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The experiences, challenges, motivations and coping strategies of informal caregivers in a Grahamstown township

by

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Declaration

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

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Abstract

The health care system in South Africa is currently under strain and it does not cater for everyone's needs. This has left a gap in society whereby you will find that the poor citizens of the country are not being catered for in terms of getting access to adequate healthcare. With this existing gap, there are Non-Governmental Organizations (NGOs) in some of the poor communities in the country. These NGOs have volunteer caregivers who go around the community and taking care of the sick people. Research has often ignored these volunteer caregivers, this current research study investigated the experiences of these volunteer caregivers. The goals of the research study were to investigate the experiences of the caregiver,the motivations of the caregivers and the challenges that they encounter and how they cope with the challenges that arise while performing their caregiving duties. The study was based on the phenomenological paradigm. This paradigm believes that the subjective experience of the individual is an essential source of information. In-depth interviews were conducted with the four participants who took part in the study. An interview guide was utilised to help guide the interview process. Interpretive Phenomenological Analysis (IPA) was used in analysing the data. IPA is a way of analysing data, which investigates how a person, in a given setting understands an experience. The findings showed that the caregivers had both negative and positive experiences. They experienced the care recipients as being appreciative of them. However, they experienced the family members of the care recipients' as being uncaring, financial constraints were also a negative experience. Several challenges were stated by the participants, including a lack of government support, alcohol abuse by the care recipients and challenging working conditions.

The participants were motivated to volunteer as caregivers by a number of things. Altruistic motivation was the first, which included the love for the community and the poverty in the community. Reciprocity was another motivating factor, as well as religious duty and career advancement. In this research study there was one coping strategy that came out, the participants stated that they seek advice and consult with someone or go for supervision within the organization when they are faced with a difficult situation. The findings in the research study were similar to those found in previous research. One notably different finding was that in previous research, the caregivers have been found to abuse alcohol in order to cope with stress. However, in this research study, the care recipients are the ones who are abusing alcohol. The research recommends that the government assists the informal caregivers, either financially or with infrastructure.

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1. Chapter 1: Introduction

1.1. Introduction to the research

The present research focuses on the experiences of caregivers and the coping strategies that the caregivers employ when they are faced with challenging and stressful situations. Furthermore, the research focuses on what motivated the participants who volunteer to be caregivers of the ill people in their community.

Non-communicable diseases are on a rise in South Africa, both in rural and urban areas. These diseases are more prominent amongst the poor people; the rise of the diseases causes further pressure on the country's health services. Non-communicable diseases along with HIV/AIDS are causing a great challenge in society and they demand communities to respond in an extraordinary way (Mayosi,Flisher, Lalloo, Sitas, Tollman& Bradshaw, 2009). Diseases like HIV/AIDS have claimed so many lives and have changed the family setup in many communities. In some households the elderly are left on their own with no one to take care of them. In some families the elderly have died from HIV/AIDS and left behind young children and young adults who are also infected by the disease. It is in such difficult situations that people in poor communities decide to stand up and volunteer to be caregivers. But not even the altruistic attempts of these caregivers are enough to deal with the gap in health care that the government cannot fill (Akintola, 2010).

This research is based in the disadvantaged JozaTownship, Grahamstown in the Eastern Cape (a township is usually a town or part of a town). During apartheid in South Africa a township was a residential area created for black people who had moved from the rural areas to the urban areas for work purposes. One will normally find a township on the outskirts of every town and city in South Africa. In other towns one will find that there are different townships that were created for the coloured, black and Indian ethnicities. The white population was found on the upper class suburbs very close to or in the city or town and very far from the black, coloured and Indian settlements (Statistics South Africa, 2001). In the Jozatownship you find the poorest of the poor and the area lacks the most basic services that the government should be providing to citizens (Ruiters, 2001), e.g. Health Care. The caregivers are also residents of JozaTownship and they are also considered to be part of the low socio-economic status group. In this community there are a lot of informal settlements, the area is overpopulated and there are high rates of unemployment (Statistics South Africa, 2001).

1.2.Motivation for the research

In South Africa, it is every citizen's constitutional right to gain access to basic health care, but in most places this is not always the case because resources are not shared equally in the country. Some people are more privileged than others and hence receive the best health care while others live in absolute poverty and receive minimal access to basic health care (Statistics South Africa, 2001). There are people who live in extremely poor conditions and they have no one to look after their health care needs. Within these poor communities there are individuals who stand up and volunteer to become caregivers of the ill people in the community. Motivation for the research is to explore the experiences of the caregivers and the kinds of challenges that they encounter and how they cope with these stressful situations. Furthermore, the motivation for this research was to explore the reasons that motivate the caregivers to volunteer whilst they are also very poor. The overall motivation for the research was to get more in-depth and insightful information about the caregivers' experiences and further enlighten the general public and government in the hope that the caregivers' experiences can inspire them to lend a hand when it comes to helping the poor with regards to health care. In South Africa, we get both the public and private health care system. The public sector serves the majority of the population but it has the poorest infrastructure and staff shortages, in terms of doctors and nurses. The private health care system only serves the wealthy 20% of the population and about 79% of doctors work in the private sector and it hence provides the best health care to the privileged few (WHO, 2008).

According toKautzy and Tollman (2008) the hospitals and primary health care services are taking strain as a result of an increase in chronic illness and hence there is an increased demand for limited services. The health care system that is currently in place in South Africa is struggling to deal with this increase in chronic illnesses because the system is usually understaffed and lacking in basic infrastructure. There is a constant change of diseases and illnesses and research will be necessary to ensure that the health care services in the country are appropriate for the context of South Africa, in terms of the disease that we get in the country and the populations that the health care services cater for(Kautzky and Tollman, 2008).

Most of the people in the JozaTownship only have access to clinics. In these clinics there are no beds; most of them are just day clinics. The patients only go to the clinics to get their medication, after that there is no one monitoring and making sure that they take the medication correctly. Some patients get worse and become bedridden. The caregivers only start to intervene at this point. The motivation for the research was to explore the caregivers' experiences in dealing with this huge and overwhelming task and further enlighten the general public.

1.3. The aim of the research

The aims of the research are:

- To investigate the experiences of the caregivers.
- To investigate the motivations of the caregivers.

- To explore the challenges of the caregivers and the coping strategies used by the caregivers from the township.

The research answers a number of questions; the following are the questions that the research addresses:

- What are the experiences of caregivers who care for sick people in this community?
- What motivated the participants to volunteer when they are poor themselves instead of looking for a proper paying jobs?
- What challenges and stressors do the caregivers encounter?
- How do the caregivers deal with challenging and stressful situations?

The research was situated in a phenomenological paradigm. This paradigm believes that the subjective experience of the individual is an essential source of information. The participants were recruited from a Care Centre in the JozaTownship, Grahamstown. Semi-structured interviews were conducted with the help of an interview guide (Appendix A).

1.4. Definitions of key concepts

For the purpose of this research the following definitions will apply:

- Caregivers: A caregiver in this context is someone who works for a Non-Governmental Organization (NGO), someone who provides care to the sick people in their community, whether the sick person is HIV positive or has a chronic illness or sick because of old age. The caregivers in this context have limitedinformal training.
- Care Recipients: The care recipients in this context are the individuals with the illness who are being cared for by the caregivers.
- Socio-economic status: Is an economic and sociological combined total measure of a person's work experience and of an individual's or family's economic and social

position in relation to others, based on income, education, and occupation (National Centre for Education Statistics, 2008).

1.5. Thesis layout

Chapter one presents the introduction and the motivation for the research, the aims of the research and the definitions of key concepts. Chapter two examines the relevant literature on the experiences of caregivers, focusing on the challenges and coping strategies and what motivates the participants to volunteer as caregivers. Chapter three describes the research design and the methodology on how the research was carried out. Chapter four will showcase and discuss the results. Finally, Chapter five will contain conclusions, limitations and recommendations.

2. Chapter 2: Literature review

2.1. Introduction

This chapter will review literature that looks at the possible motivations for people to become voluntary caregivers. First and foremost this section will look at caregivers and what being a caregiver actually entails and how caregivers experience their work. Under this section the study will also look at what volunteerism actually entails and what voluntary caregivers actually do. Furthermore, this chapter will review literature about what was found to be the greatest motivators for people to become volunteers and caregivers. Empathy and altruism will also be discussed and the role they have in influencing people to become volunteers and caregivers.

2.2. Literature review

2.2.1. Caregiving

According to Uren and Graham (2012), care-giving is a broad term which describes the process of caring for another person who is suffering from an injury or an illness. This act of caring is not only restricted to providing care to people who only have physical ailments, but care-giving also includes giving care to people who are also suffering emotionally and psychologically (Uren & Graham, 2012).

Caregivers experience both positive and negative experiences in caring for the ill. Studies by Mavundla, Toth and Mphelane (2009) and Yeap, Hamilton, Charalambous, Dwadwa, Churchyard, Geissler and Grant (2010), both reported negative experiences in their results. These studies reported that participants complained of financial difficulty, as they could not hold jobs and care for their ill family members at the same time. Caregivers in these studies also expressed frustration due to the lack of education they received about their family member's illnesses; including their medication. According to Mavundla, Toth and Mphelane (2009) caregivers reported dissatisfaction as they felt their efforts were not appreciated and acknowledged by the care receivers. Similar findings were reported in a study by Lin, Fee and Wu (2012). According to Lin, Fee and Wu (2012) caregivers who have minimal education about caring for other people tend to experience stress the most as they do not know how to deal with certain difficult situations. Caregivers also tend to suffer and experience more stress when they feel or perceive that the people that they are caring for do not appreciate their efforts (Lin, Fee & Wu, 2012). A study by Akintola (2010) shares contrasting, more positive experiences. The caregivers in this study reported that they had achieved self-growth and personal, emotional and psychological development while caring for the terminally ill. The caregivers further reported that they learnt to love and be patient as a result of providing care to patients. This was a major driving factor for the researcher to investigate these caregiver experiences because South Africa is unique and each area and its population have different qualities compared to other places within South Africa and abroad. As a result, there is a need for studies that focus on specific unique contexts.

According to studies by Hunter (2007) and Zeegward, Aartsen, Grypdonck and Cuijpers (2013) many caregivers who are providing care to the ill state that what makes caregiving worthwhile is the appreciation that they receive from the care recipients (Hunter, 2007).Zeegward et al. (2013) further states that caregivers are said to have a lot of respect for care recipients who show them appreciation and try to empathize with what it must be like for the person to have the illness (Zeegward et al., 2013). In contrast, studies by Mhaule and Ntswane(2009) and Reinhard, Given, Petlick and Bemis (2008) found negative experiences amongst caregivers. It was reported that if caregivers were not around then the family members of the care recipient would ill-treat the ill person (Mhaule&Ntswane, 2009). Conflict in families was described as causing family members of the ill person to not offer any support to the relative, this conflict was as a result of family members not being able to cope. So this shifted more responsibilities to the caregivers (Reinhard et al., 2008). Furthermore, caregivers had more negative experiences and suffered more burden because of limited financial resources (Reinhard et al., 2008).Similarly, Majumdar and Mazaleni (2010) reported that participants found it very hard to provide care to the ill because of financial constraints. It was further reported that this caused problems as it made it difficult to provide treatment and the necessary nutrition to give the ill person the best health possible and make sure they remain healthy (Majumdar&Mazaleni, 2010).

Studies conducted with carers of people living with HIV/AIDS have found that carers have a consistent unique experience. Akintola (2006) and Demmer (2006), both studies were conducted is rural KwaZulu-Natal, South Africa and they found that carers experience a lot of stigma. As a result of this stigma carers will be in denial about the illness of the care receiver. According to Demmer (2006) carers tend to experience extra stress because of the stigma as they have to keep quiet out of fear of what people would do. By keeping quiet they are also closing off the opportunity of getting support from other people. Similar studies have found that poverty adds extra stress to caregivers' experiences. A study done by Gona, Odera, Newton and Hartley (2010) reported that the available resources that can help in providing good care are hard to reach because of poverty. These findings were similar to a study done by Skovdal, Ogutu, Aaro and Campbell (2009) where carers have had to sacrifice giving care in order to fend for food because they were poor and had access to fewer resources. Uren and Graham (2012) reported that in South Africa volunteer caregivers are not exclusively motivated by the humane act of volunteering but do it out of financial need. These carers volunteer because they are being paid stipends or receiving money for their services.

Lindsey, Hirschfield and Tlou (2010) and Ogunmefun, Gilbert and Schatz (2011) found that older women who are caregivers in a rural context often suffer from exhaustion. This is reported to be caused by the fact that these caregivers are often caring for more than one person and also caring for orphans. In addition to these, the older caregivers also had to perform other household chores, i.e. collecting firewood, cooking and gardening. The caregivers in this study reported feeling overwhelmed by the care-giving duties and the household chores that they had to undertake. Ogunmefun et al. (2011) add that the older caregivers experience a lot of secondary stigma when they care for people living with HIV/AIDS. There appears to be evidence to suggest that the stigma extends beyond the community members and their family to their own spouses and grandchildren. The type of stigma that the respondents reported ranged from isolation from the family unit and isolation from the community and also verbal stigma in the form of gossip and verbal abusive language towards the caregivers. This secondary stigma has a potential knock-on effect as it will affect these older women's spouses and grandchildren as they also feature significantly in the caregiver roles (Ogunmefun et al., 2011). Furthermore, Orner (2006) reported that caregiving added extra demands on caregivers which were made worse by lack of support, poverty and the responsibility of caring for more than one family member and household chores. Stigma and prejudice added more stress to the caregivers and made the whole experience worse. Furthermore, care-giving affects a wide range of people; from the youth to the elderly but women were the most affected. If they at all received help, it was other young girls. Some caregivers did not receive any help because of gender inequalities in their own households (Orner, 2006).

In comparison, the study by Lindsey et al. (2010) looked at the experiences of young girls who are also caregivers and how they compare to the older women caregivers. The younger girls are often expected to drop out of school in order to care for the ill as it is a custom in certain cultures. The girls also drop out of school as they struggle to keep up because of exhaustion. According to Lindsey et al. (2010) very bright students become very poor students because of this. The young girls also do not get a chance to do activities that other young people do and they end up being socially isolated from their peers. With limited education, these girls compromise their chances of formal employment. The children in this study also suffered abuse from those adults they cared for, some suffered from child abuse. Depression was also common as the young girls had to witness their parent or loved one die in front of them (Lindsey et al., 2010).

Furthermore, Lindsey et al. (2010) and Orner (2006), state that the caregivers of all ages suffered from loneliness and isolation as they found themselves being in the house with the care recipient most of the time. The older women would become isolated from their support groups and the rest of the community. The young girls would be isolated from their peers and their school friends, who would otherwise provide some form of support for them (Lindsey et al., 2010).

2.2.2. Volunteerism

There are many different definitions of volunteering. It has been defined as purely a voluntary activity for no payment. However, Boessler and Ding (2010) stated that low payment is acceptable for volunteers in some community based services. In contrast, according to Ellis (2007) volunteering is choosing to act in recognition of a need, with an attitude of social responsibility and with no interest in making money (Ellis, 2007). Although there are many different definitions, most of them state that volunteering is about doing something that benefits others or the community. The act of volunteering must be of the volunteer's own free will and without coercion (Boessler& Ding, 2010).

The United Nations (UN) listed three characteristics that define volunteering. The first was that the activity should be done without the expectation of receiving any form of payment. The second is that an individual must choose to volunteer out of their own free-will. Thirdly, the activity must benefit someone other than the volunteer, although it is recognised that people who volunteer benefit in some significant way for what they do. The UN further identified four types of volunteer activity, these include: mutual aid or self-help; philanthropy, services to others; participation or civic engagement. Each of these occurs in all parts of the world (United Nations, 2001).

Furthermore, Kohn and Wohl (2010) described volunteering as empowering to the volunteer and as an agent that helps develop trust and reciprocity between individuals. The act of volunteering also empowers organizations to help sustain the feeling of community. They further reported that those volunteers who work in faith-based organizations tends to feel more connected and give more (Kohn &Wohl, 2010).

Volunteerism is not just the act of working without pay. The most striking characteristic of being a volunteer is that people go beyond their basic obligations in trying to help those in need. There are many different reasons why people start to volunteer and also continue to volunteer. Findings by Jones (2011) show that people who consider volunteerism as important identify with their company or organisation more strongly as the programme makes them feel proud about being connected to that particular organization. People who value the act of volunteerism have a greater chance of staying longer in an organization that they identify with (Jones, 2011).

According to research by Jack, Kirton, Birakurataki and Merriman (2011) volunteers in palliative care play a very important role, especially in the hospice setting. As palliative care has spread across developing countries in Africa, this has given birth to volunteer workers, who are providing the primary support for terminally ill patients, many of whom never see a health professional.

Marta and Pozzi (2008) reported that identity is an important variable between dispositional and organizational variables and the intention to volunteer. The motivation to help the other, group integration and satisfaction with the organization, are strongly related to young people's volunteer identity. Furthermore Marta and Pozzi (2008) see voluntary engagement as a way to build one's identity. This means that the youth can use their voluntary engagement as a measuring stick of their maturity and to be more receptive to social issues and society in general. Identity is seen as a crucial component of how a young volunteer will involve themselves in voluntary work (Marta &Pozzi, 2008).

In comparison, Sherman, Michel, Rybak, Randall and Davidson (2011) found that adults who volunteer experience higher life regard. They also found that adults who volunteer actually find meaning in life, volunteering provides a new sense of meaning and fulfilment in their lives. Older adults who volunteer rarely experience role loss and confusion in their lives (Sherman et al., 2011).

2.2.3. Empathy and Altruism

This section will look at how people are motivated to become voluntary caregivers through empathy and altruistic values. Altruism is the motivational state with the ultimate goal of increasing another's welfare. Altruism is a moral act of helping others rather than yourself out of the goodness of your heart. Empathy is an emotional response elicited by and congruent with the perceived welfare of someone else. Empathy is a multidimensional way of getting in touch with experiences of another person through the expressions of emotions, affects and sensations of another person. Empathy is the ability to be affected by and share the emotional state of another person, to ascertain reasons as to why they are in that emotional state and be able to identify with the other person and experience that person's experience with them. There are different kinds of altruism; there is directed altruism which is helping behaviour directed at an individual in need; there is intentional altruism, where the altruist actively seeks to benefit himself or the other person intentionally; there is also empathy-based altruism, which is help and care born from empathy with another (Waal, 2008). Furthermore, Waal (2008) states that empathy is necessary in order for the implementation of altruism, without the empathy component, altruistic acts would not exist as they would not be implemented (Waal, 2008). Motives relating to deeply held beliefs are important for an individual to show their altruistic and humanitarian concerns by helping others. The most important quality that was noted in volunteers was the fact that they provided care out of the goodness of their hearts to help those who are less fortunate; this is true altruism (Akintola, 2010).

Lange (2008) and Batson and Shaw (1991) revealed that the volunteers were more concerned with the well-being of others. This position of volunteers is a clear demonstration of altruism. These findings seem to suggest that empathy adds altruistic motivation to already existing selfish and egalitarian motivation. Batson and Shaw (1991) took this further by stating that self-sacrifice is not necessarily a characteristic of altruistic motivation. They further clarified that in the duty of volunteering to help others there may be costs involved, but there may not be any costs in other instances. In some cases there may be a benefit that comes with volunteering to help others, and volunteering will still be altruistic as long as the benefit was not an intended, ultimate goal (Batson & Shaw, 1991).

According to Batson (2008) and Batson and Shaw (1991), the empathy-altruism hypothesis claims that empathic concern felt for a person in need produces altruistic motivation to relieve that need. The empathy-altruism hypothesis also has wide-ranging practical implications. At times it can result in people avoiding or suppressing empathy in order to be spared the resulting altruistic motivation. Batson and Shaw (1991) further state that the assumption that the motivation for voluntary behaviour is egoistic is false. They further state that the empathy-altruism hypothesis claims that empathic emotion evokes truly altruistic motivation; motivation with an ultimate goal of benefiting not the self but the person whom empathy is felt for (Batson & Shaw, 1991).

This was further supported by Rhoades and McFarland (1999) who state that respondents spent most time talking about helping others and this showed that other-oriented themes were more important for the caregivers. The caregivers spoke less about self-oriented themes; altruistic themes such as helping people were more common in the stories of the respondents. Even when self-actualization and purpose in life did surface in the narratives of the caregivers, altruism was still the most dominant and important theme (Rhoades & McFarland, 1999).

Batson (2008) and Gopalan and Brannon (2006) further state that empathy-induced altruism has also been found to improve attitudes towards stigmatized out-groups. Empathy inductions have improved racial attitudes, as well as attitudes and action towards people with Aids (Batson 2008). In addition, Gopalan and Brannon (2006) report that it is more desirable to emphasize altruistic, other-oriented reasons for making people aware of the stresses involved in care-giving. One may need to focus on altruistic or other-oriented reasons when you are trying to get someone to appreciate or help another person who is in need (Gopalan& Brannon, 2006).

Haski-Leventhal (2009) has looked at altruism from a Social Psychologist and Sociologist point of view. Social psychologists have studied altruism as an interaction between person and environment, personality traits on one hand and situational factors on the other hand.

This unique situation requires unique personal features in order for altruistic behaviour to take place. In order for someone to become a volunteer, certain personality traits and certain situations are necessary (Haski-Leventhal, 2009).

Haski-Leventhal (2009) adds that Sociologists on the other hand have considered a number of theories to the study of altruism, i.e. group norms, structural and cultural feature of a community, and core values. Sociology has explained altruism as acting according to ones norms and values that one has become accustomed to in their respective communities and societies (Haski-Leventhal, 2009).

According to Wilhelm and Bekkers (2010) and Burks,Youll and Durtschi (2012) helping behaviours and empathic concern go hand-in-hand. They state that the whole principle of care is associated with helping those who need help. Burks, Youll and Durtschi (2012) add that an individual must maintain enough empathy to motivate further helping efforts. They further add that those caregivers that have high levels of empathy may experience burnout if they feel they cannot help their care recipients. Other caregivers who feel less empathy may also be less altruistically motivated and this will have a negative impact on the quality of care they offer their care recipients (Burks et al., 2012).

2.2.4. Attachment and earlier experiences

Research by Gillath, Shaver, Mikulincer, Nitzberg, Erez and Ijzendoorn (2005) and Erez, Mikulincer, Ijzendoorn and Kroonenberg (2008) found that people who had avoidant attachments were less likely to engage in volunteer activities and they had lower levels of altruistic qualities. Those with anxious attachments were found to volunteer for self-soothing and self-promoting reasons. Avoidance was associated with people spending less time on volunteer activities. High avoidance meant that they did a few volunteer activities and they dedicated even less time, and their altruistic qualities were weaker. They were motivated by other reasons for volunteering and not by altruism. Higher avoidance was also found to be linked with weaker endorsement of career-related reasons for volunteering (Gillath et al., 2005).

Furthermore, Erez et al. (2008) state that attachment avoidance and inhibited volunteerism can be explained by avoidant people's hostility towards others and the attitude that others are unworthy for help. Avoidant people also hold individualistic ideologies rather than collective-communal ideologies that inhibit volunteerism (Erez et al., 2008).

According to Gillath et al. (2005) and Erez et al. (2008), attachment anxiety was found to be associated with self-serving reasons for volunteering. This was supported by Erez et al. (2008) who found that the higher the attachment anxiety, the stronger the support of self-enhancement, social and self-protective reasons for volunteering.

Furthermore, according to Erez et al. (2008), anxiously attached individuals are more likely to volunteer when they support self-focused reasons for volunteering. This implies that egoistic motives can drive highly attachment-anxious people to volunteer (Erez et al., 2008). This will be of great interest to see what drives a person who does not fully care about others to become a volunteer caregiver. It will also be interesting to see how they perform their duties.

Mikulincer and Shaver (2005), state that attachment security provides good grounding for compassion and care-giving. They also found avoidant and anxious attachment to interfere with compassionate care-giving. Furthermore, people who had secure attachment should find it easier to perceive and to attend to other people's suffering, when compared to those who have insecure attachments (Mikulincer&Shaver, 2005). Furthermore, research on attachment seems to suggest that when children have been given care that gives them a sense of security, it makes it possible for the kids to be good parents and neighbours. This makes them generous citizens who will be able to volunteer purely out of altruistic values and the need to help other people (Mikulincer& Shaver, 2005).

In addition to attachment, Chingang, Muko and Kornfield (2008) have suggested alternate ways, which are similar to attachment, to find out if a volunteer had a healthy upbringing that could contribute to them volunteering. In their study they sought to find out the quality of care received by volunteers during childhood.

Firstly, they looked at the peoplethe volunteers lived with as children. The majority of the participants lived with their biological parents as children. Only a few participants were raised by people who were not their relatives. Their research also showed that volunteers with high commitment are more likely to have grown up with their parents than less committed volunteers (Chingang et al., 2008).

Secondly, they looked at how often volunteers moved as children. The results of their study showed that the majority of the participants grew up in one environment as opposed to the minority who grew up in different places (Chingang et al., 2008).

Thirdly, they looked at volunteer perceptions of their childhood quality of life. The majority of the volunteers thought that their quality of life was the same as other children in their communities. This was similar for most participants irrespective of their commitment to volunteer work. The volunteers considered a good childhood to mean living and growing up with parents, attending school, eating good food regularly, and receiving treatment when ill (Chingang et al., 2008).

2.2.5. Motivations for volunteers and caregivers

Asking someone why he/she volunteers could give us one of many answers. These replies might include "to help someone," "because it makes me feel good/gives me a feeling of importance," "for a new experience," "to use a current talent or skill," "to make an impact" or "to have a sense of root, belonging somewhere" (Schultinik, Riley & Schottn.d).

Research by Akintola (2010) and Ancas (1992) reported on motives of volunteering given by the participants. The motivations given were: values, community, career, protective, understanding, enhancement, reciprocity, religion, recognition, reactivity and social. O'neill and Mckinney (2003) found that caregivers were motivated to volunteer as caregivers because this brings purpose to their lives and it helps them to develop empathy. It was similar for Mhaule and Ntswane-Lebang (2009) who found that the participant's empathy was triggered by the poverty and unemployment in their communities and this motivated them to volunteer as caregivers. In contrast to these dominant themes mentioned above, a study by Pillemer, Landreneau and Suitor (1996) found that personal goals did not come up as important motivations. The study also found that religion and moral obligation were not dominant themes either (Pillemer et al., 1996).

Similar research by Maes, Hadley, Tesfaye and Shifferaw (2010) and Jack et al. (2011) found that Aids care volunteers were motivated by the fact that they found themselves positioned in unique social networks that were made up of other volunteers, patients, and divine beings. In this study cultural values were greatly emphasized. In this study volunteers often expressed expectations of divine rewards for helping others as an important motivation to volunteer. Jack et al. (2011) elaborated on this by reporting that most volunteers listed the cultural wish to help others as a key motivator. Furthermore, volunteers reported that they were proud of their volunteering roles and that this role improved their status in the local community. There was general agreement amongst the caregivers that the main reason they decided to volunteer was to care for the suffering in the villages. Most participants agreed with the suggestion that it was based upon cultural values (Jack et al., 2011).

According to research by Ancas (1992) and Akintola (2010) respondents were motivated to volunteer by reasons related to altruistic values, followed by self-enhancement, and then learning/understanding. The least important reasons for volunteering were social connection and self-protection. Additionally, Akintola (2010) states that volunteering presents an opportunity for the volunteers to work for the good of the community. Konrath, Fuhrel-Forbis, Lou and Brown (2011) echoed this by further stating that participants identified a number of incentives that motivated them to become volunteers. The following are the incentives identified in the study: achievement, recognition and feedback, personal growth, giving something back, bringing about social change, family ties, friendship, support, bonding and a feeling of belonging (Konrath et al., 2011).

What came out strongly in the study were the need to achieve and the recognition that many kinds of achievement could result in satisfaction. What kept the volunteers going was seeing their personal efforts turn something bad into good even when they were under stressful situations. Achievements do not have to be huge in order to be satisfying; a simple act that touches a care recipient's life can be a very satisfying achievement for a caregiver (Ancas, 1992).

Antoni (2009) reported that the decision to volunteer was mainly driven by extrinsic motivations. Two extrinsic factors were considered to be motivators for volunteers; a desire to increase social recognition and a desire to increase the number of friends and acquaintances. The intrinsic motivations were the desire to feel useful for others and ideal motivations. In contrast to these findings, Mkandawire and Muula (2005) found the intrinsic motivation factors to be feelings of empathy, altruism and religious convictions. They only reported on a few extrinsic motivating factors, the few that were mentioned included recognition by the community and eventual employment (Mkandawire&Muula, 2005). This notion of intrinsic factors being more important than extrinsic factors was also supported by Antoni (2009). Antoni (2009) reported that intrinsic motivations were reported as being more important than extrinsic motivations in explaining the decision to become a volunteer.

This is further supported by Meier and Stutzer (2004) who state that people who have extrinsic motivations of intrinsic motivations tend to benefit less from volunteering. Their results also found that happy people are more likely to volunteer. It was found that volunteering makes people happy and in turn people volunteer more (Meier &Stutzer, 2004).

Furthermore, Mkandawire and Muula (2005) reported that many participants stated that the main reason they accepted to work as caregivers was to help those who were in greater need than them. Many of the participants saw their work as voluntary caregivers as assisting God in caring for the underprivileged. Some of the caregivers were volunteering because of their own experiences of growing up as orphans; this was also a huge motivating factor (Mkandawire&Muula, 2005).

Research done by Akintola (2010) suggests that there are both intrinsic and extrinsic rewards for volunteers. In Akintola's study volunteers mentioned intrinsic rewards as achieving self-growth and personal emotional and psychological development. An extrinsic reward that came out was that of appreciation. Volunteers viewed the appreciation shown by their patients and by the community as a huge reward. Volunteers also seem to derive some sort of pleasure when they help their patients and their families; they also deem this happiness as a reward. Volunteers also found reward in the positive health and socio-economic outcomes achieved by their patients as a result of their hard work (Akintola, 2010). Furthermore, Ancas (1992) supported this by stating that feedback and recognition were seen as necessary motivations by the volunteers. A big incentive for volunteers appears to be the opportunity for personal growth and discovering new skills and capabilities about yourself. Many volunteers also appeared to want to bring social change to their communities and to those people they care for. Family ties also seem to play a role in motivating people to volunteer. If a person comes from a family that like to volunteer, it is more likely that they will also become volunteers. Friendship, support, bonding and feeling of belonging also pose as a great motivator for people to volunteer, as people appear to volunteer to build more social networks (Ancas, 1992). This was supported by research done by Esmond and Dunlop (2004), their results showed that values, based on deeply held beliefs of the importance of helping others, was the most important motivation, followed by reciprocity, the belief that helping others is helpful to oneself, and recognition (Esmond& Dunlop, 2004).

Similarly, a study by Pillemer et al. (1996) supported the notion of reciprocity. The volunteers were reported to be volunteering because they felt that since they were also helped in the past they should also do something to give back. Furthermore these volunteers felt that it was only appropriate if they were the ones giving the help since they have experienced exactly the same things that the people they are helping are currently going through. The volunteers were reported to be aware that by volunteering this gave them a chance to deal with their own caregiving experiences, which are often harsh (Pillemer et al., 1996).

According to Akintola (2010) the values motivation encompasses the participants' flair for caring and showing compassion for the helpless. The community motivation was all about filling the care gap in the community that is left by the government and also passion for community work. A similar study by Rodlach (2009) found that volunteers have increased commitment to their cause when they are supported by the community. These caregivers are rewarded with respect and prestige and this makes them even more committed and motivated (Rodlach, 2009).

Akintola (2010) and Wilson (2007) found that in many African countries, most volunteers are unemployed. It is not expected of people who are unemployed to support their families and to take care of other people, while they work with no monetary compensation. Many people pretend to volunteer but what they really want is a piece of donor funds (Wilson, 2007). The career motivation is not altruistic as participants claimed that they volunteer in hope that they will get employment. They see themselves as positioning themselves for employment opportunities. Some were volunteering because of religious beliefs or obligation (Akintola, 2010).

In some countries incentives are provided in the form of allowances and transport refunds. Wilson (2007) also found that volunteers do receive monetary and non-monetary incentives. However, monetary incentives are more limited than non-monetary incentives. Most volunteers come from poor socio-economic backgrounds, hence the monetary incentives are seen as being too little or non-existent (Wilson, 2007). Akintola (2010) supports this by stating that the desire for employment and financial gain was evident in all the stories told by the participants. Some caregiver volunteers felt that by volunteering this would place them in a good place to get a job within an organisation. Furthermore, some participants were longing for some sort of incentives from the government as they believed that their hard work should not go unnoticed, even though they were told they were not going to be remunerated (Akintola, 2010).

Additionally, according to Wilson (2007) it is not a case of people volunteering because of altruism. They do it so that they can be able to support their families as they come from impoverished backgrounds. The following are motivations for why people volunteer, according to Wilson's study: they do it to improve one's experience and CV; they do it for gaining recognition in the community; they do it to receive greater exposure to opportunities and for the possibility of benefitting financially in the future (Wilson, 2007).

An additional motivator was stated in a study by Akintola (2010) who found religion to be a great motivation for voluntary caregivers. Participants in both these studies saw it as their Christian duty to care for those who are poor, ill or weak. This was supported by Rodlach (2009) and Rodlack and Dlodlo (2010) who also found that most of the participants drew their strength from religion when they are faced with human suffering.

Another factor as to why people volunteer to care for others is that they had firsthand experience of family members who were sick and needed to be taken care of. This caring for a patient at home and being supported by others makes volunteers more empathic and compassionate to other people who are suffering (Rodlach, 2009). This was supported by (Akintola, 2010) who reported that volunteers usually have an underlying motivation for volunteering to care for others. The study reported that the participants had previously cared for ill or elderly members of their family. What was also an issue for people and driving force in them having to participate in volunteer activities was the fact that they saw a gap in their communities in terms of a lack of infrastructure in caring for those with HIV/AIDS (Akintola, 2010).

Luping (2011) and Boessler and Ding (2010) found a number of reasons as to why youths participate in volunteer activities. A motive that came up often was that of participants having a sense of responsibility to help others in need. Some maintained that they had a duty and responsibility to do something beneficial or meaningful for society. Some volunteers took part in volunteer activities because those activities they engaged in were closely related to what they were studying towards. So they regarded their participation as an opportunity for vocational internship. Another motivating factor for the youth volunteers was that they are taking part in order to expand their circle of contacts. Some volunteers regard participating in volunteer activities as an opportunity to look for a concurrent job, this is not an altruistic motive; they are driven by a possible future monetary reward. This was supported by Rodlach (2009) who found that the volunteer's motivations were not all altruistic. Many volunteers had anticipated that their voluntary work would lead to full-time employment. Some participants even went as far as saying that they should be patient as their volunteering would eventually lead to a paying position (Rodlach, 2009).

A study by Snyder and Omoto (2009) found that those people who became volunteers for self-focused reasons all predicted longer durations of service. Those who were motivated by values and community concern were unrelated to longevity of service. Thus, volunteers who were getting something out of their participation were more likely to stay involved longer. Volunteering for personal reasons, and not just out of relatively selfless desire to serve others, not only is common, but is more likely to lead to longer service as a volunteer (Snyder & Omoto, 2009). Snyder and Omoto (2009) were supported by a similar study by Clary, Ridge, Stukas, Snyder, Copeland, Haugen and Miene (1998) that found that volunteers who were given incentives that were closely related to their motivations were more likely to stay longer as volunteers, and they were more satisfied. This study showed that incentives can go a long way in ensuring that a person stays on as a volunteer. Analyses of the study showed that volunteers differed in their motivations. Volunteers had different histories when it came to volunteering and hence different motivations. Motivations were associated with different types of volunteering activities, and motivational differences were associated with different demographic groups (Clary et al., 1998). Furthermore, Finkelstein (2008) reported that social motives correlate with length of service. Long-term volunteers were found to be motivated more than new volunteers by a strong desire to strengthen social connections. The volunteers may be motivated by important people in their lives, such as their friends and families, who support and encourage volunteering (Finkelstein, 2008).

A study by Ibrahim and Dalton (1997) found interesting differences between the genders in regards to doing volunteer work. The males appeared to be more enticed by the externally or occupationally focused items. The females appeared to be focused on the internal or personal items in their volunteer activities. Males appear to not get much from volunteer work if the experience is not challenging and does not broaden their horizons.In contrast to this, females appear to be more influenced by the things that are more personal such as the family tradition of volunteerism. Females are also interested in getting educational experience and experience in providing a service. Motivational factors that appear to be common in both genders are those of altruism and personal satisfaction. This includes doing something good for the community and feeling good about it (Ibrahim & Dalton, 1997).

2.2.6. Coping strategies

Research has suggested that caregivers mostly use problem-solving and emotion-focused coping strategies. Research by Lin et al. (2012) suggested that caregivers who use emotion-focused coping tend to seek social support from friends and loved ones. These findings by Lin et al. (2012) are consistent with the results from a study done by Chadda, Singh and Ganguly (2007). Chadda et al. (2007) found that most caregivers use emotion-focused coping by seeking support from other caregivers who are in a similar situation. Furthermore, Gona, Odera, Newton and Hartley (2010) and Uren and Graham (2012) reported that sharing and offloading to your friends and to other people who might be in a similar situation helps to alleviate the burden. Uren and Graham (2013) found that caregivers felt that confiding in someone had positive outcomes and that it helped the caregivers cope with stress. Caregivers considered seeking support from others as a necessity to cope with their stress. It was found that without a person to confide in the caregivers could not get rid of the stress on their own. Emphasis was placed on the caregivers to seek the help themselves, and someone to provide the support was not always readily available but it's something that had to be done, a necessity. Social support played an intricate role in the caregivers' ability to provide care to patients. Similar findings were reported in several studies, Jothana, Latha and Bhandary (2010) and Zeegwaard et al. (2013) and Brodaty and Donkin (2009) found that caregivers who seek advice and support from their peers and other people who are close to them e.g. their family members, the caregivers were reported to experience less or no burden at all. Furthermore, Brodaty and Donkin (2009) found that support can come in the form of instrumental support, emotional support, and informational support (information and knowledge from both health professionals and from those who have experienced similar situations) (Brodaty&Donkin, 2009).

Contrasting results have been found in other similar studies. Some studies do not support the notion that emotion-focused coping is the best strategy and some do not support a particular coping strategy. Saavedra (2012) and Gona et al. (2010) suggest that coping strategies that work best are those that require carers to use a lot of positive thinking, whereby carers will engage in problem-solving and seek other alternatives with the hope of getting a cure. However, some studies have remained neutral: according to Sun, Kosberg, Kaufman and Leeper (2010) it is not possible to evaluate one coping strategy as being a bad or good coping style. They conclude that the usefulness of a strategy depends on the level of stress in a particular situation and the characteristics of the individual carer.

According to Uren and Graham (2013) some caregivers had stated that at times they use alcohol to cope with stress, but they did admit that it was not helping at all. Relying on alcohol as a coping mechanism for stress was often used as a temporally short term solution, ultimately making the caregiver more vulnerable to the next stressor. Other participants used their families to help them cope with the stress but the support they received from their family members was often not sufficient as the family members were more concerned about the caregivers having a job rather than the caregivers' wellbeing.

Research done by the Joanna Briggs Institute (2011) found that caregivers who developed protective resources, such as a sense of confidence, self-efficacy and reframing usually experienced fewer burdens. These protective resources refer to the way the caregiver perceives a caregiving situation and their ability to cope in difficult caregiving situations. Self-efficacy was described as having competency in caregiving and it resulted in fewer burdens. Reframing was described as the caregiver's ability to accept problems, manage and solve problems effectively, this also resulted in less burden. The caregivers' attitude towards a situation also influences how much burden and stress they will experience from performing their caregiving duties. The caregivers that appraised a caregiving situation better reported lower caregiving burden and stress while performing their caregiving duties (Joanna Briggs Institute, 2011).

Other research studies reported that caregivers often deal with burden using negative coping strategies such as alcohol use or alcohol abuse. Research done by the National Survey of Families and Households (1998) from the United States of Americaand research done by Rospenda, Minich, Milner and Richman (2010) found that caregivers who experience social and emotional burden that is brought on by duties of caregiving are more at risk of abusing alcohol. Additionally, they found that alcohol abuse by the caregivers often leads to the abuse of the care recipients (Rospenda et al., 2010). Furthermore, caregivers were found to be experiencing increased stress during caregiving and this was overwhelming for them and hence they turn to alcohol to help cope with the stress. This was further supported by

Jothanaet al. (2010) who found that caregivers use alcohol in order to forget about the hardships at work and relieve some stress that they have (Jothana et al., 2010).

2.3. Summary

Voluntary caregivers are mostly motivated by the same things in most of the literature that was reviewed. Most volunteers are motivated by their commitment to a cause and out of altruistic values to help those in need. Volunteers are valuable resources that are highly needed in society at large.

Many volunteers seem to have become voluntary caregivers because of their personal experiences of having to take care of their loved ones. Most of the volunteers especially in African countries might have had to nurse their loved ones who have been infected by HIV/Aids

People appear to be motivated to become caregivers by the simple fact that there is a need in their communities for such services. Some see their friends, family members and even neighbours struggle without many resources and this motivates them to become volunteer caregivers. Once they see this they will want to help and assist with the knowledge they gained from having to take care of their own loved ones that might have survived or died.

Some are enticed by their religious beliefs but not all are in it for selfless reasons. Some voluntary caregivers have decided to join as they hope to receive some sort of incentives. Some volunteer in hope that they will get employment and they see volunteering as their starting point into an organization. Some do it to get respect and prestige from their communities; these have got nothing to do with caring for the next person.

In cultures that practice a more collective way of living, people give their time to others more naturally. In such cultures the act of volunteering is a normal way of life. In collectivist cultures, volunteering is done purely to help the other and not for selfish reasons. Historically, African and South African cultures have been known for their collectivist qualities.

In modern society people are motivated by so many reasons in choosing to be volunteers and caregivers. With poverty and unemployment so strife in communities, it is not surprising that people become volunteers and caregivers in hope that they will be given money or a paying job.

3. Chapter 3: Methodology

3.1. Introduction

This chapter will look at what the research sets out to do, in terms of the aims of the study and the questions that it focuses on. The chapter will further explain the methodology that was employed in terms of the sampling techniques, data sources and data analysis. The chapter will conclude with reliability and validity as well as ethical considerations.

3.2. Aims of the study

The primary aim of the research is to investigate the experiences of caregiving by lower socio-economic black volunteer caregivers. These experiences will include enquiry into the motivations and challenges of the caregivers and the coping strategies used by the caregivers from the township, caregivers who work at a care centre. The research answers a number of questions. The following are the questions that the research addresses:

- What are the experiences of caregivers who care for the sick people in the community?
- What motivated the participants to volunteer when they are poor themselves instead of looking for a proper paying job?
- What challenges and stressors do the caregivers encounter?
- How do the caregivers deal with challenges and stressors?

3.3. Research design

This research is a qualitative study. The study is situated in the phenomenological paradigm. This paradigm believes that the subjective experience of the individual is an essential source of information. Hence it looks at issues from the subjective point of view. The phenomenological approach is based on a paradigm of personal knowledge and subjectivity, and emphasises the importance of personal perspective and interpretation. The phenomenological paradigm is powerful for understanding subjective experience, gaining insights into people's motivations and actions (Lester, 1999).

According to Lester (1999) the phenomenological approach is good at uncovering the true meanings of people's experiences and making the lives of people visible. Furthermore, this may not always be comfortable for parties involved in the production of a research study as the outcomes of the study may challenge long held beliefs and norms and actually expose them to be different from what everyone has always believed. Phenomenological research is also appreciated as it is often very insightful and it often challenges taken-for-granted assumptions in society(Lester, 1999).

Furthermore, Sanders (1982) described phenomenology as a qualitative research method that aims to look at lived experiences of individuals who are participating in a research study. Sanders (1982) added that phenomenology studies the experiences of the individual as they present themselves to that individual's consciousness. Phenomenology considers both what the individual observes and the personal meaning that is placed on what was observed. The researcher reports in such a way that will portray the point of view of the individual that experienced the phenomena and lived the experience (Sanders, 1982).

3.4. Sampling and Demographic description of the participants

This research sample is comprised of a purposive sample. A purposive sample is selected to suit the purpose of the study and one must have prior knowledge of the suited population that will match the aims of the study. The selected participants must have certain characteristics. Purposive sampling is very useful when one wants to reach the target sample much quicker (Babble, 2001). According to Patton (2002) purposive sampling is different from nonprobability sampling techniques. Purposive sampling depends on the judgement of the researcher to select participants that will partake in the study. The sample that is selected is usually small when compared with probability samples (Patton, 2002).

Furthermore, purposive sampling is different to other probability sampling techniques, e.g., simple random sampling and stratified sampling. Unlike these techniques, purposive sampling does not require the participants to be selected randomly from the given population in order to make inferences to the large population (Patton, 2002).

The sample is made up of caregivers who work at a township care centre in Grahamstown. The care centre looks after the ill people around the community, the caregivers do home visits. The caregivers are also residents of the township. The participants are black, in terms of race and are all considered to be part of the low socio-economic status. While looking for the participants the investigator approached the care centre and purposively asked for participants who have the above mentioned attributes, i.e. people who are black in terms of race and live in the township, people who are caregivers and who are considered to be of low socio-economic status.

The participants consist of three females and one male, four in total. The female caregivers ranged from the age of 28 to 42 years, while the male caregiver was 54 years old. Half of the caregivers were married and the other half was single. Two of the participants have passed grade 11 and the other two have passed grade 10 and grade 9 respectively.

Three of the four participants stay in the township. They stay in one-bed room houses that were built for them by the government. One of the participants lives with five other people in these small houses and two of the participants live with two other people in the small one-bed room government houses.

Two of the caregivers have been caregivers for more than three years and one for more than ten years and the last one has been a caregiver for less than one year. Three of the caregivers have been diagnosed with a serious illness in the past. This resulted in them being helped by people from the same care centre that they are working for now.

All the caregivers are unemployed and depend on social grants for a living. Once in a while the care centre receives funding from sponsors and this allows the caregivers to get a stipend for a short while. Three of the four caregivers are the main bread winners in their families. The caregivers go around the community giving care to as many sick people as possible. Most of their clients are HIV positive patients that stay in their own homes.

Thus: **Participant one** is male and 54 years old. He is married and has two children; he lives with his wife and two children. His highest level of education is grade 10. He is unemployed and is a volunteer at the care centre.

Participant two is female and 42 years old. She is single with one child; she lives with her mother and her child. Her highest level of education is grade 9. She is unemployed and is a volunteer at the care centre.

Participant three is female and 28 years old. She is single with no children; she lives with her parents, two brothers, one sister and two nieces. Her highest level of education is grade 11. She is unemployed and is a volunteer at the care centre.

Participant four is female and 30 years old. She is married with one child; she lives with her husband and her child. Her highest level of education is grade 11. She is unemployed and is a volunteer at the care centre.

3.5. Data sources

In this research the data was collected through the use of semi-structured interviews. An interview guide was developed to ensure consistency across interviews (See Appendix A). According to Smith and Osborn (2008) the advantages of the semi-structured interviews are that it facilitates rapport and empathy. It allows a greater flexibility of coverage and allows the interview to go into novel areas, and it tends to produce richer data (Smith & Osborn, 2008).

In this research in-depth interviews were conducted. The interviewer sat one-on-one with the participants. Each interview was tape recorded. The interviews were used to seek information about the caregivers' experiences while caring for the ill. The aim was to further investigate what motivated the caregivers to volunteer as caregivers. It also aimed to explore the challenges that these caregivers face and how they cope with these challenges and overcome them.

3.6. Research procedure

After obtaining ethical clearance from the University and Psychology Department Research Ethics Committee Review the investigator went to the care centre in the township, in Grahamstown. The investigator explained the research to the head of the centre. The researcher was then granted permission to speak to the caregivers and ascertain for himself if they were willing to participate in the research or not. The researcher then met with each of the participants and explained the research purpose and the kind of participants required to take part in the research. These meetings were held with each of the participants prior to the actual interview dates. This was done partly to see if the candidates were suitable and to explore if they wanted to take part in the research. These preliminary meetings were held to inform the participants of exactly what the research required from them, so as to not coerce them into something they don't want to do.

There were four caregivers present at the centre on that first day the researcher made contact and all four of them agreed to be interviewed. The investigator made appointments with the participants for a later date. On the day of the interviews, each participant was requested to sign a consent form (Appendix B) and a tape recording consent form (Appendix C). It was explained to the participants that the audiotapes would only be listened to by the researcher and destroyed once analysis has been completed.

All the interviews were conducted at the care centre in the township. The interview guide was prepared in both English and Xhosa and the interviews were conducted in the preferred language of the participants. The interviews lasted approximately 45 minutes to 60 minutes. All the interviews were conducted within the month of March 2013. There was a follow up meeting with each of the participants to clarify certain issues and to ensurethe credibility of the research. The follow up meetings lasted for approximately 30 minutes.

3.7. Data processing and analysis

Interpretive Phenomenological Analysis (IPA) was used in analysing the data. IPA is a way of analysing data, which investigates how a person, in a given setting understands an experience (Larkin, Watts & Clifton, 2006). The aim of interpretive phenomenological analysis (IPA) is to explore in detail how participants are making sense of their personal and social world, and the main currency for an IPA study is the meanings particular experiences, events, and states hold for the participants (Smith & Osborn, 2008).

The first step during analysis in this research was to first transcribe the audiotape. The interviews were done in Xhosa and as the investigator was transcribing, he translated them into English. The meaning of what the participants said was not lost because the investigator has a very good understanding of both Xhosa and English.

The transcripts were then analysed following Smith and Osborn (2008) suggestion. The researcher first read and re-read all the data and broke it down to small pieces, looking for themes line by line. Secondly the researcher further refined the themes into broader clusters by further breaking down the participant's descriptions, looking at each participant's experiences and listing them down. Clusters that came up from the second step were compared to categories and experiences. Thirdly, it was taken to a higher level by looking at relationships within and between categories. At this step the similar themes that were similar across all the participant's experiences were then written down and clustered together and this resulted in the final themes that appear in the findings section of the research study. The categories described in these three phases contained data that was similar in terms of the participant's experiences, motivations, challenges and coping strategies. At the end the individual experiences were compared to each other and across categories (Smith & Osborn, 2008).

3.8. Reliability and Validity

The research used three measures in order to ensure reliability and validity. These three measures are: credibility, transferability and dependability (Robson, 2002). Credibility is how true the data is, how the data represents the true experiences of the participants. Credibility was ensured by giving the findings of the research to the participants to check if it is in line with their experiences or not. Transferability is whether or not the results can be generalised to other similar contexts, with other caregivers from different townships in other parts of the country. Dependability is the case of consistency if new research was done using the same interview guide in a similar context. The research design and the interview guide were used to ensure dependability in this research study. See Appendix A for interview guide (Robson, 2002).

3.9. Ethical considerations

In this research the participants were informed in detail about the nature, development and aims of the research. Participants were given an opportunity to ask for clarity and to raise any issues of concern with the research prior to signing a consent form. See Appendix B for consent form and Appendix C for tape recording consent form. The participants signed an informed consent form before partaking in the study. The participants were assured of the confidentiality of the study and anonymity of their identities in the study. A copy of the signed consent form was given to the participants. In order to make sure that the participant's identities are kept confidential, the transcripts and tapes of the participants' experiences were not kept with any identifying labels. Coding was used instead of their names to ensure that no one will be able to identify the participants from the final thesis (Rice &Ezzy, 1999).

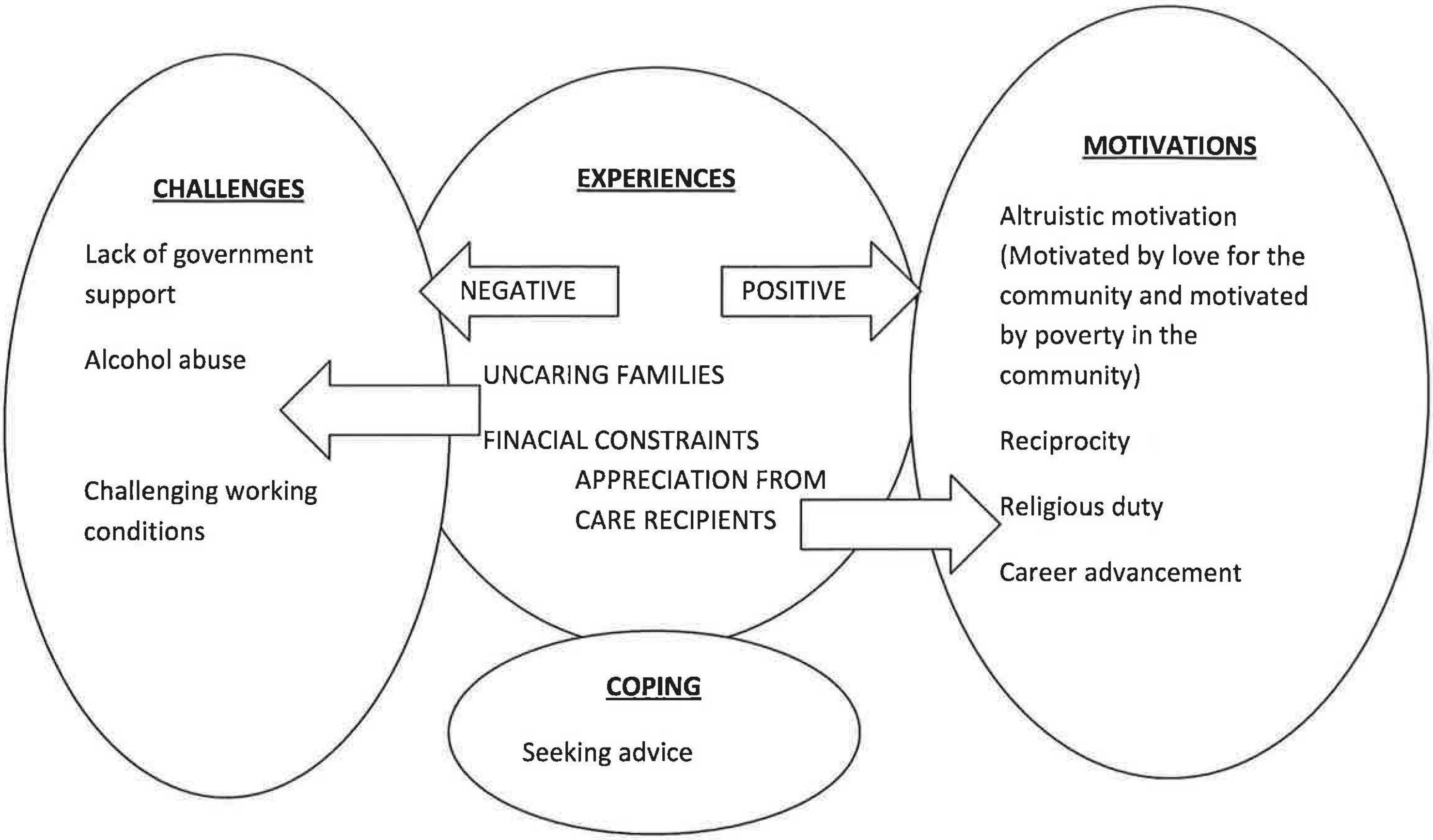
4. Chapter 4: Findings and Discussions

4.1. Introduction

This chapter will look at the findings that emerged in the research. Here the meanings of the themes and the sub-themes will be conveyed and discussed. The themes that were dominant in the research include themes such as; Theme1: Experiences, negative and positive experiences. The sub-themes for the experiences theme include: appreciation from care recipients, which is a positive experience. Other sub-themes are uncaring family members and financial constraints, which are both negative experiences. Theme 2:Challenges, the sub-themes for this theme include: lack of government support; alcohol abuse and challenging working conditions. Theme 3: Motivations, the sub-themes for this theme include: altruistic motivation, which includes being motivated by the love for the community and motivated by the poverty in the community. Other sub-themes for Motivations are reciprocity and religious duty and career advancement. Theme 4: Coping, the sub-theme for this theme include: seeking advice as a coping strategy. The themes are interwoven and can be described as being under one umbrella theme, the challenges; motivations and coping themes are all under the umbrella theme of experiences. Certain sub-themes can fit under a couple of the main themes i.e. the sub-themes under experiences can also fit under challenges and motivations. Uncaring families and financial constraints can fit under challenges. Appreciation from care recipients can fit under the motivations theme (See diagram 1 below).

The experiences, challenges, motivations and coping strategies of informal caregivers in a Grahamstown Township

Diagram 1:



The themes in this section will be discussed in a particular format; the theme will first be introduced, followed by the participants' actual words, which will be referenced in a particular way,i.e. [**Participant 1: Interview 1**]. A discussion that is supported by literature will then follow, literature supporting or conflicting that particular theme or finding. Table 1 below is a summary of the themes that will be discussed in this section:

Table 1: Summary of the themes and sub-themes

Themes	Sub-Themes
I. Experiences	• Appreciation from care recipients(Positive experience)

	• Uncaring family members(Negative experience) • Financial constraints(Negative experience)
II. Challenges	• Lack of government support • Alcohol abuse • Challenging working conditions
III. Motivation	Altruistic motivation • Motivated by the love for the community and • Motivated by the poverty in the community. Reciprocity Religious duty Career advancement
IV. Coping	Seeking advice as a coping strategy

4.2. Theme 1: Experiences

4.2.1. Negative versus Positive caregiving experiences

This theme conveys the experiences that the participants go through. The participants expressed that they experience both pleasant and challenging moments. They described the pleasant moments as reassuring and fulfilling in that they remind them of why they chose such a special career. They however also expressed challenging moments which they described as constant reminders of the poor psycho-social conditions that poor people have to endure. They described these challenging moments as bringing sadness to them and their care recipients. The supporting sub-themes will be discussed below.

4.2.2. Appreciation from care recipients

The caregivers described their care recipients as being very appreciative of the services they were offering them. They stated that this means a lot to them because it shows that they are doing something positive that makes them very happy and that when they are appreciated by the care recipients, it makes everything worthwhile. The participants also stated that because the care recipients are so receptive to their work just shows that they do need them and appreciate them, which further facilitate a good working relationship. The following is what some of the participants had to say when asked how they experience their job:

Participants had similar experiences in this regard. The appreciation that was shown to them by the care recipients gave them a sense that what they did added value to people's lives and that the service they provide was indeed a necessity. What they said was similar in nature to the following comment: "The people appreciate what is being done for them.........they appreciate the spirit, the care, the love and the dedication of the care workers"**[Participant1: Interview 1].**

Participant 1 further commented on how the care recipients might be experiencing them as caregivers. The following extract is what was reported by participant one, other participants also made similar comments to the following: "As far as I am concerned, clients are very happy with what we are doing for, the services being provided to them" **[Participant 1: Interview 2].**

The following sentiments were expressed by another participant when she was asked how she experienced her job as a caregiver: "When I tell care recipients that I won't come the next day or that they will work with another caregiver, they say no they want me, and this makes me happy because it shows that they appreciate what I do" **[Participant 2: Interview 1].**

Participant 4 remarked when asked the same question that she found caregiving to be a very pleasant job because the recipients were accepting of her. She further stated that the care recipients have never given her a hard time.

Discussion

What this means for the participants in this research is that by feeling appreciated by the care recipients, it made the difficult working conditions pleasant for the caregivers and motivated them to work under harsh conditions. A similar study by Zeegward et al.(2013) found that caregivers seldom receive expressions of love, those caregivers who seem able to talk about their efforts in recognizing signs of love, emotional closeness and companionship. These caregivers are said to have a lot of respect for the care recipients who show them appreciation and try to empathize with what it must be like for the person to have the illness (Zeegward et al., 2013).Similarly, a study by Hunter (2007) shares the same sentiments as what is stated by participants. According to Hunter (2007) many caregivers who are providing care to the ill state that what makes caregiving worthwhile is the appreciation that they receive from the care recipients (Hunter, 2007).

4.2.3.Uncaring family members

All the caregivers in the study expressed that they experienced the family members of the care recipients as not supportive and not showing much care. The caregivers expressed that other family members were abusive or just not willing to partake in caring for their relative. This uncaring behaviour was described as hindering the healing process for the care recipient and only made things worse.

The following comment by a participant expresses the frustration and difficulty that the participants in this research study have to go through in their daily duties and the effort they try to put in when trying to convince the family members of the care recipients to come on board and help take care of the ill relative: "You try to educate the family on how to look after the patient and when you are not there, they don't care for the person, you understand"**[Participant 1: Interview 1]**.

Other participants shared a similar experience as participant one above. For instance another participant said the following: "People can't take care of their own people, they leave it up to us and I so dislike it"**[Participant 3: Interview 1]**.

This following is what the participants expressed about the uncaring nature of the family members of the care recipients, the comment below even has an element of abuse from the family members of the ill person: "Sometimes you find the client is staying with her daughter and the daughter is not using the money wisely, they don't buy food"**[Participant 2: Interview 2]**. This comment by participant two can be viewed as lack of support and assistance from the other family members.

Discussion

In a study by Miller (2010) it was stated that it has long been presumed that women in families will do, and should do, caregiving to aging or frail relatives. Many researchers are rejecting these over-simplified assumptions (Miller, 2010). This was echoed in this study as the family members of the caregivers were found to be uncaring. The caregivers expressed their frustration with family members that do not care for their ill relatives. The caregivers further explained that there are a number of reasons that frustrate them when it comes to this issue. They reported that when the family members do not care, it always causes the patients to relapse because the caregivers are not there at all times of the day. The caregivers also stated that they look after so many people and some of their clients really need them because they don't have anyone else but the caregivers. It really frustrates in this sense when resources are stretched to the limit and end up not meeting the needs of those who really need them.Mhaule and Ntswane-Lebang (2009) reported that participants in their study remarked that if they did not take care of the ill person, none of the family members of the care recipient would take care of the ill person (Mhaule&Ntswane-Lebang, 2009). Furthermore, findings in the study by Mhaule and Ntswane-Lebang (2009) were that the family members of the ill care recipient went as far as provoking the ill individual. The family members of the ill person would accuse the patient of disturbing the peace and request them to leave the house because they were conceived as causing burdens to the entire family (Mhaule&Ntswane-Lebang, 2009). In a similar study by Reinhard et al. (2008) this lack of assistance and support was arising from family conflict, as a result of distress as the other family members cannot quite seem to cope with the stress of taking care of someone who is physically ill (Reinhard et al., 2008).

4.2.4. Financial constraints

Financial difficulties were described by the participants as a very big challenge for both the caregivers and the care recipients. The caregivers expressed that at times it is difficult to go on working without a stipend. Some of the caregivers are breadwinners but they continue to work because for them it is not only about the money, it's because they see the need in the community. The caregivers reported that the care recipients are also struggling as they only get the grant money and they can't even afford food that will help them stay healthy. The following extract is what one of the caregivers had to say about financial constraints when one is a volunteer caregiver.

All the participants expressed concern over the limited finances. The following extract captures their shared experiences: "The thing that stresses me in the organization, like now this is our last payment. We don't know when we will be paid again. But we wait because we love it and we cannot just quit"**[Participant 3: Interview 1].** So while money is an incentive, it is still not the primary incentive and altruism is stronger.

Discussion

The participants expressed that what they have experienced is that the lack of financial support makes it difficult for them to reach out to more people who need help. They also expressed that at some homes, the care recipients are all alone and have no families and that at times they have to provide food for that client. Without the financial support, they have to use the little money that they have to provide for their care recipients. Brodaty and Donkin (2009) found that caregiving came with a lot of challenges, including financial constraints. They found that the effects of being a caregiver are generally negative, with high rates of burden and psychological morbidity as well as social isolation, physical ill-health, and financial hardship (Brodaty&Donkin, 2009).

According to a study done by Reinhard et al (2008) limited financial resources can increase the risk of burden for the caregivers, as you might find that they often have to use their own money in order to provide essentials for the care recipients. Often caregivers who are unemployed and have low income are more prone to burden as they have limited resources to care for the care recipients (Reinhard et al., 2008). In a similar study by Majumdar and Mazaleni (2010) it was reported that the participants found it very hard to provide care to the ill because of financial constraints. It was further reported that this caused problems as it made it difficult to provide treatment and the necessary nutrition to give the ill person the best health possible and make sure that they remain healthy. It is found that often community members do not have the means to help support their neighbours who are ill because of financial reasons (Majumdar&Mazaleni, 2010).

4.3.Theme 2: Challenges

The participants in this research study expressed that most of the days they spend doing their caregiving duties are filled with a lot of challenges. The challenges that are faced by the participants on a daily basis will be discussed in this section. The challenges will be discussed under the sub-themes that follow below. The challenges that came out in the study that the participants found to be limiting their efforts in providing care to the care recipients are as follows: lack of government support; alcohol abuse by the care recipients and challenging working conditions.

4.3.1. Lack of support from government

The caregivers had a lot of grievances that they felt the government could have easily assisted them with. The caregivers felt that if the government could make mandatory funds for care centres in poor communities, the caregivers would reach so many more people. People in the poor communities do not have access to basic health services, the caregivers are the next best thing for them. However, without the help of the government, they cannot reach all these people who are in desperate need of their services.

Participants felt that the government could be doing so much more, instead they find that the government is neglecting them, this is demonstrated in the extract that follows: "There is no money and the lowest point was when we didn't get funding from Social Development"**[Participant 1: Interview 1]**.

Furthermore, another participant took it further by voicing her frustrations about how the government does not support them and overlooks them when they are doing most of the hard work without any compensation: "The side that stresses me in an organisation, like how this is our last payment. We don't know when we will be paid again. You see that is one of the things that stresses us because of we have accounts to pay. If only government knew that we, the people in NGOs work more than people in clinics you see. If only the government could do more for NGOs and always look at NGOs training to empower us"**[Participant 3: Interview 1]**.

Discussion

The participants in this study felt that the government was overlooking and not giving them any support nor showing them appreciation for the hard work that they are performing. They also felt as though they were helping the government by doing this work but the government was not showing them any support in return.Research by Akintola (2010) found that the informal caregivers' needs, in regards to support mainly focused around support from the government, the community in the area they serve. Personal needs, concerning support, focused on recognition and respect (Akintola, 2010). In this research the consensus amongst the caregivers was that the government could do so much in terms of assisting them so that they can in turn assist more people. Funding could help them in terms of transport and this will help in terms of them reaching more people. They also mentioned that a stipend could come in handy as they also have other responsibilities and it could possibly keep them motivated to stay longer.According to Richter and Peu (2004) the government can help and assist the caregivers in terms of financial support and the provision of home based care materials. The government can also help in providing assistance in organizing workshops to educate and empower the caregivers. The government can also assist to provide enough medication for the care recipients and help provide care for the caregivers (Richter &Peu, 2004). A similar study done by Motswasele and Peu (2008) found that the best way to support the caregivers is when everyone works together, a partnership that will include the government, health care professionals, informal caregivers and the care recipients (Motswasele&Peu, 2008).

4.3.2. Alcohol abuse

The participants expressed a lot of concern in regards to the amount of alcohol that is being used by the care recipients. For the participants the main concern was around the negative effects that alcohol abuse has on the care recipient's health, health that is already compromised by a certain illness. What was also distressing the caregivers was the fact that their clients are drinking because they have lost hope and they face the challenge of alcohol abuse along with hopelessness and this makes their roles as caregivers more difficult, physically and psychologically.

The following is what was expressed by one participant in regards to the hazardous use of alcohol by care recipients, the participant expressed how the alcohol hinders the healing process for the care recipients and further frustrates: "Some of the challenges are the abuse of grants they are getting from government because you know they are abusing alcohol and it affects them mentally and psychologically"**[Participant 1: Interview 2].**

Another participant expressed the following in support of what was said by participant 1 above: "People living with HIV drink a lot of alcohol, for them they see HIV as a disease that is going to kill them. They don't have hope"**[Participant 3: Interview 1].**

The following statement by a participant was also somewhat of a new finding in this current research study. It is usually the caregivers who use alcohol as a means to cope with burden. The following statement by a participant is similar to what the other participants said about the struggle and frustrations that they have because of care recipients who abuse alcohol and put their already compromised health at further risk: “The challenges I have faced mostly is this HIV because it is very rife in our community because people don’t want to accept it or claim to have accepted it but drink alcohol**[Participant 4: Interview 1].**

Discussion

The participants in this research are experiencing alcohol abuse as a massive challenge that seems to hinder their roles as caregivers. They experience the care recipients as people who have lost all hope and as people who are in denial about their illness and this leads to them not getting well and this further means that the caregivers have to devote more time to them and time is a limited resource in their line of work as there are many people in the community who need the help of the caregivers. In contrast, Rospenda et al. (2010) found that it was the caregivers that were abusing alcohol and not the care recipients. They found that alcohol abuse was a cause for concern among caregivers, as both their health and the health of the care recipients were at risk, particularly if they are responsible for assisting the care recipients with activities of daily living. They found that alcohol abuse by the caregivers often leads to the abuse of the care recipients (Rospenda et al., 2010). This finding was not replicated in the current study.

In addition, studies seem to show that alcohol abuse is usually amongst the caregivers and not the care recipients. The U.S. Department of Health and Human Services reported that caregivers are experiencing increased stress and this is overwhelming for them and hence they turn to alcohol to help cope with the stress (National Survey of Families and Households, 1998). Rospenda et al, (2010) found that caregivers who experience social and emotional burden that is brought on by the duties of caregiving are more at risk of abusing alcohol, and having an alcohol problem that might warrant them to seek professional help for (Rospenda, 2010).

Furthermore, a study by Jothana et al. (2010) found that most caregivers use alcohol in order to forget about the hardships at work and to relieve some stress that they have (Jothana et al., 2010).In contrast, the findings in this current research show that it is the care recipients who are actually abusing alcohol, as a way to cope and not think about their illnesses.

4.3.3. Challenging working conditions

The caregivers saw their working conditions as extremely challenging at times. They described them as being masked as good from the outside when in actual fact they are terrible. Participants admitted that the working conditions were not the greatest but said that they were still able to work and expressed that they were content with the working conditions since there was nothing they could do about it.

Participants were mostly dissatisfied with the working conditions that they had to work under. The following is what was expressed by one of the caregivers: "The working environment and working conditions are not conducive for care workers". "Working conditions are appalling, it's bad, and from the outside it looks good and from what we see from the outside there, it's good but that is not the reality"**[Participant 1: Interview 1].**

The following extract shows the challenges that the participants encounter when they visit the households of the care recipients. But also this shows the resilience of the caregivers as they all continue working despite the challenges that they encounter: "working conditions are hard at times; you come across challenges in some households"**[Participant 2: Interview 1].**

The following extract by a participant shows that the participant do experience challenges within their work environment but it also shows that they manage to work through these problems: "There are problems but not that much"**[Participant 4: Interview 2]**.

Discussion

Those caregivers who were appalled by the working conditions felt like government should be doing more for the caregivers and the care recipients. However, one could also argue that the participants are working for an NGO and government does not have to support. Furthermore, the government is issuing grant money which is being abused and used for alcohol. On the other hand those who admitted to it being problematic but were content with their working environment, they felt that it's no use complaining about it because there is not much that they can do about it and the care recipients cannot do anything about it either. According to Akintola (2010) the environment and personal hygiene are the most important things that contribute to the survival of the community caregivers. This goes to show that pleasant working conditions can keep the volunteers giving care for longer periods of time which will further benefit the community (Akintola, 2010).

According to Reinhard et al. (2008) caregivers need more resources in order to ensure that they reduce the risk of causing harm to the care recipients. The caregivers need to be placed in working conditions whereby they will be exposed to other support services that are available in helping them provide care to the sick. Also if the gap between the hospitals and the caregivers were to be minimized and they work in a manner that would benefit the care recipients, the caregivers work conditions could become so much better (Reinhard et al., 2008).

Furthermore, according to Motswasele and Peu (2008) the caregivers revealed that they felt exploited during the home visits that they made. They felt this way because they were not getting any support from the family members of the care recipients and all the caregiving burden was placed solely on their shoulders. The caregivers also witnessed moments when the care recipients were the ones who were being exploited. This would happen when the care recipients would be turned away from clinics and hospitals without getting any help. Furthermore, the care recipients would be kicked out of their homes by their family members and they would be shunned by their community (Motswasele&Peu, 2008).

4.4.Theme 3: Motivation

Under theme three the research will discuss what motivated the participants to volunteer as caregivers. It will particularly look at altruistic motivation and the supporting sub-themes, namely, “motivated by the love for the community” and “motivated by the poverty in the community”. Other sub-themes of the motivation theme that will be discussed are reciprocity; religious duty and career advancement as other forms of motivation that motivated the participants to be caregivers. The supporting sub-themes are discussed below.

4.4.1. Altruistic motivation:Motivated by love for the community

This was an altruistic motivator for the caregivers. The caregivers reported that the main reason they chose to volunteer as caregivers of the ill was for the love that they had for their community and for the people of the community. They expressed that the people in their community are the same as them and they feel that they understand their problems better and hence they are better placed to help them. The caregivers expressed that they could not just watch as other people suffer in the community. They expressed that their communities are already suffering from poverty, which means the people of the community must step up and help where they can for the greater good of making their communities better.

In the following extract one caregiver explained that the biggest motivator that makes them to volunteer to be caregivers is the love that they have and want to share with the care recipients by helping them: “Love is not what I get from you, it’s what I give you”**[Participant 1: Interview 2].** This captures perfectly the giving nature of these caregivers.

Other participants also commented about what motivated them to volunteer as caregivers, they mentioned the love that they have for their community and their neighbours. For instance: "I chose caregiving to serve our community and purely because of love and because I love the community. I love people; I think that is something that is overflowing"**[Participant 1: Interview 1].**

Discussion

The love that the caregivers have for their community and the devotion that they have towards their neighbours was a very strong motivating factor for them to choose to volunteer as caregivers. They even battled to explain this concept of love that they have for their community. Akintola (2010) had similar findings; he found that the caregivers 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. A key issue in people's decision to volunteer was the decimation of their communities by Aids. Participants made statements to reverse this trend hence their interest in volunteerism (Akintola, 2010). In addition, O'Neill and McKinney (2003) found a number of reasons or motivations as to why people volunteer to become caregivers. The following are some of the things that the caregivers noted as motivations for volunteering as caregivers: they stated that it brings purpose into their lives and that it helps them to develop empathy. Some stated that the whole experience of caregiving brings forth feelings of love and caring and that is why they do it (O'Neill & McKinney, 2003).

4.4.1.2. Altruistic motivation:Motivated by the poverty in the community

This was another altruistic motivator for the caregivers. The caregivers were motivated to volunteer to be caregivers because of the amount of poverty that exists in their community. The caregivers stay in the same area that they work in and grew up in the same area and know and understand the amount of poverty that is around them. The caregivers expressed that what drives them is to uplift their community and make life of the poor people better. The care recipients also appreciate this as they cannot afford to go to any other place for help and they depend on the care workers to help them because people are suffering from poverty.

Participants commented about being motivated by their communities and the need that is there and hence they volunteered to be caregivers. One states the following: "Well what caregiving means for us, it means that we have made it for our community because it's not for us? It means a broadening of our service for the community and to be able to cater for those indigenous people that are not well cared for. Being able to show love, care and support for the community"**[Participant 1: Interview 1].**

Participants felt that because of the poverty they had to take some action. This was expressed explicitly in the following extract: "I chose caregiving because I wanted to help our community because our community is very poor"**[Participant 4: Interview 1].**

Discussion

The caregivers see the need for their services and their services are very essential services. What they provide should be a basic service but in their community it is a very scarce necessity because of the poverty in the community. Poverty is what drives most low socio-economic people to volunteer as they see the lack of support and services for the poor and ill. Akintola (2010) found that caregivers where motivated to volunteer because of the poverty in the community. He found that most care recipients were unemployed, had poor housing, lacked nutritious food and experience many family problems. The study by Akintola (2010) further found that some care recipients did not receive grants, and therefore could not afford food, making it difficult for them to take medication which must be taken with meals (Akintola, 2010). Similarly, according to a study by Mhaule and Ntswane-Lebang (2009) poverty and unemployment has added more stress to ailing individuals and caregivers in the rural areas. Most of the participants were concerned about financial constraints. Most of the households are dependent on the social grant and they had to make a living from it and still try to save some money just in case there is an emergency and they need to transport the ill individual to a health facility (Mhaule&Ntswane-Lebang, 2009).

4.5. Reciprocity

Most of the caregivers in this study were once diagnosed with a serious illness in the past. Some of them were helped by caregivers from the same organisation that they work for now. All of them were very sick at one stage and they were brought back to life by someone that had offered to care for them. For this reason the caregivers were motivated to volunteer as caregivers so that they too can help other people just like they were helped. They felt the need to give back what they have been given.

Participants who participated in this research study were also very ill at some stage of their lives and they were helped by caregivers. During that experience they felt that they had gained enough knowledge on how they could also help other sick people who are in a similar position to the one they were in, the following extract by a participant displays how the whole concept of reciprocity motivated her to volunteer as a caregiver: “I was also helped, so I want to help others. I joined through being a client first”**[Participant 2: Interview 1].**

Discussion

The caregivers have this obligation to give back because they were also given life by someone who cared for them. They felt that it is only fair if they do it as it was also done for them. Similar findings came out in the research by Akintola (2010) that was done in rural KwaZulu Natal. In the research participants saw volunteering as a means to help others in order to attract good things to them. 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. Furthermore, the experience of HIV/AIDS in some volunteers' families created the need to heal old wounds (Akintola, 2010). This seems to be an international phenomenon and similarly,Dupuis, Epp and Smale (2004) found that many caregivers are very grateful and find a lot of personal satisfaction in giving back to those who have also helped them. Some described caregiving as an opportunity to give something back since they have also been previously helped in the past when they were in a similar situation (Dupuis, Epp&Smale, 2004).

One usually finds lay counsellors at the organizations that care for ill people; these counsellors are usually people who underwent a basic short training course on how to go about counselling an individual suffering from an illness. However, in this research study, the participants were not only lay counsellors because of the short informal training that they underwent. The participants in this research study are also peer counsellors as most of them were once in a similar situation at one stage and went through the process of being taken care of and hence they know the experience very well and they know how they overcame that difficult period. Hence, they are peer counsellors because they also talk about their own experiences when they were very ill and they talk to people who are having similar experiences to what they had (Teng, 2012). This gives the care recipient so much hope to have someone who overcame the same challenges that they are currently battling with (Harris and Larsen, 2007).

4.6.Religious duty

The participants also reported that they were motivated by religious reasons.The participants in this research saw it as their Christian duty to volunteer to be caregivers. All of the participants believe that by volunteering to take care of other people who are suffering and cannot look after themselves will bring them a lot of blessings from God because that is the Christian way.

The following extract shows how the participants found that the blessings they receive from God for volunteering as caregivers are worth much more than monetary incentives: "The care recipients always bless you and therefore I myself believe that, you know a blessing is better than R10 or R20 that you would be getting from the client"**[Participant 1: Interview 1].**

A participant expressed how she is encouraged and motivated by church to perform her caregiving duties in the following extract: "Church talk encourages the elderly and the sick that we care for. It also encourages me to do more"**[Participant 2: Interview 1].**

Participants also spoke about how they get blessings by volunteering as caregivers. The following is what one said in regards to the matter of being motivated to volunteer in order to receive blessings: "Being a caregiver and visiting client's homes I come back with a peaceful mind set, with more blessings from the elderly"**[Participant 3: Interview 1].**

Discussion

The caregivers are motivated by their religious beliefs and they feel that as a Christian you must help other people who are in need. The caregivers also believe that by doing well and helping others they will in turn be provided with good things by God. Some believe that because God saved them, it is their duty to repay him by doing God's work. Similar findings were found in a study by Akintola (2010) where it emerged that participants who were religious and regular church attenders, for them volunteering was seen as a fulfilment of their religious teachings and obligations to help others. He further stated that some participants were not volunteering out of a sense of religious obligation but because they felt that a spinoff could be a reciprocal act of blessings from God (Akintola, 2010). In addition, Rodlack and Dlodlo (2010) found that voluntary caregivers were often encouraged by their various churches to participate as caregivers. Their study further states that these caregivers are motivated by their own personal religious beliefs. These religious beliefs are believed to be nurtured in their various churches and these members are usually committed members of the church. They reported that those caregivers who are encouraged by their churches to participate in caregiving activities are greatly appreciated in their respective communities. Furthermore, they reported that churches provide psychological healing and provide encouragement to the sick to not lose hope and think of death before their time (Rodlack&Dlodlo, 2010).

4.7. Career advancement

There was one participant who wants to become a nurse one day. She sees caregiving as a step in the right direction in her ambitions of becoming a professional nurse one day. She stated that she had started her studies to become a professional nurse but she was forced to drop out due to financial constraints. She reported that at that moment she decided to volunteer as a caregiver because it was the closest thing to nursing. She still believes that she will become a nurse and that working as a caregiver will give her more experience.

In the following extract one participant expresses her dream of becoming a professional nurse one day and expresses how she feels that caregiving will give her the necessary experience: “When I finished grade 12 I told myself that I want to become a professional nurse”. “I still want to be a professional nurse one day”**[Participant 3: Interview 1].**

Discussion

There are those who volunteer in order to further their career and eventually get a job that they always wanted. Participant 3's statement above is a perfect example, she wanted to do nursing but couldn't because of lack of finances. She believes caregiving will give her the necessary experiences to one day become a nurse. The caregiver reported that instead of sitting at home and doing nothing, becoming a caregiver would help her move closer to her dream of becoming a nurse, as caregiving would give her the relevant experience that she needs as a nurse. Akintola (2010) found similar results, he found that 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 the vacancies. According to Akintola (2010) a very few caregivers mentioned directly that they were motivated to volunteer as caregivers to advance their careers, but many of them are motivated by it and are subtle in revealing it. The reason that they are subtle is because they fear that they will appear as being selfish and insensitive to the care recipients. Furthermore, most people who volunteer at the care organizations go in with the knowledge that internal vacancies are usually filled by the volunteers who already work for that specific organisation. Many of the community members volunteer in hope that if a vacancy comes up in the organization they will get an opportunity to get a paying job for themselves (Akintola, 2010).

4.8. Theme 4: Coping:

4.8.1. Seeking advice as a coping strategy

Seeking advice was the dominant theme that came up when the participants were asked how they deal with challenging and stressful situations. Seeking advice and support from other people who are seen as more experienced and knowledgeable was one of the most dominant coping strategies used by the caregivers.

Participants expressed that seeking support was what helped them manage their stress. One participant explains this in the following extract: "Look you will never be able to make it without support. There are times that I go and ask for people who are much worthy than me for advice. How do you deal with this, how do you deal with that"**[Participant 1: Interview 1].**

The following extract shows that when the participant was faced with a challenge she consulted with her supervisors and this was a way of getting support for herself from people she though could better deal with the situation: "I bring the challenges to my supervisor and then they go to that home"**[Participant 2: Interview 1].**

The following statement echoes what was said by participant 2 above as the participant states that when she is faced with a difficult situation or challenge, she takes it to the organization and discusses it with her supervisor: "When we find a difficult situation or a challenge, we come to our work centre and report it"**[Participant 4: Interview 1].**

Discussion

The caregivers believe in consulting other people and seeking support with people who can better deal with the problem. At other times, because of the lack of resources, they just have to be patient and let the difficult situation resolve on its own. Brodaty and Donkin (2009) found that support can come in the form of instrumental support, emotional support, and informational support (information and knowledge from both health professionals and from those who have experienced similar situations) (Brodaty&Donkin, 2009). Similarly, Zeegwaard et al. (2013) found that caregivers remain feeling competent even in difficult situations and they do not hesitate to ask for support from the social network (Zeegwaard et al., 2013).According to Uren and Graham (2013) participants in their study found that being able to tell someone about their problems and difficulties freed them of the burden of caregiving. Furthermore the participants considered it as being part of their job to seek someone to confide in and offload their difficulties and hardships. This activity of actively seeking support helped the caregivers to cope much better with the burdens of caregiving (Uren & Graham, 2013). Similarly, Jothana et al. (2010) found that the caregivers who use instrumental support seek active advice and support from their peers or from the people who are close to them e.g. their family members, the caregivers were reported to experience less or no burden at all (Jothana et al., 2010).Furthermore, being part of an organisation, supervision for the participants in this research is part of the territory and hence they get much valued support from it.

4.9. Summary

The caregivers in the research have similar experiences in regards to their caregiving careers. Most of them described encountering both positive and negative caregiving experiences as they volunteer as caregivers. They described feeling appreciated by their clients. But they also experienced uncaring family members of the care recipients and financial constraints to be very challenging in the community. The participants also expressed that they were mostly motivated by altruistic reasons and religious reasons. They reported that love for the community motivated them. They expressed that the poverty in their community motivated them to uplift their people. Religion was also a big motivator for the participants to volunteer as caregivers. The caregivers expressed that when faced with difficult situations they seek advice and support from other people who they deem as worthy to tackle that particular problem. They further expressed that being patient is sometimes the only thing they can do when faced with a difficult situation because of the lack of resources available in the community.

The participants experiences in regards to their working conditions; some found them to be appalling and others found them to beunpleasant but bearable. Alcohol abuse was also described as a problem for the care recipients. Some participants expressed the lack of support that was coming from government and how vital it would be in changing the lives of people in their communities. Some participants expressed that reciprocity was a motivating factor for them to volunteer as caregivers, because most of the participants were once diagnosed with an illness in the past and they were also helped by informal caregivers at some point in their lives, they saw caregiving as an opportunity to give back. Other caregivers saw volunteering as an opportunity for them to advance their careers and use it as a platform to gain more work experience and open doors for formal employment as a professional nurse one day.

5. Chapter Five: Conclusions, Limitations and Recommendations

5.1. Introduction

This chapter concludes the research by summarising the key aims of the research and the findings of the research. The aim of the research was to investigate the experiences of community caregivers who are considered to be of low socio-economic status. The aim was to investigate the challenges that they encounter during caregiving and the type of strategies that they employ in order to cope with these stressful situations. Another big part of the research was to investigate the motivations for the participants to volunteer as caregivers. This was deemed as an important factor as most of the caregivers are poor, but still they choose volunteer work instead of getting a paying job that will contribute positively to their livelihoods. Previous research has focused more on the challenges and coping strategies of the caregivers, but a little research has been done on the motivations of people who volunteer as caregivers.

5.2. Summary of the findings

There were four dominant themes that came out in the research. These themes were the general consensus amongst the caregivers that took part in the research. Theme one was the "experiences", under this theme the participants expressed that they experienced both pleasant and challenging moments. "Appreciation from care recipients" came out quite often from the caregivers; they experienced this as a pleasant moment. They described the care recipients as being very appreciative of their work and service that they provide. The caregivers reported that this showed them that they are doing something positive that makes them very happy and it makes their work worthwhile.

The caregivers also reported experiencing challenging moments. “Uncaring family members” was the biggest challenge that the caregivers came across. They reported that the family members of the care recipients were not supportive and did not show much care to their ailing relatives. They described this as hindering the healing process for the care recipients and only made things worse.

“Financial constraints” was another stressful challenge for the caregivers. The caregivers expressed that at times it was difficult to go to work without a stipend. The caregivers also reported that the care recipients are also struggling as they only get grant money and they can’t even afford food that will help them stay healthy.

Theme two was “challenges”, which looked at alcohol abuse, lack of government support and challenging working conditions. “Alcohol abuse” was another challenging moment that was experienced as stressful by the caregivers. The caregivers expressed a lot of concern in regards to the amount of alcohol that is being used by the care recipients. The caregivers’ express concern around the negative effects that alcohol abuse has on the care recipients’ health; health that is already compromised by a certain illness.

“Challenging working conditions”, some caregivers saw their working conditions as extremely bad. Others saw them as okay, they admitted that they were not the greatest but said that they were still able to work and expressed that they were content with the working conditions.

“Lack of support from government” was another sub-theme that came out in the research. The caregivers had a lot of grievances; they felt that the government could have easily assisted them. The caregivers felt that if the government could make funds for care centres in poor communities, the caregivers would reach many people.

Theme three was “motivation”, under theme three the research looked at what motivated the participants to volunteer as caregivers. Firstly the research looked at “altruistic motivation” which included “motivated by the love for the community”. This is an altruistic motivator for the caregivers, the caregivers reported that the main reason they chose to volunteer as caregivers of the ill was for the love that they had for the community and for the people of the community.

Another “altruistic motivator” that came out in the research was “motivated by the poverty in the community”. The caregivers expressed that what drives them is the need to uplift their community and make life for the poor people better. The caregivers reported that they stay in the same area that they work in and grew up in the same area and know and understand the amount of poverty that exists in their community.

A sub-theme that came out under theme three was that of “religious duty”. The participants saw it as their “religious duty” to volunteer to be caregivers. The participants believe that by volunteering to take care of people who are suffering and cannot look after themselves will bring them blessings from God because that is the Christian way.

“Reciprocity” was another theme that came out in the findings. Since most of the caregivers were once diagnosed with a serious illness in the past and they were also helped and assisted by people who work in care centres and they nursed them back to health. For this reason the participants were motivated to volunteer as caregivers so that they too can help other people just like they were helped.

“Career advancement” was another sub-theme that came out. One of the participants saw caregiving as a step in the right direction in her ambitions of becoming a professional nurse one day. She still believes that she will become a nurse and that working as a caregiver will give her more experience.

Theme four was concerned with the "coping strategies" that the caregivers use when faced with challenging and stressful situations. What came out in regards to coping strategies was "Seeking advice as a coping strategy". Seeking advice and support from other people who are seen as more experienced and knowledgeable was one of the most dominant coping strategies used by the caregivers.

5.3. Implications for future research and Recommendations

The research findings in this current research study are mostly similar to the findings of previous studies that have been done in the area and field of caregiver experiences in South Africa. It has given even more in-depth and detailed subjective accounts of the caregivers' experiences. This has important implications for future research on informal caregivers. The research has shown how the caregivers experience their caring careers, how they deal with challenges that they encounter. Furthermore, the research shows the kinds of things that motivated the participants to volunteer as caregivers. Future research could also look at the qualities that motivate people to volunteer as caregivers, since very limited research has been done in this area. Furthermore, future research could look at what the government can do to assist the informal caregivers from poor communities and also investigate what is stopping government from supporting such vital services. Future research could also investigate what support structures are there to help the caregivers to cope better with the challenges that they encounter. The more research done on the issue, the better the working conditions for informal caregivers will get and the better the chance of poor communities to be afforded some decent care for those who are ill and are neglected by government health care. Future research could also investigate the collectivist nature of South African communities and how communities share social responsibility.

The research recommends that the organizations that use the care workers create support structures and strategies that will better help the caregivers in dealing with challenging and stressful situations. Another recommendation is that the government could play a role in one way or another. If government cannot provide financial support, then they could provide some form of formal training that will equip the caregivers with the necessary skills to help them cope and provide efficient care for the care recipients. Furthermore, another recommendation would be initiating something that will help educate the family members of the care recipients. This platform will help the family members to take better care of their own relatives and this will help to relieve the caregivers of the extra burden.

5.4. Limitations of the Research

The research could have gone even deeper in terms of finding out what motivated the participants to volunteer as caregivers. The research could have had more in-depth outcomes if it found out how the caregivers were raised and the experiences that they went through and how all of this has contributed to the participants volunteering as caregivers.

This research only looked at the caregivers and not the care recipients. It would have been interesting to see the findings had the care recipients been interviewed and get their perspective. It would have shed more light on how the care recipients experience the relationship with the caregivers and this would have helped in terms of showing where the caregivers were getting it right and what they needed to improve in order to continue providing the best care to their clients. This would also have been fruitful for the caregivers as they would now know if they were doing a good job and not burden themselves further by stressing about their performance and focus on other important things.

5.5. Conclusion

In conclusion, this research aimed to look at the subjective experiences of caregivers of the ill. It looked at caregivers who are considered to be part of the low socio-economic status. The research looked at the individual experiences of how the caregivers experienced their jobs, in terms of the challenges and the stressful situations that they encountered. Furthermore the research showed what motivated the participants to volunteer as caregivers. The results showed that the caregivers had both challenging and pleasant moments during caregiving. The appreciation that was showed by the care recipients made caregiving worthwhile for the participants. The results showed that the caregivers had to deal with their fair share of challenges as they were faced with care recipients who abused alcohol, and uncaring family members of the care recipients. Financial constraints and lack of government support added more burden on the caregivers.

The results in this research in regards to motivating factors for the caregivers to volunteer and also the coping strategies that they used were very similar to the findings of previous research. This research recommends that the government support the care centres in these impoverished communities, either financially or in providing training for the caregivers so that they can better cope with the stresses of being a caregiver. The research adds to the body of knowledge, which can inform governmental policies and training in the field of caregiving.

5.6.Personal Reflection

This has been an eye opening experience for me. I personally have always had a lot of admiration for people who volunteer to become caregivers. I have always seen them as performing the ultimate act of selflessness and doing it out of the goodness of their hearts and expecting no incentive is truly amazing. For me this is an area that I have always wanted to research and I was grateful for finally getting the opportunity to do it. I found the individuals who participated in the research to be very strong individuals, individuals who are filled with so much hope for their own future, the future of their community and the future of South Africa. These individuals come from poverty stricken families, and they are still poor but through it all they still find the time to go around the community and taking care of other people instead of going out there and finding a paying job that will help their own families to live a better life. This I found to be the ultimate altruism.

I was fortunate in working with the people from this specific organisation. I expected to encounter a lot of challenges. In terms of finding participants and finding perfect times that would suit everyone. Surprisingly they made time for me and everything went smoothly. The interviews took a long time but it was worth it and it was a truly inspiring experience for me to be in contact with such amazing people.

However, I did encounter a challenging ethical dilemma in which I found myself not knowing what to do. With this dilemma I consulted with my supervisor and we still did not manage to come to a point where we could decide on which action to take. This was a learning experience for me and it showed me how grey the whole area of ethics is in psychology. But I believe I did take the necessary steps in trying to resolve the issue. In future I will be best equipped to deal with a similar situation because I believe that experience is the best teacher.

The best part and the most exciting part was when I went through the data and analysing it for themes. This was exciting because at first when you are faced with these huge chunks of information that at face value seem to have no particular meaning or substance to them but once you start scrutinizing everything, it's amazing what comes out. Furthermore, when you realize that the caregivers actually share so many similarities that I did not instantly pick up when I was doing the interviews because they were phrased in different ways.

The two findings that came as a surprise to me were the alcohol abuse and the uncaring family members. The alcohol abuse was a surprise because as I was reviewing the literature, many studies reported that the caregivers were the ones who were actually abusing alcohol in order to cope with the burdens of caregiving. As I was conducting the interviews, in my mind I was certain that the caregivers were going to report that they use alcohol to reduce stress at times. But this was not the case, alcohol abuse was a concern for the caregivers because the care recipients were the ones abusing it and further compromising their health care. Another finding that came as a surprise to me was the one of uncaring family members. When the participants reported during the interviews that what they battle with most of the time are the uncaring family members of the care recipients. This was an eye opener for me; I come from a very supportive family, so I never thought for once that my own family would leave me to die when I needed them the most. This just made me appreciate the love and care that I receive from my family, not everyone is fortunate enough to have what I have.However, the researcher's positive bias towards the caregivers might have had an impact on the outcomes of the study.

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Appendix A

Interview schedule

1. What made you choose care-giving as a career?
2. How do you experience your working conditions?
3. How do you experience the people that you care for?
4. What are the things that you like about being a caregiver?
5. What are the things that you dislike about being a caregiver?
6. What are the challenges that you encounter during care-giving?
7. How do you deal with challenges during care-giving?
8. What situations cause you stress during care-giving?
9. How do you deal with these stressful situations?
10. What is your highest point of your care-giving career?
11. What did the highest point of your care-giving career mean for you?
12. What is the lowest point of your care-giving career?
13. How did you deal with the lowest point of your care-giving career?
14. In hindsight, had you known what you know now about care-giving; would you still have become a caregiver?

Appendix B

Example of an agreement form for use in conjunction with the *Ethical Standards Research Protocol* - Remember to give participants a signed copy of this agreement (and keep one).

RHODES UNIVERSITY
DEPARTMENT OF PSYCHOLOGY

AGREEMENT BETWEEN STUDENT RESEARCHER AND RESEARCH PARTICIPANT

Updated 26 January 2011

I (participant's name) ______________________ agree to participate in the research project of (researcher's name) ______________________ on (short title / topic of research project).

I understand that:

1. The researcher is a student conducting the research as part of the requirements for a/an (Honours/Master's/PhD) ____________ degree at Rhodes University. The researcher may be contacted on __________ (cell phone) or ____________ (email). The research project has been approved by the relevant ethics committee(s), and is under the supervision of Prof/Dr/Ms/Mr ______________ in the Psychology Department at Rhodes University, who may be contacted on ___________ (office) or ___________ (email).

2. The researcher is interested in (short description of the main focus areas of the research / relationship between variables under investigation).

3. My participation will involve (short description of the nature of participation required and the anticipated duration of this participation).

4. I may be asked to answer questions of a personal nature, but I can choose not to answer any questions about aspects of my life which I am not willing to disclose.

5. I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. *A counselling centre may be contacted for further support on __________ (telephone) - [add this information if there is the slightest risk of distress, embarrassment or offence as a result of participation].*

6. I am free to withdraw from the study at any time - however I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation which I did not originally anticipate.

7. The report on the project may contain information about my personal experiences, attitudes and behaviours, but that the report will be designed in such a way that it will not be possible to be identified by the general reader.

Signed on (Date):

Participant: ______________________ Researcher: ______________________

Appendix C

Rhodes University – Department of Psychology

USE OF TAPE RECORDINGS FOR RESEARCH PURPOSES
–
PERMISSION AND RELEASE FORM

Participant name & contacts (address, phone etc)	
Name of researcher & level of research (Honours/Masters/PhD)	
Brief title of project	
Supervisor	

Declaration

(Please initial/tick blocks next to the relevant statements)

1. The nature of the research and the nature of my participation have been explained to me	verbally	
	in writing	
2. I agree to be interviewed and to allow tape-recordings to be made of the interviews	audiotape	
	videotape	
3. I agree to take part in and to allow tape-recordings to be made.	audiotape	
	videotape	
4. The tape recordings may be transcribed	without conditions	
	only by the researcher	
	by one or more nominated third parties:	
5.1 I have been informed by the researcher that the tape recordings will be erased once the study is complete and the report has been written.		
5.2 OR I give permission for the tape recordings to be retained after the study and for them to utilised for the following purposes and under the following conditions:		

Signatures

Signature of participant		*Date*
Witnessed by researcher		