EXPERIENCES OF HOME-BASED CARE ORGANIZATIONS IN THE CONTEXT OF THE GLOBAL FINANCIAL CRISIS

BY

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Submitted in partial fulfilment of the requirements for the degree of

Masters in Psychology (Health Promotion)

In the School of Applied Human Sciences

University of KwaZulu-Natal

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July 2014

DECLARATION

I hereby declare that this dissertation is entirely my original work, unless otherwise indicated in the text. All citations, references and borrowed ideas have been duly acknowledged. This dissertation has not been submitted to any other University for any degree or examination purposes.

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ACKNOWLEDGEMENTS

I would like to thank the following people who played important roles in the completion of this project. I am grateful to Dr Olagoke Akintola my supervisor and mentor. Thank you for your encouragement, patience, guidance, support and expert advice throughout the study. I also thank Dr Olagoke Akintola for funding this study and supporting my tuition through his researcher-linked postgraduate grant from the National Research Foundation (NRF). I would like to thank my late mom (Mrs Margaret Gwelo) for the support, guidance, prayer and words of encouragement you gave me throughout the study. Thank you mom for the sacrifices and long nights you spent with me in order to complete this study. Unfortunately you did not see the complete study but we finally made it through. May your soul rest eternal peace. To my siblings Pedzisai Gwelo, Farai Gwelo, Tawanda Gwelo and Itai Gwelo thank you for all the encouragement and advice you gave me. To my brother Tawanda Gwelo and Rumbidzayi Matangira, thank you for making my dreams come true and the support you have given me throughout my educational journey especially in the completion of this study. I am also thankful to my friends who supported me throughout the research project. Also I extend my gratitude to different home-based care organizations for granting me permission to conduct the study in their organizations and all the managers who participated in the study, without your contribution this research would not have been possible.

DEDICATION

I would like to dedicate this study to my precious and loving late parents Mr & Mrs Margaret Gwelo, who always supported and encouraged me throughout my journey. Unfortunately you did not live long to see the completion of this study. May your soul rest in eternal peace till we meet again. Love you always. To my family and friends thank you for the prayers and encouragement.

ABSTRACT

Background: The global economic crisis has posed major threats to the fight against HIV and AIDS especially in developing countries. The crisis which originated in well-developed economies such as the US in 2007/2008 (Kin & Penn, 2008) has impacted key drivers of growth in trade, investment, mining and manufacturing at a global level. However, it is unclear how this crisis is affecting small, non-profit organizations providing care and associated services to people living with and affected by HIV/AIDS.

Aim: The aim of this study was to explore the experiences of home-based care organizations in the context of the global financial crisis and its implications on the provision of services offered by home-based care organizations through the perspective of the managers.

Methods: In-depth qualitative interviews were conducted with 10 managers who work in care organizations that provide care services to people living with HIV/AIDS using an interview schedule containing open-ended questions.

Findings: The findings of the study show that the global financial crisis at the macro level has affected government and donors/funders' grants to non-profit organizations. This has resulted in a reduction of funds allocated to care organizations. Funding cuts have severely affected care organizations at the exo-level. Care organizations were forced to employ different strategies such as organizational restructuring in order to survive in the new funding environment. This led to downscaling of services and the number of communities served, retrenchment of paid staff and reduced incentives for volunteer caregivers. Organizational restructuring had profoundly implications on recruited workers at the meso-level. Paid staff were confronted with retrenchment while volunteer caregivers were confronted with rationalization of incentives. At the micro level, there were severe implications for beneficiaries of care services. People who depended on these services are at a high risk of becoming more vulnerable to diseases and poverty.

Recommendations: These findings highlight the need for the government to play a bigger role in the provision of funds and support to home-based care organizations. The government needs to incorporate home-based care into its social and economic policies to create a reliable source of funds for care organizations.

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CHAPTER ONE

INTRODUCTION

1.1 Introduction and background

The global economic crisis has posed major threats to the fight against HIV and AIDS especially in developing countries. This crisis started in well-developed economies such as the United States in 2007/2008 (International Monetary Fund, 2009; UNAIDS, 2012). The financial crisis originated from the collapse of financial markets in the US and later spread to other countries through world financial markets and broadened to an economic, social and political crisis (Rudd, 2009). This has led to significant challenges such as businesses performing poorly leading to a collapse of many firms and tightening of credit (Butterly, 2011, Edwards, 2010).

The global financial crisis reduced economic growth in many countries and led to deep cuts in national development plans (Siddiqi, 2000). The International Monetary Fund states that the global financial and economic recession led to a 5% contraction in the economies of both developed and developing countries in 2009, the first such fall in 60 years (UNAIDS, 2009). The business sector, including banks, construction and agricultural industries are highly dependent on trade, foreign direct investment and international development assistance. As a result, these sectors were hardest hit by the economic downturn that followed the global financial crisis (Purnanandam, 2011). Furthermore, the financial crisis also contributed to the economic downturn in most African countries. This led to food and oil crisis, reduced export volumes due to lower demand from overseas markets, a reduction in foreign direct investment and fewer tourists' arrivals due to pressure on individual incomes (International Labour Organization, 2009).

The global financial crisis did not spare South Africa. South Africa entered into the recession in May 2009 (Statistics South Africa, 2011). In the first quarter of 2009, 959 000 people lost their jobs in South Africa (Statistics South Africa, 2009). South Africa had been facing enormous socio-economic problems prior to the global financial crisis such as high levels of poverty, an unemployment rate of between 23% and 25%, high food prices and an electricity crisis (Antonopoulos, 2009). However, the financial crisis has worsened the problems. The global economy once helped to lift hundreds of millions of people out of poverty in developing

countries, the World Bank Group estimated that the global financial crisis would result in an additional 53 to 65 million people being trapped in extreme poverty in 2009.

Across sub-Saharan Africa, government spending on social and health services have also been affected by the global financial crisis. Government spending on health and social sectors has declined as a result of a decline in government revenues. McConnon (2008) states that, government revenue has decreased in most developing countries due to the decline in world trade and unstable economies. Tanzania for example, was reported to be the first sub-Saharan African country to announce a 25% cut in its annual budget (Palitza, 2009). Moreover, donor spending, which contributes the majority of funding in the health sector has been affected by the global financial crisis (International Monetary Fund, 2012). Most international donors have reduced the funds allocated to health and social problems. For example, Ireland reduced its Official Development Assistance (ODA) to South Africa from 13.9 million Euros to 4 million Euros. Reductions in government and donor funding could have negative implications for the beneficiaries of HIV/AIDS programmes (people infected and affected by HIV/AIDS) and those who work in non-profit organizations. This could increase the burden on public health systems which are already functioning with limited resources.

Non-governmental organizations (NGOs) play an important role in the development of a country. These organizations work on development issues, especially those around social and health issues (Lewis & Kanji, 2009). In South Africa, NGOs have collaborated with the government to address problems faced by the citizens such as the high unemployment rates, poor social and health service delivery. Non-governmental organizations rely heavily on funds from the government, corporate donors, foundations and individual donations. Leading NGOs like Save the Children, UK, Oxfam GB, UK and World Vision, USA have been severely affected by the global financial crisis (IRIN, 2008a). These organizations have been forced to scale down on services provided due to reduced income from private sector donors that had been badly hit by the recession (IRIN, 2008a; IRIN, 2009). However it is not clear how the global financial crisis has impacted small NGOs that provide home-based care programmes.

Home-based care programmes are implemented by non-profit organizations, including NGOs, faith-based organisations (FBOs), and community-based organisations (CBOs) to provide services that are not available through health care institutions (Akintola, 2011; Moshabela, Gitomer, Qhibi, Schneider, 2013). Home-based care organizations provide ongoing care to

people living with HIV/AIDS. They also offer support to patients and their families whilst addressing their material, physical, psychosocial, palliative and spiritual needs (CADRE, 2002; World Health Organization, 2002). Given the impact of the financial crisis on the investment banking sector, individuals and large international NGOs, one could surmise that smaller non-profit organizations working in communities would be severely affected. This could have negative implications for the beneficiaries of the services offered by these organizations as well as those who work for the care organizations.

1.2 Problem statement

A number of studies have explored the impacts of the financial crisis on the economy (Access Economics, 2008; Butterly, 2011; Edwards, 2010; Kim & Penn, 2008; Rudd, 2009); government spending on social and health issues (McConnon, 2008); international aid (IRIN, 2008a; IRIN, 2009); employment (Statistics South Africa, 2011); and livelihoods, poverty and households (Antonopoulos, 2009). However, it is unclear how the global financial crisis is affecting small non-profit organizations providing care and associated services to people living with and affected by HIV/AIDS. There is limited evidence on the effects of the global financial crisis on non-profit organizations such as home-based care organizations. We therefore do not know the implications of the global financial crisis on organizations providing care services and how these organizations are responding to the crisis and the implications it has on the workers and beneficiaries of the services.

1.3 Aim of study

The aim of this study is to explore the impacts of the global financial crisis on home-based care organizations through the perspective of managers. The study also aims to examine the resources available to home-based care organizations, the implications of the global financial crisis on the provision of services offered by these organizations to people living with HIV/AIDS in South Africa, and the strategies employed to cope with these impacts as seen by the managers. Findings of this study could assist policy makers in designing interventions aimed at improving financial support programmes for home-based care organizations. In the same vein, the findings will provide a broad perspective on the well-being of HIV and AIDS organizations and the ways in which these organizations can be assisted in terms of financial and technical support. Moreover, insights gained from this study could assist home-based care organizations to design different programmes to generate additional funds.

1.4 Specific objectives

- To understand managers' perspectives about how the global financial crisis has affected the resources available to home-based care organizations.
- To explore managers' perspectives of how home-based care organizations are responding to the financial difficulties
- To describe managers' perspectives of the implications of the financial crisis on the provision of services offered by home-based care organizations.

1.5 Key Research Questions

- How do managers' explain impact of the economic hardship and scarcity of resources on the availability of resources in home-based care organizations?
- How do managers' explain home-based care organizations responses to the global financial difficulties?
- What are manager's perspectives about the implications of the financial crisis on home-based care organizations?

1.6 Structure of dissertation

Chapter One: This chapter briefly introduces the study. It provides relevant background information of the study, outlines the research problem statement, states the rationale and objectives of the research and summarises the significance of the study.

Chapter Two: This chapter presents a review of the relevant literature on the impact of the financial crisis on different sectors. The literature review included broad commentary on previous research studies on the impacts of the financial crisis on the profit sector, labour market, health sector, international aid and not for profit sector. The theoretical framework that guides this study, the ecological systems theory, is also discussed.

Chapter Three: This chapter outlines the research methodology. The research design, study area, sampling method, data collection procedures, data analysis, ethical considerations and limitations are presented.

Chapter Four: This chapter presents findings from the in-depth interviews as analysed using the thematic analysis.

Chapter Five: Chapter five presents discussions of results using the ecological systems theory. It also concludes this this study discussing considerations and recommendations for future endeavours in this area research.

1.7 Chapter Summary

This chapter presented an introduction and background to the study, and the structure of the dissertation. The following chapter provides a review of the literature on the experiences of different sectors in the context of the global financial crisis.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

The term, 'financial crisis' is applied broadly to a variety of situations in which some financial institutions or assets suddenly lose a large part of their value. In the 19th and early 20th centuries, many financial crises were associated with banking panics and recessions coincided with these panics (Adamu, 2009). Other situations that are referred to as financial crises include stock market crashes, the bursting of other financial bubbles, currency crisis and sovereign defaults (Kindleberger & Aliber, 2005; Laeven & Valencia, 2008). This chapter presents a review of literature pertaining to the impact of financial crisis on different sectors. It includes broad commentary on previous research studies on the general impacts of the financial crisis on the profit sector, labour market, health sector, international aid and non-profit sector. The theoretical framework (ecological systems theory) that guided this study is also discussed.

2.2 Background to the global financial crisis

The global financial crisis originated from the collapse of financial markets in the US and later spread to other countries through world financial markets. According to Teka & Magezi (2008), the financial crisis that threatened to collapse the global economy occurred in three stages. The first was a decline in the stock indices of the world's leading banks and financial institutions in 2007, which was provoked by a transfer of risk capital from developed markets to emerging markets. The second stage in 2008 unfolded with the continuing fall in world stock markets that spilled over from 2007. The third stage of the global financial crisis is currently unfolding; it is defined by the serial bankrupting of the world's leading financial companies and the collapse of global financial markets (Teka & Magezi, 2008).

The global economic and financial crisis of late 2008 and 2009 is considered by most economists around the world as the worst economic turmoil since the great depression in 1930s (Musau, 2010). According to the International Monetary Fund (2008), the global economy experienced a deep downturn as the financial crisis spread rapidly around the world. Many advanced economies have fallen into recession whilst the rest have abruptly slowed (Purnanandam, 2011). Global trade and financial flows are decreasing while output and employment losses mount and credit markets remain frozen. This has led to many problems which include reduced business growth, sinking retail sales and the tightening of credit (Rudd,

2009). An average of 40% decline was reported in stock markets and the continued decline in world stock markets values spilled over into 2009 (Danylyshyn, 2008). This fallout was triggered by the redirection of cash flows from one class of assets to another, particularly commodities and energy resources. Many other African countries like Mauritius, Zambia, Kenya and Botswana were reported to have suffered severe declines in their stock markets.

The demand for oil and gas in international markets reduced and there was a steady stream of announcements of cutbacks in capital spending and project delays and cancellations, mainly as a result of lower prices and cash flows (Brambila & Massa, 2009). Moreover, the global upstream oil and gas investment budgets for 2009 were cut by around 21% compared with 2008 (a reduction of almost $100 billion) (Organization for Economic Co-operation and Development, 2009). Countries like Nigeria and Angola which are largely dependent on oil exporting revenue have experienced major decline in their exporting revenues (Musau, 2010). This decline has led to a decrease in their government revenues. The decline in government revenues were reported to be from 24% in 2008 to 25% in 2009 in Angola and Nigeria (Masau, 2010). Furthermore the mineral exporting industries have also experienced large revenue loss since the onset of the recession.

The demand for minerals from America has largely decreased because of the economic down turn in the developed countries. In June 2008 the production in Democratic Republic of Congo (DRC) was 34215 tons; by October 2009 production had reduced to 23562 tons (Brambila & Massa, 2009). The slowdown in mining process in countries like DRC has led to closing of extracting sectors and this has resulted in unemployment and high poverty rates (Brambila & Massa, 2009). Literature shows that Sierra Leone laid off 90% of it diamond mine workers, in Zambia some 5000 copper workers were laid off with each mining job sustaining an estimated 20 jobs in the informal economy; Botswana has temporarily closed the diamond mines that generate 80% of its exports (Brambila & Massa, 2009).

The word-wide financial and economic recession led to a decrease of about 5% in the economies of both developed and developing countries in 2009, the first such fall in 60 years (UNAIDS, 2009). In Africa, economic growth began to decrease in the second half of 2008, with average growth falling from nearly 7% in 2007 to just less than 5.5% in 2008 (Arieff, Weiss, & Jones, 2009). Sub-Saharan Africa was also affected. Nigeria, Ghana, Kenya and South Africa were the first to feel the impact due to their financial links with other regions in

the world, the region's growth rate dropped from 6.9% in 2007 to 5.5% in 2008 (International Monetary Fund, 2009). In January 2009, the International Monetary Fund reduced its growth forecast by 1.6 percentage points to 3.5%. Most countries experienced a reduction in jobs and remittances due to the recession. This had severe impacts on poverty levels and households' capacity to pay for healthcare. In addition the financial crisis had negative impacts on the global markets and this affected most commodity prices and caused major economies to stagnate (Danylyshyn, 2008).

2.3 General Effects of the Global Financial Crisis

2.3.1 Labour market

The global economic crisis has led to a serious slowdown in world economic growth and to considerable job losses. Choudhry, Marelli & Signorelli (2010) argue that the 2008-2009 global recession is still having dramatic consequences for the labour markets of many countries. It has led to mass unemployment, with workers being retrenched from formal sectors which are directly linked to global markets. The global recession has also led to a decline in remittance flow and a reduction in government spending on social services (Espey, Harper & Jones, 2010). The International Labour Organization (ILO) (2009) points out that the global economic slowdown is disproportionately affecting low-income groups. Furthermore, the World Bank (2008) states that since the onset of the 2007 global financial and economic crisis, at least 30 million women and men have joined the ranks of the unemployed thus resulting in an astounding total of 200 million people being unemployed (Antonopoulos & Kim, 2011).

Literature on past financial crisis and economic downturns suggests that young and unskilled female workers as well as migrants are particularly vulnerable and are more likely to bear the brunt of rising unemployment (World Bank, 2007). Feminists and gender activists have argued that the financial crisis has severe impacts on the poor and on women (Antonopoulos, 2009, Fukuda-Parr, 2009, Seguino, 2009). In developing countries where women are concentrated in export manufacturing industries, such as Latin America and Asia, the job losses for women were predicted to be greater than that for men (Antonopoulos, 2009). Women make up 60-80% of export manufacturing workers in low and middle income countries. These industries usually hire low skilled labour especially from women. Women have therefore been severely affected by the financial crisis (Antonopoulos, 2009). Studies of the Asian crisis have noted that the

closure of garment factories has led more young women to turn to the informal economy and sex work to compensate for their loss of income (UNAIDS, 2012). The shrinking of markets in high and middle income countries has also resulted in foreign women migrants from poorer regions and countries losing their jobs. This has exacerbated poverty in many countries (UNAIDS, 2012).

2.3.2 Health Sector

The global economic crisis has had a significant negative impact on public health and health care systems worldwide (Evans, 2009). The impact has been more on the health of the population groups with low incomes women and children. The global financial crisis affects population health through impoverishment which encompasses increasing unemployment and job insecurity, currency instability and cuts to social and health programmes (Mohindra, Labonte & Spitzer, 2011). Women and girls are more vulnerable to poor health and inadequate nutrition due to the financial crisis (Mohindra, Labonte & Spitzer, 2011).

Socio-economic scholars suggest that governments should be spending more money on social interventions as an important response to the financial crises (Antonopoulos, 2009; Seguino, 2010; Torres, 2009). However, this has not been the case in many developing countries. McConnon (2008) states that, in most developing countries, government revenue has fallen due to the decline in world trade, leading to economy instability. This has forced many governments to restructure their subsidies, increase tax and duties to increase revenue, address fluctuations in the value of hard currency and control their spending on social services (The World Bank 2009; UNAIDS, 2009). Reports show that countries that have less revenue have limited the country's ability to expand social spending (International Monetary Fund, 2009). Most governments have reduced their social and health budgets. This affects the people who depend on these programmes. They are more vulnerable to risk during a crisis (Antonopoulos, 2009). This could have significant impacts on the response to HIV and AIDS.

AIDS activists have raised serious concerns about the potential impacts of the global financial crisis on health funding, predicting devastating effects on AIDS programmes (Kardas-Nelson, 2009). The Global Fund to fight AIDS, Malaria and TB, the largest funder of AIDS programmes worldwide, has an estimated shortfall of $3billion to $5billion and has begun to dramatically scale down the number of grants it allocates to programmes. Literature shows that

Mozambique did not receive any funding from this source. Tanzania and Swaziland's domestic AIDS programmes have suffered major cutbacks (Kardas-Nelson, 2009). Tanzania was reported to be the first sub-Saharan African country to announce a 25% reduction in its annual budget (Palitza, 2009). The reduction in health budgets may pose major challenges to the fight against HIV/AIDS, leading to increased mortality and morbidity rates, greater transmission risks, an increased burden on health systems, and budgetary cuts for HIV/AIDS programmes (The World Bank, 2009).

Botswana has had a very successful and well-resourced ARV programme for years but the government announced that it would not be able to provide people who are HIV positive with free antiretroviral (ARV) treatment from 2016 onwards because of the financial global crisis (IRIN, 2008c). A study conducted by UNAIDS, WHO and the World Bank revealed that 61% of those receiving ARV treatment, expected the economic crisis to negatively impact ARV programmes, while 48% expected prevention programmes to be adversely affected, especially for Most At Risk Populations (MARPs) (UNAIDS, 2009).

2.3.3 International Aid

Health sectors in most the African countries depend heavily on the external financing and aid packages. According to Musau (2010), Africa's external funding for health sector was about 17% in 2006, however as the global financial crisis deepened, health care financing in African countries has been tremendously decreased. Aid from donors has played a significant role in many areas in developing countries (Hestad & Tjonneland, 2003). In Africa, more than 50% of total public health spending comes from aid commitments (Seguino, 2009). Aid from donors/funders has assisted the transformation of institutions, the development of new policies and the implementation and delivery of services such as health care and skills development. International aid accounts for 0.3% of Gross National Income (GNI) in developing countries however, it has fallen as GNI increased faster than the aid flow (Organization for European Economic Cooperation and Development, 2007). Ireland reduced its Official Development Assistance (ODA) to South Africa from 13.9 million Euros to 4 million Euros because of the economic downturn. The cut in funding may have severe consequences for sectors that rely on international aid.

Arieff et al., (2009) observes that the global recession has affected many African countries, leading to reduced foreign aid. Eighteen of the forty-seven countries that received funding from the Global Fund to fight AIDS, Tuberculosis and Malaria stated that grants from the Fund had ceased in 2009 and some in 2010. The Fund faced a $3 to $5 billion deficit in 2010; it was forced to postpone round 9 funding allocations until November 2009 in order to allow more time for funding mobilization (Kardas-Nelson, 2009). Moreover, while the National Strategic Plan in South Africa for HIV/AIDS 2007-2011 was projected to cost R48 billion over the five year period, the total HIV/AIDS allocation was only R11.4 billion (South African Department of Health, 2009). These statistics illustrate that HIV/AIDS programmes are underfunded; this may have serious implications for organizations that implement HIV/AIDS programmes. The harsh economic situation means that HIV and AIDS programmes will be constrained in their assistance to beneficiaries (people affected and/or infected by HIV/AIDS).

Overseas development assistance (ODA) is the primary source of health care financing for African countries especially in the fight against the AIDS pandemic (Musau, 2010). According to Roodman (2008), Norway's aid contribution to South Africa has fallen by 10%, Sweden's by 17% and Finland's by 62%. Leading NGOs such as Save the Children, UK, Oxfam GB, UK and World Vision, USA also experienced a reduction in income received from private sector donors as a result of the recession (IRIN, 2008c). In addition the programme growth of the world's top NGOs, namely, Oxfam, Save the Children of Great Britain and World Vision of the US was slow in 2009 as a result of the financial crisis (Gross, 2008).

2.4 Impacts of the financial crisis in South Africa

The global financial crisis had a severe impact on South Africa. The economy went into recession in 2008/09 for the first time in 17 years (Steytler & Powell, 2010). The labour market outcomes in South Africa were severely affected (Kganyago, 2012). In the first quarter of 2009, 959 000 people lost their jobs, the majority in manufacturing industries and the financial sector (Statistics South Africa, 2009). Literature shows that job losses were more in the construction, retail, and financial services, which were the major job gainers in the economy (Kganyago, 2012). The unemployment rate rose from 21.9% in the first quarter of 2008 to 23.5% in the fourth quarter of 2009 (Hazelhurtst, 2009). Sishoba (2009) notes that the mining sector, which is one of the biggest employers of migrant labour, shed an estimated 50 000 jobs in 2009. By the end of 2009 near a million jobs were lost (Steytler & Powell, 2010). This has negative

socio-economic ramifications for households that depend on domestic remittances from mineworkers.

The financial crisis worsened the socio-economic conditions in South Africa. As the global economic crisis hit the key drivers of growth (trade, investment, and the mining and manufacturing sectors), South Africa's economy shrink by 2.25% in 2009 (Danylyshyn, 2008). At the end of 2008, South Africa reported its first GDP deficit of -0.73 after 17 years of positive growth (International Centre Trade Sustainable Development [ICTSD], 2010). According to a survey done on the South African economy the change in the growth rate of real GDP between 2008 and 2009 represented the largest single-year slowdown on record for South Africa, and was larger than in most advanced and emerging economies (Organization for Economic Co-operation and Development, 2010). It is evident that the financial crisis contributed to the decline of key economic sectors in South Africa. Furthermore, the increase in global food prices put strain on household budgets and compromised individual resilience to further economic hardship (Arieff et al., 2009).

The main causes of the recession were related to trade and financial flows and a sharp reduction in consumer demand and private investment (Organization for Economic Co-operation and Development, 2010). Like other developing countries which are strongly integrated into the world economy, South Africa is a middle income country whose economy relies on financial services and exporting manufactured goods and primary commodities (such as gold, platinum and chrome). South Africa's economy has been affected by the sharp fall in demand for its export products and the decline in the prices of key export commodities. The global financial crisis also affected commercial credit and consumer demand decreased, export and import volumes fell and net financial inflows turned to net outflows, resulting in a sharp decline in share prices (Gordhan, 2010).

South Africa's previous socio-economic and political dispensation, which was built on the principles of apartheid, highly disadvantaged the majority population groups, mainly people of color and women. Some studies have revealed that these groups have been most affected by the global financial crisis (Antonopoulos, 2009; Seguino, 2010). These studies show that the crisis is having severe impacts on the poor, a substantial proportion of whom, are women.

2.5 Impacts of financial crisis on the Non-Profit Sector

Non-profit organizations in many countries address development issues especially those relating to social and health services (Lewis & Kanji, 2009). These organizations provide a variety of much-needed services in communities, such as serving the needs of low-income neighbourhoods and health services. They play a very important role in promoting citizens wellbeing. In South Africa, non-profit organizations have collaborated with the government to provide services in different communities.

Non-profit organizations tackle social issues and problems faced by citizens such as high unemployment and poor social and health service delivery. Reliance on non-profit organizations has increased in South Africa as the country faces the challenge of AIDS epidemic and other socio-economic problems. South Africa's health care system, like other low and middle income countries, struggles to cope with the collision of excessive health burdens: such as communicable diseases especially HIV/AIDS and Tuberculosis. Globally, South Africa is reported to be the country with the largest population of people living with HIV/AIDS (5.7 million) (Department of Health, 2011; UNAIDS, 2011). This has placed a huge burden on public health facilities that are already functioning with limited resources, including inefficient government spending, a shortage of hospital beds, a shortage of health professionals and materials (Schneider, Blaauw, Gilson, Chabikuli & Goudge, 2006). As a consequence, community members have increasingly adopted home based care in places where services are inadequate or unavailable (Schneider & Lehmann, 2010). Non-profit organizations such as care organizations are providing alternative care services to hospital care (Akintola, 2008; Department of Health, 2001). Care organizations provide comprehensive services, including health and social services, by formal and informal caregivers at home (Akintola, 2011). They provide on-going care and support to HIV/AIDS patients and their family members (CADRE, 2002; World Health Organization, 2002).

According to Moshabela, Gitomer, Qhibi &Schneider (2013), non-profit organizations can be broadly classified into three categories. Firstly, there are small community-based organisations (CBOs) organized at local grassroots level and are run by local community members. Secondly, there are larger NGOs operating at a provincial or national level, often sub-contracting CBOs to carry out their mandates. Finally, there are international agencies operating in several countries, usually associated with humanitarian missions. Akintola (2011) identified a fourth category which also operates at community level but is run by Christian Churches. These are

known as faith-based organizations (FBO). In South Africa most non-profit organizations are largely CBO in nature, and are fragmented in terms of their social network structure. They are poorly-resourced and tend to offer home-based care services and fewer community development or mobilization activities (van Pletzen, Zulliger, Moshabela, Schneider, 2013). Non-profit organizations are required to register with the government in order to receive government funding (Moshabela et al., 2013). It is estimated that more than 800 organizations, ranging from fully-funded, well-established organizations to smaller groups with limited funds are providing home-based care services in South Africa (Mabude, Beksinska, Ramkisoon, Wood & Folsom, 2008).

Socio-economic scholars suggest that, in response to the financial crisis, government should be spending more money on social interventions (Antonopoulos, 2009; Seguino, 2010; Torres, 2009). Instead, governments have reduced their budget on social spending. This has put pressure on non-profit organizations to respond to the social needs not being met by the government (Jayasinghe, 2007). This in turn has left the poor more desperate. Many people are reported to be switching from private to public health care services. Care organizations in the non-profit sector have played a vital role in communities affected by HIV/AIDS. They improve citizens' wellbeing through the provision of health and social services that the government should be providing (Akintola, 2010; Seguino, 2009). The non-profit sector regrettably suffers a quiet crisis of a triple fold dilemma (Teka & Magezi, 2008). While scholars suggest that donors should play a constructive role during the crisis, studies have shown that there has been a decrease in international funding (Roodman (2008). Banks were once the second largest category of corporate donors to non-profit organizations in the United States, but since the recession, banks and corporate executives have contributed less, resulting in fewer resources for non-profit organizations (McConnon, 2008).

Non-profit organizations rely on a multitude of sources for financial and technical support in order to provide services and sustain the organization. These include individuals, governments, foundations, development agencies, international organizations, churches and community groups as well as corporate donors (Akintola, 2011; International Monetary Fund, 2012). Studies have shown that non-profit organizations have experienced numerous challenges, including insufficient funding (Adebayo, Irinoye, Oladoyin, & Fakande, 2004; Mabude et al., 2008; Meessen, Musango, Kashala & Lemlin, 2006). The global financial crisis has exacerbated the problem on accessibility of funds. This may impact the functioning and

provision of services offered by these organizations. The predicted decline in funding for non-profit organizations has threatened their ability to provide services (Access Economics, 2008; Melouney & Mayoh, 2010). This has created uncertainty regarding the sustainability of non-profit organizations during the crisis.

2.5.1 Responses to the financial crisis by non-profit organizations

Some international non-government organizations in developing countries are embracing cost-effectiveness measures to reduce operational costs. Due to the decline in operating revenue, most NGOs have embarked on organizational restructuring. According to Integrated Regional Information Networks (IRIN) (2008a), some of the biggest development and humanitarian NGOs have retrenched staff and revised their programmes as their income streams flattened due to the global financial crisis. For example, Oxfam retrenched staff at both headquarters and regional centres, reducing 10% to 15% of variable costs instead of cutting back on the programmes supported by the organization (IRIN, 2008b). It also streamlined some of its operations in the UK, retrenching employees and not filling vacancies. Other NGOs that rely on funding from governments have frozen hiring and postponed programme expansion (IRIN, 2008b). Some NGOs prefer to slow down expansion and reduce the number of staff to reduce costs.

In response to the financial crisis, the Catholic Relief Services (CRS) have put plans in place to reduce their operations in East Asia, Eastern Europe and South America over a three-year period in favour of increased growth in Africa, South Asia and the Middle East (IRIN, 2008a). The CRS has also reduced some of the programmes offered in three areas, economic development in agriculture, micro financing and Maternal Child Health (MCH), while the programmes benefitting Africa range from ARV therapy and other AIDS projects such as care for orphans, agriculture, microfinance and water development (IRIN, 2008a).

The International Rescue Committee (IRC), which helps refugees to relocate and rebuild their lives in the wake of disasters in 42 countries, receives more than 75% of its funding from European governments, the US government, the UN and the World Bank. This NGO has indicated that despite the financial crisis, its funding has increased since October 2008 and it has not had to cut back on programmes or lay off staff, but has imposed a hiring freeze, only filling critical positions (IRIN, 2008a).

2.6 Theoretical Framework

This study draws on various levels of the ecological systems theory as its main conceptual framework. This human development theory was developed by Urie Bronfenbrenner in the 1970s. The ecological systems theory has been used by scholars, professionals and therapists to understand behaviour in different contexts (Engler, 2007). The ecological systems theory is a combination of two principles, the ecological principle and the systems principle (Bronfenbrenner, 1994) as shown in Figure 2.1.

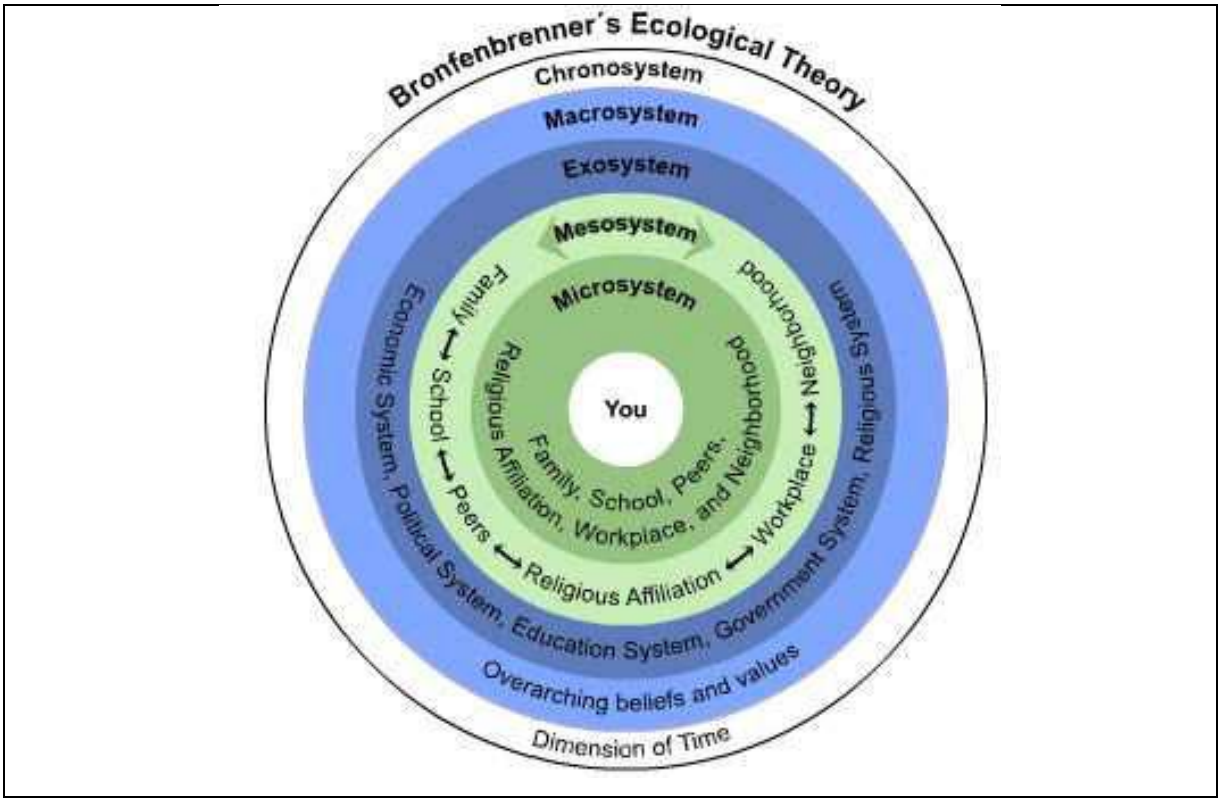


Figure 2.1 Bronfenbrenner's (1974) Ecological theory for human development

According to Wilder (2009) the term 'ecological' stems from the word ecology which is defined as the study of interactions of organisms in their environment. The systems perspective is based on the belief that people are in constant interaction with their environment and are encircled by networks that can impact an individual or an organization in both negative and positive ways (Wilder, 2009). Bronfenbrenner (1994) argued that the functioning of an organization or an individual is an evolving process of organism-environment interaction. This theory argues that the environment is multi-layered and each layer has an impact on the functioning of an organization or individual (Weiss-Gal, 2008). It also highlights people's and organization's interaction with their socio-cultural environments and shows that the

organization or an individual and their numerous and complex environments are interactive and synergistic in ways that simultaneously affect one another (Weiss-Gal, 2008).

This theory analyses how well an individual or organization fits with their environment, and is based on the assumption that when a person or an organization is connected and engaged within a supportive environment, then functioning improves (Wilder, 2009). It also focuses on the organization as part of, and integrated with other systems (Wilder, 2009). Ecological systems theory has been applied in different contexts. For example, in health promotion, it has been used to understand the experiences of family caregivers taking care of aging adults (Wilder, 2009). It has also been used to understand how environment influences child development (in terms of quality and context, rather than nature and nurture) (Bronfenbrenner, 1994). The theory has also been used by social workers to identify a client's problems (Weiss-Gal, 2008).

2.7 Ecological systems theory as applied to this study

Ecological systems theory is based on the assumption that when a person or an organization is connected and engaged in a supportive environment, their functioning improves (Davis, 2009). In this study, ecological systems theory is appropriate to describe how the different levels affect home-based care organizations in the context of financial crisis. It is also appropriate because it describes the relationship between the organization and the environment in which the organization is operating, and the outcome of the services provided. The ecological systems theory has four levels of influence which may affect the organization: micro-system, meso-system, exo-system and macro-system (Wilder, 2009). By creating these systems Bronfenbrenner encouraged researchers to examine the family, economic and political structures influencing an individual or an organization.

2.7.1 Levels of the ecological systems

2.7.1.1 The macro-system level

This level describes the nation and culture in which the organization operates. Cultural contexts include developing and industrialized countries, socioeconomic status, poverty and ethnicity (Woodside, Caldwell, Spur, 2006). In relation to this study, policy makers, government, donors/funders are found at the macro-system level. The macro-system level involves the availability or absence of policies or guidelines on funding provided by the government. These existing policies may affect home-based care organizations either negatively or positively at

national, organizational and departmental levels, especially in countries that fail to adopt these guidelines. A review of the literature reveals that the South African Government has developed a policy on funding home-based care (Department of Health, 2001). This policy provides information on the resources required and the different stakeholders that will provide such care. It also outlines the various stakeholders from the private and international development sectors that are expected to contribute resources. The government and donors/funders are also found at the macro-system level. Home-based care organizations rely heavily on funding from donors inclusive of government, foundations, churches and other community groups, as well as corporations. The availability or absence of funds and support from the government or donors may affect the functioning and sustainability of home-based care organizations at the exo-system level.

2.7.1.2 The exo-system level

This is the organizational level. It is the organization that an individual works for; this affects an individual's life either positively or negatively. In the context of this study, this is where home-based care organizations that employ workers and provide services to the community fall. This level also explains the resources available to the organization from the macro level, organizational structures, processes and systems for performing work within the organization and the organizational culture and strategies employed by the organization to accomplish its goals. For example, this level would describe the resources available (funds, home-based care materials, human resources and training) to the organization in order to provide services to the community. If an organization does not have sufficient resources, this will negatively affect the organization, its workers and the beneficiaries of the services it offers.

2.7.1.3 The meso-system level

The social agents belong to the meso-system level. In relation to this study, workers hired by home-based care organizations are found at this level. These include administrators, home-based care coordinators and volunteer caregivers. Volunteer caregivers are the backbone of home-based care organizations and are relied on by families, the community and the home-based care organizations that they work for (Akintola, 2006). Volunteer caregivers rely on home-based care organizations to provide home-based care materials, training and stipends. The presence or absence of materials, skills and knowledge may negatively or positively affect

the quality of services offered by volunteer caregivers. It can also affect volunteer caregivers' wellbeing, including their morale, motivation and job satisfaction.

2.7.1.4 The micro-system level

The micro-system level refers to the individual level and comprises the influences relating to the individual. These influences include one's immediate physical and social environment. These contexts include the setting in which the individual lives, the person's family, group peers, neighbourhood and community organizations. In relation to this study, the beneficiaries of services offered by home-based care organizations are found at this level. Beneficiaries include the patient (people living with HIV/AIDS), their family, the neighbourhood and the community at large. It is in the micro-system that the most direct interactions with social agents take place. Social agents (volunteer caregivers) interact directly with an individual and positively or negatively influence their well-being, behaviour and health. For example, a patient's health may improve or deteriorate as a result of the resources available to the organization.

The ecological systems theory can be used to demonstrate and explain how home-based care organizations' working environment can positively or negatively affect the organization. The theory emphasizes the interaction between, and interdependence of, factors within and across all levels of the organization. For example, at the macro-level, the presence or absence of funding from the government or donors/funders may affect the availability of other resources required by care organizations. This may affect the functioning and sustainability of home-based care organizations at the exo-system level and could lead to restructuring of the organization. Organizational restructuring may affect hired staff at the meso-system level and this could result in retrenchments and a loss of income or incentives. This could also affect the beneficiaries of the services at the macro-system level. A lack of sufficient funds may lead to the services offered by care organizations being rationed.

2.8 Chapter Summary

The global financial crisis has affected many world economies and this in turn has affected the fight against HIV and AIDS, especially in developing countries like South Africa and Brazil. The consequences of the global financial crisis include increased financial costs, an increased burden on health systems; budgetary cuts for HIV/AIDS programmes; reduced health budgets, cuts in external aid, increased poverty, a loss of jobs and income, and the contraction of

economic activity, affecting the public and private sector. The research methodology which was used to collect data is going to be discussed in the following chapter.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

According to Babbie & Mouton (2001), research methodology focuses on the research process, and the tools and procedures to be used. The study design; study area and participants; sampling method; data collection procedures and how data was analyzed using thematic analysis are going to be discussed in this chapter. Ethical considerations are also discussed.

3.2 Study Setting

The study was carried out in different communities within the Durban metropolis where there were home-based care organizations providing care services to people living with HIV/AIDS (PLWHAs). I interviewed ten participants who were responsible for the day-to-day running of these organizations. Different organizations have different names for such key officials, for example, managers, project managers or supervisors. Data collection took place in nine townships and one rural area, as shown in Table 3.1 below.

Table 3.1: Number of coordinators and organizations recruited

Name of the organization	Type of Organization	Location of the organization	Type of Area	Number of Participants interviewed
A	CBO	Folweni	Township (peri-urban area)	1
B	CBO	Kwamashu	Township (peri-urban area)	1
C	CBO	Ntuzuma	Township (peri-urban area)	1
D	CBO	Nazareth	Township (peri-urban area)	1
E	CBO	Kwamashu	Township (peri-urban area)	1
F	CBO	Umbumbulu	Township (rural area)	1
G	CBO	Wyebank	Township (peri-urban area)	1
H	CBO	Marriannhill	Township (peri-urban area)	1
I	CBO	Inanda	Township (peri-urban area)	1
J	CBO	Wentworth	Township (peri-urban area)	1

3.3 Study Design

This study used an exploratory qualitative approach which allowed for a descriptive explanation of the experiences of home-based care organizations in the context of the global financial crisis. Qualitative research is defined as any kind of research whose findings are not

produced quantitatively or through statistical procedures (Strauss & Corbin, 1990). A qualitative research design allows the researcher to capture the richness of human experiences such as how the real world is lived and felt (Polkinghorne, 2005). The direct effects of the global financial crisis on the provision of home-based care are not known, and a qualitative design allowed me to explore the implications of the financial crisis as seen by home-based care key personnel.

A qualitative research design uses a naturalistic approach that seeks to understand a phenomenon in its context and helps the researcher to interpret the complex reality and implications of a given situation (Merriam, 1998). According to Maxwell (1998), qualitative studies seeks to 1) understand the meaning of life experiences, 2) understand the particular context within which people act, and 3) understand the process by which events or actions take place. All these characteristics were present in this study because I wanted to gain an understanding of the experiences of home-based care organizations within the context of the global financial crisis. A qualitative research design allowed me to explore events within their cultural, social and political context. In addition it probes deep into people's lives, seeing things from the participants' perspective and allowing for creativity and advocacy on my part as the researcher as I pursued issues that are usually related to marginalized people (Bryman, 2004; Creswell, 2009; Ulin, Robinson, Tolley & McNeill, 2002). This study design permitted a holistic perspective on the subject matter by acknowledging its socio-cultural-political context (Bryman, 2004). This was crucial to the current study, as it explored the experiences of home-based care organizations in the context of the global financial crisis.

3.4 Study Sample

Home-based care organizations were selected using a snowball sampling technique. This type of sampling was appropriate because I had little experience in the field of intended study. According to Ulin et al. (2002:61) "snowball sampling is a technique used for locating informants by asking others to identify individuals or groups with special understanding of a phenomenon". It is often used to find and recruit hidden populations, which are not easily accessible to the researchers through other sampling strategies (Bailey, 2007). The first few organizations were sampled from a pool of contacts which were accessed from AIDS Care Foundations. In addition some of the interviewed care organizations referred me to other organizations that provided home-based care. According to Ulin et al. (2002), the researcher must also make a decision with regard to the selection criteria for the sample, so as avoid

possible coercion or alienation of important subgroups. In this study, care organizations were chosen if they:

1. have completed three financial and operational years in existence, so as to be able to reflect on the influences of the global financial crisis.
2. are based in the Durban metropolis.
3. are willing to participate and able to provide information on the effects of the financial crisis.

3.5 Ethical Considerations

Ethical concerns in qualitative research come into play from the beginning of a research study, throughout interaction with the participants and continue to be important until the findings are disseminated (Willig, 2008). Ethical considerations are paramount in all research. To ensure that the research was ethically sound, the research proposal including instruments used, were reviewed by the University of KwaZulu-Natal Ethics Committee.

To gain informed consent from the participants, I informed the participants about the nature of the study. The participants were requested to provide their consent by signing the informed consent form before the interview commenced. They were also informed about their right to withdraw from the study at any point without any consequences. The confidentiality and anonymity of the participants was maintained throughout the data collection process by not revealing the names of the participants or the participating home based-care organizations. Instead I used pseudonyms. I also maintained complete confidentiality with regard to data by assuring the participants that only my supervisor and I would have access to the raw data.

3.6 Data Collection Instruments and Procedure

Individual interviews were conducted with each of the participants to enable a clear understanding of their experiences in the context of the global financial crisis. According to Terre Blanche, Durheim & Painter (2006), qualitative interviewing allows the researcher to conduct an interview in a more natural, interactive form. This interpretive approach to research gave me the opportunity to get to know people intimately and understand how they think and feel. The aim of qualitative interviews is to create a dialog which explores the research problem with the research participant rather than simply putting respondents' answers into categories or testing their knowledge (Burton, 2000). It therefore requires the researcher to be open-minded, flexible; and ready to listen and learn how individual participants express their experiences.

This approach seeks to establish how people really feel about or experience a particular context; it is therefore likely to create an environment of openness and trust, allowing the interviewee to express him/herself authentically. This was achieved by asking open-ended questions and also making the participants to feel free to express their experiences. This allowed me to elicit information and to build a holistic understanding of the interviewee's point of view.

An interview schedule with open-ended questions was developed based on an extensive review of the literature on the general impacts of the global financial crisis and its implications on different sectors. The interview schedule included questions on background information about the organization (organizational demographics questionnaire, see appendix B), how economic hardship affected the resources available to home-based care organizations, the implications of the financial crisis and how home-based care organizations have responded to the crisis (see appendix C). During the interviews, I further explored and follow-up on issues and leads that emerged. The interview schedule provided direction and guided the interviews, thus ensuring that the key objectives of the research study were met. An interview schedule with open-ended questions was chosen because it allowed me to probe further. It also allowed the participants to speak about their own experiences as care managers providing services in a context which is constantly changing due to the global financial crisis. I used probes and open-ended follow-up questions to encourage the participants to express themselves freely and to provide more in-depth information without biasing later answers (Babbie & Mouton, 2001; De Vos, Strydom, Fouche & Delport, 2002).

Each participant was interviewed once and the interview took about 40 to 60 minutes. All interviews were held at the offices provided by home-based care organizations. Interviews were conducted in English or IsiZulu depending on the language the participant was comfortable with. The nature and aim of the study was explained to each participant. Each participant was asked to sign a letter of consent (see appendix A) prior to the interview. I also requested the participants' permission to use an audio-recorder prior to the interview. Audio-recording the interviews allowed me to interact with the participants and concentrate on the proceedings of the interview. I was able to pay full attention to the interviews and learn about the participants' experiences. All the interviews were later transcribed, and those interviews conducted in IsiZulu were translated into English. All interviews were confidential and the respondents remained anonymous.

3.7 Data Analysis

Data collected was analyzed using thematic analysis. Thematic analysis is used to identify potential patterns, themes and common elements within the transcriptions (Ulin et al., 2002). Likewise, Braun & Clarke (2006) argued that thematic analysis is a method for identifying, analyzing and reporting patterns (themes) within data. Thematic analysis was used for its flexibility, which allowed the inclusion of the theoretical framework (ecological systems theory) in the analysis of the data. Thematic analysis is not a linear process, but a recursive process in which reference is constantly made to the data, and data is read and re-read to ensure a refined and accurate analysis. As suggested by Braun & Clarke (2006), there is a back and forth movement through the different phases of analysis.

I began the data analysis process by reading the transcribed data. I later noted down some initial ideas about what I found interesting in the data. These notes were used for coding. I coded all the features I found across the entire data and collated relevant data to each code. According to Ulin (2005), coding may be described as putting all the text that relate to a common theme together in one place. This enabled me to identify new sub-themes and I explored them in greater depth. On completion of the coding process, I examined the coded information more closely and refined it, which led to the formation of themes and sub-themes. Further, I searched for potential themes and gathered all data relevant to each potential theme and sub-theme. Finally, I refined the themes which are presented in Chapter 4.

3.8 Chapter Summary

This chapter discussed the methodology used to collect and analyze the data for this study on the experiences of home-based care organization in the context of the global financial crisis. It also discussed the ethical issues taken into consideration and the limitations of the study. The following chapter presents and analyzes the results which emerged from the data collected.

CHAPTER FOUR

PRESENTATION OF RESULTS

4.1 Introduction

The global financial crisis has diverse implications on home-based care organizations. This chapter contains the findings on the impacts and implications of the global financial crisis on home-based care organizations through the perspective of key personnel. The findings are first presented in a summary of table of themes which are then presented according to the research questions as the major themes: managers' perspectives about how the global financial crisis has affected the resources available to home-based care organizations, its implications on care organizations and how home-based care organizations are responding to the financial difficulties. All the responses from the participants are represented in italics. The data analysis revealed the themes and sub-themes summarized in the Table 4.1 below.

Table 4.1: Themes on the experiences of home-based care organizations in the context of the global financial crisis from the home-based care manager's perspectives.

MAIN THEME	SUB-THEMES	IMPLICATIONS
The impacts of the financial crisis on the resources available to home-based care organizations	**Resources available to home-based care organizations** *Funds:* Insufficient funds, Termination of contracts by donors, No source of funding *Materials:* Insufficient Materials *Food Parcels:* Insufficient food parcels *Human Resources:* Limited number of volunteer caregivers, Increased number of volunteer caregivers leaving HBCO for greener pastures, shortage of staff	Insufficient resources have compromised the quality of services provided
	Training: Difficulties in sourcing training, Limited training, Insufficient training	Incompetent staff
Home-based care organizations' responses to the financial crisis	*Negative responses:* Increased organizational restructuring, Rationing of services and communities served, Retrenchment of staff, Rationing of income or incentives received by staff and volunteer caregivers	Led to insecurities and uncertainties, Led to reduced services for beneficiaries, Led to workers being overloaded, Led to demotivated staff with low morale
	Positive responses: Alternative income generating projects, Increased community empowerment, Increased search for funds, Introduction of new programs by the government to help communities	Home-based care organizations are now becoming more innovative, Home-based care organizations are trying to become less dependent on donors

4.2 Organizational Demographics

All the interviewed organizations were initiated by the community and were community-based organizations (CBOs) led by the community. Most of the care organizations were also registered as non-profit organizations. The South African government requires every non-profit organization to register in order to receive funding and support from the government. The majority of these care organizations are situated in townships. As shown in the summary of the profile of the care organizations interviewed in Table 4.2 below, they differed in size and the number of volunteer caregivers employed.

Table 4.2: Demographic characteristics of care organizations

CARE ORGANIZATION	YEAR IT WAS FOUNDED	TYPE OF ORGANIZATION	NUMBER OF COMMUNITIES SERVED	NUMBER OF VOLUNTEERS	NUMBER OF PEOPLE SERVED	
					Adults	Children
A	2001	CBO	2	10	180	100
B	1999	CBO	4	10	100	129
C	1999	CBO	4	10	65	20
D	2007	CBO	4	5	40	100
E	1999	CBO	6	10	100	23
F	1999	CBO	6	10	100	102
G	2002	CBO	4	30	100	40
H	1997	CBO	9	205	850	2000
I	2002	CBO	4	10	100	50
J	2006	CBO	2	5	80	30

4.3 Services provided by care organizations

Care organizations offered a variety of services to the communities they served. Nine out of the ten care organizations provided mainly basic nursing care (home-based care) in homes to people living with HIV/AIDS. Only one had stopped providing home-based care but still provided other services like a feeding scheme. The majority of the care organizations interviewed also provided diverse services such as feeding schemes, soup kitchens, care and support for orphans and vulnerable children (OVC), drop in centres for children, counselling, programmes for the elderly, AIDS awareness campaigns, youth development programmes and self-help projects such as gardening as a form of fund raising for people living with HIV/AIDS and the volunteer caregivers. These are shown below in Figure 4.1.

Figure 4.1: Services offered by care organizations

4.4 Implications of the global financial crisis for the resources available to care organizations

The effectiveness and success of an organization depend on its resources. Resources such as capital (funds), human resources (volunteer caregivers), materials (home-based care kits) and knowledge (based on training) of how to take care of an ill patient are very important for the proper functioning and sustainability of care organizations. The resources available to an organization depend on its sources of funding, its structure and its size.

The findings of the study show that the main funders of care organizations are the government; and donors/funders such as corporations; foundations and individuals. Eight of the ten care organizations were registered with the government as non-profit organizations and thus received support and funds from the government. Only four received funds from external donors in addition to funds from the government. Three of the care organizations also had income generating projects which helped them to raise money to support their programmes. One organization had never received any funding from either the government or external donors. A summary of the different sources of resources is provided in Table 4.3.

Table 4.3: Sources of funding

Care Organization	Source of funding		
	Government	External Donors	Income Generating Projects
A	✓	✓	
B	✓		
C	✓		✓
D			✓
E	✓		✓
F	✓		
G	✓		
H	✓		
I	✓	✓	
J		✓	

4.4.1. Funding

Most care organizations indicated that funds were important for running their different programmes such as home-based care services, feeding schemes and providing ongoing support to ill patients, orphans, vulnerable children and old people. Funding was also needed to pay workers such as project managers and for incentives for unpaid volunteer caregivers to buy home-based care materials for home care services and to pay for the training of volunteer caregivers. In addition, funding was needed to purchase food parcels and pay organizational expenses such as bills, rent, water, electricity and stationery. It emerged that the majority of the care organizations interviewed experienced many difficulties in accessing funds due to the financial crisis.

All the care organizations that received funding from either donors or government experienced late payment of funds. This made it difficult for them to plan ahead and draw up budgets. For example, coordinators stated that:

> *"The biggest problem is that the stipends and funding in general comes late…this is so disappointing because I do not think in South Africa where there is democracy, you have to go from April, May, June, July, August, September without payment...."(Organization A).*

> *"We tried to ask for funding from donors but they told us to wait for a year or years and this makes it difficult for us to plan ahead, draw up a budget or even to work properly" (Organization E).*

Eight of the care organizations that received funding from the government indicated that it was insufficient. They noted that the price of food and materials was increasing without commensurate increases in funding by the government. One coordinator said:

> *"The global financial crisis has affected us in so many ways. You see with the Department of X for example, they were giving us the same amount which they were giving us from the beginning six years ago. They never increased the funding despite the hardships we are facing as a result of an increase in the cost of living. They never considered that prices for food and materials are going up. The money is just not enough for the different services we are offering" (Organization F).*

Another noted:

> *"The cost of living is becoming expensive each year and the money which we receive from our donors is so little now. They ask us to make a budget and we do but the money comes in late and that money will not be able to buy stuff needed for home visits and pay all our workers" (Organization E).*

The results show that the majority of these non-profit organizations indicated that they felt that most donors had reviewed their grants to home-based care organizations because of the financial constraints. This might have led to the termination of their funding contracts with care organizations.

> *"The Department of X was giving us funding on a yearly basis but now, it has terminated our contract. We got another donor but it was terminated this very year. We are not the only organization which got its contract terminated but there are many other organizations. We were surviving from the funding and support from our donor but they told us that they no longer have money" (Organization A).*

> *"They used to renew our contracts every year but this year they told us that they will no longer renew them. The problem now is that the Department of X no longer has a contract with us because they formed a new program for health workers and they employed those 28 volunteer caregivers from our organization and felt that this was enough to cut funding for us. So they did not renew the contract" (Organization C).*

As a result of the global financial crisis, organizations are finding it difficult to find new funding sources. One coordinator said:

> *"It is not easy to get funds really; it is not easy at all. Even if you write a good proposal they do not approve it we, have suffered" (Organization F).*

Two care organizations that were receiving funding from international donors also indicated that in the past the donors used to renew their funding contracts, but that the donors had told them that once the contracts end, they would not be renewed.

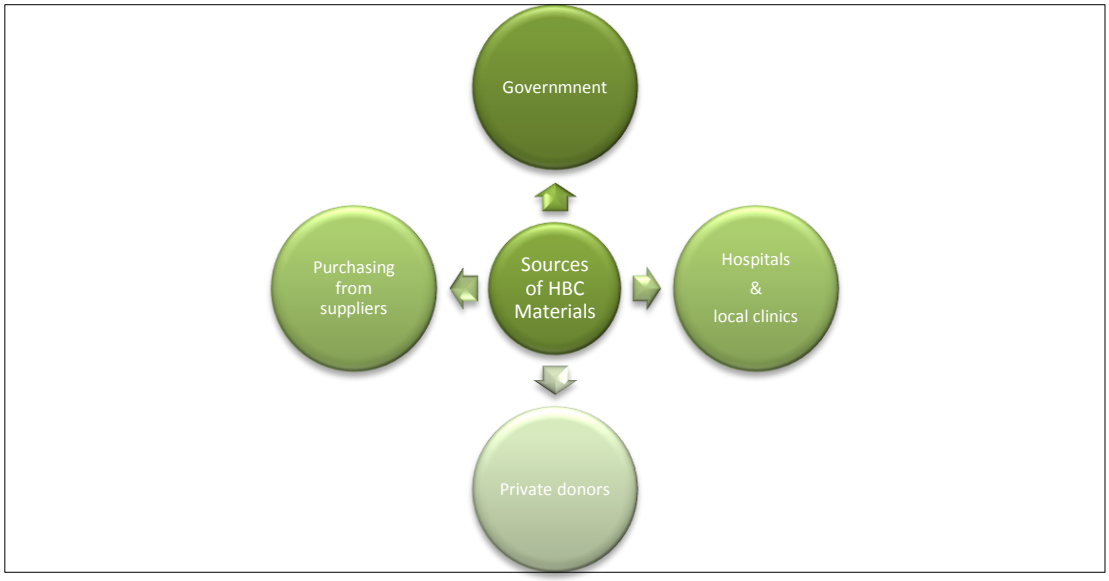
> *"They used to renew our contracts but this year they told us that they will no longer renew them" (Organization G).*

4.4.2 Home-based care materials

The findings of the study show that home-based care programmes needed care kits with materials such as toiletries for personal hygiene (soap, gloves, wiping cloth, aqueous cream, vaseline, face cloth, towels, cotton wool) for household cleaning (disinfectant, straws, drinking cups, linen savers, and tapes) and basic medication (painkillers, antibiotics, anti-diarrhea tablets, anti-nausea medication, multi-vitamins, antiseptic cream, gauze). These materials are essential items for a caregiver when caring for HIV/AIDS clients in order to promote hygienic practices and the prevention of opportunistic infections.

All ten care organizations relied on different sources for home-based care materials. The majority relied on the Department of Health. Two home-based care organizations had a good relationship with their local clinics and received materials from these clinics. One organization indicated that they received materials from some hospitals, while three got home based-care materials from international donors. Two organizations indicated that they bought their own materials from different suppliers. One care organization indicated that it used to get some materials from another big care organization near its community. Figure 4.2 below provides a summary of the different sources of home-based care materials for care organizations.

Figure 4.2: Sources of materials



Most of these care organizations indicated that they had difficulty sourcing materials. Furthermore, the materials received are insufficient for volunteer caregivers to perform their duties such as cleaning bedridden patients.

> *"With resources like home based care kits we have a big problem as you can see our shelves, they should be full with materials but there is nothing so we have a huge problem. You see the Department of X, I called them but they said they could not help us. I called another department for materials and they said they will try to get us material but we should also look elsewhere. But we have these people who are very sick who need to be taken care of. They need napkins; they need seat serviettes, condoms. What we have is very few and some materials are finished" (Organization A).*

> *"With our material supplier Department of X, it is very difficult to get what you need. They know that home based care workers are at risk because they are working in homes with people who have HIV/AIDS but they fail to give us materials like gloves and other things" (Organization I).*

Care organizations, especially those that are small, indicated that they had been operating without home-based care kits.

> *"We do not have materials. The ones that we had before were from the Department of Health but they have not given us materials since 2011; to tell you the truth we last*

received materials in May, 2009. So the volunteers are just performing home visits without materials" (Organization D).

4.4.3 Food Parcels

Poverty plays a big role in the living conditions of both patients and volunteer caregivers. Nutritious food is scarce because it is simply unaffordable. The majority of people living with HIV/AIDS were previously breadwinners but lost their jobs due to illness. Most have little or no money to buy food. Some households are headed by children or the elderly and require food parcels. Hence, most care organizations try to provide food parcels.

It emerged from the study's findings that care organizations relied on different donors for their feeding schemes, including the government, food donors (such as food suppliers or outlets), private individuals (such as local business people) and the gardening projects where the organizations grow different vegetables such as spinach, carrots and tomatoes. The donors usually supply basic foodstuffs like bread, cooking oil, maize meal, rice, beans, soup, and porridge. Some care organizations indicated that they had gardens where they grow vegetables that are used in the soup kitchens which feed the ill, the elderly and children.

The study results show that care organizations are facing difficulties in accessing food for their feeding schemes. Donors are providing very limited or no food parcels at all. The coordinators said that:

"Y Development has cut the monthly food parcels which they used to provide us with. They used to provide us with different food stuff such as porridge, soup, beans and maize meal. This is making it difficult for us to provide all our patients. This cut I blame it on the economy difficulties we are facing" (Organization H).

"What we are getting now is the food we get from the Food Bank but Food Bank is supplying whatever they have at that time. The Food Bank is not giving us everything we need to feed the orphans" (Organization A).

Three organizations indicated that they no longer receive any food parcels due to the financial crisis:

"The problem now is that we used to do a budget with Y Development and send the budget. They analysed the budget. When they analysed the budget this year, they came back to us and told us that they were no longer going to give us food parcels as they used to. We were giving food parcels to 30 families. So now they said they are not going to give us food parcels. There are orphans who come from different schools who are referred to us, and orphans who are not learning, they come here to have a balanced diet, some breakfast with us. So now this means that they will go hungry" (Organization E)

It should be noted that the lack of resources has compromised the quality of services offered by some care organizations. It is clear that limited funding and materials have affected the organizations' effectiveness. Volunteer caregivers in some care organizations were said to be providing basic care like bathing patients and cleaning patients' homes without protective gloves.

"Our volunteer caregivers perform home visits without the materials. We have taught them to use plastics as a substitute of gloves. We told them to pour water to see if there are no holes, then they tie the plastic bag on their hands and do the work" (Organization B).

"You see, they are just giving us what they have, no materials and stipend. That's where the problem is now and this is affecting the health of the volunteer caregivers and our organization so much" (Organization E).

4.4.4 Human Resources

Care organizations employed different people who were responsible for the running of the organization. Recruited staff had different roles and responsibilities depending on the position they held in the organization. The most common positions in all the care organizations were home-based care facilitators or managers and volunteer caregivers. Some organizations also had project facilitators, financial managers, orphans, vulnerable children facilitators, project coordinators and administrators. However, these roles were not found in all the organizations. The smaller organizations had a few employees who performed all the roles. It is of interest to note that the care organizations mainly relied on volunteer caregivers to provide home-based care services. Table 3 shows the number of volunteer caregivers recruited by these care

organizations compared with the previous years and the number of staff such as project managers, project facilitators and administrators recruited. The table also shows the number of patients a volunteer caregiver is responsible for. The volunteer caregivers visit these patients according to individual agreements, but it was made clear by the project managers that each volunteer caregiver had bedridden patients who they had to visit on a regular basis. It also emerged that most care organizations recruited one or two people to cook meals for children (feeding scheme) and to work in the soup kitchens for the elderly.

Table 4.4: Human resources employed by care organizations

Name of the organization	**Number of:**					
	Project Managers	**Project Facilitators**	**Initially employed volunteers**	**Currently employed volunteers**	**Volunteer Caregiver :Patient ratio**	**Volunteer responsible caregivers for children**
A	1	1	30	18	1: 10	2
B	1	0	30	10	1 :10	1
C	1	0	20	10	1:6	1
D	1	1	20	5	1:8	2
E	1	1	20	10	1:10	2
F	1	1	38	10	1:10	2
G	1	0	46	30	1:5	3
H	1	10	290	205	1:5	5
I	1	0	30	10	1:10	2
J	1	1	25	5	1:4	1

All the care organizations indicated that they were experiencing problems hiring the required number of workers, especially volunteer caregivers and facilitators. Volunteers constituted the majority of people working in care organisations. The coordinators reported that the volunteers were the backbone of the care organizations. Volunteer caregivers are people who are recruited by care organizations from communities affected by HIV/AIDS and trained to take care of people living with HIV/AIDS. They do not receive any payment. In smaller organizations the project coordinators, sometimes referred to as project managers, are responsible for many duties such as administration and facilitating different programmes because of the shortage of money to pay personnel. The project managers had overall responsibility for the day-to-day running of the organisation. The coordinators said:

"At the moment we do not have any volunteer care givers, facilitators, and administrators because of funds. Overall we had ten volunteer caregivers; an administrator and a facilitator but now we have none" (Organization B).

"Biggest problem is that our trained volunteer care givers and staff are leaving our organization because we do not have money to pay them" (Organization E).

"Due to the lack of funding, more volunteers stopped coming to work because they have not received stipends for six months" (Organization H).

Due to insufficient funds, care organizations work with a limited number of workers. They cannot afford to hire the required number of volunteer caregivers. It is also difficult to replace volunteer caregivers who quit. The remaining caregivers end up providing health care to a large number of patients. The coordinators said:

"Now we cannot recruit anyone. Volunteer caregivers are leaving us for better jobs. If a volunteer caregiver leaves us, we do not replace her because already we are struggling with the ones we have. At least those who have been volunteering understand that we do not have funds to pay them" (Organization A).

"We have lost many volunteers caregivers that it is now difficult to provide home based care. The few remaining ones are forced to take over some of the patients and at the end they have so many work to do" (Organization F).

4.4.5 Training

Training plays a crucial role in preparing the volunteer caregivers to perform their tasks effectively. The findings show that care organizations relied on external training providers like the Department of Health, Department of Social Development (DSD), Sector Education and Training Authorities (SETAs) and NGOs to provide training. Six of the care organizations indicated that they used to receive training from the Department of Health, and two indicated that they also received training from NGOs that work in the health sector. Volunteers were trained to provide a wide range of services to people living with HIV/AIDS such as basic nursing care, TB counseling, HIV/AIDS awareness, infection control, stress and trauma. They were also trained to identify health problems and to be able to determine which patients require referral to a clinic or hospital.

Most care organizations recruited volunteers from the communities they serve. These volunteers normally had no previous training or experience in caregiving. It emerged from the findings that the volunteers required training but due to the financial constraints experienced by the care organizations, they were receiving limited training.

> *"The problem is now when we get some invitation to send volunteer caregivers, we are asked to send maybe five volunteer caregivers and we have 20 volunteer caregivers, meaning some volunteer caregivers do not receive training especially the new volunteers" (Organization E).*

Most care organizations no longer receive training from previous providers like the Department of Health:

> *"The Department of X used to provide training for three weeks on home based care and they used to monitor and assess it, volunteers would get certificates. However we no longer receive any training from them and our new volunteer care givers did not get any training" (Organization A).*

> *"In the past we used to receive money from our donors to send our volunteers for training on home based care but due to the recession they have stopped providing our organization with funds for training" (Organization B).*

Two care organizations still train their volunteer caregivers constantly on home-based care. In one organization, the project manager is a retired nurse who has the knowledge and experience to train the volunteer caregivers herself:

> *"When it comes to training, I train the volunteers myself. I am a nurse by qualification and have experience in home based care because when I left nursing I worked as volunteer caregiver before I became the project manager. I know the kind of job and the knowledge and skill needed. So I usually train them myself" (Organization C).*

In another organization, the project coordinator networks and partners with different stakeholders such as the local clinic; when there is training at the clinic, the organization is invited to send their volunteer caregivers:

"We work together with our clinic; they even give us materials to use for home visits. Whenever there is training happening at the clinic for example last month there was training on TB, they told me to send my care givers and I did. So every time there is training they tell me and I send them. Sometimes the volunteer caregivers even receive certificates after completing the training" (Organization E).

Another organization indicated that their volunteer caregivers always receive training as they hire someone to provide training:

"As an organization we usually invite different people from the department of X to come train our volunteer caregivers" (Organization G).

4.5 Care organizations' responses to the financial difficulties

The financial crisis has affected care organizations in diverse ways. Despite the challenges they face, they continued to provide some services to the community. The findings of the study showed that these care organizations responded in various ways to the financial crisis in order to remain in existence. Figure 4.3 below provides a summary of the care organizations' responses to the financial crisis.

Figure 4.3: Responses to the financial crisis by home-based care organizations

It emerged from the findings that all of the interviewed care organizations had faced different challenges prior to the financial crisis. However, the financial crisis exacerbated these problems. Care organizations were forced to restructure their organizations to survive the

financial crisis. The majority had to scale down the number of services or programmes offered to the community in order to continue operating in the harsh economic environment.

> *"We have been facing many problems and the funds have been the biggest challenge. This has forced us to stop providing home visits and other HIV programs. For now we are only providing feeding scheme and OVC services" (Organization F).*

> *"Due to the lack of funding, we have reduced some of the projects such as teenage pregnancy awareness and some awareness programs like drug and alcohol abuse due to funding. It is not easy to run these programs without funds" (Organization B.)*

The financial crisis has greatly affected care organizations. Five of the care organizations indicated that they had to rationalise food parcels and the quantity of food given to the community. One coordinator said:

> *"We used to provide a feeding scheme during weekends but we no longer offer it, we now only provide the feeding scheme during the week. We also used to give our beneficiaries some groceries but now we have cut down, you will see that we now divide everything into small quantities so that at least everyone can get" (Organization E).*

One organization that previously served 13 communities had to cut down to nine due to insufficient resources. Another organization was serving six communities but had to drop to two.

> *"Last year we were hit badly by the recession, we used to work in 12 communities but now we are working in nine communities. We had to cut down on the communities so as to survive the financial difficulties" (Organization G).*

> *"Due to the insufficient resources we are receiving, we found it better to reduce the number of communities we were extending our services to. We have very limited funding so we had to drop two communities now we are left with four. At first we had six, now we have four" (Organization E).*

Some small care organizations had to scale down on the number of days their volunteer caregivers perform home visits to care for people with HIV/AIDS due to the lack of resources

such as funds and materials. This is difficult for patients who need more attention and care, such as those who are bedridden.

> *'The shortage of materials and absenteeism of volunteers make it difficult for us to provide home visits on a daily basis and this affects the patients who need help every day and every time because as Organization X we cannot do home visits every day you see. We used to do that in the past but because of the difficulties around of funds and materials we no longer do home visits daily" (Organization E).*

> "*We used to at least go for home visits on a daily basis during the week, but now with the insufficient funds and materials for home care we no longer go out for home visits on a daily basis. We now go at least three times a week, but this is not good at all for the people we do home visits for. But there is nothing we can do. We had to reduce the days" (Organization A).*

One care organization embarked on restructuring which led to the retrenchment of workers such as nurses, counsellors, administrative staff and volunteer caregivers. They also merged some roles in order to reduce costs.

> *"We had to restructure our organizations. Since we cut our communities down, we had to evaluate how each volunteer caregiver was performing. Those who were not performing well we had to dismiss them. Also we had to dissolve some positions and merge some roles in order to cut costs" (Organization G).*

The financial crisis also affected the incentives received by hired workers. Three care organizations indicated that they had to rationalize incentives to both paid and unpaid workers. Incentives such as stipends, vouchers and toiletry and food hampers received by volunteer caregivers were cut.

> *"You see, due to shortage of funds caused by financial difficulties we no longer afford to pay stipends to our volunteers, we used to give them food parcels and other things we got from our donors like clothes but we have stopped. We cannot give them" (Organization E).*

"We get some donations from donors and they donate things like food and toiletries for our volunteers. But due to the difficulties we have cut down on what we give them now" (Organization A)

It is of interest to note that the rationalizing of incentives and retrenchment of workers has affected the working relationship between project managers and volunteers. Some coordinators stated that this has affected volunteers' morale and attitudes, especially those who were previously receiving stipends. Some volunteers are now demotivated.

"The crisis has really affected the organization. My relationship with some volunteers has been affected. The volunteers seem not to understand that we are operating with limited funds and we cannot provide them with incentives anymore as we used to. Some who used to get stipend no longer receive it. This has demotivated them because they are also coming from poor backgrounds and the little we used to give them made a difference" (Organization H).

Despite the challenges faced by some care organizations as a result of the financial crisis, one organization indicated that the financial crisis has not affected working relations because the facilitators have been transparent with the care organization workers. The coordinator said:

"The hardships we are facing have not affected us. Everything was transparent in this office. So if the monies are not available, I tell them. If the money is available they get their money accordingly. So they trust us, they understand that if the money is not in we have nothing to give them" (Organization D).

Some care organizations also embarked on innovative strategies in order to survive. Four indicated that they had income generating projects or fundraising schemes such as beadwork, gardening, small businesses, sewing, candle making and various artworks. These are internal fundraising schemes. However, these projects were of limited value because product sales were low and most of the projects turned into charities.

"We have also have Organization C in Holland which is a fundraising organization which is working towards funds dispensation in South Africa". (Organization C)

"Gardening helps the organization with fresh vegetables for our soup kitchen and also fund rising because once those vegetables are sold the money is taken to help vulnerable children and orphans" (Organization D).

"We have just started these gardens as you see there. We grow vegetables and we cook for our people. We also sell some though it's not big money but we use it for small office things. We also make cement bricks used for buildings and we sell them. People around actually make big orders and they generate income for the organization" (Organization E).

It is of interest to note that many care organizations had changed their approach to how they deliver their services. The results showed that most care organizations were teaching patients' family members to provide basic home care such as bathing and feeding people living with HIV/AIDS. Most care organizations have also encouraged community members to engage in gardening and other activities which could provide them with an income so as to reduce hand-outs and dependence on the organization.

"So now what we are trying to do is to empower the communities to take on the role of service provider. We want to be more of a facilitator of service provision as opposed to being a provider of services". (Organization G)

"Due to the difficulties we are facing, we are now teaching our community members to do small projects such as gardening. These small projects will help them with vegetables. They can sell what they get and eat some of the products. This will also reduce the burden for the organization when it comes to feeding many people" (Organization C).

The financial difficulties faced by care organizations have also forced many to identify and attract new funders, both local and international.

"Now we are looking for funders from every corner. We usually network as home-based care organizations and share information about possible donors, so now we are applying every way from our local funders like government and international also" (Organization G).

"The difficulties we are facing have forced us to stand up and search for funders. We look in the newspapers and even on the internet. We have been sending proposals to different possible funders" (Organization A).

Some care organizations indicated that that the government is launching new programmes to address poverty and unemployment caused by the financial crisis. These include War on Poverty and the Expanded Public Works Programme. This has created job opportunities for volunteer caregivers. Since 2010, the government has employed volunteer caregivers to work in local clinics as community health workers. They are paid a higher stipend than they received from care organizations.

"We had 38 volunteer caregivers, but 28 volunteer caregivers were taken by the Department of Health, they were given a new name, they are no longer volunteer caregivers they are now called Community Health Workers. Here in Organization A we were giving them a stipend of R500 a month but now they are getting R1 500, a living wage as we call it in South Africa".(Organization A)

"The government has helped us. It has formed new programmes, have you heard about War on Poverty? This programme helps most community members with food so as to reduce hunger in homes" (Organization E).

"We are also getting opportunities from the government, we are sending our volunteer caregivers for training and at the end the volunteer caregivers end up with various levels of qualifications which also help them to work in clinics as community health workers" (0rganization I).

4.6 Chapter Summary

The findings of this study were presented in this chapter. The resources available to care organizations were broken down into the following categories: funding; home-based care materials; food parcels; human resources and training. This chapter also presented the findings on the different strategies that care organizations have adopted in response to the difficulties caused by the global financial crisis and other factors. The impacts of the financial crisis and other factors on the provision of services by care organizations were also discussed. It emerged from the findings that care organizations have been affected by the financial crisis in diverse ways and that these organizations have also responded to this crisis in a number of different

ways, both positive and negative. These responses had implications for the provision of the services they offered. The following chapter presents these findings in comparison with the findings of the literature review.

CHAPTER FIVE

DISCUSSION AND CONCLUSION

5.1 Introduction

This chapter analyses and discusses the findings, provides an overall conclusion to the study and provides recommendations to improve the sustainability of care organizations. The discussion of the findings is presented using the four levels of the ecological systems theory: macro-system (the level for the government, and donors/funders), exo-system (level for home-based care organizations), meso-system (level for workers within the organization), and the micro-system (level for community, patients and family members). The discussion is also presented under the following themes that were derived from the research questions:

- Managers' perspectives about how the global financial crisis has affected the resources available to home-based care organizations and its implications on care organizations.
- Managers' perspectives of how home-based care organizations are responding to the financial difficulties.

5.2 Managers' perspectives about how the global financial crisis has affected the resources available to home-based care organizations and its implications.

5.2.1 The macro-system

The government, policy makers, and donors/funders are found at this level. It is evident from the findings that, the government, through the Departments of Health and Social Development, is responsible for providing home-based care organizations with funds, home-based care kits and support. Donors and funders such as individual and international donors, foundations and development agencies are responsible for providing home-based care organizations with funds and technical support. In South Africa, at the macro-level there is a national policy on home-based care. The National Guideline on Home-Based Care (2001) states that various stakeholders from the private and international sector are expected to contribute resources for home-based care. However there is minimal information on how this is to be accomplished. This policy was reviewed in 2009. The South African Community Care Worker Management Policy Framework (2009) states in its funding guidelines that the key funders of the home-based care programme are the state, international organizations and non-profit organizations.

The findings of this study show that care organizations depend heavily on funding from donors, including government, foundations, individual and international donors, churches and other community groups, as well as corporations for resources and support. This is consistent with previous studies which showed that HIV/AIDS programmes in low- and middle-income countries receive funds from governments and international assistance through the private sector and individual donors (Kates, Lief & Avila, 2009).

The global financial crisis has affected the funding and resources made available to non-profit organizations by the government and donors/funders. Some donors failed to renew funding contracts with care organizations at the end of the funding cycle. The number of sponsorships and donations has also decreased as a result of the financial challenges faced by the government and donors/funders. This study's findings concur with those of previous studies on the consequences of the financial crisis; international aid for HIV/AIDS programmes has been constrained (Arieff et al., 2009; Seguino, 2009). For example, due to the global financial crisis, Norway's aid contribution to South Africa fell by 10%, Sweden's by 17% and Finland's by 62% (Roodman, 2008). Reduced funding for HIV/AIDS programmes implies that care organizations that rely on international aid will be affected. This may force them to reduce operational costs in order to survive.

The South African government has reduced the funds allocated to the social and health sectors especially HIV/AIDS programmes (International Monetary Fund, 2009). This may have serious consequences for small non-profit organizations that rely on government for funding and support. The study revealed that the majority of home-based care managers indicated that the government terminated its funding contract without clear reasons or explanations. This suggests that care organizations will be constrained financially, with negative implications for the services offered by these organizations. These findings suggest that the government and donors should be alerted to the implications of cutting funds and support.

The South African government has introduced new programmes aimed addressing poverty and unemployment (Lal, Miller, Lieuw-Kie-Song & Kostzer, 2010). These include War on Poverty and the Expanded Public Works Programme. These programmes have created job opportunities for volunteer caregivers working in home-based care organizations. Since 2010, the government has employed volunteer caregivers to work in local clinics as community health workers. In the past the government used to provide care organizations with stipends for

volunteer caregivers. Community health workers perform similar duties to volunteer caregivers. However community health workers are paid better stipends than those paid by care organizations. This has negative implications for care organizations that rely on volunteer caregivers. They are at risk of losing volunteer caregivers to the government health department. This highlights the need for government to work with home-based care organizations to avoid wasting resources and the duplication of services.

5.2.2 The Exo-system

This is the level at which home-based care organizations operate. Care organizations have been receiving limited funds and support from the government and donors. As a result, they are struggling to sustain themselves financially. This has greatly affected their operation and programmes. The literature shows that funding for home-based care organizations was a challenge prior to the financial crisis (Ntetha, 2010; Pallangyo & Mayers, 2009). However the financial crisis has exacerbated the problem. The results of this study also revealed that it has become difficult for home-based care organizations to find new donors due to the consequences of the global financial crisis. For example, several organizations sent proposals to different donors but received no positive outcome or feedback. These findings point to the need for donors to set specific guidelines with regard to the requirements and criteria to qualify for funding. The findings also highlight the need for the government to provide sustained support and funding to care organizations.

Furthermore, the findings of the study show that funding cuts have affected other resources needed by care organization such as home-based care material kits, volunteer caregivers and training. Home-based care organizations are unable to hire the required number of staff. As a result, the majority of home-based care organizations are operating with too few workers, especially volunteer caregivers who constitute the majority of people who work in such organisations. Most care organizations have lost volunteer caregivers to greener pastures. Moreover, volunteer caregivers need materials such as gloves and it is the duty of the organization to source these materials. The findings of this study show that home-based care organizations are operating with inadequate materials. These findings highlight the need for the government to provide these organizations with adequate materials.

As a consequence of the drastic reduction in funding and the material support received by care organizations, all care organizations embarked on restructuring. This resulted in the services offered to the community being rationed and a reduction in the number of communities served and the number of days on which the volunteer caregivers visit homes. Organizational restructuring also led to the retrenchment of paid workers. Some care organizations also rationed the incentives received by volunteer caregivers and paid staff. However small care organizations did not retrench any workers because they were already operating with too few. In terms of the strategies employed by non-profit organizations, the available literature focuses on the way in which large NGOs have responded. Some of the biggest development and humanitarian NGOs were said to have retrenched staff and revised programmes due to the financial crisis (IRIN, 2008c). Burke (1994) argues that many organizations around the world go through a period of restructuring, downsizing, re-engineering and other reforms due to unanticipated shocks in the economy. Restructuring may enable care organizations to reduce operational costs, but this has negative implications for their employees.

Fundraising schemes represented a positive response to the financial difficulties faced by care organizations. This shows that these organizations are becoming more innovative. However these projects were of limited value to the care organization because sales were low and most of the projects turned into charities. Some care organizations are empowering communities by teaching family members and neighbours of people living with HIV/AIDS how to provide home-based care. Care organizations are also encouraging community members to engage in small projects like gardening to generate income and reduce dependence on food hand-outs by care organizations. If successful, these innovative strategies will help reduce the operational costs of other programmes offered by care organizations. This highlights the need for government support for such initiatives.

Furthermore, care organizations are trying to identify and attract new funders. They are aware that they can no longer rely on a single funder and need to seek out multiple potential funders despite the reduced pool of funding caused by the financial crisis. These findings are similar to those reported by the International Monetary Fund's (2010) study on the world economic crisis: implications for Lesotho non-governmental organizations. This report highlights that NGOs in Lesotho resorted to identifying and attracting new alternative sources of funding especially from corporations and government.

5.2.3 The meso-system

The meso-system is the level where home-based care workers are found. The findings show that home-based care organizations recruit different staff such as volunteer caregivers, administrators, managers, and coordinators. However, insufficient funds mean that they are unable to recruit the required number of staff. This has negative implications for workers. Volunteer caregivers may end up caring for many patients, resulting in overload. This can have negative consequences, including burnout, and psychological, emotional and physical stress. Akintola, Hlengwa & Dageid's (2013) study on perceived stress and burnout among volunteer caregivers working in AIDS care organizations found that volunteer caregivers experience stress that could lead to burnout as a result of work overload and the overwhelming nature of their job. This may affect their health and wellbeing.

As a consequence of insufficient funds, some care organizations have retrenched workers and rationalised incentives in order to reduce organizational expenses. However, the retrenchment of workers may cause job insecurity among those remaining in the organization, impacting their job satisfaction and performance. A discussion paper on the impacts of the global economic crisis on women, girls and gender equality (UNAIDS, 2012) found that the global economic crisis has profound implications for the economic and social empowerment of women and girls at an individual and community level. Many women have lost their jobs as a consequence of the financial crisis and this affects their emotional and physical health. Moreover, the rationalization of incentives may also lead to job insecurity, demoralization, frustration and de-motivation among volunteer caregivers (Shaibu 2006). Ntetha's (2012) study on the meaning of work in the context of the financial crisis found that a decrease in employee benefits, rationed compensation, and retrenchment have negative impacts on worker morale and could lead to job dissatisfaction. Studies have also shown that the stress of losing a job or dealing with the everyday hardship caused by decreased wages can lead to mental health problems (UNAIDS, 2012). These findings highlight the need for care organizations to offer volunteer caregivers psychosocial and emotional support through regular meetings and debriefing sessions.

Limited resources prevent home-based organizations from training volunteer caregivers. The findings of this study showed that most volunteer caregivers received limited training. The nature of the patients cared for by home-based care organizations requires specific skills and

knowledge. Volunteer caregivers need to be trained to perform their tasks effectively. Insufficient training means that volunteer caregivers do not have the sufficient knowledge and skills to provide proper home-based care. In some cases, they may fail to provide proper basic nursing care; they may also fail to identify health problems which need to be referred to the clinic or a hospital. Furthermore, insufficient knowledge may cause frustration, demoralization and a fear of exposure to infection. This highlights the need for skills training that will enable volunteer caregivers to perform their duties more effectively.

Azwidihwi, Tshililo, Davhana-Maselesele, & Dphil's (2009) study on the experiences of caregivers of people living with HIV/AIDS in Limpopo province in South Africa found that these caregivers worked with limited care materials such as gloves and napkins. They feared infection and this affected their work. Working with insufficient materials may increase the risk of volunteer caregivers being infected with HIV/AIDS, TB and other infectious diseases. Moreover, the lack of materials may affect the manner in which volunteer caregivers perform their duties. All these factors may cause them to abandon some patients (Akintola & Hangulu, forthcoming 2014). Kang'ethe's (2010) study in Botswana found that a lack of materials discouraged volunteer caregivers from performing their duties and caused some to quit. These findings suggest that the government should provide care organizations with the required materials in order to reduce the risk of exposing volunteer caregivers' to health risks and to ensure that patients receive the care they need.

5.2.4 The micro-system

The beneficiaries of the services offered by home-based care organizations are at this level; these comprise people living with HIV/AIDS, family members, orphans and the community. The findings of the study show that home-based care organizations have rationed the services provided to beneficiaries. This suggests that the people who depend on these services will become more vulnerable to diseases and unemployment and may suffer from hunger. For example, scaling down a feeding scheme or food parcels affects the health of those who depend on these programmes. People living with HIV/AIDS cannot take medication on an empty stomach; they rely on home-based care organizations for food such as porridge. The literature shows that poverty affects people's well-being, especially those living with HIV/AIDS (Orner, 2006). A decline in the quantity of food may increase the risk of HIV infection among children and young people, as their vulnerability to infection increases with malnutrition and the

resulting dampening of their immune systems (Kelly, 2000). Reducing food parcels may lead to an increase in crime as community members try to make ends meet by means of illegal activities. These findings point to the need for the government to introduce new programmes to alleviate poverty.

Budget cuts in HIV/AIDS programmes by both the government and donors pose major challenges in the fight against HIV/AIDS. A lack of funds, workers, training and materials affect organizations' effectiveness and compromise the quality of services received by beneficiaries. HIV/AIDS patients could develop new infectious diseases which could cause their health to deteriorate. This finding is similar to the results of Hangulu's (2012) study on infection control. The study found that insufficient home-based care material compromised infection control practices in most care organizations.

Insufficient funds for care organizations may also lead to an increase in mortality and morbidity, greater transmission risks, higher financial costs and an increased burden on health systems (The World Bank, 2009). This highlights the need for government to intervene and help care organizations. For example, through local clinics, the government could partner with care organizations to share available resources. Care organizations should also inform the government of the implications of funding cuts for the beneficiaries of the services they provide. Home-based care organizations are playing a significant role in combating and raising awareness about HIV/AIDS in communities. This study found that some care organizations offered AIDS awareness campaigns and youth development programmes to curb the spread of HIV/AIDS and other infectious diseases. However as a result of limited resources some care organizations had to cut this service. This has negative impacts on the communities that benefited from these programmes. The lack of such programmes could increase the risk of HIV/AIDS, morbidity and mortality rates and the number of new infections. A lack of information and awareness can exacerbate HIV-infected individuals' vulnerability, as they tend to suffer more frequent and severe opportunistic infections due to weakened immune systems. The Millennium Development Goal of combating HIV/AIDS, malaria and other diseases (IMF, 2013) will not be achieved if HIV/AIDS programmes continue to suffer from insufficient resources. These findings highlight the need for support from the government to help care organizations to continue running different programmes that help to combat HIV/AIDS.

5.3 Conclusion and Recommendations

The ecological systems theory helped to shed light on the experiences of care organizations in the context of the global financial crisis. A qualitative research design was used to collect data in order to gain insight into the effects and implications of the global financial crisis on care organizations. This study showed that the global financial crisis is having profound impacts on care organizations providing AIDS care. The government, international donors, and local corporate and individual donors have reduced the funding allocated to care organizations. The inability of the government and donors to continue providing care organizations with sufficient funds and support has severely affected these organizations. Consequently, care organizations are confronted by numerous challenges such as operating with insufficient funds and home-based care materials, limited staff and insufficient knowledge and skills on how to provide home-based care. Care organizations were forced to embark on organizational restructuring, cutting back on services and the number of communities served, retrenching staff and rationing incentives. This highlights the need for the government to play a bigger role in the provision of funds and support to home-based care organizations. The government needs to incorporate home-based care into its social and economic policies to ensure a steady flow of funds to care organizations. Home-based care organizations should be involved in the planning, implementation, monitoring and evaluation of home-based care programmes so as to avoid duplication of services which wastes resources.

This study also provided insight into the effect of the insufficient funds received by care organizations on hired home-based care workers and the beneficiaries of the services offered. The government and donors should be alerted to the implications of funding cuts, not only for an organization but also for those who rely on these organizations for employment and services. Funding cuts could have devastating consequences for the wellbeing of people living with HIV/AIDS. Given the impacts of the financial crisis on care organizations, there is need for HIV/AIDS activists to advocate for sustained funding of these organizations. Given the fact that these organizations provide health care services and employment opportunities to community members, sustained funding will boost the fight against HIV/AIDS, poverty and unemployment.

For their part, care organizations need to network and collaborate with other non-profit organizations to share resources, ideas and strategies on common programmes to avoid duplication and wastage of resources. Networking will facilitate the sharing of both capacity

and expertise. Care organizations also need to diversify their sources of funding by finding more creative and innovative means to generate funds such as social enterprises, local fund raising, strengthening research to support their programmes and submitting more proposals to both local and international donors. Non-profit organizations should advocate for donor policies that support non-profit organizations' sustainability.

5.4 Areas for further research

Based on the findings of this study, it is recommended that further research be conducted on the effectiveness of home-based care organizations' responses to the financial crisis. There is also a need to extend this study to the beneficiaries of the services offered by home-based care organizations in order to gain further insight into the impacts and implications of the global financial crisis.

5.5 Limitations of the study

A number of limitations were identified in this study. The sampling technique used to recruit organizations has some limitations. That is snowball sampling procedure was used to identify home-based care organizations that were willing and interested in taking part in the study. Snowball sampling identifies participants through referrals; hence it is not representative of all home-based care organizations. Likewise, the fact that home-based care organizations referred me to other home-based care organizations which are known to them excluded other organizations. While this study may provide some insight into the impacts of the global financial crisis on the functioning of home-based care organizations, it may only represent the views of a limited group of home-based care organizations from different parts of Durban and cannot be generalized to other home-based care organizations in other areas. Only ten organizations were interviewed. However there was saturation in terms of the themes that emerged, and further interviews may merely support these themes.

This study used interviews to collect data. Participants might give answers that they feel will make the researcher happy than giving their honest opinion. However I encouraged the participants to be truthful and discouraged them from giving socially desired answers. With each interview, I had a completely different feel and interactions were also completely different. Each interview held a unique opportunity for learning. I was very fortunate to receive a positive response from all my research participants. However the researcher's interviewing skills could have been honed to follow the thread of conversation through translation. This

deficit was overcome by follow-up interviews. However, this imposed additional time constraints on the research project. Some interviews with other participants produced a lot of information and in some cases, some of the information was not related to research objectives hence some screening had to be done.

Language was another limitation because the research is not 100% fluent in IsuZulu. I relied on a colleague who is Zulu speaking during interviews and in translating all interviews in IsuZulu to English. To make sure that language did not compromise the quality of the data, all research questions were clearly stated indicating all the follow up questions and the probes. The researcher also took note of the non-verbal cues.

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APPENDIX A: INFORMED CONSENT FORM

Good Morning, /afternoon/evening, my name is Netsai Bianca Gwelo. I am a student in the School of Psychology, University of Kwa-Zulu Natal, 4041, Durban, South Africa. I am conducting research on the experiences of home based care organizations in the context of the global financial crisis. I would like to speak to you only if you willing to participate in this research.

This discussion will take about 40 minutes-1 hour. I will ask you to talk about the services you offer as an organization; the different challenges which you are facing as an organization and how this has affected the provision of services to the people you serve. Moreover I will ask you how you are responding to the financial difficulties faced by your organization. I will need your permission to use audio-tape recorders to capture our discussion.

All information that you give will be kept confidential. The information collected will be stored in my office and only research assistants working with me on this project will have access to it. Information will be used for research purposes alone and raw data will be destroyed as soon as the study is completely over. Also, we will not use your actual name or designation in reporting the findings of the study but will use disguised name to make sure that no one links the information you have given us to you.

You will not be given any monetary payments for participating in the study but your department/ organizations/ community/ the government will benefit from this study immensely. The results will help us to understand the challenges encountered by your organization in accessing resources and how this has affected your organization.

Your participation in this study is voluntary. If you agree to take part in the study, we will ask you to sign a form as an indication that we did not force you to participate in the study. Please note that you will not be at any disadvantage if you choose not to participate in the study. You may also refuse to answer particular questions if you don't feel comfortable answering them. You may also end the discussion at any time if you feel uncomfortable with the interview. In case you want to withdraw information given after the interview, you can call me on 0723245501 or my research supervisor (Dr. O. Akintola) on 031 260 7426, email: Akintolao@ukzn.ac.za.

INFORMED CONSENT FORM

I _____ have read the information about this study and understand the explanations of it given to me verbally. I have had my questions concerning the study answered and understand what will be required of me if I take part in this study.

Signature_____ Date_____

(or mark)

Zulu Version

INCWADI YEMVUME

Mina, _____Sengfundile mayelana nokuqukethwe inhlolovo. Ngiyaqonda izincazelo zenhlolovo njengoba ngazisiwe futhi ngachazelwa ngazo ngomlomo. Isiphenduliwe imibuzo yami ngalenhlolovo, ngakho ngiyaqonda ukuthi yini ebhekeke kimina uma ngiba yingxenye yalenhlolovu.

Signature_____ Usuku: _____

APPENDIX B: ORGANIZATIONAL DEMOGRAPHIC QUESTIONNAIRE

Name of the organization:	
Location of this organization:	
Number of years in practice:	
Type of organization (FBO/CBO/NGO)	
Number of communities served?	
Number of people employed by the organization;	
Number of staff that are paid	
Number of staff that are not paid	
Number of volunteer caregivers recruited by the organization	
Number of volunteer caregivers who receive stipend	
Number of volunteer caregivers who do not receive stipend	
Amount of the stipend paid to the volunteers, if any?	
Who pays for the stipends?	
What other incentives are offered being offered to those employed in your organization?	
Who pays for the incentives?	
What services do you provide	

APPENDIX C: INTERVIEW GUIDE FOR HOME-BASED CARE ORGANIZATIONS MANAGERS

MAIN QUESTION	FOLLOW UP QUESTION	PROBES QUESTIONS
1. Where does the organization get resources needed by the home-based care organization?	Funds Home-based care materials Workers Training	How often do you receive funds (contract basis, quarterly, yearly)? How often do you receive materials from donors How adequate are these resources
2. How has the global financial crisis affect the resources available to this home-based care organization?	***Funds and materials*** How much were you receiving from your donors before the economic hardship? How much was cut from the money you used to receive. How long was the contract you had signed with your donor? How long notices were you given before the contract was terminated? What were the reasons for terminating the contract? During the period when you were receiving money from your donors did you ever ask for more donations? Please explain in more detail. How has the has the economic hardship affect your organization in terms of material ***Training and Workers recruited by the organization***	How many volunteers have you lost How has this affected your working relationship with your volunteer care-givers

	How has the economic hardship affected your staff and volunteer caregiver How has the economic difficulties affect training offered by the organization	
4. How has the economic hardship ***impacted on the provision of services*** offered by your organization	How is it affecting program implementation, people you serve like the sick, old or children	
5. How has home-based care organizations responded to these financial difficulties	How have you adjusted your budgets? How have you restructured your organization? What has your organization done in response to the difficulties	
6. What other programs do you have in place to provide you with income either than funding you receive from the government	With the money you get what do you use it for? To what extent does the is the generated money helping the organization	

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01 November 2011

Ms NB Gwelo (207520177)
School of Psychology

Dear Ms Gwelo

PROTOCOL REFERENCE NUMBER: HSS/1130/011M
PROJECT TITLE: A study of the experiences of home based care organizations in the context of the global financial crisis

In response to your application dated 21 May 2011, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.
PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....

Professor Steven Collings (Chair)
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

cc. Supervisor – O Akintola
cc. Mrs S van der Westhuizen