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Community Support Groups and Home-Based Care among Persons Living with HIV and AIDS in Lira District, Uganda

Zamaradi Auma[1], Gilbert Obici[2], David Mwesigwa[3]
Public Administration and Management, Lira University, Uganda[1,2&3]
zammuma@gmail.com[1],obicigilbert89@gmail.com[2], dmwesigwa@lirauni.ac.ug[3]

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Abstract
Purpose: This study investigated the contribution of Community support groups on Home based care to Persons Living with HIV in Lira District.
Research Methodology: We adopted a cross-sectional research design among a sample of 226 respondents. Using both the Self-Administered Questionnaires and an Interview Guide.
Results: The findings suggested that Community support groups (μ=4.959, SD=0.5393) help in enhancing home-based care for PLHIV in Lira District. Further, Community support groups had a significant effect on Adherence to ART (β=0.641, P<0.05), Nutrition support (β=0.581, P<0.05), and Palliative care (β=0.638, P<0.05).
Limitations: This study covered only one district in the entire Lango sub-region yet if more districts were included, possibly the outcomes would have been different.
Contribution: This study contributes empirical evidence of the association between Community support groups and home-based care to PLHIV in Lira District. Therefore, for improved home-based care for PLHIV, stakeholders are encouraged to mobilize local communities to form Community support groups so that they can be able to offer support to PLHIV.
Practical implication: The study contributes to practice since HBC CSG can be used as a tool for improving the level of palliative care among the PLHIV in the local community given that the care for PLHIV has greatly moved away from the hospital-based to home-based.
Novelty: Studies on Community support groups are still limited since much of the literature originates from other parts save for Uganda and it is worse for Lira district.
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1. Introduction

1.1 Research background

Care for Persons Living with HIV (PLHIV), under the Home-Based Care (HBC) programs, originated in North America and Europe over four decades ago where it was emphasized that HBC ought to be all-inclusive, gainful, and prudently synchronized so as to make hospitalization a reality (Larki & Roudsari, 2020). The need for HBC has long been part of Human Immunodeficiency Virus (HIV) care before the era of Anti-Retroviral Therapy (ART) even though the availability of ART has not decreased (Halima, Patricia, Lisa, & Asabe, 2016). The World Health Organisation, governments, and caregivers of PLHIV acknowledge HBC as a necessary component of HIV care and support with the view of assisting families and caregivers in providing HIV-related care to patients with a view of reducing the

burden on hospitals caring for PLHIV. In Nepal, HIV-positive people do experience up to 25% depression and 15% engage in substance use leading to mental health disorders (Pokhrel et al., 2018). Through HBC interventions, that challenge was addressed through monthly home visits to the affected.

Scaling up HIV programs in low and middle-income countries such as in Africa necessitated both donors and policymakers to direct their interests to the roles of lay community health workers in the provision of services needed by the PLHIV (Wringe, Cataldo, Stevenson, & Fakoya, 2010). This is because comprehensive HBC programs are the best strategies for ensuring a continuum of care and support for PLHIV within their home environments. In sub-Saharan Africa (SSA), HBC agendas were established as an intervention based on specific needs given that earlier alternatives seemed to threaten the consequence of HIV and AIDS where the ingenuity of HBC was delivered through a partnership between non-state actors and health workers. Ideally, HBC includes any form of care (psychosocial, palliative, spiritual, and physical), which can be given to the PLHIV and the affected within their own homes (Massavon et al., 2014). This formula of family participation (synonymous with local citizen participation, Mwesigwa, Bogere, and Ogwal (2022)) and community involvement grew as an alternative model in the wake of the HIV and AIDS epidemic in SSA. Up to 90% of proven care can be delivered through a home-based formula, especially in rural settings (Halima et al., 2016). Thus, HBC will always play a valuable and strategic role in complementing existing healthcare services by extending the continuum of care for PLHIV and their families in their homes. For instance, studies in South Africa highlighted the significance of linking and retaining newly diagnosed clients in care using community-based interventions such as HBC, tracking of clients, and family counseling (Kave, Khuzwayo, Hatcher, & Sikweyiya, 2019). In Ethiopia, 92.8% of respondents suggested that the home is the finest environment to care for PLHIV (Larki & Roudsari, 2020).

In East Africa, HBC became an innovation in the provision of a range of services aimed to meet the needs of PLHIV in resource-limited settings (Iacono & Allen, 2011). It focused on bridging the link between healthcare services and home-based care by supporting PLHIV to get excellent care from home as exhibited in Kenya where CBOs implement 80% of the country's HIV and AIDS interventions. Meanwhile in Uganda, a community HBC program was established in 1987 as a response to the increasing number of very ill HIV and AIDS patients that left hospital wards congested, increased health workers' workload, and massive pressure on the infrastructure. This approach was pioneered by three different organizations, viz: The AIDS Support Organization (TASO), the Kitovu Mobile HIV program, and Nsambya Home Care (Massavon et al., 2014). These revelations attest to the fact that HBC has been considered a common approach to taking care of PLHIV within their home environments (Osafo, Knizek, Mugisha, & Kinyanda, 2017).

1.2 The idea of Home-Based Care (HBC)

According to Malale (2011), HBC is a form of care offered to patients from their respective homes such as palliative care, emotional support, and Godly care to offer hope that helps to realize the finest value of life. HBC is described according to various types such as informal HBC, single-service HBC, and integrated HBC (Wood, Zani, Esterhuizen, & Young, 2018). Therefore, HBC refers to the informal care and support given to the PLHIV, by the community's informal caregivers in terms of activities that tackle adherence support to PLHIV, every support that ensures the nutrition safety of PLHIV, and all aspects of palliative care offered by informal caregivers. HBC is not a new phenomenon, for example, acute deficiencies from enduring infections, a number of people wanted to stay in their home environment (Iezzoni, Gallopyn, & Scales, 2019). Access to HBC is, nonetheless, determined by the possession of resources to meet the cost and favorable government policy and legal framework. Given that HBC embraces local teamwork and networking (Mwesigwa, Acanga, Chono, & Oboi, 2023), it has been embraced worldwide as an alternative service delivery model for PLHIV to fill the gaps in the formal healthcare system.

1.3 Research gap

Several studies reveal the worthiness of CSGs when it comes to implementing activities, especially health. A study conducted in Mbandazayo, Eastern Cape province revealed that activities such as provision of food parcels and crop harvest among the PLHIV were important in inspiring recently

identified clients to stay inside the radar of clinics and nurses connected with those support groups (Kave et al., 2019). This is so despite the work stress experienced by nurses and other local government officials (Dewi, 2022; Latunusa, Timuneno, & Fanggidae, 2023). Accordingly, a systematic review by WHO (2016), identified seven cohort studies that fixed peer support effectiveness in increasing linkage to care through home calls and group care, as well as for circumnavigating the healthcare structure, besides improved psychotherapy (2016). Furthermore, Preston, Waugh, Larkins, and Taylor (2010) revealed broad outcomes associated with the participation of CSGs in linking PLHIV to healthcare services where 38% of the studies reported improved health outcomes associated with CSGs. In Uganda, HBC is regulated by MoH (2010) which outlines the empowerment of individuals and communities for an extra part in healthcare expansion by reassuring and empowering communities (as a managerial concern, Adula, Kant, and Birbirsa (2022)) to take part in managing Village Health Teams (VHTs) and Health Unit Management Committees (HUMCs) as one of the strategies in handling community health.

1.4 Problem Statement

Despite several attempts to improve the lives of PLHIV and achieve the required health status for all through interventions such as the Presidential fast track initiative (PFTI) on eliminating HIV and AIDS in Uganda, inaugurated in June 2017 to fast-track testing, treatment as well as attainment of the 90-90-90 strategy to ensure financial sustainability for the HIV and AIDS response; and ensure institutional effectiveness for a well-coordinated multi-sectoral response, has not yielded considerably in regards to community support to PLHIV (UAC, 2022). Accordingly, the National HIV and AIDS post-discharge linkage and outcomes of HIV-positive patients admitted with advanced diseases at tertiary Hospitals indicate 60% of PLHIV are linked to a lack of PLHIV support (UAC, 2022). A study conducted by Isabirye et al. (2021) among PLHIV attending the open ART delivery groups at Lira Regional Referral Hospital (LRRH), revealed that 39.3% (59/150) of the clients absconded on their medication in more than a month. Furthermore, it was revealed that the viral suppression rate of Lira district stood at 75% only, which is contrary to the 90% viral suppression policy (UAC, 2022). Much as the HBC approach plays a significant role in enhancing ART, few studies have focused on the aspect. Consequently, this study examined the contribution of PLHIV support groups to HBC for PLHIV in Lira District.

1.5 Objectives of the Study

This study examined the contribution of the community support group on HBC for PLHIV in Lira District. Specifically, the study addressed three specific objectives, namely: (i) to examine the contribution of a Community support group in Adherence to ART; (ii) To analyze the contribution of a Community support group in Nutrition support to PLHIV; and (iii) to examine the contribution of a Community support group in Palliative care to PLHIV.

1.6 Theoretical framework

This study was premised on the Social capital theory (SCT). Its basic premise is that a network provides value to its members by allowing them access to the social resources that are embedded within the network (Bourdieu, 1986; Florin, Lubatkin, & Schulze, 2003). These social networks need to be developed through investment strategies oriented towards the institutionalization of group relations, which are reliable sources of benefits. In general, social capital can be broken down into two elements: (a) the social relationship itself, which allows individuals to claim access to resources possessed by their associates, and (b) the amount and quality of those resources (Bourdieu, 1986). However, the SCT appears to be based on the fact that a person's family background and acquaintances take up an essential portion that can be taken advantage of when there is a need or leveraged for capital gain. In spite of that, the SCT is vital in illuminating and appreciating the significance of interventions in healthcare structures such as the CSG in providing care and support to PLHIV.

2. Literature review

2.1 Structure and formation of a Community Support Group (CSG)

A CSG is a gathering of people who share a common health problem. These people come together in order to share experiences, get information and provide emotional support to each other to cope with their condition. It focuses on a specific situation or condition, such as HIV and AIDS, cancer, diabetes,

or heart disease. In this manual, we are discussing support groups for PLHIV and AIDS. Support groups for PLHIV are self-forming. A support group is formed when a few PLHIV in a particular location would like to meet to share experiences and assist each other in how to live a healthy life. For a support group to be recognized by the National Association of People Living with HIV and AIDS Manual (NAPHAM) it must have at least a minimum of 15 members. There should be one support group per Group Village Head.

2.2 The Contribution of CSGs towards Adherence to ART

According to Achappa et al. (2013), adherence to ART refers to a patient's capability to follow a treatment plan, take medicines at prescribed times and frequencies, and follow restrictions regarding food and other medicines, and Ammon, Mason, and Corkery (2018) define it as an individual's competence to take drugs at recommended times, as per Byrd et al. (2019), adherence to ART is an act of appropriately taking ART throughout one's lifetime to suppress the virus. These definitions agree that adherence to ART is an aspect to do with consistency in taking ART with key concern on the specific time of taking such medication. However, they ignore the force behind the adherence which could either be individually motivated or communal motivation, and the essence of the consistency in taking such treatment that would lead to viral suppression, improved immunity, reduction in the risk of HIV and AIDS transmission, combat ART resistance which is considered useful ingredients of adherence to ART. Suleiman and Momo (2016) regarded it as the magnitude to which one's adherence to ART, nutrition, and changes in lifestyle relates to the set standard by a healthcare provider for ART to be effective, a high level of continued adherence is essential to suppress viral replication, improve immunity, and clinical outcomes, reduce the risks of developing resistance to ART, and reduced the risk of HIV and AIDS transmission. To them, adherence to ART depends on some patients' variables such as income, literacy level, and age, and of most importance to this study is social status. Also, community participation would aid HBC through the provision of services that were previously provided by professional nurses and within the health facilities. This is because HIV and AIDS require perfect or near-perfect adherence to attaining fruitful treatment outcomes. Therefore, in guiding this study, adherence to ART will refer to taking medications and other interventions which are medical and non-medical correctly as per the prescription.

Jobarteh et al. (2016) conducted a study to examine the effect of Community ART Support groups on Adherence to ART, a component of HBC in Mozambique, particularly on the retention of the treatment using the Community Adherence and Support Groups (CASG) model, a model that empowers PLHIV to achieve inter-personal relationship and relationship with the health structure in improving their care through collecting and distributing drugs in the community in turn with the study population of PLHIV on ART who are members and non-members of Community Adherence and Support Groups in the 68 health facilities within in the country and using the study population of 6,760 CASG members. The author found out that non-Community Adherence and Support Groups members had a higher loss to follow-up (LTFU) rate compared to the Community Adherence and Support Groups members, recorded that the rotational drugs collection by the six members of the Community Adherence and Support Groups decreased the facility visits acting as a sound opportunity outlay reaped by underprivileged clients throughout their social call at the clinic, sharing of the treatment experienced by the group members, counseled the group members with poor adherence leading to improved adherence, motivation and confidence resulting to better social, psychological and physical wellbeing that improved the health outcome. The model that was piloted indicated retention among Community Adherence and Support Groups members to be at 97.5% with only 0.2% as LTFU and 2.3% having died at the time of the median follow-up report after 13 months.

Kave et al. (2019) carried out a study on the effect of PLHIV support groups on adherence to art. The study was qualitative in nature and meant to ascertain the significance of support groups in connecting and maintaining the fresh HIV clients in the city of Eastern Cape revealed that adherence clubs as a form of community-based intervention intended to ease suffering, reinforce relationships and PLHIV retention has lived to its expectation in holding patients in care as support groups maintain the bond between recently identified patients and the health services, alleviate the consequence of shame, serve as a tool for both activism and coordination, and act as community openings where physical needs are

met. Concretely, the findings suggest that, with the onset of Universal Test and Treat (UTT) in South Africa, support clusters have a considerable part in retaining PLHIV who are enrolled in ART. Although the finding of the study indicated community support groups had a significant effect on adherence to ART, the study was only qualitative and therefore enabled only qualitative data to be collected. This study, therefore, bridged that gap by employing both qualitative and quantitative approaches because it enabled the collection of both narrative and numerical data.

Willis et al. (2019) revealed that community support is an ideal mechanism as the adolescents living with HIV and AIDS receiving Community Adolescent Treatment Supporters (CATS) facilities had upgraded both adherence and psychosocial welfare when compared with the young people who lacked access to CATS services. Correspondingly, Nyoni et al. (2020) revealed that a number of treatment supporters comprised of community health workers, and family members. Mokwele and Strydom (2017) alluded to the gap in the services to PLHIV in the community and attributed this to the dearth of family support. Similarly, Chime, Arinze-Onyia, and Obionu (2018) exposed an adherence level of 95% among PLHIV in peer support groups and 87% among those outside support groups. Although the study revealed a significant effect, it was conducted in a different geographical scope hence the need for a similar study in Lira district since the finding of a study by Chime et al. (2018) cannot be used to generalize the situation in Lira district.

2.3 The Contribution of CSGs towards nutrition support to PLHIV

In a study by Hodgson, Nakiyemba, Seeley, Bitira, and Gitau-Mburu (2012), community participation was found to have a direct linkage to the nutrition support to the PLHIV that was through the collaboration among the support group members in learning the agricultural skills possessed by a few group members that improved income and nutrition status for PLHIV through mushroom and passion fruit growing, and beekeeping among other practices. The gap in the nutrition to PLHIV was in the barriers to food insecurity among the PLHIV mentioned in four districts, yet lack of food is directly linked to ART adherence (Tafuma et al., 2018). However, much as the study indicated that community participation has a direct link with nutritional support to PLHIV, it was conducted in Zimbabwe and hence may not be used to generalize the effect of PLHIV support groups on nutritional support of PLHIV in Lira district. Derose et al. (2017) highlighted food insecurity as caused by interferences in group linkages amongst associates due to shame, which detached them from essential bases of nutritional care.

2.5 The Contribution of Support Groups to Palliative Care of PLHIV

Palliative care involves dynamic total care given to patients whose diseases cannot be cured to improve their quality of life (Al-Mahrezi & Al-Mandhari, 2016; Areri, 2019; Buss, Rock, & McCarthy, 2017; Radbruch et al., 2020). It involves measures aimed to improve the life of PLHIV and the relatives facing severe complaints, through avoidance, analysis, and handling of pain and other bodily, emotional, and psychic challenges. Consequently, palliative care is essential in PLHIV since some may present late opportunistic infections, co-morbidities, antiretroviral therapy toxicity, and HIV-associated cancers. Nonetheless, it has been revealed that the quality of palliative care services for PLHIV was poor in a number of health facilities hence the need for improvement by increasing and ensuring compliance with guidelines and the established referral network. Also, MacRae, Fazal, and O'Donovan (2020), revealed that community health workers involved in raising awareness and identifying and identification of individuals in need of palliative care within the community, therapeutic management of pain through the provision of oral morphine, physical therapy psychosocial and spiritual guidance during home visits. From the above studies, it was established that the gap in the provision of palliative care revealed that approximately 40 million people worldwide need the service since about 78% of them live in both low- and middle-income nations and only approximately 14% of those who require palliative care receiving. These figures suggest that a sizeable number of victims continue to lack access to Palliative care services.

In a similar study Mburu et al. (2013), it was exposed that community participation through the community systems and networks plays a substantial part in the delivery of palliative care to PLHIV, contributes to both access and support in terms of adherence, financial, bereavement and care for

orphans, connecting PLHIV to a range of services including food and income. This goes a long way in improving the lives of people who are living with HIV.

3. Research methodology

3.1 Study Population and sample

This study population included participants in the categories of health officials, caregivers for PLHIV, the PLHIV, VHTs, and the support group (see Table 1 below).

Table 1. The target population

SN	Category	Amach Town Council	Amach Sub-county	Target Population
1	Health Officials	10	11	21
2	Caregivers	54	126	180
3	PLHIV	90	210	300
4	VHTs	30	42	72
5	Support group	02	02	04
	TOTAL	**186**	**391**	**577**

Source: Amach Health Centre IV database, 2022

Health officials (professional healthcare providers officially appointed); caregivers (voluntary healthcare members selected from within a community); PLHIV (Persons living with HIV); VHTs (Village health teams); Support group (A selected group of supplementary community counselors).

The researcher used Krejcie and Morgan (1970) to determine the sample from the study population.

Table 2. Sample Size

SN	Categories	Population	Sample size	Amach T.C	Amach S/C
1	Health Officials	21	8	04	04
2	Caregivers	180	70	21	49
3	PLHIV	300	117	35	82
4	VHTs	72	29	09	20
5	Support group	4	2	01	01
	Total	**577**	**226**	**70**	**156**

Source: *Krejcie and Morgan (1970)*

Health officials (professional healthcare providers officially appointed); caregivers (voluntary healthcare members selected from within a community); PLHIV (Persons living with HIV); VHTs (Village health teams); Support group (A selected group of supplementary community counselors); T.C (Town council); S/C (Sub-county).

The study employed both simple random and purposive sampling techniques. Both purposive sampling techniques and simple random sampling methods.

3.2 Data collection and Quality control

A questionnaire survey was used to collect primary data from PLHIV and caregivers; the interview guide was used to collect information from health officers and VHTs while the documentary review was used to collect data from PLHIV community support group (Cresswell et al., 2012). To ensure content validity, a content validity index (CVI) was computed (Kothari, MacLean, Edwards, & Hobbs, 2011) and to determine the stability of measures administered at different times to the same individuals, a reliability test was done using the test re-test method (Saunders, Lewis, & Thornhill, 2009). This was achieved by administering the questionnaire to ten purposely selected respondents. Afterward, the responses on the instrument were analyzed using SPSS Version 23, and Cronbach's alpha values (Cronbach Alpha Reliability Coefficients) for each of the variables obtained. (See table 3)

Table 3. Tests of reliability

Variables	Cronbach alpha	No. of items
Community Support Group	0.805	10
Nutrition support	0.825	06
Adherence to art	0.785	06
Palliative care	0.845	07
Overall	0.815	29

Source: Field data, 2022

3.3 Data Analysis

The univariate analysis was carried out using descriptive statistics. Regression analysis was used to determine the contribution of CSG in adherence to ART, the contribution of CSG in Nutrition support to PLHIV, and the contribution of CSG in Palliative care to PLHIV. Also, content analysis was used to edit qualitative data and reorganize it into meaningful shorter sentences. Privacy and consent of the respondents were ensured throughout the study as well as confidentiality and honesty was emphasized.

4. Results and Discussion

4.1 Characteristics of Respondents

The distribution of the respondents was classified as PLHIV and caregiver as shown in Table 4.3.
The result summarised in Table 4.3 reveals that 62.6% of the respondents were PLHIV while 37.4% were caregivers. The bigger number of PLHIV compared to that of caregivers has been attributed to a situation where one caregiver takes care of more than one PLHIV within a homestead. Further, the majority of the respondents were female (62.9%) and the rest (37.1%) were male. This suggests that the majority of respondents in Amach town council and Amach sub-county were female. The difference in this percentage was ascribed to the fact that women are more readily available at home compared to me. The results in Table 4.5 indicate that respondents aged between 31 and 40 years accounted for 38.0%, followed by those between 41 and 50 years (22.5%) and the least group was between 20 years and below (05.3%). The implication of this is that people of average years ranging from 21-40 years were mostly interviewed compared to the ones below the age of 20 years and those who are 51 years and above. The qualifications of the respondents included Certificate, Diploma, or Degree. The results indicate that the majority of the respondents had a primary level of education (77.5%), followed by a secondary level (17.6%) with the least group being degree level (0.5%). This can be interpreted to mean that most of the respondents are those with primary and secondary levels of education as compared to those with diploma, degree, and postgraduate levels of education. The majority of the respondents were married (58.3%) while the minority had divorced (5.3%). This means that the majorities of the people who took part in the study are those with families and are having responsibilities.

4.2 Descriptive Statistics

Descriptive statistics were used to assess the contribution of CSG on HBC for PLHIV.

4.3 Community Support Group (CSG)

In order to assess the activities of the Community Support Group, respondents were assessed on the following ten (10) items (see Table 3 below).

Table 3. Descriptive Statistics on CSGs

No	Constructs	M	SD
1	Whether CSG helps PLHIV to access medication	4.829	.4051
2	Whether CSG helps to improve confidence, self-esteem, better-coping skills among PLHIV and AIDS	4.455	.4502
3	Whether CSG helps to encourage PLHIV and AIDS to accept their status	4.540	.5208
4	Whether CSG helps to encourage community members to go for HIV counseling and testing	4.487	.5424
5	Whether CSG helps to deal with the stigma of PLHIV and AIDS	4.246	.7059

6	Whether CSG helps to lobby for support for PLHIV and AIDS	4.455	.6735
7	Whether CSG help PLHIV and AIDS to share their life experiences as people living positively	4.503	.5223
8	Whether CSG helps to bring about health behavior change among PLHIV and AIDS	4.417	.5260
9	Whether CSG helps to create attitude change in the community on PLHIV and AIDS	4.316	.5791
10	Whether CSG helps to increase adherence to ART	4.754	.4677
Overall Aggregated Statistics		**4.959**	**.5393**

Source: Researcher's contribution using Primary data (2022)
M (Mean); SD (Standard Deviation)

The statistics in Table 3 revealed that all the items used to assess the importance of CSG to PLHIV were above average on a Likert scale of 1-5 used by the researcher. This suggested that the respondents agreed with the items in relation to the importance of CSG to PLHIV. The overall mean of a community support group is 4.959, which indicated above average performance of CSG in enhancing HBC for PLHIV and AIDS. This implies that respondents expressed that CSG helps in enhancing HBC for PLHIV and AIDS. The standard deviation of .5393 suggested heterogeneity in the views of the respondents. The documentary review carried out indicated that the record of CSG for PLHIV was available at the health facility, it also indicated that there was evidence that drugs were being given to PLHIV at the community distribution points. The record also indicated evidence that the PLHIV CSG has been trained and that the support group pays visits to PLHIV. However, a review of the document indicated that there was no evidence of the legal existence of PLHIV support group.

4.4 Adherence to ART (AA)

In a bid to assess adherence to ART among PLHIV, respondents were asked questions indicated in Table 4.

Table 4. Descriptive Statistics on Adherence to ART (AA)

No	Constructs	M	SD
1	Adherence to ART help PLHIV and AIDS maintain high CD4 cell counts	4.882	.3696
2	Adherence to ART help to prolong the survival of PLHIV and AIDS	4.759	.4286
3	Adherence to ART help to reduce the symptom of HIV and AIDS in PLHIV	4.540	.5509
4	Adherence to ART help to reduce the risk of transmitting HIV to others	4.390	.6820
5	Adherence to ART help to reduce the stigma of PLHIV	4.524	.6335
6	Adherence to ART help to suppress viral load in PLHIV and AIDS	4.759	.4762
Overall Aggregated Statistics		**4.642**	**.5235**

Source: Researcher's Contribution using Primary Data (2022)
M (Mean); SD (Standard Deviation)

The descriptive statistics in Table 4 revealed that all the items used to assess the level of adherence to ART among PLHIV were above average on a Likert scale of 1-5 used by the researcher. This suggested that the respondents were in agreement with the items in relation to the importance of adherence to ART to PLHIV. The overall mean of approximately 4.642 implied that the respondents were in agreement that adherence to ART helps PLHIV and AIDS. The SD of .5235 indicated heterogeneity.

4.5 Nutrition Support (NS)

In order to assess nutrition support among PLHIV, respondents were assessed on the following six (6) constructs indicated in Table 5.

Table 5. Descriptive on Nutrition Support (NS)

No	Constructs	M	SD
1	Nutrition support helps to improve symptom management	4.722	.5658
2	Nutrition support helps PLHIV and AIDS gain body weight	4.834	.3870
3	Nutrition support helps PLHIV and AIDS to remain strong and to be in a position to engage in income-generating activities	4.770	.4219
4	Nutrition supports the effectiveness of medications	4.733	.5217
5	Nutrition support helps improve the HIV-infected patient's resistance to infections	4.647	.6078
6	Nutrition support helps improve the quality and length of life	4.786	.4605
Overall Aggregated Statistics		**4.749**	**.4941**

Source: Researcher's Contribution using Primary Data (2022)
M (Mean); SD (Standard Deviation)

The descriptive statistics in Table 5 revealed that all the items used to assess the level of nutritional support among PLHIV were above average on a Likert scale of 1-5 used by the researcher. This suggested that the respondents were in agreement with the items in relation to the importance of nutritional support to PLHIV. The overall mean of approx. 4.749 implied that the respondents were in agreement that nutrition support helps PLHIV and AIDS. The SD of .4941 indicated homogeneity.

4.6 Palliative Care (PC)

Table 6. Descriptive Statistics of Palliative Care (PC)

No	Constructs	M	SD
1	Palliative care helps to reduce depression among PLHIV and AIDS	4.214	.731
2	Palliative care helps in symptom management support	3.904	.649
3	Palliative care helps PLHIV cope with feelings and changes related to illness	4.091	.619
4	Palliative care helps to reduce the risk of depression among PLHIV	4.021	.769
5	Palliative care helps to identify and access additional resources to provide support	4.139	.606
6	Palliative care helps to improve the quality of life of PLHIV	4.294	562
7	Palliative care consistently improves both patient and caregiver satisfaction	4.449	.697
Overall Statistics		**4.852**	**.772**

Source: Primary Data, 2022
M (Mean); SD (Standard Deviation)

The statistics revealed that the mean value for all the items used to assess the level of palliative care was above average on a Likert scale of 1-5 used. This suggested that the respondents were in agreement with the items in relation to the significance of palliative care to PLHIV. The overall mean of approx. 4.852 implied that the respondents were in agreement that palliative care aids PLHIV and AIDS. The SD of .772 indicated heterogeneity.

4.7 CSG and adherence to ART

Regarding the contribution of CSG on adherence to ART among PLHIV, a simple linear regression analysis was conducted. (Table 7).

Table 7. Model Summary for Regression

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.559[a]	.312	.308	.24123

a. Predictors: (Constant), CSG

b. Dependent Variable: Adherence to ART

The model summary of the regression test in Table 7 produced an Adjusted R Square of .308, which suggested that CSG contributed approximately 30.8% to adherence to ART among PLHIV in Lira District. This implies that CSG has a significant contribution to adherence to ART among PLHIV.

Table 8. Coefficients[a]

Model		Unstandardized Coefficients B	Unstandardized Coefficients Std. Error	Standardized Coefficients Beta	T	Sig.
1	(Constant)	1.026	.170		6.035	.000
	CSG	.641	.055	.751	11.655	.004

a. Dependent Variable: Adherence to ART

The finding indicated that CSG yielded a regression coefficient of 0.641 (0.05 level of confidence). This suggested that CSG had a significant effect on adherence to ART among PLHIV in Lira District. It was revealed that;

'CSG help to give counseling to PLHIV on the importance of taking their drugs constantly'

Another informant indicated that;

'CSG help to give health education to PLHIV on the importance of taking their drugs as prescribed by the health personal '

In another interview, it was indicated that;

'*CSG contribute to visiting PLHIV especially those who are bedridden to give them hope that they will get better if they continue taking drugs as advised by the doctor.'*

4.8 Empirical Results on CSG and Nutrition Support

Regarding the contribution of community support groups on nutrition support to PLHIV in Lira District, a simple linear regression analysis. The results from the simple linear regression as presented in Table 9.

Table 9. Model Summary for Regression

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.673[a]	.453	.450	.32262

a. Predictors: (Constant), Community support group

The model summary shows an Adjusted R-Square of .450 which suggests that nearly 45% of the variations in nutrition support among PLHIV can be explained by CSG. The finding indicates that CSG has a significant contribution to nutrition support among PLHIV. Finally, a t-test for CSG and Nutrition Support was also performed, and the results were (Table 10).

Table 10. Coefficients[a]

Model		Unstandardized Coefficients B	Unstandardized Coefficients Std. Error	Standardized Coefficients Beta	t	Sig.
1	(Constant)	1.671	.258		6.477	.000
	CSG	.581	.059	.641	9.847	.014

a. Dependent Variable: Nutrition Support

The finding shows that CSG yielded a regression coefficient of 0.581 (0.05 level of confidence). This indicated that CSG has a significant effect on nutrition support among PLHIV in Lira District. This result is in support of the qualitative of the key informants in the interview held. The interview held with the key informants indicated that;

'CSGs help to advise PLHIV on the best way of feeding so that they can remain healthy and be in a position to take their drugs well'

The interview held with other key informants indicated that;

'CSGs help to give ideas to PLHIV to plan for short term plan like the green plan to help them improve on their health'

Another interview held with the key informants indicated that;

'*CSGs help to advise PLHIV on the kind of food they should eat so that they can remain healthy and strong'*

4.10 CSG and Palliative Care

In order to address the effect of CSG on palliative care among PLHIV in Lira District, a simple linear regression was conducted. (Table 11)

Table 11. Model Summary for Regression

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.692[a]	.479	.476	.33143

a. Predictors: (Constant), Community support group

The model summary produced an Adjusted R Square of 0.476, which suggested that CSG contributed about 47.6% to palliative care among PLHIV in Lira District. The remaining 52.4% was contributed by other factors. The finding, therefore, implies that CSG has a significant contribution to palliative care among PLHIV. Furthermore, a t-test was carried out to draw out the statistical significance between CSG and palliative care. (Table 12)

Table 12. Coefficients[a]

		Unstandardized Coefficients		Standardized Coefficients		
Model		B	Std. Error	Beta	t	Sig.
1	(Constant)	.912	.209		4.364	.003
	CSG	.638	.059	.714	10.814	.017

a. Dependent Variable: Palliative Care

The finding suggested that CSG had a regression coefficient of 0.638 (0.0 5 level of confidence). This indicated that CSG had a significant effect on palliative care among PLHIV in Lira District. This result is in support of the qualitative of the key informants in the interview held;

'CSG help to make a follow up on PLHIV and AIDS to check on their condition, give them the necessary support and remind them to always seek medical help in case they don't feel well.'

'CSG help to do a home visit, give counseling to PLHIV, train them on proper hygiene, carry out nutrition education and give them some nursing care including spiritual support'

'*CSG help to counsel PLHIV who are bedridden, talks to them, advice people who have been coughing for a long time to test for tuberculosis, and gives some financial assistance where possible so that buy food.'*

4.11 CSG and HBC for PLHIV compared

Regression analysis on the effect of community support on home-based care in Amach town council and Amach sub-county was separately run. The finding is indicated in Table 13.

Table 13. Regression coefficients for Amach T/C and Amach S/C compared

	Amach T.C		**Amach S/C**	
	Beta	**p-value**	**Beta**	**p-value**
(Constant)	1.460	0.054	0.676	0.350
Community Support Group	0.627	0.016	0.519	0.024
R	0.691		0.573	
R Square	0.477		0.328	
Adjusted R Square	0.458		0.321	
Std. Error of Estimate	0.353		0.285	

Dependent Variable: Home-Based Care (Adherence to ART, Nutrition support & Palliative care)

Predictors: (Constant), CSG

The finding suggests that CSG in Amach town council (β = .628; p-value <.05) is likely to increase HBC to PLHIV by approx. 62.8% while in Amach sub-county (β = .519; p-value <.05), CSG is likely to increase home base care to PLHIV by approx. 51.9%. The result indicated that changes in HBC to PLHIV due to CSG are significant in both study locations. Hence, the aggregate effect of CSG on HBC to PLHIV is significant.

4.12 Discussion of results

The findings are consistent with that of Jobarteh et al. (2016) who conducted a study in Mozambique on a sample size of 6,760 CASG members drawn from 68 health facilities to ascertain the effect of Community ART Support groups on the Adherence to ART. Correspondingly, community support is an ideal mechanism as the adolescents living with HIV and AIDS receiving community adolescent treatment supporters (CATS) services had improved linkage to services, retention in care, self-reported adherence, and psychosocial well-being compared to adolescents who did not have access to CATS services (Willis et al., 2019). Hence, adherence among PLHIV in CSGs and among those not belonging to CSGs appears to be a helpful strategy (Chime et al., 2018).

Community participation has a direct link to nutrition support among PLHIV through collaboration among the CSG members (Hodgson et al., 2012). CSG appears to yield a significant effect on nutrition support to PLHIV. Moreover, the PLHIV support groups play a significant role in giving support to PLHIV at the home-based care level (Jack, Kirton, Birakurataki, & Merriman, 2011). This presupposes that community participation through the community systems and networks plays a substantial role but in spite of everything, community health workers involved in raising awareness and identifying and identification of individuals in need of palliative care within the community, therapeutic management of pain through the provision of oral morphine, physical therapy psychosocial and spiritual guidance during home visits (MacRae et al., 2020). As a consequence, CSG helps PLHIV to have access to palliative care.

5. Conclusion

The purpose of this study was to examine the contribution of CSG on HBC for Persons Living with HIV and AIDS (PLHIV) in Lira District. We argue that if the local community actively gets involved in HBC community support group, it will greatly help in increasing the level of adherence to ART among PLHIV in Lira District owing to the follow-up of the PLHIV within the community settings and the continuous counseling on adherence. Also, HBC CSG approach can be adapted so as to increase the level of adherence to ART among PLHIV in Lira District. HBC CSG is very instrumental in enhancing the level of nutrition support among PLHIV since it is the model which is mostly adopted by the people within the local community. While we're on the subject, the study covered only one district in the Lango sub-region.

Accordingly, based on the findings of this study that CSG had a significant effect on home-based care for PLHIV, the study, therefore, made the following suggestions:

1. Political and local leaders should mobilize the community member to form CSG so that every village have at least a CSG.
2. Documentary reviews have indicated that there was no evidence of the legal existence of the CSG. So, CSG should be legally registered and has evidence of their registration on file.
3. There should be regular training of the CSG especially in the areas of the management of HIV and HIV patients. This will help equip them with knowledge and to be in a position to help PLHIV well.
4. Members of the village health team should be incorporated or co-opted as members of CSG since they also handle health-related issues within the local community.
5. The health facility that the CSG is affiliated to should regularly monitor the activities of CSG to ensure that they work within the scope of their operations.

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