BHCC

(BARAGWANATH HOSPITAL COMFORTS COMMITTEE)

HOSPITAL AND CLINIC OUTREACH

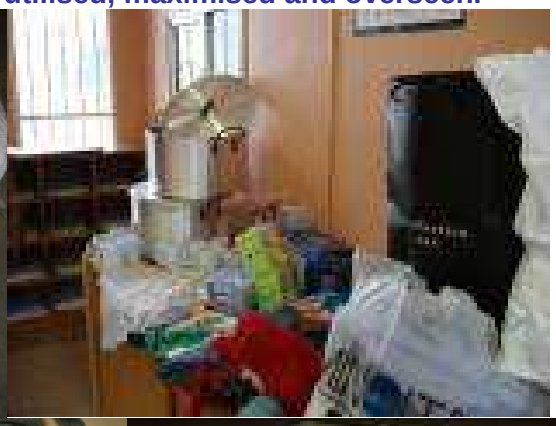
~ESTABLISHED IN 1954~

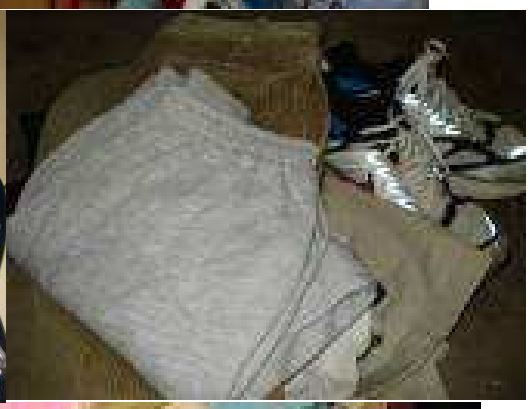
PBO EXEMPTION NUMBER: 930 006 973

NPO REGISTRATION CERTIFICATE NO: 001/252 NPO

HOSPITAL COMFORTS

"Hospital Comforts" – the provision of basic needs to destitute inpatients during a hospital stay, together with supplying replacement clothing, baby goods, recovery aids and other items, has been the core work of BHCC since the charity began in 1954. This report is aimed at explaining this aspect of our work in more detail, and to give a report-back on how donations are utilised, maximised and overseen.





History

The Baragwanath Hospital Comforts Committee was established in 1954 with a view to providing "comforts" to the patients of the Baragwanath Hospital (as it was named then). Originally started by doctors' wives, the charity has grown substantially over the years and we currently support all State hospitals in our area, including Chris Hani Baragwanath, Rahima Moosa (Coronation), Helen Joseph, Sizwe, Charlotte Maxeke (Johannesburg General) and South Rand as well as over a dozen medical clinics from the far West Rand to Central Witwatersrand, Soweto, Lenasia and Alexandra. We are receiving requests from yet further hospitals and clinics on an ongoing basis, and wherever we can, we extend our help to as many needy causes as we can. The Committee, though small and consisting purely of part-time volunteers, continues to expand its work geographically and in terms of numbers of beneficiaries. Members are from all walks of life, including secretarial, administration, computing, teaching, accounting and legal. Many of our senior members have served on the Committee for 25 years or more, and our Secretary has held the same office for 20 years. Office bearers' qualifications include Nursing degrees, B Comms, BAs, LLBs and book-keepers.

COMFORTS

It is often difficult for people in South Africa, who, by dint of being regularly employed, or who have a family or community structure around them, or maybe who are financially able to contribute to a medical aid scheme, to imagine waking up in a hospital with no family, friends or finances to face a stay in hospital, especially an unplanned stay. We all imagine regaining consciousness from an accident, should it happen to us, to find ourselves in a hi-tech hospital ward, with more than adequate equipment in case we need it, and, hopefully by then, the reassuring presence of family members who have been notified of our unconscious condition, armed with toiletries, clothing, things to make us more comfortable and to make our recovery that much easier and dignified. However, for many patients admitted to wards in South Africa, their experience, during these highly traumatic moments in their lives, is diametrically opposed to the soothing and reassuring experience most people would hope for. Over and above the serious medical or surgical condition being suffered by a patient, to have his or her dignity further robbed by the inability to remain clean and fresh, or to suffer the ignominy of leaving hospital with clothing bloodied and shredded by an accident or by the necessary action of doctors during treatment, is something we as a charity have sought to counteract since we began providing basic necessities to patients.

There are approximately 350 to 400 casualty/emergency patients admitted DAILY in the Johannesburg area, mostly to the Chris Hani Baragwanath Hospital. None of these patients would have been planning to arrive at a hospital that day. Many are unconscious on arrival and wake up in recovery wards, with no family having been able to be contacted. A high proportion of patients have very little in the way of a support system – if local, families may be too destitute themselves to help; if out-of-province, the likelihood that these people would be able to afford a return trip to Johannesburg to care for their loved-one is even more slim.

Our work in this area has undergone some changes in 2010 : clothes are no longer welcome (nor is transportation assistance) at Chris Hani Baragwanath Hospital (see below), though toiletries are being accepted, and the Charles Hurwitz TB hospital has closed down permanently. However, more and more clinics are being added to those we serve, where clothes and other goods are in desperate need, so our needs in this portfolio of our work continue to remain around the R100 000 mark annually, over and above donated goods.

In the case of casualty patients, most motor vehicle accidents, assaults or burns incidents involve damage to clothing, either as a result of the incident, or on arrival as they start to receive treatment, when doctors need to cut clothing away from the injury. Doctors have reported to us cases where patients arrive with limbs severely damaged, even pulverised (in one case by falling logs from a truck), yet pleading with them not to cut away their jeans, because they are all the clothes they possess. The distress of these patients adds to the trauma they endure, and this in turn increases the stress of the doctors treating them. One registrar despondently told us : "They arrive with nothing; they leave with even less…"

In other cases, tracheotomies or other facial appliances prevent a patient from communicating who they are, and they may spend weeks unidentified in a recovery ward with no support from their family or community. Other patients face the spectre of having contracted the HIV virus after a rape, which, they will soon learn, will involve a lifetime of treatment for them. And just generally, a patient spending any length of time in a recovery ward in hospital will frequently not have even a toothbrush, a washcloth, some shampoo or deodorant, small things on the face of it, but without which, the very dignity of the patient is threatened, his physical and psychological discomfort levels are increased, and the job of the nurses involved is made more tedious, sometimes extremely unpleasant.

Where possible, in those hospitals where we are still given access, for those patients whose family is either absent or incapable of providing the basic support they need, BHCC becomes a kind of "surrogate" family – we see to it that there are supplies of replacement clothing and shoes, basic toiletries, wash cloths and other items for which we receive frequent requests, available to the social workers and nursing staff involved at the hospitals we serve. We are often humbled by the genuine gratitude of ward sisters as we hand out basic toiletries and toothbrushes, even if it is a question of three or four items per ward.

Over and above casualty patients (all of them unplanned hospital admissions), we have also traditionally been approached for help with paediatric patients, maternity patients and newborns. Approximately 100 women at full term in their pregnancies are admitted daily to the maternity unit at CH Bara hospital, of whom 70 to 80 give birth. Almost half of these are Caesarean deliveries. Mothers well enough to leave the hospital are typically given between 4 and 12 hours after delivery to vacate the hospital. The same scenario is played out at other hospitals and clinics in the area, albeit with fewer patients. Many of the labours are unforeseen, and often a baby is born with no provision for clothing, bottles (for babies born to HIV+ mothers) or other needs for mother or baby. BHCC currently has numerous helpers to whom we supply wool and fabric, and who knit and sew blankets, clothes, tiny baby matinee jackets, vests and knitted toys, whilst we also allocate some funding towards bottles and suchlike for emergency cases. We also actively seek donations of clothing and take any baby clothes to the hospitals most in need. Whilst we are currently experiencing difficulties in accessing CH Bara hospital to provide for the needs there (see below), other hospitals, and increasingly, more and more clinics, are requesting clothing for babies (and adults alike).




Many patients admitted to hospitals have been severely burned and may need a long recovery period in cubicles in a burns unit, with no outside contact nor stimulation to ease the isolation and boredom, followed by months or years of rehabilitative therapy, involving not only transportation costs but also the cost of therapy aids which they can rarely afford themselves.


We are often approached by physiotherapists at our burns units to provide radios, reading materials or television/DVD equipment, games and aids that encourage fine motor and gross motor therapy, or which help stretch areas of flesh atrophied due to scarring, and non-perfumed creams for damaged skin. In other therapy units, physiotherapists ask for therapy aids, non-slip mats to assist amputees to eat one-handed, heat packs, stress balls, and towels and pillow cases to cover equipment and keep it hygienic between patients, among other items. Occupational therapists and psychotherapists request items to run workshops with their patients : from tea-rooms and beauty parlours to vocational workshops, such as bead-work, gardening, sewing, knitting, crocheting, baking, fabric painting and art work. Cerebral Palsied children also make use of baby seats and prams, helping them remain upright when being fed, for example. BHCC tries to make funds available to purchase all kinds of items for patients undergoing therapy, and frequently has drives for donations of games, cards, old TVs and the like.


Hindrances to our work :

In recent months, disturbingly, we have been confronted with a surprising resistance by top management at our largest hospital, the Chris Hani Baragwanath Hospital, towards patients being given the assistance that our donors can provide, particularly replacement clothing and transportation assistance (cases of patients unable to be discharged due to lack of a simple taxi fare home and having to wait patiently for some family member with the requisite financial means). The objections to our help were voiced by the CEO of Bara as follows :

a) "We are no longer in a society where white people should feel able to do politically correct good deeds for black people, because this is merely a way to perpetuate a culture of dependency by black people on white people".
b) "Storage of clothing (mainly donated (second-hand) clothing) is an abuse of valuable floor space in departments such as Social Work Department". The CEO is further convinced that every patient arrives in Trauma with a cellphone and has family quite capable of providing new clothing upon discharge. We are unable to disprove this information because, having denied us further access to the wards to check with the staff who actually deal with the patients and are aware of the needs, we are reliant on senior administrative or public relations staff to inform us about the condition of patients and their needs, or rather the "lack thereof". The staff to whom we do have access now invariably tell us that the trend towards more, rather than fewer, needs by patients (that we have witnessed over the past nearly 60 years) is erroneous, and that no patient at CH Bara hospital actually requires clothing at all, thus echoing the view of the CEO.
c) "Social Workers are wasting valuable time/State funds "doing the work" of charities, when all they ought to be doing is tracing unidentified patients, so as to reduce the patient load quicker, and thereby save money for the hospital". (Thus the more traditional compassionate work of Social Workers in assisting destitute patients is being curtailed at the hospital.)
d) "State employees should not be handling cash (taxi fares) for patients, and for the hospital to bank the donations for this transportation assistance is a lot of work, so the patients should rather simply call on family to help".

In theory, and after much persistence, we have been given permission to start supplying again the basic toiletries that we used to provide to inpatients and Occupational Therapy outpatients, as well as baby clothing for newborns being discharged. In practice, however, such is the level of fear among staff at the hospital that Social Work Department will now no longer take responsibility for the toiletries, and we are reliant on Occupational Therapists to help distribute the goods to inpatients as well as to their own outpatients. No-one at all can be found to take responsibility for the baby goods in Maternity, thus no mothers or babies have been assisted by us since late 2009. Trauma patients, faced with the loss of their clothing, simply have to do without assistance, as this is one area of provision that the CEO will not countenance, repeatedly citing the "dependency" issue as her reason. Transportation assistance has also been firmly curtailed.

At other hospitals, however, the attitude, for the moment, is far more welcoming. Indeed, at the Charlotte Maxeke hospital (formerly the Johannesburg General Hospital), the staff in the trauma section are, by contrast, still extremely caring for their patients : they recently requested a washing machine and tumble dryer so that the trauma victims' damaged and soiled clothing could be washed before storage in the kit room, thus ensuring that clean clothes will be available for these patients upon discharge. They also accept donated clothing for those patients whose clothes are irredeemably damaged and who have no-one readily available to provide replacement clothing, as well as toiletries for unsupported patients. Other hospitals, such as Helen Joseph and Rahima Moosa Mother and Baby Hospital always welcome clothing and toiletries, as do many of our clinics.

As far as our budget is concerned, other than a drop in the transportation assistance (which falls under a different item in our accounts, it is not covered under "Hospital Comforts"), once regular supplies of toiletries are once again being supplied to CH Bara, via whatever channels are available to us, the budget expenditure on these items will remain much the same as before, since most of the "hospital comforts" that are no longer welcome at the hospital were those sourced as donations (second-hand clothing, mainly). A small decline in expenditure on

wool and fabric for baby clothes will persist until we can find someone in Maternity willing to accept the clothes that we have available for newborns.

Other "gifts and comforts"

At Christmas time, we usually try to increase our level of giving to the hospitals and clinics that we serve. We generally try to help with Christmas parties, and we encourage children from our more privileged schools to donate gifts (wrapped and labelled according to gender and age), which we take to the hospitals so that those paediatric inpatients too sick to be allowed home on Christmas Day will have a gift to open.

HOW DO WE GO ABOUT PROVIDING HOSPITAL COMFORTS?

The Committee works hand in hand with the most relevant staff at all the hospitals and clinics involved, in order to obtain details of patient requirements from month to month. These would normally be social workers (who are normally the ones notified when a patient is too destitute to provide for himself or herself), but also include community rehabilitation facilitators (similar to district nurses), therapists, doctors, nursing sisters, clinicians, administrators and the like. Representatives from the Committee visit their contacts at the hospitals and clinics regularly, and receive lists of goods ideally required for specific patients who have been identified as being in need.

Appeals, Fundraising and Drives for Donations – management of income

In order to be able to respond to requests from hospitals and clinics, we first have to source the goods they require from month to month. Where possible, we try to appeal for donations of goods, to avoid having to buy these. Clothing drives, appeals for cosmetics and toiletries, games and equipment are launched regularly with schools, churches, companies and retailers, and with the general public via newspapers. Goods that cannot be sourced via donations are then purchased at the best possible prices, often with extensive pricing research done by our members beforehand. In order to sustain the levels of purchases we habitually make, we send

out appeals letters to charitable trusts and funding organisations, corporates and individuals, and hold fundraising events, at which we not only hope to raise funds but also to raise awareness for the charity. ***Our ethos is to manage donors' money with integrity and responsibility, maximise the buying power for all donations, and to make sure that every sum donated reaches as many beneficiaries as possible, avoiding expenditures on administration costs, salaries and the like (the only costs we are unable to avoid at present are bank charges and occasional stationery and postal services costs.)***

Management and control of donations and purchases

Once the goods are sourced at the best possible prices or at no cost, our representatives then return to the hospitals and clinics with as many of the requests as possible. We ensure that firm appointments are made with our official contacts at the hospital, who then accept delivery of the goods and allocate them to the relevant wards and the specific patients involved. Most items of equipment need also to be entered into acceptance registers, which enables the Health Department to keep a record of goods brought into their hospitals and clinics. Where possible, we make visits to the wards in the company of our social workers, distributing items directly, which also keeps us in contact with the ward sisters and the patients.

The beneficiaries are destitute inpatients and outpatients at the following hospitals :

- Chris Hani Baragwanath Hospital – (toiletries only, currently) inpatients, outpatients
- Charlotte Maxeke Hospital (Johannesburg General Hospital) – inpatients, outpatients
- Rahima Moosa Hospital (Coronation)- inpatients, outpatients
- Helen Joseph Hospital – inpatients, outpatients
- 6 + clinics in the West Rand Health area, outpatients
- Clinics in the Central Wits Health area, outpatients
- Clinics in the South Rand Health area and 2 in Lenasia, outpatients
- 2 major Clinics in Alexandra, outpatients, plus about 50 maternity patients monthly

It is difficult to estimate the number of patients (and staff) who benefit from these comforts, but we would probably serve, directly, 2000 patients at a MINIMUM each month, thus approximately **24 000 beneficiaries each year**. We are hoping to provide goods to the value of at least **R100 000** for the financial year 2010-11, if we can achieve the funding required.

FINANCES

Current Financial Situation and Projections until the end of March 2011

The 2009-10 Financial Year was unusually difficult from the budgeting point of view, since, due to the global economic crisis, donors tended to take a conservative approach to making donations, and many waited until the last few months of the Financial Year to contribute towards the work. Projects that had been considered for the year were largely put on hold initially. Most of the available funding was thus channelled into our three core initiatives that need to be sustainable : namely, Hospital Comforts, Bread for Life (feeding schemes inside of clinics) and Transportation Assistance. We managed to keep our expenditures on Hospital Comforts relatively unchanged from those of the 2008-9 Financial year, even though volumes increased: this was because of continued cost-cutting efforts. For the 2010-11 year, again, the expenditures should be in the region of around R100 000 (very slightly down from last year), as our lack of access to Bara hospital for many months will have had an effect, and again, we have been seeking more cost-effective sources of toiletries, and donors, too, for these, where possible, while still continuing to increase the actual physical amount of the supplies.

We have been grateful to continue receiving generous donations in the "general" category, from charitable trusts as well as from private individuals, whose ongoing support is of enormous inspiration to us, over and above the benefit we are able to pass on to our patients.

We once again re-iterate our thanks to our donors for contributing towards this initiative, which makes up a sizeable proportion of our work in terms of expenditure.

Current additional initiatives at BHCC

In recent years, we have expanded our areas of help, to include three other initiatives :

- Transportation assistance :
    a) For inpatients : where a patient is too destitute to afford a taxi or bus fare to his or her home, and where no member of the family or community is available to help, our Transportation fund provides the necessary fare to enable the patient to leave the hospital as soon after discharge as possible. For every extra night a patient takes up a bed unnecessarily, the cost to the State is calculated at R350 per night per patient. The average time taken by social workers to trace family or community members to come to the hospital to escort the patient home is 3 to 7 days.
    b) For outpatients : strict adherence to treatment plans is increasingly becoming a vital issue for patients and the Health Services alike. HIV/AIDS patients need to remain totally compliant with anti-retroviral (ARV) treatments to avoid contracting secondary infections such as AIDS-related cancers and tuberculosis (TB). TB patients, very vitally, need to remain strictly adherent to their antibiotic treatment programmes (usually up to 6 months of treatment), to avoid drug resistance occurring. Once a patient develops extensive drug resistance, he can spread such a deadly form of the illness to others, that admission to quarantine-type facilities such as Sizwe is often the preferred response to the situation. Other patients, such as physiotherapy patients, burn victims, rape victims, etc., often experience huge setbacks to their recoveries if they cannot attend their clinic as scheduled. Rather than see such costly, even deadly, interruptions to treatment programmes for lack of funds for transportation to or from the clinic, our fund extends the necessary money to ensure that patients remain as compliant as possible.
- Bread for Life – soup kitchens/feeding schemes : this initiative is aimed at outpatients at major clinics in the Johannesburg area, particularly HIV clinics, oncology clinics and TB clinics. Patients reporting to these clinics typically arrive well before the clinic opens, because the first to arrive are ensured of the first seats in the queue. Those arriving later may or may not have seen the clinicians and doctors before the clinic closes for the day (and generally that means that they will have to come back the next week). In practice, many patients leave home before it is light, to queue at taxi ranks, and will not have eaten any breakfast. They then sit in the waiting room, sometimes for the rest of the day, without being able to leave their seats to look for some lunch, for fear of losing their place. When they receive their medication, they usually need to take this on a full stomach, which is obviously a problem for many patients. We have established soup kitchens (soup, bread, peanut butter, fortified juice) at most of the major clinics we serve to combat the problem of hunger and to provide some support for their treatment programmes. These soup kitchens have the added advantage of incentivising patients to keep coming back for treatment.
- Projects – occasionally we are approached by staff at our clinics and hospitals, to help them refurbish very dilapidated areas of the facilities where they are working, and for which there is no budget from the Government. Where these "facelifts" would provide a tangible improvement in conditions for staff and patients alike, we will consider allocating funds to these, provided that our three core initiatives, "Hospital

Comforts", "Transportation Fund" and "Bread for Life" have sustainable funding for the year. Recent examples are a ward at the Charlotte Maxeke (Johannesburg General) Hospital, allocated for mothers of paediatric and neonatal patients from out of the area, which had too few beds, with some women sharing beds or climbing over others to reach their beds. We secured a donation of bunk beds, refurbished the linens and curtains and provided a washing machine for mothers to use during their stay; and the Helen Joseph Psychiatric ward, which was dilapidated and depressing in itself: in this instance, repairs, new linens and sunny colour schemes throughout gave the ward a facelift which lifted the spirits of both patients and staff. We have also provided a new treatment area (divided into two, for two consulting rooms) for the overcrowded Orchards Clinic, and are contemplating a similar project for a clinic in a squatter camp in Lenasia. Over and above the projects involving premises, we are always supportive of self-help projects, such as crafts projects and gardening projects, which combine income generation with therapy.

BHCC - HOSPITAL AND CLINIC OUTREACH
(BARAGWANATH HOSPITAL COMFORTS COMMITTEE)

FUND RAISING NO. 011 00330 002

PBO TAX EXEMPTION NUMBER (SECTION 18A):930 006 973

NON-PROFIT ORGANISATION REGISTRATION CERTIFICATE NO: 001/252 NPO

CONTACT DETAILS :

Postal :
P O Box 1454
Morningside.
2057

Telephone number : 082-901-7687
Contact person : Sue Dykes (Chairlady)
Fax : 088-011-462-8749
email : admin@bhcc.org.za

Chairperson : Sue Dykes (Sue Dykes : 082-901-7687)
Vice-Chairperson : Lynn Ferguson
Treasurers : Rose Roseveare, Gloria Tinker
Secretary : Audrey Dry
Assistant Secretary : Lindsey Stevens
Appeals Convenor : Sub-Committee headed by Sue Dykes
Bread for Life Co-ordinator : Ros O'Connor
Buyer : Lynn Ferguson
Assistant Buyer : Colleen Frost

Banking Details :
Bank : FNB
Branch : Rosebank, Sorting Code : 253305
Account Number : 503 702 77764
Account Name : Baragwanath Hospital Comforts Committee

Website : www.bhcc.org.za