusion

This chapter presented the outcomes of the research study which explored the effectiveness of CHBC programmes. The study recognised that the challenges faced in CHBC programmes in other countries according to the literature are the same challenges faced by beneficiaries in Shurugwi. The study also brought to light new problems recognised affecting many CHBC programmes. Establishing on the outcomes

of the research, one may note that there is still a lot that needs to be done although the beneficiaries of CHBC programmes have improved very well than the past years. The reason behind this is that many communities continue to struggle to improve the conditions of patients due to various problems. These problems includes the withdrawal of donors, lack of funds, shortage of resources, absence of monitoring and evaluation, shortage of employment, non-existence of assessment of patients' environment and needs and lack of food. Subsequently the main reason for beneficiaries struggling in most rural areas is as a result of high illiteracy, lack of education and high rate of unemployment. These challenges make the people to fully depend on the government /NGOs but the government creates projects for these people to reduce poverty and improve the conditions of HIV and AIDS.

Nevertheless the strategies introduced are not sustainable to help the beneficiaries for a long period of time as they are few, like the garden project. Because the garden project is mostly affected by poor rains, lack of agricultural inputs, farming skills, and there are no funds to support these projects in the long run. Moreover the help given by other organisations like NGOs contributes in deepening poverty levels of people as they are more of aid rather than progressive aid. Consequently this study discloses that, CHBC programmes in Shurugwi rural have managed to extenuate the effects of HIV and AIDs and improve the conditions of the recipients (patients).

The qualitative analysis of the study has sustained the quantitative results which institute that CHBC programmes should continue to enhance the lives of HIV and AIDs patients and other debilitating sicknesses. Henceforth they should assess the basic needs of the patients in order to improve their conditions well as asserted by the objectives of CHBC programmes.



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CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of findings and draws conclusions from the research. The study also offers recommendations that might be of great value in extenuating the impacts of HIV and AIDS and in improving the conditions of the patients as well as help the government and NGOs regarding policy and practice direction. Suggestions for further study as well as implications for social work practice are offered in this chapter.



5.2 Summary of findings

The study sought to examine the effectiveness of CHBC programmes in improving the conditions of HIV and AIDs patients and mitigating the effects of HIV and AIDs. The study used a sample of 164 benefactors of CHBC programmes in Shurugwi rural. A mixed method of quantitative and qualitative approaches was used to collect and analyse the data. Hence, 150 respondents were administered questionnaires and 14 in-depth interviews were conducted on participants. The findings of the study, therefore led to both qualitative and quantitative results. The summary of the findings of the study are presented here according to the responses that were obtained from the research questions.

5.2.1 Needs of CHBC beneficiaries

The findings of qualitative and quantitative analyses of the study confirm that the needs of HIV and AIDS patients were not being met well by CHBC programmes and other

organizations in support of the programmes. Both analyses of the findings further show that there was acute food shortages, lack of transport, shortage of CHBC kits, lack of school fees for orphans, projects and treatment vouchers. Patients require all these needs in order to improve their wellbeing. The findings further indicate that even though there were food shortages and other things, most of the beneficiaries were able to eat three meals per day as compared to only a few who could eat only two meals and one. It is maintained that although CHBC programmes are responsible for patients, they cannot afford to supply all the needs of HIV and AIDS patients but strive to empower them by educating them to become more resourceful. Hence, CHBC programmes initiate and implement projects and monitor the patients to become self-reliant in order to improve their conditions. On the other hand, it is revealed that the projects were not sustainable enough to help patients because of lack of funds.

When the beneficiaries were asked how they encounter food shortages in their household during the course of the year, the quantitative findings reveal that most of the respondents (42%) encounter food shortages any time of the month. Twenty-nine percent (29%) encounter food shortages before harvest, 16% of respondents encounter food shortages at other times and 7% respondents experience food shortages before the months-end. Furthermore food shortages were caused by various reasons that include lack of agricultural inputs, the death of the main provider, poor harvest, late rainfall, high temperatures, and unemployment, among others. The study further indicates that the beneficiaries overcome food shortages in their households by borrowing from shops for future payments, rely on aid, do petty jobs, borrow from friends and relatives, sell their garden products and livestock. Although beneficiaries try

to adjust by doing the above as the findings show, they could not sustain themselves for longer period because they only have the garden as the main project and they lack funds to support the project. More so results indicate that most patients' especially women (66%), were not educated enough and were unemployed and they had no other sources of generating income so they solely depend on donors for food and other benevolent people in the community. The findings are therefore supported by other studies that there is lack of a national strategy or policy addressing food and nutrition insecurity in vulnerable households with PLHIV (MOCHW, 2010:). Nevertheless, even though the qualitative results supplement the quantitative results, the needs of the beneficiaries were not being met well because they continue to struggle to supply their own needs.

5.2.2 The services provided to HIV and AIDS patients

CHBC programmes were meant to control, prevent, reduce the spread of the pandemic in order to improve the conditions of the patients and extenuate the effects of HIV and AIDS. The findings of the study show that the patients were provided with psychosocial support, spiritual support, nursing care, hygiene education, and referrals to health centers and monitoring drug compliance. In addition, when the participants and the respondents were asked if the services were enough to help them improve, the findings revealed that the services were helping them to a greater extent. Furthermore the quantitative results underline the fact that most respondents (62%) agreed that the services were better in improving their conditions from the time they started to receive them up to date. Only 3% of respondents were not satisfied with the services. Also, the qualitative findings show that the participants agreed that they were receiving more

knowledge than the services and other resources. Although one objective of CHBC programmes is to mobilize the resources necessary for sustainability of the service in order to decrease the spread of the pandemic and improve the conditions of patients resources continue to be a major problem as the findings portray. The implementers of CHBC programmes demonstrated good knowledge of policies and standards. However, the participants mentioned that while they attempt to adhere to the guidelines as fully as possible in their operations, the lack of adequate resources is often a constraint (MOWCH, 2010).

5.2.3 The challenges faced by CHBC stakeholders

The findings of the study provided findings on the challenges that HIV and AIDS patients and caregivers face as they try to help and improve the conditions of patients under CHBC. The quantitative finding indicates that most beneficiaries (74%) face food shortages, 72% face shortage of health kits, 53% funds, 52% resources and the least (42%) lack transport cost. The qualitative findings also point out that the patients face challenges of food, CHBC kits, gloves, cotton, soaps and money for transport to go for reviews and other essentials or even money to cater for their needs. Besides the findings reveal that the beneficiaries get advice from church, do petty jobs and get help from friends in order to improve their health conditions. Additionally when the beneficiaries were asked about the problems that needed external interventions, the qualitative and quantitative findings show that the beneficiaries needed food, money for transport, clothes, and other resources. Moreover they got help from NGOs like MASO, TASO, Oxfam, Red Cross, Lutheran church, Cadec, ward counselors, clinic, community headmen, friends and relatives. The beneficiaries highlighted that they wanted the

government and NGOs to help them with food, provide more education on the pandemic, pay school levies for their children, provide transport and more projects as well as pay them social grants and pay caregivers.

5.2.4 Perceptions of the CHBC stakeholders

In this study, it was found that most of the respondents (62%) indicated that CHBC programmes were effective in providing better services and in improving their conditions. Then 27% wished that the programme should continue and 11% argued that the programme was not effective. In addition the reasons were highlighted by the qualitative results which revealed that CHBC programmes were effective because they had managed to reduce death rates and improve the conditions of HIV and AIDS patients. Others appealed that they had no donor this year (2014) so they wished the programme could continue to support and assist them in times of need even in the absence of international donors. However, those who showed that the programme was not effective argued that it was because there are shortages of resources, donor fatigue, lack of funds, no assessments of patients' needs, lack of monitoring and evaluation of the programme.

These findings are consistent with literature which argues that reduced donor support is currently undermining the effectiveness of CHBC programmes as organizations either scale down or reach out to clients with very limited services. In the case of donors terminating the programmes, this is a drawback in mitigating the effects of HIV and AIDS (Turning Bureaucrats into Warriors, 2004). It is demonstrated by the findings that if donors continue to withdraw, this will cause more harm to the patients because HIV

and AIDS is still prevalent and there is no cure yet and it is still spreading each day. In this regards, social welfare is still needed and the government and NGOs have to come up with ways on how to fundraise to replace the diminishing external funding of these programmes. Nonetheless, it is shown that CHBC programmes have to be guided by the needs of the beneficiaries. This is also supported by the majority of the literature which emphasizes that CHBC needs careful planning and that it is crucial that operational partnerships and referral mechanisms are established at local, regional, and national levels upon implementation of the programme (Defilippi, 2005).

In addition, the quantitative and qualitative findings show that beneficiaries suggested that the government and NGOs should continue to help them improve and mitigate the effects of HIV and AIDS. These suggestions include building more health facilities in rural areas, supplying machines for CD4 count and X-rays in the available clinics in rural areas. Also, the government and NGOs should introduce them to more projects like poultry, sewing, pottery, stone carving, village lending and savings so that these projects can sustain them economically for a longer period. More so these authorities (government and NGOs) should also provide transport cost for emergency cases, give every HIV and AIDS patients grants, pay caregivers because they work very hard, educate them more on the pandemic and other chronic diseases, find a donor that provides food to HIV and AIDS patients only and supply enough CHBC kits.

5.2.5 Evaluation of CHBC programmes

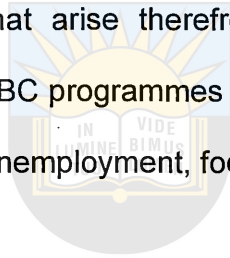
The qualitative findings of this study show that there is little or no evaluation of CHBC programmes and this hinders the effectiveness of many CHBC programmes. Some of

the problems resulting to little or no evaluation as stated by participants include funds to evaluate projects and the inappropriate type of strategies that are used to evaluate the programmes. The literature supports these specific problems in choosing suitable methods and procedures in guiding assessment of CHBC programmes. The strategies that have been used in monitoring of these programmes are only for short-term services instead of long-term services. Lavery et al. (2010) suggest that guidelines are required to deal with the role of communities for the evaluation of new technologies in global health for meaningful community engagement in order to make some investments in improving their lives.

5.3 Conclusions

The aim of the study was to explore the effectiveness of CHBC programmes in mitigating the effects of HIV and AIDS in Shurugwi rural in Zimbabwe. The study has therefore produced the evidence in respect of the effectiveness of the programme, the problems encountered by HIV and AIDS patients, the services they receive and their perceptions on the effectiveness. Building on the main outcomes of the study it is clear that CHBC programmes are effective in mitigating the effects of HIV and AIDs and in improving the conditions of HIV and AIDs patients. This is supported by the findings that CHBC programmes have managed to reduce bedridden clients, reduce death rates and they have managed to improve patients' health with those few resources. Furthermore it is also evidenced according to the findings of this study that CHBC programmes have influenced positively on the lives of many rural recipients. Nevertheless, the findings also indicate that HIV and AIDs patients are still faced with so many challenges because they lack material resources and funds; there is donor fatigue

and lack of assessment needs of the patient and little or no evaluation of the programmes. These challenges continue to hinder the full recovery of beneficiaries' health conditions. Generally, the evidence presented here rears extensive uncertainties about the importance of CHBC services in many communities in the shift of care from hospitals into societies. The shift of services into the community has worsened the living conditions of many beneficiaries. The delivery of CHBC services has negatively impacted the emotional conditions of some beneficiaries although it has helped them to accept and cope with situations that arise therefrom. This study presents strong evidence that the beneficiaries of CHBC programmes do not have recognizable positive effects on labor supply, high rate of unemployment, food shortages and poverty of many rural recipients.



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This is specifically so because there is no donor that stands to provide further help with food and other needs to assist them to improve their health conditions. The projects implemented by the CHBC programmes to help the beneficiaries are not sustainable enough due to lack of funds, farming technique skills and agricultural inputs. Nonetheless, it can be concluded that CHBC programmes are playing a pivotal role in ameliorating the effects of HIV and AIDs in Zimbabwe and in improving the conditions of HIV and AIDs patients and other debilitating sicknesses. It is also recognised that CHBC programmes are well organized and their services are being implemented for the benefactors of the programme who are in need.

5.4 Recommendations

- The government and NGOs should be concerned more in the service delivery which seeks to transform communities into better ones. Therefore the government and the NGOs should work together while engaging with communities so that they can know the patients' basic needs rather than making all the decisions for them. Hence there is need for assessment of patients' environment in order to identify the challenges and problems and tackle them together with the people in the community.
- The study has underlined that most beneficiaries are not educated especially women compared to men in rural areas. Government and NGOs should ensure a more sustainable CHBC that educates and helps the people to work for themselves rather than depending more on donors for food and other resources.
- Tongogara and Dosert wards are in region three which receives at least 650mm of rainfall every year and they also have good and poor soils for agriculture. Therefore the government and NGOs should supply or help HIV and AIDS patients and their families with agricultural inputs like fertilizers and seed so that they can be able to provide for their own needs in order to improve their conditions. Furthermore they need to educate them more on farming skills techniques because shortage of food is poverty.
- Dependency syndrome is a condition the government and NGOs should not allow to happen in many communities. Therefore they should introduce more projects especially in rural areas so that people can learn how to help themselves because every individual has the potential and strength to transform their own

lives into a better one. This will decrease the high rate of unemployment which is very high in rural areas. For example, the support group can be the key to fight poverty and HIV and AIDS in societies.

- Most CHBC programmes are run well although they face challenges and problems here and there; it is very important that assessment, monitoring and evaluation of CHBC programmes be done on a regular basis in order to see the achievements and failures which could enable a way forward to the gaps or challenges left or still being faced.
- The government and NGOs should help secondary caregivers, clinics, HIV and AIDS patients and family members with enough and necessary resources such as drugs, CHBC Kits, soaps, cotton so that the patients can improve and it will also ease the work of all caregivers in taking care of patients.
- Most patients walk a distance or travel to towns to go to clinics or hospitals for CD4 count or to get medication, which is very expensive and tiresome for HIV and AIDS patients. Yet some cannot afford the transport cost or even the cost of medication because it is expensive. Therefore it is recommended that the government or NGOs should build more clinics and hospitals in rural areas and also supply enough medication and drugs at the available clinics in the rural area on time.

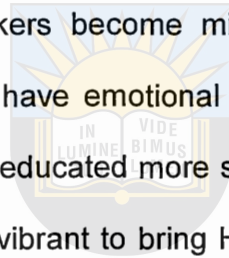
5.5 Implications for social work practice

Social work profession is a board that undertakes various and different protagonists in relation to all the societies in the world. The roles replicate different representations of

the society and conform to the social work activities. The board of social work seeks to enhance the social functioning of human beings, individual groups and the society at large and to solve social problems that vary according to communities. The core value of the social work profession supports an approach of educating and empowering the people to stand for themselves. Social work asserts that humans are capable of making a difference in their lives because they have the strengths and the potential to do so if they have guidance from this board of knowledge. This observation accentuates how humans can fully fulfill their lives well. The purpose of social work is therefore to enlighten humans to solemnly depend on themselves and to enable the beneficiaries to become self-reliant. Evidence from this study shows that most social workers just provide counseling to HIV and AIDS patients instead of applying much of their core values and social work ethics. This research study therefore suggests that social work practice assimilate the improvements of HIV and AIDs patients and help reduce the effects of HIV and AIDs in order for CHBC programmes to be effective.

As a result the patients will live a positive and meaningful life while having sustainable ways of eradicating poverty in their households. Social work requires addressing the needs of the beneficiaries by transforming their source of revenue, skills building and education created by government and NGOs programmes. According to Taylor and Francis,(2010) (as cited in the Journal of HIV/AIDS & Social Service) offers ways to: foster communication and support among social workers, advance HIV and AIDS social work practice through continuing education, advocate for programmes and policies to meet the psychosocial needs of people living with HIV and AIDS and their partners, families, and caregivers. To disseminate up-to-date information and new research in the

field promote the highest professional standards and ethics in the practice of social work in the field of HIV and AIDS. It is therefore very important that the social work profession should fully make use of their broad, free thinking visions and knowledge and skills to aid people to have a better social functioning rather than just dwelling more on counseling. As we continue with the overwhelming struggles of HIV and AIDS in all the societies the social workers should also take a lead to provide their services as asserted by Taylor and Francis above in CHBC programmes. This requires also the help from other professionals that social workers become mindful of the ways in which the comprehensive actions and powers have emotional impact on the people worldwide. Therefore social workers need to be educated more so that they can be able to help in the fight against this pandemic. It is vibrant to bring HIV and AIDS to the curriculum of social work practice so that it can be an added advantage.



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Even though some curricular monitors have been fashioned to support the curriculum of the social work courses there is need to increase more modules and courses on HIV and AIDs. Moreover they should be thorough trainings communicated by various sophisticated professionals and this will also help to strengthen the knowledge of many social work professionals. Social workers have good background knowledge on community work which includes community projects. Therefore, it is very important that they also help or take a lead in projects of the beneficiaries to strengthen, motivate and encourage them to participate in matters concerning themselves. A greater focus on literature on the subject is of utter most significant to come up with schemes for beneficiaries particularly treasured to circulate intelligences in midst of social work practitioners on the efficiency of the approaches that can be implemented for

beneficiaries. In conclusion, social work should advocate for the needs of the beneficiaries to be prominent, ordered and confidently disseminated through research that put emphases on the needs of HIV and AIDS. Therefore social work should bring positive changes into many societies and optimistically, come with ways in which social workers can pursue to attend, transform the lives of beneficiaries and help them to improve their health conditions and sustain themselves for the better.

5.6 Propositions for future studies

- The circumstance that the research study concentrated on Shurugwi rural in two wards only presents a limitation since it does not includes the other 21 wards in the district. The effectiveness of CHBC programmes on the beneficiaries may differ and maybe not applicable in other wards or other provinces in Zimbabwe. Therefore the same research needs to be undertaken in the other wards.
- A qualitative study should also make use of focus groups to further comprehend the feelings and attitudes of beneficiaries.
- ❖ This type of research can also be conducted with beneficiaries who suffer from other chronic diseases under CHBC programmes.

REFERENCES

- Akintola O. (2004). *A Gendered Analysis of the Burden of Care on Family and Volunteer Caregivers in Uganda and South Africa*. Health Economics and HIV/AIDS Research Division (HEARD). Available from <http://www.heard.org.za> (accessed on 05/7/ 2013.).
- Alpaslan, A. H.; Du Plooy, G. M.; Gelderblom, D. Van Eden & Wigson, D. J. (2010). *Research in the Social Sciences*. Pretoria. University of Pretoria, Muckleneuk
- Armiger, B. (2011). Nursing Research. *Ethics in Nursing Research: Profile, Principles, Perspective*, 26 (5): 330-333.
- ARC resource pack (2009). *ARC ModF7Study Material* .Available from <http://www.arconline.org> (accessed on 13/06/2013).
- Avert (2008). HIV and AIDS in Malawi. Available from <http://www.avert.org/aids-malawi.htm>. (Accessed on 07/11/2008).
- Avert (2008). Stigma, discrimination and attitudes to HIV and AIDS. 2008.(on line). www.avert.org/aidsstigma.htmhttp://. (Accessed on 22/11/2008)
- Basilwizi, P. (2010). *Sustainable Development Support for a Poverty Free Zambezi Valley*. Strategic Plan for 2010-2015. Zimbabwe: WFP Publishers.
- BBC News (2005). *Agriculture in Africa*. Released on 9 September
- Campbell, A. (2004). *Practitioner Research and Professional Development and education*. London: Paul Chapman.
- Carole, L. K. & Almut, G. W. (2008). *Validity and reliability of measurement instruments used in research*. Florida, Gainesville: Department of Pharmaceutical Outcomes and Policy, College of Pharmacy, University of Florida, Gainesville.

- Community home based care for people with AIDS in Botswana (1996) *Operational Guidelines National AIDS Control Programme* No 30(NACP30). Gaborone, Botswana: AIDS/STD Unit, Ministry of Health.
- Cooper, M. (2008). *Essential Research Findings in Counselling and psychotherapy*. London: Lawrence Erlbaum Ltd.
- Cornu, C. & Attawell, K. (2003). *The involvement of people living with HIV/AIDS in community-based prevention, care and support programs in developing countries*. New York: Population Council/International HIV/AIDS Alliance.
- Creswell, J.W. (2009). *Research Design: Qualitative and Mixed Methods Approaches*. 3rd Edition. California, Thousand Oaks. Sage Publication Inc..
- David, M. & Sutton, C. D. (2004). *Social Research*. New Delhi: Sage Publications.
- Defilippi, K. (2005). Integrated Community-Based Home Care: Striving towards Balancing Quality with Coverage in South Africa. *Indian Journal of Palliative Care* 11.1: 34-47
- De Vos, A. S.; Strydom, H.; Fouche, C. B. & Delport C. S. L. (2005). *Research at Grass Roots for the Social Sciences and Humanities Services Professions*(3rd ed). Pretoria: Van Schaik.
- Doctors without Borders (2013). *Internal Revenue Service as a 501 (C) Doctors without Borders* Federal Identification Number (EIN) are 13-3433452. MSF-USA Associations. Available from <http://www.doctorswithoutborders.org/publications/>(accessed 16/10/2013).

Elton, S. (2009). *What is a Strategy, Evaluation and Efficiency*. New York: United Nations.

Emmerij, Louis, Interview about the United Nations Intellectual History Project, published as an Atlantic Face piece in the website journal Atlantic-Community.org, February 24, 2009

Emmerij, L. (2010). *The Basic Needs Development Strategy: World Economic and Social Survey*. New York: United Nations.

Farmer P, Leandre F, Mukherjee J, Gupta R, Tarter L, Yong Kim J. (2001) Community-based treatment of advanced HIV disease: introducing DOT-HAART (directly observed therapy with highly active antiretroviral therapy). *Bulletin of the World Health Organization*, 79 (12).

FHI, IMPACT, CDC & USAID (2007). *Rapid Appraisal of Palliative Care and Community Home Based Care in Abidjan, Cote D'Ivoire*. Abidjan: FHI, IMPACT, CDC & USAID.

Gaborone Declaration on Community Home-based Care (2001). *First Regional (SADC) Conference on Community Home Based Care*. Gaborone, Botswana: SADC

Gordon, P.; Madzingira, N.; Shamu, S.; Bannerman, M. & Quigley, P. (2011) .Impact Assessment of the Expanded Support Programme Zimbabwe. Report to Department for International Development, Harare, Zimbabwe

Gravetter, F J & Forzano, L.B. (2003). *Research Methods for the Behavioural Science*. Library of Congress Control Number: 2010931693. New York.

Gregory, I. (2003). *Ethics in Research*. London: Continuum

Health & Development Networks, SAfAIDS (2008). *Caring from within: key findings and policy recommendations on home-based care in Zimbabwe*. Harare: Health & Development Networks (HDN) and Southern Africa HIV & AIDS Information Dissemination Service (SAfAIDS).

International Federation of Red Cross and Red Crescent Societies (2004). The case of Zimbabwe. www.ifrc.org. (accessed 25 May 2013).

Jackson, H. (2002). *AIDS AFRICA. Continent in crisis*. Safaids, Avondale, Harare, Zimbabwe.

Jackson H & Lee T. 2002. Sub-Saharan Africa, in *HIV and AIDS: A Global View*, edited by McElrath. London: Greenwood Press.

Jacques, G. & Christine, Stegling (2004). HIV/AIDS and Home Based Care in Botswana: Panacea of Perfidy? *Social Work in Mental Health*, 2.2/3: 175- 193.

Jaffar S.; Amuron, B. & Levin, J.(2009). *The impact of home-based compared with facility-based HIV-care on virologic failure and mortality: a cluster randomised trial*. Fifth IAS Conference on HIV Pathogenesis, Treatment and Prevention, 19–22 July 2009, Cape Town.

Joint United Nations Programme on HIV/AIDS (UNAIDS) (2001a). *From principle to practice: greater involvement of people living with or affected by HIV/AIDS (GIPA)*. Geneva: UNAIDS.

Joint United Nations Programme on HIV/AIDS (UNAIDS) (2002). *Report on the global HIV/AIDS epidemic*. Geneva: UNAIDS.

- Joint United Nations Programme on HIV/AIDS (UNAIDS)/ World Health Organisation (WHO) (2002). *AIDS Epidemic Update*. Geneva: UNAIDS and World Health Organisation.
- Joint United Nations Programme on HIV/AIDS (UNAIDS) (1999). *Comfort and hope: six case studies on mobilizing family and community care for and by people with AIDS*. Geneva: UNAIDS.
- Joint United Nations Programme on HIV/AIDS (UNAIDS) 2005. *Report on the global HIV/AIDS epidemic*. Geneva: UNAIDS.
- Jonker, J. & Pennink, B. (2010). *The Essence of Research Methodology: A Concise Guide for Master and PhD Students in Management Science*. Heidelberg: Journal of HIV/AIDS & Social Service. (2010). Online Journal. Haworth Press. New York. <http://www.researchgate.net>.
- Kangethe, S. M. (2004). Issues and challenges of community home based care in Africa. Case of Botswana. Unpublished Research essay for Master's Degree in Social Work. Department of Social Work, University of Botswana.
- Kangethe, S. M. (2006). Contribution of caregivers in community home based care programmes: The case of Kanye, Botswana. Unpublished PhD Dissertation in Social work, Department of Social Work, University of North West, South Africa.
- Kang'ethe, S. M. (2010a). The effect of ageing on the quality of care giving in Botswana. *Botswana Notes and Records (BNR) Journal*. 2009. Vol. 41:76-82.

- Kang'ethe S. M. (2010b). The perfidy of stigma experienced by the palliative community home based care (CHBC) caregivers in Botswana. *Indian Journal of Palliative Care*. Vol 16/Issue-1: 29-35.
- Kang'ethe SM 2011. Evidences of indigenous knowledge systems driving care giving in care programmes in Botswana. *Fort Hare Papers*. Vol 18, 2011. Pp 5-15.
- Kang'ethe, S. M. & Gutsa Takudzwa (forthcoming). Exploring the Stumbling blocks on the way to a successful Male Circumcision Campaign in Zimbabwe. In the press with *Journal of Human Ecology, India*.
- Kang'ethe, S. M. & Mangwiro, V. P. (forthcoming). Exploring the stumbling blocks lying along the success of Community Home Based Care programs in a few countries of the developing world. *In the press with the Journal of Human Ecology, India*.
- Kang'ethe S. M. (2013a). An exploration of the panacea of training palliative caregivers in Botswana community home based care programmes. An empirical case study perspective. *Journal of Social Sciences*.
- Kang'ethe S. M. (2013b). An examination of HIV campaign in South Africa towards eliminating stigmatization. *Journal of Human Ecology, India*.
- Kgathi D. L. & Ngwenya, B. N. (2006). HIV/AIDS and access to water: A case study of Home-Based Care in Ngamiland, Botswana. *Physics and Chemistry of the Earth*, 31 (15): 669-680.
- Kiley, E. & Hovorka, A. (2006). Civil society organisations and the national HIV/AIDS response in Botswana. *African Journal of AIDS Research*; 5:167-78.

- Lavery, J.V., Tinadana, P.O., Scott, T.W., Harrington, L.C., Ramsey, J.M., Ytuarte-Nuñez, C. & James, A.A. (2010). Towards a framework for community engagement in global health research. *Trends in parasitology*, 26(6), 279-83. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20299285> [Accessed May 4, 2011]
- Liberty University (2011). *Literature Review.*" <http://data.fen-om.com/int460/0-literature-review.pdf> (accessed July 1, 2011).
- Lindsey, E.; Hirschfeld, M.; Tlou, S. (2003). Home-based care in Botswana: experiences of older women and young girls. *Health Care Women International*, (6):486-501.
- Littrell M.; Thurman, T.; Chatterji, M. & Brown, L. (2007). *The Tumaini home-based care program: a case study*. Chapel Hill, NC: Measure Evaluation & Care International.
- Madebwe,, V. & Madebwe, C. (2005). An Exploratory Analysis of the Social, Economic and Environmental Impacts on Wetlands: The Case of Shurugwi District .*Journal of Applied Sciences Research*.
- Malawi Community Home Based Care Policy and Guidelines. 2005. Ministry of Health, Lilongwe: Malawi
- Marshall, C. & Rossman, G. (1999). *Designing qualitative research*. Thousand Oaks, CA: Sage.
- Marhal, B.; Kegels, G. & De Brouwere, V. (2004). *Human resources in scaling up HIV/AIDS programmes: just a killer assumption or in need of new paradigms?* *AIDS* , 18: 21035.

- Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review*, 50: 370.
- Matshalaga ,N.(2006). National Review of Community Home Based Care and Access to Treatment Services in Zimbabwe. Harare, Zimbabwe.
- McElrath, K. (2002). *HIV and AIDS: A global view*. London: Greenwood Press
- Ministry of Health (2002). *National Home-Based Care Programmeme and Service Guidelines*. Nairobi ,Kenya:National AIDS/STD Control Programme,
- Ministry of Health. (2004).Community Home Based Care and Access to Treatment Services in Zimbabwe. Commissioned By National AIDS Council Rembrandt Lane, Strathaven, Harare, Zimbabwe.
- Ministry of Health (2005). Malawi Community Home Based Care Policy and Guidelines. Lilongwe, Malawi: Ministry of Health
- Ministry of Health and Child Welfare (MOHCW).(2010).*The Zimbabwe Health Sector Investment Case: Accelerating Progress Towards the Millennium Development Goals*: Harare, Zimbabwe: MoHCW.
- Mohammad, N. & Gikonyo, J. (2005). Operational Challenges Community Home Based Care (CHBC) for PLWHA in Multi-Country HIV/AIDS Programs (MAP) for Sub-Saharan Africa. African Region Working paper Series No.
- National Community Home-based Care Standard for Zimbabwe. (2004).Ministry of Health and Child, Government of Zimbabwe.
- The National OI/ART Programme Annual Report (2009).Zimbabwe.
<http://www.unaids.org/en/dataanalysis>.(Accessed 20 October 2012)
- National policy on HIV/AIDS for the republic of Zimbabwe. (1999).www.youth policy.com
(Accessed 25 March 2014)

National Home-Based Care Programme and Service Guidelines.(2002) National AIDS/STD Control Programme Ministry of Health.Kenya.

Ndaba-Mbata, R. &Seloilwe, E. (2000). Home based of the terminally ill in Botswana: knowledge and perceptions. *International Nursing Review*, 47 (4): 218 – 223..

Nurses Association of Botswana (NAB) (2004). *Caring for the caregivers*. Gaborone: Kgotla Design.

Ogden, J.; Esim, S. & Grown, C.(2004). *Expanding the care continuum for HIV/AIDS: Bringing careers into focus*. HorizonsReport. Washington, D.C.: Population Council and International Center for Research on Women.

Oliver, P and Gregory, A. (2003). *The Student's Guide to Research Ethics*. Maidenhead: Open University Press.

Olsen, W. (2004). *Triangulation in Social Research: Qualitative and Quantitative methods in Sociology*.Hollborn Ormdkirk: Causeway Press

Peter-Piot, M. D.; Thomas, C. & Quinn, M. D. (2013) .Response to the AIDS Pandemic: A Global Health Model .*The New England Journal of Medicine*, vol23, no, 83 issue ad page numbers126-134

Pindani, M.(2008). Community home based care for HIV and AIDS patients: A Malawian experience. PhD Thesis, Pretoria. University of South Africa

POLICY Project. (2003a). *Siyam'kela. HIV/AIDS-related stigma: A literature review*. Cape Town, South Africa: USAID; POLICY Project/South Africa; Centre for the Study of AIDS at the University of Pretoria; Chief Directorate: HIV, AIDS & TB, and Department of Health. www.policyproject.com

- Population Council MOH & UN (2004). *Safe Motherhood Demonstration Project, Western Province: Approaches to providing quality maternal care in Kenya*. Nairobi, Kenya: Population Council.
- Phorano, O. M. Nthomang, K. & Ngwenya, B. N. (2005). HIV/AIDS home based care and waste disposal in Botswana society. *Journal of Botswana Notes and Records*, Vol. 37:161-178.
- Shaibu, S.(2006). Community Home-Based Care in a Rural Village: Challenges and Strategies. *Journal of Transcultural Nursing*, 17.1: 89-94.
- Stegling, C. (2000). Current challenges of HIV/AIDS in Botswana. Working Paper, no.1. Botswana: Department of sociology, University of Botswana.
- Stegling, C.(2001). Human Rights and Ethics in the Context of Home-Based Care in Botswana. Pula. *Botswana Journal of African Studies*, 15.2: 241-248.
- Suharko, C. (2007). The Role of NGOs in Rural Poverty Reduction: The Case of Indonesia and India. Graduate School of International Development. Thesis for PHD. Japan: Nagoya University Press.
- Svobodo, D. (2003). Impact Evaluation- Why, What and Who? Civic Association of Czech Republic. German.
- The Herald Features (2014). The Herald Business. Thursday 13 February: page 8
- UNAIDS (2012). *Global Report on AIDSinfo*. Available from <http://www.unaids.org/documents/>.(accessed 06/07/2013).
- Turning Bureaucrats into Warriors (2004). *Preparing & Implementing MAP in Africa. A Generic Operations Manual*. New York: World Bank.

- UNAIDS (1999). *Comfort and hope. Six case studies on mobilizing family and community care for and by people with HIV/AIDS*. Geneva, Switzerland Springer.
- UNAIDS (1999). *Comfort and hope. Six case studies on mobilizing family and community care for and by people with HIV/AIDS*. Geneva, Switzerland.
- UNAIDS.(2011).Spectrum/EPP.<http://www.unaids.org/en/dataanalysis/tools/spectrumep201> (accessed 15 October).
- UNAIDS.(2004). *AIDs Epidemic Update*. Geneva. Switzerland: UNAIDS.
- UNAIDS (2012). 'Global Report 2012: AIDS info'.<www.unaids.org/documents/.(accessed 07 October 2013).
- United Nations General Assembly (UNGASS) (2007). *Report on HIV and AIDS, Zimbabwe Country Report*.,January 2006–December 2007. Available from http://www.data.unaids.org/pub/Report/2008/zimbabwe_2008_country_progress_report_en.pdf, accessed 13 May 2008).
- United Nations Population Fund (UNFP) (2007). Country profiles, Zimbabwe. Available from<http://zimbabwe.unfpa.org/> (NFPA%20in%20Zimbabwe.htm, accessed 14 May 2008)
- United Nations Children's Fund (UNICEF) (2007). *UNICEF Humanitarian Action, Zimbabwe*.([http://www.unicef.org/infobycountry/files/Zimbabwe DU 18jun07.pdf](http://www.unicef.org/infobycountry/files/Zimbabwe_DU_18jun07.pdf), accessed 20 May 2008).
- United Nations General Assembly Special Session. (2009) Zimbabwe Country Report on HIV and AIDS Reporting Period: January 2008 to December 2009, 2010.

United Nations Food Agency.(2011). <http://www.un.org/apps/news/story.asp?NewsID>.
Zimbabwe.

Van Zyl, I. (2010). *Mutual isolation and the fight for care: ethnography of South African Home-based Healthcare Contexts. PHD thesis*. Cape Town: Cape Peninsula University of Technology.

Walt, G. (2005). Commentary: lay health workers in primary and community health care. *International Journal of Epidemiology*, 34:1251.

Waterrman, H.; Griffiths, J.; Gellard, L.; Olang, G. & O'Keeffe, C. (2006). *Action Research Project : Home-based care for people living with HIV/AIDS*. Manchester: Mild May International

Wellman, C. K. & Fand, M. B. (2005). *Research Methodology*. Cape Town: South Africa: Oxford South Africa.

Wringe, A.; Cataldo, F.; Stevenson, N. & Fakoya, A. (2009). *Delivering comprehensive home-based care programmes for HIV: A review of lessons learned and challenges ahead in the era of antiretroviral therapy*. London: Centre for Population Studies, London School of Hygiene & Tropical Medicine. World Health Organization (1999) .*Organization perspective: annotated bibliography*. Geneva, (document WHO/HSC/LTH 99/1).

World Economic and Social Survey 2010: Retooling Global Development. Sales No. E.10.II.C.1.

World Food Programme (2012).Zimbabwe 2012 Facts Figures. Available from [http://www. www.wfp.org](http://www.wfp.org) (accessed 13 September 2013).

- World Health Organisation (WHO) (1993). *Community home-based care in a resource-limited setting: A framework for action. AIDS home care handbook*. Geneva: World Health Organisation.
- World Health Organization (2002). *Community Home-Based Care in Resource-Limited Settings: A Framework for Action*. Geneva: Switzerland. WHO. Accessed 5 March 2013
- World Health Organization (WHO) (2010). Global Report. Geneva www.who.org/documents. Geneva: Accessed 06 May 2013.
- World Health Organizations (2004). *Women, Girls, HIV and AIDS. Advocacy Note. World AIDS Day Campaign*. Western Pacific: Regional Office.
- WHO, UNAIDS & UNICEF (2011) 'Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access 2011'
- Zimbabwe Human Development Report (2003). *Redirecting our responses to HIV and AIDS*. Harare: IDS and UNDP.
- Zhang, Y. & Wildenmuth, M. (2009). *Qualitative analysis of content: Applications of social research methods to questions of information in library science*. Westport, CT: Greenwood Press.

APPENDIX 1: Letter to Request to Conduct the Research

15 January 20

Number 45 Peter Falk

Athlone, Gweru

Zimbabwe

To: The Company Executive Officer

Midlands Aids Service Organization

Private Bag 880

Mkoba



University of Fort Hare
Together in Excellence

Dear Madam/Sir

REF: REQUESTING FOR PERMISSION TO CONDUCT A RESEARCH PROJECT UNDER MASO IN SHURUGWI DISTRICT.

My name is Vongai P Mangwiro. I am a lady aged 27. I am currently studying towards a Master's degree in Social work at the University of Fort Hare in Alice, South Africa. I'm kindly requesting for permission to conduct my research project under MASO in your community as it is a requirement for me to complete my studies. As a student I will gather the required information with the help of the responsible authorities like the ward counsellors and the headmen. I will also demonstrate the skill of proficiency and it would be appreciated if your community members could kindly assist me with the required information for the research to be a successful one.

As a student I will comply with the ethical issues which will be explained to all the participants before the interviews are conducted by the researcher. The participants should know that this research information will be used for academic purposes. My research title reads "An exploration of the effectiveness of Community Home Based Care Programmes in mitigating the effects of HIV and AIDS in rural areas in Zimbabwe. The case of Shurugwi rural". I have submitted my research proposal and the data collection tools to the manager Mr. Mapingire.

I am looking forward to your favorable reply. Thank you in advance.

Yours sincerely



Mangwiro Vongai Patience

University of Fort Hare
Together in Excellence

APPENDIX 2: Informed Consent Form



University of Fort Hare
Together in Excellence

DEPARTMENT OF SOCIAL WORK

FORT HARE UNIVERSITY: ALICE CAMPUS

My name is Vongai Patience Mangwiro. I am currently doing my Masters of Social Work at Fort Hare University in South Africa. This study is carried out in order to fulfil the requirements of Master of Social Work Degree. My research title is: "An exploration of the effectiveness of Community Home Based Care programmes in mitigating the effects of HIV and AIDS in Shurugwi district in Zimbabwe".

You are all welcome here and feel free. Thank you so much for agreeing to participate in this research study. Firstly I would like to clarify the following and then we can start:

The information you share will be tape-recorded.

The participants are free to withdraw from the study if they feel uncomfortable.

The participants are not forced to answer any question.

There are no benefits gained by participants from participating in this research study.

Anonymity and confidentiality will be upheld in good faith by the researcher.

The information that we will share will be kept confidential and will be used for academic purposes only. Informed consent means that you are supposed to participate knowingly

and voluntarily without being forced. The University Research Committee requires the researcher to have read the consent form for you and make sure you understand it well.

Iapprove that I have read and agreed to the terms and conditions complementing this research study. I therefore, contribute without restrictions in this study.

Signature.....

Date.....



University of Fort Hare
Together in Excellence

APPENDIX 3: Interview Schedule for Caregivers

Needs of caregivers providing palliative care to patients

1. How long have you been providing care to patients?
2. How many patients do you care for?
3. What is your relationship with the patients?
4. What are the needs of HIV and AIDS clients and their family members?
5. Do CHBC programmes provide for your needs as you provide care to patients? If yes, are they enough for you to do your work well?

Services provided to HIV and AIDS patients to improve their health conditions

6. What are the services provided to HIV and AIDS patients?
7. Can you comment on the conditions of the patients since they started to receive the services up to date?
8. Can you say they are improving and helping? Elaborate?
9. Can you comment on the services provided to the patients? /Are they sustainable enough to help clients improve well?

Challenges in providing services to patients

10. What are the problems you face as you help patients to recover?
11. How do you overcome such challenges and problems?
12. Do you think helping patients to recover has affected your life and your family?
Please elaborate.
13. Tell me about problems that needed external interventions? Did you seek help from the government /NGOs?

Perceptions of caregivers on the effectiveness of CHBC programmes

14. Do you think CHBC programmes are improving the conditions of HIV and AIDS patients well?

15. What do you think the government /NGOs should do to enhance the improvements of patients' conditions and to mitigate the effects of HIV and AIDS?



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APPENDIX 4: Questionnaire for HIV and Aids Patients and the Primary Caregivers

1. Sex

Female	Male

2. Age

18yrs- 25yrs	25yrs-35yrs	Above 35yrs

3. Marital Status

Single	Married	Divorced	

4. Level of education

Never went to school	Primary	Secondary	Tertiary

SECTION B: Needs of caregivers providing palliative care to patients *(Please tick)*

1. What are your needs as HIV and AIDS patients under CHBC programmes?

Food	
Transport cost	
Money for treatment	

Health kits	
If other specify them:	

2. How many meals do you eat per day as a patient?

None	1 meal	2 meals	3 meals and above

3. Do you encounter food shortages? If you do you can tick below more than one.

Any time of the month	Just before month end	Before harvesting	After drought	Other times:

4. What is causing food shortages in your household? (Rank)

Poor harvest due to drought	
Poor harvest due to high temperatures	
Poor harvest due to pests and diseases	
Poor harvest due to late rainfall	
Loss of livestock due to pests and diseases	
Loss of livestock due to drought	
Lack of water sources/reservoirs	

Lack of agricultural inputs	
Death of the main food provider	
Other (specify)	

5. What adjustments or possible solutions have you made to avoid food shortages if any or improve your diet? (you may tick more than one option)

Borrow food from shops for future payments	Relied on food aid
Borrow money from friends or relatives	Look for petty jobs
Sale crops Garden projects	Sale livestock
Other projects:	

SECTION C: Services provided to HIV and AIDS patients to improve their health conditions

1. What are the services you receive as clients of CHBC programmes?(you may tick more than one)

Treatment vouchers	
Food baskets	
Psychosocial support	
Spiritual support	

Nursing care	
Monitoring drug compliance	
Referrals to health centres	
Hygiene education	
Other (specify)	

2. Do you think CHBC programmes provide enough services for you to improve well? If it is yes /no explain why?

Yes	No

3. Do you think the services have managed to help you improve from the time you started receiving them up to date?

No change	Better	Fair	Worse off

4. Can you comment on the services provided to you?

Good	Excellent	Fair	Bad

SECTION D: Challenges in providing services to patients

1. What are the challenges you face as patients under CHBC programmes?

Food shortages	
Lack of funds	
Lack of transport cost	
Shortages of health kits	
Lack of other resources	
Other (specify)	

2. How do you overcome such challenges? / How does the programme intervene when you face these problems?

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3. Tell me about problems that needed external interventions?-Where did you seek help?

4. What do you think the government/NGOs should do to help you?

SECTION E: Perceptions of HIV and AIDS patients and primary caregivers on the effectiveness of CHBC programmes

1. What is your perception on the effectiveness of CHBC programmes? Elaborate?

2. Do you think CHBC programmes are effective enough in improving your conditions?

Good	Excellent	Fair	Bad

3. What do you think the government, NGOs and the donors should do to enhance the improvements of your conditions and to mitigate the effects of HIV and AIDS?

THE END: THANK YOU!