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The HIV and AIDS Community Home Based Care Programme and Its Gender Implications: The Case of Entumbane Community

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Abstract:

Bulawayo is at the heart of AIDS pandemic, with HIV prevalence figures consistently higher than other provinces in Zimbabwe, currently standing at 11,6 %. The purpose of this study was to explore and discuss gender discrepancies in HIV and AIDS community home based care programme in Entumbane' CHBC in Bulawayo. The study discussed the experiences of PLWHA who are on CHBC. In-depth interviews and focus group discussions were utilized to collect information from knowledgeable individuals regarding their own and other people's experiences, who are beneficiaries of Entumbane CHBC. A purposive sample of ninety participants from Entumbane community was purposefully selected for the study. All participants are beneficiaries of community home based care and are part of the Entumbane community. These individuals were identified for their potential to elicit valuable information since they are beneficiaries of the programme. The review literature gives some detailed analytical views on the prevalence of the pandemic and the gender discrepancies in the CHBC. The aspect of CHBC is discussed, for the role it is playing as well as the contribution it is making, albeit, in a limited manner because of resources, expertise and support from formal authority structures. In presentation, analysis and interpretations of data it is clear picture that reflects gender discrepancies in the Entumbane CHBC. The big challenge of gender imbalance in CHBC has to be squarely addressed. The fact that care giving is dominated by women demonstrates the process of gender imbalance, inequality and inequity. Conclusions were made that women and girls are at the highest risk as they bear the burden of care. It was therefore recommended that the government and its stakeholders should develop gender equality and women's social, economic status through promotion of education, provision of loans and provisions of gender sensitive trainings.

Keywords: *Community home based care, gender, implications*

1. Introduction

HIV and AIDS is having and will continue to have significant social, economic and developmental effects and consequences in most of southern Africa. The developmental impact the disease has had in Southern Africa as a region is now a matter of great global concern. The magnitude of the potential disastrous effects of the disease has several implications for sustainable development. The effects of the disease have made planning and development efforts for the future generations unpredictable. Us (2002:45) argues that the outbreak of HIV and AIDS in Zimbabwe coincided and teamed up with the current protracted economic stagnation partly brought about by the various economic structural adjustment policies (ESAP). Faced with a weakening economy, Zimbabwe like many other African countries responded poorly to the HIV and AIDS threat.

As defined by the WHO (2002), home based care is the provision of services in support of HIV and AIDS infected persons in their homes. It also includes those affected by the illness of relatives and friends, orphans and vulnerable children (OVC). The term community is included because care delivered within communities with the people themselves taking the major role in the establishment and delivery of care activities. Zimba (2001) notes that the goal of CHBC is to make appropriate quality health services available and accessible and improve the quality of life chronically ill including people with HIV related illness.

The community home based care approach has its own set-backs, much of the care, up to 90 percent is provided at home by the immediate family, friends or volunteers, with little or no training or support in performing their duties, (Defilli, 2003:35). In addition, the provision of care falls disproportionately to women and older people. Bailey (1996) notes that there are therefore gender disparities in the provision of community home based care with females being disadvantaged than males. In a study done in South Africa over two thirds of family care givers in households affected by HIV and AIDS were women and children, (Campbell 2004:92). In another study of family care for those living with the HIV in Uganda, it was noted that women were the primary care givers in 86 out of 100

illness episodes. This burden of care assumed by women and the elderly has also been recognized at the highest levels, for example Campbell (2004:89), Political Declaration on HIV and AIDS which advocated providing support and rehabilitation of these children and their families, women and the elderly, particularly I their roles as care givers.

There are many challenges that care givers face which range from burn out and impoverishment to injury increased vulnerability to illness and emotional despair, other challenges include inadequate help from home based care organizations. In a survey in Zimbabwe in Zimuto district, care givers felt that home based care organizations did not give them adequate attention as they were only interested in the sick people, (Budlender2004:21).

2.1. Research Questions

The main research questions in this study were;

- What are the aims and objectives of community home based care in Entumbane?
- What is the level of women's and men's participation in Entumbane CHBC activities?
- How do HIV and AIDS patients perceive the care, support and treatment provided to them at home?
- What are the experiences of care givers in relation to training for home based care?
- What are the problems encountered in CHBC?
- What can be done to solve the problems faced in CHBC?

2.2. Objectives

- To determine the objectives of CHBC in Entumbane.
- To establish the major players in CHBC in Entumbane.
- To discuss the benefits of CHBC in Entumbane.
- To explore the factors that hinder male participation in CHBC.
- To assess the gender inequalities created by CHBC.

2.3. Research Methodology

The research strategy was essential in assisting to explore and discuss the gender discrepancies in HIV and AIDS community home based programme in Entumbane community in Bulawayo. In this section the following aspects were presented thus research design, data collection, and data analysis. This section also has an overview of ethical considerations and the measures which were to be observed to protect the rights of the study participants. This study falls within the qualitative paradigm and takes the form of a single case study on the gender discrepancies in CHBC in Entumbane, Bulawayo.

2.3.1. Research Design

This study assumed a qualitative research design because of the nature of the problem that was under study. The major assumptions in the qualitative research are that there is no single reality and each narrative is knowledgeable on its own (Sarantakos, 2005:3). Rubin (1997:52) notes that a qualitative study is used when one seeks to "gain an understanding of the perspective of the persons being interviewed. This approach was relevant to the researchers as they explored experiences and behaviors of gender discrepancies in CHBC in Entumbane Community in Bulawayo.

Qualitative research examines life experiences in an effort to understand and give them a meaning, (Robson, 2002: 34). This is usually done by systematically collecting and analyzing narrative materials using methods that ensure credibility of both the data and the results. Qualitative research also enabled the researcher to study human action and interaction from the perspective of gender discrepancies of participants themselves (Straus, 1990). Thus qualitative research is appropriate for this study since the main aim is to determine the gender discrepancies of CHBC in the Entumbane Community and highlight the impact, value and benefit. The research also further explored the experiences and perceptions of the beneficiaries of the programs in order to understand the dynamics of the circumstances involved from the participant's point of view as they live, interact and battle with issues affecting their survival.

2.3.2. Target Population

In terms of target subjects, the focus was to access the impact of the gender discrepancies in CHBC in the Entumbane community with special reference to the beneficiaries, the people who are infected and affected by the HIV and AIDS pandemic. Therefore, the target population will consist of all people male and female who are involved in CHBC and those who are service beneficiaries of its programmes, such as PLWHA, trained care givers and volunteers from the community as well as committee members. The study was focused on ninety people in six focus group discussions and ten people who were interviewed thus the sister in charge of the Entumbane clinic, two nurses, three social workers, the councilor and three program officers of three NGOs.

2.3.3. Sample Procedure

A non- probability sampling procedure relies on available subject, as Gray and Payne (2003:166) is the location; it is acknowledged that it might be a risky sampling method. However, as these authors argue that it is justified only if the researcher wants to study characteristics of people passing the sampling point at specified times. Also the ease and inexpensive nature of this method explains its popularity. In this study the researcher used purposive sampling procedures.

A purposive sampling technique was employed to reach to the clients and participants. Purposeful sampling involved identifying individuals who would generate rich descriptions of the phenomenon. A purposive sample of twenty participants was purposefully

selected for this study. All participants are from the Entumbane community. According to Thyer (2001) qualitative research makes use of small numbers of cases to study a phenomenon in-depth. All participants are African, Shona and Ndebele speaking, male or female, infected or affected by HIV and AIDS. The individuals were identified for their potential to elicit valuable information since they are beneficiaries of the programme.

2.3.4. Data Collection Procedure

The following data collection procedures were used in this study thus;

2.3.4.1. In-Depth Interviews

The researcher gathered information by means of semi structured one on one interviews or guided interviews and focus group discussions. De Vos (2002: 298) notes that semi-structured interviews are defined as those organized around areas of particular interest, while still allowing considerable flexibility in scope and depth. This kind of interview is also known as guided interview because a check list is prepared before going into research setting to make sure that important issues pertaining to the research question and goal are not left out. A semi-structured one on one interview was used because of the strength that includes the fact that this method has an interview guide that permits comprehensive and comparable data gathering while ensuring that all the main issues are covered.

2.3.4.2. Focus Group Discussions

The researcher also employed focus group discussions. Volunteers, caregivers and community members participated in six different group discussions to elaborate on the gender discrepancies in CHBC in Entumbane. The focus group discussion was intended to explore ideas and opinions from the participants of the CHBC service with regards to the gender discrepancies. This helped the researcher to understand women more than men volunteer their time, effort and skills in the activities of the CHBC.

2.3.4.3. Data Analysis

Data analysis is the process of bringing order, structure and meaning to the mass of collected. De Vos (2002) points out that it is in this phase that the data is presented, interpreted, discussed and generalized. Qualitative researchers collect data in form written or spoken language or in form of written or spoken language or in the form that is recorded in language or in the form that is in vernacular language and then analyze the data by identifying and categorizing the themes (Bazeley 2006). Data analysis involved breaking up the data into manageable themes, patterns or trends that can be identified or isolated or to establish themes in the data (Baker 2006). As a first step of the analysis process all interviews were audio-taped, transcribed, and subjected to qualitative data analysis. Transcription and analysis of the interviews began immediately following the first interviews and was preceded by analysis of the transcribed data from the structured interviews and the focus group discussions, line by line, highlighting important ideas and themes. Thematic content analysis is a process of breaking down the text into themes and categorizing the patterns in the data. Shona and Ndebele interviews were translated into English and only the English translation was transcribed.

2.3.4.4. Data Presentation

Accurate presentation of the data and findings was made in a way that captured the essence of the gender discrepancies in the Entumbane community home based care. In presenting the results, the research returned to the voices of the participants to describe their experiences as participants or beneficiaries. Tables and graphs were used to show information collected and how it was expressed. Comments and analysis were given after presentation of data on each table and graphs. Percentages were used wherever possible to come out with findings, conclusions and recommendations emanating from the study.

2.3.4.5. Ethics and Human Rights

Ethical guidelines serve as standards and as the basis on which each researcher ought to evaluate his or her own conduct (De Vos 2002:63). Consistent with the ethical requirement of research, the researcher observed the following ethics; gaining access, informed consent and confidentiality and privacy as well the deception of respondents.

In gaining access to the participants the researcher accessed permission from the councilor and the local clinic in order to conduct the in-depth interviews and focus group discussions. Respondents were given verbal and written consent before participating in the focus group discussions and in-depth interviews. It was made clear that the participants were not under any obligation to participate as individuals and they had the chance to refuse to take part in the study and they could also refuse to answer questions at any point during the survey.

3. Research Findings and Discussions

The content was captured under seven themes that emerged from focus group discussions and in-depth interviews and they can have summarized at the level of women's and men's participation in Entumbane Community Home Based Care, PLWHA perceive of care, support and treatment given to them at home, support by the community and problems encountered in CHBC.

Results that emerged from focus group discussions and in-depth interviews addressed reciprocal issues that are presented in an integrated manner in order to compare such results from the family members and community care givers. The findings are depicted in pie charts as well as tables. These are then discussed in detail.

3.1. Biographical Data of Participants

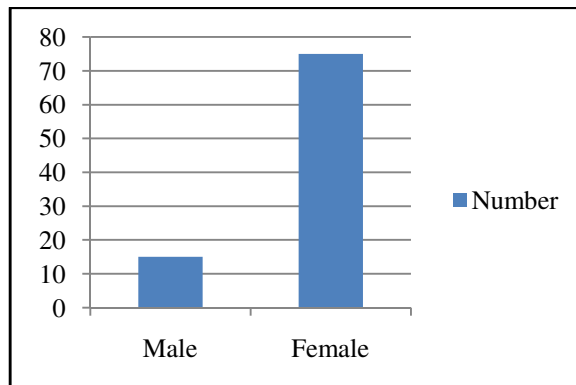


Figure 1: The Gender of the Respondents Group

3.2. Gender

It can be noted that from the above figures that most of the respondents in this program are females. Out of the ninety participants in focus group discussions, seventy-five were females while fifteen were male. UNAIDS reports on the global HIV/AIDS, (2006), states the view that the burden of dealing with the “fall out” of the epidemic rests particularly with women. Women are therefore extremely vulnerable to the effect of the epidemic. However, this profile does not represent the gender profile of all Entumbane residents. It can also be noted that the culturing of care giving as highlighted in the literature has a strong bearing with regards to the execution of the duty.

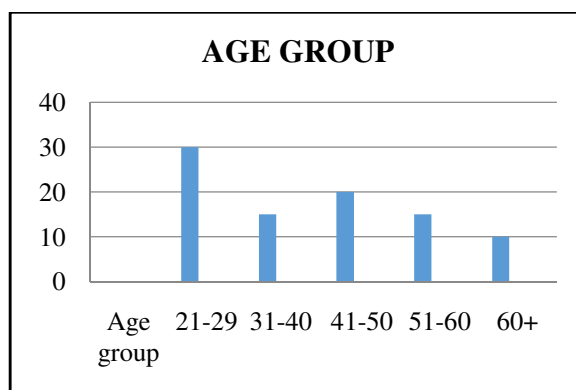


Figure 2: Participants Age Distribution

3.2.1. The Age Profile of Age Participants

Figure 2 indicates that people who are most infected and affected by HIV and AIDS were the ages of 21-30 thus young adults. Many authors concur that this is the group that is most affected by the pandemic therefore as a result it was realized that this group had the highest number of female participants in the functioning of the CHBC. From the age group 31-40 there were fifteen care givers while from 41-50 there were twenty care givers. From 51-60 there were fifteen care givers and those who were over sixty there were only ten care givers.

It can be noted that unlike from the literature review that asserts that most of the burden is put on girls that leads to most of them leaving school and old women, the study realized that there is an influx of care givers in the age range from 21-29 largely owing to the realization of the fact that most respondents noted that they want children to focus on education and it was made clear that the children only participate in complementing their duties rather than carrying the corpus of the duty. On the age profile of the participants it was also realized that the thirty percent of the age 21-30 also largely owed much due to the fact that the most the care givers had in a way realized the devastating consequences of the HIV and were seeing the disease in their homes.

3.2.2. Length of Service

From the study conducted it was noted that most of the participants were women and that most of the caregivers had a lot of years in CHBC though it can be noted that there are still some problems as well as challenges which are being experienced. The number for care giver under two years to two years is fifteen and most of the participants it was realized that were involved due to the pandemic being in their homes. From two to five years there is a sudden downfall in the number from 15 to 5 due to fatigue from the participants but the number increases in the range of five to ten years and ten years and above. It was also noted that those care givers with a lot of experience had a lot of clientele and are easily recognized in the community for the duties and services they render to the community.

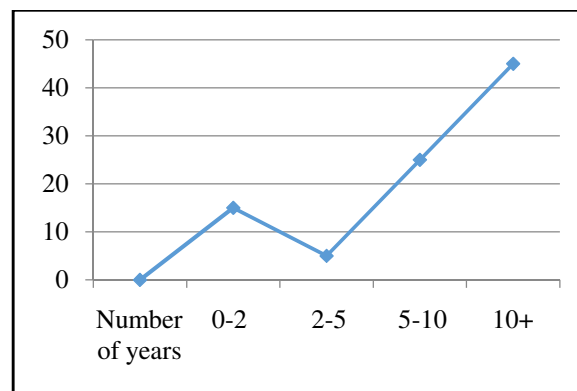


Figure 3: Length of Service

When participants were asked on the relationship between patients and the care giver, the bulk of the households said care giving is provided by immediate family members (spouse, daughter, mother, sister, brother). This illustrates the main providers for participants in the study. Relatives or spouses comprised the majority of care givers followed by health care workers and care givers or volunteers. Most of the participants mentioned that most of the care givers had developed relationship with the clients thus PLWHA and it was realized that this was conducive for the execution of the duties.

3.2.3. Main Care Providers

Majority of the participants agreed to the view that being taken care of at home is good. Most of them affirmed the view that relatives should give care and support to the HIV and AIDS patients at home. On the other hand, half of the participants indicated that although the common situation is like this, some relatives are not happy and willing to provide care to patients who are HIV positive. This then gives an impression that there are still some people in Zimbabwe who are not aware that HIV cannot be transmitted through coming for a patient as long as protective measures are taken.

Themes that emerged from the research were as follows:

3.3. Theme 1- The Objective and Benefits of CHBC in Entumbane

The AIDS epidemic is taking a devastating toll on families and communities worldwide. In its wake lies a growing burden of caring for the sick, the dying, and those left behind. In most countries the care for PLWHA takes place in the home surroundings. As stated earlier, in almost all the countries including Zimbabwe, the family has always been and still is the major provider of long term care for patients with chronic conditions including HIV and AIDS. However, the heavy burden of care cannot be shouldered by families alone. Again, the question still remains, who is qualified to provide primary care for HIV/AIDS patients?

Study respondents perceived particular advantages in involving men ranging from physical strength to some sex care provision for intimate tasks as handier to do the care. Where women are care givers it was noted that they tend to have a wider range of potential patients compared to men. The task respondents felt a man could not do was to enter a room of a woman and provide care for his mother in law. In a way both men and women in the community preferred same sex care givers for bathing.

Seventy-eight percent of the care givers and volunteers were satisfied with the adequacy of their working. Seventy-two percent of the participants were satisfied with the orientation and on the job training received. The issue of inadequacy of health and safety measures at work featured prominently in the focus group discussions, with the care givers expressing concern about exposure to diseases like tuberculosis without necessary protection.

Consistency disproportionate distribution of male and female involvement in the delivery of HIV services was explained by both men and women as a reflection of long standing societal expectation that men should provide for families. In other words, men are expected to engage in productive labor so that they can support their families. Men like the female counterparts overwhelmingly agreed that men were created as family providers as such they need to engage in activities that result in generation of income.

3.4. Major Players in CHBC in the Entumbane Community

Most respondents noted positive responses with regards to community support and participation, while others reported that local people are supporting them but noted that the support was however not enough. The locals as such did not appear to have much of the support resources adequate enough to run such a programme meaningful. There was further indication that some local churches were accepting PLWHA and insisting that they be treated like anybody else, their status did not mean they should be isolated.

Uys (2003) supports that family and community involvement in the care of their own members create general AIDS awareness in the community and this helps to break down fear, ignorance, prejudice and negative attitudes towards PLWHA. In addition, the PLWHA receive support from local business people, the local health clinic and some nongovernmental organizations and from private people.

Lewis (1979) supports that community members can identify vulnerable groups or individuals in their particular settings and develop programs that provide both support and strengthen problem solving skills;

“we work hand in hand with the local clinic because they supply us with the list of people who are taking treatment on monthly basis and then our volunteers visit them for assessment if there is a need for our intervention”.

The support from the local community pointed to culture and socialization as facets influencing the direction of care giving. Culture represents societal values, norms and practices that are passed down from one generation to another. Culture has always been the mirror of society, representing society's thinking, cherished values and do's and don'ts and it sets the pace for change in any society. In Entumbane it was noted from the respondents that there is a belief in the supremacy of men over women and of boys over girls.

3.5. PLWHA Perceivment of Care, Support, Training and Treatment Given to Them at Home

PLWHA acknowledged that the Entumbane CHBC has a positive impact in their lives. Some PLWHA respondents from the support groups in focus group discussions who realized the value of assistance they obtained earlier became volunteers participating in the community helping other PLWHA. PLWHA participants made an emphatic statement that coping with HIV and AIDS alone is a difficult experience. All participants reported that they found support groups as a viable and valuable strategy for coping with HIV and AIDS as they shared the same situation.

3.5.1. Perceivment of Care

Some PLWHA mentioned that they had accepted the illness and have disclosed their status, although it was difficult for them at the beginning. They also noted that through education and training on the disease and support groups they have been empowered on what they should do to live longer lives. Disclosure assists PLWHA to accept their status and learn coping strategies. Some clearly indicated that stress was a dangerous factor and that after disclosure and counseling it felt a load had been taken off their body and was less shy in meeting people ordinarily.

The majority of the PLWHA respondents felt that disclosing status to their loved ones was the first step to the recovery process,

“my mom was very supportive after I disclosed my status. I was very weak when I started treatment and my family was very supportive. I view my condition as all other illness and that I care about now”.

3.5.2. Positive Thinking and Living

The researcher established a growing positive attitude among the majority of these people that they have hope and generally accepted their HIV status. The respondents presented themselves as people who are well informed about HIV and AIDS and as such would be in a position to talk to other of their experiences.

3.5.3. Satisfaction with Assistance from the Care Giver

Most PLWHA who took part in the study noted that they were satisfied with the assistance they were getting from the care givers. Only a few numbers of the respondents reported being unsatisfied with their assistance from care givers. It can thus be noted that the respondents called for incentives to be availed to the care givers for their sacrifice as well as dedication in their duty which risky.

3.5.3.1. Training in CHBC in Entumbane

A number of nongovernmental organizations as well as the MoHCW are involved in training community development workers and community volunteers to assist families with community home care. The participants appreciated the capacity building initiative that they receive but argued that more training need to be done on counseling because some care givers and respondents were struggling to deal with difficult clients. Uys (2003) supports the involvement of care givers in capacity building, stating that they should be given further training in order to be effective in their diverse roles including those related to identifying and supporting PLWHA and their families.

The majority of respondents (67%) had not received formal training in CHBC. Of those who received training, the duration of training was reported as ranging from one day to two weeks. This in a way seems to show a misunderstanding between training and giving on instructions of care. Discrepancy also existed in understanding of formal training and informal training.

3.5.3.2. Assessment of Training in CHBC

Respondents reported that they received training from various governmental and nongovernmental agents ranging from informal health workers such as care givers to state registered nurses. The social workers in Entumbane noted that the majority received training from government employed nurses (41), Red Cross care facilitators trained 30 and 19 were trained by other various NGOs.

3.5.3.3. Adequacy of Community Home Based Care

Care givers were asked to rate the adequacy of CHBC in Entumbane. While 42% felt community home based care provision was adequate, the majority of respondents 58% felt the services were inadequate.

N-90

Comments on adequacy of CHBC	Frequency	Percentages
Adequate	37	42
Inadequate	53	58
Total	90	100

Table 1 Shows Care Givers Perceptions of Adequacy of CHBC

3.5.3.4. Care Giver Perceived Stress

Participants were asked to rate their perception of stress in relation with caring for the sick at home.

Encounter	Never	Occasionally	Often
Emotional and physical strain	30	42	18
Feels frustrated	48	18	29
Needs being met	65	20	15
Uncertain /apprehension about future	80	71	76
Every day hassles	70	73	58

Table 2 Shows Care Giver Perceptions of Stress in Home Based Care

The majority of the care givers mostly women perceived themselves as having stress ranging from occasional to always. The consequences of this stress on care provision are that it compromises the quality of care provided and ultimately the health of the care giver.

3.5.3.5. Enhancing the Quality of Care in CHBC

Respondents were asked to name factors that necessarily would enhance the quality of care in the home. Provision of adequate resources of care was the most cited factor (95%). Other factors included the provision of social support and counseling for clients (8.9%), community involvement (1.8%), training (6.2%), and motivation for staff (6.3%) and transport facilities (7.8%). It is interesting to find out that the provision of basic care kits is seen as the most important followed by food supply.

3.6. Theme 4- The Level of Women's and Men's Participation in Entumbane's CHBC

The study revealed serious gender discrepancy, with 85% care givers being women and only 15% being men. The care givers agreed that if the men in their society would agree to assist in care giving, this would agree to assist in care giving and this would alleviate the serious problem that care giving was facing regarding labour and possibly economics. Those care takers above forty years displayed both physiological and physical characteristics indicative of being stressed, depressed, demoralized, and worn out and poor.

The problem of sex stereotyping in occupations is fully recognized by the Zimbabwean government and these study findings support the notion that women in Zimbabwe currently bear a disproportionate burden of unpaid HIV and AIDS care and support. Based on the focus group discussions and interviews conducted there is definite need to increase the number of people currently providing CHBC?. The participants in all groups confirmed the notion that most care providers still are women.

3.6.1. Ageing and Low Educational Status Affect the Quality of Care Giving

The findings indicated that though the effects of huge gender disparities in care giving effectiveness and productivity, the caregivers advancing age and their low educational status immensely affected care giving effectiveness, efficiency and quality. This is because the elderly women, despite their experience in care giving, found it difficult to understand the dynamics of care giving effectiveness, efficiency and quality. This is because the elderly women, despite their experience in care giving, found it difficult to understand the dynamics of care giving, especially in disease progression.

3.6.2. Care Giving Conducted by Women and Girls

From the research conducted, respondents expressed dissatisfaction because care giving has been left to women in most cases with the duties being passed to the girl child. This they argued was like a punishment to them. While men and boys were freed by culture and socialization from involving themselves in care giving making women and girls to suffer from burn outs. Care givers also saw the burden of care giving as one of the reasons for the poverty of women. One respondent complained as follows,

"the tasks of care giving have been left to us women and our girl children. In this era of AIDS, it is too heavy a burden on us".

3.6.3. The Role of Women as Care Givers as Reinforced by Patriarchy

Sixty-five care givers agreed that the issue of women as care givers finds its roots in the concept of patriarchy. This is a mindset embraced and perpetuated by many cultures and traditions, asserting men's supremacy over women and children. For those caretakers who were Christians, as most of them indicated, it was apparent that the bible had a hand in strengthening patriarchy because according to biblical principles, men were given authority over women by God. The care givers further more reasoned that the role demarcation and differentiation has a biblical origin with women being apportioned relatively lighter tasks thus nurturing the sick being one of them, while men take on relatively harder tasks.

3.6.4. The Role of Women as Fostered by Culture and Socialization

All the study respondents blamed culture and socialization for determining that care giving was a task for women. Some women indicated their disbelief in this and asserted that men should help in care giving. Men should not expect women to solely responsible for care giving. All the respondents agreed that it was time that cultural beliefs, practices and stereotypes underwent a paradigm shift to face the reality of the HIV and AIDS pandemic.

3.6.5. Poverty Ratio between Women and Men

Most of the care givers, who are predominantly women indicated that care giving has been predominantly and adversely affected by the poverty of women. This ascribed to the fact that men were not assisting them in their care giving tasks, nor were they receiving

adequate assistance from family and community members. The following came out strongly from the focus group discussions, the family members, relatives and men only help very little and we are poor and need help and above all help from men is necessary.

3.6.6. Gender Stereotypes

Stereotypes of what is normal male behavior earning money and womanizing seem to serve as barriers to men's participation in CHBC. A web of gender stereotypes about essential male and female traits, status beliefs and perceptions of women and care giving keep women in voluntary HIV and AIDS care giving and keeps men out of it. Respondents noted that men stand to lose respect from other men and discretionary time by entering CHBC.

3.7. Theme 5- Factors That Hinder Male Participation in CHBC

There are number factors which can be put forward which hinder male participation which were identified from the study undertaken and these include;

3.7.1. Failure of HIV Programs to Meet Dominant Male Societal Needs

For most men participating in this study, the CHBC did not meet their expectations. First the clinic which is the focal point of CHBC created an impression that those attending were sick or unwell therefore, it appeared as though all those men who attended regardless of the fact that they were accompanying their spouses and were seemingly in perfect shape were also sick. Men in the group discussions noted that participating in CHBC reflected male admission to vulnerability as such out of touch with the general societal and peer expectation that men should always be strong.

3.7.2. Feminine Nature of HIV Services and Structures

Most programs officers interviewed reiterated that CHBC environments were predominantly feminine. Only about five percent of the men interviewed indicated that they had courage to remain in such an environment for long go through the due process and come back for repeat visits. Men participating in the study made reference to the dominant discussions, stories and conversations at such sessions as hugely repulsive to male participation. It must therefore be noted that challenges related to the so called poor design and female based to service provision is strongly interconnected with existing and reinforced societal expectations.

3.7. 3. Failure of CHBC Programs to Fit Men's Work Schedules

Thirdly most men participating in the study raised such issues as that CHBC did not take into consideration that most males were bread winners and therefore this makes it is difficult for men to participate. Most males noted that their respective employers had no provision for time out to attend CHBC. The only exceptions were people who occupied top position in their areas of work. The rest reflected that it was hard to be accommodating themselves into CHBC.

3.7.4. Privacy and Confidentiality Issues

Most men were critical that CHBC through promising the much needed confidentiality, lacked equal capacity to offer the much needed privacy. Most male respondents noted that available HIV services were highly segregated and specialized to the effect that they inadequately fuel stigma and discrimination. Therefore, most men avoided CHBC for fear of being labeled HIV positive. Expectations shared by HIV respondents reflected that they attended CHBC as a last resort.

3.7.5. Peer Pressure, Ego, and Fear of the Unknown

Men from both the Entumbane community pretended the fact they fear being labeled by their male counter parts if identified as being under CHBC. The majority of men affirmed the strong influence of their friends and social networks with regard to their involvement in HIV programs. Among social networks highlighted were friends and beer drinking peers. Peers especially the drinking ones pressured fellow friends to minimize being part of CHBC as this behavior was negatively considered reflective of a weak feminine nature.

Low male involvement in CHBC was also explained in terms of male ego and pride. More than 90% of the men and women expressed the feeling that participation in CHBC had damaging effect on their self-esteem and self-worth. Some added that frequenting or associating with such and other HIV services dented one's chances of winning additional potential suitors and even friends.

3.7.6. Negative Community Perception about Men Living with HIV

Stigma and discrimination of people living with HIV and AIDS were identified as continuing but none the less abating. The majority of respondents indicated that the remaining pockets of stigma and discrimination were instrumental in explaining low male involvement in HIV and AIDS programs. Compounded with this was general association of HIV with promiscuity.

3.7.7. Community Perceptions of Male Participation in HIV Programmes

There are two different perceptions to male involvement in the involvement in the delivery of CHBC. The majority of participants interviewed stated that males who participate in CHBC delivery are viewed as people who are taking female responsibilities. They are also seen as lazy men who do not have special programmes aligned in their lives. The study noted that males who participate in CHBC in the Entumbane community suffer a lot for example they experience loss of dignity, integrity, humanity and social status. They are

laughed at, prejudiced and scorned. Some people in the community label the members as having no other jobs to do hence wasting precious time.

3.7.8. Religious Factors

Another dominant factor inhibiting meaningful male involvement observed is religious factors. Some African independent churches among others especially in and around Entumbane believed that HIV and AIDS is for the promiscuous. Consequently, it was not their problem because they were leading faithful lives. A minority of men reflected that instead of participating in CHBC they used traditional and religious support as sources of treatment. So while they rarely used health facilities, these men were aware of HIV as a possibility.

3.7.9. Vulnerability and Risk to HIV and AIDS

The vulnerability of care givers to HIV and AIDS epidemic directly impacts on the CHBC because the volunteers some from an environment of increased prevalence and they are vulnerable as individuals. The CHBC care givers and volunteers are highly likely to contact HIV due to the very nature of their work and this tends to affect the morale of the CHBC members because it is hard to maintain motivation among volunteers when these colleagues who are infected with the virus eventually succumb to it, (UNAIDS, 1997:4).

3.7.10. Cultural Perceptions and Entrenched Traditional Beliefs

Despite the fact that HIV and AIDS has been around for more than two decades now, there are still myths and misunderstandings about it that are rooted in cultural, tradition and religious beliefs and these may hinder collective action and reciprocity (UNAIDS 1997:4). HIV and AIDS remains a largely misunderstanding phenomenon among people especially in Africa. This not only exacerbates suspicion, mistrust, fear and stigmatization, but also complicates community initiatives that are meant to address the epidemic.

3.7.11. Inadequate Resources to Support Activities

While it is widely believed that CHBC are organizations that usually start small and normally face the challenge of resources and knowledge, these organizations usually start small and normally face the challenge of resources especially in them to function and expand their services particularly when measured against the challenges and critical issues that they have to address. This makes them explore external avenues for resources, which in itself may bring problems of dependency if not well managed.

3.7.12. Lack of Technology, Coordination and Management Skills

The concept of CHBC depends on volunteers. It was noticed that most of the volunteers have limited education with a paucity of skills in management as well as information technology. This therefore makes it difficult for them to understand and interpret key national policies and strategies on HIV and AIDS and to interpret information on funding options which is normally written in English. It was also realized that due to limited literacy skills, the volunteers are not able to develop funding proposals to the standards demanded by the donor agencies.

3.7.13. Dealing with Increasing Demand for Expression of CHBC Activities

There is a tendency among CHBC to expand prematurely and to scale up services based on their initial success. They sometimes increase their responsibilities and geographical coverage in an attempt to increase their impact but unless they have the resources and skills to do so, the CHBC becomes overwhelmed and members' morale drops. Some CHBC prematurely scale up because pressure from their outside supporters.

3.7.14. Managing the Founder Member Syndrome

In most cases the formation of a CHBC is spearheaded by either one person or a small group of people. As the CHBC grows, more people join and the demand for service increases. The pioneers usually want to continue leading the CHBC activities but do not necessarily have the skills to do so. Ideally the pioneers have to learn the skills (which in most cases they are not able to do) or hire qualified people or step aside for more qualified leaders to manage the CHBC.

Unfortunately, from the research conducted it was noted that the pioneers are not always willing to pass on responsibilities to newer and more, able members. Another problem realized is that the pioneers want to be rewarded more than other members simply because they spearheaded the formation of the CHBC. Though this is not outstanding with the Entumbane CHBC, discussions with some long term volunteers reviewed that they felt they deserve allowances and that they must have full time paying positions in the CHBC. This therefore has the potential of creating conflict within the CHBC and could lead to the collapse of the CHBC if not well managed.

3.7.15. Meeting the Expectations for Rewards by Care Givers

As with most CHBCs, the Entumbane volunteers and caregivers are local residents with no formal employment and they must balance the time they spend volunteering with time they need to spend on domestic chores to fend for themselves and their families. The question of maintaining their motivation levels so that they cannot be taken for granted particularly when the CHBC offers no guarantee for rewards.

3.7.16. Managing the Emotional and Physical Stress of Volunteers

Due to the very nature of the work that volunteers do, they experience stress, especially when they are continuously taking care of long term and terminally ill patients. It was also noted that the volunteers feel helpless when the anticipated assistance from the nurses and social workers is not forthcoming to the patients. This forces volunteers to provide assistance such as food from their own resources.

3.7.17. Sustainability of the Entumbane CHBC

The study revealed that the Entumbane CHBC was not sustainable in that it required consistent donor support. An element of donor support dependency could be observed on the part of the community leaders, councilor and the social workers. They expressed fear that even if they could engage in some income generating projects to support the CHBC, they might not manage to generate enough funds for volunteers training. The only way was to seek for external assistance, which has proved not to be sustainable. The issue of dwindling supports to the Entumbane CHBC by the NGO partners by the social workers who expressed dissatisfaction about the support which they get.

4. Discussions and Conclusions

In the presentation, analysis and interpretation of data, there is a clear picture that reflects gender discrepancies in the Entumbane CHBC. The big challenge of gender imbalance has to be faced squarely. The fact that care giving is dominated by women demonstrates the process of gender imbalance, inequality and inequity. Therefore, gender campaigns that enlist gender analysis and gender mainstreaming are likely to force a paradigm shift towards a more equitable participation of men and women in care giving.

There are number of recommendations that can be put forward in order to ensure that the concept of CHBC thrives and succeeds but above all communications should play an important role. Communication is hoped will empower men to overcome fears and accusations linked to disclosure of HIV results. Similarly, the crucial role of spouses was noted in either encouraging men or hindering male involvement.

5.4.1. Introduction of Gender Redistributive Policies

To reduce gender segregation in health work, national health, HIV and AIDS and CHBC and human resources policies should be gender redistributive and explicitly promote a more equal division of responsibilities between women and men, in general and in the context of HIV and AIDS care and support.

5.4.2. Care Giver or Volunteer Training

A longer basis training programme for volunteers and care givers which interfaces theory and community home based placements should be developed. The training, which can take between three and four months should be in a way structured to avoid overloading trainees with too much theory at one go while allowing them time to practice what they would have learned with real clients. Theory sessions should not exceed five continuous days each while placements can be two to the three weeks each. In addition to this refresher courses should be conducted and they are supposed based on assessed training needs.

5.4.3. Care Giver or Volunteer Supervision

There is need to establish care giver and volunteer guidelines from dispensing care and supervision standards. These should be used alongside the existing CHBC standards. In this regard all implementing organizations involved can meet and draw guide lines on how to dispense standard care as well as developing supervision guidelines. Organizations should then agree to select team leaders from volunteers who are numerate and literate.

5.4.4. Increase Male Involvement

There is need to increase the number of male care givers as well as volunteers. To change the perceptions of men towards care it is important to engage an organization for men. Since organizations like Parade has an HIV and AIDS department, it is best to get their buy in and then do collaborative advocacy between them and CHBC organizations to encourage men to take up care for the sick.

5.4.5. Standardization of Volunteer Incentives

The incentives for volunteer should be standardized so that all care givers and volunteers get the same packages and are aware of it. For this, implementing organizations, local clinics and the care givers as well volunteers themselves need to lobby government to put in place a policy for care giver on volunteer incentives. There is also need for implementers to convene forums to discuss this issue with funding partners so that they get the buy in and support of donors in that regard.

5.4.6. Development of Fund Raising Projects

CHBC sites should engage in fund raising activities to be able to sustain their sites. The study indicated that the CHBC sites did not receive adequate funding from the local authority and MoHCW to enable them to conduct training of community care givers. It is therefore recommended that the local authority policy should include providing the sites with necessary skills for fundraising. This will in a way enable the CHBC sites to deliver effective and efficient services for the families.

5.4.7. Mainstreaming CHBC Training Manual

The CHBC training manual should be mainstreamed to incorporate the local cultural beliefs, values and perceptions to understand how the socio-cultural frame work operates in a particular context. Training packages should also include skills such as non-judgmental attitudes to enable community care givers to allow families to make their own decisions with regards to their cultural beliefs. Families who indicated that the community care givers did not respect their culture beliefs. Families who indicated that the community care givers did not respect their culture explained that the community care givers interfered with them when they wanted to take their ill family members to traditional practitioners.

5.4.8. Community Support

Community support to people living with HIV and AIDS and the CHBC programme must be mobilized to alleviate association of community care givers with HIV and AIDS. The findings of the study indicated that families believed that communities were forming an association between the community care givers and volunteers and HIV and AIDS. When a community care giver visits a family, communities conclude that the patient is infected by HIV.

5.4.9. Family Support

Families should be involved in the care and support of their ill family members to offer patients the care and compassion they need. The research findings indicated that many families were involved indicated in the provision of care by community care givers. However, the few families that were not involved indicated that community care givers did not involve them and therefore felt that it was solely the responsibility of the community care givers to bath or feed the patients.

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