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MOTIVATIONAL DRIVERS FOR NON-SKILLED KENYAN COMMUNITY HEALTH VOLUNTEERS

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ABSTRACT

Community based health volunteerism view skilled and non-skilled health volunteers as making significant contributions towards improved healthcare for mankind. They are a 'workforce' that has made significant efforts towards delivery of health services at the community level. A cross-sectional and descriptive study was carried out in Nyanza Province of Kenya. Mixed research methods were utilized to derive datum from 261 respondents. Four sampling methods were employed to select the respondents. Variables were selected and subjected to chi square testing to determine their level of significance. The largest proportion of volunteers were providing services in areas of maternal and child health followed by HIV/AIDS and malaria. Drivers that motivate volunteers to keep on providing free services include in-born leadership qualities, fulfilling religious values and serving humanity. Access to incentives such as training, supervision and follow through the support services from various agencies was reported.

Keywords: Community health volunteers, Motivation, Kenya

INTRODUCTION

Over the years, nations have put efforts that seek to improve the wellbeing of its citizens. Notably, the health outcomes in Africa have remained low despite the global and national efforts put in place. According to the Africa Union commission (2008), heath inequities that are unfair and unjust in access to health services remain common. The situation in Kenya has remained depressing, with maternal mortality ratio of 414 per 100,000 live births. In addition, the HIV epidemic has had its toll with an estimated 1.3 million people living with the virus in the country (KAIS, 2007). The World Health Organization (2007) identified six main underlying contradictions towards attaining the Millennium Development Goals (MGDs) and other global initiatives toward improved health.

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These include poor service delivery: inadequate health workforce: limited/ lack of information; inaccessible medical products: vaccines: low financing and poor leadership.

The World Health Organization (2006) indicates that there was a shortfall of human resources workforce by 57 countries out of which 37 were from Sub Saharan African countries. This amounts to a global shortfall of 2.4 million trained health workers including doctors, nurses, mid wives among others cadres. The report notes that although Africa region had 24% disease burden, only 3% of the global health workers workforce were found in Africa. The foregoing called for new innovations that would accelerate progress towards attainment of MDGs among other global initiatives. Community based health volunteerism was one such innovation, which has observed skilled and non-skilled health volunteers make significant contributions towards improved healthcare for people. Some of these volunteers have served their respective communities for many years although high drop-outs have also been registered. A number of policies related to health and development in Kenya have underscored the importance of Community Health Volunteers (CHVs). Examples here include the Economic Recovery Strategy for wealth and Employment Creation (ERS) and the Kenya health sector reforms strategic plan. These initiatives have been taken against the backdrop of inadequate workforce in the health sector.

However, the non-skilled CHVs have over the years filled this gap by providing services to majority of households. The main objective of the study is to explore the motivational drivers that have kept the CHVs inspired in performing various health and development activities. The study sets to explore the nature of voluntary services performed by CHVs and proportion of households served by the nature of services delivered.

RESEARCH METHODOLOGY

The study was a cross-sectional and descriptive study that applied both quantitative and qualitative methods of data collection. The study population covered CHVs in Lower Nyakach division of Nyanza Province, Kenya. The study area has one health facility which serves as the district hospital. It offers both basic health services and primary referral services. The utilization of the health facility is generally poor due to poor infrastructure which has contributed to the disruption between the households and health systems.

Purposive sampling (to select specified characteristics) and stratified sampling were both used. This involved the development of a sampling frame from the register of all CHVs accessed at the divisional administrative office. The sample frame was organized into three stratums; the first comprised of CHVs engaged in food security, economic and education initiatives. The second included CHVs involved in health initiatives while the last constitute CHVs engaged in administrative and religious work. The inclusion of the food security, education, administration and religious volunteer was critical because they were used as vehicles for delivering community based health care interventions; such health education messages, and related needs.

Proportional allocation was applied in the selection of CHVs based on the total number of CHVs in each stratum. Simple random sampling was then utilized where CHVs drawn from each stratum were selected. Households that were benefiting from the services rendered by the CHVs were also sampled for the study. Systematic sampling technique was used to select these households. Using the fisher sampling formula, a total of 261 CHVs were sampled. Besides quantitative methods, two qualitative methods were also used to derive qualitative datum. These were in-depth interview guide and focus group discussion guide. The discussion sessions were moderated by the researchers assisted by two note takers. In addition to note taking, tape recorders were also used.

Quantitative data was analyzed through SPSS which allowed presentation of statistics in frequency tables and graphs. Study population composition was expressed in proportions and rates. Cross

tabulation and chi-square were generated to determine associations of background variables with intermediate and outcome variables. Qualitative data was transcribed and analyzed manually based on themes, sub-themes and categories of responses obtained from each discussion session. The results from the qualitative methodologies were synchronized with the quantitative information in order to explain the conclusions drawn from the data.

RESULTS

The study interviewed 36.9% respondents within the age of 30-44, 22.6% aged 55 years and above; and 12.3% aged 15-29 years. This indicates that most of the non-skilled CHVs fall in the age bracket of 45 years and above. It is noted that more females (53.3%) were interviewed than males (46.7%). Of the 261 respondents that were interviewed, 57.0% were in polygamous marriages, 20.0% in monogamous, 17.0% were widows while 5.0% were single. The nature of services offered by CHVs was numerous. These included giving health education and promoting good health practices in relation to maternal and child health, HIV/AIDS, Malaria prevention and management. Among the tasks carried were promotion of child immunization, de-worming of children, distribution of Insecticide Treated Nets to children under five years, distribution of chlorine for water treatment, offering home based care support, referral of cases to health facilities, helping in home deliveries, encouraging mothers to go for ante-natal and post natal care, and evaluating health status of the community by carrying out health surveys twice yearly. They also maintained household registers for the villages.

Table-1: Length of service by category of work

Length of service in years	Food production	Income	Education	Maternal and Child Health	HIV/AIDS, & Malaria
<1 – 4	22	16	18	46	39
n %	8.4	6.1	6.9	17.6	14.9
5 –10	26	9	29	43	27
n %	10.0	3.4	11.1	16.5	10.3
>10	32	18.0	40	18	48
n %	12.2	14.1	15.3	20.8	18.4
Total	80	43	87	143	114
n %	30.7	16.5	33.3	54.8	43.7

Source: Research data (2010)

There was variation among CHVs in their length of service by the type of services rendered. The largest proportion of CHVs were providing services in areas of maternal and child health (54.8%) followed by HIV/AIDS and malaria (43 %).

Table-2: Distribution of services by gender

Type of service offered	Food security	Income Generation	Education	Maternal and Child Health	HIV/AIDS, & Malaria
Females n	35	17	44	100	75
%	43.8	39.5	50.6	69.9	65.8
Males n	45	26	43	43	39
%	56.3	60.5	49.4	30.1	34.2
Total n	80	43	87	143	114
%	100	100	100	100	100
P value	0.004	0.065	0.000	0.000	0.000

Source: Research data (2010)

From focused group discussions, it was clarified that women see volunteerism as a critical part of a woman's responsibility to the society and an important aspect in building social capital, which is a vehicle for promoting development. The researcher explored reasons why males of younger age brackets were not very active in offering voluntary services in the community and the majority. The respondents justified that in most household's males are the breadwinners and they therefore, spent more time engaging in paid work to fend for their families. Women on the other hand look after their homes and tend to find it easier to spend a few hours in a day on voluntary work. The mean age of CHVs offering food security services was 47, while education had a mean of 45, for mother and child health mean age was 42 and HIV/AIDS and malaria 43. These differences were not statistically significant ($p>0.05$).

The focus groups discussion sessions revealed that the older men have settled in their rural homes and have invested, making it more possible for them to undertake voluntary services. This trend continued into ages 55 and above when males begin to dominate voluntary service, reaching 22% of respondents compared to females 5% females. Male CHVs tend to be leaders in various committees, coordinators of volunteer activities, and administrators in various village structures, such as the bench of village elders. Responses from the focused discussion group sessions revealed that the older males represented the leadership of their community and were viewed as the community advisors. For this reason, they tend to give technical advice to young upcoming change agents in the community. They do this because of the great experience that they have earned over the years.

20 % of those interviewed had served as CHVs for some years since they wanted to bring about change in their community. Among issues mentioned included evidence of processes that culminated in development, growth, improved health status awareness, prevention of conditions / diseases and community education. When asked what made them continue with volunteerism, respondents described that over the years, they had witnessed changes in the well-being of the people they served. These changes included increase in household food production, increased coverage in child immunization, improved quality of education for children, emerging entrepreneur skills and evidence of improved health. The changes taking place resulted in the recognition of CHVs by the community.

Religious values of faith played a major role in motivating the CHVs to provide free service. All the CHVs were of Christian faith but from various denominations, with the largest proportion of volunteers belonging to the African Indigenous Churches (39.1%) followed by the Anglican Church (32%), African Inland Church (20.7%), while the Roman Catholic Church had 17.2%. A proportion of respondents believed that they had in-born leadership qualities that had to be put to use. Among these qualities included ability to coordinate community affairs, in-born hobby, passion for recognition and power to encourage others. 9.5% of those interviewed considered that in-born leadership qualities they possessed had been among the key drivers to the voluntary work they offered to their community.

Respondents viewed access to incentives including training opportunities, acquisition of experience, supervision and follow up by various agencies that engaged directly with CHVs. Apparently, none of the respondents raised the issue of payments in kind as a form of incentive. 73% of CHVs who served for 1- 2 years had received training; 81% of CHVs who served for 3-4 years had been trained. At the same time, 74.7 % of CHVs who served for 5-10 years had been trained. In the subsequent duration category of 16 years and above, over 85% had received training in line with the volunteer services they provided to their community. The longer the years of engagement in community work, the higher the opportunities to access training on maternal child health, HIV/AIDS and Malaria, food security, business skills besides basic management skills cut across a number of fields. Although training had been offered to the non-skilled CHVs, 72.8% had inadequate capacities in delivery of the respective tasks they had been assigned.

Besides training, CHVs saw supervision, and follow up as incentives that kept them on the job. On completing trainings, CHVs developed plans to be implemented over a period of time. The implementation process was supervised by various agencies that had offered the training which was meant to provide on job support and guidance so that knowledge and skills are fastened towards better outcomes. Follow - ups were made to assess the processes that CHVs were undergoing as a form of knowledge management. Although support services in the form of training are provided to CHVs who were involved in food production (77.5%), income generation (88%) and education (88.5%), more efforts were directed towards maternal and child health. Other forms of support service were supervision, which received 83.9 % and 81.6 % of CHVs who performed tasks related to maternal and child health, HIV/AIDS and malaria respectively. Among the agencies that provided such support services included World Vision, Care Kenya etc.

Table-3: Supportive services received by CHVs

Support service	Food production n (%)	Income n (%)	Education n (%)	Maternal and Child Health n (%)	HIV/AIDS, & Malaria n (%)
Training	62(77.5)	38(88.4)	77(88.5)	133(93.0)	105(92.1)
Supportive supervision	65(81.3)	38(88.4)	78(89.7)	120(83.9)	93(81.6)
Follow-up support	53(66.3)	35(81.4)	73(83.9)	114(79.7)	92(80.7)

Source: Research data (2010)

15.2% of CHVs were motivated to continue performing voluntary work because they wanted to give service to humanity. The key issue that emerged was the appreciation of what and how the society had invested in individuals and belief that humanity requires dignified living.

CONCLUSION

Age is a critical motivational driver in community health voluntarism. However, this driver is also pegged on gender roles and the community sanctions on what various age groups are allowed to do. For instance, while elderly volunteers are involved in food security and education, the relatively younger age group is involved in maternal child health, HIV/AIDS and malaria activities. Age does not only interplay in regard to the type of service CHVs offer, but also in the roles that men and women play. Between ages 50-54 years, the gap between males and females narrow as women make up 7% and men 5%, which is illustrative that the more people grow older, the more they are motivated to engage in voluntary work regardless of their sex.

There are more males offering services in the areas of food security and entrepreneurship, while there were more women supporting maternal and child health, HIV/AIDS and malaria. More women are involved in voluntary work than men implying that non-skilled community based voluntary work that fails to recognize the gender role division is less likely to tap on the gender role division as a motivational driver. Perold et al. (2006) depict this as a weakness in volunteerism because there were few men engaged in voluntary services since they perceive volunteerism as women's domain.

The driver behind the many years of service is the desire by of CHVs to bring about change. Among the changes desired include improved household food production and income, increased coverage in child immunization, improved quality of education for children and ability of households to prevent killer diseases. The drive for change for various CHVs is derived from their past unpleasant experiences. Sometimes the desired change is associated with the nature of benefits that the immediate families of the CHVs are likely to attain. It improves the quality of life of the

family and reduces the costs of medical and treatment among others (Kironde and Banjunirwe, 2002). Volunteerism is closely associated with social philanthropy and other studies have associated religious values as sources of motivation (Kironde and Banjunirwe, 2002; Kaseke and Dhemba, 2006). Religious values inspire people to serve humanity and this propelled the urge to give back to the community. Individuals fulfill their inner desire and remain at peace with their creator.

A small proportion of CHVs admitted that they have been motivated to perform free service having discovered that they had in-born leadership qualities that enable them coordinate and influence others to change. It is not always obvious that people will identify and tap their in-born qualities. D'Souza (1995) suggests that in the journey of life, sometimes people's potentials, talents and qualities remain untapped unless they are supported through effective facilitation processes. That access to incentives motivates CHVs to continue giving free services. The incentives include training opportunities for acquisition of knowledge in relation to the specific tasks performed by non-skilled community health volunteers. D'Souza (1995) argues that knowledge as incentive interacts by empowering CHVs to know what and how their tasks can be performed. The elderly CHVs see the opportunity for volunteerism as an incentive that provides them with space to implement additional skills and experiences acquired over the years while in various forms of employment, the relatively young see this an opportunity for mentorship and acquisition of experiences that will accord them future employment opportunities. Perold et al. (2006) observe that the quest by the youth to engage in voluntary service in South Africa is a positive move that has been necessitated by the inability of education systems to equip school leavers with sufficient skills for employment.

A large proportion of non-skilled CHVs suffer from inadequate capacities in areas of skills and knowledge. This is related to inadequate upgrading course occasioned by over concentration of agencies on maternal and child health, HIV/AIDS and malaria, at the expense of food security, which plays a major role in improving the health of households. The challenge of capacity strengthening cuts across a number of Sub Saharan African countries including Malawi and Zimbabwe (Fairley and Gallagher, 2006; and Kaseke and Dhemba, 2006). Absence of cohesion among agencies lead to volunteer services being carried out independently with host governmental agencies, failing to provide focal point support (Fairley and Gallagher, 2006; Perold et al, 2006; and Snider, 1985). The long-term effect of absence of supervision includes feeling of neglect by CHVs hence attrition of poor performance.

Although in most cases non-skilled CHVs do not mention financial support as an incentive that motivates them to perform, however lack of funds frequently disrupts implementation process especially in areas where access to work requires related materials, equipment, and travel expenses among others. There are some health and development agencies that work with non-skilled CHVs to avail access of the required inputs to discharge work. This is experienced when CHVs have to travel from one place to the other, or when they have to purchase items required to perform their work. It is sometimes assumed that CHVs will give their time, expertise, provide for their own transportation and material costs without relying on various health and development agencies, resulting in high attrition of non-skilled CHVs (Fairley and Gallagher, 2006; Perold et al. 2006; Kaseke and Dhemba, 2006).

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