

Assessing the Role of Community Care Coalition in Providing Psychosocial Support to HIV/AIDS Infected and Affected People

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Abstract Communities have their own means of managing crisis during time of difficulties and local networks like community care coalition plays prominent role in addressing basic needs of members of the community and HIV/AIDS infected people. HIV/AIDS affects all dimensions of person's life and providing psychosocial support can help the infected people and their families to cope up effectively with each stage of the infection. In light of this, the main objective of this study was to examine and evaluate the role of Community Care Coalitions (CCCs) in providing psychosocial supports to people infected with and affected by HIV/AIDS. The research design employed was both qualitative and quantitative approaches. Participants were selected using both probability and non probability sampling techniques. Survey questionnaires, FGD, and key informant interviews were used. The reliability of the survey questions was checked with Cronbach's alpha and measures of equivalence item analysis methods in pilot testing. The content validity of the items was also checked by the inter judge raters. Data obtained from survey questionnaires was analyzed quantitatively using descriptive and inferential statistics. Qualitative data was analyzed thematically in line with key elements of care and support to PLWHA and vulnerable groups. The finding indicates psychosocial support for PLWHA and their families is found to be very essential. The role of such community based care and support networks also play paramount significance in addressing the need of these target groups. The provision of psychosocial support as one separate care and support package within CCCs, create significant difference between beneficiaries level of service satisfaction, relationship between service providers and receivers for the t- value is less than the P, 0.05 with 95% CI. Therefore, the researcher believed that the care and support to PLWHA should be comprehensive enough.

Keywords: *psychosocial, community care coalition, infected, affected, satisfaction*

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1. Introduction

Communities have their own means of managing crisis faced by their members. They have been supporting each other in time of difficulties such as during impoverishment, accidents, chronic problems, sickness and death of most important members of a family (Mezegbu, 2007). Their support also extended to the family breakdown, disability, psychological and emotional distress.

The researcher believed that, in most cases for such kind of panic and untimed problems immediate and timed reaction comes from local community based support systems like; community care coalitions, *Idirs*, *Equib*, *Mahiber*¹ and other community network systems.

According to Kassaw (2006), however, the role of community based support systems is most of the time treated as informal and has been less emphasized in most literature. These community care support network systems are playing pivotal contribution in providing both individual and family based help for peoples living with Human Immune Virus/ Acquire Immune Deficiency Syndrome (HIV/AIDS) and other vulnerable members of the community. Community Care Coalitions (CCCs) are typical example of these local community based support systems.

According to Germann, Ngoma, Wamimbi, Claxton and Gaudrault (2009), CCCs may have different names in different countries depending on the local context and what national orphans and vulnerable children (OVC) policies use to describe such care groups. Community care coalitions are groups of individuals and/or organizations at local level that join together for common purpose of expanding and enhancing care for HIV/AIDS infected and most vulnerable children in communities. Those groups

¹ Ider, Ekub and Mahibers are local social networking institutions in Ethiopia that bring community members together and providing backing support during time of immoral and crises.

who provide care directly are called Community Care Groups (CCGs); those who have mainly a coordination role are called Community Care Coalitions. Community care coalitions typically include representatives of churches, volunteers and other faith based organizations, the government, businesses, and other local nongovernmental organizations (NGOs) or community based organizations (CBOs) in the community. The service they provide ranges from material, financial to physical support (Caitlin, Medley, Michael, & Kevin, 2010).

The other concept need to define clearly is psychosocial support. The word 'psychosocial' is a combination of the concepts of the individual 'psyche' and the 'social' community in which the person lives and interacts. Psychosocial support recognizes the importance of the social context in addressing the psychological impact of stressful events experienced in emergencies and other problems (Binega & Molla, 2011). In practice, this means facilitating the reconstruction of local social structures (family, community groups, schools and social settings) which may have been destroyed or weakened by an emergency, so that they can give appropriate and effective support to those suffering from severe stress, heart break frustration and hopelessness related to their experience.

Many programs for HIV/AIDS infected and other vulnerable groups have focused on material support and meeting their physical needs. Psychosocial problems are sometimes poorly understood or difficult to assess, they are often not adequately addressed by programs (FHI, 2004). As per this report, HIV/AIDS undermines and then destroys the fundamental human attachments essential to normal individual and family life development.

Peoples' infected and affected by HIV/AIDS suffer from anxiety and fear during the years of illness, and then it follows with grief and trauma with the death of a family member (WHO, 2004). Group approaches, peer support and individual counseling are needed to offer even the primary psychosocial support. Professionals include school counselors, social workers, psychologists, social welfare workers, faith based organization practitioners and other existing structures with the potential to reach AIDS infected and affected families in their communities can offer much needed psychosocial support (UNICEF, 2004a). Similarly, other publication outputs of UNICEF, (2008, 2010) also indicates teachers, health care workers, community groups and others can also contribute significant role in providing appropriate and demanding psychosocial and emotional support.

Although both government and community based supports are exerting efforts to provide comprehensive services and respond to the overall life aspect of the infected and affected people, PSS is less emphasized. Providing psychosocial support to affected family members and caregivers is the heart of the helping process. As many scholars point out, some of the elements that have been identified as key to the success of psychosocial support interventions are community ownership, engaging children and young people in planning and implementation, and tailoring activities to local cultural practices and beliefs. In addition, the researcher also believed that, community based support programs need to provide support that is developmentally appropriate, recognizing that the infected and affected people of

different ages respond differently to trauma and loss, and need support throughout their life. The study attempted to compare and contrast between service beneficiaries who have been receiving psychosocial support and those who have not yet received. Therefore, coupled these and other issues inspire the researcher to study the above topic.

Looking specifically at the role of CCCs in providing PSS have plenty of significance at helping the CCCs to extend the dimension and level of their service to include the psychological, social and emotional life aspect of the targeted group. This is because the researcher believed that, psychological, social and emotional problems are triggering factors that can magnify the impact of HIV/AIDS in both the life of infected and affected people. This study is also helpful for policy makers to design and develop effective strategies that primarily focus at meeting psychosocial and emotional problems of the targeted group. Moreover, it could pave the way for social workers intervention in helping practically the infected and affected peoples with psychosocial and emotional problems. This essay could be important for practical social workers to design and provide community services for such targeted group.

2. Materials and Methods

2.1. Research Design

This study adopts mixed research design with explanatory type; meaning that both qualitative and quantitative research approach were used. As De Silva (2010, P. 23) explained, "Mixed methods provide the opportunity for presenting a greater diversity of divergent views." From such point view, using a combination of quantitative and qualitative methods of analysis also reduces the limitation of each approach or helps to get more reliable data. In addition, De Silva indicate that "It is advantageous to use mixed research for analysis as together the data analyses from the two methods are juxtaposed and generate complementary insights that together create a bigger picture." Therefore, it was believed very relevant to use mixed research method for the present study.

2.2. Population, Sample Size and Respondents

Relevant to this study, out of the twenty CCCs in Mekelle city, two were randomly selected; one from psychosocial provider CCC and one without providing psychosocial support. The justification only two was to effectively manage the study and gain detailed data. One CCC consists of fifteen to twenty members with total of one hundred twenty service beneficiaries (PLWHA). Among the two CCCs, the first one was providing psychosocial support and the second one was without providing psychosocial support. In this case it was possible to make comparisons between the two CCCs in terms of the beneficiaries' service satisfaction level and organizational outcomes. Coordinators and HAPCO official were also participants of this study.

2.2.1. Sample Size

Determining respondents and sample size is one of the most important parts of the method section (Brhanu, 2009).

There are different ways of determining sample size from a given population. As Krejcie and Morgan, (1970, Version, VI²) developed a means of determining a proportional and representative possible sample size. If the target population is two hundred fifty (250) a total of 132 participants will be selected. In case of this study, similar sample determination application was used. Therefore, out of the total population of the two selected CCCs service beneficiaries which are two hundred twenty (220), by taking ½ (50% CI 95%) of the sampling fraction, then one hundred ten (110) sample participants were selected. Proportional distribution of participants was allocated between the two selected CCCs (strata). In proportional stratified random sampling, the size of each stratum is proportionate to the population size of the strata when looked at across the entire population. This means that each stratum has the same sampling fraction.

2.2.2. Participants

In addition to the above survey participants, two Focus Group Discussions (FGDs) were held. Each FGD had seven (7) service beneficiary members and were selected from each CCC. Besides, three (3) key informant interview respondents from the service beneficiaries of each CCC were selected considering their experience on the service and duration of membership. With regard to determining the number of FGD participants, various scholars provide different number. For instance, Morgan (2009, P.4) explains, "The ideal number for FGD is between six and eight."

On the other hand, Escalada & Heong (2009, P.11) described that, "A good size for a discussion group is between eight to ten participants per session." Considering the above arguments, the researcher has taken an average of seven participants for one group per a session. Here special care was given not to select respondents those who are already participate on FGD again in the key informant interview or survey. Besides, two (2) coordinators from each CCC and one (1) regional HIV/AIDS Prevention and Control Official (HAPCO) were selected assuming that they have better information about the CCCs functions. All these respondents were selected purposefully assuming that they could potential source of data for the study.

2.3. Sampling Technique for Survey

In selecting the representative sample size of the service beneficiaries of CCC, probability sampling technique was employed. Of the probability sampling techniques, stratified sampling technique was used with the principle of the proportional allocation. The justification to use stratified sampling as Ashley (2010, P.34) describes it that, "Stratified sample is a probability sampling technique in which the researcher divides the entire target population into different subgroups, or strata, and then randomly selects the final subjects proportionally from the different strata." Hence, firstly the sample size was determined to be 110 out of the total of 220 service beneficiaries' population. Using this principle, participants were allocated within their respective CCC strata section.

Accordingly, the CCC were consisting of one hundred ten service beneficiaries, therefore assuming the proportional sampling allocation in each group fifty five (55) participants were selected from each CCC.

2.4. Methods of Data Collection

Documents like articles, books, project reports on care and support implementation guidelines, reports of the CCC and other relevant websites were used to collect necessary and supplementary information for the effectiveness of the study.

2.4.1. Focus Group Discussion

Two FGD with total of seven service beneficiaries from each CCC were held and efforts were made to make homogeneous in terms of s sexes, age and educational, socioeconomic backgrounds. This gave the researcher the chance to collect members experience, perception, attitude and grievances on the service provision.

2.4.2. Interview

To generate necessary data semi-structured interview was conducted with the six key informants of CCC service beneficiaries (three from each CCC). Besides, two CCC coordinators from the two selected CCC and one HAPCO regional official were participated in the key informant interview. From this key informant interview, relevant data like service dimension, future plans, challenges, experiences and communication styles of the support group were collected.

2.5. Survey

Structured questionnaires were prepared to collect data with regarding to the level of satisfaction of service beneficiaries, significance difference between the two groups, the effects of communication, volunteers skill, and knowledge to PSS and to what extent the service provision was comprehensive enough in addressing the psychosocial demand of the targeted group. This questionnaire was also helpful to draw a conclusion about the reaction of CCCs service beneficiaries between those who have been receiving psychosocial support and those who are not.

2.6. Data Quality Assurance

Reliability of the questionnaire was checked by Cronbach Alpha, (α) and test- retest methods in 78 service beneficiaries of other CCC in pilot study before the actual dissemination (two weeks) of the questionnaire to the targeted group two times with one week interval. Of the total 78 pilot participants 39 were from CCC providing PSS and 39 CCC without providing PSS. The reliability of the survey questionnaires were found to be $\alpha = .769$ by Cronbach Alpha and $r = 0.78$ which was a stronger consistency.

For the interview and FGD items trustworthiness was assured by avoiding double barreled, long and complex questions. Efforts were also made to avoid leading questions and false premises. In tandem to this, six peers were invited to comment and debrief on the prepared questions (Peer debriefing). Triangulation by method and data source was held to keep the trustworthiness of the data. In other words, different methods were used to

² The original book was published since 1970 but the VI version of this book was republished in 2006

collect the qualitative data. To authenticate the genuineness of data, the researcher was established good rapport relationship between study participants.

Content validity or inter judge validity was conducted to find out if the questions were representing what they were intended to measure in a proportional way. In doing so, the variables of psychosocial support and components of care and support to HIV/AIDS infected people were well defined and then the questions were given to four raters, two of them were staffs in Mekelle University department of psychology, and the other two raters were second year post graduate students in the department of public health AAU. The rating for the questions were 1= bad, 2= good, and 3= excellent questions. As a result based on the agreement of the raters, out of the total 25 items, four items were deleted to balance the validity of the tool. The questionnaires were translated in to Tigrigna version by staffs in Mekelle University department of Tigrigna in collaboration with researcher for ease of communication to get genuine information.

2.7. Data Analysis

In order to analysis the information obtained from the survey, descriptive and inferential statistics were employed. Mean and standard deviation were employed to see the service provision practice between the selected CCCs. Correlation (Pearson product coefficient) was used to see the relationship between services beneficiaries with and without psychosocial support and satisfaction of the targeted group was measured. One way ANOVA and two sample T- test were used to look if there were significant effects and differences of CCC types on service provision, beneficiaries' satisfaction. Linear regression analysis was computed to predict if skill and knowledge efficiency problem could influence the effectiveness of the service provision. Multiple regression was used to predict states and conditions of lack of resources, community participation, coordination, skill, knowledge and efficiency problem of CCC voluntaries and coordinators could affects the provision of PSS. Percentage was used to know how many of the participants` are receiving psychosocial support from CCCs. In doing so, the Data Analysis and Statistical Software for Professionals (STATA SP. Ed. 11.1*)³ software was adopted.

On the other hand, relevant information obtained from key informants interview and FGD participants were analyzed and interpreted thematically in line with key elements of care and support to PLWHA and vulnerable groups identified by World Health Organization (WHO). The steps followed for the qualitative analysis is presented below.

2.7.1. Pre-coding

In this research all interviews and FGD were conducted in Tigrigna, every day after data collection, data or field note transcription was done repeatedly until the intended main points of the interview were achieved and then followed by translation in to English. Following the translation pre-coding were started by highlighting significant participant quotes made during the interview.

Significant statements that provide an experience of the participants were specially considered. In doing so, to make the process easy markers with various colors were used.

2.7.2. Coding

The pre-coding process was followed by making final code. In this case, the pre-coded statements, ideas, experiences of interviewees and FGD participants were summarized and arranged in to meaningful segments. According to Tuckett (2005), this needs systematic arrangement or classification and such process was helpful to simplify and focus on some specific characteristics of the data.

2.7.3. Categorizing

In this stage, attempts were exerted to coupled similar, closer and related ideas, data, and statements together which have similarity with the coded data. This categorization indicates, how the various codes were constructed into similar categorical values, how the data has given meaningful shape. Data categorization helps to sort out texts into meaningful groups, which make the data to be manageable (Tuckett, 2005). This is because; the coded data was categorized depending on the similarity and relationship of codes.

2.7.4. Themes

This is the final output of the pre-coding, coding and categorizing with analytical reflections of the researcher. In tandem to this, the main theme in this study were developed considering the categorization and main guiding research objectives. According to Tuckett (2005), themes could be concepts that explain how ideas or categories are connected. In this study besides looking themes from the coded text segments the main care and support identified by WHO were also considered.

2.7.5. Write up

Following the thematic development, writing the final composite of the findings and analyzing, interpreting and looking for meaning out of those themes were made. Initially the themes were found to be 38 and the then reduced in to 20. Finally, the identified themes are categorized under four major point's viz. psychosocial support for PLWHA and their families, types and dimensions of services provided by CCCs, ensuring home and community-based care as guiding principle of PSS, and factors affecting provision of PSS and mitigating ways. In line with this, major roles of these support groups in addressing the psychosocial demand of PLWHA and their families, service beneficiaries' level of satisfaction and main challenges that affect PSS service provision as guiding objectives of this research were analyzed. In the qualitative analysis, explanations, experiences and sayings of participants were taken directly as quotation.

3. Result

The background information of the participants of this study indicates, the highest number of participants were females in which 69(53.07%, N= 130) followed by males

³ Stata Special Edition 11.1 * Data Analysis and Statistical Software for Professionals Version 11

61(46.92%). The distribution of participants in both groups were equal 65(50%, N=130). This was done considering the proportionate sample distribution among the two selected strata. Besides, this proportionate distribution was helpful to make comparison the level of beneficiaries service satisfaction with respective to their stratum.

The duration of service receiving membership, while the range 53.07% of the participants were from two to four years and the remaining 46.92% were more than four years. From this, it is possible to say all of the participants were satisfying the pre specified participants selection criteria which was two years and above. The total numbers' of the study participants (130 or 100%) were infected with the virus in which currently receiving care and support from CCCs. However, this does not mean that the current service provision system in CCC was only for infected people hence families of these participants are included in the service package.

3.1. Psychosocial Support for PLWHA and Their Families

As per the overall collected FGD, key informant interview and survey data from service beneficiaries of CCCs indicates, it is found to be very essential to provide PSS as one component of HIV/AIDS care and support to PLWHA and their families.

Out of the total respondents (N=110) majority of them 77(70%) strongly agreed on the provision of PSS with mean average of $X=4.51$. This is followed by 21(19.1%) level of agreement. However, as compared to the beneficiaries receiving PSS; service beneficiaries those who are not given PSS are highly demanding on the importance of PSS as part of the care and support given to them with a mean level of agreement on its importance($X=4.2$). Similarly, the key informant interview and FGD participants had strongly indicated that, PSS is one of the most important types of care and support needed by PLWHA and their families. For instance one key informant said: "We PLWHA have lots of psychological, social and emotional problems and to cope up with such problems we need strong PSS and various professional helps".

On the other hand, the participants were asked whether PSS support is offered as separate care and support plan in their respective CCC. The response varied between the two beneficiary groups. The beneficiaries receiving PSS rate 95.5% of their response PSS is given as one separate care and support service package of the CCC. Whereas, beneficiaries without PSS responded to the same question 78.3% level of disagreement. Generally, from the above numerical values it is possible to understand that providing PSS as one major care and support benefit package is strongly required by both the beneficiaries with and without receiving PSS. Beside this, one CCC coordinator explained the importance of PSS as follows:

PLWHA are exposed and vulnerable to various psychological, emotional and social stresses. The physiological problem they have could be aggravated by such stressing factors. So, to strengthen the current care and support, providing PSS should be part of the CCCs service package at all level (Key informant, CCC coordinator 1, 2013).

In line with the above major idea, the survey respondents were also asked how they could see and evaluate major roles of CCCs in addressing their life demands and needs of their families. The overall research participant two sample T-test result indicates $T= 0.00$, $P<0.05$ with 95% CI which means the role of CCCs in improving beneficiaries quality of life is significantly vary between the two types of beneficiaries. In other words, there was a significant difference between beneficiaries receiving PSS and beneficiaries without PSS in evaluating the role of CCCs. Beneficiaries receiving PSS show better level of satisfaction in the major role of CCCs in improving their life than the beneficiaries without receiving PSS and this is also proved with average $X=4.75$, 2.00 of Max 5 respectively.

Besides, the respondents were presented with a question whether the nature of service given by CCC is accurately reflected their family demand. The collected survey indicates, the nature of service package designed by CCC are not fully reflected the demand of beneficiaries family. This is supported by the overall mean($X=2.1$ of Max 5) response of respondents with $\sigma=0.854$ of variance. Means, the response of both service beneficiaries decline to support the statement that states; "The designed service package by CCCs is accurately reflected my family's demand" for ($T=0.999$, $P> 0.05$). The FGD participants also respond the question as, "It is undeniable that our family members are included in the service package but it is very difficult to say the service package satisfies the need of our family demand".

This idea was supported by both types of beneficiary groups.

3.2. Types and Dimensions of Services Provision by CCCs

In this study, participants were presented with a question if the types of care and support chosen by CCCs were includes PSS. The response is computed by Two-sample t- test with equal variances and the result is presented below. This computation helps to see variation between the two groups to the types and dimension of care and support given by their respective CCC.

The two sample T- test indicates there is significant difference between beneficiaries with and without receiving PSS on the type of care and support designed package by CCCs. This is shown by $T = -.4966$, $P < 0.05$ with 95% of CI. In other words, if PSS is included as part of the designed service package; level of satisfaction of beneficiaries will increase and vice versa. Supporting the above finding, the FGD participants from the beneficiary group without PSS revealed that:

Like other vulnerable and exposed segment of the population, we are also exposed for similar psychological, social and moral problems in which it aggravates our physiological problem. So, likewise what has been done in other CCCs; we are also in need of PSS. Our concern and problem is not only about material or financial issues, it is also about moral, feeling and personal emotion (FGD from BWOPSS, 2013).

On the other hand, one way analysis of variance was also calculated for the general type of care and support designed if there was significant effect of beneficiary service satisfaction on the care and support design. It

showed that, there was no effect on the overall service beneficiaries satisfaction with regard to major design of care and support, $F(1, 108) = 132.17$, $T = 11.5$, $P > 0.05$. In other words, even though the beneficiaries show variation of satisfaction in the presence and absence of PSS, none of the group of beneficiaries of the two CCCs did not show difference on the general types and care designed service package by CCCs. The interviews and FGD discussions also support the above major finding.

Similarly, the participants were asked if the current service package aimed at future beneficiaries' empowerment. Both the beneficiaries respond the service package designed by CCCs was not aimed at future beneficiaries' empowerment. A one way analysis of variance indicates that, the designed service package has no special room for beneficiary's future empowerment. The one way ANOVA showed that, the beneficiaries never feel empowered and feel sense of ownership in their current situation, as the $F = 0.89$, $P > 0.05$. Moreover, the two sample T- test also indicate, there is no significant effect between beneficiaries receiving PSS and beneficiaries without receiving PSS as, the $T = 0.82$, $P > 0.05$ with 95% of confidence interval.

To sum up, beneficiaries showed better satisfaction with the provision of economical, physical (home maintenance) and medical care and support with correlation coefficient of $r = 0.33$ as compared to satisfaction to PSS $r = 0.011$. In other words, despite the difference observed in the provision of PSS, there is no significant difference in the economical, physical and medical care and support provision between the two groups which was evident as $T = 0.9839$, $P > 0.05$ with 95% CI.

3.3. Ensuring Home and Community Based Care as Guiding Principle of PSS

In this research participants were asked if the volunteers were committed, supportive, helpful and actively engaged during service provision time to ensure all the necessary care and support. Two-sample t- test with equal variances was calculated for beneficiaries' satisfaction if there was any difference and it showed that there was no effect of beneficiaries satisfaction on volunteers commitment and task engagement for, $T = 0.9752$, $P > 0.05$. This means, whether beneficiaries receiving PSS or not, never affect the satisfaction level with volunteers commitment and work engagement. In other words, beneficiaries from the two groups did not show variation in satisfaction with the volunteers' commitment and work engagement.

Beside this, the key informant interview with beneficiaries of the two groups showed as the volunteers are committed and serving them with total dedication. Supporting to this one FGD participant explains his opinion as: "In our group the volunteers are committed, cooperative and helpful. They respect us and the work they have. Volunteers make my experience of receiving CCCs services more enjoyable".

The participants were asked whether they have complains about the skill and knowledge efficiency problem of CCC volunteers to provide all services. The cumulative response of both the beneficiaries revealed that, 81.82% they have complain about the volunteers' skill and knowledge efficiency to provide the designed service package. To explain this, one FGD participant says: "I

think it would be valuable for volunteers to have access to various training courses, not necessarily related to their roles but generally about service provision for PLWHA and their families".

3.4. Factors Affecting Provision of PSS and Mitigating Ways

Factors like community participation, availability of resources, coordination problem, provision of training to volunteers and relationship between providers and receivers of service are found to be major factors for the success or failure of the program. The collected response was computed by Multiple regression and showed that overall beneficiaries service satisfaction is influenced by various variables in which expressed as, $F(4, 105) = 0.11$, $F = 0.985$, $P < 0.05$. When specifically coming to which component of beneficiaries satisfaction, best predictors were coordination problem among CCCs coordinators, $t = 0.187$, $P < 0.05$ and lack of resource and community participation, $t = 0.224$, $P < 0.05$, followed by relationship between service beneficiaries and providers $t = 0.245$, $P < 0.05$, for all 95% CI.

In other words, lack of resource and community participation, relationship of service beneficiaries and providers, CCCs coordinators coordination problem; decrease overall beneficiaries satisfaction (with correlation coefficients of -0.203 , -0.265 and -0.080 , $P < 0.05$ for all), respectively. In addition absence of training to CCCs volunteers was found to be third best predictor variable to the deterioration of beneficiaries overall service satisfaction, $t = 0.231$, $P < 0.05$ with $r = -0.0488$. This result is also supported by key informant and FGD participants of the two groups. During the FGD discussion of beneficiaries from the group without PSS, one participant explains that:

In order to bring all the planned action in to ground, community participation should be assured, available resources should be effectively used, coordination problem must improved among all stakeholders. Availability of trained manpower is more than crucial to the success of this program. Whether we like it or not in the absence of such things, we should not think of success in the CCCs. All concerned bodies must think of these things (FGD participant without PSS, 2013).

To identify additional hindering factors beneficiaries were also asked if they have complain and grievance with the specific group functioning of the general CCCs members. The correlation coefficients showed $r = -0.1448$ which means the CCCs specific group functioning negatively affected beneficiaries overall service satisfaction. Beside this, the two sample T- test indicate there is significant difference between the two types of service beneficiaries with regard to specific group functioning for, $T = 0.0236$, $P < 0.05$ with 95% of CI. In other words, beneficiaries receiving PSS show better satisfaction level with the specific functioning of their respective CCC group than do beneficiaries without receiving PSS. Besides, both service beneficiaries types also rate their satisfaction negatively ($r = -0.11$) as the CCC coordinators are less supportive and collaborative.

4. Discussion

As Katherine (2010) indicates, being infected by HIV/AIDS affects many aspects of people's live and the goal of psychosocial support is to focus on the physical, psychological, social and spiritual well-being. In this study the findings also revealed that psychosocial support is meant to enable both those infected and their caregivers to be able to cope with their status, helping them to make informed decisions, cope better with illness and deal more with stigma and discrimination. The current study shows that there was a statistically significant correlation between provision of psychosocial support as one component of service package within the CCC and overall beneficiaries' service satisfaction. In other words, beneficiaries receiving PSS showed strong service satisfaction as compared to beneficiaries without receiving PSS.

This result was consistent with the findings of Malale (2011) who posited that PLWHA, families and their care givers receiving psychological and social support tends to show better self confidence, good self image, use appropriate coping style and could show better satisfaction in the care and support they receive than do PLWHA and their families without receiving psychosocial support. This is also confirms with the findings of World Health Organization (2010), provision of psychosocial supports in home and community based supports address the on-going concerns and social problems of HIV/AIDS infected individuals, their partners and caregivers.

On the other hand, the current study showed statistically significance difference on the role of CCC in improving the quality life of the two beneficiary groups. This finding supports the study of Ilebani and Fabusoro conducted in Nigeria (2011). According to their study, PLWHA and their care givers receiving holistic support including PSS from community based support improved their quality life than PLWHA without receiving psychological and social support. In other words, PLWHA without psychological and social support increase their vulnerability to stigma and discrimination with poor coping style which in turn affects their quality of life.

Literature findings about the types of care and support to people living with HIV/AIDS and their families are inconsistent. The vast literature identifies material, nutritional, social, medical and psychological supports as main care and support dimensions. As previous work of Mutombo & Namuunda (2007) indicated, out of the major care and support types to PLWHA and their families, psychosocial support is found to be the most essential. Similarly, the mean score of beneficiaries in this study showed there is strong demand of beneficiaries; if psychosocial support is given as a separate care and support package within CCCs. Besides, the service beneficiaries level of satisfaction also show variation in the absence and presence of PSS as one service benefit package since the two sample t test indicate there is significant difference between the two groups of beneficiaries.

As part of this, beneficiaries overall satisfaction in line with service design in their respective CCC group was analyzed to find out if there was significant difference among them. It was revealed that there was no significant effect of satisfaction in the overall care and support design by CCCs. This finding is in contrast with the work of Germann et al. (2009) in such a way that service

beneficiaries with psychological and social support show better satisfaction and feel sense of ownership in the service design than beneficiaries without psychological and social support in their major service package. This may be due to differences in methods, specificity, tools and objectives of the study.

As indicated by Cynthia (2010), every helping profession and program should instigate feeling of ownership and responsibility in the name of the individual to identify limits imposed on him/her and to take action toward change. As one way analysis of variance in this study indicates, the current program has limited role in empowering the beneficiaries and the available service only focus on immediate need of the beneficiaries. However, this result is not supported by the key informant and FGD participants since the collected data from these participants revealed that as there is some means of empowerment strategies like a loan free of interest. This variation may be due to problems of the survey participants to understand the tools (questions).

Participation of beneficiaries in the initial service designing package was analyzed if beneficiaries were participated and contributed to it. The collected data from survey respondents, key informant and FGD participants showed that they had limited or no participation in the initial service designing process. As a result of this, their satisfaction with regard to participation in service designing is found to be very low. This is consistent with Malale (2011) who stated that care and support programs designed without active participation of beneficiaries usually end up with less beneficiaries service satisfaction. The poor performance of CCCs on beneficiaries' empowerment could be also best explained from the low beneficiaries' participation in the initial service designing. Supporting to this, Nturibi (2011) notes, in order to empower and provide comprehensive service to PLWHA and their care givers, program leaders should encourage the participation of service beneficiaries in the initial design. This is also consistent with the study of Folami & Katim (for n.d.), involved people living with HIV/AIDS in decision-making activities to create a feeling of ownership and to help them act as important component of the community. They should also feel and realize that, the society does not prejudice or undermine their capabilities. According to them, empowerment of PLWHA and their families is central to reduce stigma and discrimination.

Generally, beneficiaries showed positive satisfaction with material, medical and physical supports. However, despite its relevance, psychosocial support is less emphasized in the care and support package which brings low beneficiaries service satisfaction. This is particularly true for the beneficiary group without receiving PSS

Relying mainly on the community care coalition as caregivers have become a significant contribution in the treatment, care and support of those infected and affected by HIV/AIDS. In providing home and community based care and support, the role of CCC volunteers is second to none. Further, it was discovered that CCCs with a more diverse membership volunteers tended to show better care and support services in the beneficiaries side. As indicated by U.S. Department of Health and Human Services (2005) volunteers are necessary and extremely helpful for a healthy community development. Volunteers fill a key role in running organizations, handling day-to-day tasks,

and raising funds. Many home and community based managing organizations realize the contribution, sense of work commitment and support of volunteers is beyond mere pivotal to their success.

Even though service users appreciate the support provided, the commitment and involvement of volunteers in the service provision time, they also commented on the volunteers' skill and knowledge efficiency. The skill, knowledge and efficiency of volunteers affect the beneficiaries' services satisfaction level. Both the qualitative and quantitative data revealed that, the existing skill and knowledge efficiency of volunteers is not enough to provide the necessary service. This is also congruent with Mohammad & Gikonyo (2005) in such way that, placement of volunteers in some positions of voluntary works needs special skill and knowledge efficiency trainings which in turn affect service users' satisfaction and quality of service provision. Relationship between service beneficiaries and volunteers as determinant factor for satisfaction and quality of service provision was also analyzed. It was found that, beneficiaries feel comfort to explain their discomfort and grievances to volunteers than to CCCs coordinators. The correlation coefficient also indicates there is strong relationship ($r=0.85$) between volunteers and service users as compared to the relationship of beneficiaries and coordinators ($r=0.0089$). Beside this the current study depicts, using the existing positive relationship; volunteers feel at ease to ask feedback from beneficiaries about the nature of service provision. This went in line with Mohammad & Gikonyo (2005), due to the frequent contact between volunteers and service users; beneficiaries usually feel comfort to have good relation with volunteers and can explain their claims than do with coordinators. Moreover, these writers exposed, in most cases unlike volunteers who are behavior oriented; coordinators are task oriented.

4.1. Factors Affecting and Identified Mitigating Ways

Care and support programs run by community participation in general and the community care collation in particular are influenced by many factors. Research evidence clearly demonstrates that, most people would rather be cared at home and effective home care improves the quality of life for infected people, their family and caregivers. As indicated by Nturibi (2011), providing comprehensive and holistic care to PLWHA and their family could be influenced by strong community participation, availability of materials, coordination effectiveness and the existing relationship. In the current study, lack of community participation, limited access of resources, lack of training materials, coordination problem and lack of trainings to volunteers, coordination problem, and community participation are found to be the major factors negatively influencing the care and support program and provision of psychosocial support. The study by Folami & Katim (for n.d.) revealed that, community involvement and ownership are critical for community and home based care sustainability. Beside this, lack of supportive training to volunteers affects the quality of service provision. This also supported by U.S. Department of Health and Human Services (2005) as it reported that, realizing effective home and community based support is

consolidated by providing appropriate supportive trainings to volunteers.

The relationship between service providers (volunteers, coordinators) and service beneficiaries' also identified as one major factor that affect quality of service provision and beneficiaries service satisfaction. In other words, beneficiaries who have positive relationship with volunteers and coordinators tend to show strong satisfaction in the service provision than do beneficiaries who have poor relationship and the vice versa is true. This is supported by Mohammad & Gikonyo (2005), in such a way that, in the absence of positive and trusting relationship between service beneficiaries and providers; it is quite difficult to think of effective service provision. This went in line with work of Laura and Canaan (2009) as their work indicates, community and home based care provider organizations having positive relationship between service users and providers showed better quality services provision and receive positive feedback from their beneficiaries.

As the data from participants revealed there is no clear division of labor between volunteers and this is the result of poor group functioning. As result of this all the necessary services including PSS are not given to the beneficiaries.

Strong community mobilization, effective use of local resources, providing appropriate training to volunteers, division of labor among home visitors and coordinators and accessing service provision guiding manuals are forwarded as mitigating ways to the problem. The participants also, recommend establishing separate government structure that totally committed and dedicated to the implementation of CCCs is more than important. Besides, according to the participants establishing positive and trusting relationship between services beneficiaries and service providers is more than requirement for the successful provision of care and support within CCCs.

5. Conclusion

Despite widespread recognition of the need of the CCC service beneficiaries to receive psychosocial support, in reality the CCCs designed intervention program continue to focus on material, physical, medical and economical support to meet the physical needs of PLWHA, families and their caregivers. Such supports are crucial but it must be accompanied by effective psychosocial support initiatives. In the selected two CCCs only a very small proportion of PLWHA and their caregivers reported having received some sort of psychosocial support. It was also discovered that provision of PSS to beneficiaries improves their satisfaction in the services. The existence of PSS as one separate care and support package increases the level of communication between service beneficiaries and providers.

The focus group discussions, key informant interviews and survey data clearly indicate that the biggest obstacles to provide psychosocial support were coordination problem, lack of community participation, shortage of resources, lack of training to volunteers, poor relationship between beneficiaries and providers. The volunteers in the two selected CCCs were reported having received no formal training on how to provide service and give advice

and support to beneficiaries in the best way they could. As a matter of fact, volunteers' skill and knowledge efficiency problems were found as major bottleneck to the quality of service provision. Besides, lack of beneficiaries' participation during the initial service design leads the beneficiaries to have low service satisfaction. The current service package has also limited room in empower beneficiaries.

As per the participants, working on areas of community mobilization, establishing separate governmental structure that improve the identified coordination problem, effective utilization of existing resources, providing appropriate trainings to volunteers and accessing guiding materials like manuals are forward as means of solving the problems. In addition, improving the relationship of service providers and receivers, encouraging beneficiaries' participation and consulting them in the initial service designing are also mentioned. Last but not least as the participants say, the program should focus on beneficiaries' long term empowerment than short and immediate supports.

Finally, even though this paper attempts to highlight the role of CCCs in providing PSS to the HIV/AIDS infected and affected people. However, other interested researchers could look the role of CCCs in child care, how CCCS could bring community based social problem prevention and local development.

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List of Abbreviation

CCC- Community Care Coalitions
 HAPCO- HIV/AIDS Prevention and Control Office
 PSS- Psychosocial Support
 AAU- Addis Ababa University
 PLWHA- People Living with HIV/AIDS
 CBO- Community Based Organization
 CI- Confidence Interval

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