HIV/AIDS PATIENTS RECEIVING HOME BASED CARE IN ILALA MUNICIPALITY, THEIR NEEDS AND SATISFACTION WITH CARE

BY

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CERTIFICATION

The undersigned certify that he has ready and hereby recommend for acceptance by the University of Dar es Salaam a dissertation entitled: '**HIV/AIDS patients receiving home based care in Ilala Municipality, their needs and satisfaction with care**'in partial fulfillment of the requirements for the degree of Master of Public Health.

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Date.....08-11-04.....

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I Victorina Ludovick, declare that this dissertation is my own original work and it has not been presented to any other University for a similar or any other degree award.

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ABSTRACT

The whole issue of care and support to people living with HIV/AIDS (PLWHA) is challenging. Tanzania has also adopted home based care for these patients, however there is a limited client's based information to guide the inputs.

A cross-sectional study was conducted in Ilala Municipality in Dar es Salaam from May-June 2004 with the objective of finding out the needs of HIV/AIDS patients and their satisfaction with HBC services provided.

A total of 304 HIV/AIDS patients under HBC, aged 19-69 years were interviewed. Information was obtained through structured interviews to the patients who gave consent.

The results showed that 95.1 percent of the HIV/AIDS patients in Ilala district were satisfied with the care being given; especially those who received free medical care. The least satisfied were the young respondents; the never married, unemployed, and those expressed their needs as being financial. The main providers of the HBC services were NGOs (55.7 percent) and the family members (27.7percent). Most of the respondents (61.2 percent) had at least three meals per day especially those who received care from family members, from the NGOs and those of medium sized families. Those having

education (68.3percent), being married (29.1percent) and widowed (32.4 percent) afforded three meals and above. This shows that there is still a need for improvement. Therefore this study recommends that the Government should collaborate with the NGOs and other stakeholders to have a system in place to monitor this socio-economic gap, so that HBC services becomes an instrument of improving the quality of care of HIV/AIDS patients and hence their satisfaction.

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LIST OF ABBREVIATIONS

ADF	African Development Forum
AIDS	Acquired Immunodeficiency Syndrome
AMREF	African Medical and Research Foundation
ARV	Anti-retroviral
BoD	Burden of Disease
CCBRT	Comprehensive Community Based Rehabilitation and Treatment
CBOs	Community Based Organizations
CHBC	Community Home Based Care
CI	Confidence Interval
DANIDA	Danish International Development Agency
DCC	Dar es Salaam City Council
GTZ	Gesellschaft fur Technische Zusammenarbeil (German International Cooperation)
HBC	Home Based Care
HFs	Health Facilities
HIV	Human Immunodeficiency virus
ICASA	International Conference on AIDS and STIs in Africa
ICHC	Integrated Community Based Home Care
IDC	Infectious Disease Centre
IEC	Information Education and Communication

KM	Kilometers
MOH	Ministry of Health
MRACP	Mbeya Regional Aids Control Program
MUCHS	Muhimbili University College of Health Sciences
NACP	National Aids Control Programme
NGO	Non Governmental Organization
OI	Opportunistic Infections
PASADA	Pastoral AIDS Services Archdiocese of Dar es Salaam
PLWHA	Patient living with HIV/AIDS
SADC	Southern African Development Commission
SHDEPHA	Services Health Development in People Living Positively with HIV/AIDS
STIs	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme for HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WAMATA	Walio katika Mapambano ya Ukimwi Tanzania
WB	World Bank
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 HIV/AIDS epidemic situation globally

Governments in the developing world have emphasized the adoption and development of Home Based Care (HBC) as one of the strategies to mitigate the impact of HIV/AIDS on the health system. HBC also is expected to meet the expectations of the sick, families and the community. The task to provide the required HBC lies on non-governmental organizations, communities and civic organizations. This study is expected to answer the question: are the HIV/AIDS sufferers satisfied with care provided and the contexts influencing it. This is important especially considering that HIV/AIDS is the leading cause of the Burden of Disease (BoD), accounting for about 6% of the burden globally. More than 40million people are suffering from HIV/AIDS globally (UNAIDS 2004).

The HIV/AIDS has differentially affected poor countries more seriously thus making the global inequity in health care serious. About 70% of HIV/AIDS affected people globally are living in Sub-Saharan Africa. It has also made the poverty in those countries worse. There is also a gender inequity with women being affected more as compared to men. The main reasons for this include gender discrimination, socio-economic status, the greater effects of wars, and biological vulnerability (World Health Organization, 2000).

The HIV/AIDS pandemic was first described in the early 1980s. In Tanzania the first three AIDS cases were reported in Kagera region in 1983. By 1986 all the regions in Tanzania had reported an AIDS case. The main mode of HIV transmission in Tanzania is heterosexual accounting for 78% of all reported cases in 2001. Mother to child transmission ranked second contributing 5% of all cases. Antenatal clinic HIV serosurveillance conducted in 24 antenatal clinics in 6 regions in Tanzania mainland in 2002, revealed an overall HIV prevalence of 9.6% ranging from 5 .6% in Kagera Region to 16% in Mbeya region (Tanzania Ministry of Health, 2003). The epidemic has been on the rising trend with great impacts on all systems of life.

1.1.1 Impact of HIV/AIDS on the health sector

Impact of HIV/AIDS on the health sector included excessive loss of lives of people on their productive years, thus posing a serious challenge to productivity and economies of governments. These impacts can then be categorized according to levels of the health system. The levels include the individual, family, community, and health facilities (Tanzania MOH, 2003).

It has been observed that before the person dies of AIDS a typical adult will suffer an average of over 17 illnesses. The World Bank estimated that in Tanzania an infected person would require over 280 days of care if one would add all life time sick days

together, it will cost Tshs. 56,000/= or US dollars 290 in nursing and drugs. A child would need a total of 200 days of care and cost of Tshs. 37,600 or 195 US dollars.

Beside costs HIV/AIDS results in excessive use of health resources. For example in Tanzania reports from urban hospitals have shown that patients with AIDS occupy approximately 50 – 60% of hospital beds (World Bank, 1996). Thus at patient, family and community level HIV/AIDS leads to loss of lives, loss of production and increased need and utilization of medical care.

It has also been estimated that AIDS expenditure for care could absorb one quarter of the governments recurrent health budget, thus government will have to make difficult decisions regarding treating AIDS versus treating other illnesses (World Bank, 1996). As a consequence HIV/AIDS has also brought with it new challenges of how to provide care and support unique to those who fall sick and surviving family members. HIV has added a great burden to a grossly under funded and already overstretched health sector, therefore likely to compromise the quality of health care provision. The poor economic performance and inequalities in the health sector specifically in Tanzania have compromised ability to address HIV/AIDS. To mitigate the HIV/AIDS impact on the health system; governments have adopted among other strategies promotion of Home Based Care (HBC). This study was prompted by the need to know the needs of HIV/AIDS patients and their satisfaction, to facilitate improved care and patient's quality of life.

1.1.2 The history of HBC in Tanzania

On searching for alternatives that can efficiently serve the needs and improve the quality of life of PLWHA, the Ministry of Health through DANIDA support established a Home Based care (HBC) model in 1995 in pilot districts. The model extended care from the health facilities to the community, households and to families. The support consisted of drugs, supplies, bicycles and equipment to eight Districts in Coast and Rukwa Region. One year later the MOH and Gesellschaft fur Technische Zusammenarbeil (GTZ) (German International Cooperation) also established a programme for voluntary counselling and testing (VCT) and HBC in Mbeya Region. The main aim was to answer the needs of HIV/AIDS infected patients and their families at a reasonable cost. Within this programme in 1996 three hospitals started to provide HBC (one mission and two public), in their model of HBC they planned one visit to Person Living With HIV/AIDS (PLWHA) once every week or more frequent depending on the patients needs and their family. All HBC providers were provided with a kit after training to facilitate the provider and the family to render care to the PLWHA. An evaluation was done later and it was revealed that most of the clients were satisfied. In addition other benefits included the observation that HBC services were closer to the communities and which also enhanced the acceptance of persons living HIV/AIDS. The results influenced the decision that it was important for HBC to be included within District Health Plans all over the country. This would result in HBC integration into District Health Care delivery system, promotion and strengthening the

continuum of care for PLWHA from health facilities to their families (Koshuma et al, 2000).

Expansion and coverage of HBC has been increasing from time to time. In December 1999 WHO provided drugs, supplies and equipments to Tanzania for general care of HIV/AIDS patients. This donor support strengthened the continuity of HBC services at district level. Later in 1999/2000 UNDP provided an enabling support to extend HBC to Shinyanga and Kigoma regions. Another development partner support was realized in July 2001 when Tanzania was selected among 10 African Countries to benefit from Italian Initiative for the Fight against AIDS in Africa aimed at strengthening of Community Based Care services in 11 Districts in Tanzania mainland and Zanzibar. Through this support HBC providers have been trained, medicines and resources for HBC have been supplied, communities have been made aware of the services and clients are being cared for in the participating Districts (Tanzania Ministry of Health, 2003).

The 2003-2006 Health Sector HIV/AIDS strategy for Tanzania recognizes care and support as a critical component in the response to the epidemic. Currently there are several groups providing HBC in the country. In Dar es Salaam there is CCBRT, PASADA, Pathfinder International, AMREF, WAMATA, IDC, and MUCHS (Tanzania MOH, 2003-2006). The National Aids Control programme (NACP) strategy envisages that about 5,000 people will be receiving HBC by the year 2006, this is a

very small number compared to a total of 722,490 AIDS cases that have occurred since the beginning of the epidemic in Tanzania (Tanzania MOH, 2002).

It can then be concluded that HBC for HIV/AIDS is still at its formative stage. More important is that, there are many stakeholders both foreign and local with different interest and capacities. Home Based Care is now reported and acknowledged as the most appropriate way of responding to the ever-increasing problems and needs of the chronically ill due to HIV/AIDS and other causes. The aim of this study is to assess the current needs of HIV/AIDS patients and their satisfaction from HBC services provided towards improving their quality of life.

1.2 Statement of the problem

With the ongoing HIV/AIDS epidemic and consequently changing in needs of patients' services, the quality of care in many government facilities is becoming overstretched and quite uncertain. On the other hand the roles and sustainability of NGOs HBC services is not predictable and might need coordination. Given this situation there is a need of client-based information to guide the inputs. However, there is also limited scientifically obtained information on the current needs and client satisfaction with care being provided (Tanzania MOH, 1999). This is very common problem in developing countries and in Tanzania as well.

The whole issue of HIV/AIDS epidemic is challenging especially in provision of care and support to PLWHA. The provision of quality home based care services aims at

relieving and improving the quality of life of the chronically ill patients and their families. However patients' satisfaction varies from one level of the service to another.

At the household and community level; a patient is supposed to have social, emotional, and psychological support from their families, close friends, and neighbours as well as other people important to him or her. Spiritual support from religious leaders, prayers, scripture reading is also important. Families should be encouraged and advised about good nutrition to their patients especially on the importance of adequate food, which is rich in carbohydrates, proteins, and vitamins; environmental sanitation, accessible safe water supply and affordable housing.

The health system should make sure that all necessary equipment and supplies are in place, especially the HBC kit, that medical services are accessible and available to patients who also should have the right to information about antiretroviral drugs (Tanzania MOH, 1999). The provider of HBC services (NGOs, CBOs) should be knowledgeable and skilled about the issues of confidentiality, respect for patients, and good interpersonal relationship.

At the National level; politicians and policy makers should address issues of quality of HBC services in terms of economic hardships of the patient and families. Governments should create awareness on HBC and the services be integrated in the Districts health care systems all over the country (Tanzania MOH, 1999). Satisfaction with HBC

would then depend on the type of the needs, provider, resources in place, environment, political, and structural capabilities. However the burden of care giving is taken by the families but worst of all, in most countries care of the patient is primarily being left to women who have poor access to resources and are subject to stigma and gender discrimination (WHO, 2004). Since there is no system in place to monitor these changes of needs, we are not sure whether the quality of life of PLWHA has improved or not based in perceived satisfaction. Thus it is important to have a clear policy on HBC which will address the needs and gaps of the service that exists as well as assessing the patients' satisfaction in order to improve the quality of care of HBC services. Therefore with these containments, HBC services' main objective to improve the quality of life of PLWHA would be met and hence the purpose of this study.

1.3 Rationale of the study

Tanzania's response to the HIV/AIDS includes the establishment of the National Aids Control Programme, National Multisectoral Frame Work (NMSF), and the Tanzania Commission for AIDS (TACAIDS). The NMSF spells the strategies for mitigating the epidemic, which includes HBC services. The results of this study will provide information on the needs of the patients and their satisfaction towards care being provided to PLWHA. This will facilitate and influence policy response towards care of patients and resource mobilization.

1.4 LITERATURE REVIEW

1.4.1 Definition of Home Based Care:

Within the contexts of HIV/AIDS, HBC is any form of care given to PLWHA or patients with chronic illness in their own home and community. It can be activities that a patient does to take care of him or herself, or care given by relatives, friends, or health workers within their home and community. The main strategy is to meet the needs of the target clients and consequently improving their quality of life (Tanzania MOH, 1999).

1.4.2 What are the needs?

Globally it is estimated that about 40 million people are HIV infected (WHO, 2000). In Tanzania approximately 785,865 people are currently HIV positive (Tanzania MOH, 2003). Among these less than 5000 patients are under HBC (Tanzania MOH, 2003-2006). A study done in neighbouring Kenya has shown insufficient number of providers are involved in HBC due to stigma that is still attached to people living with HIV/AIDS; however there are many people in need of these services. The study findings suggested the need to move from awareness creation to assisting the suffering through HBC (ICASA, 2003). It is then clear that meeting the needs of those patients is very challenging.

Many people living with HIV/AIDS feel isolated and alone; often the people closer to them feel hopeless and overwhelmed. The medical and social services systems are unknown to those most needing them (UNAIDS, 2004). The needs are also defined by the morbidity conditions like diarrhoea, nutrition, and ulcers. HIV/AIDS run a chronic course, patients becoming progressively disabled. They need legal, moral and psychosocial support. Therefore PLWHA who are under HBC would require a combination of interventions to meet their needs.

Medical needs are determined by the stage in the natural history of the disease, and types of morbidity. The most important thing of meeting their needs is the provision of HBC kit that contains medicines and supplies for treatment of opportunistic infections and prevention of HIV transmission to others. The importance of human resources that is skilled on HBC, as well as finance for allowances, transport, and for purchasing necessary equipments for HBC services (Pathfinder International, 2002).

Apart from the health care needs, the patient and family would need spiritual support and counselling from religious leaders, psychosocial support from relatives, friends, neighbours and significant others, as well as supply of safe water and proper basic sanitation. The patient also needs legal support, accessible and affordable housing, disinfectants and equipments like gloves, gauze, bandages, and mackintosh (Tanzania MOH, 1999).

The disease runs a chronic course with very high demand on the patient's nutrition. There is also inadequate food intake resulting to rapid deterioration of the patients' physical condition. Provision of adequate nutrition is thus a critical component of AIDS case management. There is a need for collaboration with other sectors which deals with food production while giving education to patient and family caregivers about nutrition supplementations using locally available foods (Tanzania MOH, 2003).

Women as wives and sisters bear a high burden of AIDS from all context of life as they are most responsible for the health of all family members. Although care at home is provided freely, it has a lot of cost to the caregivers. It doesn't end with death of husband; child or a sister, or care of orphans. Also lies on grandmothers and aunts. women caregivers often get HIV themselves (WHO, 2004). Therefore the need for political commitment and continued support is crucial for the success and sustenance of HBC.

At the National level, Policy makers and politicians should address issues favouring HBC. There should be Multisectoral and International collaboration on poverty eradication, employment opportunities, woman empowerment, support on the vulnerable groups such as orphans, children living in the streets and drug abusers (Tanzania MOH, 1999).

The Pathfinder International CHBC conducted a baseline and needs assessment survey in Dar es Salaam. The aim was to generate information to guide the CHBC programme and determine areas of focus in designing and implementation of CHBC services and training. The findings were that; only 7.0 percent of the respondents reported to have had access to HBC services. About satisfaction from HBC providers 40 percent needed more home visits, 28.0 percent required guidance on treatment and counselling, 16.7 percent needed incentives for caregivers, and 14.0 percent said they would appreciate any kind of HBC given. Chronically ill respondents; 22.5 percent would like free medicines to treat opportunistic infections, and regular medical check-ups, 10.1 percent needed other HBC services, 9.8 percent needed financial support and 8.9 percent needed food supply. Almost half of the respondents stated that they didn't know their needs. Seven out of ten households caring for an ill patient expressed that they experience nutritional problems including lack of money to purchase food, access to only one meal per day, having no one to cook, and loss of appetite of the patient. The main source of care and support was from distant family members 57.0 percent, neighbours and friends 17.0 percent, Local Catholic Church (Kigamboni) 70.0 percent, PASADA 7.0 percent, CCBRT 5.0 percent and Kiwohede 2.0 percent (Pathfinder International, 2002).

The general findings from the 1999 needs assessment study done in Seattle and King County were that patients needed continuum of care and good access to opportunistic

infection medication. It was also noted that patients under HBC from the lower socio-economic status expressed greater satisfaction with the services. Conversely those from middle and upper income levels were generally less satisfied with the services. The explanation being that HBC system cannot replace the lives they have formally led, particularly with services such as food, transportation, peer emotional, and housing(Seattle and King County, 2003)

Another assessment done on quality of HBC and the needs of HIV/AIDS in Lusaka revealed that the major constrains were excessive workload, food and transport, lack of medicines (ICASA, 2003).

Another study was done among volunteers in Congo to assess whether they can deliver a sustainable HBC or not. It was found that most recipients of HBC benefited from volunteers whom they respected a lot. Thus it was recommended that regular support and supervision to enable long continuation of these services was a must (ICASA, 2003).

1.4.3 Models of HBC

There are many stakeholders in the provision of HBC and similarly there are several HBC models that could be influenced by the provider. Analysis of 67 home based care programmes in Zimbabwe had been very informative on this issue (Woelker et al, 1997). The analysis revealed information on minimum package and type of HBC design by what they provided. These included:

1. Financial assistance to patients and caregivers
2. Provision of gloves, bleach, and medical supplies.
3. First visit within one week of discharge.
4. Seriously/ terminally ill visited at least once a week
5. Programmes have a full-time trained health worker.
6. Volunteers receive structured training in nursing and counselling.
7. Access to as many health care supplies as required.
8. Access to as much food supplements as required by the patient.

It can then be concluded that there is variation in the ways HBC services are meeting the needs of the PLWHA. Also there is variation in satisfaction with care providers. The provider and type of HBC could also influence the satisfaction. In Tanzania there are several modalities of HBC delivery. The Ministry of Health has adopted the following model of HBC services delivery;

1. Hospital or facility based outreach using HBC provider.

2. NGOs-based using employed personnel.

3. Community rooted using community volunteer.

4. PLWHA frontline Health care networks, it is a HBC provision by patients together with their families with strong focus on supportive and spiritual care.

These modalities provide a level of care that is quality wise acceptable, and being cost-effective. Each modality has its advantages and disadvantages but the prime quality is the shared responsibility between institutions and communities. However success and sustainability of HBC will depend on the cost at the family and health facility levels, appropriate administration, logistics and supplies (Msumi Z, 2000 and Msobi N., 2000). If these needs are met then HBC services will be able to improve the quality of life and hence satisfaction of the PLWHA.

1.4.4 What are the benefits and constraints of HBC?

The benefit of HBC services includes; improved health of the patient, identified needs to the community, and breaking stigma. Improved health of patient is evaluated both from the patients and providers perspectives. It includes description of positive changes witnessed among patients. It requires availability of correct interventions and has one in place to make sure the patient take their medication and following up trivial changes before they become a serious health risk. Patient on the other hand also appreciates that their needs are met and don't have to travel long distance to a clinic (South Africa National Department of Health, 2002).

Community needs could include having the structures in place that will facilitate identifying needs of clients and referral. It will also enable caregivers living in communities to identify people with needs and problems through social networks and bring them to care providers. A formal communication infrastructure often doesn't exist. There fore establishing HBC will to large extent facilitate establishing those strictures. Stigma has been one of the setbacks in the control of HIV/AIDS. And it is one of the biggest challenges facing HBC programmes in Africa (Anderson et al, 2001). Caring of patients in their home is a means of breaking the cycle of fear surrounding the terminal illness and especially due to HIV/AIDS. Increased visibility of PLWHA in the community thereby would reduce the level of stigma and especially when such patients are satisfied with the care being provided. This will further facilitate

constructive discussions and rational decisions about the causative agent i.e. its transmission, prevention and care.

Reduction of stigma and consequent acceptance and satisfaction of HBC by patient and relatives would also enhance the coverage and equity in the delivery of HBC. Such instances as patients or family members requesting HBC caregivers to meet them outside their homes or leave their medicine at a shop nearby would be reduced extensively. Hence HBC would not have to fight such misconceptions as those surrounding palliative care that see the palliative caregivers bringing death to the household (South Africa National Department of Health, 2002).

Other constraints facing the implementation of HBC is lack of common understand despite that there being attempts to adopt it. The lack of common operational understanding of what is HBC could reflect the varying contexts, which determines the mode and contents of HBC, thus making common definition not of immediate importance. HBC has been acknowledged in various studies; the lack of common understanding of the concepts of home and community care was noted at all levels, even by stakeholders. Due to limited access to HBC services; caregivers spend majority of their day walking to patients, roads are unpaved and hazardous especially during wet seasons (South Africa National Department of Health, 2002). There is also inadequate number, support, and integration of HBC service providers from hospital and Districts Health Management Teams (DHMTs). Stigma that is still attached to HIV/AIDS hinders the counselling process, care and support of these patients

(Tanzania MOH, 2000). Lack of access to basic nutritional needs makes difficult for patients to comply with medicament given. It also exacerbates attack of OI and death to PLWHA (Tanzania MOH, 2002).

Notwithstanding the benefits and constraints there have been efforts to objectively establish cost-effectiveness of HBC. In 1998 an operational research on cost effectiveness of HBC services and other factors affecting its impact on chronically ill patients to HIV/AIDS was conducted in Bagamoyo district. The main focus was on total time spent with patients, distance travelled to see patients, and drugs used; this revealed that the average cost of HBC was Tshs. 1,862/= per day for the community located volunteer, Tshs. 2,443/= per day where HBC was provided by a health worker. An average hospital base care was estimated to be Tshs. 4,921/= per day at Bagamoyo hospital (Msumi Z, 2000, Msobi N, 2000). Guided by the information on HBC being cost-effective a decision was reached that by February 2002 HBC services had to be established in 28 districts in the 6 regions. Also a total number of 102 HBC trainers had to be trained in those districts (Tanzania MOH, 2002).

On the contrary some other studies have not been able to document significant cost-effectiveness of HBC. A study done in Zimbabwe on costs and quality of home-based care for HIV/AIDS patients (Woelk et al, 1997, Hansen et al, 1998) revealed that the model of care was not significantly cost-effective. In any case however hospital and home-based care should be considered as complements to rather than substitutes for each other. It has also been cautioned that HBC may not necessarily be much cheaper

than models relying more intensively on hospital based (especially if frequent home visits are considered a necessity). HBC should thus be considered an extension of the health system to communities and families. However, no one has ever given value to patients' wishes to die at home and the comfort realized from being with relatives and with familiar environment. There is also no sufficient information to conclusively compare home and hospital based care for HIV/AIDS patients. Since the clinical outcomes and quality of life of patients in the two models remains unclear, thus justifying the need of more detailed and bigger studies to evaluate HBC in resource poor countries (Woelker et al, 1997, Hansen et al, 1998).

In conclusion; HBC services should be considered as a supplement to hospital services and ensure that it meet the needs of PLWHA by improving their quality of life regardless of how cheaper or expensive it can be. There should be community sensitization and multisectoral approach to assist the HIV/AIDS suffering through HBC support and funds mobilization. This study will therefore generate information on the needs of the patients, satisfaction with care and their determinants.

CHAPTER TWO

2.0 OBJECTIVES

2.1: The broad objective

To determine the needs of the chronically ill HIV/AIDS patients receiving HBC and their quality of care satisfaction in Ilala Municipality.

2.2: Specific objectives

1. To determine the proportional of patients satisfied with the care being given.
2. To determine relationship of patient satisfaction with socio-demographic factors and providers.
3. To determine the needs of patients.
4. To determine the feeding frequency by type of food in the last 24 hours and by different patient and provider characteristics e.g. Income, family size, marital status
5. To identify the different groups providing HBC services in Ilala Municipality.

2.3: Definition of words / terms

Some of the terms and words used in this dissertation need to be defined as their meanings may vary from one situation to another depending on socio-cultural background, work experiences, and geographical location.

2.3.1: Home base care (HBC)

Can be defined as any form of care given to patient with HIV/AIDS or patients with chronic illness in their own home and community. It can be activities that a patient living with HIV/AIDS (PLWHA) might do to take care of him or herself or care given by their relatives, friends or health workers within their homes and community. HBC is meant to maximize utilization of existing available resources within the community while family and community participation is taken as a basic component in providing such care (Tanzania MOH, 1999).

2.3. 2: Quality

Is a measure of how good something is, or the degree of excellence or superiority that a thing possesses. A service is said to be of quality if it meets or exceeds the expectations of the user.



2.3.3: Quality of life

Overall enjoyment of life that is; an ability to perform various tasks.

2.3.4: Quality of care

The degrees to which health care services for individuals and population increase the likelihood of desired health outcomes and are consistent with the current professional knowledge. The patient, family, and community will accept services provided if there is satisfaction of the care being given.

2.3.5: Quality of HBC

Is the delivery of care for patients at home following the standards, which have been set. It can be;

-Quality at the health facility level

-Quality during the process of care provision.

-Quality at the output/outcome level (Tanzania MOH, 1999).

This is an approach that improves the quality of patients and their families facing the problem associated.

2.3.6: HBC provider

Is any person or a group of people that provides health care services to the patients within their home following standards that have been set (Tanzania MOH, 1999).

2.3.7: Needs

These are basic and necessary resources one would require for an overall enjoyment of life.

2.3.8: Chronically ill HIV/AIDS patient;

Is the patient who continues to be ill for more than one month, such patients include those with the disease that take long to be cured or those of life long like HIV/AIDS.

2.3.9: AIDS HBC Kit:

This is a box that contains 28 essential supplies needed to care for an ailing loved one and to prevent the spread of infection. A HBC kit is given to a trained volunteer who provides support for 10 families that are caring for relatives suffering from AIDS. These are the basic medicines and supplies needed for the day-to-day treatment and control of common infections and ailments. The items are not easily accessible or affordable to many families who need them thus the supplies provide economic and physical relief to the patient and the family (International Ministries Organization, 1999). Contents of the Kit as for Tanzania Ministry of Health are annexed in page 91.

CHAPTER THREE

3.0: RESEARCH METHODOLOGY

3.1: Description of the Study site

The study site was Ilala Municipality with its respective health facilities. Ilala is among the three Municipalities of Dar es Salaam Region which is largest city and commercial capital of Tanzania. According to 2002 population and housing census general report, the estimated population was 637,575 (of which 321,903 were males and 315,670 are females). An average household size for Ilala was 4.5.

For administrative purposes the municipality is divided into three divisions, Kariakoo, Ukonga, and Ilala. The boundaries of Ilala Municipality are the Indian Ocean, which covers the whole of the eastern part, and the Coast Region to West, Kinondoni Municipality to the North and Temeke to the South. The inhabitants of this area are of mixed tribes, races and religions. The Municipality has about 133 health facilities of which 17 are Government and 116 are private health facilities. The major illnesses, which contribute to the Burden of Disease in the municipality, include Malaria, HIV/AIDS, TB, Pneumonia, cardiovascular diseases and injuries. The district still experiences Cholera outbreak in unplanned settlements.

The Municipality has a rising impact of urbanization where unemployment rate is high. The income of the majority is generated by marginal jobs including petty businesses; fishing, farming, and some are employed in the public and private institutions. However many live in poor housing conditions. The rapid growth of urbanization is accompanied by social economic hardships, which predisposes its people especially youth to stress and difficulties in their day-to-day life.

Ilala Municipality was chosen among other Municipalities purposively partly because of its large number of people infected by HIV/AIDS with the estimated prevalence of 6.3 percent (Tanzania MOH, 2003). Among these only 1076 patients are receiving HBC (Tanzania MOH, 2000) mostly due to limited resources.

Currently about 3787 PLWHA are receiving HBC in Dar es Salaam City. Those patients receiving HBC services in Ilala are being supported from 17 health facilities in the Municipality. The facilities providing HBC are evenly distributed within the district. In each health facility there is one or two members of staff charged with HBC provision. Despite the large number of patients, it has been observed that the demand of HBC services is lower in Ilala district as compared to other Districts in the city (Tanzania MOH, 2003).

3.2: Target population.

The target population in this study was all patients with HIV/AIDS receiving HBC in Ilala district. However a representative sample of them was randomly selected for the study.

3.3: Study design

The study design was a cross- sectional study of HIV/AIDS patients receiving HBC in Ilala Municipality. It was a community-based study in which PLWHA were interviewed at their homes.

3.3.0: Sample size and sample size calculation

The sample representative of patients receiving HBC in Ilala district was selected and studied. The parameter of study was satisfaction with the care being provided. It was assumed that 50 percent of the patients or clients are satisfied with HBC. The study aimed at detecting the 50 percent with a variation of five percent higher or lower. The estimated number of patients under HBC in Ilala was 1076.We did not have enough resources to study all, thus our sample has been a representative of these patients as much as possible. The sample size was calculated by using the formula,

$n=z^2pq/\varepsilon^2$

Where n =Expected minimum sample size

z =is a standard normal deviate value which corresponds to 1.96 (at 95% Confidence Interval)

p=proportion of HIV/AIDS patients satisfaction in Tanzania. In this case it was unknown,

Therefore p was taken as 50 %(0.5).

ε =Is the Margin of error on p taken at 0.05

q = 1-p, thus 1-0.5 =0.5

Therefore n =1.96x1.96 (0.5(1-0.5)/0.05x0.05

=384.1

3.3.1: Sampling frame and sampling

With help of the HBC providers in health facilities a list of all patients under HBC was compiled. Systematic random sampling was done. Given the sample size the sampling interval was calculated.

Sampling Interval =population of the patients under HBC/Sample Size

=1076/384

=2.8

The first patient was selected from the list of patients in the register book then after every third patients in the list one was selected (systematic random sampling).

3.4.0: Reaching the patients

This was done with the assistance of infectious disease centre (IDC) authority located at the city centre. The centre deals with the home based care of HIV/AIDS patients and have a register. The IDC HBC providers know a large number of patients so it was not difficult to get the patients and the needed details. The HBC service providers from IDC together with the researchers met the community leaders. Introduced them and explained the aim of the study. A verbal consent was obtained from these leaders to proceed with the study. From the map cue known to the HBC service providers patients were identified.

3.4.1: Eligibility and consent

Participants to the study included only those male and female HIV/AIDS patients, aged 18 years and above, receiving HBC services, and who were willing to sign an informed consent form, which was provided before the interview. The consent statement was read before the patient, those patients wishing to read by themselves were also allowed to do so. Then they were asked to give informed written consent and respond to the interview. For terminally ill patients, a relative was allowed to sign the informed consent but he/she should be knowing and caring for the patients for not less than one month. Those who had no formal education signed using their fingerprints.

HBC care providers were purposively selected depending on the patients cared for. They included family members who have been trained to take care of the patient. An oral consent was requested from the providers selected.

3.5.0: Recruiting and Training Research Assistants

There were four research assistants who did the data collection together with the researcher. These were nurses who had a knowledge and experience in research and counselling. This was done bearing in mind that issues of HIV/AIDS are sensitive and require confidentiality. The research assistants were trained three days prior to the

actual date of the study on how to administer questionnaires and assist the principal investigator during data collection.

3.5.1: Interviews

Structured interviews were done at homes of the patients selected in privacy. Interview to both patients and the HBC service providers consisted mainly of close-ended questions using structured questionnaire. There were few open-ended questions that required a patient or a HBC service provider to list or mention some information. The identity of HBC service providers was obtained from patients. This was done after being interviewed from where they received care and support.

3.5.2: Research instruments

This study used interviewer-administered questionnaire. The Swahili version questionnaire translated from the English version was used. Information collected included the socio-demographic identity of the patient such as age, sex, marital status, education, and occupation. Basic types of HBC services, groups providing HBC services, needs of the patients and their satisfaction. Patient needs were later stratified into categories during analysis.

3.5.3: Pretesting research instruments

Visit of the study area was done prior to data collection to seek consent from the ward authorities, and to confirm the study area profile. Pre-testing the questionnaire was done at Buguruni Health Centre during this period. Results of the pretested instruments were used for clarifying the questionnaire to match with the respondents' socio-cultural background.

3.6: Data collection

The principal Investigator together with the research assistants collected data from the homes of the patients. After consenting, patients were interviewed using both open and closed ended Swahili version questionnaire. For those patients that were not available during data collection revisit was done twice. Information from HBC service providers was obtained from both open and closed ended questionnaire. Among the issues addressed were; types of services provided, name of the facility, profession of the provider and the training they attended, and whether they have and or use the guidelines for HBC services.

3.7: Data management and analysis

Data was collected on daily basis except for Sundays. Each interview took about fifteen to twenty minutes. The researchers checked the data collected for correctness on the same day. All information obtained was checked for correctness, coded and then entered in EPINFO version 6.04-computer software. The Principal Investigator used Epi Info version 6.04 for data analysis.

3.8: Limitations of the study

1. Resource limitation; time and funds allocated for the study were not enough to recruit enough patients to meet the study's sample size. However it was hoped that those recruited were representative of the HIV/AIDS patients receiving HBC services in the District.

2. The well-known issues of stigma attached to HIV/AIDS hindered some of the respondents from giving consent and participating freely in the study. Interviewing patients at home is a problem because; the patients could have not volunteered all the information with the fear that their HIV serostatus will be disclosed. Other studies done have even tried to interview the patients in the health facilities to overcome this problem (Pathfinder International, 1999).

3.9: Ethical issues

Ethical clearance was obtained from Directorate of Research and Publication at MUCHS. The Dar es Salaam city Authorities were requested to provide consent for the study following a letter of introduction from MUCHS. Patients were told that participation was voluntary and information obtained was highly confidential between the researchers and the patient. Informed consent was obtained from the patient prior to data collection.

CHAPTER FOUR

4.0 RESULTS

A total of 304 HIV/AIDS patients who were receiving home-based care (HBC) from different wards in Ilala District participated in the study. The percentage distribution of the study population was 24.0 percent from Kiwalani, ward, from Ukonga 17.8percent, from Buguruni 6.9percent, from Tabata 6.9percent, from Vingunguti 5.9percent, from Kipawa 5.3percent, and from Mchikichini 5.3 percent. The rest of the patients were from other villages which contributed the least. Although it was expected, there was no any patient who required referral to health facility for medical attention during the time of the study.

Socio demographic characteristics of the respondents

The respondents' age ranged from 19 to 69 years with a mean age of 36.2 years. The age group with the highest proportion was 35years and above contributing 50.0 percent of the study population. This was followed by the age group 30-34 years contributing 23.4 percent and the least was age group 19 to 24 contributing only 8.6 percent. The respondents were asked to which religious group they belonged. About half of the respondents were Muslims (50.3 percent), and 48.7 percent were Christians. They were also asked to report the highest education level each had achieved. Majority had

secondary education (68.4 percent) and only a minority had received adult education (2.0 percent)

Table1: Socio-demographic characteristics of the studied population n = 304

Age group (years)	Frequency	Percentage
19 - 24	26	8.6
25 - 29	55	18.0
30 - 34	71	23.4
35 and above	152	50.0
Sex		
Male	102	33.6
Female	202	66.4
Education		
No education	40	13.2
Adult education	6	2.0
Secondary education	208	68.4
Higher education	46	15.1
No response	4	1.3
Religion		
Moslem	153	50.3
Christian	148	48.7
Others	3	1.0
Marital status		
Married	103	33.9
Single	79	26.0
Cohabiting	31	10.2
Divorced	36	11.8
Widowed	55	8.1
Occupation		
Student	8	2.6
Employed	33	10.9
Businessman	117	38.5
Professional	14	4.6
No occupation	114	37.5
Others	18	5.9

The study also inquired into the marital status of the respondents. Those who were married were 33.9 percent. Most (38.5 percent) of the respondents were engaged in business, only 10.9 percent were employed and many others were unemployed (37.5 percent). The rest were professionals and engaged in other income generating activities (Table 1).

The respondents' awareness on HBC was assessed. Results showed that majority (99.3 percent) of the patients were aware of the existence of the services. They were asked on their source of information, and more than half (57.2 percent) of them reported to have obtained information from Community Health Workers.

The respondents were asked about the type of HBC services they received. Most of them (89.5 percent) reported that they received free medical care at home and in health facilities, counselling and education 43.1 percent, and spiritual support 30.3 percent. Those who reported that the care was provided on regular and predictable basis were 66.3 percent. Thus to some of the respondents the home based care services provided were erratic.

Identification of groups providing HBC services in Ilala Municipality

The respondents were asked to report on whether and from whom they had ever received support (home based care) within the last one year. District authorities also validated the responses in those areas. They varied from family members, neighbours

and friends, NGOs (which included CCBRT, PASADA, and SHDEPHA WAMATA), Government Health facilities, Political leaders, Churches and Mosques and Community Health Volunteers. Most of HBC services were provided by NGOs (55.7 percent) and family members (27.7 percent) (Table 2).

Table 2: Groups providing home based care and support

Groups	Frequency	Percentage
Family members	82	27.0
Neighbours and friends	9	3.0
NGOs(mentioned)	169	55.6
Others	44	14.5
Total	**304**	**100.0**

Proportion of Patients satisfied with HBC services given

The respondents were asked whether they were satisfied with the HBC they received. The majority (95.1 percent) of patients were satisfied with the HBC services provided while only 4.9 percent were not satisfied (Table 1).

Table 3: Patients' satisfaction with HBC services

Satisfaction	Frequency	Percentage
Satisfied	289	95.1
Not satisfied	15	4.9
Total	**304**	**100.0**

Respondents feeding frequencies in the last 24 hours

The respondents were asked to report the frequency of feeding they got in the previous 24 hours. It was reported that most of the respondents (61.2 percent) had three meals, while 23.4 percent had three meals or more. Those reporting one meal were 7.2 percent. In between were those who had more than three meals, the menu included breakfast, lunch, dinner and some snacks in between (Table 4).

Table 4: Meals taken in the past 24 hours

Meal	Frequency	Percentage
Once (Lunch or dinner)	22	7.2
Twice(lunch and dinner)	25	8.2
Thrice(breakfast, lunch, dinner)	186	61.2
More than three meals	71	23.4
Total	**304**	**100.0**

The study also inquired about family size and sources of income. Sixty one percent of the respondents reported that their families mainly consisted of 4 to 6 people, while 33 percent reported that they were living within the families of more than 6 people. Their main family's sources of income were fishing as reported by 53.8 percent of the respondents. Few of them depended on employment (20.1 percent).

Patients' satisfaction was assessed in relation to the providers, sex, age, marital status and religion.

Table 5: Respondent's satisfaction in relation to sex n = 304

	Sex					
	Male		Female		Total	
Satisfaction	**Frequency**	**%**	**Frequency**	**%**	**Frequency**	**%**
Satisfied	92	31.8	10	66.7	102	33.6
Not satisfied	197	68.2	5	33.3	202	66.4
Total	**289**	**100.0**	**15**	**100.0**	**304**	**100.0**

Chi square = 7.76 P-value = 0.05

Table 5 shows that female (68.2 percent) were more satisfied than males (31.8 percent). The difference was statistically significant at P-Value of 0.05.

Analysis was done to determine the relationship between satisfaction and age among the respondents.

Table 6: Patients satisfaction in relation to age

Age group (years)	Satisfaction					
	Satisfied		Not Satisfied		Total	
	Frequency	%	Frequency	%	Frequency	%
19-24	24	8.3	2	13.3	26	8.6
25-29	50	17.3	5	33.3	55	18.0
30-34	66	22.8	5	33.3	71	23.4
35 and above	149	51.6	3	20.0	152	50.0
Total	**289**	**100.0**	**15**	**100.0**	**304**	**100.0**

Chi square = 5.68 P-value = 0.017 df = 4

Those in the age group 35 years and above had the highest rate of high satisfaction (51.6 percent) as compared to those below 35 years (48.4 percent). This result shows an appreciable increase in satisfaction rate with age.

The study also analyzed satisfaction of the respondent and its relationship with education of the respondent.

Those with primary education had the highest rate (69.6 percent) of being satisfied. The next (14.2 percent) was among those with secondary education, followed by those with no formal education (12.8 percent); the rest had the least (Table 7).

Table7: Patient education in relation to satisfaction

	Satisfaction					
	Satisfied		**Not Satisfied**		**Total**	
Education	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**
No formal education	37	12.8	3	20.0	40	13.2
Adult education	6	2.1	0	0.0	6	2.0
Primary education	201	69.6	7	46.7	208	68.4
Secondary education	41	14.2	5	33.3	46	15.1
Higher education	4	1.4	0	0.0	4	1.3
Total	**289**	**95.1**	**15**	**4.9**	**304**	**100.0**

Chi Square = 5.63 P Value = 0.229 df = 4

An analysis was as well done to understand the relationship between level of satisfaction and type of expressed HBC needs. The least satisfied (53.6 percent) were those expressed their immediate needs as being financial (Table 8).

Highest satisfaction was among those who expressed their needs as being free medical care. Those in need of counselling, education and spiritual support followed them. Thus those in need of financial support are the least satisfied as they cant afford the basic needs. Once they can afford this basic need that is when they can think of nursing care, spiritual etc. Other needs that were mentioned from this study were; clothes, food, school fees for children, small scale loans for income generating activities like petty business, gloves disinfectants, and more frequent visits (Table 8).

Table 8: Patients' satisfaction in relation to their needs

Needs	Satisfaction					
	Satisfied		Not Satisfied		Total	
	Freq.	%	Freq.	%	Freq.	%
Financial support	25	8.7	3	20.0	28	9.2
Free medical care	260	90.0	12	80.0	272	89.5
Spiritual support	89	30.8	3	3.3	92	30.3
Counselling and education	124	42.9	7	46.7	131	43.1
Home based nursing care	58	20.1	1	1.7	59	19.4
0thers	53	18.4	2	13.3	55	18.1

The study also investigated the relationship between satisfaction and marital status. In all categories of marital status 90.0 percent and above reported being satisfied with care being given.

Among the respondents' marital status, 98.7 percent of the married patients were satisfied as compared to those who never married 94.2 percent (Table 9). Thus being married or probably having some one around who would care was very important for the patient. This underscores the need of stressing for love and care for such patients.

Table 9: Patients' satisfaction in relation to marital status n = 304

Marital status	Satisfaction					
	Satisfied		Not Satisfied		Total	
	Freq.	%	Freq.	%	Freq.	%
Never married	97	94.2	6	5.6	103	33.9
Married	78	98.7	1	1.3	79	26.0
Cohabiting	28	90.3	3	9.7	31	10.2
Divorced	35	97.2	1	2.8	36	11.8
Widowed	51	92.7	4	7.3	55	18.1
Total	**289**	**95.1**	**15**	**4.9**	**304**	**100.0**

Chi square = 4.93 P value =0.295 df = 4

Religion could be an important factor influencing the level of satisfaction. The analysis of satisfaction among respondents according to religion showed that Moslem had a bit higher satisfaction rate than Christians (Table 10).

Table 10: Patients satisfaction in relation to religion n = 304

Religion	Patient s satisfaction					
	Satisfied		Not Satisfied		Total	
	Freq.	%	Freq.	%	Freq.	%
Moslem	145	50.2	8	53.3	153	50.3
Christian	142	49.1	6	40.0	148	48.7
Others	2	0.7	1	6.7	3	1.0
Total	**289**	**100.0**	**15**	**100.0**	**304**	**100.0**

However the difference was not statistically significant (Chi Square = 5.43

P value<0.066 df = 2).

Someone's income can influence the level of one's satisfaction. Among the indicators of income were the types of income generating activity. Thus an analysis was done to determine the relationship.

Table11: Patients' satisfaction in relation to income

Income	Satisfaction					
	Satisfied		Not Satisfied		Total	
	Freq.	%	Freq.	%	Freq.	%
Employment	60	20.0	2	13.3	62	20.4
Farming	18	6.2	5	33.3	23	7.6
Business	2	0.7	0	0.0	2	0.7
Fishing	156	54.0	7	46.7	163	53.6
Others	53	18.3	1	6.7	54	17.8
Total	**289**	**100.0**	**15**	**100.0**	**304**	**100.0**

Chi Square = 15.57 P value = 0.004 df = 4

Those who were fishing had the highest proportion of satisfied individuals (54.0 percent) followed by those who were employed (20.0 percent). The least satisfied were those engaged in farming (6.2 percent), and among those doing business (0.7 percent). The difference was statistically significant (P value = 0.004).

The main type of provider could also influence the satisfaction of the client. Analysis was therefore done to determine the relationship. Those receiving HBC from NGOs had the highest proportion of satisfaction (55.7 percent). This was followed by a slightly lower proportion (27.7 percent) for those receiving HBC from family

members. Those who were being cared for by neighbours and friends followed this and among the others were religious institutions, community volunteers, the Government and political leaders that were caring for very few clients. This difference was statistically significant (P value < 0.001) Table 12.

Table 12: Patients satisfaction in relation to the provider of HBC services

Care Providers	Satisfaction					
	Satisfied		Not Satisfied		Total	
	Freq.	%	Freq.	%	Freq.	%
Family members	80	27.7	2	13.3	82	27.0
Neighbours and friends	6	2.1	3	20.0	9	3.0
NGOs (mentioned)	161	55.7	8	53.3	169	55.6
Others	42	14.5	2	13.3	44	14.5
Total	**289**	**100.0**	**15**	**100.0**	**304**	**100.0**

Chi Square = 16.59 P value = 0.000 df = 3

Respondents' family size was inquired to see whether this influences satisfaction. It was found that those families with 4-6 people in their households were satisfied (68.5

percent). Those with people below 4 and above 6 were the least satisfied. The difference was statistically significant P< 0.05

Respondents were also asked about their feeding frequencies, as nutrition is very important in HIV/AIDS care. This was then analyzed in relation to the HBC providers, family size, education, marital status and religion.

Those who were being cared for by NGOs had the highest frequency of feeding three meals and above (48.9%). This was followed by those who were being cared for by family members (37.1%) these groups also reported high rate of satisfaction (Table 13).

Table 13: Respondents feeding in relation to there care providers n = 304

Care Providers	Feeding (meals)									
	Once		Twice		Three times		More than three times		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq	%	Freq	%
Family members	0	0.0	6	24.0	69	37.1	7	9.9	82	27.0
Neighbours and friends	3	13.6	1	4.0	4	2.2	1	1.4	9	3.0
NGOs (mentioned)	16	72.7	15	60.0	91	48.9	47	66.2	169	55.5
Others	3	13.6	3	12.0	22	11.8	16	22.5	44	14.5
Total	**22**	**99.9**	**25**	**100.0**	**186**	**100.0**	**71**	**100.0**	**304**	**100.0**

Chi Square = 38.72 P value = 0.000 df = 9

A high number of family members could compete with a patient for the family level resources. The relationship between family size and frequency of feeding was determined. Those patients with family size of 4 to 6 people had the highest feeding frequency of three meals and above and this was statistically significant $P < 0.05$ (Table 14). Thus medium sized families are providing the best care. Probably this is the optimum number of people to balance resources between patient's need and that of others.

Table 14: .Feeding frequency in relation to the family size

	Feeding (meals)									
Family Size	**Once**		**Twice**		**Three times**		**More than three meals**		**Total**	
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**
Less than 4	5	22.7	3	12.0	11	5.9	1	1.4	20	6.6
4 – 6	12	54.5	15	60.0	118	63.4	39	54.9	184	60.5
Above 6	5	22.7	7	28.0	57	30.7	31	43.7	100	32.9
Total	**22**	**100.0**	**25**	**100.0**	**186**	**100.0**	**71**	**100.0**	**304**	**100.0**

Chi Square =17.30 P value = 0.027 df = 6

Analysis was done to understand the relationship between education and the feeding frequency. All those who have had some education had a higher rate of feeding. However there was no significant relationship.

Table15: Feeding frequency in relation to education

Feeding(Meals) Education	Once		Twice		Three times		More than three meals		Total	
	Freq.	(%)	Freq	(%)	Freq.	(%)	Freq.	(%)	Freq	(%)
No formal education	5	22.7	4	16.0	23	12.4	8	11.3	40	13.2
Adult education	0	0.0	0	0.0	4	2.2	2	2.8	6	2.0
Primary education	16	72.7	19	76.0	127	68.3	46	64.8	208	68.4
Secondary education	1	4.5	2	8.0	28	15.1	15	21.1	46	15.1
Higher Learning	0	0.0	0	0.0	4	2.2	0	0.0	0	0.0
Total	**22**	**100.0**	**25**	**100.0**	**186**	**100.0**	**62**	**100.0**	**304**	**100.0**

Chi Square = 10.28 P- Value = 0.591 df = 12

Marriage or having a close company could guarantee better quality of care to a patient. The study analyzed the relationship between marriage and feeding frequency (Table 16).

Table 16: Feeding frequency in relation to marital status

Marital status	Feeding(Meals)									
	Once		Twice		Three times		More than three meals		Total	
	Freq	%	Freq.	%	Freq.	%	Freq.	%	Freq	%
Never married	7	31.8	10	40.0	67	36.0	19	26.8	103	33.9
Married	5	22.7	5	20.0	46	24.7	23	32.4	79	26.0
Cohabiting	0	0.0	4	16.0	24	12.9	3	4.2	31	10.2
Divorced	3	13.6	3	12.0	25	13.4	5	7.0	36	11.8
Widowed	7	31.8	3	12.0	24	12.9	21	9.6	55	18.1
Total	**22**	**100.0**	**25**	**100.0**	**186**	**100.0**	**71**	**100.0**	**304**	**100.0**

Chi Square = 22.77 P value = 0.029 df =12

Those married and widowed had the highest number of meals i.e. they could afford more than three meals (32.4 percent and 29.6 percent) respectively. This difference was statistically significant at P value of 0.029. This suggests that those married are having good support from their spouses. Among those widowed they could be having support from their families. Those cohabiting (4.2 percent) and divorced (7.0 percent) were the least to have more than three meals as compared to those who never married (26.8 percent).

The respondents were of two main religions Moslems and Christians. The analysis revealed that Moslems (49.3 percent) afforded three meals and above than Christians (47.9 percent) Table 17.

Table 17: Feeding frequency in relation to religion

Religion	Feeding(Meals)									
	Once		Twice		Three times		More than three meals		Total	
	Freq.	%	Freq	%	Freq.	%	Freq.	%	Freq.	%
Moslem	11	50.0	11	44.0	96	51.6	35	49.3	153	50.3
Christian	11	50.0	14	56.0	89	47.8	34	47.9	148	48.7
Others	0	0.0	0	0.0	1	0.5	2	2.8	3	1.0
Total	**22**	**100.0**	**25**	**100.0**	**186**	**100.0**	**71**	**100.0**	**304**	**100.0**

Chi square = 3.85 P-value = 0.697 df = 6

CHAPTER FOUR

DISCUSSION

The study was done among PLWHA in Ilala district; it has been able to establish that the level of satisfaction was high (95.1 percent) but varies among respondents. Findings of this study revealed that providers of the HBC services were NGOs, although some patients were dissatisfied with their care. Family members ranked the second among other providers. It is also interesting to note that medium sized families (4-6 people) delivered the best care.

Frequency of meals was still low because of respondents' low socio-economic status mainly due to unemployment, leading to dissatisfaction especially among young people. Married respondents were satisfied by care probably because they had someone around taking care of them. However, there is a need for further improvement of the gaps that exist within the HBC services.

Frequency of meals need to be increased

Although a good number of respondents reported to have three meals (61.2 percent); only 23.4 percent afforded three meals or more i.e. snacks in between lunch and dinner. This rate is much lower than what is recommended for HIV/AIDS patients, because inadequate food intake makes difficult for patients to comply with

medications given. This might lead to rapid deterioration of the patient's physical conditions (Tanzania MOH, 2002). This implies that patient's perception of HBC satisfaction doesn't include feeding. Current studies have revealed that seven out of ten respondents experience nutritional problems mainly due to lack of money to purchase food thus access to only one meal per day. About 8.9 percent of the respondents in this study needed food supply (Pathfinder International, 2002). It is therefore important that policy makers, HBC providers focus on financial assistance, food storage and on continuing giving education to patients and family caregivers about the importance of nutrition (Tanzania MOH, 2003).

Young people are the Least Satisfied with home based care

The study has shown that the least satisfied respondents aged 19 to 34 years (48.4 percent). Satisfaction among the older age group (35 years and above) could probably be due to accumulated capital and wealth that the younger ones do not have. This implies that there is a need to support this group of patients, as some are still dependants.

Low financial status leads to dissatisfaction

Among the expressed HBC needs in this study, the least satisfied respondents were those in need of financial support (8.7 percent) as they could not afford many basic needs. This was also noted in the study done by the Pathfinder International, whereby 9.8 percent of the respondents needed financial support mainly for purchasing food, medicine and transport to the health facilities. Similar findings were obtained from a study done in Zimbabwe whereby analysis on the Minimum Package for HBC services was established, this included the financial assistance to patients and caregivers (Woelker et al 1997). Thus policy issues need to focus on the ability of patients to be able to afford the basic needs. This could then be followed or complimented with other needs.

Being never married or cohabiting leads to dissatisfaction

The study showed that among other marital status the never married respondents were satisfied with the care been given by 94.2 percent, however only 26.8 percent of them had more than three meals. One of the possible explanation observed in a recent study was having no one to cook, this implies that for a never married patient missing one meal or so is quite common (Pathfinder International, 2002). On the other hand cohabiting patients were found to be satisfied by 90.1 percent but when we consider their nutritional status; they had the least feeding rate, only 4.2 percent had more than

three meals. This raise the issues of having intervention that could enhance families' socio-economic wellbeing as well as special support to those who are cohabiting, divorced and who had never married.

Low income and unemployment leads to dissatisfaction

The fishing and employed respondents had the highest rate of satisfaction (54.0percent and 20.0 percent respectively). The least were the farmers and those who were doing business. This is contrary to the general findings from a study done in Seattle and King County on HIV/AIDS services need assessment, which showed that; patients who entered the care system from the lower socioeconomic levels expressed greater satisfaction with the services. Conversely, those from middle and upper income levels expressed greater dissatisfaction this was because HBC services could not replace the lives they had formerly led (Seattle and King County, 1999). This stresses the need for interventions that could facilitate mitigating poor economic status of the patients so as to improve the quality of care and hence satisfaction.

Family and non-family HBC providers (NGOs) leads to satisfaction

Those respondents cared by NGOs (55.7 percent) and their family members (27.7 percent) had the highest satisfaction rate as well as the feeding frequency. This was

true for a study that was done in Dar es Salaam which identified the main source of care and support being from NGOs (84 percent), followed by family members (57.0percent) and 17.0 percent was from neighbours and friends.(Pathfinder International, 2002). Therefore family members should take the presence of NGOs to improve care of their patients for the sustenance of HBC services. Another study done in South Africa revealed that caregivers spend majority of their day walking to patients, roads unpaved and hazardous (USAID, 2002), thus HBC providers (non-family) need to be very committed and motivated to conduct HBC services. Other experience showed in Mbeya about challenges of HBC services is that most of the non-family providers work on part time basis, when they are tired and therefore they can't meet patients' demands (Koshuma et al, 2000).

Role of family size in home based care

Analysis done in this study has showed that; those respondents with the family size of 4 to 6 people in the household had the highest frequency of feeding (54.9 percent). Probably medium sized families provide the best care to patients as it is possible to balance resources between them and the patient needs. Therefore policy issues concerning HBC services should focus on those patients from household with less than 4 or more than 6 members; while also encouraging NGOs to educate and work with family members in the provision of care.

CHAPTER SIX

6.0: CONCLUSION

HBC services in Ilala Municipality are of acceptable quality as evidenced by high satisfaction (95.1percent). However improvement was needed since this satisfaction varied among respondents socio-demographic characteristics. The findings of this study allow the following conclusions to be made: -

1. Most of the respondents were satisfied (95.1 percent) with the quality of care provided. Majority of those satisfied were married, female, aged 35 years and above educated, employed and those who received care from the NGOs. This also explained their feeding pattern.

2. Majority of the unsatisfied respondents needed financial support as they couldn't afford basic needs like food (had few meals), clothing, and housing hence living in a very poor state.

3. Providers were mainly NGOs (55.7percent) and family members (27.7percent) although almost all patients received services from more than one HBC provider.

6.1: RECOMMENDATIONS

1. The Government especially the Ministry of Health and other investors should provide counselling and encourage people to do HIV screening so that they start ARVs early and have employment opportunities and hence improve their socio-economic status.

2. Continued family size monitoring either though religious or government regulations and family planning to improve the quality of care of HIV/AIDS patients using family members as they provide that kind of care appreciated by the patients.

3. NGOs providing HBC should be encouraged to educate clients and family members on nutrition and care. The family members should be involved on the care of their relatives.

CHAPTER SEVEN

7.0: REFERENCES

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