

Motivation of community care givers in a peri-urban area of Blantyre, Malawi

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SUMMARY

The main objective was to determine motivating factors for community care givers (CCGs), the services they provided to the community, and to identify sources of CCGs' material supplies. A cross sectional qualitative study was done using in-depth key informant interviews with community care givers and traditional leaders. Analysis was based on themes utilizing content analysis. Most of the CCGs were housewives. Intrinsic motivating factors included feelings of empathy, altruism and religious convictions. Extrinsic motivators were rarely mentioned and these included expected opportunities for loans to start businesses, recognition by the community and eventual employment. The services that CCGs provided in their communities included; offering psycho-spiritual support, providing clothes, food and money to the under-privileged and paying school fees for orphans. In many instances the community care givers were spending from their own personal resources to help the under-privileged, while support from non-governmental organizations could only be sourced erratically. Mobilising resources from the local community through contributions was not seen a viable option. Intrinsic factors are an important motivator for community health volunteer CCGs in the peri-urban area of Blantyre. There is need for community groups to explore the feasibility of tapping from local material and financial resources.

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Introduction

The WHO/UNICEF Primary Health Care Conference of 1978 in Alma Ata proposed the establishment of national community health workers programs [1]. It was intended that community health lay workers would fill the gap for unmet curative, preventative and health promotion health needs of communities. These community health workers would facilitate the achievement of equity in health care, promote multi-sectoral collaboration and promote the use of appropriate technologies [2]. Community health workers or community care givers (CCGs) have been successfully used in several settings in the supervision of treatment of

tuberculosis patients under the DOTS (directly-observed treatment short course) [3]. For instance, in the Northern Cape Province of South Africa, female unemployed community lay health workers supervised DOT with cure rates as good as those obtained through supervision by clinic staff [4]. With the advent of HIV/AIDS, and the realization for the need of a "continuum of care and support", CCGs are increasingly being recognized as a crucial arm of health care services delivery [5] within home-based care programs.

Malawi is among the countries in southern Africa that have been heavily affected by the HIV/AIDS pandemic. HIV infection rates

among adults in the general population have been estimated at 14 per cent in 2003 [6]. As a result of the HIV scourge, there have been increased incidences of tuberculosis, Kaposi's sarcoma and orphans and the elderly without family members to take care of their daily needs [7]. The majority of hospitalized adult patients attending both the surgical and medical wards in Malawi, are HIV infected [7-10]. There is high in-patient mortality and those patients discharged from hospital to the community eventually rely on community care givers for health care, psychosocial and economic support.

The present study was carried out in Ndirande, a peri-urban area of Blantyre, Malawi. Some of the problems encountered by orphans living in Ndirande, Blantyre had been described by Muula et al, in 2003 [11]. Community care givers were identified as an important source of support and livelihood for many of the orphans in Ndirande. As the CCGs were among the sources of support among orphans in the area, we aimed to determine the sources of material and financial support for the running of volunteer groups, motivation for being a CCG and the expectations that the volunteers had from their work.

Materials and methods

Ndirande is a poor peri-urban area of Blantyre, in southern Malawi. It constitutes high density residencies, the majority of which are from unburnt earth bricks with corrugated iron roofs, settlements are unplanned and are in the jurisdiction of traditional leaders. In-depth interviews were held with 27 consecutive community health volunteers and 4 traditional leaders. All traditional leaders in the following villages were contacted and interviewed: Matope, Chakana, Mtambalika and Kusagame. As for community care givers, a community-led service organization was approached to identify all its members who offered care to chronically ill patients as volunteers. Consecutive community workers were visited and recruited in the study. To be a community volunteer, some had offered themselves for service, others had been identified by the community as "helpful people". An interview proforma or checklist [12] was used and WM conducted all the interviews.

These were taped and later transcribed. Content analysis based on themes was done [13,14]. Main outcome measures were: motivation to work as CCG, sources of material support and supplies for the work, expectations from the work as a CCG.

Ethical clearance

Ethical clearance was obtained from the University of Malawi College of Medicine Research and Ethics Committee (COMREC). Permission to conduct the study was obtained from traditional leaders. All study participants gave verbal informed consent.

Results

Motivation for voluntarism

The desire to help others in much greater need than themselves was reported by many of the participants as the reason they accepted to work as CCGs. Many of them indicated that they perceived their work as assisting God in caring for the underprivileged. Four of the CCGs reported that they were motivating through their own experience, having grown up as orphans.

"I still remember how I grew up as an orphan. Helping others makes me feel that we can lift up the burden of being an orphan from them."

Three respondents suggested that being parents they also realized that they would die and could leave behind orphans. *"If we start something now, even when we die, our own children may have something to fall back on."* Most of the CCGs indicated that the benefits of being a CCG were not material here on earth but rather spiritual in heaven. *"We are doing God's work and our reward is not on this world, rather in heaven."* A traditional leader also responded by saying that CCG's work seemed non-paying but the rewards in the short term but compensation would be in heaven. While many of the CCGs did not expect any material gain, four respondents indicated that they would not mind financial assistance. One respondent said, *"At least if we could get some loans to enable us have small business enterprises. In that way we could help others much better."* One respondent reported that working as a volunteer was beneficial in that it

occupied much of his time as he had nothing else better to do.

The CCGs were specifically asked whether they perceived visits by other organizations and individuals such as district social welfare staff as a motivating factor. "At least they tell us where we are doing well and where we should improve," reported one woman. Four participants indicated that they did not perceive the visits as motivating while 23 indicated that they benefited from such visits. One respondent said, "It really does not matter whether they visit us or they do not. We just work as usual." Lack of medicines was mentioned frequently as a shortfall in the work of the community health volunteer and this was mentioned to be a de-motivator as CCGs felt helpless when they visited a patient with physical needs 'potentially' requiring medical treatment. "Sometimes we go to visit the sick who may just require medicines for pain and yet we do not have such medications. We feel impotent," reported a female volunteer.

What services were the CCGs providing?

The CCGs had identified chronically ill people, including those with HIV/AIDS, the aged, young people and orphans as vulnerable groups that they would serve. The elderly living with orphans was particularly recognized as a much vulnerable group. The services that the CCGs provided in their communities included; visiting the sick both within hospital and at home, assisting with household chores such as sweeping the house and yard, bathing the patients and helping out with cooking. Some CCGs reported paying school fees for orphan children in secondary school (Primary education is offered for free in Malawi). They also provided meals and foodstuffs, accompanied orphaned children and chronically sick persons to the hospital, offered HIV counseling and escorting patients who had accepted HIV testing to testing centers. Volunteers also offered psycho-spiritual support mostly through prayer and companionship.

Sources of material support

When asked how they obtained material resources to assist the needy, most of the CCGs

indicated that they were using their own personal resources. "Sometimes we visit the orphans and see they have nothing to eat. We have no option other than sharing with them whatever we have. A few times World Vision has helped us, but this is rare," reported a woman CCG.

While it was realized during the study that much of the material support to the orphans and the sick was coming from the CCGs themselves, utilising an iterative approach [15], CCGs were asked whether they had asked the surrounding community for support. "Everyone is seeing what the volunteers are doing within the community. We need not ask people for assistance. Those that wish to help should just help of their own free will other than asking them for help," reported one traditional leader. Another traditional leader suggested that; "People may misinterpret the initiative. They would say this is not the Malawi Congress Party time when members of the youth league used to extort people of their property. Things have now changed." Community support was therefore not being actively sought.

Discussion

Most of the CCGs in the present study reported being motivated to being a volunteer by intrinsic factors such as feelings of empathy, altruism and religious convictions. Only a few volunteers reported anticipation for extrinsic factors such as monetary incentives. Based on the behaviour reinforcement theory, rewarding people with incentives for performing tasks they already enjoy doing and have high interest may be counterproductive as such may fail to achieve improved performance [16]. The belief of the CCGs in our study was that the reward for their contribution to the health of others was not here on earth but rather in heaven. Kironde reported that young people working as volunteers in a tuberculosis DOTS program were motivated by the novelty of the program, prospects of employment after having experience of a volunteer and desire not spend time idle [3]. Only one of our participants reported that volunteer work filled her idle time that would have been unproductively spent.

We were concerned, although not surprised that the volunteers and their traditional leaders did not perceive the surrounding community as a potential source of material supplies for use by the volunteers. Part of the reason for the current perception is the change of political situation in Malawi where a former government under the Malawi Congress Party (MCP) was forcing people to contribute materially or financially to political party expenses. Since the political landscape has changed, it is currently perceived that any community resources mobilization must be desisted. Non-governmental organizations (NGOs) however do periodically assist volunteers groups with material resources, but this found to be erratic in the area understudy. This could be explained at least in two ways. Firstly, in Malawi, many of the NGOs are implementing their own programs, in selected areas and do not perform the role of donor. Secondly, local community care groups may lack the necessary skills to write proposals that may attract donor funding.

It is possible that CCGs in the study may have been biased to give a sense of lack of support from community, government and NGOs in anticipation of support from the researchers. However, we believe this would also have been countered by the fact that the purpose of the research was well explained to the CCGs that participated in the study.

This study has demonstrated that intrinsic motivating factors rather than extrinsic factors were prominent incentives for community health volunteers in Blantyre, Malawi.

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