

What motivates people to volunteer? The case of volunteer AIDS caregivers in faith-based organizations in KwaZulu-Natal, South Africa

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Volunteers are increasingly being relied upon to provide home-based care for people living with AIDS in South Africa and this presents several unique challenges specific to the HIV/AIDS context in Africa. Yet it is not clear what motivates people to volunteer as home-based caregivers. Drawing on the functional theory on volunteer motivations, this study uses data from qualitative interviews with 57 volunteer caregivers of people living with HIV/AIDS in six semi-rural South African communities to explore volunteer motivations. Findings revealed complex motivations underlying volunteering in AIDS care. Consistent with functional theorizing, most of the volunteers reported having more than one motive for enrolling as volunteers. Of the 11 categories of motivations identified, those relating to altruistic concerns for others and community, employment or career benefits and a desire by the unemployed to avoid idleness were the most frequently mentioned. Volunteers also saw volunteering as an opportunity to learn caring skills or to put their own skills to good use, for personal growth and to attract good things to themselves. A few of the volunteers were heeding a religious call, hoping to gain community recognition, dealing with a devastating experience of AIDS in the family or motivated for social reasons. Care organizations' poor understanding of volunteer motives, a mismatch between organizational goals and volunteer motivations, and inadequate funding meant that volunteers' most pressing motives were not satisfied. This led to discontentment, resentment and attrition among volunteers. The findings have implications for home-based care policies and programmes, suggesting the need to rethink current models using non-stipended volunteers in informal AIDS care. Information about volunteer motivations could help organizations plan recruitment messages, recruit volunteers whose motives match organizational goals and plan how to assist volunteers to satisfy these motives. This could reduce resentment and attrition among volunteers and improve programme sustainability.

Keywords Caregivers, caregiving, home-based care, motivation, PLWHA, volunteers, HIV/AIDS

KEY MESSAGES

- The functional approach to motivations provides a useful framework for understanding the motivations of volunteer caregivers of people living with HIV/AIDS in a developing country context.
- Information about volunteer motivation could help care organizations plan recruitment messages, recruit appropriate volunteers and assist them to satisfy their motives. This could reduce resentment and attrition among volunteers and improve programme sustainability.
- Since many people volunteer for career-related motives and would not want to continue volunteering for the long term without remuneration or career achievements, policymakers and care organizations need to plan to remunerate volunteers and create career development models or stand the risk of losing them, with negative effects on the public health care system.
- Volunteer motivation has implications for training plans and budgets of care organizations, international organizations and the health care system.

Introduction

Volunteering involves committing time and energy to provide a service that benefits someone, society or the community without expecting financial or material rewards. It has historically been practiced in various communities and fields worldwide. Although individuals may help others or volunteer spontaneously, it is the ongoing planned help (Omoto and Snyder 1995; Clary *et al.* 1998) carried out through voluntary associations that is the focus of this paper. In the formal health service delivery arena, volunteering became popular worldwide after the Alma Alta Declaration (WHO 1978). **Volunteering is a core element of community participation in primary health care, which was seen as the broad philosophy and key strategy for achieving Health for All (WHO 1978; Walt 1988).** Accordingly, various communities, especially in developing countries, engaged the services of volunteers in various cadres at the primary health care level (Walt 1988; Friedman 2002; Schneider *et al.* 2008). However, researchers have argued that a **decline in interest in the use of volunteers occurred in the 1980s and early 1990s in South Africa, due to a combination of factors including donor fatigue and inadequate support from the new South African democratic government (Friedman 2005; Schneider *et al.* 2008).** In the mid-1990s, a substantial increase in funding for HIV/AIDS and child survival programmes led to a renewed interest in the use of volunteers in health care (Schneider *et al.* 2008).

In South Africa as in many sub-Saharan African countries, there has been a severe shortage of financial, material and human resources in public hospitals (Shisana *et al.* 2002; Wadee and Khan 2007). At the end of March 2008, 35.7% of health professional posts were vacant in the country's public health sector; 40.3% of posts for professional nurses were vacant and 34.9% of posts for medical practitioners (Health System Trust 2008). As a consequence of this and the high prevalence of HIV/AIDS in the country, public hospitals lack the capacity to care for the growing numbers of people living with AIDS (PLWHAs), who comprise close to half of public health facility users in the country (Shisana *et al.* 2002). Drawing on the notion of community participation in health care, the government is promoting home-based care for PLWHAs as a way of easing the burden on public health care facilities. However, home-based care programmes are mainly initiated by churches, community groupings and non-governmental organizations (NGOs) and

few receive support from government. These organizations rely mainly on unpaid volunteers who are recruited from HIV/AIDS-affected communities and trained to assist families in their local communities in providing home care for the ill. Regrettably, accurate estimates of the number of volunteers or the number of care organizations making use of volunteers are not available, but it is **widely believed that volunteers form the cornerstone of most care programmes (Russel and Schneider 2000; Steinberg *et al.* 2002; Akintola 2004; Akintola 2008).**

In South Africa, volunteer caregivers (also referred to as home-based carers) constitute one of several cadres working in a range of specialized positions within the primary health care structures under the broad name of community-based health workers (CBHWs)¹ (Friedman 2002; Schneider *et al.* 2008). However, their roles sometimes overlap with those of other CBHWs (Hlophe 2006; Schneider *et al.* 2008).

Volunteers in home-based care have been shown to confront considerable but unique challenges. **First, the majority of volunteers are unemployed and not remunerated, yet they use their own meagre resources to help their patients (Blinkhoff *et al.* 2001; Akintola 2008).** Second, **volunteer caregivers devote considerable time to care work, with a substantial proportion working full-time, sometimes 7 days a week (Akintola 2008).** Third, AIDS care volunteering is also associated with significant psychological and physical burdens, including the risk of infection with HIV/AIDS/TB (Blinkhoff *et al.* 2001; Akintola 2004; Akintola 2006a). Given the difficulties confronting these volunteers, AIDS care organizations do not seem to be an attractive setting for people who choose to volunteer. This begs the question: why would anyone volunteer to provide informal AIDS care?

Although home-care organizations experience some difficulties in recruiting volunteers, an even greater challenge, as demonstrated by studies in Zambia, Namibia and South Africa, is that of **ensuring volunteer satisfaction and retention over the medium to long term (Blinkhoff *et al.* 2001; Steinitz 2003; Akintola 2004).** Anecdotal evidence and studies among South African care organizations have revealed widespread dissatisfaction and a high rate of attrition among volunteer caregivers, with far-reaching implications for the sustainability of the programmes (Akintola 2004; Marincowitz *et al.* 2004). A study of volunteers in a home-based care project in the Limpopo province of South Africa showed that 27% quit the programme

and a further 5.5% were no longer active within a year of receiving training (Marincowitz *et al.* 2004). An understanding of volunteer motivations might provide insight into issues influencing AIDS volunteer recruitment, satisfaction, retention and attrition. Yet little is to be found on what motivates people to volunteer their time and energy to caring for PLWHAs in Africa.

This study draws on functional theorizing proposed by various authors (Clary *et al.* 1992; Snyder 1993; Omoto and Snyder 1995; Clary *et al.* 1998) in understanding volunteer motivations. The functional approach is concerned with the personal and social functions served by an individual's thoughts, feelings and actions (Snyder 1993). The functional approach holds that people volunteer in order to fulfill important underlying social and psychological functions, which the authors called motive functions; and that different people can and do perform the same volunteering activities in order to satisfy different functions. These motive functions, according to the authors, are critical to initiating and sustaining volunteering behaviour. We reviewed previous research that applied the functional approach as a conceptual framework to explore motivations of AIDS volunteers (Omoto and Snyder 1995) and volunteers in a wide variety of other settings in the United States and Australia (Clary *et al.* 1998; Esmond and Dunlop 2004). Ten categories of functions served by volunteering were identified:

1. Values: satisfying humanitarian obligation to help others or showing empathy for others;
2. Community: concern for and worry about community;
3. Career: seeking career-related benefits/connections, skills or experience;
4. Protective: reducing negative feelings about oneself;
5. Understanding: desire to better understand how to help others in society or exercise skills that are unused;
6. Enhancement: desire to feel better about oneself or be needed by others;
7. Reciprocity: attracting good things to oneself;
8. Recognition: needing recognition of one's skills and contribution;
9. Reactivity: addressing own current or past issues; and
10. Social: meeting the expectation of or getting the approval of significant others.

Clary *et al.* (1998) argue that people can be recruited into volunteer work by appealing to their own motive functions. Following functional theorizing, we sought to understand what motivates people to volunteer as caregivers in community home-based care programmes in an African setting.

Methods

Study setting and context

Volunteers working in two faith-based organizations (FBOs) operating in 16 communities in KwaZulu-Natal province of South Africa constituted the primary focus of the study. The FBOs share many similarities with other NGOs except that they are founded on Christian principles of reaching out to others, and they provide patients with spiritual support over and above the basic nursing care, emotional, material and logistical

support provided by other programmes (Akintola 2004: 12). However, they are inclusive in their service to non-Christian patients as well. Further, volunteers are drawn from people of varied religious and ideological persuasions in AIDS-affected communities who are willing to work in AIDS care.

Both FBOs encourage volunteering. However, their inability to provide stipends or remuneration stems from pragmatic reasons rather than ideological or philosophical considerations: they are unable to access any financial, material or technical support from government and are therefore primarily dependent on donors who are averse to funding caregiver salaries or stipends. Given the urgent need to reach large numbers of people who require home care, the FBOs therefore have to rely primarily on unpaid volunteers since they are unable to employ professional health workers such as professional nurses or doctors for hands-on care. They nevertheless maintain a small complement of paid management staff. In contrast, some other NGOs with government funding pay their volunteers stipends. However, it is important to note that the government only funds stipends of a limited number of volunteers in each NGO that meet their criteria, while the remaining volunteers in the same NGOs are not paid stipends.

The FBOs use a similar training curriculum to conduct a 6-week training on the theory and practice of home-based care, counselling, tuberculosis prevention and treatment and nutrition. Trained volunteers are required to work on average 3 days a week, but in practice most are on call to attend to patients every day and night. As part of their volunteer development programme, one of the care organizations enrolls volunteers in palliative care training courses in their affiliate hospital, and these are paid a stipend for the 6-month period of their training. This equips them with skills that could potentially be used to seek paid employment in other palliative care facilities. The FBOs also provide various incentives as a way of showing appreciation and rewarding their volunteers such as provision of groceries, end of year gift vouchers, food parcels for the very needy, umbrellas, shoes, allowances for uniforms and subsidies for their children's school fees, toiletries including sanitary towels, and in the case of one FBO, access to free health care in the affiliate hospital including antiretroviral (ART) treatment.

Participants

This qualitative study made use of interviews and focus group discussions. Participants were volunteer caregivers of PLWHAs and key informants selected purposively because it was thought they possess information that can shed light on the research question and thus provide rich data (Ulin *et al.* 2002). They were drawn purposively from six of the 16 Zulu-speaking communities served by the FBOs. Five of the communities are semi-rural (townships) and one is an informal settlement.² The FBOs were selected because: they had some of the largest (550 combined population) volunteer bases in the province and thus a large pool of potential participants to draw from; they operate in a wide variety of communities (16); and they expressed a willingness to participate in the study. The communities were selected purposively with the help of the FBOs because they were easily accessible and were willing to participate in the study.

The management of the NGOs also convened meetings with volunteers where the purpose of the study was discussed and those who consented to participate in the study were recruited. Volunteers were selected purposively if they were: enrolled and trained as volunteer caregivers by one of the participating NGOs; providing care to someone with clinical AIDS; caring for a minimum period of 3 months; willing to respond to questions about their motivation for volunteering. Only one of the 58 volunteers who attended the NGO meetings and were invited to participate refused, citing her lack of interest. Only two of the 57 participants were males. Participants' ages ranged from 22 to 55 years. Most had between 7 and 12 years of education but two participants had university education. Only nine were employed, mostly in the informal economy. Interviews were also conducted with 10 key informants such as home-based care managers (2), coordinators of volunteer caregivers (6) and community clinic/programme nurses (2).

Procedure

Ethical permission for the study was obtained from the ethical review board of the Faculty of Human Sciences of the former University of Natal, Durban, South Africa and from the NGOs. The study was conducted over a 17-month period from December 2003 to April 2005. Interviews were conducted in community resource centres or participants' homes, depending on participants' preferences and logistics. Verbal informed consent was also obtained from participants before interviews were conducted. Interview schedules and focus group schedules consisting of topic guides and open-ended questions were used to conduct in-depth interviews and focus group discussions with participants. The caregiver interview and focus group schedules focused on socio-demographic variables and the motivations for volunteering, i.e. the social and psychological functions that participants wanted to satisfy by volunteering.

All the interviews and focus group sessions were conducted in Zulu by three trained interviewers from the study communities and took between 40 and 120 minutes to complete. The decision to use community members came from discussions in the meeting with the participants and the management of the FBOs. Participants indicated that they would prefer and be more comfortable with community members than interviewers from outside the community. Cognizant of potential bias that the use of community members might impose on the data, a 2-day training was organized for the interviewers, focusing on interviewing skills and objectivity. Interviewers were trained to refrain from imposing personal values and experiences on those of the study participants (see Ulin *et al.* 2002: 32). The researcher also closely supervised the interviewers and was present at all the interviews. Having taken all these measures, we are confident that the data reflect the perspectives and experiences of the participants as accurately as possible.

Data analysis

All interviews were audio-taped, and data were transcribed and translated by two research assistants. Any differences in the transcripts and translations were resolved before analysis began. Analysis was done manually by the author, beginning with immersion in the data and with guidance from the literature on the functional approach to volunteering (Omoto

and Snyder, 1995; Clary *et al.* 1998; Esmond and Dunlop 2004). Hayes theory-led approach was used to analyse the data (Hayes 1997). To begin with, the 10 motive functions previously documented in the literature on functional theorizing comprised *a priori* themes or categories for organizing the data. Thereafter, constant comparison was used; each item was compared with the rest of the data in order to identify themes consistent with the organizing themes (Strauss and Corbin 1990). Data consistent with each of these organizing themes were identified and codes assigned before data were grouped accordingly. At the same time data were constantly checked to identify any new themes emerging (Hayes 1997; Ulin *et al.* 2002). Once the pieces of text relating to the organizing and emergent themes were put together, texts were further explored to identify subthemes (Ulin *et al.* 2002).

In order to improve overall data quality and reduce the possibility of researcher bias, which could occur because the analysis was being conducted by the researcher alone, data were validated by triangulating information from volunteers with that of key informants. Additionally, as part of the analysis process, emergent themes were constantly discussed with key informants and representatives of the volunteers, and differences in interpretation were corrected.

Findings

Volunteering served a variety of functions for study participants. Each participant reported between two and four motives for volunteering. Religion, a function not previously described in the reviewed literature on functional approach, emerged as a separate theme/function. The religion function is distinct from the 10 functions identified in the literature as it encapsulates motivations flowing solely from a strong belief in God and adherence to religious obligations of service to others. The motivations, in order of pervasiveness, were: values, community, career, protective, understanding, enhancement, reciprocity, religion, recognition, reactivity and social. With the exception of religion and education discussed later, there was no particular pattern to the responses about motivation with regard to other demographic factors. Given that there were only two males in the sample, it was impossible to establish a pattern among male volunteers. Nonetheless, it emerged that both were volunteering to satisfy similar motive functions: values, career, protective, understanding and recognition. Additionally, not only were motivations relating to values and community functions the most commonly mentioned, they were also often the first to be mentioned. Only a handful of participants distinguished the primary motive for volunteering from the secondary motives. The core themes are presented along with subthemes. Subthemes are used to clarify the nuances relating to volunteer motivations in this study context.

Values

As indicated earlier, most participants' motivations related to the values function, with almost all participants mentioning this motivation. Their responses highlighted the suffering of patients in great need of care and participants' altruistic and humanitarian concerns for them.

Showing compassion for the helpless

Providing help to those who need care out of a deep concern for them in their 'helpless' condition was important to volunteers:

"I was worried about people who are sick, particularly those who do not have someone caring for them."

"You see so many people are sick and they need some help."

Flair for caring

A flair for caring for the ill was an underlying motivation. Many of these participants had previously provided care for ill or elderly members of their own family:

"I had the love to look after sick people. Someone told me about the training...and I decided to become a volunteer."

Community

A key issue in people's decision to volunteer was the decimation of their communities by AIDS. Participants made poignant statements about the need to act to reverse this trend hence their interest in volunteering. This motivation was nearly as frequently mentioned as that relating to values.

Filling the care gap in the community

Some were responding to the care and support needs of the ill, thereby filling the care gap left by government and community members:

"I have seen my community going through a lot and I have seen a need to help my community."

"I saw that there are many sick people in our community who required care and I was also willing to become somebody who could help them."

Passion for community work

A few of the participants had a passion to work in any area that would contribute to community development. Volunteering presented a clear opportunity to work for the good of the community. Statements such as *"I have got love for the community"* and *"I like working with the community"* capture this subtheme.

Career

Unlike the values and community motivations, only a few of those volunteering to satisfy career motives mentioned this directly. Most of the participants mentioned it indirectly while answering other questions once they became comfortable with the interviewer, indicating that they were possibly discussing it cautiously. Subtle as the career motive appears, the managers of the NGOs and other key informants indicated that, going by interactions and informal discussion with volunteers, the desire for career-related benefit was one of the strongest motives, but it is concealed because volunteers do not want to appear selfish or insensitive to the plight of the ill.

Getting one's foot in the door

Care organizations typically filled internal vacancies for paid staff from their pool of volunteers. Many community members

who were aware of this offered to volunteer as a way of getting themselves in line for a job with their organization:

"I chose to volunteer because I thought it was going to be easy for me to get a job and I have been volunteering for a very long time now...but have not secured employment."

Positioning oneself for employment opportunities

Although FBOs refrain from promising volunteers employment, the project managers and co-ordinators indicated that the FBOs seek out employment opportunities in other institutions for volunteers who distinguish themselves. Some participants felt that working in care organizations would place them in a better position to gain on-the-job experience, have first hand information about vacancies for paid jobs in other organizations and at the same time secure a recommendation from their managers to support their application for these vacancies:

"I believe that volunteering channels me to the right paying job."

"I volunteer so that I can get the experience which is necessary for me to get a job."

A co-ordinator discussed the influence of career development opportunities on some volunteers:

"If somebody (a volunteer) got a job in the hospital for instance, in the palliative care department there is enthusiasm and hope (among other colleagues) that: 'perhaps some day I will get one too if I work hard...and don't relent'."

Key informants also revealed that volunteers put pressure on the management of the FBOs to get them employed and that those who are not successful express disappointment and frustration. Some volunteers become resentful and others quit in bitterness after trying unsuccessfully to secure employment. A volunteer co-ordinator said:

"Some of the volunteers were saying things like: 'I have been working for a year and nothing is happening'."

Longing for a token of appreciation

Notwithstanding the fact that care organizations are upfront about not remunerating volunteers, some participants felt strongly that their hard work will not go unnoticed or unappreciated by the government for long:

"Perhaps sometime in future the government will give us something for our labour although they explained to us that we are volunteering. One day good things will come out from it (volunteering). We will surely get a reward someday."

"I knew when I came here (to volunteer) that there was not going to be any payment but you know sometimes one feels like asking: 'when will I be getting paid?'"

A key informant indicated that almost all the volunteers in one of the organizations threatened to quit when they misconstrued an announcement made by government to mean that the government had approved a stipend for all volunteers in the

country, which they felt the organization was reluctant to implement.

Protective

Volunteering offered the opportunity for the idle and unemployed to keep themselves occupied and busy.

Avoiding idleness

The high rate of unemployment in the study communities means that there are a lot of people who stay at home idle. Many of the participants indicated that they were volunteering because of the lack of a job or something to do. High school graduates and the two males in the sample constituted the majority of people in this category. A male focus group participant said:

"Volunteering keeps us busy. Yes, I want to keep myself busy because there are no jobs and we are sitting at home doing nothing."

A young girl who had just completed but failed her high school examinations said she was volunteering in the meantime while waiting to re-sit her examinations. Another said: "I do not want to stay home doing nothing; the devil finds work for idle hands to do". They also pointed to the negative effect of idleness on one's physical and mental health. As volunteers usually find the hands-on experience interesting, they develop a deeper love for and attachment to the job and find it difficult to quit the programme:

"I enrolled initially because I was unemployed and doing nothing but as time went by I felt I had to do it from my heart to help the sick people in their own homes. Now I enjoy caring for sick people."

"At first I just went there because I had nothing to do at home, but as time went on I saw a need to help sick people and became really involved."

Asked what they would do if they found a paid job, many indicated a willingness to continue volunteering on a part-time basis, preferably at weekends.

Understanding

The motivation to develop new caring skills and use previously acquired skills for care work was fairly widespread.

Equipping oneself

Volunteering enables participants to learn new skills that they would otherwise not have had the opportunity to learn. These skills are not intended for use in securing employment but to equip them for HIV prevention and care for self, family and community members:

"In my family there are many people who have died of AIDS. I needed the help to get the training in order to help people and to protect myself from infection. The first thing that happened was that my sister got sick and my mother fell sick too and just died recently. And it hurt me a lot to see my mother die like that. After

that I saw that other neighbours too were sick. This is why I like to be a carer (volunteer) because it helps me learn skills."

For others who did not have an infected person in the family or neighbourhood, volunteering was a way of preparing for the rainy day:

"I want to get experience, which I think is important. The knowledge we get from doing voluntary work becomes useful as well in our families. When this disease (AIDS) strikes I will know what to do."

Putting one's skills and competences to good use

Some others who had provided care for someone previously felt that they had a better understanding of the physical and emotional needs of patients and wanted to apply their hard-earned expertise by volunteering. One woman who had previously provided care to her husband who had just died of AIDS and an adult son living with AIDS said:

"It is easy for me to take care of the sick person. I mean... I feel I am in a better position to care for the ill because I know how it feels to have HIV/AIDS and to be sick and dying."

Another participant said:

"I am an experienced woman and I know how difficult it is to care for someone who is suffering from AIDS."

Some felt the need to put their skills and experience acquired elsewhere in primary health care into use in AIDS care:

"I was formerly a community health worker, then I dropped out and I stayed at home. Later when I heard about the volunteer programme I decided to join."

Enhancement

Volunteering was also seen as a way of fulfilling one's dreams, thereby improving one's self-esteem or feelings of self-worth.

Staying true to one's dreams

For some, volunteering is a way to stay true to their dreams of becoming a professional nurse and keep hope alive that they would one day be able to achieve these dreams:

"My wish was to become a nurse but because I did not have money I could not fulfill my dreams, yet I like to help sick people."

Reciprocity function

A few saw volunteering as a means to help others in order to attract good things to themselves.

Reaping the fruit of one's labour

Some saw volunteering as sowing good seeds that will grow and yield good fruits from which they would reap—usually non-monetary reward—in future:

"Some day we too will need help and get help from others."

"I always think that whatever happens to the next person might happen to me as well, anytime, so you never know, you

may become sick as well and you will need someone to care for you."

Hoping for spiritual benefits

Some participants were not necessarily volunteering out of a sense of religious obligation but because they felt that a spin-off could be a reciprocal act of 'blessings' from God:

"Sometimes you have a big sin in front of God and by helping another person with your love and care perhaps that sin will be reduced."

Religion

Religion emerged as a separate theme for participants who were religious and regular church attenders, for whom volunteering was a fulfilment of their religious teachings and obligations to help others.

Heeding a religious call

Religion was central to some of the participants' motivations to volunteer. Those volunteering for religious reasons were committed Christians who saw themselves as representatives of God on earth and believed that volunteering was a way of showing God's love and care for others. Some of them had been volunteering as part of their religious obligations prior to the advent of AIDS. They used to visit the sick and the elderly in their homes, as a collective, to pray for them and assist with chores. Volunteering in AIDS care was therefore seen as a calling to a higher duty, requiring an extension of the scope of their religious obligations. They therefore heeded the call to volunteer without hesitation, in the AIDS care organizations, once invited by their church:

"I see myself as an extension of God's work on earth... I want God to reach the sick using my hands."

"We've been helping the ill before in our church... but this is more critical because we have to learn to care for the seriously ill."

Recognition

A few were attracted to volunteering in order for their skills and contribution to be recognized by their community.

Desiring recognition

A few of the participants were motivated by the recognition that they received as volunteers. The badges and uniforms worn by volunteers were an attraction to some because they make volunteers easily recognizable within the community. This brings respect from some members of the community, particularly community leaders who see them as community builders.

Reactivity

The experience of HIV/AIDS in some volunteers' families created the need to 'heal' old wounds.

Forestalling recurrence

An excruciating experience of providing care for family members without the requisite knowledge, skills and support serves

as an eye opener to the plight of others, triggering the need to forestall recurrence among those in similar situations:

"When my daughter was sick, I did not know what to do... I used to care for her, wash her and touch her without gloves because I did not know anything about AIDS, so when the opportunity of volunteering as home-based carers came, I decided to take it so that I can help the sick in my community. My child died because I could not help and I saw a need to stand up for others."

"My sister died and now I decided to do this job because I saw that there are so many orphans as a result of the disease."

Social

Significant others, particularly friends, were instrumental in people's decision to volunteer.

Saying yes to friends

Some of the participants learnt about volunteering through friends who were already volunteers. While some had a previous inclination to volunteer, others decided to volunteer because they did not want to say no to or disappoint their friends. Volunteering also provides an opportunity to be in the company of and to work together with friends:

"One day one of my friends came and asked me if I would be happy to work (volunteer) and help people in their homes. I said yes, and she took me for training."

Discussion

Data on volunteer AIDS caregiver motivations to date are from anecdotal evidence and the scant studies focusing on caregivers' experiences of burden in home-based care in Africa (see UNAIDS 2000; Blinkhoff *et al.* 2001; Steinitz 2003; Marincowitz *et al.* 2004; Hlophe 2006). This is the first study to systematically use theory to provide new insight into why people volunteer in informal AIDS care in an African context. The functional approach (Omoto and Snyder 1995; Clary *et al.* 1998; Kiviniemi *et al.* 2002) helps illuminate the fact that various participants were volunteering to serve a variety of different functions, and for all the participants, volunteering served more than one function. The study illuminates the nuances in the complex motivations of people who volunteer in AIDS care in an African context.

Motivations relating to altruistic and humanitarian concern for others and community were the most commonly mentioned corroborating assertions about the strong sense of community that exists among Africans (UNAIDS 2000). This finding extends knowledge in the area of functional theorizing, providing a nuanced understanding of the community function by highlighting the fact that people volunteer to satisfy a geographic community motive as opposed to the community of interest motive reported among the gay community in the USA by Omoto and Snyder (1995). The finding also highlights the perceived lack of effective response by government to the care needs confronting AIDS-affected communities, which has left a care gap that volunteers are trying to fill.

A striking finding is that many were volunteering to satisfy career and protective motive functions. This supports findings of a previous South African study which documented career motives among volunteers in a TB programme (Kironde and Klassen 2002). However, it is inconsistent with previous studies among AIDS care volunteers in Africa (Blinkhoff *et al.* 2001; Steinitz 2003), which have tended to suggest that community members volunteer mainly for altruistic reasons. The majority of participants wanted to satisfy a variety of motives at the same time: altruistic motives to others and community, avoiding idleness, and securing employment and remuneration (Clary *et al.* 1998). Given the context of high unemployment occasioned primarily by lack of skills (Statistics SA 2009), it seems reasonable that unemployed individuals view volunteering as a way of fulfilling their dreams of getting skills training, thereby improving their labour market opportunities.

Given that volunteers are not remunerated, ensuring volunteer satisfaction should be a key concern for these organizations. While they are able to receive training necessary for employment, the inability of the majority to secure employment within the NGOs due to a lack of budget for paid positions led to non-satisfaction of their career motives. Notwithstanding the fact that career was not the most frequently mentioned motive by volunteers, the fact that many volunteers become resentful and threatened to, or actually, quit when unable to secure employment or receive a stipend underscores the strength and significance of the career motivation and suggests that it should not be taken lightly. This finding supports Clary *et al.*'s argument that volunteers may quit if their motive functions are not satisfied (Clary *et al.* 1998). It may also partly explain the high turnover rates of volunteers that have been recorded in one of the FBOs, and in home-based care programmes in South Africa more broadly (Russel and Schneider 2000; UNAIDS 2000; Akintola 2004; Marincowitz *et al.* 2004).

Together these findings raise broader questions that go to the very core of the philosophy of community participation in primary health care which underlies the use of volunteers in health care systems in many developing countries. It also raises questions about the long-term sustainability of using poor and unemployed community members as volunteers in home-based care without remuneration, suggesting the need to rethink current policies and funding to include volunteer remuneration and the creation of career paths for volunteers. To be sure, the most successful volunteer programmes with low volunteer attrition rates in other contexts in primary health care have been those that have introduced stipends or honoraria for volunteers (see Walt 1988). While some volunteers receive stipends from government and other donor agencies through their CBOs/NGOs, the majority of volunteers are non-stipended (Akintola 2006b). Yet the magnitude of the care gap left by the government's inability to provide adequate AIDS care services to people who need them makes it necessary for the NGOs to expand their services rapidly to needy communities, even in the absence of funds for caregiver remuneration, causing them to rely heavily on non-stipended volunteers.

Though beneficial, the incentives currently provided by FBOs, earlier discussed, such as gift vouchers, shoes, toiletries, groceries among others, are clearly insufficient to address the issue of dissatisfaction. Thus while a key concern of the FBOs

should be to continue to provide volunteers with incentives, it will be difficult to sustain volunteer interest strictly with these incentives. Given the work that volunteers do and their needs, volunteers' quest for career development and remuneration is justified. The fact that organizations that are able to receive funding from the government do give some volunteers a stipend, while other volunteers, like participants in this study, do not receive stipends highlights an inequitable distribution of home-based care resources. Further, volunteers could be aware of friends working for other organizations who receive stipends, making it even more difficult to expect these volunteers to work without remuneration or career advancement. Therefore there is a need for the South African government to revisit health policy on funding of volunteer care programmes to explore and apply a more equitable funding strategy that is inclusive of all organizations doing genuine home-based care work. This will require a substantial increase in the budget for home-based care and partnerships with development agencies. Information from this study could also be used by the FBOs and policy-makers for donor education to address the issue of reluctance on the part of funders and development partners to fund caregiver stipends and career development.

In addition, the FBOs could take advantage of an understanding of these motivations to build a model for career development for volunteers which could be of mutual benefit to the organization and the volunteers. This could be done by using information about volunteer motives to design volunteer development models that will assist volunteers to satisfy their career motive, and then incorporating these models into the FBOs' proposals and budgets for funders and development partners. For instance, volunteers who have dreams of becoming nurses could be assisted through organizational development to achieve this underlying motive.

Understanding the motive function in this study reflect actual and potential need for care and requisite skills training among family and community members. Thus an exploration of the feasibility of expanding care organizations' scope of work to enrol community members as volunteers for short periods to gain hands-on experience is an imperative. This approach could help build up a critical mass of community members who are competent carers. Further, moving towards achieving universal access to ART in the context of capacity problems in public health facilities across the African continent would require the training of volunteers to act as ART treatment supporters to improve adherence to treatment, as has been done successfully in Zambia and Uganda (Mulenga and Lungowe 2005; Apondi *et al.* 2007).

Finally, given that the FBOs operate an inclusive recruitment policy, one cannot surmise that all participants will be religious. However, it is clear that religion played a major role in the decision of some participants to volunteer. The motive is distinct from the values function in this population because it focuses on motivations that are linked strictly to religion or religious obligations. This then necessitates the emergence of a new theme since it was not previously described in the literature reviewed on functional theory (Omoto and Snyder 1995; Clary *et al.* 1998; Esmond and Dunlop 2004).

While the study provides important perspectives about volunteer motivations, a number of limitations highlight the

need for caution in interpreting the data. First, the qualitative design, which drew participants from communities that were easily accessible and willing to participate in the study in one province in the country, makes it impossible for findings to be generalizable to other volunteers in other provinces or settings. Second, participants were drawn from FBOs that do not give stipends to their volunteers; motivations of volunteers in other non-governmental care organizations as well as those linked to government home-based care programmes or those using stipended volunteers may be different. Third, the fact that only two male volunteers participated in the study limits our understanding of the motivations of male volunteers. Finally, save for noting that some motivations were more frequently mentioned than others, one can neither appreciate the strength of any of the motivations nor distinguish the primary motive from the secondary motives. Quantitative studies will therefore be required to assess the strength of volunteer motivations.

Conclusions and implications for policy and programmes

The functional approach helps shed light on the motivations of volunteer caregivers of PLWHA. This study shows that insight into volunteer caregiver motivations can provide valuable information with which to plan recruitment messages for volunteers and to recruit volunteers whose motives fit those of the organizations. It could also help volunteers to avoid unrealistic expectations of organizations and thereby prevent or reduce dissatisfaction, resentment and eventual attrition. Organizations can thus strive to create an environment conducive to satisfying the motive functions of volunteers whose motive functions match the goals of the organization.

The importance that participants seemed to attach to their career and protective motives suggest that many of the volunteers do not intend volunteering for the long term in home-based care organizations without remuneration or career achievements. This highlights the need for care organizations to plan for training and retraining of volunteers in the short term. This will have implications for the training budgets of these organizations as well as the sustainability of the programmes. Given the heavy reliance on volunteers in AIDS care, the cost of using professional carers for home or hospital care, and the prevailing unemployment in HIV/AIDS affected communities, organizations will need to develop innovative means of retaining volunteers for the long term. This may include the introduction of stipends or the development of a model for career development to enable volunteers to satisfy their career motive and stay longer, thereby improving programme sustainability.

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Endnotes

- ¹ Community health workers in South Africa include directly observed therapy, short course (DOTS) supporters, home-based carers, lay counsellors, prevention of mother to child transmission, support group facilitators, adherence counsellors, community rehabilitation facilitators, first aid workers, lay health workers, community resource persons, etc. (Friedman 2002; Schneider *et al.* 2008)
- ² Informal settlements also referred to as squatter settlements or shanty towns are a common feature of urban areas in post-apartheid South Africa. They are communities that have arisen outside government plans for settlement mainly as a result of the urgent need for shelter by the urban poor. They are characterized by a dense proliferation of poor make-shift housing made from diverse material and typically lack access to basic social amenities such as potable water, flush toilets, electricity, roads and health clinics.

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