The Impact on Funding and Replicating Home Based Health Care Programs in South Africa Due to the Number of People Dying of AIDS

A Project Report Presented to the
Faculty of Spring Arbor University

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by

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This is to certify that the Project Thesis prepared

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Entitled _____Home Based Health Care_____

Has been accepted by the faculty of Spring Arbor University

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This Project Thesis is not to be regarded as confidential and its use as a sample in future classes is not restricted.

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Chapter 1

Introduction

The first chapter of this thesis will define the problem of how the numbers of those sick and dying of AIDS in South Africa influences the ability of communities to fund and implement home based health care programs. This chapter will not only define the problem but also review the history of the problem, give pertinent details as well as define the scope and parameters of the study.

Statement of Purpose

South Africa is experiencing an HIV/AIDS crisis. According to the Southern Africa Diaconal Partnership (SADP) representative, "Every day there is 1,800 new HIV infections. Every day 800 people die of AIDS-related illnesses. This will amount to 292,000 AIDS deaths by the end of 2005". The enormity of this problem has left clinics and hospitals unable to meet the needs of AIDS victims. People sent home to die, often alone, need help. Community volunteers are attempting to meet some of these needs through home-based health care programs.

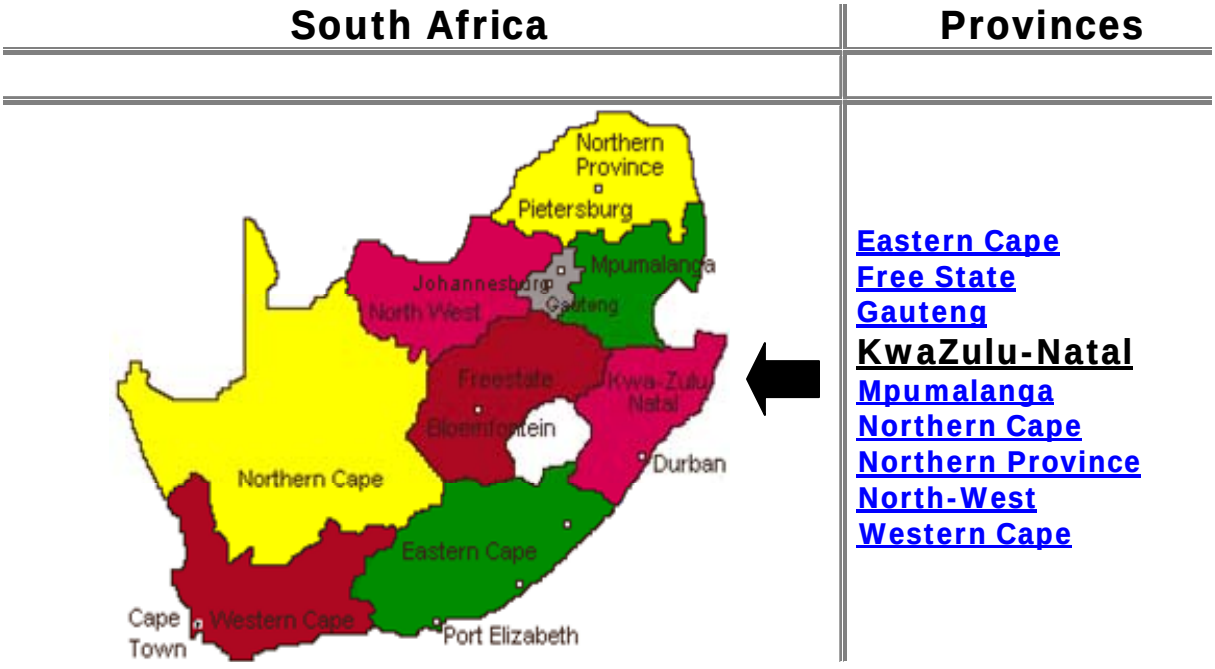
According to the Canadian International Development Agency (CIDA), the term capacity development or capacity building means, "Helping women, men, and children in developing countries, their communities and institutions, to acquire the skills and resources needed to sustain their own social and economic progress". The purpose of this project is to obtain funds to train and build capacity in volunteers and then replicate these volunteer community home-based health care (HBHC) programs for the terminally ill in South Africa. The study evaluated the ongoing program in order to determine current costs involving training, number of volunteers, number of clients served, medicines provided, medical packs used, and transportation. The proposed study seeks to evaluate

services in the current program, add new sites and communities, and promote ways that these programs become self-sustainable. The term self-sustainable refers to creating local capacity to respond to HIV needs in the community in an ongoing matter.

Setting of the Problem

The proposed study will focus on the province of KwaZulu-Natal in South Africa. See figure A.

Figure A



South Africa is a little less than twice the size of Texas with approximately double the population. According to the AIDS Epidemic Update December 2004 from the World Health Organization, "Southern Africa remains the worst affected subregion in the world, with data from selected antenatal clinics in urban areas showing HIV prevalence surpassing 25%, having risen sharply from around 5% in 1990. South Africa continues to

have the highest number of people living with HIV in the world. An estimated 5.3 million people were living with HIV at the end of 2003 in South Africa – 2.9 million of them women. At this point in time, there is no indication that this trend is reversing". See figure B

Figure B

Estimated HIV prevalence 1999-2003 by province among antenatal clinic attendees

Province	1999 Prevalence % *	2000 Prevalence %	2001 Prevalence %	2002 Prevalence %	2003 Prevalence %
KwaZulu	32.5	36.2	33.5	36.5	37.5
Gauteng (GP)	23.9	29.4	29.8	31.6	29.6
Free State (FS)	27.9	27.9	30.1	28.8	30.1
Mpumalanga (MP)	27.3	29.7	29.2	28.6	32.6
North West (NW)	23.0	22.9	25.2	26.2	
East Cape (EC)	18.0	20.2	21.7	23.6	27.1
Limpopo (LP)	11.4	13.2	14.5	15.6	27.5
Northern Cape (NC)	10.1	11.2	15.9	15.1	16.7
Western Cape (NC)	7.1	8.7	8.6	12.4	13.1
National	22.4	24.5	24.8	26.5	27.9

AVERT is an international HIV and AIDS charity based in the UK, with the aim of AVERTing HIV and AIDS worldwide.* *figures from 2001 report*

History and Background of the Problem

The Christian Reformed World Relief Committee (CRWRC) is a nonprofit, relief and development organization of the Christian Reformed Church of North America. CRWRC, formed in 1962 primarily as a domestic relief organization, is serious about

Jesus' love for the poor and afflicted. One part of the work of CRWRC is to prepare and equip local deacons to do work that brings relief in times of disaster. Another part of the work is long-term development. This work now occurs both domestically and internationally. CRWRC has approximately forty staff located in the United States and Canada and ninety international field staff located in twenty-seven countries.

In 1998, CRWRC began working in southern Africa in partnership with the Uniting Reformed Church of Southern Africa (URCSA). This partnership consisted of the URCSA, CRWRC, the Reformed Church in America (RCA), and several individual Reformed and Christian Reformed congregations. Because this was a multifaceted consortium, the name of the sending body is the Southern Africa Diaconal Partnership or SADP. The facilitating representatives of this partnership, onsite in South Africa were Lou and Jan Haveman. In December 2004, a South African woman, Dithloriso Bojosi was appointed as replacement for the ongoing work.

In 2001, the first home based health care project began in Dingaanstat, South Africa, which is located in the province of KwaZulu-Natal. With the help of a Canadian short-term volunteer working under the CRWRC representatives, a strategy and prototype for a home based health care program identified the aim of providing volunteers to visit sick people in their homes, as hospitals could not accommodate everyone. The twenty-one volunteers selected and trained by the local department of health began visiting homebound clients in this first attempt of this type of program. The program was entitled "A Home Based Health Care Program for the Chronically Ill." Avoiding the use of HIV/AIDS in the program title because of the stigma of the AIDS label does not belie

the fact that the majority of the clients are HIV positive and usually suffering from full-blown AIDS.

HBHC is a health care service provided by community volunteers to terminally ill homebound patients, who because of the increasing number of victims, hospitals can no longer provide the needed care. Church groups, government programs, agencies, and non-governmental organizations (NGO's) support this program. The nurses of the local clinics or hospitals are supervisors and advisors of home caregivers who are all unpaid volunteers. HBHC is a viable, reproducible program desperately needed in South Africa. Because of the economic downturn in the United States and subsequent decrease in denominational giving, along with the gaining strength of the South African Rand, adequate funds to continue and replicate this program are not available. CRWRC is not able to increase the amount of current funding, and matching funds, which were expected

from South Africa, are not forthcoming. In order to make this program strong and eventually self-sustainable, it will take a significant infusion of capital to initiate community capacity building.

The URCSA is the implementing partner of the CRWRC programs in South Africa. The church wishes to be true to its calling by being a place where those infected and affected by HIV will feel safe to share their pain, encourage their members to become involved in AIDS prevention, support and care programs, and make resource materials available for church based programs and projects. Congregations and church members will take responsibility for prevention programs, practical support, and care programs within congregations and in distressed communities eventually becoming completely self-sustaining. The URCSA has 758 congregations and a membership of 1.5 million covering all provinces of South Africa as well as the countries of Lesotho and Namibia. Although CRWRC's significant focus is on the province of KwaZulu-Natal, there are similar programs beginning throughout South Africa, as resources become available.

Scope of the Problem

The three components to CRWRC's ongoing HIV/AIDS work in South Africa are awareness training, HBHC, and orphans. The focus of this paper is on the HBHC outreach in one of the nine provinces – KwaZulu-Natal. There is an estimated population of 8,500,000 people in KwaZulu-Natal, which accounts for 20% of the total population of South Africa. KwaZulu-Natal is the province hardest hit with HIV/AIDS and is an area where CRWRC has started a number of HBHC programs. Although awareness training is essential and the plight of AIDS orphans is devastating, the scope of

this paper is addressing only the care and support of the sick and dying and their families who are located in the single province of KwaZulu-Natal.

Importance of the Project

In October 2001, the Uniting Reformed Church of Southern Africa adopted a Statement on HIV/AIDS where it declared:

"The Church of Jesus Christ must come to terms with the HIV/AIDS pandemic. As a church, we have no choice. No community that claims to be founded on the principles of the ministry of Jesus Christ has a choice. In obedience to our Lord, the head of the Church we will follow Him where He will lead us in the fight against HIV/AIDS".

The SADP representative also shared the following statistics:

- Twenty-five percent of all deaths in South Africa are AIDS-related.
- By 2010-2015, the average life expectancy at birth could be only 47 years. In the absence of AIDS, the expected life expectancy was 63 years.
- At present, there are at least 560,000 AIDS orphans.

The enormity of this pandemic makes it difficult to try to plan a meaningful strategy. How does one begin to make an impact when confronted with such devastating statistics? In order to take the first steps, the church in South Africa has to make inroads into the mind-set of the people. Ignoring a problem does not make it go away. Only in the last couple of years have congregations and communities been able to speak out about what is happening and then attempt to find ways to address at least some aspects and issues of HIV/AIDS. That is the purpose of the URCSA Strategy on HIV/AIDS published in November 2003, which outlines the three-step process of mobilization, prevention, and care and support.

Conclusion

The problem of HIV/AIDS worldwide is everyone's problem. This first chapter, addressing the death and dying that communities are facing alone without adequate resources needs a solution. HBHC programs already address this problem by providing community volunteers to give care and support to their friends and families. More volunteers and more HBHC programs need funding to build capacity to continue this important ministry. Care and support is what HBHC is all about. It is the church and community's response in addressing one aspect of the HIV/AIDS pandemic. Replicating the number of home based health care programs to meet these needs is essential and building community capacity to maintain and sustain these programs is paramount.

Definition of Terms

AIDS	Acquired immunodeficiency
Capacity Building	Acquiring skills and resources needed for self-sustainable social economic progress.
CCHI	Christian Connections for International Health
CIDA	Canadian International Development Agency
CRWRC	Christian Reformed World Relief Committee
HBHC	Home based health care
HIV	Human immunodeficiency virus
JRCT	Joseph Rowntree Charitable Trust
NGO	Non-governmental agency
Palliative Care	Palliative care, often called comfort care, is providing relief to a terminally ill person through symptom management and pain control.
RCA	Reformed Church in America
SADP	Southern Africa Diaconal Partnership
Self-sustainable	Creating local capacity to respond to needs in the community in an ongoing matter.
URCSA	Uniting Reformed Church of Southern Africa
USAID	United States Agency for International Development

Chapter 2 – Literature Review

Introduction

Chapter 2 is a literature search on the selected thesis topic of how the numbers of those sick and dying of AIDS in South Africa influences the ability of communities to fund and implement home-based health care programs. This chapter looks at AIDS in the world today, narrowing the search to South Africa, specifically the province of KwaZulu-Natal in order to stay within the parameters of the thesis. Because the issue is so large, this chapter will also discuss the viability of long-term sustainability of communities supporting this program. Chapter 2 will cover this information in four sections, AIDS in Africa, AIDS in the province of KwaZulu-Natal, South Africa, care of the terminally ill and home-based health care, and the cost, sustainability and support of homebound patients.

Gennich (2004) points out:

"The Bible is clear about our interconnectedness. In I Corinthians 12, Paul says that 'God has combined the members of the body, and has given greater honor to the parts that lacks it…If one part of the body suffers, every part suffers with it; if one part is honored, every part rejoices with it'. This is no different from the African philosophy of *ubuntu* (I am because you are). In Zulu traditional caring system, a disease is an indication of unhealthy individual or communal life. Ill health is not just the physical pain of a concerned individual. 'It is the spiritual and mental pain of the whole group to which the sick person belongs'. Health is not life to the next generation. All things, therefore, work together to take care of and stabilize the life of the group. Sickness is seen as a serious threat to life and causes great anguish in the family, especially when it

affects a young person, who is to be the carrier of the life of the tribe. Because of this threat to the family, the clan, the nation, it is to be avoided at all costs. This short summary of the Zulu caring system indicates that the clinical notion of home-based care: offering nursing assistance, advice about keeping healthy and perhaps help with taking drugs, cleaning and cooking, is not adequate for what is required. Care in the Zulu sense means helping someone to see themselves as a valuable part of the community, as contributing to its very life" (p.46).

AIDS in Africa

According to CNN-UN (1998), "Children born today in 29 sub-Saharan African nations face a life expectancy of just 47 years because of the toll of the AIDS pandemic is taking on the region, according to the latest population report from the United Nations" (p.1).

Information from the Centers for Disease Control and Prevention showed in 2003, an estimated 5.3 million South Africans were HIV-positive. This report showed 12.1% of the study population was HIV-positive" (p.1).

In the publication, The Lancet (2004), a featured author in *Medicine and Health Policy*, Adele Baleta was publicly critical of South Africa's President Thabo Mbeki. She cited President Mbeki's lack of focus on AIDS in South Africa writing, "South Africa has the highest HIV/AIDS caseload worldwide, with 5.3 million people infected, and the government has been accused of failing to react with urgency to the problem. It was only after sustained domestic and international pressure that the government agreed last year to provide treatment at state hospitals. Mbeki has in the past been accused of lack of leadership over HIV/AIDS and aligning himself with AIDS dissidents" (p.541).

According to Donnelly (2004) of Washington's Knight Ridder Tribune Business News, "For years, a few leaders in Africa pushed the fight against AIDS, including President Yoweri Museveni of Uganda, President Fergus Mogae of Botswana, and for Malawi Vice President Justin Malewezi. Many AIDS activists in the West sharply criticized the lack of direction from leaders, especially South Africa, where President Thabo Mbeki effectively delayed treatment programs by questioning whether HIV caused AIDS. Mbeki has since dropped that challenge, and South Africa has begun a rollout, if slowly, of antiretroviral treatment programs" (p.1).

AIDS in the South African province of KwaZulu-Natal

In an interview with Dr. Leana Uys, Giarelli and Jacobsw (2001) cited in *The Journal of the Association of AIDS Care*, "Human suffering from the HIV/AIDS epidemic in Africa has reached unprecedented proportions. In 1998, an estimated 50% of all new infections in sub-Saharan Africa occurred in South Africa; and it is predicted that by the year 2003, South Africa will be experiencing a negative population growth" (p.1). This in fact occurred.

In the British Medical Journal, Carlisle (2003) states, "In South Africa, which carries 25% of Africa's burden of the disease, five million people are in need of palliative care, including home support and pain relief. Yet only 250,000 of them receive it, said Liz Gwyther, chief executive of St. Luke's Hospice, Cape Town" (p.1069).

Care of the Terminally Ill and Home-based Health Care

In the periodical, AIDS Care, Gibbs, Ellershaw, and Williams (1997) state, "There is a high prevalence of symptomatology among patients with HIV disease. Many

generic hospices can offer skilled multidisciplinary symptom control and psychosocial care, complementing other HIV specialist services" (p.601).

According to Perry (2001), "Although it is a difficult emotional and physical challenge to care for a loved one who is dying, the experience can also be positive if you know what to expect and what to do. When there is no hope of recovery and death is inevitable, the caregiver's goal is to do everything possible to help the person die peacefully, with dignity and without pain" (p.156).

In the periodical, Nevada RNformation, Schneider (2005) states, "Hospice is for people who have been told by their physician that their condition will likely result in death in six months or less. Dedicated team professionals bring comfort, support, and peace at this stressful time" (p.14). Hospice is a well-known concept in the United States. It is an organization, which provides an alternative way for people to face death with dignity surrounded by their loved ones while remaining in the comfort of their own homes. HBHC is a similar concept with one major difference. HBHC staffing is entirely unpaid volunteers from the community.

According to Nsutebu, Walley, Mataka, and Simon (2001):

> "Home-based care coverage in Africa is currently very low and likely to reduce drastically in the near future. The very limited involvement of governments in the provision of home-based care services appears to be one of the main reasons behind the low coverage of home-based care in Africa. Governments therefore should provide some form of basic home-based care services and/or strength support to other institutions providing home-based care. In order to facilitate governments' involvement in home-based care

activities, an analysis of tasks performed by community nurses and volunteers is used to identify tasks that government, missionary, or NGO employed nurses maybe able to provide without, or with very limited, donor assistance. However, further research and development is needed to develop affordable, feasible, and sustainable home care programs that can be implemented by staff working in government, NGO, and missionary health facilities. In addition, innovative strategies are required to establish effective partnerships between the NGO, missionary, and government health facilities. There is an urgent need to expand and replicate the experience of home-based care programs in Africa" (p.240).

Manier (2002) writes in the Knight Ridder Tribune Business News in Washington, "HIV has so thoroughly devastated parts of southern Africa. Very often women are the ones who make sure their children get the right education, said Bernhard Schwartlander, HIV/AIDS director at the World Health Organization. If the center pole of the family is affected by HIV, it has an impact on a large scale" (p.1).

Cost, Sustainability, and Support of Home Bound Patients

Pistorius (2002) indicates that volunteers are essential in running home-based programs; however, there is a great deal of frustration due to the lack of resources and inability to meet the pressing needs. She states, "Many of them (volunteers) expressed how their voluntary community work had given them a sense of meaning and purpose, because they were unemployed and feeling useless. We are committed to do our work in the community voluntarily and the people we serve have no food. However, when we visit homes of our patients, we are faced with no traveling allowance and no material

support to assist our duties or the needs of our patients, such as dealing with the lack of ambulance services" (p.43).

In the periodical *Health Promotion International*, Crisp, Swerissen, and Duckett (2000) state, "Irrespective of the processes and strategies used to achieve capacity building, this term can be applied to interventions which have changed an organization's or community's ability to address health issues by creating new structures, approaches and/or values. These will be ongoing without need for future funding. However, this approach which produces systemic change should not be equated with the provision of short-term pilot or demonstration funding from other sources to address health issues" (p.100).

Christian Connections for International Health (CCIH) provides field-oriented information resources and a forum for discussion and networking for Christian organizations working in international health. Arole (1998) states, "By addressing social issues, people are empowered and have equitable access to all facilities. The close linkages of health with other factors – such as environment, sanitation, safe water – need to be recognized. These programs may initially require a large investment, but in the long term they lead to sustainability and effectively improve health" (p.7).

In the various publications, articles, and interviews presented in this chapter the four sections identified were covered. Chapter 2 outlined information covering AIDS in Africa, AIDS in the province of KwaZulu-Natal, South Africa, care of the terminally ill and home-based health care, and the cost, sustainability and support of homebound patients.

Chapter 3 – Option Selection

The third chapter of this thesis will look at all three option choices to determine the best option for this project. In order to make an informed selection, one needs to look carefully at each option available and determine the one best suited. This chapter will outline requirements for each option and then present the best selection.

According to the thesis workbook, Option 1 is *applied design intervention.* This means that Option 1 requires a specific intervention that can be implemented and evaluated during the time of the MOD program. The intervention for this project is to replicate home-based health care programs and the number of volunteers to meet the needs of people dying alone without care. It is impossible to see results with the designated time limit required. Therefore, on that point Option 1 is not a viable selection.

The workbook shows Option 3 as an *alternative policy decision*. Option 3 requires one to evaluate at least three alternatives, outlining their strengths and weaknesses and submit them to a policy-making board or agency. This option implies a connection to the organization that would allow one the freedom and status to submit such policy changes. In my current position, this again is not a viable option to select.

The workbook shows Option 2 as a submission of *grant proposal.* The problem outlined is one of enormous proportions with a lack of funding in each of the following categories:

- To increase the number of HBHC programs
- To increase the number of volunteers
- To give volunteers some type of incentive stipend

Therefore, Option 2 is the selected option. This option is a grant proposal submission to request funding to increase the number of HBHC programs and the number of volunteers in the Zisize Home-Based Care Project so that people sent home to die alone will receive the care they need.

The three options included applied design intervention, grant proposal submission, and alternative policy decision. The requirements necessary for each of these options immediately ruled out Option 1 and Option 3. Option 2 is the preferred selection since funding is the major issue of the project thesis problem.

Chapter 4 – Description of the Proposed Intervention

Summary of the Problem

In South Africa, every day there are 1,800 new HIV infections and every day 800 people die of AIDS-related illnesses. This will amount to 292,000 AIDS deaths by the end of 2005. At this time, there is no indication that this trend is reversing. KwaZulu-Natal is the province hardest hit, which has estimated population of 8,500,000 people accounting for 20% for the total population of South Africa.

The enormity of this problem has left clinics and hospitals unable to meet the needs of AIDS victims. They send people home to die alone. Community volunteers are attempting to meet some of these needs through home-based health care programs. Currently, there are three home-based health care programs under the project name of Zisize Home-Based Care Projects in the province of KwaZulu-Natal. The population within this project is approximately 30,000 people. There are sixty-nine volunteers covering this area. In short, the problem is:

1. Insufficient number of home-based health care programs
2. Not enough volunteers
3. Too many people dying alone without care

The three project thesis options included applied design intervention, grant proposal submission, and alternative policy decision. The requirements necessary for each of these options immediately ruled out Option 1 and Option 3. Option 2 is the preferred selection since funding is the major issue of the project thesis problem.

Objective I

Decrease the number of people dying alone at home without care in the province of KwaZulu-Natal by 50% within the first year of obtaining funding.

Hypothesis A – A significant number of volunteers in the Zisize Project believe more than 50% of people dying from HIV infections are dying alone without the support of health care.

Hypothesis B – A significant number of volunteers in the Zisize Project believe increasing the number of home-based health care programs by 100% would decrease the number of people dying alone.

Objective II

Increase by 100% the number of home-based health care programs in the Zisize Project within the first year of obtaining funding.

Hypothesis A – A significant number of volunteers in the Zisize Project believe there are not enough communities willing to start a home-based health care program.

Hypothesis B – A significant number of volunteers in the Zisize Project believe in order to increase the number of home-based health care programs by 100% - from three programs to six, more money is necessary for training, supplies, and volunteer stipends.

Objective III

Increase the number of volunteers in the Zisize Project by 100% within the first year of obtaining funding.

Hypothesis A – A significant number of volunteers in the Zisize Project believe there are not enough volunteers to meet the needs of the community.

Hypothesis B – A significant number of volunteers in the Zisize Project believe more money is necessary for training and stipends to increase the number of volunteers by 100% from 69 volunteers to 138.

Description of the Proposed Intervention

The funds will be used to increase the number of home-based health care programs and the number of volunteers in the Zisize Home-Based Care Project and move outward replicating these programs throughout the province of KwaZulu-Natal.

Objective I

Decrease the number of people dying alone at home without care in the province of KwaZulu-Natal by 50% within the first year of obtaining funding.

Hypothesis A – A significant number of volunteers in the Zisize Project believe more than 50% of people dying from HIV infections are dying alone without the support of health care.

Hypothesis B – A significant number of volunteers in the Zisize Project believe increasing the number of home-based health care programs by 100% would decrease the number of people dying alone.

To collect data for the above hypothesis a survey will be given to all sixty-nine current volunteers in the three home-based health care programs in the Zisize Project. The following questions will be on the survey.

Question 1		
How many people do you believe die alone without health care in KwaZulu-Natal? Please circle a, b or c. below:		
a. 25% - 50%	b. 50% - 75%	c. More than 75%
Question 2	**Yes**	**No**
If more home-based health care programs were added, would the number of people dying alone go down?		
Question 3 – If you answered **"yes"** to Question 2, please mark below the reasons more home-based health care programs have not been started.		
Not enough communities will start a home-based health care program because there is:	**Yes**	**No**
1. Not enough money to train new volunteers		
2. Not enough money for medical packs and supplies		
3. Not enough money for volunteers to live on		

Data Collection

Sixty-nine community volunteers (the total of current volunteers) in the three home-based health care programs of the Zisize Project will all be surveyed. They will be asked to complete a survey, which contains questions regarding the number of people dying alone in the province of KwaZulu-Natal and questions on whether or not increasing the money for training, supplies, and stipends and thus increase programs would decrease the number of people dying alone.

Data Analysis

Question 1 on the survey will address Hypothesis A and Question 2 will address Hypothesis B for Objective 1. If a significant number of volunteers in the Zisize Project circle "b" or "c" to Question 1, it will be concluded that the hypothesis is true. Otherwise, it will be concluded that the hypothesis is false. If a significant number of

volunteers answer "Yes" to Question 2, it will be concluded that the hypothesis is true. Otherwise, it will be concluded that the hypothesis is false.

Objective II

Increase by 100% the number of home-based health care programs in the Zisize Project within the first year of obtaining funding.

Hypothesis A – A significant number of volunteers in the Zisize Project believe there are not enough communities willing to start a home-based health care program.

Hypothesis B – A significant number of volunteers in the Zisize Project believe in order to increase the number of home-based health care programs by 100% - from three programs to six, more money is necessary for training, supplies, and volunteer stipends.

To collect data for the above hypothesis a survey will be given to all sixty-nine current volunteers in the three home-based health care programs in the Zisize Project. The following questions will be on the survey.

Question 4	**Yes**	**No**
Do we need more home-based health care programs?		
Question 5		
If you answered "Yes" to Question 4, please mark below the reasons more home-based health care programs have not been started.		
Not enough communities will start home-based health care programs because there is:	**Yes**	**No**
1. Not enough money to train new volunteers		
2. Not enough money for medical packs and supplies		
3. Not enough money for volunteers to live on		

Question 6	Yes	No
If more home-based health care programs were started, do you believe more patients could be helped?		
Question 7		
If you answered "Yes" to Question 6, please mark below the reasons more home-based health care programs have not been started.		
Not enough communities will start a home-based health care program because there is:	Yes	No
1. Not enough money to train new volunteers		
2. Not enough money for medical packs and supplies		
3. Not enough money for volunteers to live on		

Data Collection:

Sixty-nine community volunteers (the total of current volunteers) in the three home-based health care programs of the Zisize Project will all be surveyed. They will be asked to complete a survey, which contains questions regarding the number of people dying alone in the province of KwaZulu-Natal and questions on whether or not increasing the money for training, supplies, and stipends and thus increase programs would decrease the number of people dying alone.

Data Analysis

Question 4 on the survey will address Hypothesis A and Question 6 will address Hypothesis B for Objective 1. If a significant number of volunteers in the Zisize Project answer "Yes" to Question 4 and 6, it will be concluded that the hypothesis is true. Otherwise, it will be concluded that the hypothesis is false.

If a significant number of volunteers answer "Yes" to Question 5 and 7, it will be concluded that the hypothesis is true. Otherwise, it will be concluded that the hypothesis is false.

Objective III

Increase the number of volunteers in the Zisize Project by 100% within the first year of obtaining funding.

Hypothesis A – A significant number of volunteers in the Zisize Project believe there are not enough volunteers to meet the needs of the community.

Hypothesis B – A significant number of volunteers in the Zisize Project believe more money is necessary for training and stipends to increase the number of volunteers by 100% from 69 volunteers to 138.

To collect data for the above hypothesis a survey will be given to all sixty-nine current volunteers in the three home-based health care programs in the Zisize Project. The following questions will be on the survey.

Question 8	**Yes**	**No**
Do we need more volunteers in the home-based health care programs?		
Question 9		
If you answered "Yes" to Question 8, please mark below the reasons more volunteers have not been trained.		
	Yes	**No**
1. Not enough people will work as a volunteer		
2. Not enough money to train new volunteers		
3. Not enough money for medical packs and supplies		
4. Not enough money for volunteers to live on		

Question 10	Yes	No
If more volunteers were added, could more patients be seen?		
Question 11		
If you answered "Yes" to Question 10, please mark below the reasons more volunteers have not been trained.		
Not enough communities will start a home-based health care program because there is:	Yes	No
1. Not enough people will work as a volunteer		
2. Not enough money to train new volunteers		
4. Not enough money for medical packs and supplies		
5. Not enough money for volunteers to live on		

Data Collection

Sixty-nine community volunteers (the total of current volunteers) in the three home-based health care programs of the Zisize Project will all be surveyed. They will be asked to complete a survey, which contains questions regarding the number of volunteers there are in the Zisize Project and questions on whether or not increasing the number of volunteers would help to meet the needs of more communities.

Data Analysis

Question 8 and 10 on the survey will address Hypothesis A and Question 9 and 11 will address Hypothesis B. If a significant number of volunteers in the Zisize Project answer "Yes" to Question 8 and 10, it will be concluded that the hypothesis is true. Otherwise, it will be concluded that the hypothesis is false.

If a significant number of volunteers in the Zisize Project answer “Yes” to Question 9 and 11, it will be concluded that the hypothesis is true. Otherwise, it will be concluded that the hypothesis is false.

Limitations of the Data Collection Plan:

Limitations include:

- A random selection from the communities will not be done. Those selected to complete the survey are the 69 volunteers who work within the communities. The survey will be given to all 69 volunteers with the help of the administrator of the Zisize Project. These volunteers would be the most knowledgeable regarding the communities in which they work.
- The knowledge of the volunteers may be limited to just their own community areas and therefore not accurate regarding percentages of people dying alone throughout the province. This needs to be clearly stated.
- Some of the volunteers may be illiterate or have limited reading ability and will need to have the survey read to them and completed by another person.
- English is likely a second language for all the volunteers, therefore the administrator of the Zisize Project will be required to assist most of the volunteers in completing the survey.
- Questions 3, 5, 7, 9, and 11 are given to solicit more information to allow facilitating an action plan once funds are granted. These questions all involve the following detail from the example below:

If you answered "Yes" to Question 10, please mark below the reasons more volunteers have not been trained.		
	Yes	**No**
1. Not enough people will work as a volunteer		
2. Not enough money to train new volunteers		
3. Not enough money for medical packs and supplies		
4. Not enough money for volunteers to live on		

- Mr. Buthelezi sent the completed 57 surveys via DHL air postal service from South Africa.

The attached survey in the Addendum was field tested with the Statistics instructor.

Chapter 5 – Researching and Choosing Funding Sources

In South Africa, every day there are 1,800 new HIV infections and every day 800 people die of AIDS-related illnesses. KwaZulu-Natal is the province hardest hit, which has an estimated population of 8,500,000 people accounting for 20% of the total population of South Africa. The enormity of this problem has left clinics and hospitals unable to meet the needs of AIDS victims. They send people home to die alone. Community volunteers are attempting to meet some of these needs through home-based health care programs. The problem is insufficient number of home-based health care programs, insufficient number of volunteers, and too many people dying alone without care. This chapter will research and select funding sources in order to address these problems.

Criteria for Selection

In each of the funding agencies researched, there were very specific guidelines and criteria. This project thesis met some of these guidelines, which included the following:

1. To improve domestic and international policies:
    - To apply universal protections of human rights to issues concerning HIV/AIDS
    - To expand access to HIV/AIDS healthcare and treatment, and
    - To ensure access to accurate information about HIV/AIDS
2. To amplify global awareness of HIV/AIDS and to facilitate broad-based change in attitudes to reduce stigma and change behavior
3. Programs that directly serve the needs of vulnerable children

4. Grassroots responses to needs that raise resources within the community
5. Programs that demonstrate strong leadership and community ownership
6. Organizations with a history of effective community action
7. Innovative responses to the situations of children/youth affected by HIV/AIDS

Actual Sources Researched

The grant writer from CRWRC encouraged researching the small grant makers who funded limited community-based projects as opposed to government organizations or large foundations. By disallowing the larger and/or government funding agencies, this eliminated organizations such as the United States Agency for International Development (USAID), Kellogg Foundation, and even the South Africa Department of Health.

Using the website Guidestar.org to peruse the various funding agencies available as well as a general Internet search displayed various options. Some of the organizations looked at in a more in-depth matter included the John M. Lloyd Foundation, International Fund for Health & Family Planning, Samaritans Purse, Firelight Foundation, Mustard Seed Foundation, Joseph Rowntree Charitable Trust, and Pfizer Health Literacy. These project theses met more criteria from the three funding agencies from that list, the Firelight Foundation, the John M. Lloyd Foundation, and the Joseph Rowntree Charitable Trust and therefore were selected.

Firelight Foundation

The mission of the Firelight Foundation is to "support and advocate for the needs of children/youth orphaned or affected by HIV/AIDS in sub-Saharan Africa". Some of the funding criteria include:

- They attempt to make resources available to grassroots organizations that increase the capacity of communities to care for people made vulnerable by HIV/AIDS.
- They usually give one-year grants of $5000 to $10,000.
- In the funding criteria on the website it is stated, “We believe that grassroots programs arising in direct response to real needs within the local community are often the most effective”.
- One of the eligible countries listed on the website is South Africa.

Areas of funding strictly prohibited include:

- Individuals
- Government entities
- Programs designed to influence legislation
- Academic or medical research

Steps to request funding include:

- Letter of inquiry which includes a summary of the project needing support
- Amount of money being requested
- Information regarding the activities and goals of the project
- Financial information for the most recent financial year
- Currency used and current exchange rate

The Decision Process:

- Deadline for letters of inquiry – October 15, 2005
- Notification by November 25, 2005 if they are interested in the full proposal
- If declined, they will explain why

- Funding awards will be made by May 2006

John M. Lloyd Foundation

The mission of the John M. Lloyd Foundation is to fund and support "novel, entrepreneurial projects that have a high likelihood of affecting social change with regard to HIV/AIDS".

1. To improve domestic and international policies:
    - To apply universal protections of human rights to issues concerning HIV/AIDS
    - To expand access to HIV/AIDS healthcare and treatment, and
    - To ensure access to accurate information about HIV/AIDS
2. To amplify global awareness of HIV/AIDS and to facilitate broad-based change in attitudes to reduce stigma and change behavior.
3. The grant limit is $20,000.00

Areas of funding strictly prohibited include:

- More than once per calendar year to any single organization
- More than three consecutive years to any single project
- To annual campaigns
- To operating budgets of established organizations
- To capital expenditures (physical plant, equipment, endowment)
- To indirect costs
- To individuals

Steps to request funding include submitting a Concept Letter (maximum 4 pages in length) composed of the following:

- Brief statement of the issues to be addressed, history, organizations prior involvement with these issues.
- Brief summary of the project
- Amount of money needed and information of sources of support
- Information regarding the activities and goals of the project
- Approximate starting date and duration of the project
- Organization's annual budget and list of current directors and officers

The Decision Process:

- Deadline for Concept Letter must be received by August 15 for the Fall Cycle and December 15 for the Spring Cycle
- Concept Letters reviewed favorably by the board will be asked to submit a Formal Proposal
- No awards date was given

Joseph Rowntree Charitable Trust

The mission of the Joseph Rowntree Charitable Trust (JRCT) is an independent, progressive organization committed to funding radical change towards a better world.

The JRCT makes grants to individuals and to projects seeking the creation of a peaceful world, political equality and social justice. They chiefly support work undertaken in the UK, Ireland and South Africa.

Funding criteria include:

- Support work that promotes a just and peaceful South Africa:

  - By addressing the problems of violent conflict on all levels of society
  - By building a strong human rights culture
  - Through the reduction of rural poverty

- Following a review and consultation during 2002/3, they now fund only projects and organizations in KwaZulu Natal.

Steps to request funding include:

- Letter of inquiry which includes a summary of the project needing support
- Amount of money being requested
- Information regarding the activities and goals of the project
- Financial information for the most recent financial year
- Currency used and current exchange rate

The Trust has only three grant cycles:

- Deadline for letters of inquiry for the current cycle – December 5, 2005
- Notification by March 18, 2006 for a decision
- If declined, they will explain why

Chapter 6 – Summary of Results

Introduction

The enormous problem of HIV/AIDS in South Africa is devastating the country. So many people diagnosed with AIDS are sent home to die alone without assistance or healthcare of any kind. Community volunteers are attempting to meet some of these needs through home-based health care programs. Because of the escalating numbers of victims, there are not enough home-based health care programs, not enough volunteers, and not enough money to replicate programs or increase the number of volunteers being trained. The purpose of obtaining information from the home-based health care volunteers in the Zisize Project was to provide statistical data to demonstrate that in order to replicate more programs, increase volunteer involvement, and ultimately reduce the number of people dying alone in their homes more money is needed.

The data collection consisted of surveying all the current volunteers working in the Zisize Project. Sixty-nine community volunteers (the total of current volunteers) in the three home-based health care programs of the Zisize Project will all be surveyed. They were asked to complete a survey, which contains questions regarding the number of people dying alone in the province of KwaZulu-Natal and questions on whether or not increasing the money for training, supplies, and stipends and thus increase programs would decrease the number of people dying alone.

Data Analysis

Question 1		
How many people do you believe die alone without health care in KwaZulu-Natal? Please circle a, b or c below:		
a. 25% - 50%	b. 50% - 75%	c. More than 75%
9	37	11

Hypothesis A of Objective I states that a significant number of volunteers in the Zisize Project believe more than 50% of people dying from HIV infections are dying alone without the support of health care. A significant number of volunteers in the Zisize Project circles "b" and "c" to Question 1, therefore it is concluded that Hypothesis A is true.

Chi-Square values for the number of volunteers who believe more than 50% of people in KwaZulu-Natal die alone without health care.

	a. 25% - 50%	b. 50% - 75%	c. More than 75%
Number Surveyed	9	37	11
Number Expected	19	19	19

Confidence level = 95%
Computed Chi-Square = 25.68
Chi-Square Table Value = 5.99

The computed chi-square value of a 95% confidence level is 25.68, which is greater than the chi-square value of 5.99. Therefore, the results are statistically significant and the researcher can claim with confidence that volunteers believe that more than 50% of people in KwaZulu-Natal die alone without health care.

Question 2	**Yes**	**No**
If more home-based health care programs were added, would the number of people dying alone go down?	57	0

Hypothesis B of Objective I states that a significant number of volunteers in the Zisize Project believe increasing the number of home-based health care programs by 100% would decrease the number of people dying alone. One hundred percent of

volunteers answered “Yes” to Question 2, therefore it is concluded that Hypothesis B is true.

Question 3 – If you answered **“yes”** to Question 2, please mark below the reasons more home-based health care programs have not been started.		
Not enough communities will start a home-based health care program because there is:	**Yes**	**No**
1. Not enough money to train new volunteers	47	10
2. Not enough money for medical packs and supplies	57	0
3. Not enough money for volunteers to live on	49	8

1. Not enough money to train new volunteers calculated to 82%.
2. Not enough money for medical packs and supplies calculated to 100%.
3. Not enough money for volunteers to live on calculated to 86%.

The hypothesis states that a significant number of volunteers believe there are not enough money in each of the categories, 1, 2, and 3. Since more that 50% believe this to be true, this hypothesis is accepted as true.

Question 4	**Yes**	**No**
Do we need more home-based health care programs?	57	0

Question 4 on the survey addressed Hypothesis A of Objective II. One hundred percent of volunteers answered “Yes” to Question 4, therefore it is concluded that Hypothesis A of Objective II is true.

Question 5		
If you answered “Yes” to Question 4, please mark below the reasons more home-based health care programs have not been started.		
Not enough communities will start home-based health care programs because there is:	**Yes**	**No**

1. Not enough money to train new volunteers	57	0
2. Not enough money for medical packs and supplies	57	0
3. Not enough money for volunteers to live on	38	19

Question 5 on the survey addressed Hypothesis B of Objective II. A significant number of the volunteers answered "Yes" to each of the three questions under Question 5, therefore it is concluded that the hypothesis is true.

1. Not enough money to train new volunteers – 100%.
2. Not enough money for medical packs and supplies – 100%.
3. Not enough money for volunteers to live on – 67%.

Question 6	Yes	No
If more home-based health care programs were started, do you believe more patients could be helped?	57	0

Question 6 on the survey addressed Hypothesis B of Objective II. One hundred percent of volunteers answered "Yes" to Question 6, therefore it is concluded that Hypothesis B of Objective II is true.

Question 7		
If you answered "Yes" to Question 6, please mark below the reasons more home-based health care programs have not been started.		
Not enough communities will start a home-based health care program because there is:	Yes	No
1. Not enough money to train new volunteers	57	0
2. Not enough money for medical packs and supplies	56	1
3. Not enough money for volunteers to live on	47	10

1. Not enough money to train new volunteers – 100%.
2. Not enough money for medical packs and supplies – 98%.
3. Not enough money for volunteers to live on 82%.

Question 8	**Yes**	**No**
Do we need more volunteers in the home-based health care programs?	57	0

Question 8 on the survey addressed Hypothesis A of Objective III. One hundred percent of the volunteers answered "Yes" to Question 8, therefore it is concluded that the hypothesis is true.

Question 9		
If you answered "Yes" to Question 8, please mark below the reasons more volunteers have not been trained.		
	Yes	**No**
1. Not enough people will work as a volunteer	0	57
2. Not enough money to train new volunteers	57	0
3. Not enough money for medical packs and supplies	57	0
4. Not enough money for volunteers to live on	48	9

A significant number of the volunteers answered "Yes" to each of the last three questions under Question 9, therefore it is concluded that the hypothesis is true.

1. Not enough people will work as a volunteer – 100% disagree suggesting that if money was available, people would be willing to work as a volunteer.
2. Not enough money to train new volunteers – 100%.
3. Not enough money for medical packs and supplies – 100%
4. Not enough money for volunteers to live on – 84%.

Question 10	Yes	No
If more volunteers were added, could more patients be seen?	56	0
(No answer – 1)		

Question 10 on the survey addressed Hypothesis A of Objective III. A significant number of the volunteers answered "Yes" to Question 10, therefore, it is concluded that the hypothesis is true.

Question 11		
If you answered "Yes" to Question 10, please mark below the reasons more volunteers have not been trained.		
Not enough communities will start a home-based health care program because there is:	Yes	No
1. Not enough people will work as a volunteer	0	57
2. Not enough money to train new volunteers	57	0
3. Not enough money for medical packs and supplies	57	0
4. Not enough money for volunteers to live on	57	0

Question 11 addressed Hypothesis B of Objective III where one hundred percent of volunteers answered "Yes" to each of the last three questions, therefore it is concluded that the hypothesis is true.

1. Not enough people will work as a volunteer – 100% disagreed suggesting that if money was available, people would be willing to work as a volunteer.
2. Not enough money to train new volunteers – 100%.
3. Not enough money for medical packs and supplies -- 100%.
4. Not enough money for volunteers to live on – 100%.

Conclusion

A survey was completed and returned by 57 out of the 69 of the current volunteers. All questions on the survey resulted in almost identical responses. Therefore, this researcher is convinced that lack of money to replicate home-based health care programs and increase the number of volunteers is a serious problem. A significant number of volunteers believe more money is needed in order to gain more volunteers. Adding more volunteers would allow more people to receive the care they so desperately need.

Chapter 7 – Conclusions and Recommendations

Statement of Purpose

As this thesis has already stated, South Africa is experiencing an HIV/AIDS crisis of enormous proportions. It is out of control where every day there is 1,800 new HIV infections. Every day 800 people die of AIDS-related illnesses. This will amount to 292,000 AIDS deaths by the end of 2005. The enormity of this problem has left clinics and hospitals unable to meet the needs of AIDS victims. People sent home to die, often alone, need help. Community volunteers are attempting to meet some of these needs through home-based health care programs.

Conclusion

In an attempt to exhibit the need of volunteers to meet the serious challenges of their communities, a survey was completed. All questions on the survey resulted in almost identical calculations. Therefore, this researcher believes that lack of money to replicate home-based health care programs and increase the number of volunteers is a serious problem. A significant number of volunteers believe injecting more money into the program will positively influence the growth and replication of services. This brings a significant statement of need. In order to bring adequate health care to community members who are sick and dying of AIDS-related illnesses, more money is essential to grow these programs.

Recommendation

It is the recommendation of this researcher that three grant proposals be submitted to obtain funds for the home-based health care programs under the direction of the Zisize Project. These grant proposals will be submitted to the John M. Lloyd Foundation , the

Joseph Rowntree Charitable Trust, and to the Firelight Foundation. By obtaining funding, more programs can be started and more volunteers can be recruited. By increasing the "helpers", those being "helped" can also be increased. The goal of this grant money is to alleviate as much suffering as possible and bring dignity to those sick and dying.

Further Research

The research done in this project touched on only a small portion of the HIV/AIDS crisis in Africa. So much more needs to be done, especially in the realm of prevention. There are many organizations addressing this area and many others as well, such as the plight of AIDS orphans, child-headed households, extreme poverty, AIDS awareness, AIDS education, and much more. The small step taken in this project thesis, focused on the need for communities to be helpful and compassionate to their neighbors.

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Appendix A

Reflections

Reflecting on why I decided to apply to the MOD program, a number of reasons come to mind. I had applied for this program years ago when I was living in Lansing, and was accepted. Then prior to beginning the program, my husband and I decided to accept a position in South Africa for three to five years. Therefore, I placed this dream of earning a bachelor's degree on hold and our time in South Africa increased to eight years.

When we knew that we were nearing the end of our full-time involvement in South Africa, I began again looking into working on my degree. This time, however, we would be living in Grand Rapids and there were a number of other options available; Calvin College, Western, Cornerstone, and again Spring Arbor. After researching all of them, I still came back to Spring Arbor. I like that it is a Christian college and the focus on adult degree-completion studies was, I believe, by far the best.

The MOD program seemed to be the one that met my current needs and was a direction I wanted to continue when seeking employment. Being an R.N., many people assumed I would pursue a BSN. I had no desire to go that route. I had worked in the business/administrative world for many years after my nursing career and found I like the environment and preferred it over nursing.

When I discovered that the MOD program would begin in August 2004 or possibly again in January or February, 2005, my husband and I looked at our best options. In March 2005, my husband would be taking six months to walk the entire Appalachia Trail. This would be good time for me to immerse myself in the demanding

schedule of the MOD studies. Because I could not be assured that the second MOD class would begin as hoped in January, we decided that I would return early to the States while my husband finished our work and closed our home in South Africa. This plan worked out well for both of us.

I must admit that initiating this course of studies was a real challenge and took me way outside my comfort zone. Although I am the oldest student in my cohort group, I have felt welcomed and affirmed. We have such a varied group and it has made our class interesting and informative. I have found the instructors knowledgeable and experienced. Of all the classes, I was most fearful of the Critical Thinking and Research Writing. I found it a challenge but I learned so much and gained an enormous amount of confidence in my writing. The writing is reinforced with every module by doing the Critical Synthesis Paper and therefore continues to build confidence and give more experience and thus gain expertise. I found this module so helpful and something I will use in my work in the future.

When I first began the program, I was surprised to learn that we would be expected to write a project thesis paper. I have never heard of a bachelor's program than required a thesis. A number of people have remarked that this program seemed more like a master's program. Although I was not excited about writing a thesis and it has certainly demanded a amazing amount of time, it has been a learning experience that will serve me well in the future. The process is outlined very well and takes us through each module, applying the material we learn and building from each point. It would have been an overwhelming project, but the process we followed was so helpful from module to module. I could have never imagined doing the statistic section without first completing

the statistic module. I appreciated the input and direction we received from our project advisor.

With only six weeks to go before completing this program, I am excited about finally reaching my goal of obtaining a bachelor's degree. I have dreamed of this for a long time. Seeing my husband receive his master's degree and each of my children receiving their bachelor's degree has spurred me on. Now it is my time and I am very proud of myself.