PRINT: ISSN 0970-9274 ONLINE: ISSN 2456-6608
J Hum Ecol, 53(1): 57-64 (2016)
DOI: 10.31901/24566608.2016/53.01.07

The Hurdles Underpinning HIV and AIDS Community Home Based Care Programs in Zimbabwe and Possible Remedies

Vongai P. Mangwiro[1] and Pius T. Tanga[2]

Department of Social Work and Social Development, University of Fort Hare, Private Bag X1314, Alice 5700, South Africa
E-mail: [1]<200909461@ufh.ac.za>, [2]<ptangwe@ufh.ac.za>

KEYWORDS HIV and AIDS. Zimbabwe. Community Home Based Care. Caregivers. Family Members

ABSTRACT This paper investigated the hurdles underpinning HIV and AIDS Community Home Based Care Program (CHBC) in Zimbabwe as well as possible remedies. The study was exploratory and descriptive in nature and it used the mixed method approach of quantitative and qualitative designs. The sample comprised 150 HIV and AIDS patients, 50 primary caregivers and 10 secondary caregivers. The study found that the hurdles confronting these HIV and AIDS of CHBC programs included lack of food, funds for transport, treatment vouchers and other essentials. The paper recommends that it is important that the government and NGOs should provide food baskets to patients, devise strategies on how to raise money and provide the beneficiaries of CHBC programs with enough resources in order to improve their living conditions and standards.

INTRODUCTION

HIV and AIDS has become the most challenging disease worldwide and Zimbabwe is one of the countries that has been affected like any African country. The pandemic has left so many challenges and problems in many societies as child-headed families, grandparents and relatives are left with the burden of taking care of the children of the deceased. These challenges include poverty, lack of knowledge among caregivers, old age, and lack of resources, lack of transport, donor fatigue and lack of money. According to UNFPA (2007), the HIV epidemic, the emerging tuberculosis (TB) and HIV co-infection, severe droughts which are closely linked with food shortages and poverty, have significantly impacted the progress with regard to population and development issues in many countries. In sharp contrast, Jackson (2002) and UNAIDS (2004) stipulate that 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. 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 policymakers are tasked to ensure that they enhance the basic needs of HIV and AIDS patients and other chronic patients in order to improve their overall conditions.

Moreover Lindsey et al. (2003) argue that even if caregivers receive training they experience poverty, social isolation, stigma, psychological distress, and lack basic caregiving education. Kang'ethe (2006, 2013) also contend that their services are a panacea amidst dwindling economic resources, and 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 makes it difficult for some caregivers, especially the elderly to understand the dynamism of caregiving. Consequently, the undesirable consequence of HIV and AIDS in this area is of great concern. HIV and AIDS pose serious threats not only to nutrition, but also to food security in general.

Conversely, many donors who have been supporting CHBC programs 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 (Dcotors without Borders 2013). CHBC programs presently receive inadequate financial sustenance to cater for program activities. It is important that these researchers suggest that the NGOs and government should come up with strategies that seek to stop these challenges impeding the successfulness of the CHBC programs.

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. 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 program achievements and also to guarantee satisfactory levels of program administration and culpability.

RESEARCH METHODOLOGY

Research Domain

The research was conducted in the Shurugwi rural area, which is situated in Midlands Province in southern Zimbabwe. The aforementioned is located 33km away from the headquarters of Gweru, which is 350km away from Harare. The two wards Tongogara and Dosert in Shurugwi district are generally populated by 11,489 inhabitants of the Karanga tribal people who form a wide range of the inhabitants and minorities like Ndebele-speaking people (Madebwe and Madebwe 2005). They are four health clinics in these two wards, which are very small and yet the area has a large number of people that need help and there are few nurses who generally help the patients. The area has been chosen because of its experiences of illiteracy and poverty. The area also has been seriously affected by HIV and AIDS.

Research Design: Mixed Method

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 of 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 in definite 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 better understanding of the inquiry problem than both methods can alone. The qualitative method has covered the gaps left by the quantitative method 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 participant's 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 researchers to gain attentiveness of peoples' attitude, value system and concerns regarding the hurdles that are being faced HIV and AIDS patients, primary and secondary caregivers in Zimbabwe.

Sampling Strategy

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 sam-

ple 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 were the best methods of data collection for this study as they enabled quick comparisons and address the aims, objectives and prompt questions. The tools helped investigate the hurdles that were being faced by HIV and AIDS patients, caregivers and family members. The researchers were assisted by the two supervisors and other secondary caregivers who distributed the questionnaires to the patients and their primary caregivers and the researchers later conducted the interviews.

Data Collection Instruments and Data Analysis

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 to the HIV and AIDS patients and the primary caregivers. The second stage comprised of the in-depth interviews with 10 secondary caregivers and four key informants (CHBC officers' from NGOs and the government CHBC coordinators).

Data analysis is a method of collecting, modeling, and altering data with the goal of emphasizing valuable data, signifying conclusions, and supporting conclusion making (Wellman et al. 2005). The research study analyzed the data using both quantitative and qualitative methods. For quantitative data, the researchers presented the data using frequency tables and graphs while qualitative data was presented according to one key theme that emerged during the interviews. The quantitative analysis was used to apply prevailing data to inaugurate the effectiveness of CHBC programs in improving the conditions of HIV and AIDS patients. Qualitative data analysis was used also to analyze data as the data required an approach, which is appropriate to analyze texts, visuals or narrative, such as content analysis or discourse analysis. The information was analyzed and interpreted according to the data collected using the thematic content analysis technique method.

Ethical Considerations

Ethical clearance was obtained from the University to conduct the study. Also, written permission was obtained and the Midlands Aids Service Organizations, where their clients and key informants were working with them were interviewed. All participants were made to sign informed consent and this ensured their confidentiality, privacy and anonymity. The researchers allowed the respondents to participate voluntarily and were free to withdraw at any time during the study. Debriefing sessions were held with HIV and AIDS patients, given that this pandemic is still seen as a taboo in most communities.

FINDINGS

Quantitative Findings

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 on the one hand, sixty-six percent were female respondents. On the other hand, thirty-four percent of the respondents were males. Table 1 illustrates the group between the ages of 35 years and above formed the largest component of the respondents in this study with seventy-two percent. This group is followed by respondents aged 26 to 35 years with seventeen percent. The last group are those aged 18 to 25 years with eleven percent.

Table 1: Age groups of the respondents

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

Needs of Primary Caregivers of CHBC Programs and Expectations from the Government

More so Figure 1 shows the need of caregivers and what the beneficiaries want the govern-

ment and NGOs to help them with in order to improve their well-being and living conditions. About twenty-six percent of the 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 eighteen percent 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 with 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 two percent of the respondents explained that they need help of school fees for children and orphans.

Hurdles Underpinning the CHBC Program

Figure 2 shows the responses that were given by the caregivers and the patients about the hurdles facing the CHBC program. One hundred and thirty-seven responded and the majority of the respondents (74%) indicated that the main problem affecting the program is food shortages, followed by seventy-two percent who agreed that CHBC kits are not enough. About fifty-three percent of the respondents mentioned that lack of funds is another hurdle and fifty-two percent reported the lack of resources.

Possible Remedies to the Hurdles

Remedies Within the Immediate Vicinity

The caregivers and HIV and AIDS patients were, however, asked how they overcome the hurdles facing the CHBC program. The results are shown in Figure 3. Twenty percent of respondents stated that the problem of food shortage is possibly remedied by them doing some petty jobs for other people in exchange for food or money. This is followed by twenty percent who indicated that they receive advice from church members on how they can improve their conditions. Moreover, thirteen percent of the respondents agreed that they receive help from their relatives and friends when they are in need. Four percent of the respondents revealed that sometimes they sell their garden products.

Remedies from External Interventions

Moreover, the caregivers and HIV and AIDS patients were also asked about the problems that

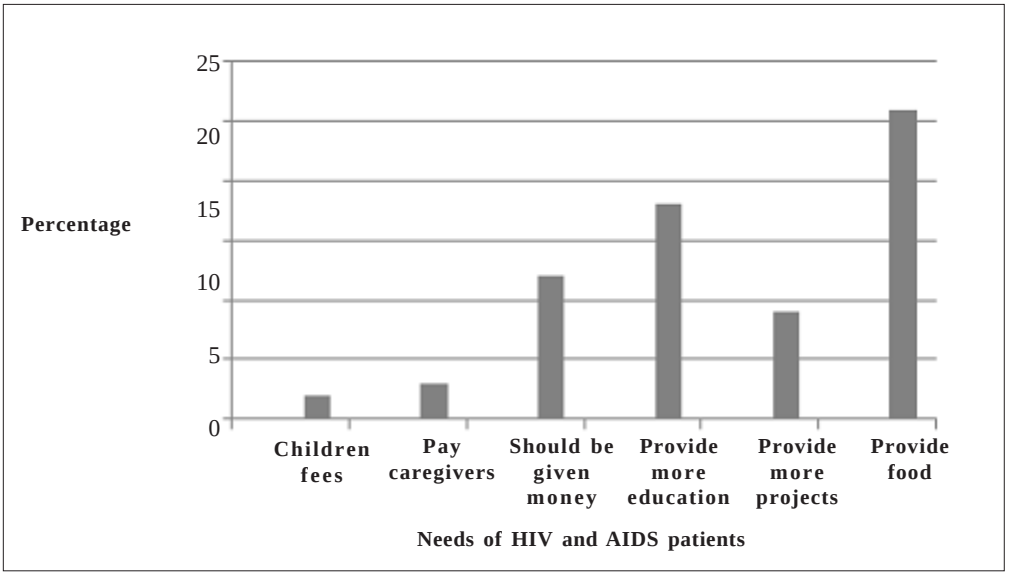

Fig. 1. Needs of primary caregivers and HIV and AIDS

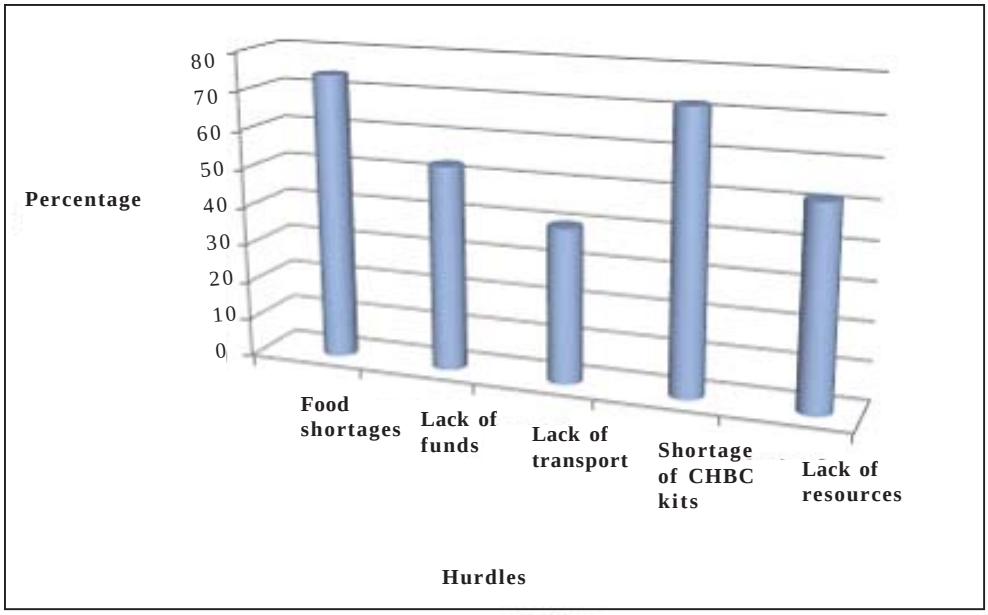

Fig. 2. Hurdles underpinning CHBC programmes

needed external interventions and where they get help. Figure 4 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 programs when they wanted money, pain killers and transport. About twenty-eight percent reported that they got help from the clinic of pain killers, cotton and other drugs. Twenty-eight percent also showed that they received help with mon-

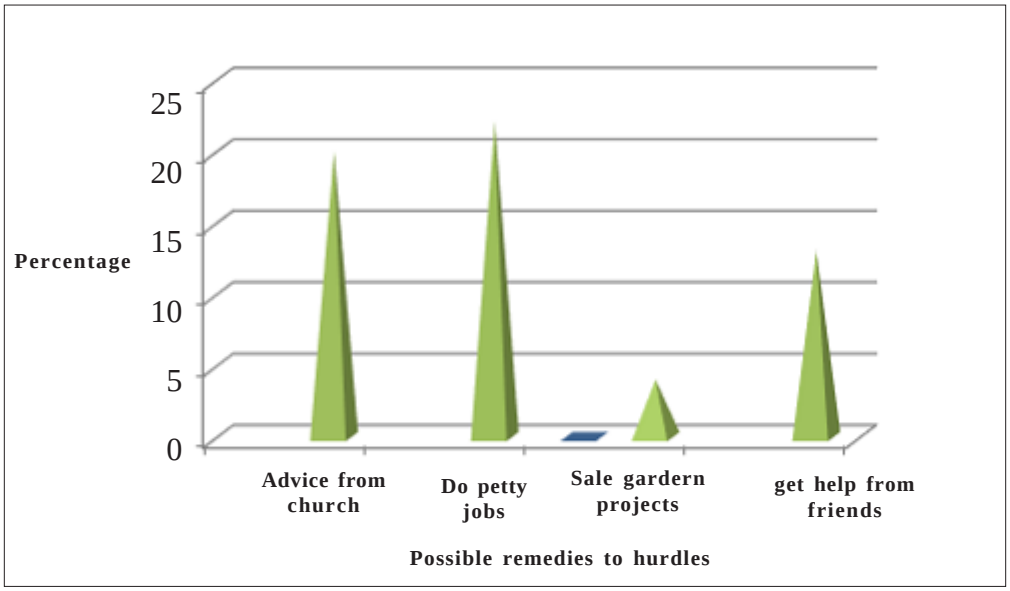

Fig. 3. Possible remedies to hurdles

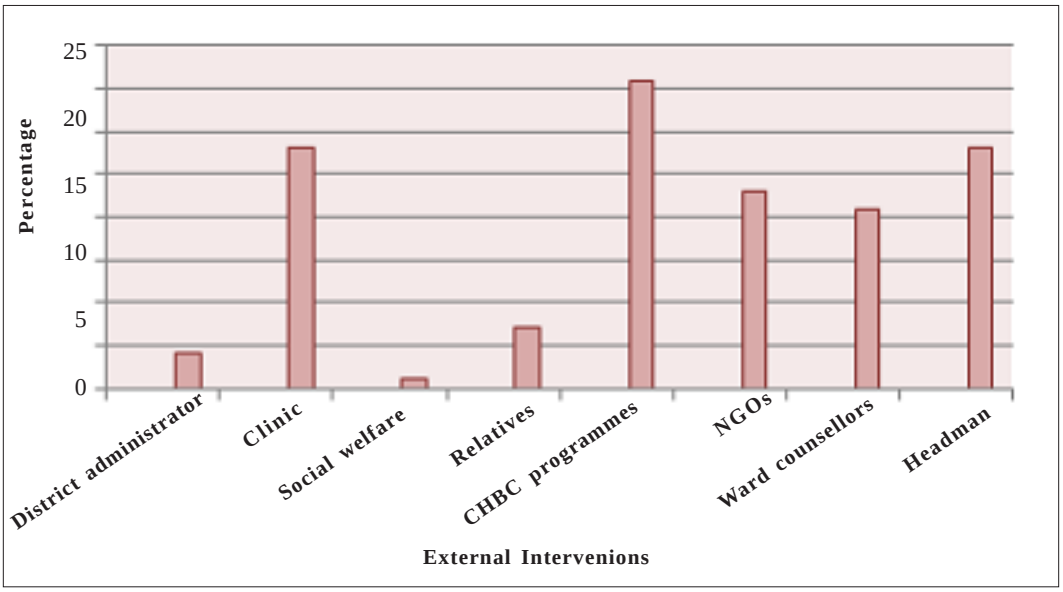

Fig. 4. Possible remedies from external interventions

ey and food from their village headmen. Furthermore, twenty-three percent of the 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 showed that they also got help from their ward or community counselors when they wanted money and food. Seven percent said that they received help from their relatives. Four percent received help from the District Administrator and one percent indicated that they got help from social welfare in the form of school fees for orphans and births.

Qualitative Findings

The Hurdles Facing 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. 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 program 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 resources 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 ten participants agreed that they use their own resources sometimes to help and they also seek help from the NGOs, social welfare, clinics, chiefs, counselors, headmen, relatives, and friends of the patients and from the CHBC programs 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 by helping people. Three participants explained that it was very difficult for them to take care of the patients, especially those that they are related 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 the food is distributed to all the people in the community by NGOs and government. Seven participants mentioned that there is a 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 the 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 the 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.

DISCUSSION

The research brought an insight that they are many challenges that are being faced by HIV and AIDS patients, family members and caregivers in the long run as they provide care to HIV and AIDS patients. Even if the government and NGOs have tried to provide resources and funds to support CHBC programs, still these challenges hinder the recovering of patients. Evidence from this study, therefore, reveals that most projects that are implemented in many rural areas are not sustainable enough to help HIV and AIDS patients overcome food shortages in their households. Because gardening projects are the only projects effected to equip families to increase food in their families. Basilwizi (2010) in support of the results, argues that poverty alleviation projects have left a legacy of increased vulnerability and impoverishment amongst the displaced communities due to entitlements losses. 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. The issue is that the government and 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 one sees NGOs and the government distribute food especially in the Shurugwi rural area. 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 program sometimes leave or terminate before the beneficiaries are stable enough to stand by themselves, and this becomes a barrier also to the implementation of successful CHBC programs.

It is very important to know the kind of challenges faced by HIV and AIDS patients, family members and the caregivers in order to improve their conditions well. The study shows that there are many services provided to patients by CHBC programs, 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 sixty percent of the respondents agreed that the program was not providing better services because of lack of food, drugs, CHBC kits, money and transport cost. The program does not have enough resources, but provides knowledge to caregivers on how to take care of patients. 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, the 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. (2009) contend that despite the positive political and economic climate that has served to place comprehensive HBC programs 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 programs. This explains the reasons for the suggestion that the government and NGOs should help them with the following resources, and 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 in farming techniques and adequately assess the needs of patients.

CONCLUSION

The hurdles faced by HIV and AIDS patients, primary caregivers and secondary caregivers are hindering the improvements of HIV and AIDS patients and the successfulness of CHBC programs in reducing the effects of the pandemic. These hurdles include lack of knowledge among caregivers, lack of resources to use, donor fatigue, lack of transport, and lack of food. These hurdles cause problems for HIV and AIDS patients and all the caregivers in improving the conditions of HIV and AIDS patients without the resources needed to help them. This paper requests that the government and NGOs and other organizations in support of the programs help CHBC programs with enough resources and funds in order to overcome the abovementioned challenges.

REFERENCES

Basilwizi P 2010. *Sustainable Development Support for a Poverty Free Zambezi Valley. Strategic Plan for 2010-2015.* Zimbabwe: WFP Publishers.

Campbell A 2004. *Practitioner Research and Professional Development and Education.* London: Paul Chapman.

Cooper M 2008. *Essential Research Findings in Counselling and Psychotherapy*. London: Lawrence Erlbaum Ltd.

Creswell JW 2009. *Research Design: Qualitative and Mixed Methods Approaches.* 3rd Edition. California, Thousand Oaks: Sage Publication Inc.

David M, Sutton CD 2004. *Social Research.* New Delhi: Sage Publications.

Doctors without Borders 2013. Internal Revenue Service as a 501 (C) Doctors without Borders Federal Identification Number (EIN) are 13-3433452. MSF-USA Associations. From <http//:www. doctorswithoutborders. org/publications/> (Retrieved on 16 October 2013).

Jackson H 2002. *AIDS Africa: Continent in Crisis*. Harare, Zimbabwe: Safaids, Avondale.

Kangethe SM 2006. *Contribution of Caregivers in Community Home Based Care Programmes: The Case of Kanye, Botswana.* Thesis, Unpublished. Department of Social Work. Mafikend: University of North West.

Kang'ethe SM 2010. The effect of ageing on the quality of care giving in Botswana. *Botswana Notes and Records (BNR) Journal*, 41:76-82.

Kang'ethe SM 2013. An exploration of the panacea of training palliative caregivers in Botswana community home based care programmes. An empirical case study perspective. *Mediterranean Journal of Social Sciences* (in press).

Lavery JV, Tinadana PO, Scott TW, Harrington LC, Ramsey JM, Ytuarte-Nuñez C, James AA 2010. Towards a framework for community engagement in global health research. *Trends in Parasitology*, 26(6): 279-283.

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.

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,* 1(2): 228-233.

Olsen W 2004. *Triangulation in Social Research: Qualitative and Quantitative Methods in Sociology*. Hollborn Ormdkirk: Causeway Press.

Wellman CK, Fand MB 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 and Tropical Medicine.

UNAIDS 2004. *AIDS Epidemic Update*. Geneva. Switzerland: UNAIDS.

United Nations Population Fund (UNFP) 2007. Country Profiles: Zimbabwe. From <http://zimbabwe .unfpa. org/NFPA%20in% 20Zimbabwe. htm> (Retrieved on 14 May 2008).

Paper received for publication on March 2015
Paper accepted for publication on December 2015