

COMMUNITY ATTITUDE TO HOME CARE FOR
PERSONS WITH AIDS: A CASE STUDY OF
ALAVANYO SUB-DISTRICT IN THE VOLTA
REGION

BY

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DECLARATION

This dissertation is based on my own independent work apart from the references, which have been dully acknowledged. I declare that this work has neither been accepted in any form for any other degree nor concurrently been submitted in candidature for any other degree.



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DEDICATION

**I DEDICATE THIS WORK TO MY HUSBAND MR. DANIEL
KOJO MANU AND OUR SON DANIEL NANA-KWAME
ABOKYI NYINAH.**



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ACRONYMS

AIDS	Acquired Immune Deficiency Virus
ARVs	Anti-retro Viral Drugs
ADRA	Adventist Relief Agency
ADEC	All Age Development Centre
BCC	Bahaviour Change Communication
CBOs	Community Based Organizations
CHAG	Christian Health Association of Ghana
DHMT	District Health Management Team
ECR	Expanded and Comprehensive Response
GAC	Ghana AIDS Commission
GACC	Ghana AIDS Control Commission
GHS	Ghana Health Service
HIV	Human Immuno-deficiency Virus
NACP	National AIDS Control Programme
NGOs	Non-governmental Organizations
NSF	National Strategic Framework
PLWA	People Living With AIDS
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
SSS	Sentinel Surveillance System
STI	Sexually Transmitted Infection
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YMCA	Young Men Christian Association

ABSTRACT

Acquired Immune Deficiency Syndrome (AIDS) is a disease caused by the human immuno-deficiency virus (HIV). The disease since its discovery some two decades ago in America has assumed epidemic dimensions and has claimed millions of lives globally (Jackson, 2002).

AIDS is a disease caused by the HIV that attacks and damages the body's immune system rendering it incapacitated to fight infection. It has a long incubation period of between two to fifteen or even twenty years (MoH, 2001). The disease condition is usually associated with long period of hospitalization and very high expenditure (MoH, 2001, Nabila et al, 2001). This has prompted the need to consider alternate ways of caring for PLWHA. Home-based care where patients would receive the care they need in their usual place of residence is one option considered to reduce expenditure significantly. The success of home-based care would however depend on the care patients receive within the home with co-operation from community members. It is in the light of this that this study seeks to identify knowledge of HIV/AIDS among community members, their reaction to PLWHA and their attitudes to home care for patients.

The study which has both quantitative and qualitative forms was conducted in the Alavanyo sub-district in the Volta region of Ghana. Respondents were sampled from the only urban community in the sub-district and two rural communities. It was a descriptive survey and in all 273 respondents were interviewed. All respondents had ever heard of HIV/AIDS. Ninety-two percent of respondents knew it could be prevented and many were knowledgeable about the prevention methods. Generally, knowledge was found to be very high. However, AIDS was not perceived as a problem. Just about 24 % of

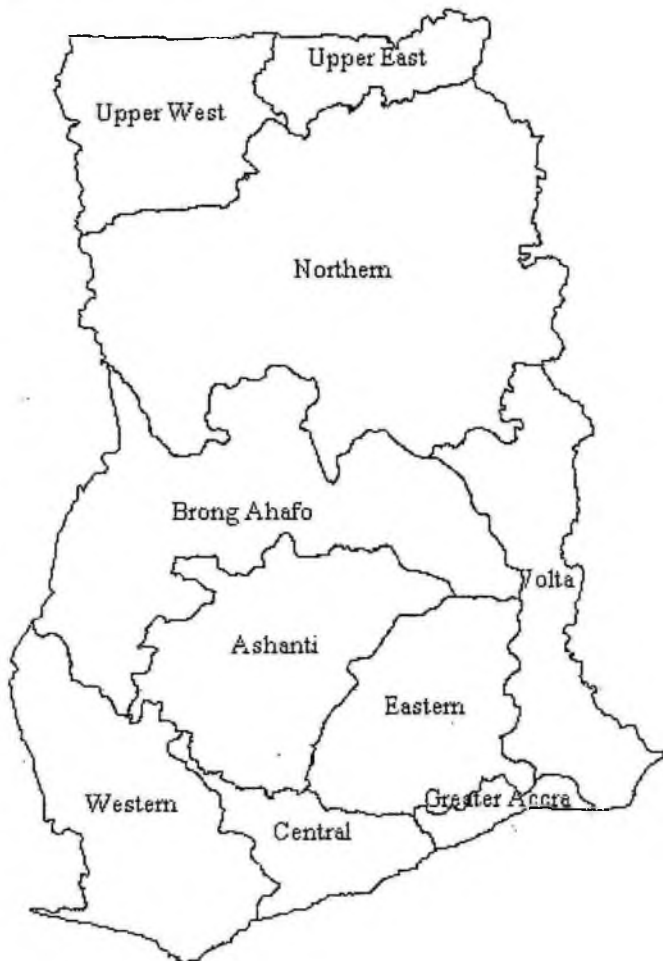
respondents thought AIDS was a problem. About 41 % could not tell whether AIDS was a problem whilst 26 % were of the opinion that AIDS was not a problem. About 83 % of respondents were willing to live in the same house with an infected person, whereas 78 % were willing to share the same bathroom with PLWHA. Almost 90 % of respondents were of the opinion that PLWHA should be given some form of care. However, 43.5 % opted for the provision of home care whilst 44.2% identified hospital care as a preferred place of care for PLWHA.

Peoples' reaction to PLWA regarding living together and sharing the same bathroom, was very positive. The study showed that almost equal number of people would want either hospital care or home care for PLWA. The choice of hospital care for PLWA could be based on poverty of caregivers, stigmatization of family members and eventual death of the PLWA.

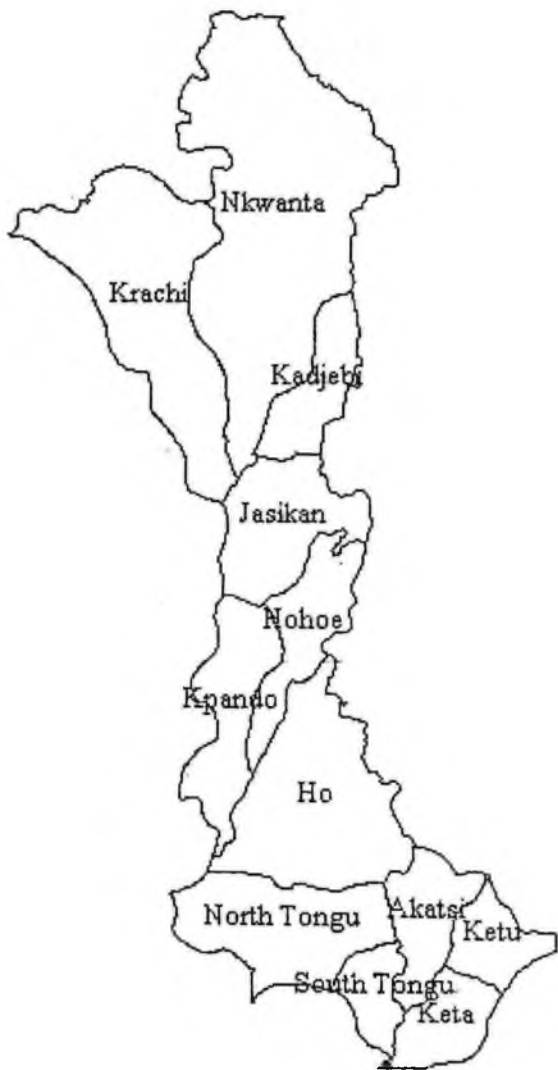
The element of stigma can not be ruled out as the qualitative component of the study showed that PLWHA tended to be avoided by even some close relations. Denial of the disease among infected persons and their relations exist .

There is the need to embark on intensified education and pragmatic measures to minimize stigma and denial. Support for PLWHA and their caregivers is a very important step that could greatly minimize stigma and denial and at the same time improve upon the well being of both the infected and affected and for that matter promote home-based care. Financial assistance, medication and counseling services for PLWHA and caregivers are essential in the success of home-based care.

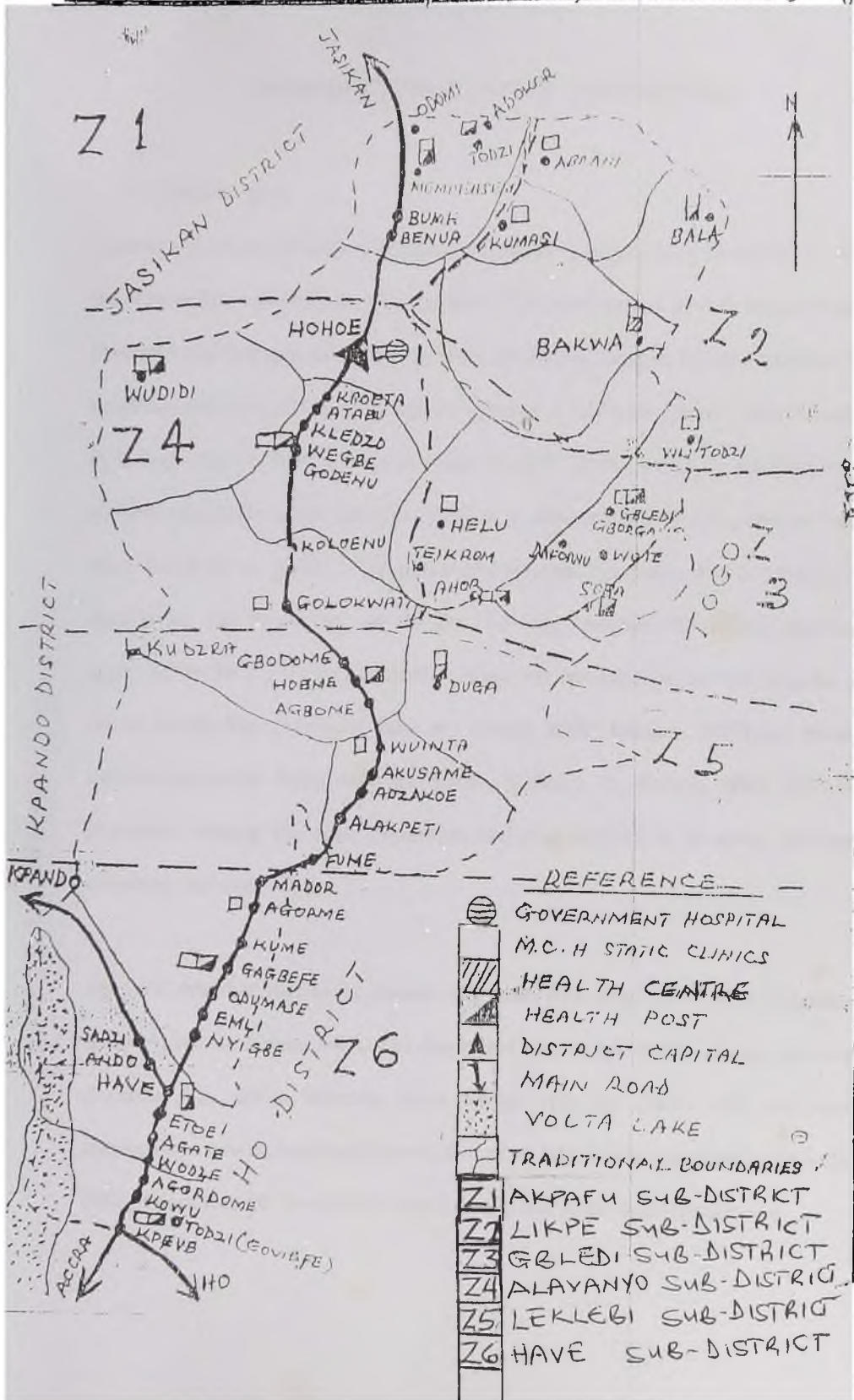
MAP OF GHANA



MAP OF VOLTA REGION



'HEALTH INSTITUTIONS' - HOHOE DISTRICT.



CHAPTER ONE**INTRODUCTION AND RESEARCH METHOD****1.1 Introduction**

Acquired Immune Deficiency Syndrome (AIDS) is caused by a retrovirus known as the Human Immunodeficiency Virus (HIV). This virus causes disease in only humans. It attacks and damages the immune system rendering it unable to fight infection. This condition makes the body vulnerable to disease. It has a very long incubation period of between two to fifteen years or more (NACP, 2001). It has claimed the lives of millions of people worldwide and continues to claim more lives since no cure has yet been found for it. AIDS, a debilitating illness has become a global pandemic, so devastating that by the end of the year 2000 an estimated 60 million people had acquired the HIV infection worldwide since the epidemic began two decades ago. About twenty-two million of them are already dead (Jackson, 2003) and about 36 million people are living with the disease globally. By January 2000, HIV/AIDS prevalence among the adult population had exceeded 20 % in seven developing countries (Jackson, 2003).

The HIV, which transmits the disease AIDS was first identified in 1983 (Aggleton et al, 1994) but the disease itself, was discovered in the early 1980's among gay men in America. The tables however, have turned over the years, with heterosexual transmission now accounting for over 70 % of all HIV-infections worldwide (Jackson, 2003). More than 90 % of HIV-infected people live in the developing world.

The downturn in AIDS cases in the United States and other developed countries gives a glimpse of hope to the world. Unfortunately, the epidemic continues to accelerate in other parts of the world, notably in sub-Saharan Africa and on the Indian sub-continent.

Uganda happens to be one of the few countries in the developing world that has succeeded in recording a significant reduction in the prevalence of the HIV/AIDS infection from 30 % in the 1980s to 10 % in the 1990s, due to relentless efforts (Dzokoto, 2000). The number of infected persons continues to rise in most regions of the developing world with sub-Saharan Africa being the hardest hit. Twenty-five million (70 %) of people living with HIV/AIDS (PLWHA) globally are in sub-Saharan Africa with nearly 1 in 10 infected people in the general population within the age 15-49 years (Lamptey, 2002). In southern African countries like Namibia, Zimbabwe, Botswana, Swaziland and Lesotho prevalence levels are highest reaching 20 to 40 percent (Lamptey, 2002).

Although HIV/AIDS is a global problem, intervention programmes have brought the disease under control in Europe and most parts of the developed world. The availability of anti-retroviral (ARV) drugs to reduce the viral load, adoption of healthy lifestyles and good nutrition may be responsible for this success. The predominant modes of virus transmission may also account for the success story in the developed world; intravenous drug injection and drug abuse and homosexual transmission account for over 80 % of HIV infections in Europe (Aggleton et al, 1994).

In the developing countries however, heterosexual transmission account for over 70 % of HIV infection (Jackson, 2002). Socially acceptable lifestyles of multiple sexual partners with poor acceptance and use of protective devices could contribute to the accelerated rate of infection. In addition, the cost of ARV is too expensive for most developing countries. Limited infrastructure and woefully inadequate numbers of trained health care providers in the formal set up for public health services is a common feature of sub-Saharan Africa. This situation is further compounded by the HIV/AIDS pandemic in the face of limited beds and health care providers to care for the affected who require prolonged care. Given the constraints faced by governments in developing countries in the provision of healthcare and the galloping rate of AIDS cases, it has become essential to consider more sustainable and economically viable alternatives of care for PLWHA such as home-based care. This current study seeks to explore home-based care as an alternative to caring for PLWHA.

1.2 Background to HIV/AIDS in Ghana

Since 1986 when the first cases of HIV/AIDS were reported in Ghana, the numbers have increased from 42 to 63,071 by 2002 (GHS Report, 2002). The rate of increase is so high that it has multiplied many folds in less than twenty years since it was first reported. Although for the first time there has been a reduction of the reported cases in the years 2001 and 2002, this cannot be attributed to a fall in actual cases. The number of cases reported from 1986 to 2002 is presented in Table 1.1 below. This is quite frightening as studies estimate that reported cases forms just about 40 % of actual cases. Close to 90 % of all reported cases occurred in adults between 19 and 49 years who forms the economic work force and for that matter the backbone of the national economy (MoH, 1995) .

Table 1.1: Reported cases of HIV positive in Ghana from 1986- 2002

Year	1986	1987	1988	1989	1990	1991	1992	1993	1994
No. of cases	42	112	646	2334	2010	2442	2699	2371	2330
Year	1995	1996	1997	1998	1999	2000	2001	2002	
No. of Cases	2578	3295	3833	4854	7752	6289	10538	8946	

Source:(NACP,2001)

The rate of increase is quite alarming for which reason drastic measures are required. The prevalence rate of 3.6 as at 2001 is quite high and could easily get out of hand if urgent and drastic measures are not instituted. Data from HIV sero-prevalence surveys of sentinel sites across the country show an increasing prevalence rate from 2.6 percent in 1994 to 4.6 percent in 1998 (GAC, 2002). The sample population comprises pregnant women who attended antenatal clinic at the health facility. Prevalence among commercial sex workers, a high-risk group, is much higher.

Based upon the prevailing trend, the National AIDS Control Programme (NACP) has projected national prevalence rates to increase to 6.4 % by 2004, 8.2 % by 2009 and further to 9.5 by 2014 (GAC, 2002). It is encouraging to realize that perhaps the vigorous moves taken to combat the disease is already yielding fruits with a fall in the national prevalence rate of infection from 4.6 percent in 2000 to 3.6 percent as at 2001 if that is anything to go by. Heterosexual contact accounts for the highest mode

of all HIV infections of about 80 % followed by mother-to-child transmission of 15 % with other blood contacts including blood transfusion for the remaining 5 % (NACP, 2001).

In response to the HIV/AIDS situation, the government of Ghana has adopted the global initiative of Expanded Comprehensive Response (ECR) to the HIV/AIDS epidemic. This strategy for mobilizing adequate resources and capacity to respond to ECR may offer the solution to the fight against AIDS.

The Ghana AIDS Commission (GAC) has been instituted as the supra ministerial and multi-sectoral body set up to direct, manage, co-ordinate, monitor and evaluate all activities in the fight against AIDS. The objective of GAC is to reduce the incidence of HIV/AIDS by 30 % by 2005 and improve the quality of life of PLWHA and infected persons (GAC, 2001). There are community-based organizations (CBO) and NGOs across the country whose activities involve AIDS prevention and management. For example, the Christian Health Association of Ghana (CHAG), Action Aid, Adventist Development and Relief Agency (ADRA) and the Ghana Red Cross are all doing a lot in the fight against AIDS.

1.3 PROBLEM STATEMENT

Based on sentinel surveillance data, Hohoe had HIV/AIDS prevalence of 5 % in 2000 (Aleka, 2001). This is higher than the national prevalence. Thus, concerted effort is required to address the situation.

Home-based care is an essential component of the continuum of care for PLWHA in Ghana's HIV/AIDS strategic framework for 2001 to 2005 instituted by Ghana AIDS Control Commission (GACC). The pressure on the health facilities in the country has become a challenge as the number of PLWHA continue to rise. The growing number of PLWHA and related complications will greatly strain health infrastructure. Using 1994 estimated AIDS cases; patients with HIV-related diseases would have occupied 20 % of all hospital beds in the country at the time. By the year 2010, it is estimated that AIDS patients would occupy over 90 % of all hospital beds (WHO Report, 2000). Following this, provision of good quality home-based care for PLWHA is considered as one effective way of reducing pressure on health facilities. It is expected that the home-based care would also promote a supportive environment from family members and friends.

Specific sentinel surveillance data among pregnant women at the antenatal clinic in the Hohoe government hospital reveal a rising trend of prevalence from 2.3 % in 1994 to 5 % in 2000 (Aleka, 2001). Table 1.2 below gives a picture of pregnant women who tested positive out of all antenatal attendance to the health facility. Apart from 1996 when there was a drop in reported cases, there has been a consistent increase indicating a high rate of transmission. A significant proportion of the population is already infected and needs to be cared for, considering the effect of the infection.

Besides caring for the infected especially in the home and community could minimize stigma associated with HIV/AIDS and contribute to the reduction of further transmission.

Table1.2: HIV Sentinel survey report for Hohoe District

Year	1994	1995	1996	1997	1998	1999	2000
Percent	2.3	3.2	2.1	4.2	4.0	4.4	5.0

Source: (Aleka, 2001)

The 2001 surveillance data for Hohoe is 3 % prevalence. Table 1.3 also gives details of the numbers and prevalence in different age groups for 2001. There has been a drop in the prevalence rate from 5 % in 2000 to 3 % in 2001. This encouraging trend may be due to a number of factors including public education. However, the many already infected with HIV/AIDS need to be cared for. All the HIV positive infections fall within the 20 –44 year age group and this call for concerted effort to fight against the disease, recognizing the devastating effect it may have on the national economy.

Table 1.3: Results of HIV test by age-group for 2001 sentinel survey-Hohoe

Age group (years)	Number tested	Number positive	HIV (%) prevalence
15-19	48	0	0
20-24	147	4	2.7
25-29	119	4	3.4
30-34	111	3	2.7
35-39	62	2	3.2
40-44	13	1	7.7
45-49	0	0	0
Total	500	14	3.0

Source: (NACP, 2001)

Following the increasing threat of HIV/AIDS in Hohoe, the District has been active in HIV/AIDS control programmes. The District Health Management Team (DHMT) organizes vigorous educational talks to institutions, churches and other social gatherings (Hohoe DHMT, 2001). There are many NGOs such as Pro-Link, Young Men Christian Association (YMCA) and, ADEC actively involved in education on HIV/AIDS and also assisting in care and support for PLWHA in the district. The District Assembly has also instituted community-based organizations to offer care and support to PLWHA.

Most HIV/AIDS programmes in Ghana are tailored towards prevention, however caring for the already infected persons remains an important component in the effort to curb the spread of the infection. More importantly is home-based care that has the tendency to fight against stigma, which comes up strongly against seeking health care for the disease.

The study therefore seeks to determine community perception and attitude to home care of HIV/AIDS as well as to identify coping strategies for PLWHA and their caregivers. The study would unfold some of the problems confronting home care for PLWHA. This information would be invaluable in educating PLWHA and caregivers and the community in general in order to improve upon home care for PLWHA. More so, as home-based care is being explored especially in resource-constrained settings globally as a viable option to hospital based care for the PLWHA, it is essential to explore the situation on the ground in regards to home care.

1.4 General Objective

The general objective of the study is to determine community knowledge and attitude to home care for people living with HIV/AIDS in the Hohoe District of the Volta Region.

1.5 Specific Objective

In furtherance of this objective, the study focuses on the following specific objective issues:

1. To determine community awareness about HIV/AIDS.
2. To determine community knowledge on the mode of transmission and prevention for HIV/AIDS.
3. To determine community reaction and attitude towards persons living with HIV/AIDS.
4. To determine community reaction to home care for PLWHA
5. To describe coping strategies of PLWHA and their caregivers at home.

1.6 Definition of Concepts

The WHO clinical case definition of AIDS for Africa also known as the Bangui case definition applies to this study. The signs and symptoms by this definition are divided into major and minor ones. AIDS in adults is defined by the existence of two major and at least one minor sign. In addition to this should be a positive test for HIV.

Major Signs

1. A loss of 10% of body weight in a short period
2. Chronic diarrhoea persisting for more than a month

3. Chronic fever for more than a month

Minor Signs

1. Persistent cough for more than a month
2. Generalized itchy skin lesions (dermatitis)
3. Recurrent herpes zooster (shingles)
4. Oral candidiasis (thrush)
5. Chronic herpes simplex
6. Generalized enlargement of lymph nodes.

PLWHA - People Living with HIV/AIDS for the purpose of the study are defined as persons who have been clinically diagnosed as HIV positive.

Caregiver – A caregiver is defined as a person or organization that is committed to providing basic care services or material support including education and counseling for a person or persons living with HIV/AIDS on a regular or consistent basis.

Home Care – This refers to services or support offered to PLWHA at home or their usual place of residence.

1.7 METHOD OF DATA COLLECTION

1.7.1 Study Design

The design of the study was descriptive and cross-sectional in nature.

1.7.2 Study Population

The target population consists primarily of male and female community members who are fifteen years and beyond. It also involved persons living with AIDS and their caregivers.

1.7.3 Sampling Technique

Purposive sampling was used to select the only sub-district with an urban population. This was meant to allow for urban and rural comparison as well as cover a more representative district population. Alavanyo sub-district where Hohoe township is situated was therefore selected.

Random sampling was used to select two sub-urban communities out of eight in Hohoe town. The names of the seven urban communities were identified and written on pieces of paper of equal dimension. Each piece of paper was then folded, squeezed, put in a container, and shuffled. Two communities were then picked out of the lot. The communities were Torkoni and Ahado. The same procedure was used to select two of twenty- two rural communities in the sub-district. The communities selected were Alavanyo Wudidi and Ve Dafor.

1.7.4 Sample Size

Two hundred and eighty people were targeted for interview. The sample size was calculated using EPI 6 software package. A prevalence rate of 5 % and the district population was used to determine the sample size. The youth and adults of fifteen years and beyond were sampled for interview. Three PLWHA and their caregivers targeted for were interview.

1.7.5 Data Collection Techniques

Both quantitative and qualitative methods of data collection were used. Individual questionnaire was used to conduct interviews to obtain information on the attitude of community members about home care for PLWHA. This technique was used to capture individual attitude towards home care and reaction to PLWHA. Three research assistants were recruited and trained for one week. Data collection however took three weeks to complete.

About 60 % of the interviews were conducted in urban communities. This was due to their larger populations as against 40 % in the rural area. In all 273 interviews were conducted for the survey. Seven forms were rejected because they were not properly filled. One hundred and fifty-five questionnaires were from the urban while 118 were from the rural communities.

Systematic sampling was used to select houses where interviews were conducted. At one end of every community, a bottle was spun and whichever house the mouth of the bottle pointed was the first house where interviews were conducted. In a systematic order the third house after the previous interviews, becomes the next house where

respondents were interviewed. Not more than three respondents were interviewed in each household or compound. The completed questionnaires were checked on daily basis and given serial numbers before data entry.

In-depth interviews were also employed to obtain information from PLWHA and caregivers. Pro-Link, a non-governmental organization already working on HIV/AIDS in the communities was very helpful in facilitating access to PLWHA and caregivers. I went out with one of the HIV/AIDS counselors from Pro-link to visit the PLWHA in their homes where the interviews were conducted. Practically it was not possible to record the interviews due to the sensitive nature and stigma associated with the disease. Notes taken during interviews became the only information available for the study. Only two in-depth interviews with PLWHA and one with their caregivers were successfully done.

1.7.6 Pre-testing of Survey Instrument

A community that was not included in the study was selected for pre-testing. Each trainee was made to interview four people within the target population preferably two males and two females. Issues arising from the pre-test were discussed after which final corrections on the interview guide and semi-structured questionnaire were made to get ready for data collection.

1.7.7 Data Processing and Analysis

The completed questionnaires were thoroughly checked for the second time to ensure that they were correctly filled. A suitable screen was designed for data entry. The quantitative data was analyzed using the EPI 6.0. Software package. Analysis was

based on frequencies and percentages to determine the general perception and attitude to home care for HIV/AIDS. Two by two tables were also generated to compare rural and urban responses with the main variables to determine where significant differences existed.

The qualitative data being in-depth interviews with PLWHA and caregivers were treated as case studies and analyzed manually.

1.7.8 Ethical Considerations

Ethical consent was sought from all relevant authorities including the district assembly, chiefs and opinion leaders from all the communities where interviews were conducted. As part of community entry, the nature and essence of the research was explained particularly to the chiefs, opinion leaders, community health volunteers and the "gong-gong" beater. Suitable days for the questionnaire administration were agreed upon together with the health volunteers and assemblymen. The "gong-gong" beater then informed community members about the survey. Informed consent was sought from all sampled respondents before questionnaire administration. Under no circumstances were target respondents coerced for interview.

For interviews with the PLWHA, informed consent was sought and an appointment date for interviews agreed upon with the individual. Much more caution was employed to interview PLWHA and caregivers. Respondents (PLWHA and caregivers) were provided with some cakes of soap and a token amount of money after the interviews. All respondents however, were, assured of confidentiality.

1.7.9 Study Limitations

Financial and time constraints were a major limitation. Some focus group discussions could have been included in the study but for time and financial constraints. Financial constraints and limited duration of time as well as heavy work load, limited the number of interviews and restricted the study to just one sub-district and not the entire district

Identifying PLWHA and obtaining their consent was one of the biggest hurdles. Stigma and denial were so strong. Hence, fewer interviews with PLWHA than expected were conducted. Obtaining support from organizations to be able to identify and interview PLWHA and caregivers was also a problem due to the high level of confidentiality and trust they needed to keep with their clients. It was not possible to understand and follow all that took place due to language barrier. In addition, stigma and denial associated with the sick conditions of PLWHA did not allow for recording.

1. 8 LITERATURE REVIEW

1.8.0 Introduction

This section highlights some literature on HIV/AIDS and home-based care. It is categorized under three main headings for easy reading. These are knowledge of HIV/AIDS and home-based care concept, community attitude to PLWHA and reaction to home care and coping strategies for PLWHA and caregivers.

1.8.1 Knowledge of HIV/AIDS

Report of the Ghana Demographic and Health Survey show a very high level of HIV awareness of 99 % for men and 97 % for women (GSS, 1999). Another study conducted in Navrongo also showed a high level of awareness of 97 % for men and 94 % for women(Akazili et al, 2001). This indicates that knowledge of HIV/AIDS particularly awareness is universal.

There are however some misconceptions about HIV/AIDS as revealed in a study conducted in the Krobo district of Ghana. HIV/AIDS was recognized as a disease for people who traveled outside while others related the infection to evil spirits (Mensah, 1994). In this regard education on active knowledge about HIV infection is required to change this misconception.

1.8.2 Merits of Home-based Care

A descriptive study conducted by the World Health Organization in 1989 revealed that some innovative home care programmes that provide a variety of services to PLWHA have been developed in Africa since 1987 (WHO Report, 2000). It would

however be helpful to know how they have fared and challenges they have encountered as they would be very informative to future programmes.

One of the many approaches that are seriously being considered is to deal with HIV/AIDS as a chronic disease. Responding to AIDS as a chronic disease however means emphasizing quality of life and well being of PLWHA and not the disease (Bennett, 1988).

It is estimated that PLWHA would require acute hospitalization for just 10 % of their illness. Alternative services of care for most of the AIDS condition include home and hospice care, residential care and housing, skilled nursing facilities and other community based services (Beresford, 1989).

Home care does not only have the potential of reducing congestion at the health institutions but also provide patients with a wide range of services besides clinical care. Services provided to patients include counseling, health education, food supplements, spiritual assistance and other material assistance (Banda, 1999).

Home-based care has been widely adopted and incorporated into many HIV/AIDS national intervention programmes including Ghana in view of its immense benefits in providing care and support to patients and caregivers. It's potential to minimize transmission of HIV infection and to mitigate the impact of the disease on both the infected and affected could be tremendous.

Another study however identified some problems encountered by home care agencies that deliver health care services to PLWHA. It was realized that there is a potential for stress in view of the intensity of illness manifestation and the complexity of treatment regimen (Allen et al, 1992).

According to Nsutebu (2002), home care programmes in developing countries have suffered drawbacks due to limited support from governments. He adds that if home care would succeed, then more resources are required to develop affordable feasible and sustainable home care programmes (Nsutebu et al, 2002).

1.8.3 Community Reaction to PLWHA and Attitude to Home Care

A study carried out in Addis Ababa in Ethiopia to assess the attitude of community towards home care for PLWHA showed over 90 % of respondents regarding hospital as the best place to care for patients. It was observed however that this was due to fear and misconceptions of people about the disease. About fifty-five percent of participants were willing to give home care for PLWHA (Berhane, 1995).

Studies in Uganda and other developing countries have shown positive response to home care for the following reasons: desire for constant family attention, choice of food, relaxed atmosphere, opportunities to seek other forms of treatment besides hospital care and cost effectiveness. The study recommended that efforts to make home care acceptable by both patients and care givers should be enhanced. It also recommended that future studies should focus on the concerns and information needs of primary caregivers (Mwiinga, 1991).

Studies in Zambia and other places show that patients continue to seek the help of traditional healers while receiving home care (Chela et al, 1990). The spiritual aspect comes up strongly as religious practice plays such an important role in most African settings where the disease is most prevalent. Often times, modern and formal health systems have tended to dwell on the germ theory and for that matter the physical aspect of illness. However since human is also a spiritual being, it is even most appropriate to consider the spiritual dimension as an essential component of holistic health care. Moreover, this could best apply in the home care certain.

In most parts of the developing world, religion is highly esteemed and revered. Often times religion and disease and for that matter healing are integrated as traditional as well as faith healers constitute an important set of health service providers particularly in developing countries.

AIDS patients in many countries have experienced rejection and isolation. However, traditional family structures in Africa and other developing countries have shown themselves to be caring and supportive to persons suffering from AIDS (Hubley, 1994). Home-based care has therefore, a potential to succeed in making considerable impact on care and support initiatives.

1.8.4 Coping Strategies

Home care is increasingly becoming a very important resource for the care of PLWHA. Even more valuable is the availability of informal caregivers who are willing and ready to help. Studies show that there is stress involved in the care of

PLWHA. Hence, home care nurses need to anticipate and address the needs of both PLWHA and their caregivers (Baker, 1999).

A community response to AIDS study also revealed that although community members are doing their best to cope with the complicated aspect of the AIDS epidemic, they need help to overcome fear and stigma associated with the disease (Anderson, 1994).

The main problems facing PLWHA appear to be that of deepening poverty, isolation and ability to satisfy basic needs such as food, and shelter; rejection by communities and formal services, and fear for their children (Russell et al, 2000). Home care could perhaps bring the disease out in the open and confront the myths and prejudices that surround it. Then the disease could be perceived as a community problem and not only for the sick or infected person.

1.8.5 Conclusion

In view of the numerous benefits that home-based care could offer and its suitability to the developing world, it remains incumbent on particularly African governments to provide the enabling environment and resources necessary to support home-based care programmes. It cannot be gainsaid that much of the burden of HIV care in developing countries is already falling onto households and communities. This is why it has become imperative for governments to act now than ever.

1.9 Conceptual Framework

The worldview of a people reflects to a considerable extent the historical and environmental circumstances of the people (Assimeng, 1981). Environmental determinism where environmental conditions a people find themselves plays an essential role in their way of life. Lifestyles and ideologies of a people also influence health issues among others. It is for this reason that background variables play a very important role in this study.

Community attitude to PLWHA and homecare may be influenced by a number of socio-demographic and independent variables. Socio-demographic variables like age, sex, religious beliefs and other aspects of culture as well as marital status and one's occupation as well as level of education could influence one's attitude to PLWHA and homecare.

Reaction to health issues differs with gender, as females and males perceive things differently by virtue of sex. In order to overcome this bias, almost equal number of males and females were targeted. With respect to age, older persons react and perceive things differently from the youth. The married people have a more responsible attitude towards health issues than the unmarried, and level of education among others are all taken into consideration in determining community attitude to home care. Pertaining to HIV/AIDS issues, people with higher level of formal education are likely to be more informed on HIV/AIDS. These variables are all taken into consideration in obtaining representative views of the population.

Independent variables such as residence, whether urban or rural is one most important factor that could greatly influence community attitude. General knowledge about HIV/AIDS, perceived mode of infection, transmission and knowledge about prevention practices are some major variables this study seeks to consider. Other equally important variables are the need for care and preferred place of care. The independent variable is home care for PLWHA.

NATIONAL RESPONSE TO HIV/AIDS AND POLICY ISSUES**2.0 Introduction**

This chapter focuses on the national response to the HIV/AIDS pandemic. It therefore highlights some of the structures, activities put in place by the government to minimize the impact, and effect of the epidemic and curb further spread of HIV.

2.1 National Response

National response towards curbing the HIV pandemic has been tremendous. The NACP was first established in 1987 in the early stages of the disease under the MOH to co-ordinate the national response to the HIV/AIDS epidemic. The NACP consequently played a leading role in the drafting of the National Policy Document on HIV/AIDS in 1997. The draft policy that is yet to be formally adopted is aimed at creating a favourable environment for HIV/AIDS control and prevention programmes and offer care and support to HIV/AIDS infected persons and PLWHA. The draft policy and the National Strategic Framework are concurrently designed to address the epidemic. With time, however, the epidemic situation has worsened rendering it not just a health problem but a developmental problem as well. The age group mostly affected is 15-49 who forms the work force of the national economy.

The basic functions of GAC include the provision of leadership and the co-ordination of HIV/AIDS programmes and activities of all stakeholders through advocacy, planning research, monitoring and evaluation and resource mobilization (GAC, 2002).

The national prevalence rate is 3.6 percent. It is however estimated that by the year 2005, one million, two hundred (1,200,000) people would be living with the HIV.

HIV/AIDS was initially managed as a disease and for that matter the National Response focused on the health sector as the main implementers through the NACP of the Ghana Health Service.

In 1992 governments and donors realized that HIV/AIDS was not just a health problem but a developmental one, affecting and impacting negatively on all sectors. It has grave crisis on the socio-economic development of most sub-Saharan countries. To this point, it was realized that a national response involving all sectors was an essential approach. This led to the development of the National Strategic Framework (NSF). This further necessitated the establishment of the GAC with the aim of coordinating the activities of the various sectors. GAC has therefore come out with HIV/AIDS sector plan of action for ministries and departments. These include; Defense, Education, Food and Agriculture, Health, Interior, Justice and Judicial Service, Local Government, and Rural Development, Manpower Development and Employment, Ghana Employers Association, Offices of the Head of Civil Service, Trade Union Congress, Roads and Highways, Tourism, Communication and Transport, Women's Affairs, Youth and Sports. In addition, government demonstrated commitment by instituting district response initiative (DRI) at the district level. This has however been replaced by community based organizations (CBO).

2.2 National Draft Policy

The objectives of the draft policy are;

- Reduce the impact of morbidity and mortality as a result of HIV/AIDS in the general population.
- Ensure that the basic human rights of persons infected with HIV and persons with AIDS are protected and upheld.
- Ensure that HIV infected persons and persons with AIDS are provided with adequate medical and social care including counseling.
- Ensure that access to social and economic opportunities remain open to HIV infected persons and persons with AIDS.
- Ensure that adequate attention is paid to groups such as women who have been found to be vulnerable to HIV.
- Ensure that there is a consistent programme of information and education and HIV/AIDS among the population especially among youth and that, this increased knowledge is translated into an increase in attitudinal and behavioural change.
- Decrease vulnerability to infection, reduce stigmatization and discrimination and minimize the socio-economic impact of the epidemic.

2.3 National Strategic Framework

Objectives of the National Strategic Framework on HIV/AIDS for the period 2001-2005 are:

- To reduce the incidence of HIV/AIDS by 30 percent by 2005.
- To improve the quality of life of people living with HIV/AIDS and those infected by it.

2.4 Sentinel Surveillance System (SSS)

Surveillance is such an essential public health tool in acquiring information in order to monitor trends of a disease situation for action to be taken. In 1990, the Ministry of Health instituted the HIV sentinel sero-surveillance system to complement already existing AIDS surveillance (GAC, 2002). The objectives of the SSS are:

- To obtain information on the prevalence of HIV infection in the sentinel populations.
- To provide information for monitoring the trend of HIV infection in the sentinel population over time.
- Provide information for the evaluation of the AIDS prevention and control activities

The SSS procedure which is recommended by WHO (2000 Report) and is applied in many countries (GAC, 2001) involves anonymous testing of blood samples of pregnant women 15-49 years in some selected sentinel sites across the country. In the year 2001, there were twenty-three antenatal sites selected across the ten regions of the country. The prevalence rate of HIV among pregnant women in the country ranges between a low of 1.1 % and a high of 6.6 % in Sunyani in the Brong Ahofo and Agomenya in the Eastern region respectfully (Ghana HIV/AIDS Strategic Framework, 2001):

2.5 Expanded and Comprehensive Response (ECR)

The ECR is a global approach adopted by various countries to effectively address the HIV/AIDS pandemic. It involves the mobilization of adequate resources and organizational capacity to effectively deliver an expanded and comprehensive response to the HIV/AIDS epidemic (Lamprey et al, 2002). Increased geographical coverage as well as intensified multifaceted technical strategies forms an essential approach towards fighting the epidemic. The components to ECR include strategic planning of programmes, outlining technical strategies and interventions and effective administration and management of programmes. The technical strategies for the national response include the following:

- Management of Sexually Transmitted Infection (STI).
- Promotion of abstinence and faithfulness through behaviour change communication (BCC).
- Promotion of condom use.
- Promotion of Voluntary Counseling and Testing (VCT).
- Prevention of Mother to Child Transmission (PMTCT).

Heterosexual transmission accounts for about 80 % of HIV transmission in Ghana. Mother to child accounts for 15 % of HIV transmission while the other modes account for 5 % . For that matter more efforts are targeted at prevention of heterosexual transmission and prevention of mother to child transmission.

STIs are known to increase the risk of HIV infection nine folds (Ghana HIV/AIDS Strategic Framework, 2001).

Controlling of other sexually transmitted diseases through early detection is strongly promoted through the ministry of health. Abstinence among the youth, faithfulness among sexual partners and condom use for those who cannot abstain and casual or commercial sex workers are target specific prevention strategies.

VCT is another strategy that is being promoted. In line with this, centres are being established across the country to facilitate the process. Prevention of mother to child transmission is also strongly pursued with the administration of ARV such as nevirapine as MTCT accounts for a substantial proportion of transmission. Behaviour change communication is the main educational tool that is employed for most of the other strategies mentioned.

It is in the light of these background national strategies, that the survey on community knowledge on HIV/AIDS and attitude to home care is explored.

CHAPTER THREE**SOCIAL STRUCTURE OF HOHOE DISTRICT****3.0 Introduction**

This chapter describes the study area. A fair knowledge about the study area is essential to better appreciate and understand findings of the study. This chapter therefore focuses on the location, socio-cultural activities and social infrastructure in the area.

3.1 Geographical Location

Hohoe district is one of the twelve districts in the Volta Region, located in the central part of the region. Hohoe is 110 kilometres from Ho, the regional capital and 220 kilometres from Accra, the national capital. The district is bordered to the north by Jasikan; to the south by Ho and Kpando districts; to the east by the Republic of Togo and to the west by Kpando. Hohoe District is located within longitude 0 15 E and 0 45E and then latitude 6 45N and 7 15N. It covers a land area of 1172 square kilometres.

Alavanyo is one of the six sub-districts in Hohoe district. Hohoe town, the only urban area in the district is located in Hohoe District. The other sub-districts are Akpafu, Likpe, Have, Leklebi and Gbledi. Alavanyo is bordered to the north by Akpafu, to the south by Have, to the west by Kpando and Likpe to the East.

3.2 Topography

The district is mountainous towards the eastern part where the Akwapim-Togo ranges stretch along the southeastern borders of the country. Mountain Afadjato, the highest mountain in Ghana (880.3 metres high) is located on these ranges. These ranges also stretch northwards of the district towards the Akpafu ranges. The northwestern part of the district is also mountainous. The topography is however low lying towards the middle strip of land.

The mountainous nature of the area makes it a tourist destination and this potential of the district is further enriched by a number of waterfalls. Prominent among them are, Wli and Sasa near Alavanyo, and Tagbo near Laiti Wote. Two main rivers emerging from the waterfalls, Dayi and Koloenu from the east flow through the district towards the southwest and eventually drain into the Volta Lake.

3.3 Climate and Vegetation

There are two peaks of the rainy seasons (a major one from May to August and a minor one from September to October) and a dry season from November to April. Annual rainfall is between 102 cm and 121cm. The vegetation is trans-seasonal with forest and semi-savanna vegetation zones.

3.4 Population

The projected population for 2003 is 161,937 with an annual growth rate of 2.7 percent. There are over 120 communities in the district. The district is predominantly rural with Hohoe township being the only urban area.

3.5 Socio-political Organizations

The identified ethnic groups in the district are the Ewe, Logba, Likpe, Akpafu, Lolobi and the Santrokofi. Christianity is the main religion practiced with over 90 % of the population being Christians. The main church denominations are Roman Catholic and the Evangelical Presbyterian Church. There are a few Muslims who are mostly settlers. Traditional religion is also practiced.

Cultural performances such as drumming and dancing of Borborbor, Agbadza, Asafo and some Islamic dances are usually performed at occasions like festivals and funerals.

Gbi Traditional Council is a traditional administration headed by Togbe Gabusu VI, the paramount chief who presides over divisional and sub-chiefs. Queen mothers also form a very important part of the traditional administration. They are responsible for women affairs. The queen mother occupying the paramouncy of the same traditional area is Mamaga Dewotonyo II.

3.6 Economic Activities and Infrastructure

The main economic activities include farming, trading and livestock rearing. The crops cultivated are primarily cassava, rice, maize, and yam. Some other crops that are cultivated in different parts of the district include cocoa, plantain, cocoa yam and okra. Some of the crops are processed for instance cassava is processed into cassava dough and then palm oil from palm fruits.

Some industrial activities include ceramic works at Ve-Koloenu, oil palm extraction at Logba and Fodome, cassava dough processing also at Fodome and blacksmithing in some communities.

There are five financial institutions in the district all located in Hohoe town to boost economic activities. They are Agricultural Development Bank, Ghana Commercial Bank, Barclays Bank, Asubonten Rural Bank and Wetu Rural Bank. The regional branch of the Bank of Ghana that supports almost all financial institutions in the region is located in Hohoe town.

3.7 Communication and Road Network

Hohoe is a busy commercial town with many banking institutions and an automated telephone link to other parts of the country. There is an Internet facility in Hohoe town in a few commercial centres. It also has a second-class road that links it to the regional capital and Accra and another tarred road from the district to the Republic of Togo. In addition, a main road links Hohoe up to the northern part of the country, which, however, is in a deplorable state. There are many feeder roads that link most communities to Hohoe town.

3.8 Utility Supplies

The availability of electricity and the supply of potable water are crucial determinants for human settlements and development. Almost the entire district is connected to the national grid. Hohoe town and most rural communities have electricity supply.

There is portable water for drinking. Pipe borne water is available in Hohoe town and some big communities. In most rural communities however, borehole and stream are the main sources of water for domestic use.

3.9 Health

The district has thirty-three health institutions; one mission health centre, three (3) private clinics and twenty-nine government health centres. There are three non-governmental organizations that focus on reproductive health issues. There is a district hospital, and an Onchocerciasis Chemotherapy Research Centre located in Hohoe. The NGOs are Pro-Link, All Age Development Centre (ADEC) and Young Men Christian Association (YMCA). The first two organize HIV/AIDS programs whilst the third is a safe motherhood initiative but also incorporates HIV/AIDS education in its programs.

3.10 Schools

The district is endowed with many first and second cycle educational institutions.

There are about ninety-one pre-schools, eighty-one primary schools and eighty-four Junior secondary schools. There also ten secondary schools, five commercial and Technical Institutes, and two post-secondary Teacher Training Colleges. Apart from the Training Colleges, most of the basic and secondary schools are strategically located to serve all the communities.

3.11 Conclusion

Hohoe District although predominantly rural, has many educational institutions. It also has many health facilities but traditional herbal practice is very popular. The geographical location and physical features of Hohoe make it an important commercial centre and transit point as well as tourist.

CHAPTER FOUR**FINDINGS AND DISCUSSIONS****4.0 Introduction**

This chapter presents and discusses findings of the survey. These findings and discussions of the study revolve around; the background characteristics of respondents, awareness of HIV/AIDS including knowledge of transmission and prevention, community reaction and attitude to persons living with HIV/AIDS and community attitude to home care.

4.1 Background Characteristics of Respondents

The background characteristics of respondents form a very important component of the study since it could greatly influence the way people think and perceive issues as well as knowledge on health matters. This would therefore offer a better understanding and interpretation of findings.

The largest age group of respondents forming 22 % of the study population was 25-29 years. Closely followed by this was 20-24 age group at 20 % and 15-19 at 14 % . For 30-34 and 40-44 age groups, there was an equal percentage (11%) of responses. The age groups with the least respondents are 34-39 and then 50 years and above at 10 and 2 % respectively.

The study population is largely youthful and captures the population being threatened.

The female and male proportions are representative, as the female population is slightly higher than that of the male.

The study population comprises mostly Ewes at (88 %), Akan at (5%) and others (7%).

The population is largely Christian with 92 % being Christians, 6 % being Muslims and 2 % being traditional religion adherents.

About 46 % of the population are single; 48 % are married, 5 % divorced and 2 % widowed.

The majority of the people have had some education; only 7 % have never been to school. Almost one in two (47%) of respondents had attained junior secondary school or middle school education, 36 % had secondary and higher education whilst 8 % had attained primary education.

Being a commercial and a farming area, 30 % of the population in Hohoe engages in a form of trading. Twenty percent are farmers whilst 23 % are students. A bulk of the 'other' category comprises hairdressers, mechanics, and apprentices (19%). Table 4.1 presents background characteristics of respondents.

Table 4.1: Background Characteristics of Respondents

Background Characteristics	Freq. (N=273)	Percent
Age		
15-19	38	13.9
20-24	53	19.4
25-29	60	22.0
30-34	31	11.4
35-39	26	9.5
40-44	30	11.0
45-49	30	11.0
50+	5	1.8
Gender		
Female	157	57.4
Male	116	42.6
Ethnicity		
Ewe	240	87.8
Akan	13	4.8
Others	20	7.4
Religion		
Christianity	252	92.3
Islam	15	5.5
Traditional Religion	4	1.5
Other	2	0.8
Marital status		
Single	125	45.7
Married	130	47.6
Divorced	14	5.2
Widowed	4	1.5
Highest level of education		
None	19	7.0
Primary	22	8.1
JSS/Middle	127	46.7
Secondary or Higher	98	36.3
Other	7	2.6
Occupation		
Farming	54	19.8
Teaching	22	8.1
Trading	84	30.8
Student	62	22.7
Other	51	18.7

4.2 Awareness of HIV/AIDS

A respondent could only contribute meaningfully if the one has ever heard of HIV/AIDS. Respondents were therefore asked if they have ever heard of HIV/AIDS. All the 273 respondents in the survey irrespective of their background claimed to have ever heard of HIV/AIDS. Thus, awareness on HIV/AIDS is very high. This is in line with the 1998 data of the Ghana Demographic and Health Survey (GSS, 1999) where over 97 % of respondents had ever heard of HIV/AIDS. Another study conducted in Navrongo showed equally high level of awareness (Akazili et al, 2001). This presupposes that educational messages through the mass media and other national strategies have gone down to the communities reaching both rural and urban populations alike.

Questions were also asked to determine the perceived risk group contracting HIV/AIDS. A summary of responses is presented in Table 4.2. As the table shows, the largest response (44.9 %) indicated that everybody was at risk of contracting HIV/AIDS. About 20 percent response showed that promiscuous men are at risk, followed by prostitutes, 18 %. Then about 12 % said the youth were the risk group.

Although everybody is at risk of contracting HIV/AIDS, less than 50 % think so. Findings also give the impression that some groups of people are perceived to be more at risk than others. Thus everybody, promiscuous men, prostitutes and the youth in a descending order of risk groups. This perception could be deceptive since it would give people who do not fall in these risk groups a false sense of protection.

Table 4.2: People perceived to be more at risk of contracting HIV/AIDS

Risk Group	Freq.	Percent
Children	1	0.3
Adult men	2	0.7
The youth	35	11.9
Everybody	132	44.9
Prostitutes	53	18.0
Promiscuous men	60	20.4
Other	11	3.7
Number of Responses	294	100

Respondents were asked if they have ever seen an AIDS patient. Twenty-eight percent answered in the affirmative, while 72 % answered in the negative. Respondents were also asked how they could tell if someone has AIDS. The highest of 60 % of respondents said people living with AIDS (PLWA) grow lean. Eighteen percent said they get sick all the time, 16 % said they could not tell. Only 2 % mentioned blood test as how they could tell if someone has AIDS, 6 % mentioned diarrhoea and 2 % mentioned cough.

Growing lean is the most common feature associated with PLWA. Getting sick all the time is also associated with PLWA. These may not be far from true as PLWA loose at least 10 % of their body weight and get sick most of the time due to the breakdown of the immune system. A substantial number of the people could not tell if someone has AIDS. Much education is therefore required in the area of signs and symptoms of AIDS. About a fourth of the population has ever seen an AIDS patient.

4.3 Knowledge of HIV/AIDS Transmission and Prevention

Knowledge on the mode of HIV/AIDS transmission was ascertained. There were multiple responses and so respondents could mention as many as possible, the modes of transmission they know. There were multiple responses. About 46 % of responses indicated sexual intercourse as a mode of transmitting HIV/AIDS, 34 % responses stated the use of sharp objects and injections, about 11 % stated blood transfusion and about 5 % indicated through birth as mode of HIV/AIDS transmission.

There were no misconceptions as to whether the disease could be transmitted through curses or witchcraft. An earlier study conducted in Addis Ababa however, contravenes this as misconceptions about the disease were observed by some participants in the study (Berhane et al, 1993).

Another study conducted in the Krobo district in Ghana revealed that HIV/AIDS was associated with people who traveled outside the country and evil spirits. These misconceptions has implications for HIV/AIDS education programmes (Mensah, 1994)

Table 4.3 Knowledge on the mode of HIV transmission

Mode of Transmission	Frequency	Percentage
Sexual Intercourse	261	45.8
Through Birth	28	4.9
Use of sharp objects/Injection	196	34.4
Through Blood Transfusion	62	10.9
Through curses	3	0.5
Witchcraft	0	0
Other	20	3.5
Number of Responses	570	100
Responses on whether HIV can be transmitted through eating with an infected person		
Response	Frequency (N=273)	Percent
Yes	33	12
No	198	73
Don't Know	42	15
Responses on whether HIV can be transmitted through touching an infected person		
Yes	9	3
No	246	91
Don't know	18	6

Responses to whether HIV can be transmitted through eating or touching is also presented in Table 4.3. Seventy-three percent were of the opinion that HIV could not be transmitted through eating with an infected person, whilst 12 % gave a positive response. Fifteen percent however said they did not know whether HIV could be transmitted through eating with an infected person. Respondents were also asked whether HIV could be transmitted through touching an infected person. Ninety-one percent were of the view that touching could not transmit HIV. Three percent however said HIV was transmittable through touching whilst 6 % could not tell.

Knowledge on HIV transmission is very high, a step in the right direction. People are therefore more likely to be careful the way they behave or act in order not to expose them to the risk of infection. Superstitious beliefs such as witchcraft and curses are not largely considered responsible for HIV transmission. Conversely, as we all know, HIV is transmitted from one person to the other by: unprotected sexual intercourse, blood/blood products, mother to child transmission, needles and infected sharp objects.

Table 4.4 presents responses on whether HIV/AIDS is preventable and by what means. Ninety-two percent of respondents were of the opinion that the disease could be prevented, 5 % gave a negative response whilst 2 % could not tell. Other responses on mode of prevention were also gathered. A total number of 390 responses were obtained. About 39 % responses were obtained for abstinence, 36 % for being faithful and 26 % responses for condom use.

Nine in ten respondents were of the view that HIV is preventable. Abstinence, faithfulness to one's partner and condom use are among the main methods promoted by the HIV/AIDS Control Unit for prevention against HIV/AIDS (Lampitey et al, 2002). These strategies are appropriately targeted at different sections of the population. Knowledge on these preventive methods was equally high. It cannot be denied that condom use is totally effective against HIV prevention and this could have influenced responses.

Table 4.4 Possibility and knowledge on modes of HIV prevention

Responses	Frequency	Percentage
Can HIV be prevented		
Yes	252	92.4
No	15	5.3
Don't know	6	2.3
Total	273	100.0
Modes of HIV prevention		
Abstinence	150	38.5
Condom use	101	25.9
Being faithful	139	35.6
Total Responses	390	100.0

Responses on whether HIV/AIDS is a problem are presented in Table 4.5. As to whether HIV/AIDS is a problem in the community, only 26 % of respondents thought so, 25 % did not think HIV/AIDS was a problem. Almost 50 % of all respondents did not think HIV/AIDS was a problem. Differences between urban and rural responses were also determined as shown in Table 4.5. Whilst 41 % of respondents in the rural area were of the opinion that HIV/AIDS was a problem, just 15 % of urban respondents were of that opinion. About a fourth of both rural and urban respondents thought HIV/AIDS was not a problem. Only a third of rural respondents could not tell whether HIV/AIDS was a problem. However, three in five urban respondents could not tell whether HIV/AIDS was a problem.

To think that HIV/AIDS is no problem is quite serious considering the fact that everybody is at risk. Just one in four respondents see HIV/AIDS as a problem. It cannot be gainsaid that HIV/AIDS is a global problem that has claimed millions of lives and has had devastating effects on affected persons, the infected and national

economies (Jackson, 2003). It is also quite fascinating to realize that significant difference (p value of 0.00) exist between urban and rural responses. More people in the rural area see HIV/AIDS as a problem than in the urban area. One would have thought that the urban area would be better informed about HIV/AIDS as a problem. It may however be possible to think that AIDS patients or seriously sick people tend to retire to the rural communities, coupled with the fact that information in small communities spread much faster than in urban areas.

Table 4.5: Whether AIDS is a problem in the community

	Rural		Urban		Total	
	Freq.	%	Freq.	%	Freq.	%
It's a problem	49	41.4	23	15.0	72	26.4
No its no problem	29	25.0	38	24.2	67	24.5
Don't know	40	33.6	94	60.8	134	49.1
Total	118	100	155	100.0	273	100.0

P value is 0.00 thus very significant

4.4 Community Reaction towards PLWHA

The reactions of community members to PLWHA whether negative or positive would greatly determine acceptance or otherwise of persons infected with HIV by the community. There is no doubt that reaction can greatly influence care for PLWHA.

Table 4.6 shows responses on living together and using the same bathroom with PLWHA. Respondents were asked whether they would like to live with or use the

same bathroom with a person infected with HIV/AIDS. This was aimed at ascertaining their reactions to PLWHA. In addition, whether there were rural and urban differences in people's reactions. These are well presented in Table 4.6. Eighty-three percent of respondents in all said they would like to live with a person infected with HIV/AIDS whilst 17 % said they would not. With a p value of 0.376, there was no significant difference between rural and urban responses.

Regarding the use of the same bathroom with an infected person, almost 78 % said they were willing to use the same bathroom with infected persons whilst 22 % indicated otherwise. Comparing rural and urban responses however, more people in the urban area, (84 %) than in the rural area (69 %) were willing to use the same bathroom with infected persons. Sixteen percent and 31 % in the urban and rural areas respectively were not willing to use the same bathroom with infected persons. The p value is 0.004 indicating a significant difference. Twice as many people in the urban residence as in rural residence are not willing to use same bathroom with PLWA.

About four in five respondents were ready to live together with PLWHA in the same house. Although this is impressive, the remaining 20 % who were not in favour of living with PLWHA perhaps need to be informed of the need to accept to live with PLWHA. Three in four do not mind using the same bathroom with infected persons. People are more scared using the same bathroom than merely living together. The reasons mentioned were that there might be bloodstains of infected person left in the bathroom and so one needed to be careful or possibly avoid completely using the same bathroom. People are skeptical about PLWA and would want to avoid them.

A caregiver expressed her sentiments: "*People around tend to ignore us and even her own brothers are ignoring her because they are afraid they might get infected*".

Findings of a study to assess community attitudes to home-based care for PLWA in Kenya indicate that due to inadequate information about the disease and care expectations, people were ambivalent towards the sick (Olenja, 1999).

Table 4.6: Responses (yes/no) on if one would live with or use the same bathroom with PLWHA

	Rural Freq.	%	Urban Freq.	%	Total Freq.	%
If one would like to live together with PLWHA in the same house						
Yes	95	80.2	131	84.3	226	82.5
No	23	19.8	24	15.7	47	17.5
Total	118	100.0	155	100.0	273	100.0
P value 0.376						
If one would use same bathroom with a person infected with HIV/AIDS						
Yes	82	69.3	130	84.1	212	77.7
No	36	30.7	25	15.9	61	22.3
Total	118	100.0	155	100.0	273	100.0
P value 0.004						

4.5 Community Attitude to Home Care for PLWHA

Community reaction and response to care for PLWHA was determined through questions on whether PLWHA need to be catered for. Moreover, if so, where they should be cared for, and whether respondents were willing to do things in common with PLWHA. Close to 90 % of all respondents agreed that PLWHA must be cared for, 8 % did not see the need to care for PLWHA whilst 3 % really could not tell. In

the rural area however, 92 % of respondents were of the opinion that PLWHA must be cared for whilst 86 % in the urban area were of the same opinion. The p value is 0.059 showing no significant rural-urban difference in responses.

Respondents also answered questions on the preferred place of care for PLWHA. There were about equal number of respondents (44 %) who preferred both home and hospital care. No significant differences were observed between rural and urban residents. A study conducted in Addis Ababa produced similar results as 55 % of respondents expressed willingness to give home care for persons with AIDS. Majority of the respondents (90 %) regarded hospital as the best place to give care to PLWA (Berhane, 1995).

Community members largely agree that PLWHA must be cared for. However there was no preferred place between home care and hospital care. There is a fair balance between home care and hospital care. It would however be interesting to go further to determine why home or hospital care is indicated.

Findings of a study to assess community attitudes to home-based care for PLWA in Kenya have a preference for institutional based care as opposed home-based care for PLWA (Olenja, 1999). Low economic status of families in most developing countries militates against providing adequate home care and this can be the basis for preference for institutional care.

Findings from the case study showed that the church could be a useful resource in terms of care and support to its members. Apart from counseling and providing some

material support, the psychological disposition of infected persons could improve. The state of hopelessness and trauma of stigma may be replaced by faith and a positive disposition to live with the disease.

A WHO study group examines the options. It points clearly to the benefits that home-based care offers to the patient, while stressing that the personal and health needs of caregivers in the home must not be compromised (WHO, 2001). The study argues that it is time for health systems to take responsibility for providing caregivers in families and communities with the support they need both to help make their tasks more bearable and to bring a greater share of benefit to the patient.

Table 4.7: Whether PLWHA must be cared for and where they should be cared

	Rural		Urban		Total	
	Freq.	%	Freq.	%	Freq.	%
Must PLWHA be cared for?						
Yes	109	92.2	134	86.4	243	88.9
No	9	7.8	14	9.1	23	8.5
Don't know	0	0.0	7	4.6	7	2.6
Total	118	100.0	155	100.0	243	100.0
P value 0.059						
Where PLWHA should be cared						
Home	46	42.3	59	44.3	106	43.5
Hospital	46	42.3	61	45.6	107	44.2
Other	17	15.4	14	10.1	30	12.3
Total	109	100.0	134	100.0	243	100.0
P value 0.441						

The home, where the patient lives with family members, and where friends and other members of the community are, is frequently more appropriate.

Who should care for a relative or friend infected with HIV/AIDS was also ascertained from respondents. Forty-seven percent said family members should care for them, 35 % said health workers, and 6 % said government whilst 4 % said they should be left to die. Comparison of responses by residence shows significant differences with a P value of 0.003 as shown in Table 4.8. Almost equal percentage of responses identified the family as responsible for the care of a relative or friend who has HIV/AIDS.

The family is mostly considered responsible for the care of a relative who has HIV/AIDS. This however does not represent even half of all respondents. The health worker follows from about a third of all respondents. It is encouraging though, that the government is not largely seen as responsible for the care of PLWHA. Considering the high level of stigmatization associated with HIV/AIDS, it was expected that more people would not show compassion. This was however, the contrary, as very small fraction would rather leave PLWHA to die and thus show no care at all. Significant differences in responses come in comparing both rural and urban responses. The differences are more significant with responses to the health worker and government. More people in the urban area think the health worker should do the caring whilst more people in the rural area think the government should do the caring.

Table 4.8: Who should provide care for a relative or friend who has AIDS ?

	Rural		Urban		Total	
	Freq.	%	Freq.	%	Freq.	%
Family	51	47.2	62	46.5	114	46.8
Health worker	30	27.4	56	41.7	85	35.1
Government	12	11.3	3	2.4	16	6.4
Left to die	4	2.8	8	5.5	10	4.2
Other	12	11.3	5	3.9	18	7.3
	109	100.0	134	100.0	100.0	243
P value of 0.003 significant difference						

4.6 Coping Strategies

In all cases of interviews conducted with PLWHA and a caregiver, none had formal education. The PLWHA were both in their mid ages and have been married before, but were not staying with their husbands due to their ill-health condition. In both cases, their mothers were caring for them. Their sick situation nonetheless affected their work, family life and community relations in general. Both cases of PLWHA were no longer able to work due to their ill health. Their family lives were at stack in that one of the cases had not disclosed her HIV status to her husband for fear of divorce.

Stigma, which is still strong, remains a problem for PLWHA and their relations as reflected in the case studies. The quantitative data however gave a different picture as respondents were largely willing to do things in common with their relations infected with HIV/AIDS. Although a few close relations reached out to care for their infected relations, some others avoid them. All over the world, stigma and discrimination has silenced open discussions of the HIV/AIDS epidemic (UNAIDS, 2002). It is for this reason that the World AIDS campaign for 2002-2003 focused on stigma, discrimination and human rights. Perhaps for fear of divorce, case one could not disclose her status to her husband. It is therefore not likely that other friends are informed about her situation and for that matter may not realize any need for assistance. In the second case however, even though she and her mother had to confront the stigmatization, disclosing the situation to others such as church members was an opportunity to get assistance. Besides, she was able to attend social gatherings and received counseling from the church. Some community groups particularly

religious organizations could play a very important role in the provision of support for home-based care.

It was also discovered that denial is so strong particularly in some rural communities visited. Even for those whose infected relations had passed away, they still denied that the deceased died of AIDS. And yet these people complained that in the recent past when their dead relative was still alive, they were not offered any support although some people came to offer support to PLWHA. Due to this problem, attempts to interview caregivers of deceased relations proved futile. The caregiver of case one was not available to be interviewed. It was discovered that caregivers were more likely to be mothers of infected persons whose role as caregivers greatly affected their economic activities and relations with others.

4.7 Introduction-Case studies

This section consists of three case studies; two with PLWHA and one with a caregiver of a person infected with HIV/AIDS.

4.7.1 Case One

She is a thirty year old Togolese who has been staying in the village for about a year. She is married with two children and a Christian with no formal education. She is a seamstress but has stopped sewing due to ill health. She lives with her mother and stepfather. The first time she heard about HIV/AIDS was three months ago. She however could not tell when the sickness started.

Her mother and stepfather help care for her, but she is able to cook by herself sometimes. She feels sad and surprised about her situation. She no longer stays together with the husband due to her ill health but receives some form of financial assistance from him. She has not disclosed her HIV status to her husband and so it has not really affected her marital relationship. An amount within the neighbourhood of over ₵100,000 is spent a month on treatment. Health is the most important thing to her, literally put; "anything that will make me healthy", she said.

4.7.2 Case Two

She is thirty years old, a Christian but has never been to school. She has had four partners in life and has two children. One of her children died due to ill health. One of her partners also died of AIDS a few years ago. She was a trader but had to stop due to ill health. She first heard about HIV/AIDS on the radio a long time but got to know her HIV status about six months ago at the hospital through a blood test. The message was delivered to her mother at the hospital who later informed her. She is presently staying with her mother and no longer stays with her husband because he does not care about her anymore. The mother and her church assist her greatly. Her church pays her hospital bills and provides her with food. She is able to attend church activities but does not visit friends. She eats alone not even with her mother. Sometimes she chats with the grandmother, mother, and children. The church offers prayers for her and provides her with food and money for treatment, and she spends over ₵ 20,000 monthly on treatment. How to get healthy is the most important thing to her now.

4.7.3 Case Three-Caregiver (Mother of case two)

She is a forty-six year-old and the mother an AIDS patient who is also the caretaker. She is a Christian, has no formal education and a divorcee with nine children. She is a seamstress but is no longer engaged in any income-earning job because she has to take care of her sick daughter. She said she first heard AIDS was an incurable and shameful disease. In addition, she heard that one should not do things in common with PLWHA. She has however been educated by nurses and so now sees AIDS as a normal disease. Her daughter has been sick for about a year now. Before she was tested at the hospital for HIV, she had ceased menstruation and was frequently sick; say about three times a month. She was infected through sex from a promiscuous man who died about one and half years ago. She prepares herbal concoction for her to drink, baths her, washes her clothes, and generally cares for her. Her church members assist a lot by buying soap and drugs for her and counsel her as well. She and her sick daughter have become an eyesore in the community. She expressed how people relate to them in these words: "People around tend to ignore us and even her own brothers are ignoring her saying they are afraid they might get infected". She also used to collect second hand clothes to sell and get profit on commission basis. When her daughter fell sick, she used her madam's (The person from whom she collects the goods) money to send her to hospital and has not been able to pay back. Community relationship has also affected her business greatly. She is scared she might be infected. She says she does not protect herself in anyway. She does not even have gloves or disinfectant to wash the victim's clothes. She is however, careful not to have cuts on her body.

4.8 Herbal Treatment for HIV/AIDS

In the process of data collection, it was discovered that a herbal practitioner popularly known as Dr. Hudarsi of Talent Herbal Centre in Hohoe is able to treat AIDS patients. A follow up on this information through personal interactions with the man was made. Upon entering his office there was a notice boldly printed on HIV/AIDS treatment. Thus, treatments were in doses: high dose, medium dose and low dose. Although Dr. Hudarsi indicated that he could not say for sure that he has a cure for HIV/AIDS, he mentioned that some of his clients who came with HIV positive test results, later tested negative after giving them treatment. Also the patients who are usually weak and are unable to work get better and are able to go about their normal duties after treatment. He has been operating since 1998 and is specialized in the treatment of male infertility, high blood pressure, and diabetes. He is faced with financial constraints to go through the laid down procedures of testing the potency and efficiency of his herbal preparations. He admitted that he needed assistance especially in the area of laboratory for HIV/AIDS test and research into the active ingredients contained in his herbal preparations.

CHAPTER FIVE**CONCLUSION AND RECOMMENDATIONS****5.1 CONCLUSION**

At a time when home-based care is being considered as a suitable alternative to hospital based care the world over, it is only appropriate that knowledge of HIV/AIDS, attitude to PLWHA and home care of community members are determined in order to adopt a suitable approach. Home care is a laudable concept as it provides patients the opportunity to live within a familiar environment to receive care.

Findings of the study showed a high level of awareness of HIV/AIDS. All respondents have heard about HIV/AIDS. In addition, knowledge on transmission was high; 96 percent of respondents knew that HIV/AIDS could be prevented. Knowledge on the modes of transmission was equally high. Reaction of respondents towards PLWHA was positive, as (83%) they were willing to live PLWHA as well as willing to use the same bathroom (78%) with them. The element of stigma can not be ruled out as the qualitative component of the study showed that PLWHA tended to be avoided by even some close relations. Almost 90 percent of respondents were of the opinion that PLWHA should be given some form of care.

The home care and hospital were equally considered as the place to care for HIV/AIDS. Denial by affected persons particularly relatives was present. It was also

observed that infected persons most of the time travel away from home. The most important thing to PLWHA certainly is to get well.

Home care however puts a lot of burden on family members who often do not have the wherewithal to meet the basic needs of PLWHA. Technical assistance such as counseling is needed for PLWHA and caregivers to enable them overcome the psychological trauma, stigma and denial.

Although respondents appreciate that family members need to care for their infected relations, community and governmental support is essential. The burden of home care cannot be borne by the family members alone but calls for governmental and community support. A lot still remains to be done towards the provision of home based care for PLWHA and their caregivers.

5.2 RECOMMENDATIONS

Based upon findings of the study, the following suggestions are recommended to improve on existing structures towards the fight against the HIV/AIDS in general and home care in particular. Although the findings may not be the true reflection of the entire district, nonetheless these recommendations could be useful in improving the situation not only in the district but the nation as a whole.

- The Ghana Health Service should establish counseling units equipped with trained counselors at all health facilities particularly the regional and

district health facilities to offer counseling services for PLWA and caregivers.

- The District Health Directorate must intensify education on the dangers and impact of HIV/AIDS on the community through the churches, mosques and public places to reduce the spread, stigmatization and denial associated with HIV/AIDS. In this way community members would appreciate the gravity and seriousness of the situation.

- The Hohoe DHMT as well as other national programmes supported by the Ghana AIDS Commission also needs to intensify education on the need to provide home care for PLWHA. Education should also be targeted at community groups and associations on the need to provide care and support for PLWHA and their caregivers.

- The Ghana AIDS Commission should put in place an effective monitoring mechanism to oversee the activities of the CBOs to ensure that monies allocated for the control and prevention of HIV/AIDS are judiciously applied to reach particularly PLWHA and their caregivers.

- The Ghana AIDS Commission and interested NGOs should provide free counseling, treatment and support in terms of finances, food, clothing and

shelter for PLWHA and their caregivers. By so doing, others who deny living with the disease and their family members would come out to access the free treatment and support.

- The Ministry of Health should intensify research into herbal treatment for HIV/AIDS. To this effect, well organised structures should be put in place at the grassroots and district levels co-ordinate activities of herbalists. The herbalists identified to treat HIV/AIDS ought to be supported to test the potency of herbal preparations and to be offered the required assistance to improve upon treatment practices.

- The Ghana AIDS Commission should involve herbalists in their programmes particularly in the area of care and treatment of PLWHA since they are partners in health care delivery.

- The study recommends that the Ghana Health Service puts in place an effective referral and follow-up system at the health facilities to facilitate effective implementation of home-based care, with appropriate procedures for monitoring and evaluation.

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APPENDIX A**QUESTIONNAIRE ON COMMUNITY PERCEPTION ABOUT CARE FOR PLWHA**

SERIAL NO.....NAME OF INTERVIEWER.....

DATE OF INTERV.....NAME OF COMMUNITY.....

SECTION A. BACKGROUND INFORMATION

1. Gender a) Female b) Male
2. Age a) 15-19 b) 20-24 c) 25-29
 d) 30-34 e) 35-39 f) 40-44 g) 45-49
3. Marital Status
 a) Single b) Married
 c) Divorced d) Widowed
4. Highest level of Education
 a) None b) Primary c) JSS/Midl sch
 d)Secondary e) Post Secondary f) Tertiary
 g) Other specify.....
5. Main Occupation
 a) Farming b) Teaching c) Trading
 d) Student e) Other specify.....
6. Religion
 a) Christianity b) Islam c) Traditionalist
 d) Other specify.....

7. Ethnicity

- a) Ewe b) Akan c) Other specify.....

SECTION B. KNOWLEDGE ABOUT HIV/AIDS TRANSMISSION

8. Have you ever heard about HIV/AIDS?

- a) Yes b) No

9. Which people do you think are at risk of contracting AIDS?

- a) Children b) Adult men c) The youth d) Everybody
e) Prostitutes f) Promiscuous men f) Other specify.....

10. Have you ever seen someone who has AIDS?

- a) Yes b) No

11. How do you know if someone has AIDS?

- a) Sick all the time b) Grows lean
c) Has rashes on the skin d) Other specify.....

12. How is HIV/AIDS transmitted?

- a) Through sexual intercourse b) Through birth
c) Use of sharp objects /injection d) Through blood transfusion
e) Through curses f) Witchcraft
g) Don't know h) Other Specify.....

13. Can HIV/AIDS be transmitted through eating with an infected person?

- a) Yes b) No c) Don't know

14. Can HIV/AIDS be transmitted through touching an infected person?

- a) Yes b) No c) Don't know

38. What help should be given to caregivers?

- a) Counseling b) Food c) Medicine d) Money
 e) Other specify.....

39. Who do you think should provide help to caregivers?

- a) Family members b) Community members c) Health workers
 d) Government e) NGOs f) Other specify.....

40. What help do you think should be given to AIDS patients at home?

- a) Counseling b) Food c) Medicine d) Money
 e) Other specify.....

APPENDIX B

CASE STUDY GUIDE FOR PLWHA

Good morning/afternoon. Thank you for granting us audience. We are staff of the Ministry of Health and Organizations offering care and support for PLWHA and their caregivers in this community. I am ...and my other friends are.... We need information from you that can enable us improve upon the nature of care and support. What ever you tell us would be confidential and so feel at home with us. (Excuse R to record interview)

(Indicate name of community and gender of R on cassette)

SECTION A. BACKGROUND CHARACTERISTICS

1. How old are you?
2. What is your level of education?
3. What is your religion?
4. Are you married or do you have a partner?
5. Are you staying together with your husband? If no why?
6. Do you have children?
7. What work were you doing before you got ill?
8. Are you still working?
9. How long have you been ill with the illness.
10. How did you get to know that you had AIDS.

SECTION C. NURSING AND DOMESTIC CARE.

11. Who are you staying with?
12. Who helps take care of you?
13. What is your relationship with the person/people who help to care for you?
14. What exactly does this person/people do to help you?
15. Apart from what you have mentioned what kind of support do you get from other people?
16. Are you able to attend social activities? (Mention what kind of social activities). If no, why?

SECTION D. COPING STRATEGIES.

17. How do you pay for treatment and medication that you receive?
18. How has the disease affected the relationship with your family (husband, wife, children, external relations) before you fell ill? (probe: eating together, going to social gatherings, conversing).
19. How has the disease affected the relationship with your friends?
20. How has the disease affected your marriage and children?
21. How has the disease affected you education and work?
22. As an AIDS patient what are the things that are most important to you?