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Full Length Research Paper

Community attitudes towards male involvement in home based care activities for people living with HIV and AIDS in Maseno Division, Western Kenya

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Home-based care has emerged as an effective method of providing cost-effective and compassionate care to those infected with HIV and AIDS. Traditionally, women have been in the forefront in the provision of care for those infected with HIV/AIDS. However, there was low male involvement in home-based care services and little research has been done. This paper assesses community attitudes towards male involvement in home-based HIV care activities in Western Kenya. It is a cross-sectional descriptive study. Current activities were used as major dimensions to select all the functioning support groups from a list of all HIV and AIDS care givers in Maseno division obtained from the Ministry of Health in Kisumu. Simple random sampling was then used to select 14 support groups which were involved in HIV and AIDS care and support. The study was done in the month of May 2008. Semi-structured questionnaires were used to collect both quantitative and qualitative data from a sample of 248 caregivers, selected from registered support groups, in Maseno division of western Kenya. A three stage thematic approach was used to analyze the qualitative data .Quantitative data was cleaned, coded, entered and analyzed using SPSS (Version 12.0) computer software. Statistical procedures carried out included descriptive and inferential analyses. Overall, 29% of the caregivers were male, 75% took care of close relatives and 59.7% of the respondents had not received formal training on home-based care. Male caregivers performed significantly fewer nursing activities compared to the general activities. Although 92% agreed that men should be involved in care giving, the study further revealed that there is low level of male involvements (μ=1.97, SD= 0.95), statistically significant association between community attitude and level of male involvement in HBC activities ($r = -0.39$, $p = 0.001$) and statistically negative attitude towards male involvement (χ^2 =34.526, p=0.001) in home-based HIV care activities. Full participation of males' involvement in HIV home care is hindered by the negative attitude from men and the community at large. There is need to address it through seminars and workshops that should be organized by the government and non-governmental organizations to improve and encourage males in giving home-based care services.

Key words: Male involvement, home based care (HBC), community attitude, people living with HIV and AIDS(PLWHA).

INTRODUCTION

An estimated 33.2 million people worldwide were living with HIV at the end of 2007 hence the need to explore effective strategies for care and support (UNAIDS, 2007). Home-based care (HBC) emerged as an effective method of providing cost-effective and compassionate care to those infected and affected with HIV and AIDS. HBC is not a replacement for hospital care but is instead, part of a comprehensive continuum of prevention, 'care treatment' and support services that include family, community and various levels of health care providers (Pathfinder International, 2008). When a family member is infected with AIDS, women and girls provide most of

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the care to the ill, as expected by society. Globally, up to 90% of such care is provided in the home by women and girls (Pathfinder International, 2008). There is low male involvement in home-based care activities in Kenya (Onyango, 2009; Kenya AIDS NGOs Consortium, 2006).

But as HIV and AIDS take its toll, it is becoming apparent that women alone cannot shoulder the responsibility of HBC work. They need their male counterparts to complement their efforts for the necessary care. Despite the magnitude of the problem, men have played a less direct role in the care of the chronically ill. As a result, many women and girls have left work (both formal and informal) and school to provide this care, and most have taken on this role in addition to their existing reproductive and productive roles. However, there have been few documented programs and little research into the most effective ways to increase male involvement (Kipp et al., 2006). Male's involvement is important for carrying out sustainable community HBC grassroots interventions. Home-based care is an appropriate patient support approach to care. Indeed, many people prefer to be cared for in their home and communities.

A study done in South Africa indicated success in mobilizing men as volunteer home-based caregivers, although the authors emphasized that many challenges remains (Bacon et al., 2002). This study was carried to assess the community attitude towards male involvement in home-based care activities for people living with HIV and AIDS in Maseno division, Western Kenya.

MATERIALS AND METHODS

This was a cross-sectional descriptive study done in the month of May, 2008, whose study population comprised HIV/AIDS caregivers. The study used both quantitative and qualitative data collection methods. Primary data were collected from the respondents through personal interviews using a semi-structured questionnaire.

Study site

This study was carried out in Maseno division of Kisumu West district, Nyanza Province, Kenya. Maseno division is a rural area with a population of 82, 223 (43, 506 males and 38, 717 females) people accounting for approximately 14% of the Kisumu West district population (CBS-Kenya et al., 2004). Approximately 45% of the population in the division are poor with the main sources of their income as; low subsistence farming, small-scale business and casual labour; however, many of the youths are not gainfully employed (Ministry of Finance and Planning, 2001). There are 8 health facilities and 30 community based organizations involved in HBC for PLWHAs. In Kisumu district there was a prevalence of 11.2% HIV and AIDS and an average of 3, 500 PLWHAs were under HBC services (Jones, 2006).

Study population

The study included 248 caregivers, sampled from a sampling frame that included 420 home-based caregivers who was involved in HBC activities and registered in Maseno division. Our inclusion criteria comprised of consenting persons of either gender, above 18 years of age, residing in the study area that were providing HBC service to people living with HIV/AIDS (PLWHAs). They were required to be registered members of a community based AIDS support group. And were approached and permission sought to interview members of a support group through their contact persons to whom we explained the aims and purpose of the study. Meetings were held with members of the support groups to explain the study aims and procedures. Thereafter, individual members volunteered to participate in the study after providing written consent.

Sampling technique

Purposive sampling was used to identify the study area and simple random sampling was used to select functioning support groups which were involved in HIV and AIDS care and support. Maseno division was purposely selected for logical convenience to the researcher and because it had a high prevalence of HIV positive people of 8% in comparison with the national prevalence of 7.8% (UNAIDS, 2009). The location and current activities were used as major dimensions to select the functioning support groups. Thereafter, simple random sampling was also used to select the actual participants (Mugenda and Mugenda, 1999). Sampling was done by numbering all 420 caregivers in each support group by using a table of random numbers. The starting point in the table was determined by randomly picking a page and dropping a finger on the page with eyes closed. Then numbers were chosen up and down, until the 248 required sample size was obtained. Once a number was chosen, it was not chosen again. A list of all HIV and AIDS care givers in Maseno division was obtained from the Ministry of Health office, Kisumu.

To get the required sample size that was involved in the study, individual caregivers were selected proportionately across the 14 functioning support groups during their meeting (Table 1), using the following formula:

$$\frac{n_i}{n} \times N$$

Where n_i = number of group members in the support group; n = total number of group members in all the support groups; N = required sample size.

Data collection

A semi-structured questionnaire was administered by two research assistants to consenting participants, at the meeting venue of the support groups. The questionnaire was developed to include level of male involvement, demographic, attitude, social and cultural variables. The items on attitude and opinion included Likert-type scales with responses ranging from 1 (strongly agree) to 5 (strongly disagree). To measure the level of male involvement, we asked 13 questions on aspects of home-based care (counseling, accompanying patient to clinic, bed bathing, following up patients) and the response was measured on a 5-item Likert scale (ranging from not at all=1, to completely involved=5). We then computed the mean level of involvement for each activity and also ranked the mean values to identify the most and least preferred care activities. The instrument also included open-ended questions to assess the community attitude and views on how to tackle them to involve men in HBC activities. The interview lasted for an average of 20 min. We had a male and female research assistant who had completed secondary education, spoke the local Dholuo language and were residents of Maseno division.

The questionnaire was pre-tested with 20 formal caregivers from

Table 1. Distribution of respondents by community based organizations (support groups).

Name of support group	Number of caregivers	Desired sample size per group proportion (percentage)
Ampath support group	49	29 (12.69)
Zingatia post test club	46	27 (10.88)
Positive men against Stigma	44	26 (10.48)
Grail COFFIDO support group	37	22 (8.87)
Mercy drop women group	34	20 (8.06)
Rise talk post test club	32	19 (7.66)
Wings of love	30	18 (7.25)
Bongu women group	29	17 (6.85)
Baraka support group	25	15 (6.05)
Misiani women group	24	14 (5.65)
Kakamu self help	22	13 (5.24)
Oloo women group	19	11 (4.43)
Nema support group	17	10 (4.03)
Kakamun Group	12	7 (2.82)
Total	420	248

Maseno division who were not included in the study, to refine it and identify any potential errors. The pretest sample was similar as possible to the study sample and the interviews took place in conditions similar to those of the actual questionnaire administration. The consent form and semi-structured questionnaire were translated into the local Dholuo language.

Ethical consideration

The permission to carry out the research was obtained from Maseno University, School of Graduate Studies, Medical Officer of Health of Kisumu west District, Commissioner of Kisumu District and the area Chief. The permission was sought to interview members of a support group through their contact persons to whom we explained the aims and purpose of the study. Meetings were held with members of the support groups to explain the study aims and procedures. Thereafter, individual members volunteered to participate in the study after providing written consent.

Data management and analysis

Quantitative data was cleaned, coded, entered and analyzed using SPSS version 12.0 for Windows (SPSS Inc., Chicago, IL) computer software. Descriptive (frequencies, percentages, means and standard deviations) and inferential analyses was performed to determine the association between socio-cultural constraints and level of male involvement in HBC activities.

From the Likert scale, mean scores were used to create the rank as recommended by Guberman et al. (2001). Interpretation of the descriptive statistics was used to identify the significant constraints. The five point Likert scales were treated as if it is interval and computed the mean statistic. Mean values of 2.50 and above were considered negative attitude while a mean below 2.49 was considered positive attitude. The mean score that was above 2.50 was considered presence of socio-cultural constraints, while below 2.49 was considered no presence of socio-cultural constraints. Attitude with mean above 2.50 was considered positive attitude while mean below 2.49 was considered negative attitude. Correlation analysis was performed to compute the strength of association and cross tabulation to measure the statistical significance (from Pearson's chi-square). Subsequently, multiple regression analysis was used to investigate the trends in the significant relationships. The confidence level chosen for this study was 95%.

A three stage thematic approach was used to analyze the qualitative data: In the first stage, transcribed document were read and re-read in order to generate explanation addressing the basic research open-ended questions; during the second stage, these were sorted into specific themes; lastly, the third stage was the systematic organization (coding) of the entire data and matching it with the relevant research questions. This allowed for an understanding of the extent to which the qualitative data generated information directly related to the primary aim of the study and provided explanations for the key findings from quantitative analysis.

RESULTS

The overall response rate was 224 (90%) out of 248 potential participants invited. Some of the reasons for non-response included inability to attend interviews due to bad weather (heavy rains), refusal and incomplete data.

Socio demographic characteristics

Majority of the caregivers (161 (71%)) were female compared to 63 (29%) who were male. The mean age of the participants was 38.24. The mean age of the males was 40.05, while that of the females was 37.53 at p=0.134 (not statically significant). Most of the respondents (79 (37.4%)) were aged between 30 and 39 years. Nearly half (105 (47.9%)) had secondary level of education while only 22 (10%) had no formal education. More than half (123 (56.2%)), of the respondents were married and 105 (49.3%) had no formal employment. The majority of the respondents (130 (59.7%)) had not been formally trained on home-based care while only 88 (40.4%) were trained.

The gender of the care recipients was variable: 144 (68.2%) were attended by both male and female, 38 (18%) were female and 29 (13.7%) were male. Most of the patients (61 (31.3%)) were aged below 19 years while 6 (3.1%) were 50 years and above. About three quarters of the respondents were taking care of other relatives (164 (74.9%)) followed by grandchildren (17 (7.8%)) and spouses (15 (6.8%)). The number of patients taken care of by the respondents ranged from 1 to 20 with a mean of 4 (SD = 3.1). Table 2 is a summary of the demographic characteristics of the participants.

Level of male involvement

This study concentrated on 13 practices/activities in home based care (HBC) operationally coded as variables. A descriptive analysis of the reported levels of male involvement per activity was done. The respondents reported varied extent of male involvement in the practices. Almost all of the HBC practices had high frequencies reported of no male involvement except only 18 (8.4%) who participated in buying food to take home or make referrals to the health centers. Overall, the men participated less than women in all the HBC activities except assisting in lifting the patients or physical therapy, (22.4 vs. 23%) and providing first aid for burns and wounds (25 vs. 19.3%).

The overall reported level of male involvement was established per respondent and the frequency categorized into the respective category. Majority (42.9%) of the males felt that males were involved to a little extent, while majority (44.9%) of females felt that the males were involved to some extent (Figure 1). On open-ended respondent in the study said, "*Fathers can not take care of the sick. They only help out with money once in a while".* Another woman remarked, "*You know males, they are not that sensitive. Mothers can take care of so many things. Most males do not like taking care of sick people… women are patient and caring. Men cannot be like that".* There was a feeling that men do not want to work with women and if they do, they want to assume leadership and command the women. Further analysis indicated the following ranked mean scores in terms of level of male involvement per activity in Table 3. Overall, most score for individual activities were low involved from nursing to general activities on level of male involvement except for buying and taking food home (μ=2.95, SD=1.15) and making referral to health care centers (μ=2.72, SD=1.18) for which their mean scores were higher than 2.50 in Table 3.

Association of male involvement with socio-demographic factors

On cross tabulation socio-demographic variables of the respondents with the overall reported level of male involvement, there was statistically significant relationship with occupation and number of patients being taken of by the respondents. Those respondents who had high number patients (10 and above) were statistically more likely to report lower levels of male involvement than those who had lower number of patients (χ^2 =61.69, p= 0.025). Also, those respondents who reported to have no employment were statistically more likely to report lower levels of male involvement than those who had employment (χ^2=17.18, p=0.046). Similarly, response from open-ended questions indicated that males found it difficult to work as volunteers as they were breadwinners. Even though they were unemployed they were given some stipends. However, they felt the stipends they received were too low and not able to satisfy their societal role of being a breadwinner - *"Men can not work for volunteer in HBC because they are breadwinners; who should provide for the family, maybe, if they are paid".* Another respondent indicated that: "*even if they are free, men do not like working where they are not paid, even at home they ignore helping in domestic work*". An increase in the stipends may help enhance recruitments of males to care-giving. Men are ignorant when it comes to some work at home, such that they are left for their wives.

On further analysis of open-ended questions, other reported beliefs which hinder male involvement in HBC activities were identified: majority of the respondents (102 (56%)) indicated that in their community, HBC activities are believed to be the work of women; 50 (27.6%) respondents indicated that men fear getting infected with HIV, while 43 (22.4%) said that they should be paid for any HBC activities they do. Additionally, 57 (31.5%) respondents said that men feared being associated with HIV and AIDS in home-based care activities, 49 (27.2%) indicated that the men felt they may be perceived to conduct wife inheritance when giving HBC services to the opposite sex, while 36 (19.9%) indicated that men did not have the heart of caring that can induce them the HBC activities for the sick and others. Lastly, 20 (11%) indicated that men are ignorant when it comes to some work at home, such that they are left for their wives (Table 4).

Table 5 presents results of the descriptive analysis of the caregivers' reported attitude of the community towards various practices. Over 50% of the care givers agreed that men should be involved in care giving for people living with HIV; HBC programs makes little effort to involve men and that men volunteers can attend HBC training. They were not in agreement that HIV voluntary services are meant for women and the male patients should be attended to by men only. However, it was not clear if the men were wiling to be involved in HBC activities or not (Table 4).

Ranking of the caregivers perceptions on community attitude towards male involvement

The attitudes towards various practices were scored and

Table 2. Socio-demographic characteristics of the respondents (N=224).

Variable		Gender				Total	
		Male		Female			
		n	(%)	n	(%)	n	(%)
Age (years)	19-29	5	(8.2)	39	(26.0)	44	(20.9)
	30-39	29	(47.5)	50	(33.3)	79	(37.4)
	40-49	18	(29.5)	38	(25.3)	56	(26.5)
	50-59	3	(4.9)	15	(10.0)	18	(8.5)
	60 and above	6	(9.8)	8	(5.3)	14	(6.6)
Education	None	1	(1.6)	21	(13.5)	22	(10.0)
	Primary	2	(17.5)	39	(25.0)	50	(28.8)
	Secondary	33	(52.4)	72	(46.3)	105	(47.9)
	Tertiary	18	(28.6)	24	(15.4)	42	(19.2)
Marital status	Married	48	(76.2)	75	(48.1)	123	(56.2)
	Single	2	(3.2)	9	(5.8)	11	(5.0)
	widow or widower	11	(17.5)	70	(44.9)	81	(37.0)
	Divorced/separated	2	(3.2)	2	(1.3)	4	(1.9)
Occupation	salary employment	7	(11.5)	6	(3.9)	13	(6.1)
	self employment	31	(50.8)	53	(34.9)	84	(39.4)
	casual employment	6	(9.8)	5	(3.3)	11	(5.2)
	None	17	(27.9)	88	(57.9)	105	(49.3)
Gender of the patients the respondent has	Males	6	(10.3)	23	(15.0)	29	(13.7)
	Females	12	(20.7)	26	(17.0)	38	(18.0)
	both sexes	40	(69.0)	104	(68.0)	144	(68.2)
Age(Years) of the patients the respondent has	19 and below	6	(11.5)	55	(38.5)	61	(31.3)
	20 to 29	15	(28.8)	42	(29.4)	57	(29.2)
	30 to 39	18	(34.6)	21	(14.7)	39	(20.0)
	40 to 49	11	(21.2)	21	(14.7)	32	(16.4)
	50 and above	2	(3.8)	4	(2.8)	6	(3.1)
Relationship with the patient	Partner	8	(12.7)	7	(4.5)	15	(6.8)
	Parent	4	(6.3)	3	(1.9)	7	(3.2)
	Child	4	(6.3)	12	(7.7)	16	(7.3)
	Grand child	2	(3.2)	15	(9.6)	17	(7.8)
	None	45	(71.4)	119	(76.3)	164	(74.9)
Formal training of the respondents in HBC	Yes	24	(38.7)	64	(41.0)	88	(40.4)
	No	38	(61.3)	91	(58.9)	130	(59.7)

they ranged from 4.12 down to 3.62. On order of reducing negativity (based on these mean scores), the community was perceived to bear the following attitude scores for the various variables: men and boys should be involved in HBC (μ=4.12, SD=0.62), HBC volunteering is meant for women (μ=3.85,SD=0.74), HBC programmes do little to involve men (μ=3.73, SD=0.72), men are willing to be involved in HBC activities (μ=3.72,SD=0.83), male patients be attended by male only (μ=3.70, SD= 0.95) and male volunteers can attend HBC trainings if invited (μ=3.62, SD= 0.73). Overall, all the score for individual attitude variables were negative for which the score was higher than 2.50 mean score.

Caregivers' perceptions on attitudes of selected community members

The total frequencies of almost all the caregivers' perceptions on attitudes of selected community members

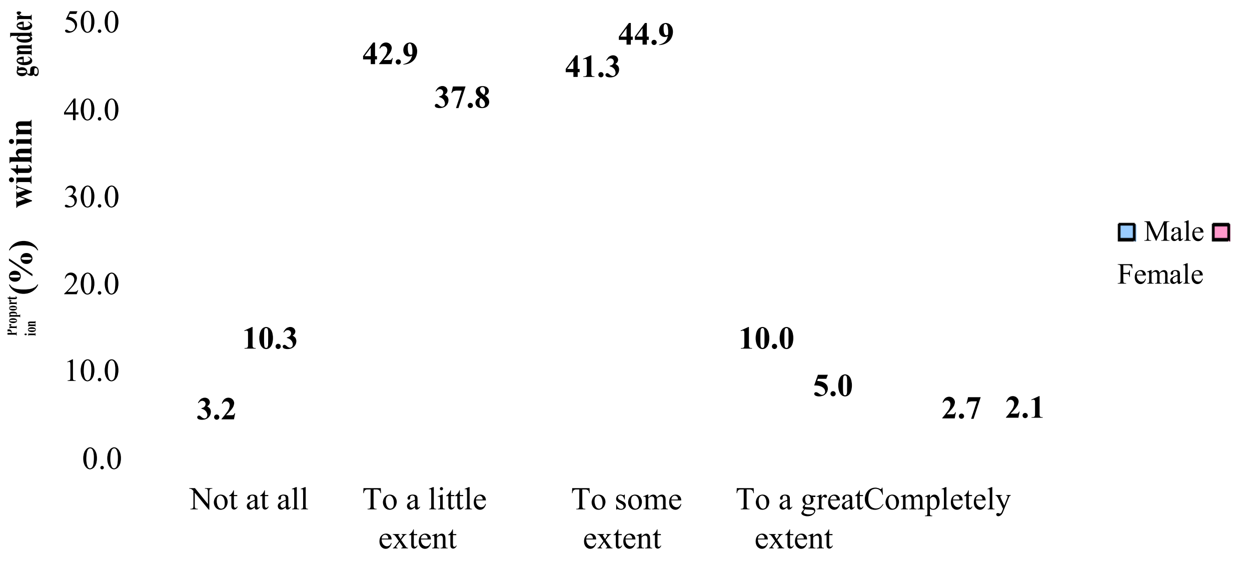

Figure 1. Reported level of male involvement in home-based care (N=224).

Table 3. Total ranking of the level of involvement by mean scores (N= 224).

Involvement activities	Mean score	Standard deviation
Nursing activities		
Change soiled beddings	1.33	0.61
Bed bath HIV and AIDS patients	1.61	1.42
Support lift and physical therapy	1.68	0.74
Provide first aid for burns and wounds	1.71	0.71
Monitoring the health of the HIV patients	1.80	0.87
Follow up drug prescribed to patients	1.81	0.96
General activities		
Attending home-based care trainings	1.86	0.83
Cook and feed HIV and AIDS patients	1.91	0.99
Fetch water and make cleanliness	1.98	0.88
Counseling and giving spiritual support	2.03	0.80
Attending home-based care trainings	2.22	1.17
Make referral to the health care centers	2.72	1.18
Buy and carry food to home	2.95	1.15
Total mean score	1.97	0.95

Table 4. Socio-cultural factors hindering male involvement.

Factors	Number	%
Fear of HIV infection	50	27.6
HBC work for women	102	56
HBC activities not paid	43	22.4
Fear of being associated with AIDS patients	57	31.5
Perceived to conduct wife inheritance	49	27.2
Men lack heart of caring	36	19.9
Men’s ignorance	20	11

Table 5. Attitude towards practices on male involvement (N=224).

Variable	Response	Total	
		N	(%)
Male patients should be attended to by male only	Disagree	168	(78.9)
	Neither agree nor disagree	34	(16.0)
	Agree	11	(5.2)
HBC volunteering is meant for women	Disagree	142	(67.3)
	Neither agree nor disagree	32	(15.2)
	Agree	37	(17.6)
HBC programmes do little to involve men	Disagree	65	(31.6)
	neither agree nor disagree	24	(11.7)
	Agree	117	(56.8)
Male volunteers can attend HBC training	Disagree	21	(.9.9)
	Neither agree nor disagree	45	(21.3)
	Agree	145	(68.7)
Men are willing to be involved in HBC activities	Disagree	90	(42.5)
	Neither agree nor disagree	68	(32.1)
	Agree	54	(25.4)
Men should be involved in care giving for people living with HIV	Disagree	12	(5.8)
	Neither agree nor disagree	9	(4.3)
	Agree	188	(89.9)

were indicated to be the highest negative except the attitude of the 145 (67.1%) PLWHAs indicated to be the highest positive. However, their proportions varied in percentages as shown in Table 5.

Ranking of caregivers' perceptions on attitudes of the selected community members

The mean score for general attitude ranged from 2.98 down to 1.77. The mean score ranked as follows in descending order were; attitude of patients (μ=2.98, SD=1.09), men (μ=1.95, SD=0.72), family members (μ=1.76, SD=0.64) and society members (μ=1.57, SD=0.61). Overall, most score for caregivers' perceptions on community member attitudes were negative except that of patients (μ=2.98, SD=1.09) for which the mean score was higher than 2.50.

General caregivers' perceptions on attitude of community members towards male involvement in HBC

On further analysis of the various reported caregivers' perceptions on attitudes of selected community members, 96 (46.2%) reported that community members had a negative attitude as displayed in Figure 2.

Attitude as an influential factor on level of male involvement

On cross tabulation of the general caregivers' perceptions on attitude of selected community members against the reported level of male involvement, results indicated statistically significant association between community attitude and level of male involvement in HBC activities (r = -0.39, p = 0.001). Further analysis found out a relationship: those respondents who reported negative attitude were statistically more likely to report lower levels of male involvement than those who reported positive and enthusiastic attitudes (χ^2=34.53, p = 0.001). These findings may suggest that community's negative attitude make a negative influence on male involvement in HBC for people living with HIV and AIDS.

DISCUSSION

Gender disparity in terms of roles was observed to exist in the studied population. The results from the random

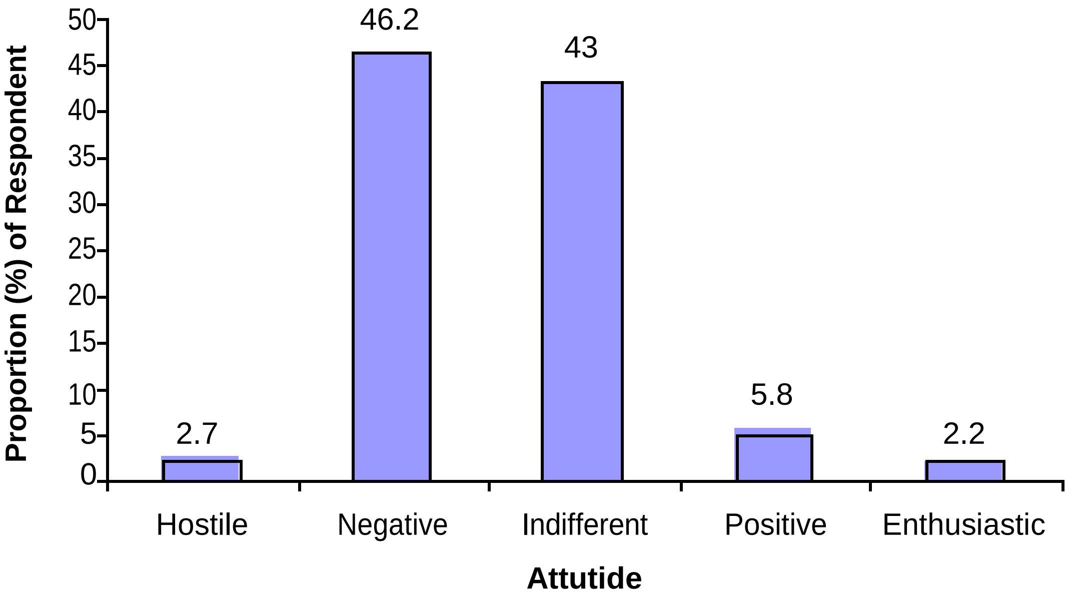

Figure 2. Caregivers' perceptions on attitudes of selected community members (N=224).

selection of the caregivers showed that the majority of respondents (caregivers) were females compared to males. This gave evidence that there was low male involvement in HBC programmes and activities in the study area. The result concurred with other studies by Kavuma et al. (2004) and Kenya NGOs Consortium (2006) who mentioned low male involvement in HBC interventions being reported by health workers and service providers both at institutional and community grassroots levels. Further review of literature indicates that males did not volunteer to become caregivers; often they had no choice because the females were not available (Kipp et al., 2007).

Additionally, the majority of the age category of the caregivers was 30 to 39 years; followed by 40 to 49 years on both genders that were in the younger and middle age group, although a significant difference ($p<0.005$) was noted on age category of 19 to 29 years where more women were involved in the care than men. Since HIV and AIDS mainly affect the population between 15 to 45 years (Kipp et al., 2006), this study results also showed that between 19 and 49 years had more patient taken care of by the respondents due to HIV epidemic affecting the age group.

The majority of the respondents had not been formally trained on home-based care services. This concurred with a study done in Kiambu, Kenya, which indicated very few caregivers had appropriate training and were worried about their lack of knowledge and yet, were to care for patients. It was evident that they lacked a framework that would provide the capacity to facilitate home-based care. Such a framework would bridge the gap between the noble concept of HBC and the reality of HBC (Olenja, 1999). Similarly, in Botswana family care giving was poor because family caregivers were not trained to provide basic care (Ndaba-Mbata and Seloilwe, 2000).

From this study, results revealed a generally low level of male involvement. However, on specific elements of involvement, males were seen to be slightly more involved in buying and taking food home compared to the other HBC activities. Some activities were much lower like the nursing activities; feeding, bathing, and wound care. This concurred with a study done in eastern Zimbabwe which found that voluntary caregivers had difficulties to provide certain nursing activities (Johnson, et al., 2003). It also agreed with a study done in South Africa which indicated that men rarely assisted with care giving. When men do assist like bathing patients, cleaning and treating pressure sores, women caregivers often feel uncomfortable as opposed to when men assist with hospital visit and arranging transport for the sick (Akintola, 2004).

The research findings exhibited a noticeable community attitude that hindered male involvement in HBC for PLWHAs. The study revealed the presence of negative attitude toward male involvement in the community which might be induced by socio-cultural factors because HBC is traditionally, in Africa, believed and left to be the work of girls and women (MacNeil, 1996). Therefore, men have the stereo-type attitude toward care giving activities due to gender roles. The study concurred with a study done in South Africa on the general consensus that many of the affected families and the communities in general did not provide support but instead, held negative attitude toward the volunteers and volunteering which changed after frequent visits (Akintola, 2005). This suggested that people's general attitude towards people with HIV and AIDS determines whether or not they will really care for them, as well determines male's involvement in care. This agrees with a study done in Kiambu, Kenya which showed that the community in general reacted negatively with regard to the care for people with HIV and AIDS (Olenja, 1999). However, the patients indicated a positive attitude towards male involvement in HBC for PLWHAs which showed that they were willing to be attended by men, suggesting that a sick person would like to get help from anybody, even men. These findings were also similar to those by a study done in South Africa which showed that men were willing to participate and provide care and support to the HIV positive partners during pregnancy (Kunene, 2003). This could happen because for the case of married couple, they still have intimate love for each other unlike for the case for male caring for the other family member or community members.

On cross tabulation of the general attitude of selected community members against the reported level of male involvement, results indicated statistically significant relationship. Those respondents who reported negative attitude were significantly more likely to report lower levels of male involvement than those who reported positive, indifferent and enthusiastic attitudes. Also, in the open- ended questions, the male feel that men need to be sensitized toward home-based care and that more information about the field should be made available to them. Men still look down on care-giving, and this may be due to lack of information on what the field entails. Within the community, care-giving is still portrayed as women's work, and for this to change, more information and education should be given to men and the community.

CONCLUSION AND RECOMMENDATIONS

The study indicated low male involvement and a negative attitude influence on the level of male involvement in HBC for people living with HIV and AIDS. There is need to make the involvement of men in the care of sick family/ community members more positively acceptable to alleviate some of the women's high work load. Therefore, trainings through seminars and workshops should be organized by the government and non-governmental organizations to improve and encourage male in giving home-based services.

Limitations of the study

The limitations of the study were the following:

1. The population surveyed represented formal caregiver and health workers involved in HBC activities in Maseno division. In this case, the study may not be generalized to all HBC programmes outside Maseno division.
2. Lack of ability for the researcher to control extraneous factors in the HBC activities current training and general HBC trends.

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