

# **CHAPTER SIX**

## **ANALYSIS AND DISCUSSION**

### **INTRODUCTION**

The information gathered from the various data collection tools is discussed in this chapter. For the sake of clarity, the findings are discussed according to the two phases of the study as outlined in Chapter Five. They should be regarded as inter-related rather than discrete, linear phases.

In summary, this study explored the motivations and expectations of volunteer home based carers of the Community Outreach Centre, St Mary's, caring for people with HIV/AIDS in the Mariannhill area. The purpose was to find the answers to four key research questions:

- How do home based carers define 'volunteers' and 'home based care'?
- What motivates home based carers to join the programme?
- What needs and expectations do the home based carers have specifically of the COC?
- What do the home based carers expect of NGO's, CBO's and FBO's in order to sustain their commitment?

This chapter presents the findings in relation to these questions. As outlined in Chapter Five, the data was analysed, in part, according to the three activities formulated by

Collins (1998). Accordingly, the data was organised into themes and sub themes. The findings reported in this Chapter are therefore, related to the patterns that emerged from the five focus group discussions. Where direct quotes are used, the participants have not been identified by name – so as to protect their identity. However, these quotes are recorded in italics. The study's phases are briefly outlined in Table Two.

<b>Table Two: Research phase, data collection tool and total participant numbers</b>		
<b>Research Phase</b>	<b>Data collection tools</b>	<b>Total participant number</b>
One (Pilot exploratory study)	Semi-structured interviews	25
Two (Participatory component)	Semi-structures interviews Focus groups Case studies	30

## **6. 1 PHASE ONE**

### **6.1.1 Pilot exploratory study**

For the pilot study, the research facilitator met with the full compliment (352) of home based carers of the COC to discuss the intention and purpose of the study. The option to be part of the study was opened to all the home based carers. Twenty-five home based carers volunteered to be part of the pilot study. Their demographic characteristics are reflected below in Table Three.

<b>Table Three: Demographic characteristics of the home based carers of the pilot study</b>		
<b>Category</b>	<b>Results</b>	<b>Percentage</b>
Gender	Male (1)	4%
	Female (24)	96%
Age	20-30 yrs (1)	4%
	31-40 yrs (20)	80%
	41-50 yrs (4)	16%
Race	Black (25)	100%
Religion	Roman Catholic (15)	60%
	Protestant (6)	24%
	Shembe (4)	16%
Marital status	Single (21)	84%
	Married (4)	16%
Number of years as a volunteer at COC	0-1 year (1)	
	1-2 years (11)	
	2-3 years (11)	
	4-5 years (7)	
Previous volunteer experiences	None (100%)	

### Discussion of Table Three

From the above table four percent of the participants were male. This refutes the misconception that home based carers are only female. This finding is consistent with findings made by Akintola (2004), Marenga (1995), and Ogden et al (2004) that, while women practice as home based carers, a small number of men also volunteer in this capacity.

80% of the participants were between the ages of 31 and 40 years. Generally, people in this age group should be remuneratively employed and form an integral part of the economic income of a country. In contrast, with the high unemployment rate in South Africa and the scarcity of employment opportunities, many people falling in this age

category, are unemployed. Many HIV/AIDS affected households in South Africa are overly dependent on government and remittances (Steinberg, Johnson, Schierhout, and Ndegwa, 2002; Samson, 2002; Akintola, 2004).

All of the participants (100%) practiced Christianity. Christianity values service to others and also emphasizes the importance of work above idleness. In studying volunteering, Claassens (2004) found that prayers, and belonging to a religious order, have some therapeutic benefit to the volunteers.

Interestingly, 84% of the participants were single. This is in keeping with the assertion that most of the women are primary caregivers and also heads of households, and this was attributed mainly to the high prevalence of non-marriage in the community (Akintola, 2004).

The pilot study's understanding of the terms 'volunteer' and 'home based carer' were explored. All home based carers interviewed stressed that a *volunteer* is someone who: works for free; does not expect to get paid for the work he/she does; and he/she offers himself/herself for service without being forced to do so. They defined a *home based carer* as someone who: cares for the sick in his/her community; someone who does not expect to get paid for this work but does so because he/she feels like helping the community, especially as many people are dying of HIV/AIDS. Clearly, their understanding corresponds with definitions in the literature but emphasized involvement

with HIV/AIDS infected and affected people. Morris (1996), for example, defines a volunteer as ‘a person who helps and provides a service out of his/her own free will.’

The research facilitator identified six reasons why the home based carers volunteered in the COC programme: altruism; personal experience with illness and death, religious reasons; Ubuntu; empowerment; and employment. Three themes emerged alluding to the participants’ expectations as home based carers of the COC: personal satisfaction; training; and acknowledgement and appreciation. Three themes emerged regarding their expectations of the role NGOs, FBOs and CBO had to play in sustaining their commitment: ongoing training; rewards; and lobbying and advocacy.

### **6.1.2 Motivational factors**

**Altruism** – Participants defined altruism as ‘a selfless act of care given to a person in need’, such as they are doing as home based carers of the COC programme. They did not associate altruism with repayment (cash or kind), but understood altruism to reflect the personal satisfaction they derived from having helped an ailing patient. The following quotation illustrates this further.

*It makes me happy and satisfied to help others; I want to give something back to our people and community.*

**Personal experience with illness and death** – All participants had had some experience of losing a loved one to illness. Some even had multiple experiences of such. The

participants recalled strong emotions felt during those bereavement periods and subsequently were able to be more empathic towards patients and families experiencing similar grief and trauma. The example below substantiated their stand.

*I lost my sister and brother to HIV. I want to help other families  
so that they can handle this pain when it is their turn.*

**Religious reasons** – Participants’ perceived religion to be synonymous with ‘Christianity.’ While twenty four percent were Protestants and sixteen percent were Shembe, both these orders have Christianity as its base and so therefore the participants understood religion to mean Christianity. The quotation below bore relevance to their understanding of religion.

*For helping others I will get closer to God. God will bless me and  
my children will benefit from the good I do.*

**Ubuntu** – Participants defined Ubuntu, on a literal level, as ‘brotherhood or sisterhood’. Their understanding of this concept of Ubuntu in a community setting was one of togetherness; of helping each other; of caring for each other; and of humanity.

*How can I be happy when my brothers and sisters (neighbours) next  
door are dying; are hungry; are sick? It is my duty to help; to care;  
and to feed.*

**Empowerment** – Participants defined empowerment as ‘skills building and training’. They understood this concept of capacity building as not only enhancing their own skills and knowledge, but also as enhancing the capacities of the community at large.

*The training has made me believe in myself and I know that I can become somebody ‘big’ one day. I want to be a good role model to the other youth and adults of my community s o that they too can be uplifted.*

**Employment** – Participants’ defined employment as ‘paid work’. While they did not overtly discuss ‘volunteering as a road to employment’, they did have some expectation of some form of employment, at some point in time. The quotation below lends support to this understanding.

*I am unemployed. By volunteering, I can keep busy. Maybe I will be lucky and the COC will employ me as they have done with my other colleagues.*

### **6.1.3 Expectations of home based carers**

**Need for Personal Satisfaction** – Participants’ defined personal satisfaction as ‘being happy from within’. In the context of their volunteer experience as home based carers, their understanding of the concept: personal satisfaction reflects the inner happiness they feel when they see some degree of improvement in the health condition of their patients.

*I expect my patient to get better after receiving help from me. This makes me very happy inside.*

**Need for Training:** - Participants defined training as ‘formal (theory) and informal (practical) courses that are taught to enhance knowledge and understanding’. The training that the participants obtained from the COC gave them hope for employment. Whilst waiting for employment, the training has assisted them to offer better quality home based care to the patients in the communities.

*I expect COC to train me so that I can give better care to my patients. I expect to get employment, especially with the good training COC gives me.*

**Need for Acknowledgement and Appreciation** – These terms, as defined by the participants, alluded to their ‘need for recognition and praise for a job well done, and to be rewarded in some way’.

*I expect COC to continue giving us incentives (egs. Sanitary pads, biscuits, Christmas money vouchers, shoes)*

Albeit that there is a paucity of locally specific literature on the motivations and expectations of home based care volunteers, the responses from the pilot group (above) were in keeping with the findings of Akintola (2004) and Classens, (2004) who identified the motivations of volunteers as being largely for altruistic reasons, religious reasons, and



for the love of people (Ubuntu). The expectations of training and personal growth and development were suggested by the pilot group.

Two interesting themes emerged: a large group of single, unemployed women expected to benefit from volunteering by 'getting a foot in the door' for employment. The second interesting theme was the home based carers' perception that their services helped heal the HIV positive patients as opposed to helping patients and their families become more comfortable with dealing with the illness.

#### **6.1.4 The Role of NGOs, CBOs and FBOs in sustaining home based carers' commitment:**

The home based carers' expectations of NGOs, FBOs, and CBOs can be subdivided into the following themes: ongoing training; rewards; lobbying and advocacy.

**Ongoing Training** – Participants defined ongoing training as 'training that takes place continually'. There was a general feeling of satisfaction with regard to the training received from the COC. However, they identified the need for these programmes to be extended in all organizations.

*These organizations must provide ongoing training as this will help us do better work and even get jobs so that we can feed our families and give something back to our people in the community.*

**Rewards** – Participants defined rewards as ‘gifts received in appreciation of good work done’. They expressed overwhelming gratitude for the rewards received. This was especially remarkable in view of their dire socioeconomic situations.

*Home based carers should be rewarded, for example, with a stipend, medals, and certificates. Home based carers must be given recognition in the organizations they serve and be part of the staff complement.*

**Lobbying and Advocacy** – Participants defined these terms as ‘legally acceptable ways of voicing problems/grievances with the higher authorities, for example, the Local Government.’ Participants felt that the views of the NGOs, CBOs, and FBOs needed to be consolidated into one voice on pertinent community issues as quoted below:

*Our people need grants and ID documents – these organizations must help them to get it. They must talk to the government to help out people by creating more jobs, improving the health facilities and building us houses so that our people can live properly.*

Claassens (2004) indicates that, for the partnership between the home based carers and the NGOs, CBOs, and FBOs to be effective, the dominant needs of the volunteers should not only be recognized, but also met. From the responses of the participants it became clear that they were satisfied and that their needs were adequately met for ongoing

training and rewards. There remained a scope for ongoing training and coordinated lobbying and advocacy from NGOs, CBOs, and FBOs.

## **Summary**

The findings of this locally specific pilot project were consistent with findings of studies reviewed in the literature. The motivations, expectations, and needs that drove the participants to volunteer were identified. By identifying these motivations, expectations, and needs, it should be easier to find ways to meet them. This will be a key to sustain home based carers in the field. The research facilitator recognised the methodological limitations of the pilot project and decided to pursue further research, utilizing a participatory research strategy.

## **6.2 PHASE TWO**

### **6.2.1 Participatory Component of the study**

According to Tandon (1988) participatory research attempts to present people as researchers themselves in pursuit of answers to the questions of their daily struggles and survival. The research facilitator, in the participatory method of data collection, trained five co-research facilitators to facilitate focus group discussions. The focus group discussions were guided by the semi-structured interview schedule, developed in the pilot study. The research facilitator undertook to use case studies to further explore the motivations and expectations of the home based carers of the Community Outreach

Centre, St Mary's and in so doing, captured their experiences and expectations. Where relevant, these will be reflected in italics. Five focus groups, with a total of 30 participants, were conducted in the second phase of the study.

### **6.2.2 Focus Group Composition**

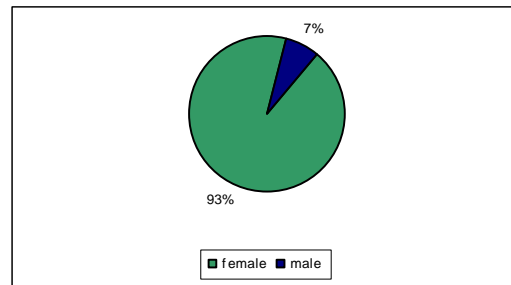
Five focus groups were conducted using a stratified random sampling, according to the five categories of training offered by the COC. In total 30 home based carers of the COC participated in this study. Table Four provides the demographic characteristics of the 30 home based carers from the five focus groups.

Table Four: Demographic Details of the Five Focus Groups					
	Group 1	Group 2	Group 3	Group 4	Group 5
<b>Gender</b>	Female (6)	Female (6)	Female (6)	Female (6)	Female (4) Male (2)
<b>Age</b>	20–30 (4) 31–40 (2)	20–30 (5) 31–40 (1)	20–30 (1) 31–40 (4) 41–50 (1)	20–30 (3) 31–40 (3)	20–30 (2) 31–40 (4)
<b>Race</b>	Black (6)	Black (6)	Black (6)	Black (6)	Black (6)
<b>Religion</b>	R. Catholic (6)	R. Catholic (1) Protestants (5)	R. Catholic (2) Protestants (1) Shembe (1) Zionist (2)	R. Catholic (1) Protestants (1) Shembe (2) Wesley (1) Methodist (1)	R. Catholic (1) Protestants (4) Assembly of God (1)
<b>Marital Status</b>	Single (5) Married (1)	Single (6)	Single (3) Married (3)	Single (5) Married (1)	Single (5) Married (1)
<b>How long as a volunteer at COC</b>	1,5–2 yrs (3) 2,5–3 yrs (2) 4–4,5 yrs (1)	4–4,5 yrs (1) 5+ yrs (5)	1,5–2 yrs (1) 2,5–3 yrs (1) 3,5–4 yrs (3) 4–4,5 yrs (1)	1,5–2 yrs (1) 2–2,5 yrs (1) 3–3,5 yrs (1) 3,5–4 yrs (1) 5+ yrs (2)	2–2,5 yrs (1) 3–3,5 yrs (1) 3,5–4 yrs (1) 4–4,5 yrs (3)
<b>Have you volunteere d before?</b>	No (4) Yes (2)	No (5) Yes (1)	No (5) Yes (1)	No (6)	No (4) Yes (2)
<b>For how long?</b>	4 yrs at ANC Youth League 1 yr at Vusiswe Day care centre	1 yr at Thokozani Day Care Ccentre	1 year at ABET	n/a	3yrs at KwaNdengezi Care and Support Centre 3 yrs at the Youth Organization

The biographical profile of the respondents who participated in the focus groups reflect their gender, age, race, religion, marital status, period of volunteering at COC, and previous volunteering experiences. These will be discussed separately below.

## Gender

Participants' gender is reflected in Figure Four.

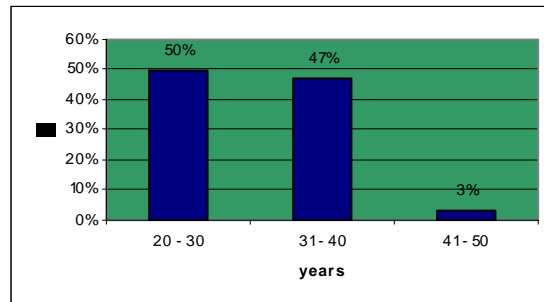


**Figure Four: Distribution of participants according to gender**

Statistically, there are more women than men in this community and consequently, more women head up their households (Urban Strategy, 2001). Clearly, as indicated in Figure Three, females are more active in the volunteering field. This may be the result of the deeply entrenched social expectation in this community that care and nurturing is a woman's job and as such home based care for the sick, should be undertaken by women. This is consistent with the findings of a survey conducted by Marenga, (1995). The participants reflected that as they were all Zulus, the women were expected to fulfill matriarchal functions.

## Age

The respective age categories of the participants are indicated in Figure Five



**Figure Five: Distribution of participants according to age**

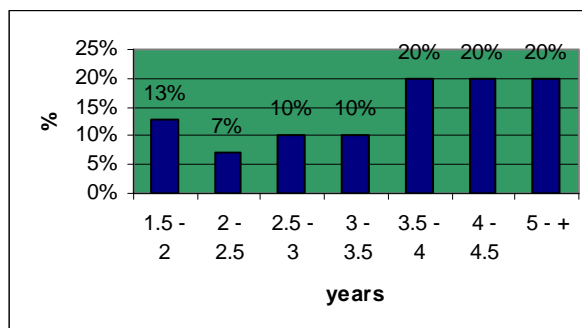
Figure Four reflects that the highest age category for volunteers at COC was between 20 and 30 (50%), followed by 31 and 40 (47%), and 41 and 50 (3%). For 50% of the participants (20 and 30 years) this age ought to be an economically active period in the developmental life cycle of an adult. Sadly, due to escalating unemployment rates, many people in this community find themselves without jobs. Some participants suggested during the focus groups, that they have volunteered early in life, as they believe this will help them secure employment, by undergoing training as a volunteer. South Africa, remains among the most unequal in the world with regard to income distribution (Census 2001). It notes that poverty and inequality have four outstanding characteristics - race, gender, region and type of area. Whilst the wealthiest South Africans continue to be White urban dwellers and the poorest tend to be Black, rural dwellers, inter-racial inequalities have stabilized in recent years, whereas *intra*-racial inequalities are widening. Rural women are a particularly vulnerable group of poor workers (Marenga, 1995).

## Race

All the participants in this study phase were from Mariannhill, a predominantly Black community. This is probably as a result of the old apartheid era in South Africa where the different races were allotted fixed areas of abode, according to the Group Areas Act, Act No 41 of 1951. Land is an emotive issue in South Africa. Decades of apartheid legislation have created profound inequalities concerning housing and land. The removal from the South African Statute Book of the Group Areas and Land Acts is an important step. Sadly, the removal of apartheid laws has failed to bring about any structural change in the existing inequitable distribution of land, housing or control over agricultural production (Land Commission African National Congress, June 1991). The areas serviced by the COC has predominantly low income Black families and no interracial mixing is observed.

## Period of volunteering

The time period that the participants had served as volunteers for the COC is reflected in Figure Six.



**Figure Six: Period of volunteering**



Most participants had volunteered for four and more years (60%), twenty percent volunteered for between two and a half and three and a half years, seven percent volunteered for between two and two and a half, and thirteen percent volunteered for between one and a half and two years. These variables are supported by Kruger and Schreuder (1999), who maintain that volunteers are a diverse, rather than homogeneous group. Variables that influence the number of years that home based carers volunteer include the participants' environment, community norms concerning volunteering, social background, education, economic status, attitudes and beliefs, personality. Most of the participants were unskilled and found it difficult to secure employment in the open labour market. Despite living in an environment of poverty, these participants shared a culture of Ubuntu and humanity.

### **Previous volunteer experiences and the duration thereof**

80% of the participants had not volunteered previously. COC is the first project in which they had volunteered. Only twenty percent of the participants had served as volunteers at other organizations – some for as long as four years. The repertoire of their volunteering experience was within the health and caring field. For example, some participants volunteered at care and support centers; youth organizations; and day care centers. Interestingly, none of the Community Facilitators had had previous volunteer experience, which one may have expected.

### **6.3 FINDINGS OF FOCUS GROUP DISCUSSIONS: THEMES AND SUB-THEMES**

In the following discussion, themes and sub-themes are presented together with actual quotations recorded from the focus group discussions and case studies. This is done ‘to give voice to the perceptions and experiences of the home based carers’ of COC who participated in this research project.

### **6.4 DISCUSSION OF THEMES AND SUB-THEMES**

The themes and sub-themes that emerged from the transcriptions are discussed in four parts and aim to answer the four critical research questions as outlined in Chapter One. Since the majority of the participants were Zulu speaking, the co-research team worked together to translate the quotes of the participants, into English to minimize the risk of misinterpretation.

#### **6.4.1 Definition of *Volunteer* and *Home Based Carer* as Described by the COC Home Based Carers**

Through the processes of brainstorming and nominal group techniques, the five focus groups suggested their understanding of the terms: *volunteer* and *home based carer*. The four most commonly suggested definitions of *volunteer* and *home based carer* derived from using a nominal group technique, are tabulated below.

Table Five: Common definitions of <i>volunteer</i> and <i>home based carer</i> as suggested by the Five Focus groups		
Term	Definition	Frequency within each focus group
Volunteer	<i>Someone who works without getting paid or expecting to be paid.</i>	15
	<i>Someone who is always available to help.</i>	7
	<i>Someone who offers his/her service off his/her own accord</i>	4
	<i>Someone who gives of his/her time for the betterment of a good cause</i>	4
Home Based Carer	<i>Someone/a volunteer who is caring and likes to help the sick and helpless by being trained in home based care.</i>	12
	<i>God's helper whose reward is seeing the patient get better.</i>	9
	<i>A loving person who does not mind working at odd hours of the day or night just so that the patient is well.</i>	5
	<i>Someone who is respected in the community and values confidentiality</i>	4

The co-research facilitators compiled these meanings into the following definitions:

*A **volunteer** is someone who provides a service of his/her own free will, without the expectation of being remunerated.*

*A **home based carer** is a volunteer who is trained in home based care to take care of the sick in their home. This person is well respected in the community, values confidentiality and sees himself/herself as God's helper.*

The home based carers' perceptions and understanding of the terms 'volunteer' and 'home based carer' are consistent with the review in the literature. The White Paper for

Social Welfare (1997) defines a volunteer as a professional or non- professional person who provides a service to a welfare or development organization, usually without reimbursement. According to the Department of Health (September, 2004:8) a home based carer is defined as ‘a person who is trained to provide support and to meet the physical, psychological, spiritual and social needs of PLWAs, and those that have other chronic conditions, and their families.’

#### **6.4.2 Home Based Carers’ Motivations for Volunteering at COC**

Participants identified three main themes for volunteering as home based carers. These are intrinsic factors; the value derived from volunteering; and motivational factors. Each theme has sub themes and these will be discussed separately.

**Intrinsic motivating factors** – Participants defined intrinsic motivating factors as ‘essential or inherent selfless qualities that a person needs to have in order to volunteer’. Following Ryan and Deci (2000:19) ‘intrinsic motivation is defined as the doing of an activity for its inherent satisfaction rather than for some separable consequence. When intrinsically motivated, a person is moved to act for the personal satisfaction or challenge, rather than because of external prods, pressures, or rewards.’ Three primary intrinsic motivating factors emerged: Service to others was expected of **servants of God**; **altruism** -voluntary services to others provided them with opportunities to interact with people and thereby increase their personal happiness; and service to others and a **spirit of care and support (Ubuntu)** which is indicative of one’s humanity towards mankind. The participants seemed to own HIV/AIDS as a community issue. This is in stark

contrast to what we hear about the stigma surrounding HIV/AIDS but in keeping with the spirit of Ubuntu.

Table Six, below, represents Theme One with the identified sub-themes

<b>Table Six: Theme One and sub-themes</b>		
<b>Theme</b>	<b>Sub-themes</b>	<b>Frequency within each focus group</b>
Intrinsic motivating factors	• Servant of God	13
	• Altruism	9
	• Spirit of care and support (Ubuntu)	8

### **Servant of God**

All the participants belonged to the Christian faith. 40% of the participants believed that by volunteering, they were perpetuating the good work of God. They saw themselves as vehicles that allow for God's work to be widely spread. Some of the responses that supported this statement are:

*'I volunteer because I feel that God will look at me favourably when it is my turn to die.'*

*'My culture tells me that if I do good in this lifetime, when it is my time to die, I will go straight to Jesus.'*

*'My belief in God makes me do this work – I am God's hands, His merciful servant.'*

All the participants seemed to agree that it was largely the power of, and the belief in, God that motivated them to volunteer. It is worthy of mention here that each focus group session began and ended with a prayer. These prayers were said to invoke the guidance of God to remain with them while they were out performing His work, which is in keeping with the Christian faith.

### **Altruism**

30% of participants agreed that to be a volunteer in home based care entails a passion for serving and caring for people. They defined altruism to mean ‘the selfless task of caring for members of the community who cannot care for themselves’. This definition is supported by the following suggested by Deci and Ryan (1985:12) that ‘altruistic motivation derives from a perception that other people are in need and that action from the volunteer will alleviate the situation’. Some of the participants’ responses were:

*‘I do this (voluntary) work (home based care) because I love my people.’*

*‘To love is to serve – I love my people, therefore I serve them.’*

*‘It makes me happy when I help someone who is sick. I feel happier when that patient gets better.’*

It is clear that a passion to serve and a love of people sustained participants’ motivations to volunteer. By having this strong passion or love for fellow man entrenched in them,

they were able to serve, in spite of the many difficulties and adversities they were faced with on a daily basis.

### **Spirit of Care and Support (Ubuntu)**

The participants repeatedly defined voluntary home based care to be about giving from the heart. Twenty six percent of them equated it with Ubuntu, a spirit of caring, supporting and uplifting their fellow people as illustrated in the following quotes.

*‘I too am poor. I cannot give my people money but I can give them my heart, my love.’*

*‘Even if I have a little (food) I share if my patient has nothing.’*

*‘My heart is big and open – I give and I get. God is great.’*

A strong sense of Ubuntu cements the relationship between home based carers and patients. Even faced with adverse conditions themselves, many of the home based carers feel obliged to share and give freely and unconditionally, both of their time and resources.

### **Values of volunteering**

Participants described the values of engaging in home based care as being beneficial at both personal and community levels. Two values associated with volunteering as a home

based carer at COC were suggested as the sub-themes: personal empowerment; and community empowerment.

Table Seven, below, represents Theme Two with the identified sub-themes

<b>Table Seven: Theme Three and sub-themes</b>		
<b>Theme</b>	<b>Sub-themes</b>	<b>Frequency within each focus group</b>
Value of volunteering	• Personal empowerment	17
	• Community empowerment	13

### **Personal Empowerment**

56% of participants' defined personal empowerment as the skills and knowledge obtained from practical and theoretical training they received from the COC. They felt empowered by this training they received. It increased their knowledge about disease and its management, and more so, built up their confidence in themselves. The following quotes reflect these sentiments:

*'I learnt a lot of new skills and the trainings have helped me understand about many illnesses and how to help care for people with those diseases. It has made me revisit my attitude towards HIV/AIDS patients – I am no longer afraid to talk to them or touch them'*

*'I sometimes feel like a celebrity because people want to talk to me about my work (voluntary home based care), they want to know about me, they like to follow in my footsteps.'*



*'I used to be a very shy person who did not like to talk. Now that I know about HIV/AIDS, which I learnt from COC, I feel confident to talk to anybody. They respect me for my knowledge.'*

A pride in their growth, development and status in the community clearly encouraged participants to stay on in the COC programme. Participants felt confident and secure in themselves as a result of their participation in home based care programmes. They felt that they had gained useful knowledge on HIV/AIDS, its care, and management.

### **Community Empowerment**

44% of the participants felt that the training enabled them to educate the community and motivate them to take necessary precautions to protect themselves. They found this very empowering. Themes that emerged were: a gained sense of confidence in the community because of the skills and knowledge learnt; a sense of serving as a positive role- model in the community; enjoying the recognition received from the members of the community; the experience as a home based carer has been a self-actualizing one; and experiencing the empowerment themselves had motivated the home based carers to empower the community at large. Laverack and Labonte (2000:126) define community empowerment as 'a part of a bottom-up approach by which people experience more control over decisions that influence their health and lives, as a result of knowledge, skills and training received.' This then filters through to the other members of the community. Because of their personal empowerment, the home based carers were more active within their communities by canvassing for more volunteers, involving others in HIV/AIDS

awareness and related activities, and imparting the knowledge they have gained with the community members.

The above themes were illustrated by the following quotes from the participants:

*'I feel motivated because my Local Councilor knows about COC.....he therefore refers people to me for my help. ....this important man knows my name, the work I do and he values me so much that he talks to the youth to be just like me!'*

*'COC is part of the St Mary's Hospital. I feel so proud and important to be part of this well know hospital. People respect my knowledge and advice because they know that I was trained by a hospital programme.....they listen to my advise.....they seek my help to give educational or motivational talks.'*

*'.....because I am long in this (COC) programme, it has helped me in my self growth. I find that I have begun recruiting people into the (COC) programme. ....I want them in (COC), so that many people can be trained to care for the thousands of sick people in the community.'*

Joining COC was an empowering experience for the home based carers. They had earned credibility in their communities and their advice and guidance were sought by community leaders and high profile people, obviously aware of the need to address HIV/AIDS issues. Their acquisition of knowledge and skills was used to educate other members of the

communities. Their motivation and enthusiasm spilled over to others who also started involving themselves in volunteering.

### **Motivational factors**

Home based carers' motivations are complex and are not easily understood. Steinberg et al (2002) suggests that there are five different types of volunteer motivations: altruism; social motivation; goal-directed motivation; material motivation; and social responsibility. Participants defined motivational factor as 'the reasons why people volunteer'. They described five main motivational themes: altruism; religious obligations; repayment of 'debt'; incentives; and employment. Each of these will be discussed separately.

Table Eight, below, represents Theme Three with the identified sub-themes

<b>Table Eight: Theme Three and sub-themes</b>		
<b>Theme</b>	<b>Sub-themes</b>	<b>Frequency within each focus group</b>
Motivational factors of volunteering	• Altruism	10
	• Religious obligations	9
	• Repayment of 'debt'	6
	• Incentives	3
	• Employment	2

### **Altruism**

Altruism was the most frequently identified motivational factors among the five focus groups (33%). UNAIDS (2000) noted that there is a strong sense of community and a rich tradition of doing community work and reaching out to one's neighbour or sick friend in

Africa. The participants described altruism as a feeling of satisfaction that they experienced when they were doing something good and meaningful to alleviate some (or a part) of their patients' sufferings. The participants felt that as people are dying in large numbers, it was very difficult to ignore this. They felt compelled to aid the sick in the community. The following excerpts illustrate this:

*'My neighbours were sick for years and they had no family to care for them. I am a single parent and I have no work. My family is poor and we often have no food but I just could not ignore these sick people'*

*'Long before joining the COC, I used to visit and care for the sick in my community. I realised that the basic training my mother gave me was not enough to care well for these people. I needed specialised training, so I joined the COC. To me it is like a calling – it makes me feel good.'*

There are many examples of people serving the interests of others. To some these altruistic acts are a part of everyday life and are not unusual (Claassens, 2004).

### **Religious Obligations**

30% of participants agreed that a sense of religious obligations motivated them to volunteer as home based carers. Many felt driven by the "Golden Rule" of doing good to others, and expecting good to be returned at, some point, to them as well. Through interaction and observation, the co-research team concluded that religion plays a focal

part in the lives of the participants. It shapes their responses to situations and guides their actions. The following quotations exemplify this observation:

*'My religion tells me that if I do good, my children will be blessed. I want my children to always be happy, healthy and well and therefore I try my best to do good at all times.'*

*'I think that Indian people believe in the Law of Karma.....I think that this is true to my religion as well because I know that if I do good to others, good things will come back to me and my family.'*

The participants were firm believers in God and their religion. They took their religious obligations seriously and conscientiously. They believed that the positive therapeutic effect that praying had, could positively influence other facets of their lives. It provided an opportunity to engage in group prayer meetings where, not only scriptures from the Bible were read and discussed, but group counseling and sharing also took place. Often, this was the only avenue they had to express their feelings and to ventilate.

### **Repayment of 'debt'**

All participants had some personal experience with death and dying: either lost a loved one to an illness, or were involved with or nursing a loved one who was very ill at the time. They viewed volunteering as providing them with an opportunity of working through the losses of their loved ones. Twenty percent of them strongly expressed the need to repay the love, support and encouragement they had received from their

communities while they were caring for their loved ones. They saw their role as home based carers as a healing ritual, an opportunity to enable them to work through unresolved losses of their loved ones and to deal with their own bereavement and grief. By serving others and providing bereavement counseling, many participants saw this as providing them with a socially acceptable way to work through their own grief. The following are a few illustrations:

*'I lost my daughter to HIV/AIDS. When this happened I did not know what the disease was. Now that I have joined COC I know a lot about it (HIV/AIDS). I cannot bring my daughter back but I can help another mother by saving her daughter so that that mother does not hurt like I did.....and still do.'*

*'I have my late sister's children whom I care for. They too are sick and I was helpless as I have no children of my own – I am not a mother. I did not know a lot about raising children. The training (Child Care Training) I received at COC has helped me understand children, how to care for them when they are ill, and how to educate them on healthy living. Many other ladies are in my position and I want to help them and the children. This is my repayment of debt.'*

### **Incentives**

Ten percent of participants suggested that the implementation of an incentive scheme, as a reward for volunteering, was a strong motivating factor. They expressed appreciation for the incentives given to them by COC. The incentives they were most appreciative of

were: free medical treatment from the St Mary's Hospital; personal hygiene supplies such as sanitary pads; token gifts on special days such as Mothers Day and Valentines' Day such as biscuits, deodorants, umbrellas or shoes. Most expressed that they understood the funding constraints of the COC and were very appreciative of the incentives they received. Some of that appreciation is illustrated in the following examples:

*'The free medical treatment I get from St Mary's Hospital (because I am a home based carer) makes me very grateful to COC. I feel like I want to do more for my community because I am fit.'*

*'I am very grateful for the sanitary pads that COC gives us every month. My family are very poor and we cannot afford to buy food. (Sanitary) pads are a luxury that we cannot afford to buy. Now I look forward to a 'period', not like before when I used to worry about what to use.'*

*'Most of us are mothers and although we know that our families are poor, sometimes we secretly hope that our children or boyfriends will give us a little gift for Mother's Day or Valentine's Day. COC tries to give us gifts to celebrate these special days. I remember that we got a big packet of Bakers biscuits for Valentine's Day and lotion and roll-on for Mother's Day. I felt special.'*

Due to funding constraints, the COC cannot provide monetary incentives. Home based carers are alerted to this at the screening meeting. However, and in spite of this, these volunteers still choose to volunteer (COC Fact book, 2005).

## **Employment**

It is clear that for some the incentive scheme that the COC has is appreciated and helps to sustain their motivation and commitment, but one cannot conclude that this was an overriding motivation. The home based carers were initially reticent about sharing this and only gave expression to these later in the focus group discussions. Only seven percent of participants voiced the desire and hope for employment as being a motivating factor to volunteer as a home based carer. At screening workshops with prospective groups of volunteers, employment was discussed and no promises or guarantees were made to them about employment. However, the COC has to continue to make every effort to assist the home based carers in securing employment. The COC had employed thirteen of the staff of seventeen from the volunteer complement (COC Fact Book, 2005), which most of the home based carers knew. This, indirectly, gave them hope for employment. Whilst their ideal was to be considered for employment at COC, they believed that they could transfer their skills to any organization. They hoped that their commitment to the programme would increase their chances of being noticed, as was in the instance of the other home based carers employed at the COC. The following are the participants' comments:

*'The training at COC is free and good. I feel happy and confident that I will be able to get a job – if not at COC then, in another organization working with home based care.'*



*'At the first screening day (workshop) I was told that volunteering does not mean that I will be getting a job. ....But still I joined COC. Now that I see my other friends getting jobs, I know that my turn will come too. One of my colleagues applied for a job seven times at COC and now she is working there.....maybe I will have to apply many more times, but I can wait. I have faith in God.'*

In spite of the fact that the COC does not promise employment for their home based carers, COC makes practical efforts to secure employment for them. The COC encourages home based carers to apply for positions when they become vacant in the hospital or in the other programmes of St Mary's. COC assists them to write up their resumes, and submits their applications. COC provides certificates of performance and certificates of courses completed. It also serves as a referee.

This section outlined the factors that motivate this locally specific group of home based carers. It is evident that these motivational factors strengthen their commitment to the COC. Interestingly, the motivational factors for volunteering outlined in the literature review correspond with the motivating factors to volunteer as home based carers of the COC, as illustrated by the participants of this study. However, the theme of Ubuntu, which is synonymous with South African Black culture, stood out in this study. McSweeney and Alexander (1996) explain that the motivational factors of volunteers are crucial in trying to understand volunteerism, and retaining them as a core group of volunteers.

### 6.4.3 Needs and Expectations of Home Based Carers from COC

Participants defined a need as ‘a want or a desire to have’ and expectations as ‘looking forward for something with eagerness’. Themes Four and Five address the participants’ needs and expectations respectively, and each sub theme enunciates their assertions, which are qualified by quotations.

#### Needs of volunteers

From literature, it is evident that home based carers have needs. McSweeney and Alexander (1996) identified the need for good quality training, appropriate to the role the volunteer fulfills, as important for the volunteer. The predominant need, as confirmed with the participants of this study, was for training. As training is a broad concept, it is further sub divided into sub-themes: theoretical training; practical training; refresher courses; and specialized training

Table Nine represents Theme Four with the identified sub-themes

Table Nine: Theme Four and sub-themes		
Theme	Sub-themes	Frequency within each focus group
Needs of volunteers - Training	• Theoretical training	12
	• Practical training	8
	• Refresher courses	6
	• Specialized training	4

### **Theoretical Training**

Throughout the focus group discussions the participants concurred that effective, relevant training is an important need in any home based care setting. Good and sound theoretical training was identified as the foundation for effective ongoing performance. 40% of participants suggested that the effectiveness of the theoretical training not only enhanced their practical skills but also enhanced their chances of securing employment. Training modules such as basic counseling- five days course; and palliative care - thirteen days course, stood the home based carers in good stead for securing employment. The following quotes illustrate this:

*'The training is intensive and free. It opens doors for employment. There are shortages of professional nurses: with this basic training, I will go onto study to become a nurse. But I will not leave my community.'*

*'My sister took an overdose of tablets. She went to the hospital and got help. She then told me that she was HIV positive. I just hugged her because I know from my training that I would not get the virus from hugging. We will slowly (gradually) tell our family but for now I am her support. COC has helped me to learn about the disease (HIV/AIDS).'*

### **Practical training:**

Twenty six percent of participants felt that practical training should follow on from the theoretical training. In the practical training, that what was learned in theory was consolidated. This was done through the medium of role-plays and simulated learning

experiences. Newly trained home based carers accompanied the more experienced home based carers on patient visits so that they were able to observe and learn how to apply the theoretical training in real life situations. The following are some of their responses:

*‘Sometimes during the training we are taught a skill. For example: to turn a patient. In training (theory), it looks very easy. But when you are in the patient’s home and need to turn a patient, it is very scary. You think that you are going to hurt or drop the patient. It helps when, as new home based carers, we go on patient visits with more experienced home based carers or our Facilitators or Area Coordinators. I like that very much’*

*‘The practical training helps me to do the same thing (task) over and over again. It makes me feel confident when I am with a patient on my own.....but sometimes I still get nervous – then I think about my trainer, and how she did it, and I feel brave again.’*

### **Refresher courses**

Refresher courses were not only seen as an invaluable method of enhancing practical skills through ongoing rehearsals, but also as a means of updating home based carers about new information on HIV/AIDS and treatment methods. Through the COC’s continuous process of monitoring and evaluating the quality of care rendered to patients by the home based carers, the Community Facilitator and/or Area Coordinator was able to identify which refresher courses were needed. The number of home based carers needing refresher courses determined the method of course delivery: either one-on-one or group refresher training. Twenty percent of participants acknowledged the need for

refresher courses throughout the year and/or when required, as expressed in the quotations below:

*‘Sometimes I forget a skill that I was taught. Then I tell my Facilitator and she shows me. If a lot of us are having the same problem, she and the Area Coordinator give us refresher training. This is good.’*

*‘I know that treatment of patients gets better every day and we have to know what these news methods are. Therefore, I think that refreshers courses are very important.’*

### **Specialized Training**

Fourteen percent of participants mentioned the need for specialized training, especially when required to perform specialized tasks. Participants especially recognized this when the COC expanded its work to include Orphaned and Vulnerable Children and Palliative Care. The following exemplifies their perspectives on the issue:

*‘I was always afraid of death and became scared when I thought that my patient was going to die. However, when I was trained in Palliative Care, I found that when the sick patients were close to death, they would call out to me and I would just hold their hands, talk softly to them, and help them to pass on. I am now not afraid of death or the process of dying.’*

*'I never knew about the term "development milestone in a child", and I never knew how important each stage is in the healthy development of a child is. The training in Child Care, and the exposure we got working in the hospital ward and a school for disabled children, made me see the importance of observing our children and stimulating them – even mentally retarded children.'*

As pointed out in Chapter Four all participants had completed the six compulsory training in home based care at COC, and some had furthered their training in the other optional courses. (See '**Appendix Two**'). McSweeney and Alexander (1996) argue that once a volunteer has been accepted in an organization, he/she must be trained in the required area of performance. By making training available to the home based carers, it may result in improved services and a sense of satisfaction on their part. Schindler- Rainman and Lippit (1975), and Byron (1974) state that for organizations to be viable, they must have an ongoing training plan in place, as it helps volunteers to meet challenges as they arise and progress in the development of skills and productivity. The COC appears to have adequately fulfilled the participants' need for effective training as 40% of the participants saw theoretical training as enhancing practical skills, twenty six percent of participants saw practical training as consolidating what was learnt in the theory, twenty percent acknowledged that the COC fulfilled the need for refresher courses, and fourteen percent saw the need for specialized training to perform specialized tasks. .

## Expectations of COC Home Based Carers

Throughout the focus group discussions, the participants agreed that home based carers have expectations. Their expectations were subdivided into three sub themes: personal development; acknowledgement and appreciation; and personal contact.

Table Ten represents Theme Five with the identified sub-themes

Table Ten: Theme Five and sub-themes		
Theme	Sub-themes	Frequency within each focus group
Expectations of the volunteers	• Personal development	11
	• Acknowledgement and appreciation	10
	• Personal contact	9

## Personal development

36% of participants in the study expressed the need for personal development and ‘growing into a better person’. This required that the home based carers were engaged in meaningful activities; were in touch with themselves (self awareness); and made healthy lifestyle changes. These are reflected in the following quotes:

*‘Before I joined the COC I was not occupied. I was bored and I saw my friends do wrong things when they were bored and unoccupied. By joining COC and serving my community it has made me grow into a better person – I have a purpose and meaning in life.’*

*'The training and new skills that I have learnt has made me a better person. Not only am I able to give better care to my patients, I am also able to teach my family about healthy living. I am more knowledgeable about health issues, especially HIV/AIDS.'*

### **Acknowledgement and appreciation**

33% of participants indicated that they expected some kind of acknowledgement for their services – the source of the acknowledgement was not as important as the acknowledgement itself. In the management and retainment of volunteers, demonstrations and appreciation plays a crucial part (Claassens, 2004). The co-researcher team found this to be true to this study. Participants ranked appreciation and acknowledgement as their highest expectation. Interestingly, also, was the finding that the source of the appreciation/acknowledgement was not as important as the acknowledgement itself. Appreciation could be expressed by the COC team and patients, or the community members. These were reflected in the following quotes:

*'I have a few patients who are getting better day-by-day. ....but they do not have money to eat well and stay healthy. They asked me for help. I asked my Area Coordinator and she got me seeds from COC to help these patients start a vegetable garden. Now we have a good garden and they thank me for asking COC for help. My Area Coordinator also praised me for talking up for my patients.'*



*‘When I look into the eyes of my patients and see the love and appreciation they have for me.....and when I hear them talk about the positive difference I have made in their lives, I feel very happy because my work is appreciated’*

### **Personal Contact**

30% of participants valued the personal contact they had with their patients, the community and the COC. It created a sense of belonging and kinship with other members of the community that is reflected in the following quotes:

*‘Sometimes people in the community tell me that I am stupid to volunteer and work without getting paid. This hurts me and sometimes I feel like I should stop (volunteering). Then when I visit my patient and see how much she needs me, and how happy she gets to see me, I forget about the other nasty people.’*

*‘I feel useful and wanted when I am serving my community. I have suffered many losses in my home (deaths) - by touching the sick and helping them get better, it makes me feel as if I am part of that family. I miss my family, but my patients and my community is my family. I **belong** here!’*

Pell (1972) argues that, by having a good understanding of volunteers, one needs to have a good understanding of the psychology of a human being. The organization must understand what their volunteers’ expectations and needs are, from it. Pell (1972) suggests that the following factors are particularly applicable to understanding the needs

and expectations of volunteers: the need for recognition as an individual; and the need for accomplishment.

From the above discussions, the co-research team concluded that home based carers in any setting, (NGO, CBO or FBO); seem to have the same basic needs and expectations, plus additional needs and expectations that are individual and/or culture specific.

#### **6.4.4 The Role of NGOs, CBOs and FBOs in Sustaining Volunteer Commitment**

NGOs, CBOs and FBOs have a pivotal role to play in sustaining the motivations and commitments of volunteers. One such way is by canvassing, through participatory research, what the motivations and expectations of their volunteers are and together, to develop programmes to sustain the commitment.

#### **The role of NGOs, CBOs and FBOs in sustaining the commitment of the COC home based carers**

Participants felt strongly that the NGOs, CBOs, and FBOs had an integral role to play in supporting volunteers and ensuring their commitment to the courses and programmes. They also saw these organizations as being empowered to challenge government on issues of concern. This was most interesting because it highlighted an area for NGOs, CBOs, and FBOs to be more critical of the role they are playing by exploring the following three questions: to what extent are they assisting volunteers and home based carers to develop themselves into a formal body so that their voice can be heard; to what

extent are NGOs, CBOs, and FBOs challenging government departments about the backlog; and to what extent are they forming interagency alliances to ensure that tasks are accomplished. Their perceptions of the role of these bodies are suggested in the following sub-themes: accountability; poverty alleviation; and active agents of change.

Table Eleven represents Theme Six with the identified sub-themes

<b>Table Eleven: Theme Six and sub-themes</b>		
<b>Theme</b>	<b>Sub-themes</b>	<b>Frequency within each focus group</b>
Role of NGOs, CBOs and FBOs in sustaining the commitment of the COC home based carers	• Accountability	15
	• Poverty alleviation	10
	• Agents of change	5

### **Accountability**

50% of participants expressed that NGOs, CBOs and FBOs needed to hold the Departments of Social Development, and Home Affairs accountable for their failure to deliver on their promises. Government had stated publicly that once the aforementioned departments had received the correct documentation, it would take about three months before the person actually would receive a social grant (Collins and Rau, 2003). However, the home based cares were despondent as this was not the case as presented in the examples below:

*‘COC gave us many in-service trainings on grants: the different types of grants, what documents a patient needs, where to go to apply for the grants, and how much each grant is worth. I have been running around with my patients to get the papers (relevant*

documents) and now that we have applied, it is almost one year and we have not heard anything. When I go to the office (Dept of Home Affairs), they tell me to wait. In the meantime my patient is suffering. My Councilor and COC is going to challenge the government on this because my people and I are tired of waiting.'

'COC told us what papers (documents) to get before we visit the Social Worker for foster care. But when I visited the Social Worker, she asked me to wait as she has more cases that are urgent. My patients and I have been waiting for a long time. Sometimes I think that my patients think that I am lying because nothing is happening.....COC manager held meetings with the Department of Welfare and COC was given permission to refer its statutory matters to the Local Department of Welfare's office for finalization. At least this will help our people.'

Participants' stated that NGOs, CBOs and FBOs are well placed to document and report ineffective service delivery on the part of the government. As the NGOs, CBOs and FBOs have a more grass roots, hands-on relationship with the communities, they should provide a voice to highlight the plight of the people.

### **Poverty Alleviation**

33% of participants' suggested that NGOs, CBOs and FBOs need to recognize that social grants are a significant way of alleviating poverty – therefore, they should find ways to partner governmental departments to assist them to roll out social relief and to be more proactive in poverty alleviation programmes. They agreed with Howlett (2004) that these organizations should assist to arrange registration drives/campaigns where the

Departments of Home Affairs and Social Development could be present to facilitate relevant grant applications. The following quotations illustrate this:

*'Many of our people do not have IDs (Identity Documents). They also do not have money to go to town (Durban or Pinetown) to apply for their papers (identity documents). The government keeps saying that they have a lot of money to pay grants – we should get the grant officers to us in the community so that our people don't have to catch a taxi to go to them. I raised this at our community meeting and my Councilor said that it was a good idea. He will try and get these officers to visit our communities. At least then our children won't starve.'*

*'I know that the Department of Agriculture has money to assist people to start food/vegetable gardens. I read this in the paper (newspaper). Although COC gives us seeds, this is not enough. We need to take from the government as well as it is there for the poor people. Maybe COC, my church, and my Councilor can help us to get some seeds from the government.'*

### **Agents of Change**

Seventeen percent of participants' described NGOs, CBOs and FBOs as being agents of social change. They saw them as activists and representatives of the community who had been entrusted with the task of lobbying for better services and equality for the communities. The following is what the participants had to add:

*‘Volunteers are a strong force and the government should see that the good work we are doing is in fact helping the country to handle the AIDS problem. If the government recognizes us (home based carers) as integral role players in society then this will encourage the youth to also volunteer.’*

*‘We (home based carers) have a lot of experience working in the communities. If the government just speaks to us and listens to us, then together we will be able to fight this disease (HIV/AIDS).’*

NGOs, CBOs, and FBOs need to avoid seeing volunteers as stereotyped ‘do-gooders’, but need to view them as active agents of change. NGOs, CBOs and FBOs need to recognize as their responsibility to provide an environment that is conducive to volunteering, so that a culture of volunteering can be nurtured and sustained. As discussed in Chapters One Two and Three, the health institutions alone cannot cope with the burden of care of the HIV/AIDS patients and therefore, the government relies on volunteers to assist in the continuum of care process, more and more. It is therefore, vitally important that NGOs, CBOs and FBOs to recognize the value of ‘shared dialogue’ with volunteers (Berry and Guthrie, 2003). The government should also be included in these talks as there is a need for all role players to work together, rather than in competition with one another.

## **SUMMARY**

In this chapter the demographic details of the participants were presented together with the responses of those home based carers who participated in the focus group discussions.

The major themes in the study were relevant to understanding the motivations and expectations of a locally specific group of home based carers caring for HIV/AIDS patients in Mariannhill were presented.

A participatory learning and person-centered approach guided the theoretical framework of this study. A qualitative data analysis model guided the main themes and sub-themes. Consequently, no complex statistical analysis of the data took place. These methods were compatible and appropriate to the study's guiding framework.

Consistent with the literature, the study's findings indicate that motivations and expectations of volunteers vary according to their personal reasons for volunteering. However, and still consistent with the literature (Pell, 1972) the following factors are particularly applicable to understanding the needs and expectations of volunteers: the need for recognition as an individual and the need to develop a sense of accomplishment.

Some of the findings in this study conferred with the findings in the literature reviewed. These common motivating themes for volunteering as home based carers were: pure altruism, unemployment, hope for future reward and reciprocity, religious considerations, experiences with HIV/AIDS in the family, previous experience or interest in paramedic or community work, hope of securing employment, empowerment, and personal experience with death and illness. Interestingly, the community appeared to take ownership of the HIV/AIDS pandemic and not shy away from it, as is so often the case in many communities faced with this disease. The home based carers' needs and

expectations as volunteers were identified as: a need for personal satisfaction, a need for training, and a need for acknowledgement and appreciation. The main expectations of the home based carers were for: personal development; acknowledgement and appreciation; and personal contact. The home based carers saw the role of NGOs, CBOs, and FBOs to be integral in supporting volunteers and ensuring their commitment to the programmes. This was interesting as it may force these organizations to be more critical of the role they are playing in campaigning for the rights of home based carers, developing policies on volunteering, and influencing interagency networking and service delivery. They perceived the role of NGOs, CBOs, and FBOs to be one of: accountability; poverty alleviation; and active agents of change.

The significance of this study was that it was a locally specific account of the motivations and expectations of a group of home based carers' caring for HIV/AIDS patients in the Mariannhill area and therefore, it was bound to present differences from the literature. The main differences in themes were:

- The spirit of Ubuntu described as care and support for fellow people, appears to be particularly synonymous with the Zulu culture. Interestingly, the participants felt a deep sense of Ubuntu, as well as altruism, for volunteering. While altruism tended to bring about a sense of self gratification for having done a selfless deed, Ubuntu brought about a sense of togetherness and belonging where the home based carer, by helping community members, was able to take ownership of the problem and proactively helped in alleviating that problem



- Using volunteering as a healing ritual to assist participants to recover from the bereavement of their own loss/es.
- The expectations of ongoing training and development to increase their chance of obtaining employment, which will make them attractive to the open labour market.
- The ‘pay back’ concept of giving back to the community in crisis what the community gave to them when they were in crisis was a predominant theme. This also tied in with the Ubuntu concept of care and support. Because the need for support of home based carers is so great, the COC needs to explore and develop methods for increasing support for home based carers in the programme.
- Religion and praying was an integral part of the participant’s socialization. Therefore, the pastoral component of home based care was always present when participants visited their patients, or held group meetings.

Chapter Seven consolidates the study’s findings and makes several recommendations. These recommendations are predominantly derived from the participants of the study and seek to enhance the effective utilization of volunteers by the COC, and other service providers, by highlighting the motivations and expectations of volunteers in the care of HIV/AIDS patients.