VOLUNTEERING FOR HEALTH SERVICES IN KINTAMPO, GHANA: IN WHOSE INTEREST?

BY

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DECLARATION

I hereby declare that apart from the references to other people's work (s) which have been duly acknowledged, this thesis is the product of my independent research work under the supervision of Professor Kodjo Senah and Dr. Stephen Afranie. I further declare that as far as I am aware, this thesis has not been submitted in part or in whole for the award of any degree in any other university elsewhere.

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DEDICATION

I dedicate this thesis to my beloved mother, ***Vida Abena Nyarkoa*** of blessed memory

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S. A-A

ABSTRACT

To address the challenge of health workers shortage, Ghana like many African countries, uses community volunteers to assist in the provision of certain health services to rural and hard-to-reach communities. However, few studies have been done in the country to ascertain the motivation for volunteering and the retention of these volunteers. Adopting the Homan's Social Exchange Theory as its theoretical perspective, this study examines the motivation for volunteering and the retention of volunteers working on health-related activities at the community level in Ghana. Using a sequential mix-method design, a survey was carried out among 205 volunteers in Kintampo North and South districts. This was followed with twelve (12) In-depth Interviews among health workers and community opinion leaders and two (2) Focus Group Discussion sessions with volunteers. The results reveal that personal interest (32.9%) and community selection of volunteers through community leaders (30.2%) were the main motivation for volunteering and the retention of volunteers. Others were monetary and non-monetary incentives. The Ministry of Health, Ghana Health Service, NGOs and other volunteer user agencies are encouraged to strengthen monetary and non-monetary incentives as key motivation for volunteering and the retention of volunteers. Also, attention should be paid to community selection of volunteers through community leaders since it gives volunteers traditional authorization.

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LIST OF ABBREVIATIONS

BARIDEP-	Brong-Ahafo Rural Integrated Development Programme
CBV-	Community Based Volunteers
CHO-	Community Health Officers
CHPS-	Community-Based Health Planning and Services
CHW-	Community Health Workers
CoHN-	Community Health Network
FGD-	Focus Group Discussions
GSS-	Ghana Statistical Service
IDI-	In-depth Interview
KHRC-	Kintampo Health Research Centre
KNM-	Kintampo North Municipality
KSD-	Kintampo South District
MoH -	Ministry of Health
PRHETIH-	Primary Health Training for Indigenous Healers
PHC-	Primary Health Care
TBAs-	Traditional Birth Attendants
VHW-	Village Health Workers
WHO-	World Health Organization

CHAPTER ONE

Volunteering in Health Care Delivery: A Global Overview

The global shortage of skilled, motivated, and supported health workers is universally acknowledged as a key development challenge. This is because, this shortage is a critical barrier to strengthening health systems and improving the prospects for achieving universal health coverage (WHO, 2006). In 2006, the World Health Organization (WHO) estimated a worldwide shortage of 4.3 million health workers (WHO, 2006). In 2013, WHO again reported that, the shortage has shot up to 7.2 million and it is estimated to go up to 12.9 million by 2035. In this regard, the report warned that, if nothing is done to address the shortage of health workforce now, it would have serious implications for the health of billions of people across all regions of the world (Campbell et al., 2013; WHO, 2013). In view of this, calls for innovative and effective approaches that address the workforce challenge have resulted in many cadre of Community Based volunteers (Spencer, Gunter, & Palmisano, 2010).

Community Based Volunteers (hereinafter CBV) are lay members of communities who work in association with the local health care system in both urban and rural environments. They usually share ethnicity, language, economic status and life experiences with the community members they serve (Spencer, Gunter, & Palmisano, 2010). CBV play a vital role in linking diverse and hard to reach population to health and social service systems. Thus, they serve as a bridge between professional health staff and the community and help communities identify and address their own health needs (Bhattacharyya, 2001; Spencer et al., 2010). In view of this, CBV serve as frontline workers and are increasingly used by Ministries of Health to extend health services to local settings. Their effectiveness has been documented across various disciplines

including Public Health, Nursing, Biomedicine, Social Work, Community Development and the Social Sciences as a whole (Bhattacharyya, 2001; Spencer et al., 2010).

CBV take many forms and are referred to by different names in different countries such as Community Based Volunteers in Central African Republic, Community Health Volunteers in Sudan as well as Health Promoters in Columbia. They may also be Community Social Workers, Traditional Birth Attendants (hereinafter TBAs), Community Midwives, and other health-related persons who live in the community (Spencer et al., 2010). In Ghana, these volunteers are called Community Based Surveillance Volunteers (hereinafter referred to as volunteers). CBV may be government or a Non-Governmental Organizations (NGO) supported volunteers, working from their homes and making home visits to their neighbours (CoHN, 2012). They provide information to health system managers that may otherwise never reach them and encourage health system managers to comprehend and respond to community needs. They conduct health promotion and education activities, provide basic health services for their communities, and/or mobilize communities for health programmes and activities (Bhattacharyya, 2001). In addition to the above, volunteers in Ghana, record vital events such as births, deaths and unusual health events to the health system for the necessary interventions as such they are also seen as community disease surveillance officers.

Volunteering for providing community health and social services has long been in existence with the famous Chinese barefoot doctors of 1950 as pacesetters in this regard. The barefoot doctors lived in the communities they served, focused on disease prevention, whilst combining western and traditional medicines to educate people and provide basic treatment. China's barefoot doctors movement was a major inspiration to the Primary Health Care (PHC) movement leading to the International Conference on PHC in Alma-

Ata, in the former Soviet Republic of Kazakhstan in 1978. The Alma-Ata Declaration emerged as a major milestone of the twentieth century in the field of public health, and it identified PHC as the key to the attainment of the goal of Health for All by the year 2000 (WHO & UNICEF, 1978).

These notwithstanding, motivation of volunteers is still a highly debated issue. This is because, the dynamics of volunteer motivation is important to the success or failure of programmes that require their services. Some universally accepted views suggest that, there exists practically no evidence that volunteerism can be sustained for long periods and community health workers who are generally poor require earnings (Lehmann & Sanders, 2007b). However, in Kintampo, volunteers working with the health system have relatively been retained and their retention has contributed to the success of health programme that requires their services in the area.

The problem

Africa's health workforce has been insufficient and this has been a major constraint to improving health and reducing the burden of disease on the continent (Awases, Gbary, Nyoni, & Chatora, 2004). The shortage of health workers in Africa and other developing countries is particularly acute at the district and community levels (WHO, 2007). In Ghana, in spite of the increase in the number of trained health workers in the past years, there is still inadequate health workers particularly in the rural communities (Pillinger, 2011). This is because of the lack of support and incentives to attract and retain them. There is also the lack of in-depth understanding of the factors that motivate and attract health workers to work at district and community levels (Lehmann & Sanders, 2007; WHO, 2007).

An important dimension of the response to address the health workforce challenge has been a resurgence of the interest of various countries in and attention to CBV programmes. Many developing countries including Ghana are increasing their investment in and implementing large-scale CBV programmes to extend social services and health care to hard-to-reach populations, and to expand coverage of key interventions (WHO & UNICEF, 1978). In Ghana, the Community-based Health Planning and Services (hereinafter CHPS) [1] is one of such programmes, which aim at taking health care to the door-steps of Ghanaians through Community Health Officers (hereinafter CHOs) and volunteers. However, most often than not, the focus has been on training volunteers in order to get the best out of them. On the contrary, training of volunteers alone will not ensure the effectiveness and sustainability of programmes (Naimoli , Frymus, Quain, & Roseman, 2012). There is the need to support and motivate volunteers who most often than not are local people.

In view of this, volunteers in rural communities are supported by the health system and community support groups, such as a Village Development Council or Community Health Committee [2] in the case of CHPS in Ghana (CoHN, 2012). These volunteers are therefore part of the social setting of both the health system and community system and this comes with strengths and weaknesses. On one hand, these volunteers are empowered by belonging to both systems; while on the other hand, they may be uncertain as to where their loyalties and interests lie. Though they may be a social group with one purpose, their interest and reason for volunteering may vary according to the expectations of the benefits and socio-political context of the activity (CoHN, 2012).

[1] CHPS is a primary health care strategy for extending and making quality health services accessible to people in remote communities in Ghana.
[2] Community Health Committee is a component under CHPS. It is usually made up of opinion leaders, selected community members and health staff in the community. Their roles in the community are to manage and guide volunteers and more importantly provide traditional authorization and advocacy to the process.

Therefore, the question which comes up immediately is, in whose interest are these volunteers working? Are they volunteering for themselves, their communities or the health system? To this end, though volunteers extensively complement the health system to extend health services to rural communities in Ghana, few studies that have investigated what motivates them to offer voluntary services have been done among volunteers in the northern regions of Ghana.

In one of the studies in northern Ghana, Dil (2012), found the "community" as the main motivating factor among volunteers. In this regard, they were motivated to volunteer because of the love for their communities. Also, they were found to be selfless because the community selected them. However, there were disincentives such as incorrect community perceptions of volunteers, problems with transportation and equipment, and the lack of payment for ad hoc tasks such as National Immunization Days (Dil, Strachan, Cairncross, Korkor, & Hill, 2012).

In another study, it was found that, volunteers in the Kassena-Nankana East and West Districts of Upper East region, were motivated to volunteer because of the desire to help community members and sick people at the community level. In this study, it was also identified that, incentives such as raincoats, torch lights and wellington boots were the mechanisms used to retain and sustain volunteer activities (Acheampong, 2012).

(Agyeman, 2014) also observed that, popularity, community recognition, and the desire for good health for community members were the main motivations among volunteers in Savelugu in the Northern region of Ghana. However, volunteers found the absence of regular pay and non-monetary rewards such as T-shirts, cutlasses, soap and free medical services as the greatest disincentives.

Whilst motivation of volunteers in the northern regions of Ghana are considerably known, there is a dearth of evidenced-based study on motivation for volunteering and the retention of volunteers in other parts of the country where volunteers are also used. It is against this background that this study sought to investigate the motivation for volunteering and the retention of volunteers in Kintampo North Municipality and South district of the Brong-Ahafo Region of Ghana.

Rationale of the study

Given the enormous contribution of volunteers in health care delivery systems, gaining understanding of volunteer motivations is important in order for health care managers to develop effective volunteer recruitment and retention strategies (Clary, 2004). In Ghana, the results of this study will help the Ministry of Health (MoH), Ghana Health Services (GHS) and other stakeholders in the health sector to further understand motivation among volunteers at the community level in order to retain them. At the study site, the findings will help the health directorates as well as the Kintampo Health Research Centre (KHRC)[3], who extensively utilize the services of these volunteers to retain them.

Better still, research on volunteer motivation and retention will contribute to the existing stock of knowledge that explains why people offer voluntary services and explore the reasons underpinning volunteers' commitment to offer voluntary services. The study will also identify the factors affecting volunteers' satisfaction, experience and their intention to volunteer for future health-related activities.

[3] Kintampo Health Research Centre (KHRC) is one of three field research centres of the Health Research Unit of Ghana Health Services. It is located in Kintampo, Brong-Ahafo Region and conducts public health and biomedical research to improve the health status of less privileged people in the region, Ghana, Africa and the world as a whole.

General objective

The general objective of this study is to examine the motivation for volunteering and the retention of volunteers working on health-related activities at the community level in Ghana.

Specific objectives

1. To find out what motivate volunteers to offer voluntary services.
2. To examine the factors that affect the work of volunteers.
3. To assess work satisfaction among volunteers.
4. To explore the role of community anchor in sustaining volunteerism among volunteers

Operational definition of key concepts

Motivation: factors that influence people to initiate and continue to offer voluntary services.

Factors affecting work: these include the number of years volunteers have worked, how volunteers go for routine work activities, time spent by volunteers to reach the nearest or farthest place of visit and the type of services they provide.

Work satisfaction: the extent to which volunteers have realized their reasons for volunteering.

Community Anchor: Chiefs, elders as well as community opinion leaders.

The next chapter is devoted to literature and theoretical perspective underpinning this study.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL PERSPECTIVE

The role of volunteers in the delivery of health services in various parts of the world has been documented in several works by various scholars and researchers. In view of this, this chapter begins with a review of literature on motivation among health Volunteers in different countries and the sociocultural context. This review highlights the key findings in the various studies. This chapter also examines some key theories of volunteers' motivation in order to situate this study in a theoretical perspective.

In Sri Lanka, over 100,000 Community Health Volunteers work part-time carrying out preventive health and health promotion activities in their communities. The main motivator among these volunteers is the influence of Buddhism which is a predominant religion. In Buddhism, the merit acquired through good deeds is an important and a central concept and this is said to have influenced the willingness of health volunteers to give voluntary services (Walt, 1990).

The large population of literate young men and women in Sri Lanka is attributed to the policy of free education for all which has been implemented since 1940s. In view of this, those in the relatively remote areas have at least eleven or more years of education just as their counterparts in developed countries. By the 1970s the levels of education in Sri Lanka had risen tremendously in the villages as well as the age of marriage. Young men and women after school are confronted with the problem of unemployment and few higher education opportunities. The demand for job vacancies on vocational courses and in higher education was higher than the supply and in such circumstances volunteering for health activities at the local level was attractive. For many unmarried young women volunteer work gave them an opportunity to move about in the community (Walt, 1990). In a

nutshell, it was concluded that, a combination of Buddhism and enlightenment which is easily identified with education and relatively autonomous female population were the major motivators among volunteers thus voluntary work was seen as a legitimate activity for the large middle class women in Sri Lanka (Walt, 1990).

In Nepal, female Community Health Volunteers were introduced into the health system in 1988 as a part of the Health for All by 2000 Movement. Their role has been considered very important in reducing maternal mortality rate (assisting in referrals) and under-five mortality in the past years. Their voluntary involvement in health service delivery has also been identified as one of the most cost-effective strategies for addressing human resource crisis and increasing access to health care especially among the rural segment of the country. Their motivation and retention has been identified as important factors for successfully sustaining and extending PHC services to local communities (Swechhya & Kamaraj, 2014).

In effect, the single and most crucial question then is what motivates volunteers in Nepal? To this end, two components of motivation were identified, that is, the desire to volunteer and motivation to continue as a volunteer. The motivation to be a volunteer is premised on personal goals like the desire to serve. These rural women are often opportunity deprived so they see volunteering as a medium to fulfil their personal goals of working. Volunteer work is, therefore, perceived as useful and valuable as it helps them achieve some personal fulfilment. Volunteerism is also perceived as an obligatory duty by some women due to pressure from the society and other family members. This kind of volunteering is therefore not considered as volunteerism in the true sense of the word. Forced volunteerism is probably one of the reasons for dissatisfaction among some of the volunteers in Nepal (Swechhya & Kamaraj, 2014).

On the other hand, the sense of reciprocity is considered as a motivation to continue as a volunteer in Nepal. For volunteers, community membership is expressed in moral obligation to pay back what the community has given to them. This represents a strong inherent motivation to continue offering voluntary services. The reward of service also emerged as motivation to continue voluntary work. Some volunteers expressed sympathy towards the sick and relate their recovery to their voluntary service as compensation. The satisfaction gained is considered as motivation to continue offering volunteer services. In addition, volunteerism is considered a spiritual duty. This symbolizes connections of volunteerism with deeply rooted religious beliefs as various religions promote the concept of selfless service as espoused in Buddhism in the case of Sri Lanka. Volunteerism is also regarded as a means of personal growth which is highly valued. In view of this, volunteers in Nepal have the vision to preserve wisdom in their family through inheritance of voluntary service. Lastly, volunteering fulfils social needs of identity and belongingness which is highly treasured by women, especially in the context of a patriarchal society like Nepal where women's individuality is dominated by family or husband's name (Swechhya & Kamaraj, 2014; Walt, 1990).

Likewise, volunteers' affiliation with the health system in Colombia is usually, though not always, a status symbol that generates power and respect for volunteers within the community. Volunteers in Colombia ranked having influence in the community as the most important reward influencing their work performance. This influence made the volunteers opinion leaders on a variety of issues of concern to the community. The fact that influence in the community is highly valued by volunteers adds a dimension to their roles that few other health workers, particularly those based in institutions, can share (Bhattacharyya, 2001; Robinson & Larsen, 1990). Identification badges, uniform, and

relationships with "outsiders," (Health researchers, donors, health managers etc) as in the case of Kitwe, Zambia, can increase the status of health volunteers in a community.

In Kenya, it was observed 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. In effect, volunteers offer voluntary services because they want to bring about changes in their communities. Indeed, the volunteers contend that, they continue to volunteer because they have witnessed changes in the well-being of the people they serve. These changes included increase in household food production, increased coverage in child immunization, improved quality of education for children, emerging entrepreneurial skills and evidence of improved health. The changes taking place resulted in high recognition of Volunteers by the community (Ochieng et al., 2012).

Four levels of motivation were identified among health volunteers in Tanzania. They include individual, family, community and organizational levels. At the individual level, volunteer apply knowledge gained to their own problems and those of their families and communities. Families and communities provide moral, financial, and material support, including service fees, supplies, money for transportation. At the organizational level, government and its development partners provide motivation in the form of stipends, potential employment, materials, training, and supervision but irregular remuneration and supplies discourage volunteers. Although, the volunteers in Tanzania work without receiving salary, their motivation to volunteer is largely intrinsic and egoistic rather than altruistic which looks at volunteerism as willingness to help others (Greenspan et al., 2013).

Motivations among volunteers in Malawi are not too different from the cases of Sri-Lanka, Columbia, Nepal and Kenya. In Malawi, the desire to help others and the notion of

assisting God in caring for the underprivileged were seen by Community Care Givers as the reasons for volunteering (Mkandawire & Muula, 2005). A notable observation about motivation among volunteers in Malawi is that some of them are motivated to help others because of their previous unfavourable life experiences such as growing up in orphanages. Just like the case of Columbia, the volunteers were also motivated by the fact that they are seen as part of the opinion leaders in their communities and also serve as focal persons to organizations who want to work in their communities(Bhattacharyya, 2001; Mkandawire & Muula, 2005; Robinson & Larsen, 1990).

In Ghana it was found that, volunteers in the Kassena-Nankana East and West Districts of Upper East region, were motivated to volunteer because of the desire to help community members and sick people at the community level. In this study, it was also identified that, incentives such as raincoats, torch lights and wellington boots were the mechanisms used to retain and sustain volunteer activities (Acheampong, 2012). This finding affirms the fact that volunteers in this context value these items as such they are likely to continue volunteering the more they receive them. It is therefore important for volunteer user agencies to strategically incorporate some reasonable amount of incentives into their programmes in order to get the best out of the volunteers.

In another study, Dil (2012), found the "community" as the main motivating factor among volunteers in the northern region of Ghana. In this regard, they were motivated to volunteer because of the love for their communities. Also, they were found to be selfless because the community selected them. However, there were disincentives such as unfavourable community perceptions of volunteers, problems with transportation and equipment and the lack of payment for ad-hoc tasks such as National Immunization Days (Dil et al., 2012). As regard unfavourable perception, volunteers may be perceive by

community members as salaried workers because of their association with the health system. This perception is likely to demotivate volunteers to offer their services selflessly.

Adopting qualitative research methods, (Agyeman, 2014) also observed that popularity, community recognition, and the desire for good health for community members were the main motivation for volunteering and the retention of volunteers in Savelugu in the Northern Region of Ghana. Similar to what Dil (2012) found, these volunteers found the absence of regular pay and non-monetary rewards such as T-shirts, cutlasses, soap and free medical services as the greatest disincentives. This means that, volunteers in this area expect some form of monetary and non-monetary incentives from the health system and other user agencies. The question of whether there are volunteers in the true sense of the word comes up here because these volunteers are likely to quit their services if the benefits they expect are not forthcoming.

The qualitative research method used by Dil (2012) and (Agyeman, 2014) generated rich and detailed data that contributed to the in-depth understanding of the volunteers' motivation in the study areas. This notwithstanding, the qualitative research approach of investigating does not enable us to identify the common or general incentives that facilitate the motivation and retention of the volunteers. The result of these studies are therefore less generalizable. Hence the use of mixed method adopted by this study.

In sum, the review has shown that extensive research has been done on community volunteer's motivation in Africa and other developing countries where volunteers are mostly used to extend health services to hard-to-reach communities. This notwithstanding, studies on volunteer motivation and retention in Ghana have been concentrated in the Northern regions. This means that knowledge on motivation for volunteering and the retention of volunteers in other parts of the country is lacking, though volunteers are also

used in these areas for health service after CHPS was adopted as a national PHC policy. Also, these studies either used quantitative or qualitative research approach. It therefore important to know what motivates and facilitate the retention of these volunteers in other parts of Ghana using both quantitative and qualitative research approaches. In addition, this study will situate volunteers' motivation in a theoretical perspective to explain why volunteers offer services. In view this, it is worthy to broadly review some theories of volunteer motivation before zeroing down to the theory adopted by this study.

Theories of Volunteer Motivation

Various theories explains the underlying reasons for helping behaviours. A traditional way of understanding volunteers motivation is based on the principles of altruism or selflessness (Phillips, 1982; Rehberg, 2005). In this regard, it is envisaged that individual's primary motive for offering voluntary services is the desire to assist others. However, contrary to the selfless principles of motivation, volunteers may also offer voluntary services to directly or indirectly benefit themselves and/or their relatives. This type of service often offers opportunities for volunteers' own siblings and other family members (Silverberg, Ellis, Backman, & Backman, 1999). In UK, it was found that individuals engage in voluntary services for their own personal gains. This means that the primary reason for volunteering was not altruistic but rather to meet the needs of the volunteer and /or family (Shibli, 1999).

Subsequently, volunteer motivation has also been explained from different perspectives. The Unidimensional Model of Motivation argues that, volunteers are motivated by both altruistic and egoistic motives (Cnaan & Goldberg-Glen, 1991). On the other hand, the two-dimensional model argues that, the altruistic and egoistic motives are distinct(Frisch & Gerrard, 1981). The egoistic motives are related to the attainment of tangible rewards

such as career-related benefits. Volunteers motivated by egoistic motives engage in volunteer service to improve their own welfare. However, individuals motivated by altruistic motives engage in volunteerism with the purpose of improving the welfare of others. Similarly, extrinsic and intrinsic theories of volunteer motivation are also two-dimensional. In effect, intrinsic motivation is inherently satisfying and volunteers with this type of motivation engage in volunteerism because of inherent satisfaction (Finkelstien, 2009). Activities that are extrinsically motivated, however, are performed because of the external outcome that they yield.

The three-dimensional models of motivations divide volunteer motivation into altruistic, material and social dimensions. Largely, researchers have accepted the three categories and their contents as justification for volunteer motivation. Altruistic motives emphasize the importance of concern for others while material motives are derived from the desire for material rewards (Widjaja, 2010). Social motives also appeal to social perception as motivating factors. Examples of the social motivators are prestige and recognition. The question that arises here is, can a fine line be drawn among material and social motives and egoistic motives? On the part of the volunteer, the expected social and material benefits are egoistic since the aim of the volunteer in this regard is to improve his or her own welfare. Therefore, the attempt to draw a distinction between the two is just a matter of semantics.

The Functional Motivation Theory also known as Multi-Dimensional Model, analyses a broader range of volunteer motivation. The theory is based on two basic principles: (a) that individuals engage in purposeful activities to fulfil certain goals and (b) that individuals perform the same activities to serve different psychological functions (G. Clary et al., 1998). The underlying principle here is that volunteers engage in volunteerism because it fulfils certain psychological needs. In view of this, volunteers who may be engaged in the

same activities may have different reasons or motives for doing so. The theory implies that individuals will begin and continue to volunteer as long as the activity matches and fulfils the individual's motivational concerns (Clary & Snyder, 1999).

The functional motivation theory or the Multi-Dimensional Model identified six broad functions served by volunteering which falls under the following categories such as value, understanding, social, carrier, protective and enhancement. The value type of motivation is related to the opportunities to express one's values associated with altruistic and humanitarian concerns for others. The understanding motive deals with opportunities for new learning experiences, to exercise one's knowledge, skills and abilities. The social factors of volunteer motivation is about the opportunities to be with one's friends or to engage in an activity viewed favourably important by others. Also, the career is about the experiences that may be obtained from participation in volunteer work. Other function that volunteerism serve, is protective, thus reducing guilt over being more fortunate than others and addressing one's own personal problems. Finally, the enhancement function is to satisfy the ego for growth and development (Clary et al., 1998).

Another principle of volunteer motivation is Abraham Maslow's Hierarchy of Needs theory. In this context, it is argued that, volunteers have needs that are met through activities that best satisfies those needs. As Maslow postulated, motivation is driven by the existence of unsatisfied needs (Maslow, 1943; Neher, 1991). The five levels of needs are survival needs (food, cloth, shelter), safety needs (the need to be protected), love, affection, belonging needs, esteem needs (status within a set up) and finally self-actualization needs (personal growth and renewal). It is important to note that, esteem needs may be classified as internal or external. Internal esteem needs are related to self-esteem and achievement. In effect, volunteers with these kind of motivation are affiliated with duties that are very task orientated, where volunteers work to benefit others.

External esteem needs are those that relate to social status and recognition and these are usually met through leadership roles. Also, volunteers who are motivated by social needs are looking for experiences that will allow them to interact with others. Their motivation is based on the need to develop friendships, to belong to some group or organization and the need to give and receive love.

Finally, Clary et al. (1998) suggested that the extent to which the volunteering experiences fulfil these functions relates to satisfaction with volunteer activities. This is in line with the argument that there is a linkage between volunteer satisfaction, volunteer motivations and actual experience (Farrell, Johnston, & Twynam, 1998). The theoretical basis for this linkage has been drawn from consumer behaviour and social exchange literature which contends that an individual's satisfaction results from a comparison between the rewards and cost of an experience relative to expectation (Blau, 1964; Homans, 1961). Consumers tend to purchase a product or participate in a service based on their previous satisfying experiences (Farrell et al., 1998). This is also in consonance with the success proposition of the rational exchange theory which states that the more often an action is followed by a reward, the more likely a person will repeat the behaviour (Blau, 1964; Homans, 1961). That is, if volunteers are satisfied and their motivational needs are met, then they would likely come back to volunteer in future.

Theoretical perspective

Based on the above review of the theories of volunteer motivation, the study adopted the Social Exchange Theory as its theoretical perspective. This is because, in all the theories of volunteer motivation explained above, individuals who engage in volunteerism are motivated to act on the basis of rational considerations. This implies that, volunteers

weigh the consequences of alternative lines of conduct in terms of the turnover they are likely to generate.

The Social Exchange Theory was formally advanced between the late 1950s and early 1960s in the work of sociologists George Homans and Peter Blau (Blau, 1964; Homans, 1958, 1961). Homans and Blau portray individuals as strategic actors who use the resources they have at their disposal in an effort to optimize their rewards. Thus, they contend that individuals are motivated to act not on the basis of tradition, unconscious drives or some type of structural imperative, but rather on the basis of rational considerations: namely, weighing the consequences of alternative lines of conduct in terms of the profit they will likely generate (Blau, 1964; Homans, 1958, 1961).

The exchange framework is built upon the combination of the central tenets of behaviourism and elementary economics where human behaviour is envisaged as a function of its pay-off. The framework is primarily concerned with the factors that mediate the formation, maintenance, and breakdown of exchange relationships and the dynamics within them. Embedded within the exchange framework are core assumptions about the nature of individuals and about the nature of relationships (Homans, 1961). For the purpose of this study, George Homan's first three core propositions of human behaviour in formal or informal interaction were adopted.

The Stimulus Proposition states that if the previous occurrence of a particular stimulus has been the occasion on which an individual's action has been rewarded, then the more similar the current stimulus is to the past one, the more likely the person is to repeat the action. This is followed by the Success Proposition which states that the more often an action is followed by a reward, the more likely a person will repeat the behaviour. Lastly, the Value Proposition states that, the more valuable a particular reward is to a person, the

more often he will perform a behaviour so rewarded. Individuals are rational beings and within the limitations of the information that they possess, they calculate rewards and costs and consider alternatives before acting.

Volunteers in the study could be volunteering because there are good enough evidence to show that they will receive benefits and rewards. For example, volunteers in the study area have been rewarded in their previous volunteering activities. Some of the personal benefits volunteers have received include, honorarium (monetary incentives), rain coats, bicycles and T-Shirts (Kirkwood et al., 2010; Kirkwood et al., 2013; Manu, 2012). Also, volunteers at the study site may be volunteering because stakeholders who engage them, pay monetary compensation. For example volunteers are given allowance for extra duties during national programmes such as National Immunization Day. Though these amounts may be relatively meagre, the volunteers show much appreciation for them.

However, it is important to note that, not all volunteers in the study site could be volunteering because of material benefits. Some could be offering voluntary services because of the desire and the need to help community members. This is particularly so because other factors such as the social structure has the power to influence human behaviour. In spite of this, the Social Exchange Theory is still relevant to this study because, whatever the motive for volunteering is, it is largely the outcome of some rational considerations.

The next chapter is also dedicated to a review of literature on important PHC programmes in Ghana that used community based volunteers.

CHAPTER THREE

VOLUNTEERS IN PRIMARY HEALTH PROGRAMMES IN GHANA

Introduction

The history of extending health services to rural communities in Ghana pre-dates the Alma Ata conference on PHC in1978. In this regard, Ghana has used volunteers in various PHC programmes to increase access to health services in rural communities since 1970. This chapter therefore seeks to review the historical trends of community volunteering in Ghana paying attention to the nature and role of Volunteers in such programmes. In effect, this chapter starts by discussing the political economy of Ghana to provide the overarching context within which the concept of health volunteers emerged.

Volunteers in Primary Health care Programmes in Ghana

A little over a decade after independence, the Ghanaian economy and social conditions changed for the worse. Confronted with the problems of balance of payments deficit, rising unemployment and increasing levels of crime and smuggling, Ghana became a challenging and unattractive place for it Citizens to live and work. In view of this, several newly independent countries in Africa took advantage of the country's woes and hired Ghanaian professionals to assist in their development. Teachers, doctors and other health professionals, administrators, and lawyers migrated to Uganda, Botswana, Nigeria, and Zambia (Bump, 2006; Dzorgbo, 2001; Senah, 1989).

The deteriorating social and economic downslide got worsened by the middle of 1970s because of successive unsuccessful civilian and military regimes and continued in 1980s. The country therefore experienced dramatic negative growth rates, hyperinflation, food shortages, massive unemployment and deterioration of infrastructure in the area of transportation and communication networks. The economic decline in turn weakened the health and social welfare systems (Dzorgbo, 2001; Senah, 1989). The economic and social

downturn ushered in a period of heightened migration that continues today. As a results, most Ghanaians migrated to Nigeria at an estimated rate of 300 people per day to find work in the booming oil economy. Though most of them were unskilled or semiskilled, they were complemented by a significant number of skilled professionals working as doctors, engineers, surveyors, pharmacists, teachers, and nurses (Bump, 2006). The exodus of doctors, nurses and other health professionals affected the effort of governments to extend health services to the rural communities. To address this challenge, various PHC programs were implemented and volunteers were very instrumental in this regard (Senah, 1989).

In Ghana, the initial practical step toward extending health services to rural communities with the support of volunteers was the setting up of the Danfa pilot project in 1970 (Senah, 1989; Twumasi, 2005). To improve the health and welfare of the rural population, the project established among other things, health centres to provide basic health services. In order to accomplish this, the project relied on indigenous village volunteers to support the trained/professional health centre workers in the provision of basic health services. These volunteers were recruited and trained by the project to become Village Health Workers (hereinafter VHW) in their own communities. Other trained volunteers were TBAs and Health Education Assistants (Moore et al., 1979; Neumann, Prince, Gilbert, & Lourie, 1972).

The VHW were trained to recognize basic health problems, give routine care, and make referrals. They were also trained on how to carry out education on health and sanitation as well as Family Planning. In effect, their basic role was the provision of basic health services to community members who experienced routine health problems between visits by representatives of the conventional health team. TBAs were also trained to perform safer deliveries, monitor women during prenatal period and to recognize and appropriately

refer high risk women and complications. Lastly, Health education assistants were also trained on basic techniques of health education. All these trained volunteers eventually became valuable resources for their communities (Moore et al., 1979; Neumann et al., 1972).

Drawing on the experience and lessons from the Danfa Project, the Brong-Ahafo Rural Integrated Development Programme (hereinafter BARIDEP) started in 1975. BARIDEP aimed at achieving good health through community involvement and developing a PHC strategy for Ghana (Asante, 1979; Konadu, 2008; Senah, 1989; Twumasi, 2005). Like the Danfa project, volunteers were selected and trained to become VHW working in their own communities. The volunteers carried out health education and special projects (such as sanitation projects) under the supervision of government employed health professionals based in Kintampo. Utilization of these volunteers enabled the physicians to spend more time on clinical work. In effect, the volunteers assisted health professionals in solving local health problems. Subsequently, the BARIDEP experiences, failures, and achievements were used to start the Primary Health Care Programme in Ghana. (Asante, 1979; Senah, 1989; Twumasi, 2005).

Using evidence from the Danfa and BARIDEP research projects, the Ministry of Health adopted VHW system as part of the PHC strategy in 1978. However, the VHW system was abandoned in the 1980s because, it was confronted with organizational, resource, training, monitoring and supervision challenges (Nyonator, Awoonor-Williams, Phillips, Jones, & Miller, 2005). Due to the failure of the VHW system, the desire by government to implement other volunteer systems waned until UNICEF proposed an approach to volunteer services known as the Bamako Initiative. The Bamako Initiative was adopted by African health ministers in 1987 in Bamako, Mali, to implement strategies to increase the availability of essential drugs and other healthcare services for sub-Saharan Africans. In

Ghana, the Initiative was promoted as a model for addressing weaknesses in previous volunteer systems, while maintaining reliance on volunteer health providers (Ofori-Adjei, Amoa, & Adjei, 1990; Ofosu-Amaah, Fassin, & Gentilini, 1989). In this project, community volunteers were trained to sell essential drugs to the members of their communities. However, the challenge with this project was that, some volunteers did not return the proceeds from the sale of drugs but kept them for personal use primarily because the community failed to support them (van der Geest, 1992).

Another PHC model which involved community volunteers is the Primary Health Training for Indigenous Healers (hereinafter PRHETIH) programme in Techiman, Ghana. PRHETIH is an off-shoot of a research conducted by an Anthropologist called Dennis M. Warren on Bono disease concept and strategies. The programme was inaugurated 1979 and supported by the Ministry of Health to increase the biomedical knowledge and skills of traditional healers who volunteered to participate in the programme. Also, the programme was designed to foster closer cooperation and understanding between Traditional Medicine Practitioners and Biomedical Practitioners (Akhtar, 1987; Ariës, Joosten, Wegdam, & Van Der Geest, 2007; Warren, Bova, Tregoning, & Kliewer, 1982). Subsequently, PRHETIH succeeded in establishing a relationship between Ministry of Health and Traditional Healers Association as well as various categories of indigenous healers. The indigenous healers who volunteered were mainly TBAs, herbalists and traditional priest/priestess. These volunteers willingly refer cases they could not treat themselves to the hospital because of the relationship they have with the hospital (Ariës et al., 2007; Warren et al., 1982). This notwithstanding, the programme was faced some challenges that eventually led to its collapse.

Also, as part of efforts to revive volunteer programmes, the Navrongo experiment known as Community Health and Family Planning Project was launched in 1994 by the Ministry

of Health in Ghana. Among other strategies, the project aimed at using under-utilized social resources of community organization, chieftaincy, lineage and social networks to enhance volunteer services (Nazzar, Phillips, Asobayire, Aglah, & Binka, 1995; F. K. Nyonator, Awoonor-Williams, Phillips, Jones, & Miller, 2005). This new approach was developed by discussing volunteer activities in previous PHC programmes with community leaders. These discussions elicited their opinion on why the volunteer systems were unsuccessful, and developed a consensus on new directions for mobilizing volunteer support (Nazzar et al., 1995).

The Navrongo volunteer workers were known in the local parlance as *Yezura Zenna*, meaning a "person who is in charge of the wellbeing of the community". *Yezura Zenna* were young men and women who were recruited by community leaders on the basis of their commitment to community work. The volunteers served as a link between the project and traditional system of government. The Navrongo experiment was generally successful and generated official interest in replicating the experiment in all districts of Ghana (Nazzar et al., 1995). The key difference between volunteers in Bamako Initiative and the Navrongo experiment is that, volunteers in the Navrongo experiment were closely linked with existing traditional groups rather than independent drug salesmen serving individuals in the case of the Bamako Initiative.

The Community Health and Family Planning Project was renamed as CHPS and adopted in 1999 as a national PHC initiative for scaling up the Navrongo experiment. Aimed at extending health services to rural and deprived communities, CHPS became one of the health sector components of the national poverty reduction strategy (Awoonor-Williams et al., 2004; Binka et al., 2009; Nyonator et al., 2005). Under the CHPS framework, volunteers supports Community Health Officers in extending health service to rural communities in Ghana. The CHPS as the national PHC strategy, has harmonized volunteer

schemes in vertical programmes that were unsustainable and established mechanisms for the decentralization of health care (Nyonator, Awoonor-Williams, Phillips, Jones, & Miller, 2003).

Volunteers in the CHPS receive two-weeks of training on primary health care, hygiene, and treatment of minor ailments, family planning, sexually transmitted infections and other endemic diseases. This is done to prepare them adequately for community activities in their respective communities. These volunteers after the training return to their communities to check on children and mothers who are ill or pregnant and to educate villagers about health, hygiene, and sanitation (NHRC, 2001). Community-related issues are taken to the chief, elders who work in collaboration with the Village Health Committee. The volunteers are thus very important in the implementation of the CHPS and extending primary health care in Ghana.

Challenges of volunteers in PHC programmes in Ghana

The challenges facing volunteers are similar to those affecting PHC in general. The principle of selecting community members and training them to carry out basic health care tasks in their own community appear to be excellent. However, many challenges arise in the implementation of this strategy.

One of these challenges is the ambiguity that characterizes the position of the volunteers and the questions that arises on their motivation to volunteer. Some of these questions include, do they stand for their community or represent the interest of the government embodied in the nearby health institution? Will they be staying in their community or do they consider their training a useful stepping stone toward employment outside the village? These and other questions were the reason for setting this study. For example the idea of voluntary community participation in health care delivery in the CHPS appears to

be unclear. I view of this, volunteers expect at least some remuneration from the health system for working (Binka et al., 2009).

This brings us to the challenge of remuneration among volunteers in PHC programmes in Ghana. It is argued that volunteers who work in deprived communities with poor standard of living expects remuneration. However, the following questions always come up: Should they be paid and by who? Or should they work on a voluntary basis? The answers to these questions also depends on how the position of volunteers is viewed by themselves as well as the community (van der Geest, 1992). This explains why most volunteer programmes have been vertical in nature; that is different programmes that run with designated budget for a specific period of time. In this regard, once donor funds for projects run out, volunteers on the project go into extinction. In Ghana, the CHPS has not been given a nationwide coverage because of the lack of political will to scale it up coupled with the problem of erratic donor funding (Nyonator et al., 2003; Nyonator et al., 2005).

Lack of professional supervision and logistical support are other challenges to the efficient functioning of Volunteers in PHC programmes in Ghana. Without professional supervision and material supplies, volunteers feel frustrated and unable to carry out their tasks. It is particularly inconvenient if they do not receive regular supply of work materials. These volunteers feel their trustworthiness is harmed if they cannot even perform their routine activities of detection and referral of cases. As a consequence, community members barely turn to volunteers on any health issues.

Conclusion

In spite of the above challenges, volunteers play a key role in PHC at the local level in Ghana. They inspire their communities to utilize health service available at the community level. However a successful implementation of volunteer system would require dedication

and hard work from the Ghana Health Service at all levels, as well as communities themselves.

Followed by this chapter is a description of the site where this study was conducted.

CHAPTER FOUR

PROFILE OF THE STUDY AREA

Introduction

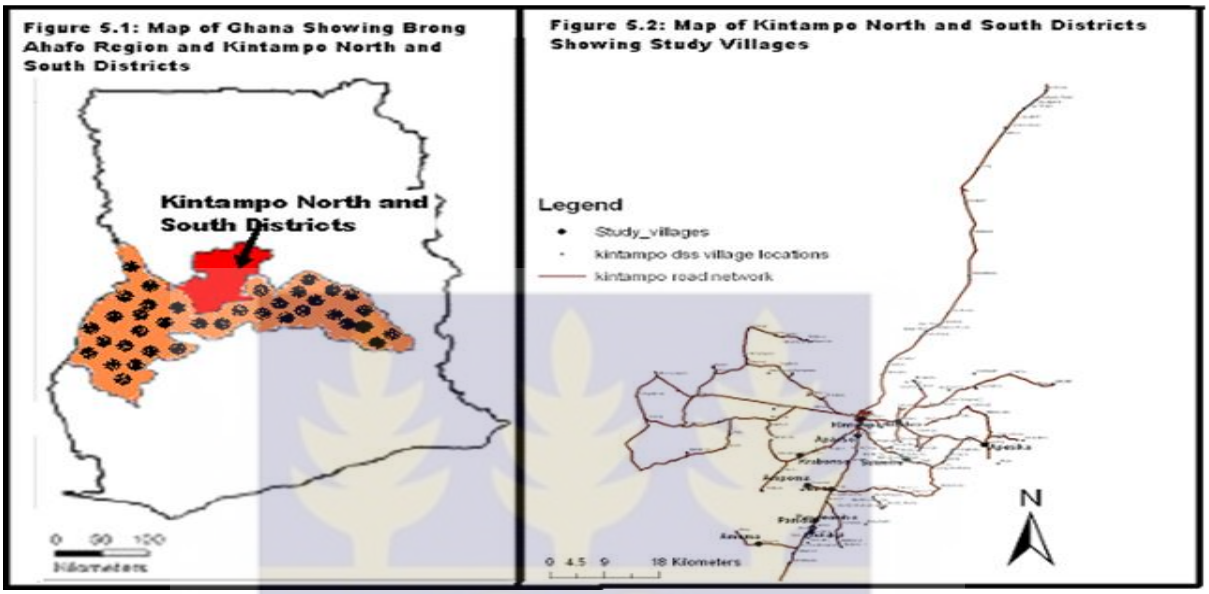
Durkheim argues that, environmental and social structures are largely responsible for the way people behave or act. According to him, though these structures are external to the individuals, they have powerful influence on human behaviour. This chapter therefore, describes the environmental and socio-cultural characteristics of the study site to understand the context within which people volunteer. It is also necessary because, it set a background for an appreciation of the cosmology of the people in area and the need for people to volunteer to address the problems that confront them. The features described include location and rainfall pattern, population and settlement, major economic activities, agriculture and markets. Others are the types of health facilities and the epidemiology, traditional set-up, ethnicity, religion and education status as well as the kinship, values and taboo systems of the study site. Lastly, the chapter further describes the type of festivals and tourist attraction, water and electricity supply as well as law enforcement.

Study location and rainfall pattern

The study site is made up of two political administrative districts. They are located the Brong Ahafo Region of Ghana within the forest-savannah, transitional ecological zone. Altogether, by road, the two districts are about 130km away from Sunyani (the regional capital) and 429km from Accra (the national capital). They are bounded to the north by the Northern Region, to the east by Atebubu and Nkoranza districts, to the south by Techiman District and to the west by Wenchi and Tain districts. The study site covers an area of 6,621.34 $km^{2.}$ The area experiences mean monthly temperatures in the range of 18^0C to 38^0C and rainfall averaging 1,400mm-1,800mm per annum. Also, there are two defined

seasons: rainy season between April and October each year when malaria transmission peaks and a dry season from November to March each year (GSS, 2014a, 2014b).

Figure 1: Map showing the location of study site



Population and settlement

The total population of the study area is approximately 176,480 inhabitants living within 161 communities. The total population is about 4.6% of the total population of the Brong Ahafo Region. Settlements are mainly concentrated in the southern part of the districts and along the main trunk road linking Kintampo to the Northern Region. The population is slightly urban than rural (GSS, 2014a, 2014b). In this context, some community members assist in linking the rural dwellers to the local health services. These volunteer are therefore, seen as the foot soldiers and community disease surveillance officers of the health system.

Major Economic Activities

The economy of the study area can be described as purely agrarian in that most of the residents are farmers. Between 60% and 90% of the population is engaged in agriculture and its related activities as their main economic activity.

The remaining 10% are distributed among commerce, industry and services. Agriculture being the major economic activity constitutes the main source of household income in the area. The major food crops produced in the area are yam, maize, cowpea, cassava, rice, plantain, egushie, groundnut and beans. Cashew, mango, tomatoes, onions, water melon, garden eggs and soya beans have the potential to increase the incomes of farmers. Despite the efforts of the farmers, frequent bush-fires, high cost of agriculture inputs, inadequate extension services, prevalence of pests and diseases, inadequate access to credit and poor market prices and market facilities account for the low yield of farm produce in the area (GSS, 2014a, 2014b). There are weekly markets at Kintampo on Wednesdays, Jema on Tuesdays, Babatorkuma on Sundays, Dawadawa and Gulumpe on Fridays and New Longoro on Saturdays. All communities come to these markets to sell or buy their needed goods. Apart from Kintampo and Babatorkuma, which have well-constructed markets, there are no other well-constructed markets in the study site (GSS, 2014a, 2014b). These market days are important to volunteers and the health system as a whole because, most of the people do not go to farms on these days. In view of this, the CHPS compound in the study site usually schedule their clinics on these days to maximize Out-Patients Attendance. Volunteers also take advantage of these days to organize community members for health education and other health related activities

Health

There are 20 CHPS compounds (10 in KNM and KSD respectively), 7 health centres (4 in KNM and 3 in KSD) and 2 referral hospitals (that is, 1 in each district). There are 4 private hospitals and 2 maternity homes (that is, 1 in KNM and 1 in KSD). The 2 referral hospitals are headed by medical officers. The health centres are managed by medical assistants. Where there are no medical assistants, the place in taken care of by midwives. The CHPS compounds are also managed by CHOs who live in the community. Health

service is largely accessible due to the presence of the CHO in the various communities. In fact, there is at least more than one CHO in most of the CHPS compounds at the study site. Accessibility to health care is also enhanced by the presence and activities of KHRC at the study site. Residents who willingly participate in some of the research projects of KHRC enjoy some free medical service. Children who are enrolled are sometimes registered for free with the National Health Insurance Authority. Some of the projects also provide vehicles for referral services during emergency. In this regard, volunteers serve as contact persons who assist in making the referrals. The districts are entirely under the Demographic Surveillance System of KHRC which provides information on the population dynamics such as births, deaths and migration based on 6 months updates. Volunteers significantly contribute in recording some of these vital events. All compounds have been given numbers and digitized for easy identification of individuals in their homes. The study area is endemic in terms of malaria transmission with a parasite prevalence of more than 50% among children less than 10 years of age. Malaria transmission occurs perennially and the major vectors are Anopheles gambiae and Anopheles funestus with slightly more than a quarter of children under five using bed nets. Studies carried out among children less than five years of age in the area showed that children on the average could suffer up to seven episodes of malaria in a year (Osei-Kwakye et al., 2013).

Traditional political set-up, religion and education

There are two main traditional paramountcies in the study area. These are the Nkrwanzamanhene and the Momanhene paramountcies. Each of these paramountcies have divisional chiefs under them. The ethnicity of the study area is heterogeneous with the Mo and Nkoranza being the custodians of the land. There are however, a large proportion of northern ethnic groups that form the third force at the study site not forgetting other Akan,

Ewe, Ga and others. In terms of religion, Christians dominate, comprising 62.2% of the total population and the Muslim Community 29.6%. This is largely due to immigration of settler farmers from the north who are mostly Muslims. Traditional religion still has a place in the study area and is practiced by 8.2% of the population. More than a half of the population (60.7%) in the study area are literates. However, there are more non-literate females (45.8%) than non-literate males (32.6%)(GSS, 2014a, 2014b).

Kinship, Values and Taboos

Both the extended and nuclear family systems exist at the study area. While the Nkoranza practise matrilineal system of inheritance, the Mo practise patrilineal system. Taboo systems in the study area vary from one ethnic group to another. Whilst the Mo forbids farming on Fridays, the Nkoranza forbid such activity on Tuesdays. The Mo also believe that an individual who sets bushfire will die when he gets to Old Longoro (the traditional headquarters of Mo) unless he goes through some spiritual purification. Another taboo enforced is the rearing of black goats. Thus, any black goat that gets to the Mo Land is slaughtered to pacify the gods. Some of these are structures put in place to regulate human behaviour and protect the environment. As explained earlier, the health system takes advantage of the days that community members do not go to their farms to carry out health activities in the communities. These are the days volunteers also use for home visit to do health education and other health related activities.

Festivals and tourist attraction

Festivals celebrated in the study area include the Yam and Bush Burning festivals by the Mo, Nkyefie festival of the Bono, Damba festival of the Dagomba and Gonja, Munufie festival by the Nkoranza and Krubi festival by the Wangara settlers in Kintampo. The study area is unique in tourist attractions. Tourist attractions include the Kintampo

Waterfalls along the Kintampo-Tamale road, the Fulla Falls at Yabraso, which is about eight kilometres from Kintampo, along the New Longaro road, and Nante Waterfalls at Nante, along the Techiman-Kumasi road and Chirehin Waterfalls at Chirehin. Another interesting place for tourists to visit is the burial ground of World War II British Military officers who died in Kintampo. Also, the study area is located at the geographical centre of Ghana and a wall has be erected around the spot. Other sites include the Bosomoa Forest Reserve with its flora and fauna, the Slave market, night lamp at Kunsu and Caves at Jema, Kokuma, Chirehin. Also, there is an alligator pond at Amoma (GSS, 2014a, 2014b).

Water and Electricity Supply

The sources of water in the study area are streams, rivers and other water bodies. This situation has changed because, over the years, community development projects have added bore holes and hand-dug wells to these water bodies. The construction of water-providing facilities is sometimes sponsored by NGOs through the Ministry of Local Government and Rural Development and the Community Water and Sanitation Project or individual households. The situation is different in Kintampo. Since 2001 the German Government through the German Technical Cooperation has established a water supply system in Kintampo. Kintampo North and South were connected to the national electricity grid in November, 1992. Electricity supply to the area is supervised by the Volta River Authority/ Northern Electricity Department. Schools, hospitals and health facilities, government department and KHRC basically rely on the electricity for their operations. It is interesting to note that, the current erratic electricity supply is having a toll on the reporting of unusual health events and referral activities of volunteers since they rely on mobile phone calls to get in contact with health workers and drivers of public transport during emergency. When there is power outage volunteers have to wait or travel long distance to charge their phones in Kintampo or Jema that is if they have power supply

Law Enforcement

The police are key players in law enforcement activities in Ghana. The police in KNM and KSD have their headquarters in Kintampo and Jema respectively. Both KNM and KSD are directly under the Wenchi Police Divisional Command which also comes under the headquarters in Sunyani, the Regional capital of the Brong Ahafo Region. The following units exist to facilitate law enforcement. They include The Criminal Investigations Department, Domestic Violence and Victims Support Unit and Motor Traffic and Transport Unit.

The study area has a Magistrate's court. Disputes are settled in line with the dictates of laid down legal processes and procedures. The role of traditional rulers in the enforcement of laws cannot be ruled out. Due to modernity, their roles have seen some drastic changes. Nonetheless, they are still an important stakeholder in the enforcement of law and order. Some civil matters are settled by the community chiefs; those that are beyond their powers as the custom of the area have spelt out are settled by the paramount chief. A party which is not satisfied with the outcome of the settlement of a dispute may make an appeal at the court of the Paramount Chief. Mention must also be made that all ethnic groups from northern Ghana have their leaders in all the communities. They also play similar roles in law enforcement.

Conclusion

The discussion on the social structure in this chapter provided ethnographic insight into the study site. Though the focus of the study is on the motivation and retention among volunteers, a description of the study area situated the study in the sociocultural and environmental context within which people volunteer. Key sociocultural factors that facilitate the work of volunteers are the markets and forbidden days for farming. Volunteers take advantage of these days to do home visits. Also volunteers assist in

linking residents to the health system since about half of the people live in rural communities.

The next chapter presents the research methods used for this study.

CHAPTER FIVE

RESEARCH METHODS

Introduction and study design

This chapter presents methods of data collection and procedures used for carrying out this study. This is because, the success of a research project is greatly enhanced when the study design or plan of work is well stated and elaborated. Having accomplished this, the steps necessary for writing the research project and successfully executing it becomes easier to identify and organize (Kumekpor, 2002). For the purpose of this study a mixed method study design was adopted. Mixed methods involve combining quantitative and qualitative research methods to generate new knowledge (Stange, Crabtree, & Miller, 2006). The primary advantage of using both quantitative and qualitative research methods is that, they provide different perspectives and usually complement each other. Also, both methods used together, provides variations in data collection which leads to greater validity (Creswell & Tashakkori, 2007).

Mixed method can involve either concurrent or sequential use of quantitative and qualitative methods (Stange et al., 2006). This study was sequenced, beginning with the quantitative method. The quantitative method was followed up with qualitative method in order to better understand and explain the quantitative results. Also, this was done to reveal other information not previously anticipated by the researchers.

Quantitative approach

A cross-sectional survey was conducted among the respondents. Cross-sectional survey collects data to make inferences about a population of interest at one point in time (IWH, 2009). This study investigated the factors that facilitate the retention of volunteers that offer voluntary health services at the local level at the time of data collection. In this

context, this approach helped in the collection of data on different variables to see how they might relate with the reasons why people volunteer. The cross-sectional study design enabled us to identify the common incentives that motivate the volunteers at the study site.

Study Population and Sampling Frame

Volunteers in the Kintampo North Municipality (hereinafter KNM) and Kintampo South District (hereinafter KSD) were the main respondents for the quantitative approach of the study. Altogether, there were approximately 410 volunteers in the study site distributed across 161 communities. There were 226 of them in the KNM and 184 in KSD. These listings were pooled together and used as the sampling frame.

Sample Size and Sampling Technique

In all, 205 respondents were selected for the cross-sectional survey. Out of the 205 respondents, 113 of them were selected from KNM and 92 from KSD. Respondents were stratified or grouped into districts and randomly selected. Fifty percent of the total number of volunteers in each district were selected. The sampling techniques used, helped to ensure that respondents in each district within the study population were adequately represented in the study sample. Also, these techniques were used because, in a cross-sectional study such as this, important subgroups of people may have different views or life experiences or work-related behaviours. Without representation from all the subgroups, the results could be inaccurate or bias (Kumekpor, 2002).

Qualitative approach

Qualitative methods were used to explore important themes such as male dominance among volunteers which emanated from the survey to better understand and explain the results. This is because, the survey results may not sufficiently provide the human motivation behind certain preferences and behaviours. Therefore, the qualitative research approach provided the researcher with the perspectives of the respondents on their

volunteering experiences. Also, this approach helped to explore and understand the mental processes underlying their voluntary behaviours. Despite claims that qualitative approach is unscientific, it does satisfy some of the key aims of science that is, description and understanding of phenomenon. The preliminary findings of the survey were used to generate thematic areas together with other areas of interest and were explored further using In-depth Interviews (hereinafter IDI) and Focus Group Discussions (hereinafter FGD).

In-depth interviews

In-depth interviewing is a qualitative data collection technique used for conducting intensive interviews with individuals to explore their perspectives on a particular idea, program, or situation. In-depth interviews are useful for collecting detailed information about a person's thoughts and behaviors or to explore new issues (Boyce & Neale, 2006; Kumekpor, 2002). This is because, respondents can answer questions in as much details as they want. Also, more valid information about respondents attitudes, values and opinion can be obtained, particularly how the respondents explain and contextualize issues. Further, like focus groups, the researcher can adjust questions and probe further during the process of interviewing.

In this study, IDIs were conducted in 4 communities (2 from KNM and KSD respectively). Respondents were opinion leaders, Health staff at the CHPS compound and public health officials at the health directorates in the study site. Community opinion leaders (chiefs, assemblymen and a Unit Committee Chairman) were interviewed to explore the role of the community in motivating CBV. Interviewing them was very important because they are influential and their decisions shape opinions in local communities. At the health directorate, Directors of Health Services, a Public Health Nurse and a Disease Control Officer who double as CBV coordinator were interviewed to

further understand motivation among CBV. CHOs and a Health Assistant at the CHPS compound were interviewed because they work directly with CBV and understand their experience as volunteers.

For the purpose of this study, a total of 12 IDIs were conducted. One (1) was conducted with a Chief, 2 with assemblymen and 1 with a Unit Committee Chairman. Others include 2 IDI with Directors of health services, 1 with a Disease control Officer, 1 with a Public Health Nurse, 3 with CHOs and 1 with a Health Assistant.

Picture 1: IDI with a Chief

Picture 2: IDI with a CHO

Focus Group Discussions

The goal of understanding human behaviour may require more than one data collection technique and FGD is one of them. FGD is important for gathering information about the way people behave and the motivations that underlie these behaviours. This is because, FGD allows for the expression of views, opinions and counter-opinions on attitudes, beliefs and practices. It also enables the researcher to note and identify minority and majority opinions of specific issues(Kumekpor, 2002). Based on the outcome of the survey, 15 volunteers who took part in the survey were purposively selected for FGDs. Out of the 15 volunteers, 9 were selected from KSD and 6 from KNM. In each focus

group were discussants who said they were satisfied as well as those who indicated they were dissatisfied. The two category of respondents were put together to understand the diversity in their experiences and preferences.

Table 1: Summary of methods and respondents used to for the study

Issues	Methods/Tools	Respondents
Motivation to volunteer to offer services	Questionnaire, FGD and IDI	CBVs, Health Administrators, CHPS staff and Community opinion leaders
Factors that affect the work of volunteers	Questionnaire, FGD and IDI	CBVs, Health Administrators, CHPS staff and Community opinion leaders
Volunteers work Satisfaction	Questionnaire, FGD and IDI	CBVs, Health Administrators, CHPS staff and Community opinion leaders
Role of community anchor in sustaining volunteerism among volunteers	FGD and IDI	Health Administrators, CHPS staff and Community opinion leaders

Ethical Considerations

Ethical clearance was obtained from the Institutional Ethics Committee of KHRC where data was collected. All field assistants were trained on confidentiality and participants were assured that data would be used for the intended purpose. Written Informed Consent Forms were obtained from each participant of the survey, FGDs and IDIs. Consent forms were read in English or in the common local language (Twi). In the case where the respondent was non-literate, the Consent form was read aloud to the participant in the presence of a literate witness who was not part of the research team. Consent was obtained through a signature or thumbprint. In the case of the FGD and IDI, during the consent process, participants were made aware that they will be digitally recorded, and the recording device was only turned on once consent was obtained. Participation was voluntary and respondents were duly informed about the likely benefits and risks associated with the study (see appendixes 5-7). Respondents were not compensated for their time taken by the researcher. However, they were assured that the information they

will provide, will help GHS and other stake holders to understand and know how best to motivate and retain the volunteers. For respondents who travelled from their community for the FGD, a token was provided to cater for lunch and transportation.

Reflections and challenges from the Field

Generally, respondents were happy to participate in this study. In fact most of them, including health administrators, and opinion leaders willingly shared their experiences and personal challenges, especially during the FGD and IDI. Respondents had independent views and they were not afraid to share their experiences. There was the tendency for respondents to passionately and vividly share their experiences (either good or bad).

However, like most research projects, this study also had some challenges. At the beginning of the survey, it was difficult getting respondents to interview at first time visits because most of the volunteers were farmers and leave for their farms very early in the morning. In this regard, respondents were targeted for interviews on market days when most of them do not go to farm. This strategy was used to schedule IDIs with community opinion leaders. It was also difficult reaching out to respondents in communities with unmotorable roads and poor telephone network coverage. Respondents in this category were targeted for interviews on their visit to the nearby communities on market days.

Data collection process, management and analysis

Field assistants were recruited and trained to support data collection for the survey. The field staff were experienced and trained data collectors of KHRC. Field assistance were trained on how to ask questions to avoid inconsistencies in the process of asking the questions. During the training, survey questions were read out, explained and translated into Twi which is the common language spoken at the study site.

All completed questionnaires were manually checked for completeness and logged for easy access. Independent double data entry with verification was carried out in Microsoft SQL. Quantitative data were analysed using Stata 12 (College Station, Texas, 7845, USA). The data were presented in tables and graphs. Descriptive statistics such as proportions were used to summarize categorical and binary variables, whilst means were used to summarise quantitative variables.

On the other hand, all FGDs and IDIs were audio-recorded and transcribed verbatim. Records of happenings during interview sessions was kept. This was incorporated into the analysis to enhance interpretation of data. Interview transcripts were imported into Nvivo 8. Major themes of interest were developed taking into consideration the objectives of the study. The data were summarised according to the themes and presented as narratives to complement the quantitative findings.

Picture 3: Training field staff for Data Collection

Picture 4: On the field for data collection

Limitations of the study

As explained earlier, interviewers had to rephrase and translate questions into other languages where respondents do not understand English or Twi. The process of rephrasing and translation could compromise the import of the questions and responses. Also, this is likely to affect the quality of some of the responses.

It was also realized that, some of the respondents gave socially desirable responses to questions investigating especially their motivation for voluntary services. Perhaps, these respondents felt that they could be perceived as opportunists if they had mention anything contrary to the generally held beliefs that, people volunteer for services because of their desire to help others.

Notwithstanding these limitations, the outcome of this study provides insight into the behaviour of volunteers at the study site.

The next chapter is dedicated to data presentation and analysis.

CHAPTER SIX

DATA PRESENTATION AND ANALYSIS

Introduction

This chapter presents and analyses data collected from the field of study. The data are analysed in line with the objectives of the study which generally sought to examine motivation for retention among volunteers in carrying out health services at the local level in Ghana. As indicated in chapter one, the specific objectives of this study are to *determine why people become volunteers, to examine the factors that affects the work of volunteers and to assess volunteers work satisfaction. Finally, the study explored the role of community anchor in sustaining volunteerism among volunteers.* As part of examining the factors that affect motivation among volunteers, their socio-demographic characteristics were also analysed.

SOCIO-DEMOGRAPIC CHARACTERISTICS OF RESPONDENTS

In every research project, personal characteristics play an important role in how respondents express their views on issues. In view of this, respondents' characteristics namely, age, gender, education, marital status, religion, ethnicity and socioeconomic status were analysed in this section.

Age of respondents

Age is an important characteristic in understanding the views of people about a particular phenomenon. This is because the stage in a person's life affects one's predisposition and decision to act (Funes, 1999). Also, studies have shown that different age groups have different value systems that impact on aspects of their social behaviour (McLennan & Birch, 2008). It is against this background that the age groups of respondents were analysed.

The data showed that the volunteers in the study site, cut across the different age groups with most (40.5%) of them being 50 years and above. This finding gives credence to the fact that, in all voluntary works, there are different age groups of people participating but the difference may be in the reasons for participation (E. G. Clary & Snyder, 1991). Most of the volunteers are 50 years and above possibly because, people who are below this age may be looking for paid jobs. In this regard, people below the age of 50 years who volunteer are likely to be volunteering for opportunities to enhance their well-being. On the other hand, volunteers of 50 years and above are likely to be volunteering with social motives; for example the desire to help others (E. G. Clary & Snyder, 1999).

Below is a table showing the distribution of age groups of respondents.

Table 2: Age groups of respondents

Age groups	Number of respondents	Percentage (%)
20-24	10	4.9
25-29	16	7.8
30-34	25	12.2
35-39	26	12.7
40-44	24	11.7
45-49	21	10.2
50 and above	83	40.5
Total	205	100

Source: Field survey, December, 2014.

Gender of respondents

Gender is an important variable which affects any social or economic phenomenon in every society. This is because society has ascribed roles to individuals based on their sex. Gender roles as a product of social interaction give individuals' cues about what sort of behaviour is expected of them and volunteering behaviour is not an exception (Assimeng, 1999; Dolphyne, 1991; Nukunya, 2003). Hence, gender is analysed to describe the gender characteristics of volunteers in this study. The data revealed that, 84.9% of respondents were males. This is expected since within the study site, males are mostly household

heads/gate keepers and are more likely to take volunteering responsibility than women who are subordinates to men. Situating it in a broader context, the Ghanaian society is still largely patriarchal, where men continue to dominate in most spheres of life (Nukunya, 2003; Oppong, 1973; Oppong & Abu, 1987). This is congruent with the *dominant status model*, which emphasizes less participation for minorities/marginalized because of their less prevalent social positions in a sociocultural context (Lemon, Palisi, & Jacobson, 1972).

Also, women are not likely to volunteer because of their gender roles within the sociocultural arrangements of the study site. Women are responsible for all household chores such as cooking and cleaning as well as taking care of their husbands and children. In view of this, women do not have much time to engage in pro-social behaviours such as volunteering for community health services.

Furthermore, there are more male than female volunteers because of the nature of the activities volunteers are expected to engage in. Some of these activities include frequent home visits and community mobilization for health activities such as national immunizations. These activities are seen as very tedious since sometimes the volunteers are required to travel long distances to work. This finding is further elaborated by a discussant during an FGD session with volunteers.

"……I take care of four communities, one is about four kilometers away and I walk. In view of this, it is difficult for a woman to walk for about four kilometers carrying medicine. A woman is not as strong as a man and so a lot of them are not able to volunteer" (FGD with volunteers, KSD).

The implication of this finding is that, the sex of volunteers involved in voluntary programmes is largely determined by the nature of the work and the gender roles involved.

For example, contrary to the finding in this study, a similar study in Malawi showed that all volunteers were females. This is because, volunteers were required to visit the sick at the hospital or home and assist with household chores such as sweeping, bathing the patients and helping out with cooking. These roles are generally female oriented within the sociocultural arrangement of Malawi (Mkandawire & Muula, 2005). Similarly, in Kenya, it was observed that, volunteers are mainly women because, they see volunteerism as a critical part of a woman's responsibility to the society (Ochieng et al., 2012). Also, in Nepal, volunteers are females because, they assist in referring pregnant women in labour (Swechhya & Kamaraj (2014).

Educational background of respondents

Education is an important factor that affects people's attitudes and their understanding of any social phenomenon. In this regard, the educational status of people influences their decision to act or take responsibility. It therefore becomes imperative to know the educational background of the respondents. The data show that, the majority (59%) of the respondents have had middle or junior high school education. This is followed by 32.7% of respondents who have been to technical, commercial or senior high schools.

This finding is consistent with demographic trends at the study site, since most of the respondents for this study were males and are likely to have acquired basic school education. Research has shown that, a higher percentage of females have no education, as compared to males at the study site. This disparity in gender becomes more apparent as one climbs the academic ladder, with less females making it to junior and senior high schools. This is explained by teenage pregnancy and the sociocultural arrangement that prefer males education to females (Owusu-Agyei et al., 2012).

Also, the majority of respondents have had primary school education and above because to be a volunteer one should be able to read and write. Those who have been to secondary

school education and beyond might be looking for lucrative jobs. The response below summarizes this finding:

"Mostly, we select those who can read and write so that, they will be able to put down information for us" (IDI with a Public Health Nurse).

Contrary to the selection criteria, 2% of volunteers have no formal education. This was explained in the response captured below at an IDI session with a Disease Control Officer.

"Preferably, we need someone who can read and write. But where there is nobody in the community who can read and write and is willing to do the job, we encourage lay persons to volunteer. But what they do is that, when an event occurs, they take the recording book to someone in the community who can read and write or when the health worker visits the community he/she will do the necessary entries"

The table below shows the educational background of respondents.

Table 3: Educational background of respondents

Educational background	**Number of respondents**	**Percentage (%)**
Middle school/Junior High School	121	59.0
Technical /Commercial/Senior High School	67	32.6
University	5	2.4
Primary	4	2.0
Polytechnics/Nursing /Teacher Training	4	2.0
No formal education	4	2.0
Total	**205**	**100**

Source: Field survey, December, 2014.

Marital Status of respondents

Marriage is an important social institution that shapes the attitudes and behaviour of people. This is because married people are regarded as more responsible and matured and this affects their decisions to act. It is therefore important to know the marital status of volunteers in the study area.

The data show that, the majority (76.6%) of respondents were married. This is possible because, in Ghana and for that matter the study site, married people are regarded as responsible and capable of taking up positions such as a community volunteer. As studies have shown, it is only when a person is married, that he/she is taken seriously in social deliberations (Assimeng, 1999; Nukunya, 2003). Volunteers at the study site, are engaged in community mobilization and health education. In view of this, being married is more likely to enhance the acceptance of volunteers in the performance of their duties.

However, this finding is contrary to evidence from a similar study in Columbia, where 60.7% of the volunteers were unmarried (Walt, 1990).

The table below shows the marital status of respondents at the study site.

Table 4: Marital status of respondents

Marital Status	Number of respondents	Percentage (%)
Married	157	76.6
Living together	13	6.3
Widow	5	2.4
Divorced/Separated	8	3.9
Single	22	10.7
Total	**205**	**100.00**

Source: Field survey, December, 2014.

Religious background of volunteers

Beliefs, religious activity and social networks play an important role in increasing volunteering among individuals. Putman and Campbell (2010) heightened religion as a key predictor of volunteerism. They argue that churches, synagogues and mosques are places that encourage volunteerism and introduce individuals to religious and secular service. Also, these places of worship provide social ties that make it likely for an individual to respond to a request to volunteer (Putnam & Campbell, 2012). The data show that, the majority (69.8%) of the respondents were Christians followed by 23.4% of them who were Muslims. Volunteers who are Christians are more likely to volunteer because of

their religious principles which encourages services to others. Christians are also motivated to offer voluntary service because, there is the hope of receiving rewards in heaven for good deeds. There is also a strong ethic of volunteerism in Islam. Islam encourages Muslims to demonstrate their faith by offering voluntary services to make the world a better place.

This finding is supported by evidence from similar studies among volunteers in Sri Lanka. The study identified that volunteerism is a visible feature in Sri Lanka because of Buddhism. This is because merit gained through good deeds is a central concept or tenet in Buddhism and this encourages Buddhists to volunteer. Also, Community Health Volunteers in Nepal, who are predominately Buddhist and Hindus see volunteerism as a spiritual duty which they consider as a way to attain religious advantage (Walt, 1990).

The table below shows religious background of respondents.

Table 5: Religious background of respondents

Religious background	**Number of respondents**	**Percentage (%)**
Christian	143	69.8
Muslim	48	23.4
No religion	6	2.9
Traditional African, spiritualist	5	2.4
Other	3	1.5
Total	**205**	**100.00**

Source: Field survey, December, 2014.

Ethnic background of respondents

Ethnicity is an important concept in everyday life. This is because members of ethnic groups are bound together by a number of commonalities such as history, language, culture and religion (Assimeng, 1999; Nukunya, 2003). Ethnicity therefore shapes the behaviour and the way people interact. In view of this, ethnicity is analysed to know the ethnic distribution of volunteers and to explain how it helps or constrains voluntary work in the study area.

The data show that 29.8% of the respondents were Akan, followed by 16.6% of Mo. These are the two dominant ethnic groups in the study area and are likely to be more among the volunteers. The rest of the respondents belong to other ethnic groups especially from northern Ghana. This is so because, the study site shares borders with the northern parts of Ghana.

In a multi-ethnic set-up such as the study area, ethnicity is relevant for effective volunteer work. In this regard, volunteers are effective when they belong to the same ethnic group with the people in their work communities. The reason being that volunteers are required to interact with community members and volunteers who share culture and language with community members are likely to be more effective in the performance of their duties. For instance, during health education and community mobilization, volunteers who speak the same language with the people will be effective in passing on the health information.

Socio-economic status of respondents

The socio-economic status of people influences their decision and motivation to offer voluntary services. In this regard, research has shown that, people with high socioeconomic status are more likely to volunteer than people with low socioeconomic status (Evans & Saxton, 2005). In view of this, socioeconomic status of respondents is analysed to understand the living standards of volunteers in the study site.

Socioeconomic status is measured based on ownership of durable household assets of the respondents. This measure is considered to be a better or more valid reflection of socioeconomic status than monetary income, since they capture long-term wealth and cover both monetary and non-monetary wealth (Rutstein & Johnson, 2004). Also, household assets were used as a measure because, respondents may be uncomfortable or unwilling to truthfully report their actual income and/or their monetary wealth.

Respondents may also struggle to remember all of their possible sources of income (Fry, Firestone, & Chakraborty, 2014).

In this study, socioeconomic status was derived by using Principal Components Analysis for household assets. This method was used to summarize the household assets based on their relative importance and weighted score. The items included radio, television, satellite TV, computers, video deck/VCD/DVD, telephone (fixed line), mobile phone, refrigerator, bicycle, motorcycle, cupboard/wardrobe, electric fan, gas/electric cooker, private car, chicken or ducks, cattle, sheep/goats and pigs. For instance, respondents with a satellite TV, refrigerator, gas/electric cooker and a motorcycle are likely to be wealthier than respondents with mobile phones and bicycles.

The analyses of the data revealed an even distribution of respondents across the five categories. This implies that volunteers in the study site share similar socioeconomic status. This is because most of the volunteers were mainly farmers and work as volunteers on part-time As a results, volunteers felt the need to support each other by volunteering because they share common features that bind them together as one people. This finding is in consonance with the socioeconomic dynamics of the area since apart from those who live in peri-urban towns of Kintampo and Jema, the rest of the population are largely rural and share similar socioeconomic status. The results is also in keeping with the description of community-based volunteers as people who usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve.

The table below show the socioeconomic of respondents.

Table 6: Socioeconomic status of respondents

Socioeconomic status	No. of respondents	Percentage (%)
Poorest	41	20.00
Second	41	20.00
Third	41	20.00
Fourth	41	20.00
Least poor	41	20.00
Total	**205**	**100.00**

Source: Field survey, December, 2014.

MOTIVATION TO VOLUNTEER

The overarching goal of the social scientist is to systematically study individuals as social beings in order to understand why people behave the way they do. It is therefore important to know and understand why volunteers at the study site offer voluntary services without pay. This is because, as the Social Exchange Theory contends, individuals are motivated to act based on rational consideration. In this regard, the individual calculates the consequences of different lines of conduct before he/she acts in order to maximize the benefits of their action. Under this section, reasons for becoming volunteers were analysed.

The reasons

Reasons for volunteering are analysed because, whilst behavioural scientists largely assume that human actions are patterned, individuals still make room for choices. For instance, some scholars argue that, volunteers' motivation is based on the principles of altruism (Phillips, 1982; Rehberg, 2005). Others also contend that, volunteers offer services to directly or indirectly benefit themselves and/or their relatives as the Social Exchange Theory suggests (Silverberg et al., 1999). In a study such as this, respondents may have several reasons for volunteering. However, to be able to report the salient motivators among volunteers at the study site, respondents were limited to select one important reason why they chose to volunteer.

The data gathered show that personal interest (32.7%), community leaders' selection (30.2%), significance of the work (14.6%), and the desire to help others (7.3%), were the most important reasons for volunteering among the volunteers at the study area.

Personal interest as motivation among some volunteers includes, community recognition, popularity leading to being elected as an assemblyman and the opportunity to further one's education. Some of the respondents were also motivated to volunteer because of some material benefits such as bicycles. A respondent made this observation:

"The recognition is the personal interest. When people volunteer, they become leaders and they take advantage of that opportunity to move on to other positions like the assemblyman. Assemblymen are elected, so if you are active in the community as a volunteer, everybody knows you, so when you stand for election as an assemblyman, you are likely to win" (IDI with a Director of Health Services).

A similar study in Nepal revealed that volunteers see volunteering as a medium to fulfil their personal goals of working. Volunteer work is therefore perceived as useful and valuable as it helps them fulfil their personal interest (Swechhya & Kamaraj, 2014).

Also, community leaders' selection came up as a reason for volunteering because, the social structure of the study area is such that, each community is headed by a chief and his elders. In view of this, the Health Directorates select the volunteers in consultation with the chiefs and elders. As a result, they have a substantial influence as to who becomes a volunteer in their respective communities (Awoonor-Williams et al., 2004). In effect, volunteers are motivated to give out their best when selected by the chiefs and elders since they count themselves privileged to have been recognized and selected. This finding is similar to what Dil (2012), found among volunteers in the Northern Region of Ghana, where volunteers were motivated to offer services because of the love for their communities and their selection by community members.

As regards the significance of the work, respondents felt compelled to volunteer because of the need to complement the health system to improve on the health of their community members. As a result, volunteers assist health staff at the CHPS compounds and outreach programmes to provide health services to the people. This finding is in line with the goal of PHC, which emphasizes the right and duty of community members to participate individually or collectively in the planning and implementation of their health care (Fred Binka et al., 2009; Fred Binka, Nazzar, & Phillips, 1995; MoH, 1999). This finding was corroborated at an FGD as captured in the response below.

"Because of the inadequate staff at the health facility, we devote our time to assist with the weighing and immunizations to reduce the pressure on the staff. Also, when there is the need to distribute mosquito nets, we help in this regard" (FGD with volunteers).

The desire to help the community also was one of the reasons for volunteering. In this regard, volunteers had the desire to assist in improving the health and wellbeing of their people. This is because more often than not, volunteers belong to the same ethnic group of the people they serve. Volunteers therefore have that sense of belonging, hence the need to help their people as a way of demonstrating their affection. Volunteers in this category are able to express their humanitarianism values (G. Clary et al., 1998). This finding was confirmed by a volunteer at an FGD sessions thus:

"This work is voluntary and I am doing the work because I love my community. If I don't love my community and I am asked to distribute mosquito nets, I won't do it. Before you can be a volunteer, you should have your community at heart…." (FGD with volunteers).

This finding is comparable to results from similar studies conducted in the Upper East and Northern Regions of Ghana. In these studies, it was found that, volunteers were motivated to volunteer because of their love for their communities (Agyeman, 2014; Dil et al., 2012).

The above analysis reveals that, though volunteers are engaged relatively in the same activities, they have different reasons or motives for doing so (Clary & Snyder, 1999). This is particularly so because, according to Maslow's hierarchy of needs, people have needs and they will get their needs met through activities that best satisfies those needs (Maslow, 1943; Neher, 1991). This explains why most of the respondents as revealed above, have volunteered to satisfy their personal interest. In summary, two categories of volunteers could be identified at the study site. There are those who are willing to volunteer because of the desire to help their community and the need to complement the staff strength of the health system. These type of volunteers are usually selected by their community leaders because of having demonstrated willingness and commitment to volunteer in the past. Then there are those who are willing to volunteer because, they want to satisfy their personal desires. However, whichever way one looks at it, volunteers in one way or the other, volunteered for a reason after having rationally calculated the benefits or otherwise of their actions as suggested the Social Exchange Theory. The table below, shows the details of responses on reasons for offering voluntary services.

Table 7: Reasons for volunteering

Reasons for volunteering	Number of respondents	Percentage (%)
Personal interest	67	32.7
Community leaders selection	62	30.2
Significance (value) of the work	30	14.6
Desire to help community	15	7.3
Work content	8	3.9
Acquisition of knowledge	8	3.9
Family suggestion	5	2.4
Familiarity with community	4	2.0
Other	4	2.0
Work condition	2	1.0
Totals	205	100.0

Source: Field survey, December, 2014.

Reason for community leaders' selection

As identified earlier, community leaders and elders play an important role in the selection of volunteers at the study site. It therefore becomes imperative to know the factors these leaders consider in the selection of volunteers. In view of this, respondents who are volunteers because they were selected by community leaders, gave reasons for their selection.

The data show that the majority (42%) of respondent were selected because they can read and write. This was followed by 19% of respondents who were selected because they are credible members of their communities. This result corroborates the earlier finding that, most of the volunteers at the study site have had middle school education. Also, community leaders select people who they know to be credible, so that they can be easily accepted by the community members. Furthermore, volunteers represent their respective communities at health workshops and training. As such these leaders select volunteers who they think are credible or trustworthy enough to represent them. This finding is elaborated in the responses below.

"We had a community meeting and they said they needed someone who is trustworthy and patient to assist in the immunization for non-communicable diseases. The chief and elders selected me because they know I am credible" (IDI with Assemblyman).

Below is the table showing details of reasons why community leaders selected volunteers.

Table 8: Reasons for community leaders' selection

	Reasons for community leader's selection						**TOTALS**
	Level of education (read and write)	Credibility	Community acceptance	Previous role as a volunteers	Good communication skills	Familiarity with community	
Community leader's selection	42%	19%	7%	6%	6%	5%	**100**

Source: Field survey, December, 2014.

Motivation to continue volunteering

Since the inception of CHPS in 1999, volunteers have continued to assist health staff in the provision of health services and in conducting health research at the study site (GHS, 2002; Manu, 2012). It is therefore imperative to identify the reasons for volunteers' continuous availability for health services and research projects. In order to understand the most salient reasons, respondents were asked to select the most important reason why they continue to volunteer.

The data show that the majority (68.2%) of the respondents continue to offer voluntary services because of the desire to help others whilst 15.1% indicated satisfaction accrued from helping others. However, this finding comes with lots of despondency from respondents as a result of the several challenges that confront volunteers at the study site. Some of these challenges involve the lack of logistics such as raincoats and wellington boots. These and other challenges explain why the majority of the volunteers said that the only thing that sustains and keeps them going, is the desire to help their communities. The implication is that volunteers are not generally satisfied with some aspect of their work but cannot stop volunteering because of the love for their community. This finding is reiterated by a volunteer at an FGD session as encapsulated in the response below.

"……the reason why we continue to work in spite of all challenges is that, I volunteered to help my community to address health problems. Also, I am doing it for God" (FGD with volunteers).

The second dominant reason that is satisfaction from helping others also matches with what Clary and Snyder (1999) found in their application of theory of motivation in their volunteer study. In this study, it was identified that, initiating and continuing to volunteer depends on the interaction between the particular motivation the volunteer has and their actual experiences. This result is also in line with the tenets of the Social Exchange theory,

where behavior is considered as a function of its pay-off (Homans, 1958). In this study, some volunteers have continued to work because of the satisfaction they derive from helping their community members.

The above finding, is also consistent with results from a similar study in Nepal. Findings from this study revealed that, some volunteers expressed sympathy towards the sick and relate their recovery to their voluntary service as compensation (Swechhya & Kamaraj, 2014). Also, volunteers in mother-to-mother support groups in rural Ghana were found to be motivated by their desire to help other mothers have healthy children (LINKAGES, 2003; Lourdes, Carmel, Kerry, & Fiona, 2006). This finding was evident in the responses of volunteers during the FGDs. The response as captured below summarises this position:

"For me, I don't receive anything but once I have decided to do the work. I am encouraged to continue working once the community members benefit from my work. I am fulfilled by the fact that, I am doing something to help develop my community and country" (FGD with volunteers).

However, this result is contrary to Bhattacharyya's (2001) findings which indicated attrition rate in community health project to be between 3.2% and 77% with volunteers having a higher rate. The conclusion from this study indicated that volunteers do not continue to offer services when the hope of their involvement leading to paid employment do not materialize (Bhattacharyya, 2001).

The table below shows the details of responses on reasons why respondents continue to offer voluntary services.

Table 9: Motivation to continue volunteering

Motivation to continue as a volunteer	Number of respondents (n)	Percentage (%)
Desire to help others	140	68.3
Satisfaction from helping others	31	15.1
Acquisition of knowledge/learn	12	5.9
Future employment	8	3.9
Social recognition/prestige	7	3.4
Other	7	3.4
Totals	205	100

Source: Field survey, December, 2014.

Opportunities for promotion

According to Clary et al. (1998), one of the reasons why people volunteer is the desire to gain career-related experiences and to increase job prospects. Volunteers with this motivation see volunteer service as a means to help their career progression. Going by this, respondents were asked about their knowledge of any opportunity for promotion or career progression as a volunteer. This is because, almost all the respondents were mainly farmers and work as volunteers on part time.

The data revealed that the majority (87%) of respondents do not know of the existence of any opportunity for promotion. This is followed by 10% of respondents who were not sure of whether or not any opportunities existed for promotion. Even though the volunteers were not aware of any opportunities for promotion, some of them have hopes for possible career progression as volunteers. This is as a result of the fact that in the past, some volunteers gained admission into health training institutes among others because they were volunteers. This finding is reiterated in the response below.

"I thought that I would be assisted to continue my education at a college of health if I serve as a volunteer and l have good results. My intension for volunteering was not to work for pay, but I had the idea that if any opportunity comes, the doctors and the

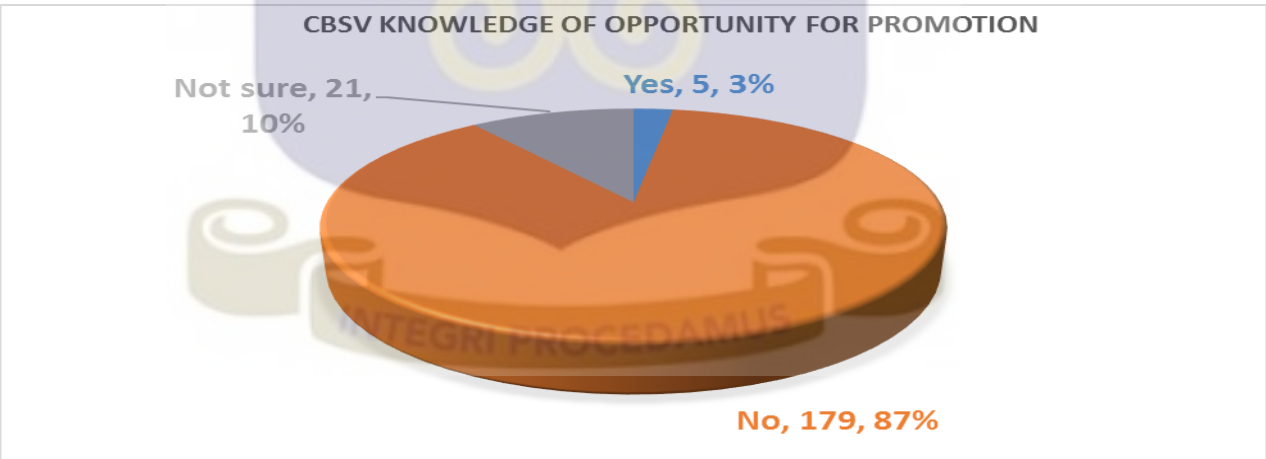
researchers could assist me to further my education. For instance, one of the volunteers in this community was assisted to pursue a course in Wenchi and is currently working with Ghana Health Service. So, I have been waiting for such opportunity but have not had anything yet" (FGD with volunteers).

The above show that some respondents continue work as volunteers because they hope to enhance themselves. As the Social Exchange Theory posits, individuals act in all case to satisfy their interest based on rational consideration.

Conversely, in a similar study in Sri-Lanka, 60% of respondents disclosed that they volunteered because they were certain volunteering could lead to future employment. This is because, the government had announced that volunteers with required qualifications will eventually have access to training and jobs in the health department (Walt, 1990).

The figure below shows details of responses on knowledge of opportunities for promotion

Figure 2: Opportunities for promotion



Source: Field survey, December, 2014.

Monetary Incentives

Volunteerism implies that receiving monetary benefits for work done is unethical (White, 2006). Contrary to this, volunteers offer their services for various reasons, ranging from altruistic to community interest, and are motivated by different incentives including

monetary benefits (Pawlby, 2003). It is, therefore, important to understand the monetary incentives that motivates volunteers at the study site.

As is reflective of the traditional principle of altruism in volunteering, almost all the volunteers (99.5%) claimed they do not receive monetary payments for services rendered. In other words, this study was able to establish that it is common knowledge among the respondents that they are not to receive financial rewards for their services as encapsulated in the response below:

"*The work is purely voluntary, so we have volunteered. We know there is no pay for the work we do……" (FGD with volunteers).*

Nonetheless, some volunteers (49.3%) receive per diem when they go for training and workshops, whilst 88.8% responded that they receive extra duty allowance when they work on programs such as the national immunization against Polio. The response below summarizes this position:

"Apart from the T-Shirt, boots and bicycles that we give them, when they are involved in any programme, we give them extra duty allowance; we pay them allowance for work done. Also, when we call them for training, we pay them their transportation fare and per diem" (IDI with a Disease Control Officer).

To a considerable extent, volunteers do not consider these moneys as payments since they do not come on regular basis.

The results from this study is not different from elsewhere. In a similar study in Savelugu, Ghana, it was found that, volunteers are paid after they have assisted in health campaigns or mass health programmes (Agyeman, 2014). Also, volunteers in Zambia who partake in service programmes, receive monetary incentives in the form of allowances and transport refunds at seminars (Wilson, 2007).

From the above analysis, it is clear that, even though volunteers know they are not to be paid, they gladly receive monetary incentives when they are given. Without mincing words, this is what a volunteer had to say.

"The programme managers should continue with the small gifts they give us occasionally. For instance, the day I received the bicycle and the bag I was given fifty Ghana Cedis. I think if they continue like this, anytime they call upon me, I will stop whatever I am doing and answer their call" (FGD with volunteers).

This finding re-echoes the position of Social Exchange Theory which states that there is no such thing as volunteerism; individuals are motivated to act on the basis of rational considerations by weighing the consequence of alternative lines of conduct in terms of the turnover they are likely to generate. In this regard, the more valuable a particular reward is to a person, the more often he will perform a behaviour so rewarded. As captured in the response above, the volunteer promised his/her readiness to volunteer anytime he/she is called upon because the money he/she received is valuable to him/her. In effect, though volunteers in this study were motivated by several reasons including the desire to help others, the provision of financial rewards are essential in motivating them. This is particularly so because in a developing country, such as Ghana, community based volunteers in rural settings are poor and require monetary incentives to sustain their interest in the work (Shumba, 2007).

Below is a table showing the details of responses on monetary incentives received by volunteers at the study site.

Table 10: Monetary incentives

Monetary Incentives	**Yes**		**No**		**Total N (%)**
	n	***%***	***n***	***%***	
Monthly Honorarium	1	0.5	204	99.51	205 (100)
Per diem	101	49.3	104	50.73	205 (100)
Extra duty allowance	182	88.8	23	11.22	205 (100)

Source: Field survey, December, 2014.

Non-monetary incentives

Most volunteers are not paid yet many devote much time and work hard for health and community services. In view of this, it is important to explore what other factors motivates volunteers to work without being paid. The data show that, continuous training (70.2%) is a key non-monetary incentives among volunteers at the study site. A discussant at an FGD made this observation in support of this finding:

"Though the work is voluntary, most of us learn a lot of things from it which helps us in our life; we get a lot of training. We have been here (Health Directorate) on several occasions; the hospital also calls us; training in how to handle children, cholera and a lot of things; because you have volunteered, the health people call you"

This finding is in agreement with the postulations of the Functional and Multidimensional motivation theories that deal with opportunities for new learning experiences, exercising one's knowledge, skill, and abilities as volunteer motivation for offering services. As indicated in the response above, some respondents are motivated to volunteer because, they benefit from skills training and these skill are used to their personal lives.

Also, the results is in line with Bhattacharyya's (2001) argument that learning new skills is one of the main reasons for volunteering. Bhattacharyya intimated that apart from the opportunity to learn new skills and receive education, training enables volunteers to interact with higher levels of professional staff and obtain other benefits that they will not obtain if they were not volunteers. Similarly, in Nepal, further training enabled volunteers to identify causes and treatment of night blindness and to recognize fast breathing as a major sign of acute respiratory infection (Curtale, Siwakoti, Lagrosa, LaRaja, & Guerra, 1995). The implication is that their ability to offer treatment augmented their motivation. Also, continuous training gave village health helpers in Kenya enough motivation to continue working even without financial support (Kaseje, Spencer, & Sempebwa, 1987).

Other non-monetary incentives that serve as motivation among volunteers at the study site include, uniforms, backpacks, cap (45.4%) and food (52.7%) during training. Food served during training are sometimes "continental" in nature and much appreciated by volunteers as such a good source of motivation among them. Furthermore, recognition and prestige as well as the preferential treatment some of them receive at the various health facilities also came up as non-monetary incentives among volunteers. The response below substantiates this finding:

"It is a prestige for volunteers in their community; they call them 'doctors' so they feel proud to be working with the health people. Sometimes, when you are visiting them and you pre-inform them, they will put on their t-shirts and ID cards. In some of the facilities, they are treated free because they are volunteers. Because we work hand-in-hand, whenever they find themselves in a facility, they do give them preferential treatment. If you were the one, how will you feel?" (IDI with Municipal Director of Health Services).

In this regard, though volunteers are not trained health workers, they feel they are 'doctors' by association with health workers and this in turn motivates them. In a similar study in Savelugu, in the Northern Region of Ghana, volunteers cited popularity and recognition by the community as factors that sustain their interest in voluntary work. In Mexico, Logan (1988) found that local drug sellers are seen as doctors (Casi Como doctor). In view of this, people present their health complaints and describe their symptoms, expecting them to diagnose their illnesses and to recommend treatment (Logan, 1988). Volunteers at the study site enjoy similar status.

Below is a table showing the details of responses on non-monetary incentives received by volunteers at the study site.

Table 11: Non-monetary incentives

Non-monetary Incentive	Yes		No		Total n (%)
	n	%	n	%	
Training	144	70.2	61	29.76	205 (100)
Means of transport	96	46.8	109	53.17	205 (100)
Uniform, backpacks, Cap,	93	45.4	112	54.63	205 (100)
Discount medicine, free ticket for care	6	2.9	199	97.07	205 (100)
Subsidized accommodation	2	1.0	203	99.02	205 (100)
Free accommodation	1	0.5	204	99.51	205 (100)
Food ration/meals	1	0.5	204	99.51	205 (100)
Food during training	108	52.7	97	47.32	205 (100)

Source: Field survey, December, 2014.

FACTORS THAT AFFECT THE WORK OF VOLUNTEERS

Several factors such as the characteristics of work may affect volunteers in different set-ups and this in turn affects their levels of motivation. In view of this, understanding the interactions between the nature of volunteers work and their motivation is of considerable importance. In this section, the years of work of volunteers, how volunteers go for routine work activities, time spent by volunteers to reach the nearest or farthest place of visit and the type of services provided by volunteers are analysed.

Years of work experience

Volunteers who have consistently been involved in voluntary activities over a long period of time have positive implications for the programmes. This is because, in addition to the experience they bring to bear on the work, they also serve as role models for new volunteers to continue offering voluntary services. The implication is that volunteers who are more satisfied are most likely to continue offering voluntary services. Also, the existence and availability of more experienced volunteers suggest less turnover among those involved.

The data show that, on the average, the respondents have worked for about 13 years as volunteers. Volunteers have worked for this long because of the benefits they derive from helping their communities. The response below strengthens this finding.

"In 1992, I was given a certificate. If you are sick or any of your family member is sick and goes to the hospital, you are not allowed to join the queue. I use the certificate anytime I go to the hospital. So if I stop this work, I will lose this opportunity" (FGD with volunteers). This finding is also in consonance with the Social Exchange Theory which states that, the more valuable a particular reward is to a person, the more often he will perform a behaviour so rewarded (Homans, 1958, 1961). In this regard, volunteers continue to work because of the benefits they enjoy as volunteers.

Volunteers and Routine Activities

As a director of health services observed, "volunteers are the foot soldiers for health services" at the study site. To this end, a typical volunteer is a surveillance person in the community who reports and documents unusual health events for the necessary interventions. They also report births and deaths, mobilize communities for health programmes, assist in the referral of emergency cases, and support Community Health Officers in the provision of health services. Furthermore, volunteers do home visits to do family planning education and encourage mothers of newborns to observe all the necessary newborn practices as directed by health professionals. In view of this, the ability of volunteers to move about efficiently is important in carrying out these activities. This implies that inability to move about efficiently could demotivate volunteers in the performance of their routine activities. It is therefore imperative to analyse how volunteers move around to carry out their routine activities.

The data indicate that, the majority (69.3%) of volunteers walk to carry out their routine activities followed by 24.4% who move with bicycles. This discrepancy among volunteers

is as a result of the different (vertical) volunteer programmes run by different development partners and organizations within the health sector in Ghana. Presently, some of the organizations that use the services of volunteers at the study site are, World Vision, World Education Ghana, KHRC and the Health Directorates. For instance, World Vision uses some volunteers in programmes such as water, sanitation and hygiene, child health and nutrition. Also, KHRC use some of these volunteers for its research projects and clinical trials. As a results, volunteers are given different incentives such as bicycles, motorbikes and T-shirts since their activities may differ according to the organization and programme. For instance, it was revealed that some volunteers under KNM were provided with bicycles through the support of Guinea Worm National Secretariat. The response below is a confirmation to this finding.

"……we have given the volunteers bicycles we received from the Guinea Worm National Secretariat. So now, almost all the volunteers have bicycles which they use for their activities and also their private jobs" (IDI with a Disease Control Officer).

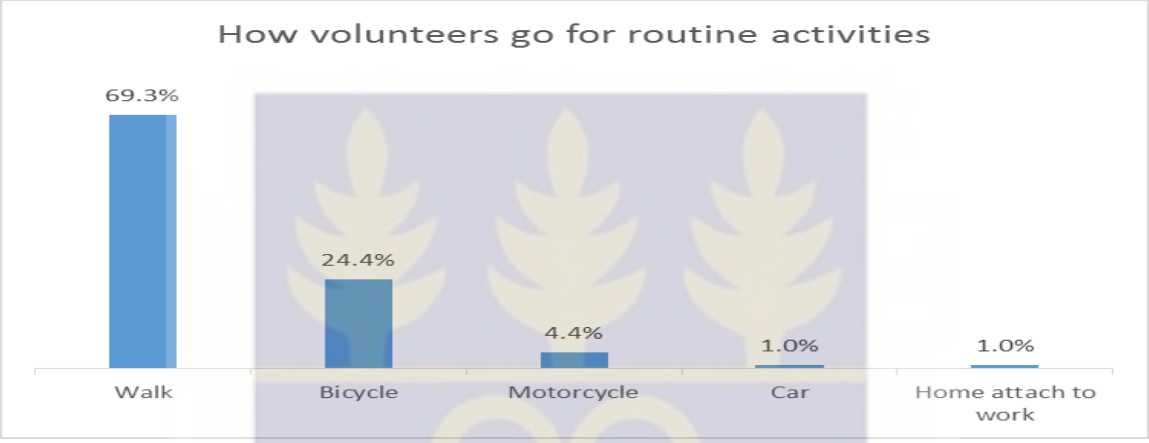
On the contrary, volunteers in the KSD generally walk to carry out their routine activities. This is because, unlike their counterparts in the KNM, they have not been provided with bicycles. This is possibly so because, these volunteers may not be involved in the Guinea Worm project which provided bicycles to volunteers in the KNM.

Due to the verticalizing of programmes, volunteers in the KSD feel cheated for not being given bicycles like their counterparts in KNM. Volunteers feel cheated because they are oblivious of the fact that they work on vertical programmes with different incentive packages and support systems. This is a source of apathy among the volunteers. As pointed out by a discussant: "*For instance, you give someone in Kintampo North a bicycle but you didn't give the person in the south and the person will have to walk to do the work.*

If it happens this way, it means there is cheating and once there is cheating I have to stop" (FGD with volunteers).

Below is a figure showing the details of responses on the major means by which volunteers go for routine activities at the study site.

Figure 3: Volunteers Routine Activities



Source: Field survey, December, 2014.

Time spent by volunteers to reach nearest or farthest place of visit

Considering the fact that the majority of volunteers at the study site walk to carry out routine activities, the time spent in walking could affect their motivation. It is, therefore, relevant to analyse the time spent by volunteers to reach the nearest or farthest place of visit.

The data show that the majority (65.4%) of volunteers spend less than 15 minutes to the nearest place of visit. This is because the majority of the volunteers live/reside in relatively smaller communities and do not have to walk a long distance to work. This partly explains why volunteers, particularly those in KSD, still work though they have not been provided with bicycles. The response below further explains this position:

"As community based volunteers, they work in the communities where they live. They are not supposed to walk long distance across communities. (IDI with a Disease Control Officer).

However, some volunteers walk relatively long distances to attend to residents of isolated houses and this demotivates these volunteers.

Table 12: Volunteers travel time

Time spent	Visit to nearest place		Visit to farthest place	
	n	(%)	n	(%)
Less than 15 minutes	134	65.4	51	24.9
15 minutes- Less than 30 minutes	26	12.7	43	21.0
30 minutes- Less than 60 minutes	24	11.7	49	23.9
60 minutes or more	6	2.9	45	22.0
Home attached to place of work	15	7.3	17	8.3
Totals	**205**	**100**	**205**	**100**

Source: Field survey, December, 2014.

Services provided by volunteers

The type of services provided by volunteers have been identified as a major source of motivation for voluntary work. For instance, volunteers in Nepal are motivated by the fact that they have been trained to identify causes and treat certain minor ailments (Curtale et al. 1995).

The data show that volunteers at the study site mainly provide child health services (80.5%), care for new born (50.7%) and referral services (53.2%). The provision of these services is expected because, in line with the goals of PHC, volunteers support health workers in extending these health services to people in the rural communities. For instance, in 2009 KHRC trained some volunteers to identify pregnant women in their communities, visit them during pregnancy and in the first week of life to promote essential newborn-care practices such as weighing and assessing babies for danger signs and make

referral where necessary (Manu, 2012). Their source of motivation hinges on the fact that they are respected for the services they provide.

In this regard, it is important to note that volunteers are motivated to work because they are seen and regarded as 'doctors' in their communities. Below is a table showing the details of responses on services provided by volunteers.

Table 13: Services provided by volunteers

Services provided	Yes		No		Total N (%)
	n	%	n	%	
Child health	165	80.4	40	19.51	205 (100)
Family planning	49	23.9	156	76.10	205 (100)
Care for new born	104	50.7	101	49.27	205 (100)
Referral	109	53.2	96	46.83	205 (100)

Source: Field survey, December, 2014.

VOLUNTEERS SATISFACTION

Most volunteer motivation research generally point to the fact that, satisfaction of volunteers about their work plays an important role in voluntary behaviour (Ferreira, Proença, & Proença, 2012). For instance, as the functional motivation theory posits, individuals begin and continue to volunteer as long as the activity matches and satisfies their motivational concerns (Clary & Snyder, 1999). In effect, volunteer motivation are positively linked to volunteer satisfaction. That is, volunteers who are satisfied with their work, are motivated to continue offering voluntary services. It is therefore important to analyse volunteers, work satisfaction to further understand their motivation at the study site.

To assess volunteers' satisfaction, respondents were made to answer ten (10) close-ended questions with Likert-style five-point scale responses (very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, very dissatisfied). A Likert Scale is a five (or seven) point scale which is used to allow respondents to express how much they agree or disagree

with a particular statement on their attitude such as work satisfaction in this study (Bowling, 2014). The data were then summarized into frequencies and percentages to describe the distribution of responses for each Likert question. To further explain volunteers' satisfaction, univariable linear regression analysis was performed to test for association between volunteer satisfaction with the various components of their work, and their overall level of satisfaction. Also, the same analysis was done for monetary incentives, non-monetary incentives and their overall of satisfaction.

Overall, respondents were very satisfied (38.1%) and satisfied (49.8%) with their work as volunteers. These results are indicative of the fact that, most of the respondents mentioned they are satisfied as volunteers. The reasons attributed to their satisfaction are not different from the factors that motivate respondents to start and continue offering voluntary services. Some of the reasons for volunteers' satisfaction is the prestige and respect they enjoy from members of their communities as well as health professionals. Like the volunteers in Mexico, volunteers see themselves as health workers since they are the first point of call for health workers who visit their communities (Logan, 1988). Also as revealed earlier, some volunteers are satisfied because they are given preferential treatment when they go to health facilities for their personal medical care. The response below strengthens this position:

"I am satisfied because I do not join the long queue when I go to the hospital. I always get treatment before most of the people I meet at the hospital. This is all because of the work I do for free. I learned that, you reap what you sow. That is why I will continue to work as a volunteer" (FGD with volunteers).

The level of satisfaction shown by the majority (50.7%) of respondents of their work location is not out of place. This is because, as revealed earlier, volunteers are selected from within their communities; and as such, they share ethnicity, socio-economic status

and life-style experiences with the people they serve. Also, volunteers do not have to travel long distances to work. Similarly, the majority (58%) of the respondents are very satisfied because of the training they receive as volunteers. As revealed earlier, volunteers use the knowledge and skills acquired during training in their private lives hence they are motivated and satisfied.

However, it is remarkable to note that most of the respondents were dissatisfied (29.8%) and very dissatisfied (23.9%) about the community members' support. In as much as they are respected by the members of their communities, volunteers feel they are not fully encouraged and supported in this regard. This is because community members perceive they are paid for the work they do. Some volunteers are apprehensive by this perception community members carry about them and this in turn demotivates them.

Volunteers dissatisfaction with community members' support, contravene the purpose of the CHPS which is a community-based service delivery that places emphasis on a better cooperation with households, community leaders and social groups. This cooperation is aimed at addressing the demand side of service provision and in recognizing the fact that households are the primary producers of health (Fred Binka et al., 2009)

Furthermore, most (34.6%) of the respondents were very dissatisfied with the Community Health Committee support. Community Health Officers are to collaborate with volunteers and Health Committees to provide preventive and primary health care (MoH, 1999).

However, some respondents also expressed dissatisfaction about their work as volunteers. One major reason for this attitude is that volunteers feel they are always sidelined or rejected when there are monetary rewards involved in health programmes. Some volunteers argue that whenever there is money involved, some programme managers

recruit their friends and relatives to do the work. In this regard, some volunteers get agitated and apprehensive. Also, some volunteers argued that, even when they do the same work with other people, they are paid meager amounts as compared to the others. Volunteers consider this as discriminatory and demoralizing. To this end, a discussant at an FGD unhappily recounted his/her experience.

"Not long ago, the programme managers recruited students and their children to work with us (volunteers) on a project. Everybody got GHC 200.00 for the five days and we were given GHC 15.00. Can you imagine this? Someone who does not know anything got GHC 200. That is what demoralises me sometimes (FGD with volunteers).

The linear regression analysis confirmed that, the level of health services volunteers provide, the number of hours they work, location of their work and community members' support are significantly associated with the overall satisfaction of volunteers with p-value of 0.01 and below. As regards monetary incentives, per diem received by volunteers during training is significantly associated with volunteers' satisfaction with a p-value of (0.05). Lastly, the ownership of items (non-monetary incentives) is significantly associated with volunteers' overall satisfaction with a p-value (0.03). *(See appendix 1: tables 14, 15and 16)*

The findings from the univariable linear regression analysis corroborate the earlier findings that volunteers are satisfied with the level of health services they provide and their work location. Lastly, volunteers' satisfaction with their hours of work is expected since they do not work full time. Volunteers at the study site choose the days and hours of work themselves to suit their schedule as a discussant explained: *"Working as a volunteer*

is more fulfilling than working with salary. This is because, you work at your own pace and leisure with no pressure"

It is however interesting to note that, volunteers are satisfied with community members though they claim that they do not give them much support because they perceive volunteers are paid. This is because volunteers consider the respect from community members, health workers and the prestige that comes with the work as enough motivation to continue offering voluntary work.

THE ROLE OF COMMUNITY ANCHOR IN MOTIVATING VOLUNTEERS

Community leaders' support is essential in ensuring the sustainability of community-based health programmes (Amare, 2009). This is because they provide traditional authorization to the programme as well as the workers on it (MoH, 1999). With this in mind, the role of community leaders in facilitating and sustaining the motivation of volunteers were explored.

The role of Traditional Authority

It was generally upheld among respondents that the Traditional Authorities (Chiefs and elders) in the various communities do not do much to motivate and sustain volunteerism among volunteers. A Disease Control Officer despondently made this observation.

"That is one of the challenges because when I was talking about their selection; you know I said we involve the chiefs, opinion leaders. We made them aware that, the volunteers work is not a paid job. So once the person is working for the community, we would have expected that at least once a while, the community will mobilize and probably go and clear the person's farm say once in a month or something. But that is one of the things the communities have failed to do and that is something that I think demotivates volunteers.

These are some of the things we expect the communities to do but they don't do it" (IDI with the, KNM).

As corroboration to the position of the Disease Control Officer, a volunteer also said this at an FGD session.

"Since our elders selected us as volunteers, they don't help us in any way. They said once we are working with health workers, they pay us. It is a lie if I tell you our elders give us something"

This finding reveals that both the health system and the volunteers expect the traditional authorities in the various communities to reward (usually non-monetary) volunteers for services provided. The health system is in support of this because volunteers in communities who receive rewards are motivated to continue offering voluntary services. In effect, volunteers in communities that do not receive any reward from the traditional authorities get demoralized. This is particularly so because during meetings volunteers share their experiences and challenges from their communities. This finding also strengthens the position of the Social Exchange Theory, which argues that, there is nothing like volunteerism in the true sense of the word since volunteers expect rewards for the services they provide.

It also came up that much is not seen of the traditional authorities partly because they are oblivious of their roles. As pointed out by a respondent: *As at now we don't have any support from these people because they don't know their roles. We are planning to arrange a meeting to spell out their roles to them. So that they will come on board to help us sustain the volunteers in the system (IDI with a Director of Health Services).*

On the contrary, some respondents also pointed out that chiefs and elders in one way or the other play an important role in motivating and sustaining volunteerism among

volunteers. Although not a general phenomenon, a health assistant who was once a volunteer recounted his experience of having been given a parcel of land by the chief of his community for working hard as a volunteer. Also, some of the volunteers are recognized as opinion leaders in their communities and as such take part in decision making. Therefore, it suffices to say that support from traditional authority may not be direct as most volunteer may expect but are inherent in the recognition and traditional authorization they receive as volunteers. The response below summarizes this finding.

"As a volunteer you serve as an opinion leader. So every decision the traditional authorities take you are invited to take part……" (FGD with volunteers).

This finding is similar to what pertains among volunteers in Columbia, where volunteers ranked as having influence as opinion leaders on several issues in their communities as an important reward for offering services (Bhattacharyya, 2001; Robinson &Larsen, 1990).

The role of Community Health Committee

It was commonly upheld by respondents and discussants that, the CHCs exist in some communities but are not fully functional in the performance of its duties which include encouraging and motivating volunteers. Others alluded to the fact that some of the CHCs have totally collapsed. This is what a respondent had to say to that effect.

"The health committee has collapsed! Recently we (health workers and community leaders) deliberated upon it. We have even sent letters to the various ethnic groups as well as the various religious bodies to give us support. This is because, there are certain information that need to go out but since we do not have representatives from the various ethnic groups, we cannot send it anyhow……" (IDI with a Health Assistant).

The need to have representatives of ethnic groups on the health committee is very important for information dissemination. This is because representatives will be able to

effectively communicate with their people in the language that they understand whenever there is the need to pass on information to them.

However as appreciated in the response above, efforts are being made to revamp the CHCs to help in the holistic provision of health services at the local level. The confirmation can be seen in the response below:

"We have reactivated our municipal health committee. Chiefs, church leaders and other stakeholders have been brought on board. We started last year and later last year, the fourth quarter we were able to elect or executives….."(IDI with a Director of Health Services).

The role of Community members

Similar to the above findings, most of the respondents mentioned that the members of communities do not support or motivate volunteers. Respondents argued that some community members feel that volunteers are paid as such there is no need to support them in any way. According to some volunteers, the actions and inactions of some community members demotivate rather than motivate them. The responses below sums up community members' perception of volunteers.

"We (volunteers and community members) all know the work it voluntary. But someone would ask: Wouldn't you have stopped if there is no pay? You take pay; most people say that. In view of this some people say very unpleasant things about volunteers. They say that there is money in it, whilst we don't get anything. If it continues this way, I could think of stopping for another person to come and try and see if there is money in it" (FGD with volunteers).

This finding was confirmed by a health administrator:

"Some people in the communities think the volunteers are receiving so much that, the volunteers are not disclosing to them. In fact, this is the problem volunteers are facing. Recently when we gave them bicycles and they went back to their communities, the people were like you see, they have gone for bicycles. So they think the volunteers are receiving so much. Because of this, when you ask the community members to do something for the volunteer, they wouldn't do it" (IDI with a Public Health Nurse).

Notwithstanding the general view held by most of the respondents, others are of the view that they enjoy some social support from community members which in turn motivates them. Below is how a volunteer recounted the support he gets from the members of his community.

"When I have any personal program, all the community members attend, even during the naming ceremony of my child I received a lot of support from the community members." (FGD with volunteer).

Conclusion

This analysis has revealed significant and interesting issues that relate to the motivation and retention of volunteers. The next and the final chapter summarises the key findings from this study. It also discusses some recommendation based on the findings from the study.

CHAPTER SEVEN

KEY FINDINGS AND RECOMMENDATIONS

Introduction

Globally, health workers are inequitably distributed, with severe discrepancies between developed and developing countries. This workforce shortage is acute in developing countries where there is inadequate staff in rural areas compared to big towns and cities. In all, sub-Saharan Africa faces the greatest challenge of health worker shortage. Though Sub-Saharan Africa constitutes 11 percent of the world's population and has 24 percent of the global burden of disease, it has only 3 percent of the world's health workers (WHO, 2006). In this regard, the health worker shortage has been a major impediment to achieving the Millennium Development Goals of reducing child mortality, improving maternal health and combating HIV/AIDS and other diseases such as malaria.

To address the health worker shortage, attention has been paid to the delegation of simple health care tasks assigned to skilled personnel to less skilled workers. That is with supervision and support, volunteers and community health workers with limited training have significantly contributed to the provision of efficient health services, particularly in the rural areas. To this end, the focus is usually on the training of volunteers and community health workers. However, apart from the northern regions of Ghana where motivation among volunteers are considerably known, there is lack of knowledge on what motivate volunteers in other parts of the country where volunteers are also used. Therefore, the sociological question that lingers on is, what motivates volunteers in other parts of Ghana to continue offering services? Underpinning the legitimacy of this all important question is the principle of the Social Exchange Theory which emphasize that human behaviour is based on rational considerations. That is, individuals weigh the

consequences of alternative lines of conduct before they act. This is because like the hedonic principle, human behaviour is always geared towards maximizing pleasure and avoiding pain.

Considering the above discussions, this study generally sought to examine the motivation for retention among volunteers working on health-related activities at the local level in Ghana. To achieve this general objective, a number of specific objectives were outlined. They include, what motivates the volunteers to offer services, factors that affect the work of volunteers and assess satisfaction among volunteers. The study further explored the role of the community anchor in sustaining volunteerism among volunteers. Below are the key findings outlined according to the objectives of this study.

Key findings

As regards what motivates people volunteer, it was realized that the personal interest of volunteers, community leaders' selection, significance of the work and the desire to help others were the main reasons for volunteering. However, the desire to help others and the satisfaction accrued from helping others were the main motivators that has kept volunteers to continue offering voluntary services.

In terms of monetary incentives as motivation for volunteering and retention, it was realized that almost all volunteers do not receive monthly honorarium as incentives for voluntary work done. However, volunteers receive per diem and transport fare for attending training and extra duty allowance for engaging in national programs such as the National Immunization Days. These monetary incentives were seen as a very important motivation among volunteers at the study site.

Still on what motivates people to volunteer, it was found that continuous training received by volunteers is a key non-monetary incentive at the study site. Other vital non-monetary incentives include, bicycles, Wellington boots, raincoats, bags, T-shirts, community recognition and prestige and preferential treatment for care seeking. However, these items are not uniformly distributed to all volunteers because of the different programmes/projects run by different organizations at the study site. Whilst some volunteers are given bicycles, wellington boots because of the nature of their work, others are given just T-shirts. It is therefore interesting to note that, in as much as volunteers who receive these items are motivated, those who get less or nothing at all feel cheated and demotivated. This is because volunteers perceive that all of them are working for GHS and should be treated equally.

For the factors that affect the work of volunteers, it came to the fore that, on the average volunteers at the study site have worked for more than a decade. This is because volunteers are generally satisfied about their work. Whilst some volunteers have worked for these number of years because of the need to help their community, others are on board because of the monetary and non-monetary benefits that comes with the work. Furthermore, it was also found that the majority of volunteers walk to carry out their routine duties. However, this is more pronounced in the KSD because they have not been provided with bicycles. The situation is quite better in the KNM because most of them have been provided with bicycles by the Health Directorate through the support of the Ghana Guinea Worm Secretariat. Eventually, volunteers in both districts who did not receive the bicycles feel cheated and demotivated as volunteers.

It was also found that the majority of volunteers spend less than 15 minutes to reach the nearest place of visit to carry out their duties. This was seen as a source of motivation among volunteers because they are community-based and do not travel long distances to

reach out to residents. Nonetheless in communities where there are isolated or farm houses, volunteers walk for relatively long distances and this breeds apathy. On the services volunteers provide, it was realized that they were mainly involved in the provision of child health services, care for new borns and referral services. This serves as a source of motivation since volunteers see the services they assist in providing as a way of helping their community and health staff. They are also motivated because of the respect and the prestige that comes with the work. Also, because they are volunteers, they do no join the long queues when they attend health facilities.

On satisfaction, volunteers generally expressed satisfaction with their work because of the monetary and non-monetary incentives they receive. In spite of the general feeling of satisfaction among volunteers, some of them also felt dissatisfied which was unequivocally voiced out. This dissatisfaction largely stems from the discrepancy in the distribution of items due to the vertical (different programmes) at the study site.

Further, it was generally held that community chiefs and elders do not play significant roles in sustaining motivation among volunteers after they have been selected. This is partly because chiefs and elders are not aware of their roles as stake holders within the CHPS framework. It was however noted that, this was not entirely the case as some volunteers indicated that chiefs and elders in their communities play some supportive roles in their work as volunteers which in turn motivates them. These volunteers alluded to the fact that chiefs and elders see them as opinion leaders in the communities and as such they are involved in decision-making. Furthermore, as commonly noted, respondents pointed out that Community Health Committees exist in most of the communities but are not functionally active except for a few. In view of this, there is an indication that some conscious efforts are being made by the health directorates in the study site to revive these committees.

Finally, it was generally upheld that the attitude of some community members demotivate volunteers because they believe that volunteers are paid. On the contrary, some volunteers reported enjoying some social support from community members during funerals and naming ceremonies which in turn motivates them.

Other findings

Beside the above findings that address the objectives of the study, there were other interesting findings that came up.

- It was revealed that, though most (40.5%) of the respondent were 50 years and above, age is not essentially a predictor of volunteerism among volunteers at the study site since respondents fall under all the age groups. In effect, age was not a criteria for volunteering once the person is willing or is selected by the community to represent them as a volunteer.
- Furthermore, it came to the fore that the majority (84.9%) of volunteers were males. The male dominance among volunteers at the study site is largely attributed to sociocultural factors and the nature of activities carried out by the volunteers. In terms of the sociocultural factors, most women feel subordinate to men and so feel reluctant to engage in the same activities with them. This is particularly so because the study site is largely patriarchal in nature and the decision of women to engage in prosocial behaviours such as volunteering is subjected to the acceptance or rejection of men who are mostly gate keepers. Also, the responsibilities of women at home such as cooking and taking care of children constrain them from volunteering because they may barely find time to do community service. As regards the nature of activities, women are demotivated to volunteer because the routine activities of volunteers appear to be

tedious if not difficult. This is evident in communities where volunteers would have to walk long distances to visit isolated compounds and farm houses.

- Also, educational background of respondents were seen as a major criteria for the selection of volunteers. This is because volunteer are expected to document vital health events that occur in their communities for the necessary interventions. The level of education does not really matter once the person is able to read and write. This notwithstanding, it was noted that in communities where there are no persons who are able to read and write, illiterates who are willing to volunteer are given the opportunity to do so. Educational background was also a contributing factor to male dominance among volunteers because comparatively women tend to be the less educated at the study site.

- It was also established that the majority of the volunteers were married. This is because, in Ghana, married people are regarded as responsible and capable of taking up positions such as a community volunteer. As studies have shown, in Ghana, it is only when a person is married, that he/she is taken serious in social deliberations.

- It was also identified that volunteer's fall under almost all the ethnic groups at the study site. In a multi-ethnic set-up such as the study area, ethnicity is relevant for effective volunteer work. In this regard, volunteers are effective when they belong to the same ethnic group with the people in their work communities. The reason is that, volunteers are required to interact with community members and volunteers who share culture and language with communities are likely to be more effective in the performance of their duties particularly in the dissemination of information.

- It was also found that the majority of the volunteers were Christians followed by Muslims. This is largely because Christians and Muslims are more likely to volunteer

because of their religious principles which encourage services for others. For Christians, there is the hope of receiving rewards in heaven for good deeds. There is also a strong ethic of volunteerism in Islam which encourages Muslims to demonstrate their faith by offering voluntary services to make the world a better place.

- Furthermore, it was established that volunteers share similar socioeconomic status. In view of this, volunteers felt the need to support each other by volunteering because they share common features that bind them together as one people. Also, these communities lack adequate health staff to attend to the health needs of people as such the need for some indigenes to volunteer to support the health system.
- It also came up that the majority (87%) of respondents do not know of the existence of any opportunity for promotion. However, it was noticed that though volunteers are not aware of any opportunities for promotion, some of them hope for possible career progression as volunteers. This is as a result of the fact that some volunteers in the past have gained admission into health training institutes.

In a nutshell, almost all the above findings are largely supported by the key tenet of the Social Exchange Theory adopted by this study which espouses that, individuals engage in actions for various reasons that are rationally calculated. To this end, individuals arrive at decisions to act or not to act after weighing the consequences of alternative lines of conduct in terms of the benefits they are likely to generate. It is therefore not a surprise that most of the respondents were motivated to volunteer because of their personal interests which hinges on monetary and non-monetary benefits that come with the work. Even though respondents claim that the desire to help others is what sustains their motivation to continue volunteering, it was realized that this was not entirely the case. This is because, volunteers enjoy some non-monetary benefits that they cherished. Key

among the non-monetary incentives are the respect and the prestige that volunteers enjoy from their communities as well as health workers.

However, it is not always the case that individuals' rational choices prevail in the decision to become a volunteer at the study site. Durkheim argues that, social structures (social facts), whether fixed or unfixed are capable of exercising external constraints on people. In this context, though individuals have the chance to accept or reject the offer to volunteer, it is highly impossible to reject it once selected by community leaders. The reason is that, in traditional Ghanaian communities such as the study site, traditional leaders (that is chiefs and elders) command enormous authority over their subjects or citizens. To this end, a community member who rejects the offer to volunteer will be seen as a deviant and nobody will like to be seen as such. Even under this circumstance, one cannot entirely separate their motivation to volunteer from the non-monetary benefits of volunteering. This is because, in addition to the respect and prestige volunteers enjoy, they know they will become opinion leaders once selected.

Recommendations

Based on the findings of the study, the following suggestions and recommendations, have been outlined as follows:

As regards reasons for volunteering, the Ministry of Health, Ghana Health Service, NGOs, and other volunteer user agencies should take note of the four most salient motivators among volunteers at the study site. This will help them in the recruitment and retention of volunteers given that the ministry is acknowledgeable of what motivate volunteers to initiate and continue to offer services. More importantly, user agencies should pay attention to community leaders' selection since it gives volunteers traditional authorization and also serve as an important motivation among volunteers at the study site. In this

regard, the community in itself serve as a source of motivation for volunteers because of their social status as opinion leaders and the recognition that comes with it.

This notwithstanding, the health directorates at the study site should encourage the establishment of context specific community incentive system to motivate volunteers. The elders of the various communities should engage community members on the possible incentives preferably non-monetary for volunteers. Community members in the process should be sensitized by the health directorates that volunteers are not paid so there is the need for the community to support them as enshrined in CHPS. The support could be volunteers' exemptions from communal labour, payment of community levy and helping volunteers to work on their farms periodically. Once the incentive package is agreed upon, a committee preferably the Community Health Committee should be tasked to ensure that it is implemented.

Closely linked to the above, there is also the need for the Ministry of Health and Ghana Health Service to establish a general incentive package for volunteers across the country. Though the work is voluntary, volunteers work in pro-poor communities where the standard of living is relatively low. Incentives in the form of monthly honorarium (monetary) will motivate volunteers to give out their best to complement the health system. In addition, the Ministry of Health should task heads of their health training institutions to give preference to qualified volunteers when they apply for admissions. This will serve as a great source of motivation to volunteers who have the aim of enhancing their career.

Also, to whip up the motivation among volunteers, the Disease Control Officers who double as volunteer coordinators should frequently visit the volunteers in their various communities to interact with them. Such visits are great sources of motivation among volunteers because they feel recognized as part of the health system.

On factors that affect the work of volunteers, the health directorate at the study site should lobby the government of Ghana and other benevolent organizations through the ministry of Health to acquire bicycles for volunteers. This will serve a great deal in motivating and facilitating the work of volunteers in carrying out their duties. In this regard, the distribution of bicycles to volunteers should be done in consultation with chiefs, elders, CHOs and other stake holders at the study site, to avoid misinformation across the two districts. In view of this, where the items are not for general distribution but designated to some volunteers of specific projects, the health directorates should clearly explain this to the other volunteers within and across the districts. This calls for a periodic consultative meeting between the two health directorates on how to handle monetary and non-monetary incentives for volunteers on vertical (different) programmes. This is extremely important because when volunteers are not well informed on the distribution of certain items to selected volunteers within or across the district for specific projects, the rest feel cheated and demotivated.

On the role of community anchor in motivating volunteers, there is the need for the health directorates at the site, to organize a stake holders meeting to strategize and to reorient chiefs and elders as well as community members on the voluntary nature of the work of the volunteers. The focus of the meeting should be to explain and reiterate the aim of CHPS in Ghana; that is extending health services to rural communities and their roles as stake holders and that of the volunteer in achieving this aim. This will clarify and remind them of their roles and the need for them to support the volunteers to continue offering voluntary services to complement the health system.

Further, the health directorates at the site in collaboration with the CHOs and community chiefs and elders should form health committees where there is none and revamp the existing ones that are not functional. This is important because, as part of their duties

within the CHPS, the health committees see to the welfare of the volunteers to ensure that they are motivated.

Agenda for future research

This study found among other things that community leaders' selection is a key motivator among volunteers. However, this study did not explore how the selection is done. It is therefore suggested that future research on volunteers at the study site should critically examine what goes into the community leader's selection of volunteers. This is important because their selection have enormous influence on volunteers' motivation as revealed by this study. Also, future research should engage the communities to identify context specific non-monetary incentives that could be put in place to motivate and retain volunteers.

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APPENDICES

Appendix 1: Descriptive statistics and univariable linear regression analysis of volunteer satisfaction

Table 14: Volunteers work satisfaction

		Very satisfied	Satisfied	Satisfied nor dissatisfied	Dissatisfied	Very Dissatisfied	Total
Level of services	*n*	101	97	6	0	1	205
	%	49.3	47.3	2.9	0	1	100
Non-monetary incentives	*n*	27	64	15	62	37	205
	%	13.2	31.2	7.3	30.2	18.1	100
Working hours	*n*	79	88	11	19	8	205
	%	38.5	42.9	5.4	9.27	3.9	100
Location of work	*n*	104	57	5	19	20	205
	%	50.7	27.8	2.4	9.3	9.8	100
Training	*n*	119	74	2	8	2	205
	%	58	36.1	1	3.9	1	100
Supplies for work	*n*	73	75	9	39	9	205
	%	35.6	36.6	4.4	19.0	4.4	100
Community members support	*n*	36	48	11	61	49	205
	%	17.6	23.4	5.4	29.8	23.9	100
Health Committee support	*n*	14	52	13	55	71	205
	%	6.8	25.4	6.34	26.8	34.6	100
Supervision received	*n*	95	71	15	21	3	205
	%	46.3	34.6	7.3	10.2	1.5	100
Overall Satisfaction	*n*	78	102	3	9	13	205
	%	38.1	49.8	1.5	4.4	6.3	100

Source: Field survey, December, 2014.

Table 15: Volunteer satisfaction of work components and overall satisfaction

Variable	95% CI	P value
Level of health services	(0.17-0.58)	<0.01
Non-monetary incentives	(0.00-0.22)	0.05
Working hours	(0.06-0.33)	0.01
Location of work	(0.08-0.30)	<0.01
Training	(-0.14-0.23)	0.64
Medical supplies	(0.01-0.25)	0.04
Community members support	(0.05-0.25)	0.01
Health committee support	(-0.06-0.16)	0.38
Supervision received	(0-.09-0.20)	0.45

Source: Field survey, December, 2014.

Table 16: Monetary and non-monetary incentives and overall satisfaction

Incentives	95% CI	P value
Monetary Incentives		
Monthly honorarium	(-0.19-3.03)	0.39
Per diem for training	(-0.50-0.08)	0.05
Payment (extra activities)	(-0.02-0.90)	0.06
Non-monetary incentives		
Uniform, back packs	(-0.46-0.11)	0.23
Discount medicine etc.	(-0.96-0.78)	0.84
Training	(-0.12-0.52)	0.23
Food ration/meals	(-1.19-3.03)	0.39
Free accommodation	(-2.20-2.03)	0 .94
Sub. accommodation	(-0.57-2.41)	0.22
Transport	(-0.32-0.27)	0.85
Food during training	(-0.03-0.56)	0.08
Ownership of items	(0.04-0.63)	0.03

Source: Field survey, December, 2014.

Appendix 2: Questionnaire for CBSVs

UNIVERSITY OF GHANA **DEPARTMENT OF SOCIOLOGY** **Study title: Motivation among Community Based Surveillance Volunteers (CBSV) In the Ghana Health Care Delivery System** **CBSV FORM**	**CBSV FORM NO**	FORMNO

COMPLETE ONE FORM FOR EACH CBSV

1. BASIC INFORMATION ON CBSV

1.1. Community/Village Code: …….... COCODE

1.2. Community name:..... CONAME

1.3. CBSV ID:..... CBSVCID

1.4. CBSV Name: ..... CBVNAM

1.5. Date of Interview……..... CDINTER

1.6. Compound no…… CCOMPID

1.7. Permanent ID of respondent: …… CPERMID

1.8. FW code FWCODE

2. DEMOGRAPHIC CHARACTERISTICS OF CBSV:

2.1. Sex : …… 1. Male 2. Female SEXCBV

2.2. Age: …… CBVAGE

2.3. Highest educational level reached? CEDLEVEL

1. None	2. Primary school	3. Middle,/continuation school, JSS, JHS	4. Technical, commercial, SSS, secondary school, SHS
5. Post secondary – nursing, teacher, polytechnic, etc.	6. University	7. Other, specify:	

2.4. Number of years completed at the highest level reached? [88 = NK, 00 = no Education] LNUMYRS

2.5. Are you currently single, married, or living with a partner, widowed, divorced or separated?

1. Married	2. Living together	3. Widowed	CMARSTAT
4. Divorced	5. Separated	6. Single, unmarried	

2.6. What is your religion?

1. Christian	2. Muslim	3. Traditional African, spiritualist	4. Pagan (No religion)	CRELIGN
5. Other Christians (specify)				

2.7. What ethnic group do you belong to?

1. Akan: e.g.Bono, Ashanti, Fanti.etc.	2. Mo	3. Dagarti, Frafra, Kusasi	4. Ga, Ewe Adangbe,	5. Sisala, Wala	ETHNIC
6. Gonja, Dagomba, Mamprusi	7. Konkomba, Basare	8. Bimoba, Chokosi	9. Other (specify)		

3. HOUSEHOLD AND SOCIO-ECONOMIC CHARACTERISTICS OF CBSV

3.1. Number of people in your household: [ ][ ] HHSIZE

3.2. Number of Children under 5 in your household: [ ][ ] HHCBHD

3.3. Number of Children under 18 (excluding children under 5) in your household: [ ][ ] HHCHDV

3.4. Do you or your household own:

3.4.1 Radio?……	1. Yes	2. No	RADIO
3.4.2 Television ……..……..……..	1. Yes	2. No	TV

3.4.3 Satellite TV?	1. Yes	2. No	SAT_TV
3.4.4. Computers?	1. Yes	2. No	COMP
3.4.5. Video deck/ VCD/DVD?.....	1. Yes	2. No	VIDEOD
3.4.6. Telephone (fixed line)?.....	1. Yes	2. No	PHON
3.4.7. Mobile phone?	1. Yes	2. No	MOBILE
3.4.8. Refrigerator/ fridge/freezer?.....	1. Yes	2. No	FRIDGE
3.4.9. Bicycle?	1. Yes	2. No	BIKE
3.4.10. Motorcycle?.....	1. Yes	2. No	MOTOR
3.4.11. Cupboard, wardrobe, room divider?	1. Yes	2. No	DIVIDER
3.4.12. Electric fan?	1. Yes	2. No	FAN
3.4.13. Gas or electric cooker?	1. Yes	2. No	GAS
3.4.14. A private vehicle/s?	1. Yes	2. No	PRIVEH
3.4.15. Chickens or ducks?	1. Yes	2. No	DUCKS
3.4.16. Cattle?	1. Yes	2. No	COW
3.4.17. Sheep or goats?	1. Yes	2. No	GOAT
3.4.18. Pigs?	1. Yes	2. No	PIG
3.4.19. Other animals?	1. Yes	2. No	OANIMAL

3.5. Do you or does anybody in your household use the internet?	1. Yes	2. No	INTERNET

3.6. Does your household have electricity from the national grid?	1. Yes	2. No	ELECTRIC
3.7. Do you/your household use electric generator?	1. Yes	2. No	GENERAT
3.8. Do you/your household use solar energy to provide electricity?	1. Yes	2. No	SOLAREN
3.9. Do you/your household uses kerosene lantern to provide light in the evening?	1. Yes	2. No	LANTERN

3.10. What is the **main** source of **drinking** water for members of your household? ***(Only one option)***?

1. Private pipe in Residence/ compound	2. Public Pipe	3. Private closed well / borehole in residence/compound	DWATER
4. Public closed well /borehole	5. Private open well water in residence/ compound	6. Public open well water	
7. Surface water -spring, river/stream, pond/lake, dam and dugout	8. Rainwater harvested in residence/compound	9. Tanker	
10. Bottled water / 11. Sachet water	12. Other, specify:		

3.11. How long does it take for you to go to your main water source, get water and come back?

1. Less than 15 minutes	2. 15 minutes- less than 30 minutes	3. 30 minutes – less than 60 minutes	WATERLOC
4. 60 minutes or more	9. NA / drinking water source is in compound		

3.12. What do you think about the availability of water from your **main** drinking water Source?	1. A problem	2. Not a problem	PDWATER

3.13. In the last two weeks, how frequently has water been available from this source?

1. All the time	2. Several hours a day	3. A few times a week	4. Less frequently	5. Not at all	8. NK	ADWATER

3.14. What kind of toilet facility does your household **use**?

1. Own flush toilet	2. Flush toilet in compound	3. KVIP latrine	4. Traditional pit toilet	5. bucket/pan latrine	6. No facility/bush field	HTOILF

3.15. What type of fuel does your household **mainly** use for cooking?

1. Electricity	2. LPG/Natural Gas	3. Kerosene	4. Charcoal	5. Firewood, Straw	6. Other:	HFUEL

3.16. What are the main material of the **floor** of the rooms in your house

1. Natural floor: Earth/sand/mud, mud mixed with dung	2. Rudimentary Floor: Wood planks, palm/bamboo	FLOOR
3. FINISHED : Parquet or polished wood, linoleum, ceramic tiles, cement, carpet, terrazzo	4. Other:	

3.17. What are the main materials of the **roof** of your house**?**

1. Aluminum/Zinc	2. Thatched	3. Bamboo	4. Tiles	5. Cattle dung	6. Other:	ROOF

3.18. What are the main materials used for the **wall of your house.**

1. Mud	2. Cement blocks	3. Sand crate and plaster	4. Burnt bricks	5. Wooden boards	6. Other:	WALL

3.19. Annual household Income (including other household members' [888888 = NK, 777777= Refused							INCOME

4. Motivation: Why and how CBSV became volunteers

4.1. What was the main reason for deciding to become a CBSV? (**Choose one**)

1. Work contents	2. Work condition	3. Significance of work	4. Family's suggestion	REASCHO
5. Community leaders selection		6. Acquisition of knowledge	7. Personal interest	
8. Familiarity with the community	9. No specific reason	10. Other, specify		

4.2. If the answer to question 4.1 is 5 "community leaders selection", Why were you selected?

1. Level of education (read and write)	2. Familiarity with community	3. Credibility	CBWSE
4. Previous role as a volunteers	5. Good communication skill	6. Community acceptance	
7. Other specify.....		99. NA	

4.2.1. How was the selection done?

1. Recommended by the people in the community	2. Election	3. Self nomination	CBSEL
4. By the orders of the chief and elders	5. Other(specify)	9. NA	

4.3. Why do you continue to offer voluntary services as a CBSV? (**Choose one**)

1. Acquisition of knowledge/learn	2. Future employment	3. Social recognition/prestige	REASCHO
4. Desire to help others	5. Satisfaction from helping others		
8. Sense of reciprocity	9. Other, specify:		

4.4. Are there any opportunities for promotion?	1. Yes	2. No	8. NK	OPPOMTN

Instruction: If question 4.4 is No or Not Known, record NA for questions 1.4.1 to 4.4.3

4.4.1. How long does it take to be promoted from one rank to another rank? [in years]			99.NA	LPROMTN

4.4. 2. Have you ever been promoted?	1. Yes	2. No	3. Not due for promotion	99. NA	EPROMTN

Instruction: Answer question 4.4.3 if 4.4.2 is 1(Yes) otherwise record NA

4.4.3. How long did it take you to be promoted from your previous rank? [in years]			99.NA	TPROMTN

What type(s) of monetary incentive do you receive as a volunteer, if any?

4.5.1. Monthly honorarium?	1.Yes	2.No	SUPSLRY
4.5.2 Per diem when attending training?	1.Yes	2.No	SUPTR
4.5.3 Payment for extra activities (not routinely provided)?	1.Yes	2.No	SUPEXT
4.5.4. Other, specify.....			SUPSPC

What non-monetary incentives do you receive for the work you do, if any?

4.6.1. Uniforms, backpacks, cap, etc.?	1.Yes	2.No	INCUNIF
4.6.2. Discount medicines, free tickets for care, vouchers, etc.?	1.Yes	2.No	INCDISC
4.6.3. Training?	1.Yes	2.No	INCTRN
4.6.4. Food ration/meals?	1.Yes	2.No	INCFOOD
4.6.5. Free accommodation	1.Yes	2.No	FREEHOUSE
4.6.6. Subsidized accommodation?	1.Yes	2.No	SUBHOUSE
4.6.7. Means of transport?	1.Yes	2.No	INCTRP
4.6.8. Food during training/meetings?	1.Yes	2. No	FOODTM
4.6.9. Others specify.....			INCOTR

4.7. Do you have access to any of the following as a result of being a CBSV?

4.7.1. Radio?.....	1.Yes	2.No	WRAD
4.7.2 TV?.....	1.Yes	2.No	WTV
4.7.3 Computer?	1.Yes	2.No	WPC
4.7.4. Internet access?	1.Yes	2.No	WINTERNE
4.7.5. Fridge or freezer?.....	1.Yes	2.No	WFRIDGE
4.7.6 Air conditioner/cooler/fan?	1.Yes	2.No	WAC
4.7.7. Bicycle?.....	1.Yes	2.No	WBICYCLE
4.7.8. Motorcycle?.....	1.Yes	2.No	WMOTOR
4.7.9. Car?.....	1.Yes	2.No	WCAR
4.7.10. Power Generator?	1.Yes	2.No	WSCALE
4.7.11. Solar energy.....	1.Yes	2.No	WSOLAR

4.7.12. Kerosene lantern.....	1.Yes	2.No	WKEROLA
4.7.13 Flashlight.....	1.Yes	2.No	WFLLIGHT
4.7.14 Rechargeable lamp.....	1.Yes	2.No	WRECHLA
4.7.15. Baby weight scale?.....	1.Yes	2.No	WBABYSC
4.7.16. Examination gloves ?	1.Yes	2.No	WGLOVES
4.7.17. Thermometer?.....	1.Yes	2.No	WTHERMO
4.7.18. Stethoscope?	1.Yes	2.No	WSTETHO
4.7.19. Antibiotics?.....	1.Yes	2.No	WANTI
4.7.20. Malaria RDT kit?.....	1.Yes	2.No	WRDT
4.7.21. Vaccine carrier?.....	1.Yes	2.No	VACAM
4.7.22. If other specify			OTHERS

4.8. Do you own any of these things mentioned above because you are a CBSV?	1.Yes	2.No	CBVOWN

5. Factors that affect the work of the CBSV

5.1. How long have you been working as a CBSV?			WKYRS1
5.2. How long have you been working in this community or catchment area?			WRCYRS

5.2.1. How many communities do you work in?			NAMOTHR
5.2.2 How many years have you been working in this/these community (ies)			NYEOTHE

5.3. How do you go for your routine activities from your home?

1.Walk	2. By bicycle	3. By motorcycle	4. By car	9. NA: home attached to work place	COMEANS

5.4. How long does it take you from your home to the nearest place of visit to carry out your routine activities?

1. Less than 15 minutes	2. 15 minutes- less than 30 minutes	3. 30 minutes – less than 60 minutes	COMMNE
4. 60 minutes or more	99. NA, home attached to work place		

5.5. How long does it take you from your home to the farthest place of visit to carry out your routine activities?

1. Less than 15 minutes	2. 15 minutes- less than 30 minutes	3. 30 minutes – less than 60 minutes	COMMFAR
4. 60 minutes or more	99. NA, home attached to work place		

5.6. How well did you know about this community before you started to work here?

1. Not at all	2. Hardly	3. Somewhat	4. Well	5.Very well	FAMILIAR

5.7. As a CBSV in this community or area, do you provide any of these services?

5.7.1. Child health services?	1.Yes	2.No	CBCHS
5.7.2 Family planning services?	1.Yes	2.No	FMSCB
5.7.3 Antenatal or postnatal services?	1.Yes	2.No	APNCB
5.7.4. Care for the newborn?	1.Yes	2.No	NBSCB
5.7.6. Curative services?	1.Yes	2.No	CRSCB
5.7.7. Delivery services (actual delivery of newborns)?	1.Yes	2.No	DLVCB
5.7.8. Referral services	1.Yes	2.No	REFCB
5.7.9. Other services, specify			OTHCR

5.8. How many times do you visit each of your working communities in a month? [ ][ ] MCOVER

5.9. How many days do you work per week as a CBSV? [ ] WORKDAYS

5.10. How many hours do you work as a CBSV per a working day? [ ][ ] WORKHRS

5.11. How many compounds do you visit on an average on a working day as a CBSV? [ ][ ] PATIENT

5.12. Do you have a written job description of your current work as a volunteer?	1. Yes	2. No	8. NK	JOBDISC

6. CBSV Satisfaction and attitude

6.0. How do you rate your satisfaction for the following? Also, please provide reasons or any comments.

6.1.Content of health services you are providing	1. Very satisfied	2. Satisfied	3. Neither Satisfied Nor dissatisfied	4. Dissatisfied	5. Very dissatisfied	SATCON
6.1.1 Reasons for your answer						REASO1
6.2. Level of health services you are providing	1. Very satisfied	2. Satisfied	3. Neither Satisfied Nor dissatisfied	4. Dissatisfied	5. Very dissatisfied	SATLEVE
6.2.1 Reasons for your answer						REASO12
6.3. Non-monetary incentives	1. Very satisfied	2. Satisfied	3. Neither Satisfied Nor dissatisfied	4. Dissatisfied	5. Very dissatisfied	SATNMON
6.3.1 Reasons for your answer						REASO13
6.4. Working hours	1. Very satisfied	2. Satisfied	3. Neither Satisfied Nor dissatisfied	4. Dissatisfied	5. Very dissatisfied	SATHOUR
6.4.1 Reasons for your answer						REASO55
6.5. Location	1. Very satisfied	2. Satisfied	3. Neither Satisfied Nor dissatisfied	4. Dissatisfied	5. Very dissatisfied	SATLOC
6.5.1 Reasons for your answer						REASO61

6.6. Training	1. Very satisfied	2. Satisfied	3. Neither Satisfied Nor dissatisfied	4. Dissatisfied	5. Very dissatisfied	SATTRR
6.6.1 Reasons for your answer						REASO77
6.7. Medical supplies for work	1. Very satisfied	2. Satisfied	3. Neither Satisfied Nor dissatisfied	4. Dissatisfied	5. Very dissatisfied	SATMED
6.7.1 Reasons for your answer						REAS99
6.8. Support from community members	1. Very satisfied	2. Satisfied	3. Neither Satisfied Nor dissatisfied	4. Dissatisfied	5. Very dissatisfied	SATMEM
6.8.1 Reasons for your answer						REAS100
6.9. Support from community health committee	1. Very satisfied	2. Satisfied	3. Neither Satisfied Nor dissatisfied	4. Dissatisfied	5. Very dissatisfied	SATCHC
6.9.1 Reasons for your answer						REASO11
6.10. Supervision you received	1. Very satisfied	2. Satisfied	3. Neither Satisfied Nor dissatisfied	4. Dissatisfied	5. Very dissatisfied	SATSP
6.10.1 Reasons for your answer						REASO12
6.11. Overall satisfaction with your work	1. Very satisfied	2. Satisfied	3. Neither Satisfied Nor dissatisfied	4. Dissatisfied	5. Very dissatisfied	SATALL
6.11.1 Reasons for your answer						REASO8

END OF CBSV FORM. CHECK YOUR FORM FOR COMPLETENESS AND THANK THE RESPONDENT

Appendix 3: Focus Group Discussion Guide for CBSVs

UNIVERSITY OF GHANA
DEPARTMENT OF SOCIOLOGY

Motivation among Community Based Surveillance Volunteers (CBSV) In the Ghana Health Care Delivery System

Focus Group Discussion Guide for CBSVs

Interviewer's Name:
Interview date:
District:
Community [interview location]:
Interview start time:
Interview end time:

Theme1: Knowledge and perception of volunteering

[Please I would like us to begin our discussions by talking about volunteering]. Ask them about the following:

1.1 What is volunteering? **Probe:** What is our understanding of the word volunteering?
1.2 Who is a volunteer?

Theme2: Motivation: Why and how CBSV became volunteers

[Now, I would like you to tell me why CBSVs offer voluntary services]

2.1. Is your work as a CBSV purely voluntary?

2.2. As CBSVs, why did you agree to offer voluntary service?
[**PROBE]:** "***Community's leader's selection, personal interest,*** Work content (job description), working conditions, significance of the work, family suggestions, prestige in society, etc"

2.3. How were you selected? How is the process done?
[**PROBE]:** *"Are they elected, nominated, at the order of community chiefs and elders etc etc)*

2.4. What qualities do they look out for in the selection of CBSVs?
[**PROBE]:** *"Do you consider educational level? What level of education is required?*
"Being male or female
"Familiarity with community"
"Good communication skills"
"Community acceptance and Credibility"
"Previous role as a volunteer"

2.5. As CBSVs why are men more than women? **Probe**: Any sociocultural reasons?

2.6. Why do you continue to offer voluntary service as a CBSV?

2.7. At point will you stop volunteering?

Theme3: CBSV satisfaction

3.1. How would you rate your satisfaction of the work CBSV in your community/district?
[**PROBE]:** "very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, very dissatisfied

3.2. What do mean when you say you are Very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, very dissatisfied? Almost all of you indicated one of these categories during the quantitative interviews

3.3. Why are you satisfied or not satisfied?

Theme 4: Local Institutions and community support for CBSVs

4.1. What roles do local institutions such as traditional authorities and other religious bodies play in sustaining volunteerism among CBSVs?
[**PROBE]:** encouragement, follow up, and promotion of community acceptance

4.2. What roles do local associations play in motivating CBSVs?
[**PROBE]:** Youth association, women association etc.

4.3. What support do individual community members offer to CBSVs?

4.4. What factors motivate local authorities to continue offering support to CBSVs?
[**PROBE]:** witnessing visible changes, successful referrals, contribution to community empowerment etc

Conclusion: Suggestion and recommendation

[Please we are almost finished with our discussions. I have one more question to ask]

What do you think is the most important issue to consider in motivating CBSVs to keep offering voluntary services?

Probe: If the respondent thinks that something can be done to motivate and sustain volunteering among CBSV

THANK YOU FOR YOUR TIME AND INFORMATION SHARED. DO YOU HAVE ANY QUESTIONS?

Appendix 4: In-depth Interview Guide for health administrators and opinion leaders

UNIVERSITY OF GHANA
DEPARTMENT OF SOCIOLOGY

Motivation among Community Based Surveillance Volunteers (CBSV) In the Ghana Health Care Delivery System

In-depth Interview Guide for health administrators and community opinion leaders

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Interviewer's Name:
Interview date:
District:
Community [interview location]:
Interview start time:
Interview end time:

Socio-demographic and interview information

[Please I would like us to begin our discussions by talking about ourselves]. Ask them about the following:

1.1 Age:
1.2 Sex:
1.3 Ethnicity:
1.4 Main occupation:
1.5 Position/status in community:
1.6 Number of years served in that position:
1.7 Place of residence/Community:

[WARM UP QUESTIONS]

Can you tell me a little bit about yourself and your role as a [a health administrator, chief, assemblyman etc] *(this will be dependent on who the person is and how they identify*

Theme1: Motivation: Why and how CBSV became volunteers

[Now, I would like you to tell me all that you know about CBSV and why they offer voluntary services]

1.1 What do you know about Community Based Surveillance Volunteer (CBSV)?
[**PROBE]:** "What do they do?"
"Home visits, community mobilization, health education, child health services etc"

1.2. How are CBSVs selected? How is the process done?
[**PROBE]:** *"Are they elected, nominated, at the order of community chiefs and elders etc etc)*

1.3. What qualities do you look out for in the selection of CBSVs?
[**PROBE]:** *"Do you consider educational level? What level of education is required?*
"Familiarity with community"
"Good communication skills"
"Community acceptance and Credibility"
"Previous role as a volunteer"
1.4. Is the work of a CBSV purely voluntary?

1.5. Why do you think CBSVs agree to offer voluntary service?

[**PROBE]:** "Work content (job description), working conditions, significance of the work, family suggestions, prestige in society, personal interest etc"

Theme2: Working conditions of a CBSV

2.1 How do CBSVs go for their routine activities from their homes?
[**PROBE]:** "Walk, bicycles, motor cycles, car etc"

2.2 On the average, how many communities does a CBSV cover?

2.3 On the average, how many household do CBSVs visit on a working day?

2.4. Which type(s) of benefit does a CBSV receive as a volunteer?
[**PROBE]:** "Monthly honorarium, per diem when attending training, duty allowance etc"

2.5. What non-monetary incentives do CBSVs receive for their work, if any?
[**PROBE]:** "Uniforms, backpacks, cap, discount medicines, free tickets for care, subsidized accommodation etc"

26. How would you rate your satisfaction of the work CBSV in your community/district?
[**PROBE]:** "very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, very dissatisfied

Theme3: Local Institutions and community support for CBSVs

3.1. What roles do local institutions such as traditional authorities and other religious bodies play in sustaining volunteerism among CBSVs?
[**PROBE]:** encouragement, follow up, and promotion of community acceptance

3.2. What roles do local associations play in motivating CBSVs?
[**PROBE]:** Youth association, women association etc.

3.3. What support do individual community members offer to CBSVs?

3.3. What factors motivate local authorities to continue offering support to CBSVs?
[**PROBE]:** witnessing visible changes, successful referrals, contribution to community empowerment etc

Conclusion

[Please we are almost finished with our discussions. I have one more question to ask]

What do you think is the most important issue to consider in motivating CBSVs to keep offering voluntary services?

Probe: If the respondent thinks that something can be done to motivate and sustain volunteering among CBSV

THANK YOU FOR YOUR TIME AND INFORMATION SHARED. DO YOU HAVE ANY QUESTIONS?

APPENDIX 5: INFORM CONSENT FOR FOCUS GROUP DISCUSSION (FGD)

University of Ghana Department of Sociology Study Title: Motivation among Community Based Surveillance Volunteers (CBSV) In the Ghana Health Care Delivery System Informed Consent form (Focus Group Discussion)	Subject No:

Introduction

My name is [Interviewer's Name]. I am from the Kintampo Health Research Centre and a student of the University of Ghana. I am conducting a survey on Motivation among Community Based Surveillance Volunteers (CBSV) In Kintampo North Municipality and Kintampo South District. Motivation here means what influences you to offer voluntary services. I am inviting you to take part of this study because you are a Community Based Surveillance Volunteer (CBSV) and a resident of this municipality/district. I will provide you information about the study, and request you to take part in an interview. In the course of explaining the study to you, you could stop me for clarification if you do not understand anything. You could also ask me any questions. I want to make sure you have all the information you need to decide whether to take part in the research or not.

Why the need for this study?

Community Based Surveillance Volunteers (CBSV) play important role by offering voluntary health-related services within the Ghana health care delivery system. However, we do not know what motivates these volunteers to offer these voluntary services. In view of this, the purpose if this study is to find out what motivates CBSV in carrying out health related activities at the local level in Kintampo north municipality and Kintampo south district. In doing so, we will ask you questions on why and how you became volunteer, factors that affect you work as a CBSV and how satisfied you are as a CBSV. We will also ask you about the role of community leaders in sustaining volunteerism among CBSVs. The results of this study will help the Ministry of Health (MOH), Ghana Health Services (GHS) and other stakeholders in the health sector to understand what motivates CBSVs within the CHPS framework.

What is expected of you?

If you agree to be part of this study, you will sign this form and I will continue to ask you some questions. The discussion will take between 45 minutes to an hour.

Risks or discomforts

There is minimal or no risk for taking part in this study. You will however be asked some questions, to which the responses might sound personal to you. You have the right not to answer any question which makes you uncomfortable. However, for us to be able to know and understand what motivates you to offer voluntary services, we would be glad if you could answer all the questions we ask you.

Benefits

You will not get any direct or monetary benefit for participating in the study. The information you will give us will help the Ministry of Health and Ghana Health Service to understand what motivates CBSVs in order to get the best out of them.

Confidentiality

The information that is collected from you will be used only for the purpose of this study. Only study investigators, and ethical authorities will have the right to look at study materials. We will not use your name or any information that will make it possible to identify you when we are talking or writing about this study. The information you will provide will be kept under lock and key during and after

the study period. The staff who will be speaking to you have been well trained and will not give out your information to anyone outside the study.

Voluntariness and right to withdraw

Being part of this study is completely voluntary. You have the right to leave the study at any time, or to decide not to answer any question. If you decide not to take part in this study, your decision will not affect you in any way.

Persons to contact

If, at any time, you have questions related to this study, you may contact the following persons: Mr. Samuel Afari-Asiedu (0243831933) Kintampo Health Research Centre (KHRC) and University of Ghana, or write to the following persons: Professor Kodjo Senah and Dr. Stephen Afranie through this address: University of Ghana, Department of Sociology, Post Office Box LG 65, Accra, Ghana. If you have questions as regards your rights as a study participant, please contact the chairman of the KHRC ethics committee; Dr. Eyison, at the College of Health and wellbeing, Kintampo or you can call him on telephone numbers 03520 92035 or 0209121255

Statement of consent

I confirm that I have read the information and consent form or the information and consent form has been read to me. I have asked questions and received answers concerning the areas I did not understand. I have voluntarily given consent to participate in this study. By signing this form, I have not waived any of my legal rights. I have the right to withdraw from the study at anytime without it affecting me in any way. I will be given a copy of this consent sheet.

Confirmation of consent (Participant)

Name of respondent/participant.....

Signature/left thumb print of respondent.....

Date(dd/mm/yyyy).....

Confirmation by witness

I have witnessed the accurate reading of the consent form to the potential participant and the individual has had the opportunity to ask questions. I confirm that the individual has willingly consented.

Name of witness.....

Signature/left thumbprint of witness.....

Date (dd/mm/yyyy).....

Certification by individual seeking consent

I certify that I have explained to the individual, the nature and purpose of this study. I have answered all questions that have been raised and have witnessed the above signature on the date indicated below:

Name of investigating team member.....

Signature.....

Date.....

Appendix 6: Informed Consent for CBSVs

University of Ghana Department of Sociology Study Title: **Motivation among Community Based Surveillance Volunteers (CBSV) In the Ghana Health Care Delivery System** Informed Consent form	Subject No: 000422

Introduction

My name is [Interviewer's Name]. I am from the Kintampo Health Research Centre and a student of the University of Ghana. I am conducting a survey on *Motivation among Community Based Surveillance Volunteers (CBSV) In Kintampo North Municipality and Kintampo South District.* Motivation here means what influences you to offer voluntary services. I am inviting you to take part of this study because you are a Community Based Surveillance Volunteer (CBSV) and a resident of this municipality/district. I will provide you information about the study, and request you to take part in an interview. In the course of explaining the study to you, you could stop me for clarification if you do not understand anything. You could also ask me any questions. I want to make sure you have all the information you need to decide whether to take part in the research or not.

Why the need for this study?

Community Based Surveillance Volunteers (CBSV) play important role by offering voluntary health-related services within the Ghana health care delivery system. However, we do not know what motivates these volunteers to offer these voluntary services. In view of this, the purpose if this study is to find out what motivates CBSV in carrying out health related activities at the local level in Kintampo north municipality and Kintampo south district. In doing so, we will ask you questions on why and how you became volunteer, factors that affect you work as a CBSV and how satisfied you are as a CBSV. The results of this study will help the Ministry of Health (MOH), Ghana Health Services (GHS) and other stakeholders in the health sector to understand what motivates CBSVs within the CHPS framework.

What is expected of you?

If you agree to be part of this study, you will sign this form and I will continue to ask you some questions. The interview will take about 30 minutes. You will respond to questions that will be read out to you from a questionnaire.

Risks or discomforts

There is minimal or no risk for taking part in this study. You will however be asked some questions, to which the responses might sound personal to you. You have the right not to answer any question which makes you uncomfortable. However, for us to be able to know and understand what motivates you to offer voluntary services, we would be glad if you could answer all the questions we ask you.

Benefits

You will not get any direct or monetary benefit for participating in the study. The information you will give us will help the Ministry of Health and Ghana Health Service to understand what motivates CBSVs in order to get the best out of them.

Confidentiality

The information that is collected from you will be used only for the purpose of this study. Only study investigators, and ethical authorities will have the right to look at study materials. We will not use your name or any information that will make it possible to identify you when we are talking or writing about this study. The information you will provide will be kept under lock and key during and after

CERTIFIED: KINTAMPO HEALTH RESEARCH CENTRE INSTITUTIONAL ETHICS COMMITTEE

the study period. The staff who will be speaking to you have been well trained and will not give out your information to anyone outside the study.

Voluntariness and right to withdraw

Being part of this study is completely voluntary. You have the right to leave the study at any time, or to decide not to answer any question. If you decide not to take part in this study, your decision will not affect you in any way.

Persons to contact

If, at any time, you have questions related to this study, you may contact the following persons: Mr. Samuel Afari-Asiedu (0243831933) Kintampo Health Research Centre (KHRC) and the University of Ghana, or write to the following persons: Professor Kodjo Senah and Dr. Stephen Afranie through this address: University of Ghana, Department of Sociology, Post Office Box LG 65, Accra, Ghana. If you have questions as regards your rights as a study participant, please contact the chairman of the KHRC ethics committee; Dr. Eyison, at the College of Health and wellbeing, Kintampo or you can call him on telephone numbers 03520 92035 or 0209121255

Statement of consent

I confirm that I have read the information and consent form or the information and consent form has been read to me. I have asked questions and received answers concerning the areas I did not understand. I have voluntarily given consent to participate in this study. By signing this form, I have not waived any of my legal rights. I have the right to withdraw from the study at anytime without it affecting me in any way. I will be given a copy of this consent sheet.

Confirmation of consent (Participant)

Name of respondent/participant.....

Signature/left thumb print of respondent.....

Date(dd/mm/yyyy).....

Confirmation by witness

I have witnessed the accurate reading of the consent form to the potential participant and the individual has had the opportunity to ask questions. I confirm that the individual has willingly consented.

Name of witness.....

Signature/left thumbprint of witness.....

Date (dd/mm/yyyy).....

Certification by individual seeking consent

I certify that I have explained to the individual, the nature and purpose of this study. I have answered all questions that have been raised and have witnessed the above signature on the date indicated below:

Name of investigating team member.....

Signature.....

Date.....

Appendix 7: Informed Consent for IDI

University of Ghana Department of Sociology Study Title: Motivation among Community Based Surveillance Volunteers (CBSV) In the Ghana Health Care Delivery System Informed Consent form (In-depth interviews)	Subject No: 000017

Introduction

My name is [Interviewer's Name]. I am from the Kintampo Health Research Centre and a student of the University of Ghana. I am conducting a survey on Motivation among Community Based Surveillance Volunteers (CBSV) In Kintampo North Municipality and Kintampo South District. Motivation here means what influences you to offer voluntary services. I am inviting you to take part of this study because you are a Community Based Surveillance Volunteer (CBSV) and a resident of this municipality/district. I will provide you information about the study, and request you to take part in an interview. In the course of explaining the study to you, you could stop me for clarification if you do not understand anything. You could also ask me any questions. I want to make sure you have all the information you need to decide whether to take part in the research or not.

Why the need for this study?

Community Based Surveillance Volunteers (CBSV) play important role by offering voluntary health-related services within the Ghana health care delivery system. However, we do not know what motivates these volunteers to offer these voluntary services. In view of this, the purpose if this study is to find out what motivates CBSV in carrying out health related activities at the local level in Kintampo north municipality and Kintampo south district. In doing so, we will ask you questions on why and how you became volunteer, factors that affect you work as a CBSV and how satisfied you are as a CBSV. The results of this study will help the Ministry of Health (MOH), Ghana Health Services (GHS) and other stakeholders in the health sector to understand what motivates CBSVs within the CHPS framework.

What is expected of you?

If you agree to be part of this study, you will sign this form and I will continue to ask you some questions. The interview will take about 30 minutes.

Risks or discomforts

There is minimal or no risk for taking part in this study. You will however be asked some questions, to which the responses might sound personal to you. You have the right not to answer any question which makes you uncomfortable. However, for us to be able to know and understand what motivates you to offer voluntary services, we would be glad if you could answer all the questions we ask you.

Benefits

You will not get any direct or monetary benefit for participating in the study. The information you will give us will help the Ministry of Health and Ghana Health Service to understand what motivates CBSVs in order to get the best out of them.

Confidentiality

The information that is collected from you will be used only for the purpose of this study. Only study investigators, and ethical authorities will have the right to look at study materials. We will not use your name or any information that will make it possible to identify you when we are talking or writing about this study. The information you will provide will be kept under lock and key during and after the study period. The staff who will be speaking to you have been well trained and will not give out your information to anyone outside the study.

Voluntariness and right to withdraw

Being part of this study is completely voluntary. You have the right to leave the study at any time, or to decide not to answer any question. If you decide not to take part in this study, your decision will not affect you in any way.

Persons to contact

If, at any time, you have questions related to this study, you may contact the following persons: Mr. Samuel Afari Asiedu (0243831933) Kintampo Health Research Centre (KHRC) and University of Ghana, or write to the following persons: Professor Kodjo Senah and Dr. Stephen Afranie through this address: University of Ghana, Department of Sociology, Post Office Box LG 65, Accra, Ghana. If you have questions as regards your rights as a study participant, please contact the chairman of the KHRC ethics committee; Dr. Eyison, at the College of Health and wellbeing, Kintampo or you can call him on telephone numbers 03520 92035 or 0209121255

Statement of consent

I confirm that I have read the information and consent form or the information and consent form has been read to me. I have asked questions and received answers concerning the areas I did not understand. I have voluntarily given consent to participate in this study. By signing this form, I have not waived any of my legal rights. I have the right to withdraw from the study at anytime without it affecting me in any way. I will be given a copy of this consent sheet.

Confirmation of consent (Participant)

Name of respondent/participant.....

Signature/left thumb print of respondent.....

Date(dd/mm/yyyy.....

Confirmation by witness

I have witnessed the accurate reading of the consent form to the potential participant and the individual has had the opportunity to ask questions. I confirm that the individual has willingly consented.

Name of witness.....

Signature/left thumbprint of witness.....

Date (dd/mm/yyyy).....

Certification by individual seeking consent

I certify that I have explained to the individual, the nature and purpose of this study. I have answered all questions that have been raised and have witnessed the above signature on the date indicated below:

Name of investigating team member.....

Signature.....

Date.....

Appendix 8: Decision of Scientific Review Committee

Kintampo Health Research Centre
Ghana Health service P. O. Box 200
Kintampo
Brong Ahafo Region
Tel: +233-3520 92037Fax:+233-38872

In case of reply the Number and date of this Letter should be quoted.

My Ref.: SRC/081014

Your Ref. No.

8 October 2014

The Principal Investigator,
Motivation among CBSVs In Ghana Health Care study
Kintampo Health Research Centre
P.O. Box 200
Kintampo

Dear Principal Investigator,

Decision on your protocol

Your protocol entitled **"Motivation among Community Based Surveillance Volunteers (CBSVs) In Ghana Health Care Delivery System"** has been reviewed.

It is my pleasure to inform you that the protocol was given full approval by the Scientific Review Committee (SRC). Please submit a soft copy of the final protocol to the SRC for records keeping.

You are also required to submit a copy of the final protocol to the Kintampo Health Research Centre Institutional Ethics Committee for ethical approval before commencement of the study.

Accept my congratulations.

Seth Owusu-Agyei
(Chairman)

Appendix 9: Ethical Approval Certificate

Kintampo Health Research Centre (KHRC) Institutional Ethics Committee (IEC)
P.O Box 200
Kintampo, B/A
Ghana, West Africa

Tel: +233(3520)92037 (Ext 117)
E-mail: fred.kanyoke@kintampo-hrc.org

FULL ETHICAL APPROVAL CERTIFICATE

Samuel Afari-Asiedu
Kintampo Health Research Centre
Box 200
Kintampo, B/A
Ghana, West Africa

Date: 23rd October 2014

Study File Number: 2014-28

Title of study: Motivation among Community Based Surveillance Volunteers (CBSVs) in Ghana Health Care Delivery System

Principal Investigator(s): Samuel Afari-Asiedu

Supervisor(s): Prof. Kodjoh Senah, Dr. Stephen Afranie

Type of Review: Full Board Review

Approval Date: 14th October, 2014

Expiration Date: 14th October, 2015

1. The Kintampo Health Research Centre Institutional Ethics Committee (IEC) is constituted and operates in conformance with requirements of 45 CFR 46, 21 CFR 50, 21 CFR 56 and section 3 of the International Council on Harmonization Guidelines. The OHRP Federal wide Assurance number for the committee is 00011103; the IRB registration number is 0004854.

2. The above study in title was reviewed by the IEC on 14th October, 2014.

3. A full ethical approval was granted for implementation of the study.

4. The following documents were reviewed and approved;
   - 4.1 Motivation among Community Based Surveillance Volunteers (CBSVs) in Ghana Health Care Delivery System. Version 2
   - 4.2 Informed consent form (In-depth interview), version 011014
   - 4.3 Informed consent form (CBSV), version 011014
   - 4.4 Data collection tools
   - 4.4.1 In-depth interview guide for health administrators and community opinion leaders
   - 4.4.2 CBSV questionnaire, version 260914
   - 4.5 Study Budget

File number: 2014-28

Page 1 of 2

THE CHAIRMAN, KINTAMPO
HEALTH RESEARCH CENTRE
INSTITUTIONAL ETHICS
COMMITTEE

Kintampo Health Research Centre (KHRC) Institutional Ethics Committee (IEC)
P.O Box 200
Kintampo, B/A
Ghana, West Africa

Tel: +233(3520)92037 (Ext 117)
E-mail: fred.kanyoke@kintampo-hrc.org

4.6 Curriculum Vitae of Principal Investigator

5. During study implementation, the IEC must be informed within 72 hours by the principal investigator (PI) of learning of any (a) unexpected, serious, study related adverse events; (b) disclosed adverse events, or (c) unanticipated problems with the study which may pose risk to study participants or others.

6. Changes or modifications to this research activity must be submitted and approved by the IEC before they are implemented.

7. PI(s) would be required to submit application for renewal of this approval certificate (if necessary) plus a progress report.

8. PI(s) is required to notify the IEC of study completion (end of data collection/last follow-up) or early termination of the research project.

9. Submit final report of the study three months after approval certificate expires (study closure)

10. Before conduct of the study, submit original/final copy of your informed consent forms for an **authentication stamp** before making photocopies for your consent process.

11. Regulated study records, including IEC approvals and signed consent forms, must be securely maintained by PI(s) and available for audits for three years after the study is closed with the IEC.

Sincerely,

THE CHAIRMAN, KINTAMPO
HEALTH RESEARCH CENTRE
INSTITUTIONAL ETHICS
COMMITTEE

.....

Mrs. Charlotte Agyeniang-Tawiah
Vice-Chair
Institutional Ethics Committee
Kintampo Health Research Centre

File number: 2014-28