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Challenges Facing Home Based Care Projects on HIV/AIDS Management in Africa

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Abstract:
HIV/AIDS has continued to pose a major challenge to the social-economical development of Africa since the infection was first diagnosed in Kenya in 1984. All the sectors of the African economy have been negatively affected by the epidemic as exemplified by rising numbers of orphans and vulnerable children and currently estimated 2.4 million loss of household goods, reduction of labor and thus productivity. As a result, several NGO'S have come up with Home Based Care programmes to care for the affected and the infected. Irrespective of the objectives set by these home based care programmes, members that are less privileged in the community and in the country are still languishing in untold suffering, they live in abject poverty. The objective of the study was to establish the challenges of Home Based care projects in HIV/ Aids management in Africa. The specific objectives included: establishing how project monitoring and evaluation affected home based care projects, determining the effects of funding policies, assessing how training of human resources influenced home based care projects and finding out how advocacy initiative and community mobilization affected home based care project in HIV/Aids management in Africa. Descriptive research design was used to carry out an in-depth study of the various NGOS in order to come with relevant findings. The study targeted employees of the NGO'S in African Countries using questionnaires and carried out a census. The collected data was analyzed using descriptive statistics and the data was presented in the form of percentages and tables. Among the key findings established in the study were that advocacy initiative and community mobilization had a major effect on home-based project in HIV/Aids management. Project monitoring and evaluation was also found to have a relatively high influence on home-based projects in HIV/Aids management (77.9%). Training of human resource had a relatively low influence HBC projects in HIV/Aids management, (75.5%) when compared to funding policies (67.3%). The researcher recommends that all the necessary efforts should be made to fund the HBC projects, impart skills on monitoring and evaluation, donors should also get flexible reporting formats, and beneficiaries of these projects should be active in those Projects activities.

Keywords: *HIV/AIDS, HIV/AIDS Home based care projects, HIV infection, HIV management*

1. Introduction and Background to the Study

Sub Saharan Africa has the highest burden of HIV and AIDS in the world. According to Poku (2005) owing to HIV/AIDS on the continent, many countries across Africa are now witnessing reduced life expectancies, crumbling and overburdened health systems and fragmented socio-cultural coping networks. According to UNAIDS (2008) tuberculosis remains the most common opportunistic infection for people living with HIV, including those on antiretroviral therapy and a leading cause of death for people living in low income countries. HIV and TB have become co-epidemics in Sub Saharan Africa and in August 2005 the World Health Organization (WHO) declared the TB epidemic in Africa to be a regional emergency. According to WHO (2005) the annual incidence of TB has risen two to three times in Sub Saharan Africa since 1990 in line with the increase in HIV infections. The high rates of HIV/AIDS and other communicable diseases increases pressure on health resources; and health budgets are getting smaller.

Project management as a profession has evolved within the last seventeen years. It has however been embraced in great way by many organizations as an effective way to ensure success in a very dynamic and competitive world. A project goes through different phases, namely; initiation, planning, execution and closure and project manager needs to be familiar with those phases for effective management (Westland, 2006). A project is considered to be successfully completed if it is done on time, within a budget and meets all the original speculations (Kendal and Kendal, 2006). According to Pearlson and Saunder (2006) projects are measured against budgets of cost, schedules of deliverable and the amount of functionality in the system scope.

Home based care programs (HBC) are associations that are organized by people to mobilize the potential of their collective power. They fall under society organizations which include NGOs, FBOs, CBOs and National networks associations. HBC project is a notion of social development which is said to result in the fulfillment of people's aspirations for personal achievement and happiness. It promotes adjustment between individuals and communities hence fostering freedom, security and engenders a sense of belonging and social purpose (Midgley, 1986). Home based care projects are inherently complex hence require a high level of skill from project staff, substantial funds and realistic timescale. Participatory planning often generates high local expectation. Success is vulnerable to the local perception of the project and hence any public failure in components. HBC projects are not cheap to implement in terms of cost per unit area. They tend to have high administrative cost as they demand significant numbers of high quality staff. Most HBC projects can easily be compromised by donors for results (Adams, 2004). According to Palmer (2006), the vision of Home Based Care (HBC) in Africa is one of quality care being made available to all who need it, spanning a continuum from the health facility to the community and to the family. This care ought to be accessible to all in need, sustainable, free of stigma, and supported by motivated and informed communities and health service providers. The care also ought to be comprehensive and continuous being extended from the health facility to the homes. Both within the health facility and at home level, care focuses on the patient through the provision of physical, social, psychological, emotional and spiritual care.

Tawil, Verster and O'Reilly (1995) cited Community involvement as a vital precondition for creating the apparent health-enabling social environments that enable and support people in optimizing their opportunities for health and well-being .The HIV/ AIDS epidemic has expanded to all corners of the globe and no country and sector has been unaffected (Jackson and Lee (2002). An estimated 22.5 million people were found living with HIV by the end of 2007 with approximately 1.7 million additional people being affected with HIV during that year. AIDS claimed the life of an estimated 1.6 million people in sub-Saharan Africa leaving more than 11 million children orphaned (UNAIDS, 2007). UNAIDS, 2007 also claims that over two-thirds of people living with HIV(PLHIV) are from sub-Saharan Africa. The region also accounts for almost three-quarters of all AIDS-related deaths globally.

According to Edoh (2004), Home based cares is meant to be a support mechanism for the hospital system and the PLWAs and their families; a way to empower communities to respond to the impact of HIV/AIDS themselves by supporting them through the process. He further indicates that when there is a sick or dying person in the house, someone has to care for them by supporting them through the process. Home based care programmes started in North America and Europe when it became clear that hospital care was too expensive, and that family and other specialists found it difficult to cope on their own with the demanding nature of caring for people living with HIV/AIDS (PLWA) (Spier and Edwards, 1990). In most African countries, there are now well developed home based care programmes and systems, although access to these programmes is still not universal (Uys and Cameron, 2003). According to USAID (2010) when discharged from a hospital most Africans with AIDS are cared for by family, friends or volunteers with limited nursing knowledge and skills, no professional back-up, and very little understanding of the virus and its consequences. To address the overwhelming need for home-based care, CHBC (community home based care) programs have the potential to bring about important health and social benefits for the patients, families, and communities. Home based care is defined as, any form of care given to ill people in their homes. Such care includes physical, psychosocial, palliative and spiritual activities. The goal of CHBC is to provide hope through high quality and appropriate care that helps ill people and families to maintain their independence and achieve the best possible quality of life. (WHO, 2005).

1.1. NGOs Involved in Home Based Care Projects in Nyeri

According to Strategic pillar 1, (NACC, 2012) in health sector HIV service delivery the Universal Access targets for an integrated approach, prioritized package in HIV prevention, treatment, care and support. The pillar ensures that all the service providers including public and private sectors, FBOs and NGOs provide the package of care, prevention, treatment and support. The NGOs involved in HBC programs in Africa include: Caritas Internationalis which is a confederation of 164 Roman Catholic relief, development and social service organizations operating in over 200 countries and territories worldwide. Collectively and individually their mission is to work to build a better world, especially for the poor and oppressed. The first Caritas organization was established by Graham Oldman in November 1897. Other national Caritas organizations were soon formed in Switzerland (1901) and the United States (Catholic Charities, 1910). USAID carries out U.S. Foreign policy by promoting broad-scale human progress at the same time it expands stable, free societies, creates markets and trade partners for the United States, and fosters good will abroad. U.S. Foreign assistance has always had the twofold purpose of furthering America's interests while improving lives in the developing world. In order to support these goals, President John. F. Kennedy created the United States Agency for International Development by executive order in 1961.

Action aid is an international organization, working with over 15 million people in 45 countries for a world free from poverty and injustice. Its head office is in Johannesburg. It is one of the few international development organizations with head offices based in Africa. They also have offices right across Asia, the Americas and Europe. The organization helps people use their own power to fight poverty and injustice, in the belief that that's how real change happens – for families, for communities, for whole societies.

Maingi (2010). The Kenya Network of Women with AIDS (KENWA) is a grass roots Community Based Organization formed and run by women living with HIV/AIDS irrespective of race, culture, religion or social status. It was started in 1993 by five HIV infected women who together with their children had been rejected by their families because of their HIV status. The organization was registered as a Non-Governmental Organization in 1998. KENWA operates seven drop-in centers in slum areas, an orphanage and a main office that is concerned with finances and action coordination. The organization focuses on destitute women and children living in seven slum areas in Africa.

2. Statement of the Problem

A number of investments have been made on HIV/AIDS interventions in areas of health education, condom distribution, voluntary counseling and testing, and antiretroviral drug treatments. However, as HIV rates continue to rise, stigma remains stubbornly resistant to change, and access and adherence to treatment and support remain inconsistent (Gregson *et al*., 2007). There are around one million people and their families affected by the HIV pandemic that are not being cared for by a dedicated home based care team. Where such programmes have been implemented and evaluated, People Living With Aids(PLWAs), their caregivers as well as health service providers are all convinced of their intrinsic value (Uys, 2001). A need therefore exists for more services like those to be set up. This is not one organization's task, but the responsibility of every community and service providers (Uys and Cameron, 2003). Breaking the silence of the HIV/AIDS pandemic requires an integrated approach to the whole question of HIV/AIDS. While it is imperative to provide care to the HIV patient, it is essential that there is also a focus on the caregiver's needs. They are an integral part in the fight against HIV/AIDS (Muchiri and Humphreys, 2002). Chlole (2001) opinionates, that despite the recognition of the vital care work that goes on in the home, home based care organizations are not sufficiently supported. Inevitably, PLWAs suffer due to this inadequate care. Yet home based care should not be regarded as a cheap solution. Many countries such as Africa does not provide nurses who provide home based care, they should therefore empower the home based care workers. Moreover as noted in Ngumo (2009), despite the home based care initiatives that the non-governmental organizations have put in place, many members of the less privileged community in the country have continued to languish in untold suffering especially because they live in abject poverty. Therefore, the study aimed at establishing the challenges facing the Home-based care projects in HIV/Aids management.

2.1. General Objective

The general objective of the study was to establish the challenges facing home based projects on HIV/Aids management in Africa.

2.2. Research Questions

To address the above objectives, the following set of research questions were used

a) How does project monitoring and evaluations affect home based care projects on HIV/AIDS management in Africa?
b) How does funding policy affect home based care projects on HIV/ AIDS management in Africa?
c) How the training of human resource influences home does based care projects on HIV/AIDS management in Africa?
d) How does the advocacy initiative and community mobilization influence the home based care projects on HIV/AIDS management in Africa?

2.3. The Conceptual Framework

The conceptual framework illustrated the relationship between the independent variables which were the challenges faced by the home based care projects of PLWAs and the dependent variable (implementation of home based care projects) and the intervening variables which are government policies, social political aspects and culture of the victim.

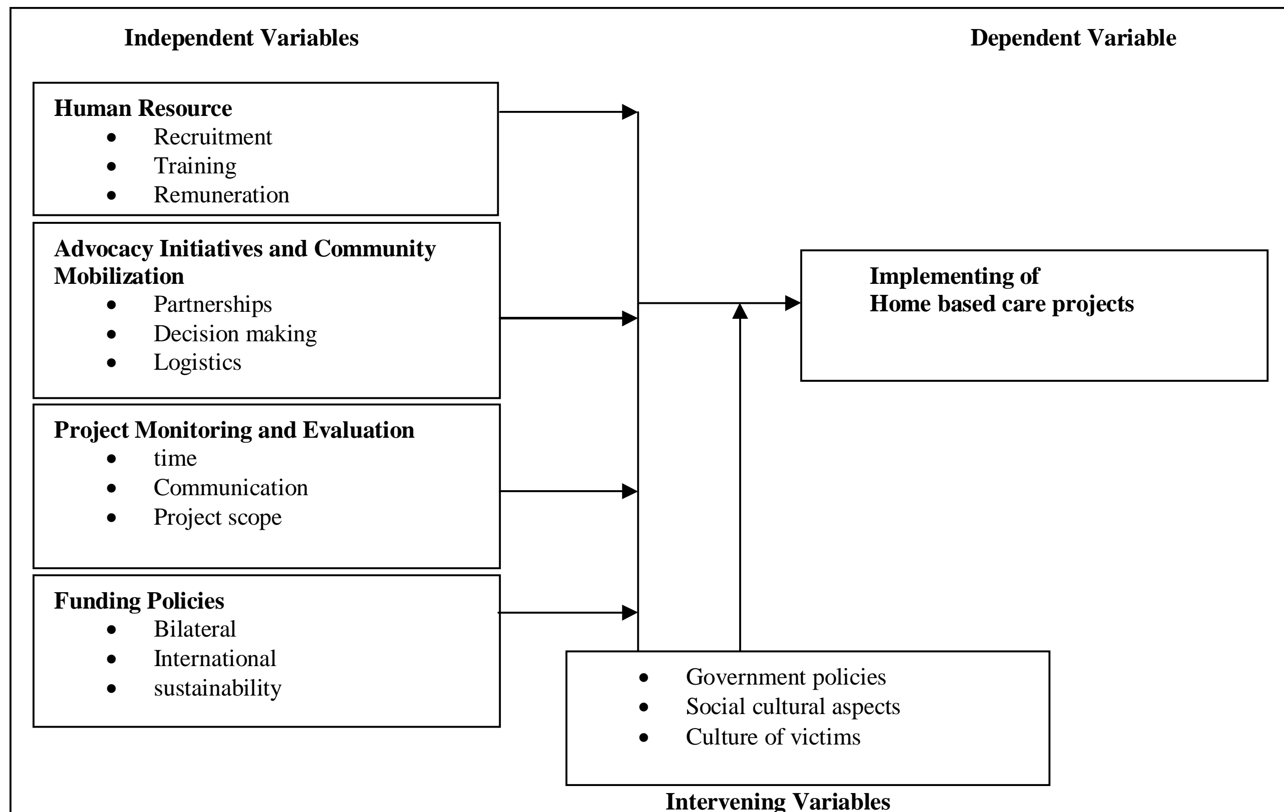

Figure 1: Conceptual Framework
Source: author 2013

According to Mkosi Mochona *et al.* (2005) No matter how much funding can be sourced for the continued development of these organizations, the question still remains, to what extent the projects should be complementing government services, rather than replacing or overlapping with them. All stakeholders recognize the need to reduce the burden of caring for HIV-positive children at a hospital level, and also that community-based organizations could be capable of offering comprehensive care to HIV-positive children. This is only possible if the community level organizations are part of the referral network, and receive adequate financial support and training to manage the complexity of caring for these children, many of whom are orphans.

HIV related tasks may include purchasing, administering and supporting adherence to ARV drugs and medication for HIV related pain if the infected person is receiving treatment, as well as helping with nutrition, as the person's diet may differ from other members of the household. Monitoring and recording progress, making notes of events such as toilet visits, fluid intake and symptom occurrence are other tasks that can be undertaken by family and home based care workers and volunteers.

Advocacy by an individual or by an advocacy group normally aim to influence public-policy and resource allocation decisions within political, economic, and social systems and institutions; it may be motivated from moral, ethical or faith principles or simply to protect an asset of interest. Advocacy can include many activities that a person or organization undertakes, including media campaigns, public speaking, commissioning and publishing research or poll or the 'filing of friend of the court briefs'. Lobbying, often by Lobby groups is a form of advocacy where a direct approach is made to legislators on an issue which plays a significant role in modern politics**.**

3. Research Design and Methodology

The research design was a descriptive survey. The study was highly descriptive in nature as it facilitated collection and in-depth analysis of data. Gray (2001) emphasizes the use of descriptive research method being a process of data collection in order to answer questions concerning the current status of the subjects being studied Merriam (1988) points to traditional research as being based on the assumption that there is a single, objective reality that one can observe, understand and measure. Qualitative research, however, assumes that the world consists of more than one reality and that these realities are highly subject to multiple interpretations (Merriam, 1988). "It is primarily the nature of the enquiry which should decide which methods are most suitable" (Volan, 2003). This study investigated the challenges faced by Home Based Care in providing home based care and training in Africa. This study falls within the qualitative research paradigm. According to Cresswell (1994) a qualitative study is an inquiry process of understanding a social and human problem based on building a complex, holistic picture, formed with words, reporting detailed views of informants and conducted in a natural setting. Denzin and Lincoln (1998) argue that, "qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them." They suggest that this approach is multi-method in focus, making use of several kinds of empirical materials, such as case studies, personal experiences, life stories, interviews, observations, and a variety of different texts. Despite the various methodological streams that characterize qualitative

research, Denzin and Lincoln (1998) suggest that these various methods are all interconnected through a common focus on 'problematic moments and meanings in individuals' lives'. The qualitative paradigm has been chosen for it blends well with the research topic that needs to be explored in detail. For this study the case study design was chosen. A case study is an ideal design for understanding and interpreting educational phenomena. A case study design is employed to gain an in-depth understanding of the situation and meanings for those involved. The interest is in process rather than outcomes, in context rather than a specific variable, in discovery rather than confirmation; insights gained from case studies can directly influence policy, practice and future research (Merriam, 1998). Denscombe (2003) argues that "one of the strengths of the case study approach is that it allows the researcher to use a variety of sources, a variety of types of data and a variety of research methods as part of the investigation." In the case study design Cresswell (1994) notes that the researcher becomes an active learner who can tell the story from the participants' view point. The case designs were preferred not only for pragmatic reasons which include convenience, limited time and finances to undertake multiple case studies rather it has been considered for the descriptive information gained will be revelatoryces. Yin (1993) raised concerns regarding subjectivity in terms of the research process using the case study design. During this case study process efforts were made to be aware of my own biases and how these could influence data collection and analysis.

3.1. Data Collection

The use of multiple data collection methods is critical in attempting to obtain an in-depth understanding of the phenomena under study. This strategy adds rigor, breadth, and depth to the study and provides corroborative evidence of the data obtained (Denzin & Lincoln, 2000). This is especially critical in case studies. The researcher analyzed documents, carried out observations for various studies done on the same subject.

3.2. Validity and Reliability

Validity is defined as the accuracy and meaningfulness of inferences, which are based on the research results Mugenda & Mugenda, (1999). In other words, validity is the degree to which results obtained from the analysis of data actually represents the subjects under study. According to Borg and Gall (2006), validity is the degree to which a test measures what it purports to measure. Borg and Gall argue that content validity of an instrument is improved through expert judgments

3.3. Reliability

Reliability is a measure of the degree to which a research instrument yields consistent results (Mugenda and Mugenda 2003). This study employed Cronbach alpha coefficient to test the reliability of the instruments. It is an index of reliability associated with the variations accounted for the true score of the underlying construct (the hypothetical variable that is being tested). Cronbach alpha coefficient ranges in value from 0-1 and was appropriate for use for questions with two possible answers or multipoint questionnaires such as the rating scale. The coefficient was calculated using the formula,

$$\alpha = \frac{N \cdot \bar{c}}{\bar{v} + (N-1) \cdot \bar{c}}$$

Here N is equal to the number of items, c-bar is the average inter-item covariance among the items and v-bar equals the average variance. From this formula, it is clear that if the number of items increases Cronbach's alpha increases. Additionally, if the average inter-item correlation is low, alpha will be low. As the average inter-item correlation increases, Cronbach's alpha increases as well (holding the number of items constant). In the study the computation of Cronbach's alpha using SPSS, and how to check the dimensionality of the scale using factor analysis was used. A dataset that contained four test items - q1, q2, q3 and q4 were used. This represented the four study objectives. The alpha coefficient for the four items was 0.839, suggesting that the items had relatively high internal consistency. A reliability coefficient of 0.70 or higher is considered "acceptable" in most social science research situations according Gall and Borg (2006).

3.4. Data Analysis

Thematic analysis by Braun & Clark (2006) was used to analyze all the transcribed data. Thematic analysis focuses on searching within transcripts for the emergence of patterns of shared understanding and themes. Thematic analysis involved the following steps (Braun & Clark, 2006). The first step of the data analysis process was reading, understanding and knowing the research data. This step began with the planning of interviews and focus groups as well as during the identification of the research participants. This means that by the time the data analysis began, the researcher already had a preliminary understanding of the phenomena being explored (Terre Blanche *et al*., 2006). The first step in analyzing the data for this study involved familiarizing and immersing oneself with the data to be analyzed. The immersion process allowed the researcher to engage in more reading and rereading of the many transcribed transcripts of the interviews, whilst looking for emerging themes and developing explanations. Patterns of all common themes were identified (Ulin *et al*., 2002). The second step involved identifying themes that shared the same words, styles and terms that were used by participants. These themes were used to set up connections. Themes that emerged from the text were used; displayed in detail then reduced to essential points under major themes stated in the objectives. The identification of themes was more than simply summarizing content; it occurred with consideration given to processes, functions, tensions, and contradictions (Terre Blanche et al., 2006). Each theme was examined in an attempt to discover the core meanings and feelings of the participants. This then allowed an overall evaluation, interpretation and assessing of the emergent themes and how these related to each other (Ulin *et al*., 2002). Terre Blanche *et al*., (2006), states that the third step in data analysis is coding. The data was marked according to themes

using the research questions as a guide. Step four involved the breaking down and coding of the data into themes. Different concepts that were expressed by the participants in several ways were grouped together under a single theme. Each theme was then elaborated in more detail. The final step involved putting together the interpretation of the data, and checking it (Terre Blanche *et al.*, 2006

4. Research Findings and Discussions

4.1. Introduction

This chapter focused on data analysis, interpretation and presentation. The purpose of this study was to establish the challenges facing home based projects on HIV/Aids management in Kenya.

Table 1 illustrates the response rate of the respondents who were sampled and interviewed in the study. The study targeted 4 top managers and 134 staff. The response rate was 100% for managers and 88.1% for staff who were sampled and completely filled in and returned the questionnaire. The high response rate is attributed to the fact that the researcher employed 3 research assistants to personally administer the questionnaires and ensure they are filled in by the respondents.

Category	Sample Size	Response	Percentage
Management	4	4	100
Staff	134	118	88.1

Table 1: Response Rate

4.2. Demographic Data of the Respondents

In this section the researcher sought to establish the demographic data of the respondents and looked at their gender, age and education level, year worked in the organization, departments worked and positions held. Their responses are highlighted in the Table 2.

Category	Frequency	Percentage
	Gender	
Male	55	44.3
Female	68	55.7
	Age in years	
Below 25 years	42	34.4
26 – 35 years	33	27.0
36 – 45 years	31	25.4
Above 46 years	16	23.1
	Education Level	
Secondary	21	27.2
Tertiary	56	45.9
University	41	33.6
Post graduate	4	3.3
	Years worked in the organization	
Below 5 years	74	60.7
6 – 10 years	31	25.4
11 – 20 years	13	10.7
21 years and above	4	3.3
	Department worked	
No response	19	15.6
Procurement	27	22.1
Storekeeper	9	7.4
Field officer	56	45.9
Others	11	9.0
	Position held	
Community based representative	22	18.0
Nongovernmental organization representative	28	23.0
Faith based organizations representative	31	25.4
Business organization representative	29	23.8
Administrator of home based care institutions	2	1.6
Staff in home based care organizations	5	4.1

Table 2: Demographic Data of the Respondents (n=122)

From the Table 2 above, 55.7% of the respondents were female while 44.3% of the respondents were males. 34.4% of the respondents were aged below 25 years, 27.0% of the respondents were aged between 26 to 35 years, 25.4% of the respondents were aged between 36 to 45 years and 23.1% of the respondents were aged above 46 years. 45.9% of the respondents indicated that they had tertiary education, 33.6% of the respondents had a university education, and 27.2% of the respondents had secondary education while 3.3% of the respondents had post graduate education. 60.7% of the respondent had worked in their respective organizations for less than 5 years, 25.4% of the respondents had worked for 6 to 10 years, 10.7% of the respondents had worked for 11 to 20 years and 3.3% of

the respondents had worked for over 21 years. 45.9% of the respondents were field officers, 22.1% of the respondents were in the procurement department and 7.4% of the respondents were store keepers. 25.4% of the respondents were faith based representatives, 23.8% of the respondents were business organization representatives, 23.0% of the respondents were Non-governmental organization representative, 18.0% of the respondents were community based representative, 4.1% of the respondents were staff in home based care organizations and 1.6% of the respondents were administrator of home based care institutions

4.3. Advocacy Initiative, Community Mobilization and Other Stakeholders Participation on Home Based Care Projects

In this section the researcher sought to find out how advocacy initiative and community mobilization affect home based care project in HIV/AIDS management in Kenya. The respondents were asked to indicate if the community participated on HIV/Aids home care projects, the number of stakeholder forums they had in the year 2011/2012 and the number of stakeholders they had. Their responses are indicated in the Table 3 below.

Category	Frequency	Percentage
Community participation on HIV/Aids home based care projects		
No response	11	9.0
Yes	100	82.0
No	11	9.0
Number of stakeholder forums held in the year 2011/2012		
No response	13	10.7
None	39	32.0
One	39	32.0
Two	21	17.2
Three	8	6.6
More than three	2	1.6
Number of stakeholders in the organization		
No response	15	12.3
None	46	37.7
Five to ten	38	31.1
Ten to fifteen	9	7.4
Fifteen to twenty	12	9.8
More than twenty	2	1.6

Table 3: Advocacy Initiative, Community Mobilization and Other Stakeholders Participation on Home Based Care Projects (n=122)

From the Table 3 above, 82.0% of the respondents indicated that indeed the community participated in HIV/Aids home base care projects while as 9.0% of the respondents indicate that the community did not participate. 32.0% of the respondents indicated that there had been to one stakeholders forums in the year 2011/2012, 32.0% of the respondents had been to none, 17.2% of the respondents indicated that there had been to two stakeholders forums in the year 2011/2012, 6.6% of the respondents indicated that there had been to three stakeholders forums in the year 2011/2012 and 1.6% of the respondents indicated that there had been to more than three stakeholders forums in the year 2011/2012. 37.1% of the respondents indicated that they did not have any stakeholders, 31.1% of the respondents indicated that they had five to ten stakeholders, 9.8% of the respondents indicated that they had fifteen to twenty stakeholders, 7.4% of the respondents indicated that they had ten to fifteen stakeholders and 1.6% of the respondents indicated that they had more than twenty stakeholders.

4.4. Monitoring and Evaluation of HIV/ AIDS effects on Home Based Care Programs

In this section the researcher sought to establish how project monitoring and evaluation affects home based care projects in HIV/AIDS management in Kenya. The respondents were asked to indicate if NGOs were involved in the monitoring the implementation of these programmes, who was responsible for project monitoring and evaluation, how often the projects in their organizations were monitored and who was responsible for the CBHC program. Their responses are shown in Table 4 below.

Category	Frequency	Percentage
NGO's involvement in monitoring the implementation of the programmes		
No response	2	1.6
Yes	95	77.9
No	25	20.5
Monitoring and evaluation responsibility*		
Leaders	20	15.7
Managers	42	33.1
Community members	41	32.3
Donors	8	6.3
Sponsors	16	12.6
Frequency of monitoring and evaluating home based care projects		
No response	17	13.9
Very highly often	9	7.4
Highly often	42	34.4
Slightly often	25	20.5
Often	28	23.0
No use	1	0.8
Organization responsibility in CBHC program		
No response	19	15.6
Staff	40	32.8
Volunteers	63	51.6

Table 4: Monitoring and Evaluation of HIV/AIDS Home Based Care Programs Training and Availability of the HIV/AIDS Home Based Caretakers (n=122)

From the Table 4 above, 77.9% of the respondents indicated that the NGOs were involved in monitoring the implementation of these programmes in the county while 20.5% of the respondents indicated the NGOs were not involved. 33.1% of the respondents indicated that the managers were responsible mostly for project monitoring and evaluation, 32.3% of the respondents indicated that the community members were responsible mostly for project monitoring and evaluation15.7% of the respondents indicated that the leaders were responsible mostly for project monitoring and evaluation, 12.6% of the respondents indicated that the sponsors were responsible mostly for project monitoring and evaluation and 6.3% of the respondents indicated that the donors were responsible mostly for project monitoring and evaluation.. 34.4% of the respondents indicated that home based care projects are monitored and evaluated highly often, 23.0% of the respondents indicated that home based care projects are monitored and evaluated often, 20.5% of the respondents indicated that home based care projects are monitored and evaluated slightly often, 7.4% of the respondents indicated that home based care projects are monitored and evaluated less often and 0.8% of the respondents indicated that there was no use in monitoring and evaluating home based care.

5. Training and Availability of the HIV/AIDS Home Based Caretakers

In this the researcher sought to assess how training of human resources influences home based care projects on HIV/AIDS management in Kenya. The researcher asked the respondents to indicate if the organization conducted workshops/refresher courses, frequency of refresher courses, how volunteers are remunerated, number of training courses attended, any training need assessment prior to the training, purpose, relevance and duration of training. Their responses are highlighted in Table 5 below.

Category	Frequency	Percentage
If organization conducts workshops/refresher courses		
No response	7	5.7
Yes	92	75.4
No	23	18.9
Frequency of refresher courses		
No response	16	13.1
Monthly	22	18.0
Between 6 – 12 months	50	41.0
Yearly	30	24.6
After 5 years	4	3.3
Remuneration of volunteers		
No response	13	10.7
Paid	9	7.4
Compensated	66	54.1
Left unpaid or compensated	34	26.9
Number of training courses on home based care projected implementation attended		
No response	4	3.3
None	22	18.0
One	35	28.7
Two	38	31.1
Three	6	4.9
More than thrice	17	13.9
Any training needs assessment prior to training		
No response	11	9.0
Yes	63	51.6
No	28	23.0
Don't know	20	16.3
Areas of training*		
Guidance and Counseling	71	42.8
Finance Management	29	17.5
Monitoring and Evaluation	24	14.5
Gender equality	16	9.6
Project Planning	26	15.7
Purpose of training		
No response	7	5.7
Don't know	9	7.4
Build new skills and knowledge	86	70.5
Train others	19	15.6
Relevance of the training to project implementation		
No response	10	8.2
Very relevant	35	28.7
Relevant	59	48.4
Irrelevant	14	11.5
Very irrelevant	4	3.3
Duration of training		
No response	9	7.4
Less than 1 week	65	53.3
1 to 3 weeks	29	23.8
3 weeks to 1 month	13	10.7
More than 1 month	6	4.9

Table 5: Training and Availability of the HIV/AIDS Home Based Caretakers (n=122)

From the Table 5 above, 75.4% of the respondents indicated that indeed their organizations conducted workshops/refresher courses while 18.9% of the respondents indicated that their organizations did not conduct workshops/refresher courses. 41.0% of the respondents indicated that the refreshers courses were conducted between 6 and 12 months, 24.6% of the respondents indicated that the refreshers courses were conducted yearly, 18.0% of the respondents indicated that the refreshers courses were conducted monthly and 3.3% of the respondents indicated that the refreshers courses were conducted after 5 years. 54.1% of the respondents indicated

that the volunteers were compensated for their services, 26.9% of the respondents indicated that the volunteers were normally left unpaid or uncompensated and 7.4% of the respondents indicated that the volunteers were paid for their services. 31.1% of the respondents indicated that they had attended training courses in home based care project implementation twice, 28.7% of the respondents had attended the training courses once, 18.0% of the respondents had never attended the training courses, 13.9% of the respondents had attended the training courses more than thrice and 4.9% of the respondents had attended the training courses thrice. 51.6% of the respondents indicated that indeed thee was a training needs assessment prior to the training, 23.0% of the respondents indicated there was no training need assessment prior to the training and 16.3% of the respondents indicated that they did not know if there was a training need assessment prior to the training. 42.8% of the respondents indicated that they had attended training on guidance and counseling, 17.5% of the respondents had attended training on finance management, 15.7% of the respondents had attended training on project planning, 14.5% of the respondents had attended training on monitoring and evaluation and 9.6% of the respondents had attended training on gender equality. 70.5% of the respondents indicated that the purpose of the training was to build on new skills and knowledge, 15.6% of the respondents indicated that the purpose of the training was to enable them train others and 7.4% of the respondents did not know the purpose of the training. 48.4% of the respondents indicated that they found the training relevant with respect to their day to day project implementation, 28.7% of the respondents found the training very relevant, 11.5% of the respondents found the training to be irrelevant and 3.3% of the respondents found the training to be very irrelevant. 53.3% of the respondents indicated that the training took less than 1 week, 23.8% of the respondents indicated that the training took 1 to 3 weeks, 10.7% of the respondents indicated that the training took 3 weeks to 1 month and 4.9% of the respondents indicated that the training took more than 1 month.

5.1. Funding Policies in Home Based Care Projects Implementation

In this section the researcher sought to determine the effects of funding policies on HIV/AIDS management in Kenya . The respondents were asked to indicate where CHBC projects funds came from, if funding policies are a challenge on the implementation of these HIV/AIDS home care projects and extent to which funding policy is a challenge to home based care projects. Their responses are shown in Table 7 and Table 6 below.

Category	Frequency	Percentage
CHBC project funding		
No response	6	4.9
Sponsors	74	60.7
Government	3	2.5
Private organizations	26	21.3
Members	13	10.6
Challenge of funding policy on the implementation of HIV/AIDS home care projects		
No response	11	9.0
Yes	82	67.2
No	29	22.9
Extent funding policy is a challenge to home care projects		
No response	6	4.9
Very greatly affects	15	12.3
Greatly affects	60	49.2
Moderately affects	30	24.6
Slightly affects	10	8.2
No effect	1	0.8

Table 6: Funding Policies in Home Based Care Projects Implementation (n=122)

From the Table 6 above, 60.7% of the respondents indicated that community home based care projects got their funds from sponsors, 21.3% of the respondents indicated that community home based care projects got their funds from private organizations, 10.6% of the respondents indicated that community home based care projects got their funds from members and 2.5% of the respondents indicated that community home based care projects got their funds from the government, 67.2% of the respondents indicated that indeed the funding policy was a challenge on the implementation of the HIV/AIDS home based care projects and 22.9% of the respondents indicated that the funding policy was not a challenge. 49.2% of the respondents indicated that the funding policy as a challenge that greatly affected the home based care projects, 24.6% of the respondents indicated that the funding policy as a challenge that moderately affected the home based care projects, 12.3% of the respondents indicated that the funding policy as a challenge that very greatly affected the home based care projects, 8.2% of the respondents indicated that the funding policy as a challenge that slightly affected the home based care projects and 0.8% of the respondents indicated that the funding policy had no effect on the home based care projects.

5.2. Rating of Funding Policies in Home Based Care Projects Implementation

In this section the researcher sought to rate the opinions of the respondents with respect to funding policies on home based care. It is imperative to state the criteria for analysis of the data that was used to answer this investigative question. A five point Likert scale was used to interpret the respondent's responses. According to the scale, those instances the respondents felt that there were inadequacies in terms of funding resources was awarded 1 while those instances they the funding resources were adequately provided for was awarded 5. Mean (weighted average) and standard deviation were used to analyze the data. From the findings, the researcher noted that those statements with a mean greater than 3.0 were rated to as having a strong influence while as those with a mean less than 3.0 were rated as having a least influence. On the same note the higher the standard deviation the higher the level of dispersion among the respondents.

Category	Mean	S.D	Interpretation
Availability of funds, drugs and other materials	2.55	1.136	Unavailable
Adequacy of funds. drugs and other materials	2.58	1.191	Inadequate
Reliability of sources of materials	2.63	1.254	Unreliable
Timely release of these funds by the government and other NGO's	2.55	1.449	Untimely release

Table 7: Rating of Funding Policies in Home Based Care Projects Implementation (n=122)

From the Table 7 above, all the respondents indicated that there was no available and adequate fund, drugs and other materials to be used in home based care, there was also no reliable source of materials and neither timely release of funds by the government and other NGOs.

6. Findings and Discussions

Previous research on community home based care in Botswana has argued that the quality of most care programmes is dependent on their management. In Botswana it is usually elderly caregivers who manage most care giving programmes. Most of the caregivers have a low or no educational background with little relevant skills needed in HIV/AIDS care. According to Kang'ethe (2004) with little or no skill, due to inadequate or no training, most caregivers are not able to ensure good quality care. A further concern highlighted by UNAIDS(2000) is the challenging nature of providing home and community based care for caregivers, specifically in terms of dealing with an incurable and heavily stigmatized condition on an ongoing basis. The burden on caregivers is worsened by the living conditions of caregivers themselves who are frequently unemployed, lacks training and adequate resources such as medication and health care material to provide quality care. On the community level, a study conducted in, sub Saharan Africa by Akintola (2006) on sources and the nature of support that volunteers received, findings revealed that some volunteer carers received support from community leaders and councilors in raising awareness. Family members of the patient and other community members had positive attitudes towards them and PLWHA; they helped in assisting carers to do their work such as bathing the patients. On the contrary, volunteer caregivers in this study did not receive support from some family members and some community members. For example, due to stigma some patients were hidden in their rooms, beaten for soiling themselves, denied food and denied access to volunteer caregivers. Some were abandoned and this caused more burdens of care work for the volunteer caregivers.

Additionally, volunteer caregivers were ridiculed by their family and some community members because of the nature of the work. Issues of stigma on the patients and ridiculing of volunteer caregivers pose threats to volunteer care giving work and has a negative impact on infection control practices in that volunteer caregivers will have limited access to patients; there will be high HIV/AIDS morbidity and mortality rates among PLWHA in HBCOs; there could be more burdens of care on volunteer caregivers resulting in more stress and HBCOs and the government could fail to meet its objectives of managing the HIV/AIDS pandemic. The findings of this study suggest that there might be a link with the findings of two different studies, one performed in, sub Saharan Africa (Akintola, 2008) and another in Botswana (Kang'ethe, 2010). These studies revealed that most caregivers did not receive support from community members due to stigma and this caused them to be stressed. The findings of this study also adds new knowledge on what could hinder proper infection control practices in 68 HBC programs for PLWHA by volunteer caregivers. These findings highlight the need to educate community members on the impacts of stigma and discrimination towards PLWHA and also the importance of supporting the work of the volunteer caregivers including the role of HBCOs.

6.1. Lack of Funds

According to the World Health Organization (2002) one of the most serious challenges facing any Home Based Care (HBC) programme is how to fund and sustain the programme over the long term. In some countries, the government is responsible for funding most home based care programmes. In other countries, the primary sources of funding may be international or national donor agencies, NGOs and faith-based organizations. Funding partnerships might also be developed between the government and non-governmental donor agencies. Home based care organizations receive funding and technical support mainly from international non-governmental organizations and development agencies. However, very few donor agencies fund caregiver stipends or salaries (Department of Health, 2004). There is abundant evidence throughout the world of programmes that were evaluated as being successful and necessary but were discontinued. This usually came about because funding either stopped or was inadequate to sustain the programme. The Department of Social Development (2001) notes that every eventuality cannot be considered in budgeting and allocating funds, however, checks and balances should be in place; that addresses funding and sustainability from planning through

implementation and evaluation. With the epidemic showing little or no signs of abating, communities are finding it impossible to sustain support. This is due to dwindling material and financial resources in the face of a massive epidemic that affects almost everyone in high-prevalence communities. Despite declining financial and material support, families and communities still provide physical, emotional and moral support. Akintola (2004) notes that community level support comes from volunteers working with home- based care organizations that represent the main source of support for HIV/AIDS affected families. They provide varying degrees of support depending on the level of resources available to them. Care organizations provide patients with medical care and food to affected households.. Households meet these costs in a number of ways, including altering household composition; withdrawing savings or selling assets; reallocating labor; withdrawing children from school; and depending on an extended family system and the community to support and help them**.**

6.2. Policy Recommendations

The researcher makes the following recommendations from the key findings of the study. Much as there are a lot of funds being invested in the fight against HIV/AIDS, very little is trickling down to the grass root NGOs that are at the forefront of combating HIV/AIDS. There is a need for the donors to provide more resources to the NGOs, so that their activities can have impact. With insufficient funds, monitoring and evaluation is looked at as a luxury and hence the projects do not benefit from it. With more funds the NGOs can train and retain the critical skills that they are lacking especially in monitoring and evaluation. The findings found a critical lack of expertise in monitoring and evaluation of projects implemented by the NGOs. There is need for training in this aspect of monitoring and evaluation. Donors in conjunction with government should institute programmes to impart HIV/AIDS projects, monitoring and evaluation skills amongst the local NGOs. It is imperative that the implementers of these projects have skills in monitoring and evaluating them.

Donors need to relax the reporting requirements. Most the donors have stringent, time consuming and laborious reporting requirements. There is a need for donors to identify simpler and friendlier reporting formats for the recipients of their funds without compromising their interests but at the same time not overburdening the NGOs. There is a need for the NGOs to involve all the stakeholders in the design of the HIV/AIDS projects. The beneficiaries should not be passive recipients of the services the project is offering. An active involvement of the beneficiaries such as PLWHA will mitigate the challenges of collecting, monitoring and evaluation data from them. It has got an added advantage of demonstrating accountability to them and also ensuring sustainability of the project when the donors withdraw funding.

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