# CRITICAL ANALYSIS ON THE VIABILITY OF USING COMMUNITY BASED SURVEILLANCE VOLUNTEERS IN HEALTH SERVICE DELIVERY


**BY**

**RICHARD KWASI HENNEH B.Sc(Hons) Nursing**




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# DECLARATION

I hereby declare that this submission is my own original research and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of this University or any other institution. References from the works of others have been duly acknowledged.



Richard Kwasi Henneh ..... 28/09/09

**Student** Signature Date

Student ID Number : 20065939

Certified by:

Dr Seth Owusu-Agyei ..... 28/09/09

**Supervisor** Signature Date

Certified by:

Prof. Edward Badu ..... 15/10/09

**Dean of Institution** Signature Date

# ABSTRACT

The use of Community Health Volunteers (CHVs) to support health delivery systems in Ghana has been employed since the implementation of the Primary Heath Care in 1978. Ironically most of the previous CHV schemes could not be sustained. Nonetheless, the success of any community health programme depends very much on the extent to which the community participates. Invariably the non-viability of CHVs could undermine the success of any community programmes. Thus knowing how viable the present community health volunteer's schemes are would be useful to health planners and/ or health managers.



The main objective of the study was to ascertain the viability of using Community-Based Surveillance Volunteers (CBSVs) in health delivery systems.

A descriptive cross-sectional study using both quantitative and qualitative methods was employed. A total of 132 CBSVs were randomly selected using a table of random numbers. Records of CBS volunteers at the North and South district health directorates, health facilities and in the communities were also updated and reviewed. Community leaders and health workers directly involved in CBS volunteers were interviewed as key informants. History of previous village or community volunteers were also elicited using the snowball technique.

Majority of the respondents, 118 (89.4%) intended to work as volunteers for good. Besides, the level of satisfaction and motivation and morale among the CBSVs were found to be high. Volunteers expected financial and material gains from both the community leaders and the health

workers. Nevertheless whilst the health workers have significantly supported the CBSV in terms of money, Wellington Boots, rain coats, etc. the community leaders were yet to support the volunteers.

The present scheme was found to be an improvement over the pervious ones in areas of supervision, communication, training and capacity building; there were positive features which could make the scheme viable. However the spirit of volunteerism where people use their time, effort and energy to help their communities without asking for financial gains are found to be at the lowest in the study area which is a threat to the viability of the scheme.



It is recommended among other things that the Ministry of Health, Ghana Health Service, District Assemblies for Nkoranza North and South district as well as other stakeholders should mobilize financial resources to support the CBS volunteers regularly.

# DEDICATION

This piece of work is dedicated to my wife, Mrs. Paulina Henneh and my children Bridget, Amanda, Gillian and Richard (Jnr) for their prayers, patience and support during the period of the programme. I also dedicate this work to my mother Grace Akua Ameaa who has made me what I am today.

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Last but not the least, I thank my wife Paulina Henneh and my children Bridget, Amanda, Gillian and Richard Jnr for their tolerance, warmth and encouragement; these motivated me to work hard to produce this piece of work.



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| | |
|---|---|
| AFP | Acute Flaccid Paralysis |
| AIDS | Acquired Immuned Deficiency Syndrome |
| BARIDEP | Brong Ahafo Rural Integrated Development |
| CBSV | Community-based Surveillance Volunteer |
| CCA | Community Clinic Attendant |
| CHC | Community Health Committee |
| CHPS | Community-based Health Planning and Services |
| CHV | Community Health Volunteer |
| CDD | Community Drug Distributors |
| CDFPV | Community-based Distribution of Family Planning Volunteer |
| CDTI | Community Distributors of Ivermectin |
| CP | Community Participation |
| CSM | Cerebrospinal Meningitis |
| DHMT | District Health Management Team |
| FP | Family Planning |
| HIV | Human Immuno-Deficiency Syndrome |
| IMC | Institutional Management Committee |
| ITN | Insecticide Treated Net |

| | |
|---|---|
| KHRC | Kintampo Health Research Centre |
| KRHTS | Kintampo Rural Health Training School |
| MCH | Maternal and Child Health |
| NID | National Immunisation Day |
| PHC | Primary Health Care |
| TB | Tuberculosis |
| TBA | Traditional Birth Attendant |
| VHV | Village Health Volunteer |
| WHO | World Health Organisation |

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# CHAPTER ONE

## 1.0: INTRODUCTION

In this chapter, the topic under study has been introduced by giving a brief background to the subject, the statement of the problem that warranted the study and the rationale, the conceptual framework that guided the study, the research questions and the objectives for the research.

### 1.1: BACKGROUND OF THE STUDY

The use of Community Health Volunteers (CHVs) to support health delivery systems has been employed since the implementation of the Primary Health Care. However most of these CHVs were short-lived. They come with the zeal to do exuberant work but only to disappear into thin air when they are faced with challenges. Within the past thirty years the health sector has worked with myriads of community health volunteers. They included the community clinic attendants (CCAs), Village health volunteers (VHVs), Community Drug Distributors (CDD), Community Distributors of Ivermectin (CDTI ) volunteers, Community-based Health Planning and Services (CHPS) volunteers, Community-based Distributors of Family Planning (CDFP) volunteers, National Immunization Days (NID) volunteers and Institutional Management Committees (IMCs). Even the traditional birth attendants (TBAs) are eventually being face out as the trained TBAs are no longer considered as skilled attendants. Nonetheless, the success of any health programme depends very much on the extent to which the community participates. Thus knowing how viable the community health volunteers or village health volunteers are is very useful to health planners or health managers.

This study critically analyses the prospect or viability of using community-based surveillance (CBS) volunteers in health delivery systems.

## 1.2 STUDY AREA

The study was conducted in the Nkoranza North and South districts (formerly Nkoranza District) in the Brong Ahafo Region. However, since the profiles for the two districts were being finalized at the commencement of the study, the researcher by rule of thumb described the districts as one.



The district has an estimated population of 157.125 with an assumed projected annual growth of about 2.5%. There are 190 communities in the district. The district shares boundaries with Kintampo South District in the North, Techiman District in the West, Atebubu-Amantin District to the East, all in the Brong Ahafo Region, as well as Offinso District in the South and Ejura-Sekyere-Odumase District in the South East.

The district's vegetation is mainly of the forest –savannah transition zone. Farming forms about 70% to 80% of the occupation in the district. The main indigenous ethnic groups are the Brongs. The people are predominantly Christians. There are also a calculated number of Moslems and traditionalists.

The district has been demarcated into eight (8) sub-districts to facilitate access to health services. There currently exist one hospital, eleven health centres and two community-based health planning and services (CHPS) compounds.

Apart from the health staff, the district also makes use of trained traditional birth attendants (TBAs) and community-based surveillance volunteers (CBSVs) in the health delivery systems. Within the past four years, about 420 CBSVs have been trained.

### 1.3: STATEMENT OF THE PROBLEM

Since 1978 when the global primary health care initiative was launched, there have been several efforts to strengthen community participation in the provision of essential health care, and one structure that has been paramount in delivering primary health care activities is the establishment of the community health volunteers scheme. Invariably, the progressive involvement of the community health volunteers in the provision of essential health care has led to the solution of numerous health problems at the local level. Most community programmes and projects were implemented using the community health volunteers. However the successes of these programmes were short-lived because the community heath volunteers schemes could not be sustained.



In Ghana, within the past thirty years the health sector has worked with myriads of community health volunteers under different names and capacities. These included the community or village health volunteers (CHV or VHV), community clinic attendant (CCA), community drug distribution (CDD) volunteers, ??? (CDTI) volunteers, Community-based Health Planning (CHPS) initiative volunteers, Community-based Distributors of Family Planning (CDFP), National Immunization Days (NID) volunteers, Institutional Management Committees (IMCs). All these community health workers or volunteers could not be sustained. Even the trained traditional birth attendants (TBAs) programme is now being strangulated to die slowly.

The approach for all these CHVs is that they had one or few specific functions which they were supposed to render. Hence there were so many different volunteers co-existing in the communities which made their sustainability highly impossible due to inadequate funds to support their organization, poor supervision and lack of motivation. For instance, there were volunteers for guinea-worm eradication, onchocerciasis control programme, community-based health planning and services (CHPS), weaning food projects and nutrition surveillance, family planning campaign as well as volunteers for national immunization days (NIDs). Even there were volunteers for institutional management committees.



In an attempt to address this problem of unsustainability of CHVs that the Brong Ahafo Region has identified the Community-based surveillance volunteers (CBSVs) who were originally trained to support guinea-worm eradication, to be doing all health activities in the communities. Thus, currently the new approach being used in the Brong Ahafo Region of Ghana is somewhat a polyvalent volunteer scheme. The CBSV is supposed to do active case search for diseases such as buruli ulcers, Guinea worm, yaws ,acute flaccid paralysis; Ivermectin distribution, health education, support the organization of Child Welfare clinic, and promotion of ITNs. In some districts in the Brong Ahafo Region such as Techiman, Wenchi, Tain, Kintampo North, Kintampo South, Nkoranza North and Nkoranza South, the role of the CBSVs has been expanded to include taking care of the newly born babies and their mothers.

With this current approach the CBSV appears to be the panacea to address community involvement in health care. Nonetheless, the critical question is whether the CBSV is a viable option. In other words, is the CBSV scheme as being operated in the Brong-Ahafo Region viable? It is hoped that the study will provide answers to this and many more questions.

## 1.4: SOME PERTINENT RESEARCH QUESTIONS

The study was set out to address the following research questions:

- Is the CBSV approach a more viable option to Village Health Volunteer?
- How challenging could the numerous duties of the CBSV be?
- Do CBSVs have the capabilities to do the different things they have to do?
- Are they motivated to work?
- What are the expectations of the CBSVs?



## 1.5: STUDY OBJECTIVES

### 1.5.1 MAIN OBJECTIVE

The main objective of the study was to ascertain the viability of using Community–Based Surveillance Volunteers (CBSVs) in health delivery systems.

### 1.5.2: SPECIFIC OBJECTIVES

The specific objectives were:

1. To review the previous VHV systems in order to ascertain why they were not viable
2. To determine whether CBSVs have the capabilities to do the different things they have to do
3. To find out whether CBSVs are motivated to work.
4. To look at the expectations/ level of satisfaction of the CBSVs
5. To make the necessary recommendations to the appropriate stakeholders of health care.

## 1.6: RELEVANCE OF THE STUDY

It is over 30 years now since Ghana started using community or village health volunteers in community health programmes/ projects. Yet the sustainability of the volunteers has always been a mirage. However the success of any community health programme depends on the extent to which the community participate through the community health volunteers. The study is therefore relevant for health managers and health service providers as well as community leaders as the findings could be used as inputs or impetus to make the current CBS volunteers scheme viable.



## 1.7: THE SCOPE OF THE RESEARCH

This study was designed to identify and describe strengths and weaknesses in the present community health volunteers scheme as being operated in Nkoranza Nortth and South districts of the Brong Ahafo Region of Ghana. Thus the study critically analyzed the scheme and came out with factors or features that could enhance its viability as well as those that could undermine it. The study did not intend to test for the level of significance of any of the variables found to either enhance or undermine the viability of the CBS volunteers scheme.

## 1.8: DEFINITIONS OF VARIABLES TO BE MEASURED

Detailed definitions of variables to be measured in the study are discussed in Chapter 3 under the 3.2 sub-title. Few operational definitions are outlined here.

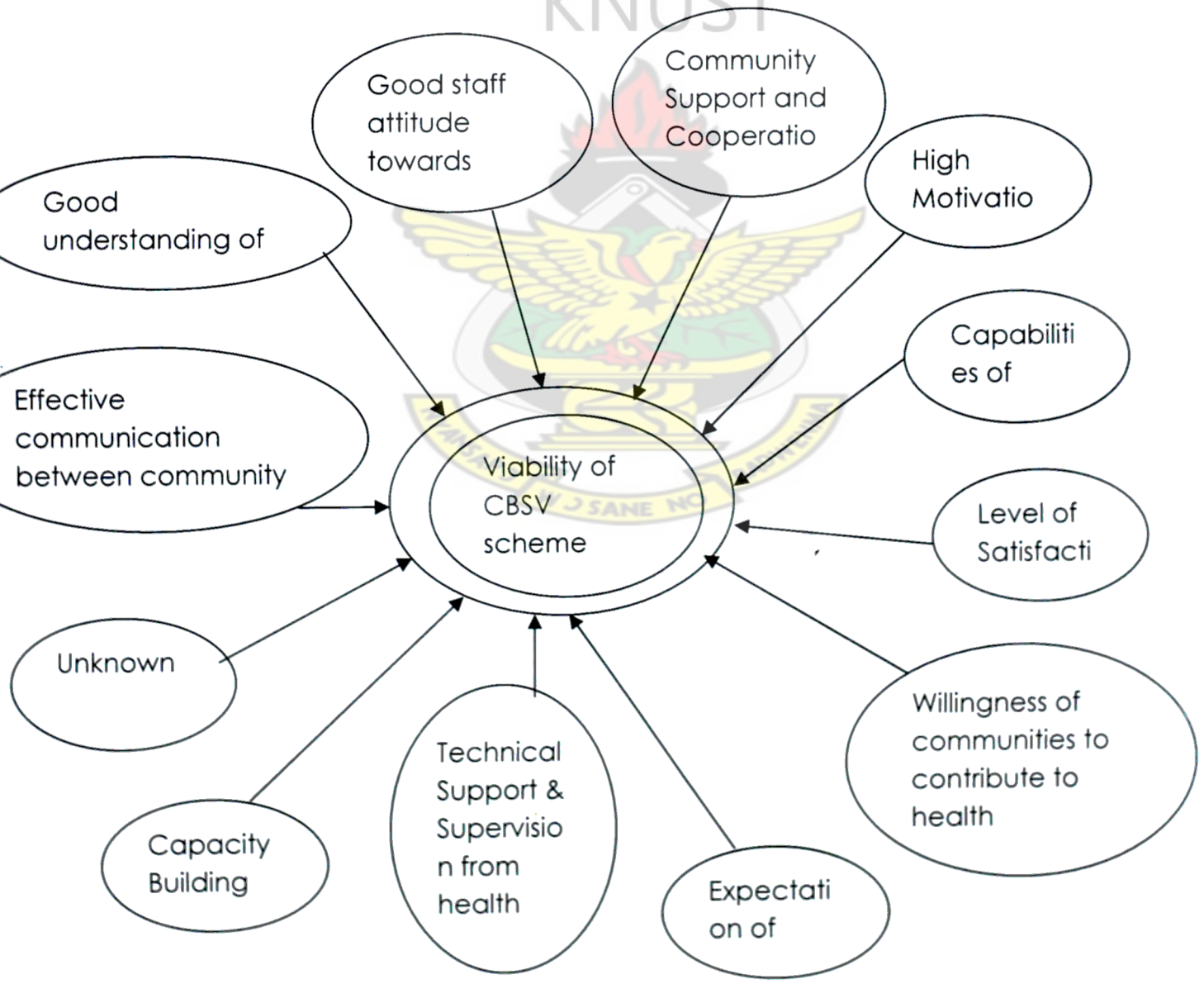
- **Community Health Volunteer (CHV):** Is a person selected by the local community or with their agreement to deal with matters relating to the health of individuals, families in

a community. The term is synonymous with Community health worker (CHW) or Village health volunteer (VHV)

- **Community-based Surveillance Volunteer (CBSV):** Is a community health volunteer originally trained for guinea-worm eradication programme but now has his roles expanded to cover all community health activities.
- **Viability:** Refers to the sustainability of the CSBV scheme.

**1.9 : ANALYSIS DIAGRAM: FACTORS ENHANCING VIABILITY OF CBSVs SCHEME**






**SOURCE: AUTHOR'S CONSTRUCT, MARCH 2009**

# CHAPTER TWO

## 2.0: LITERATURE REVIEW

In this chapter, relevant literature introducing Community participation (CP) in health development process, the concepts of volunteerism and community health volunteers (CHVs), use of CHVs in Ghana, and the concepts of Community-based surveillance volunteers as applied in the Brong Ahafo Region of Ghana have been reviewed.

## 2.1 INTRODUCTION

The conceptual gap between communities and health planners or health service providers has always led to the failure of many development projects or programmes. Henneh (1998) identified community participation (CP) as a key factor in the improvement of these development projects or programmes. Earlier Adam and Smith (1989) had observed that without CP and involvement "Health for all by the year 2000 would not be realized. And indeed the year 2000 has passed without health for all eluding us. Invariably the concept of CP is the brain-child of the Alma Ata Conference on Primary Health Care (PHC) held in 1978, where participants conceived CP in health development process as a means to an end and as an end in itself (Pappoe, 1993).

One school of thought defines CP as health activities that members of the community carry out themselves; very distinct from those being provided by the formal professional health services (Askew in Akhtar, 1991). According to this interpretation, CP is seen as a means to a more efficient and effective health care using community health volunteers (Henneh, 1998).

A literature review of MOH (1996), White 1982, cited in Pappoe (1993), Philips (1990), WHO (1991) and Henneh (1998) has also indicated that:

- With good mobilization, community on its own has potential resources which can be utilized for the benefit of the majority.
- When well sensitized, the needy majority can do a lot more in their own environment than by health services in isolation.
- The right of decision on what affects the daily life is in the hands of the community. The phenomenon increases self-confidence.



Considering the above, one can say that the success of any health programme depends very much on the extent to which the community participates in the programme, using community health structures including the community health volunteers. A review of the literature indicates that it is the conception applied by most national health programmes in the third world including Ghana (Pappoe, 1993).

## 2.2 THE CONCEPTS OF VOLUNTEERISM

**Volunteerism** is the willingness of people to work on behalf of others without being motivated by financial or material gain. **Volunteers** may have special training as rescuers, guides, assistants, teachers, missionaries, **amateur radio operators**, writers, and in other positions. Majority work on an impromptu basis, recognizing a need and filling it, whether it be the dramatic search for a lost child or the everyday giving of directions to a lost visitor. In **economics**, **voluntary employment** is unpaid **employment**. It may be done for altruistic reasons, for example **charity**, as a **hobby**, community service or **vocation**, or for the purpose of

gaining experience. Some go so far as to dedicate much of their lives to voluntary service (Townsend et al, 1999).

Australian Council of Social Service (1997) defined volunteering as "work which provides a service to the community is done of one's own free will and is done without monetary reward."

Volunteering, in fact is the most fundamental act of citizenship and philanthropy in our society. It is offering time, energy and skills of one's own free will. It is an extension of being a good neighbour, transforming a collection of houses into a community, as people become involved in the improvement of their surroundings and choose to help others.



From the Ontario's Good Neighbours Campaign report (2007), when you take the time to volunteer and help neighbours you strengthen local bonds, enrich community life, and contribute to a greater sense of security in your neighbourhood. According to Random House Webster's Unabridged Dictionary (1997), Volunteerism is defined as the policy or practice of volunteering one's time or talents for charitable, educational, or other worthwhile activities, especially in one's community. This definition, however fails to capture the real essence of volunteerism– the effect it has on the volunteers themselves. According to the Wikipedia (2007) volunteering does not only involve helping one's community, it helps oneself. Thus, Volunteerism, in its conceptual form, includes the individual or collective efforts of willing individuals, known as volunteers, to act in ways which work toward the betterment of oneself, other individuals, communities, and/or society. This definition remains subjective in its ambiguity regarding the meaning of betterment, as well as in the sense that the means to bettering oneself may be in direct opposition to the means necessary to better another individual or society

Pakistanis for example, consider volunteerism to be one of the important tools for addressing the problem of exclusion. It provides a vehicle for empowering excluded population groups to gain access to opportunities (ibid, 2007).

By caring and contributing to change, volunteers decrease suffering and disparity, while they gain skills, self-esteem, and change their lives. People work to improve the lives of their neighbours and, in return, enhance their own.

Other working definitions of Volunteerisms from Wikipedia (2007) include the following:

- Volunteerism is the willingness of people to work on behalf of others without being motivated by financial gain.
- The reliance on volunteers to perform an important social or educational function.
- Performing an act of kindness, freely giving of your talent, time, and effort for the simple fulfilment of community expectations.
- Is the theory, act, or practice of being a volunteer or of using volunteers in community service work?
- Refers to engaging in activities where the primary emphasis is on the service being provided and the primary intended beneficiary is clearly the service recipient.



## 2.3: WHO IS A VOLUNTEER?

There are many definitions, but no universal agreement. The following are working definitions.

**Volunteer,** *verb* - To choose to act in recognition of a need, with an attitude of social responsibility and without concern for monetary profit, going beyond one's basic obligations (Ellis & Campel, Undated)

**Volunteer,** *noun* – from the *perspective of the doer*: Someone who gives time, effort and talent to a need or cause without profiting monetarily (ibid)

**Volunteer,** *noun* – from the *perspective of the recipient of service*: Someone who contributes time, effort and talent to meet a need or further a mission, without going on the payroll (ibid).

## 2.4: TYPES OF VOLUNTEERS

Volunteers come from all walks of life, representing all ages and demographics. They volunteer for many different reasons and offer vastly different types of skills and services. They include accountants who sit on boards, someone who is visually impaired may work by phone, another person who is developmentally challenged may tend gardens, and a new Pakistani may program computers (ibid).



## 2.5: WHY DO PEOPLE VOLUNTEER?

Some have chosen to become involved so they can provide a needed service, solve a problem or advance a worthy cause; others look for personal development. Many volunteer for both altruistic and personal reasons. People make contacts, learn skills, gain work experience, build self-esteem, improve their health, sometimes finding paying jobs and sometimes turn their lives around through volunteer work. They don't work for money; they work for less tangible but equally important forms of remuneration such as satisfaction, appreciation and the opportunity to build skills. Volunteers are seeking increasing (Townsend, 1999).

## 2.6: THE CONCEPTS OF COMMUNITY HEALTH VOLUNTEERS (CHVS)

CHVs are members of their own communities and are trained in basic health promotion, prevention and cure. They include traditional birth attendants (TBAs) and traditional practitioners. The term CHV is used synonymous with VHV (village health volunteer). Increasingly CHVs or VHVs are seen as important primary health workers, and usually work best when supported by good local community organization (Johnstone & Ranken, 1994).

The structure, mode of selection and activities of CHVs differ from one place to another. For instance in Pakistan CHVs are selected by community or village health committees (CHC or VHC) [ibid] whilst in Ghana they are mostly selected by the entire community. In some part of Sudan the interested members of the community come out voluntarily to form the voluntary group. In Ghana, the community-based surveillance volunteers (CBSVs) as well as other VHVs are mostly selected by the entire community members. In some instances the traditional authorities and some opinion leaders such as the assemblymen select them (DHMT Report, 2004).

As stated earlier, the activities of the CHVs differ from one place to another. Some CHVs perform a single activity such as Public sanitation, Vaccination Programme, Family Planning and Surveillance whilst others such as the CBSVs in Ghana are engaged in multiple activities. There are also CHVs who are engaged in a small programme area such as the volunteers for Cleaning Campaign in Khartoum, Sudan; Income Generation for the elderly Project in Vilcabamba, Equador; Bee-keeping Project in Kenya; Tree Planting Project in Somalia; Grandmother's Community Kitchen Programme in Lima, Peru; The Elders' Day Centre Projects in Ratmanala, Sri Lanka; "Reach" Home Visiting Programme in Dominica; Blind Men's Association in

Gujarat, India; Ivermectin Distribution in Onchcerciasis Special Intervention Zone in Ghana and The Sing Community Nutrition Project also in Ghana ( Johnstone and Ranken, 1994; Ray,1986; Wood, 1981; WHO ,1989; and Henneh, 1998, and DHMT Report, 2006)

In the spirit of volunteerism CHVs do not work for money. Many people work for other reasons than just for money. What is important is good management to make people work more interesting and rewarding so that people would want to give their best effort. This is MOTIVATION, or getting the best out of people ***without necessarily paying them*** (Johnstone & Ranken, 1994).



Nevertheless one school of thought contends that CHVs need not be totally dependent on voluntary, unpaid work. The community health committee (CHC) or community leaders could arrange for a local fee-for service such as a small payment or gift. However such decisions should be made by the CHC alone and any problems arising with payment should be settled between the CHC or community leaders and the volunteer workers. The district authorities e.g. District Assembly and District Health Directorate can support the CHVs or VHVs in other ways than in payment such as supplying regular health education materials, providing on-going training workshops and arranging progress meetings (Johnstone and Ranken, 1994).

Another possibility is that the higher authorities could give a one-off payment for attending a training programme (called an attendance allowance or a clothing allowance). It should be made clear that this is a once only allowance, and not payment, and should cover lost earnings/ travel for attending a workshop.

This concept of voluntary work scheme has been adopted successfully in Sudan, Pakistan, India, Indonesia and Malawi. The volunteers worked independently from outside help and did not receive payment. The group success and viability however depended on their motivation to work for their community, high spirit of volunteerism and regular meetings and team support (ibid).

In Zambezia a better refined community volunteer structure or model known as Community Council had successfully been used by World Vision for a number of health projects. The community council comprises two groups of people: the members of the council and the volunteers. There are usually between 5 and 10 members and between 10 and 20 volunteers in each council. The members of the Council are leaders of the community, usually a traditional leader, an administrative leader, representatives of various religious groups and political parties, traditional healers and traditional birth attendants. The volunteers are usually women and a few young men. Some Community Councils also have a Mother's Group, created more recently, with the objective of demonstrating to other women enriched foods for malnourished children.

The members of the Council and the volunteers were trained together. The role of the volunteers is to visit 10 houses in the village regularly to pass on what they have learnt, to look for signs of illness and to encourage people to seek treatment or to take actions that prevent sickness. The role of the members of the Council is to organise the work of the volunteers, prepare reports and maintain contact with the local health unit and local government. In practice the role of the members of the Council has also been to support the volunteers when they have difficulty in carrying out their work. Nevertheless, in the early stages of the work of a Council there is often resistance to the advice given to households by the volunteers and back up by members of the community with a leadership role is important.

The concept community health volunteer has however failed in countries such as Ghana. Even the TBAs and traditional practitioners could not sustain free voluntary work. They are now charging user fees. It is on this past failure of Ghana's voluntary work scheme especially in the villages that this study was set out to ascertain the viability of the Community-based surveillance volunteers (CBSVs) scheme.

## 2.7: USE OF COMMUNITY HEALTH VOLUNTEERS (CHVS) IN GHANA

In Ghana several attempts have been made at promoting community participation using Community Health Volunteers, especially in Primary Health Care activities. These include the Brong Ahafo Rural Integrated Development – BARIDEP (Beausoleil et al, 1978 cited in Henneh 1998), DANFA Rural Health Project (DANFA, 1979) and several missions initiated as part of the PHC programmes notably the Ashanti- Akim Rural Health (1979). The conclusions of all these projects indicated that the progressive involvement of the community in the provision of essential health care led to the solution of numerous health problems at the local level (Letsa et al, 1992).

Notwithstanding all these, in Ghana there has been difficulty in sustaining the community health volunteers. For instance the Village Health Worker (VHW) scheme which was introduced by MOH in the 1970s to provide health care could not be sustained (Amuah et al, 1993; Alirigia, 1997; Henneh, 1998).

In the Upper West Region of Ghana for example a number of Village Health Volunteers (VHV) were trained to run a number of health projects. These included Sanitation campaign, Adoption of Family Planning (especially in men), the Weaning Food Project, Guinea worm eradication

Programme, Immunization for the preventable diseases, Nutrition Surveillance, MCH/FP, AIDS, Tuberculosis (TB) and Leprosy control (Henneh, 1998). It is reported that these programmes initially got on well but started slowing down in the early 1990s (Swai, 1993). The BARIDEP (Beausoleil et al, 1978 cited in Henneh, 1998) and DANFA Rural Health Project (DANFA, 1979) suffered the same fate. But one cardinal factor that runs through all these community projects/programmes is that their pivotal structure namely the health volunteers could not be sustained (Amuah et al, 1993).

This study therefore looks at the viability of the new scheme using relatively new approach - the Community –Based Surveillance Volunteers (CBSVs). These volunteers originally trained to support the Guinea-worm Eradication Programme now have their roles expanded to cover the following:

- Active case search of diseases such as buruli ulcer, yaws, acute flaccid paralysis (AFP), Celebro-spinal meningitis (CSM), etc.
- Distribution of Ivermectin to communities in the onchocerciasis intervention zones
- Tuberculosis control volunteers and enablers
- Community support structures to support people living with HIV/AIDS
- Volunteers for National Immunization Days NIDs
- Supporting child welfare outreach services
- Health education and health promotion
- Taking care of the newly born babies (DHMT Report, 2007).

## 2.8: THE IMPORTANCE OF HEALTH VOLUNTEERS ON HEALTH PROGRAMMES

Over the years health volunteers have played significant roles in the promotion and implementation of health programmes. In fact, the importance of volunteering in the overall health and well-being of communities is highlighted in an article by Edgar (1990) entitled "Dead neighbourhoods have no volunteers." The article suggests that the lack of volunteering is an indication of lack of life of the community. Nevertheless in rural Australia, it may be equally justifiable to suggest that lack of volunteering (such as lack of volunteer ambulance drivers) may cause a lack of (or loss of) life in rural communities. This view appears to be supported in a recent report prepared by the Australia Fire Authority's Risk Management Division which points out that "the viability of many Australian emergency services depends on the strength and commitment of their base of volunteer members (Reinholtd et al, 1998). Gaspar and Robson (2004) observed that health volunteers do have a very good level of knowledge of the subjects in which they were trained and positive impacts were reported: the building of latrines, the use of ITNs, increases in level of pre-natal and post-natal and family planning consultations, the number of births taking place in the health facilities, the number of children whose weights are being controlled regularly and attending vaccination session, more rapid transmission to the health service about cases of AFP, measles, cholera and meningitis

Other studies such as Newland-Foreman (1997), Norton (1998) and Putnam (1996) underscored the importance of volunteerism in health service delivery and health promotion.

Pence et al (2005) looked at the effect of community nurses and health volunteers on child mortality in Ghana. The study known as the Navrongo Community Health and Family Planning Project was a longitudinal community trial of alternative organizational strategies for health

service delivery in a rural, impoverished area of Ghana. In one area, nurses were placed in communities with doorstep visitation and service responsibilities. A second area included training of a local health volunteer and community involvement in health delivery. A third area combined both strategies. Under-five mortality rates were calculated and Poisson regression was used to adjust for potential confounding characteristics. The results were that, in areas with village-based community nurse services, under-five child mortality fell by 14% during five years of program implementation compared with before the intervention, with reductions in infant (5%), early child (18%), and late child (39%) mortality. The volunteer intervention was associated with a 14% increase in mortality, primarily driven by a 135% increase in early child mortality. Areas with both nurses and volunteers saw an 8% increase, with small increases in all age groups. Mortality in a comparison area with standard Ministry of Health services fell by 4% during the same time period. These results suggest that convenient, accessible professional nursing care can reduce child mortality in impoverished African settings. However, they do not demonstrate a beneficial effect of community volunteers and suggest a possible negative impact on children's survival. In other words the results suggested that the use of health volunteers in health service delivery is not an effective service delivery model.



## 2.9: VIABILITY OF COMMUNITY HEALTH VOLUNTEERS

A review of the literature revealed a number of factors which influence the viability of volunteerism. They included recognition of work, motivation. Community support, adequate training, facilitative supervision, high communal spirit and team work.

In Mozambique, the Zambezia Community council approach discussed earlier identified two key factors which influence the sustainability of the Community Councils. One is the running-costs of the Council itself, of which the most important aspect appears to be the maintenance of the bicycle and (in some cases) the bicycle-ambulance. As noted above, it would seem that the expectation has been that the Councils themselves would pay for this maintenance, possibly from the fund derived from the profit on sale of nets.

The other aspect of sustainability is motivation, which potentially comes through Councils seeing their work as being valued, through seeing the value of what they are doing (to individuals, families and the community as a whole), through continued support and through being linked into a wider system of health and other activities (Gasper and Robinson, 2004 & UNICEF Mozambique, 2001)

Townsend et al (1998) identified demographic changes as major factors undermining the viability of emergency services in rural communities using volunteers. These included changes in population level, age profile, ethnic diversity and socio-demographic characteristics of rural residents. In most of the small rural communities from which participants were drawn, population levels were declining. This reduced the overall pool from which volunteers could be withdrawn. Factors contributing to this decline have included technological developments, agricultural restructuring and young people moving from rural areas to pursue work or study (Strong et al, 1998).

In Ghana however, there has been difficulty in sustaining the community health volunteers. For instance the Village Health Worker (VHW) scheme which was introduced by MOH in the 1970s

to provide health care could not be sustained (Amuah et al 1993; Alirigia, 1997; Henneh. 1998). They included the volunteers for BARIDEP (Beausoleil et al, 1978 cited in Henneh 1998) and DANFA Rural Health Project (DANFA, 1979).



# CHAPTER THREE

## 3.0: METHODOLOGY

This chapter gives account of the methods used in collecting data for the study. It gives a brief profile of the study area, outlines the study design, data collection techniques and tools, definition of study variables, the study population, sample size and sampling techniques. Ethical considerations, limitations of the study and assumptions made, have also been indicated in this chapter.

## 3.1: STUDY DESIGN AND METHODS



The study was a descriptive cross-sectional study using both quantitative and qualitative methods. The methods employed included reviewing and updating CBS volunteers records at the district health directorates, health facilities and in the communities; administering questionnaires to CBS volunteers and interviewing community leaders and health workers directly involved in CBS volunteers activities. History of village or community health volunteers elicited using snowball technique.

### 3.1.1: REVIEWING AND UPDATING CBS VOLUNTEERS RECORDS

Four hundred and twenty (420) CBSVs were trained for the Nkoranza North and Nkoranza South districts (formerly the Nkoranza District). Since then many of the CBSVs have either resigned, died, or moved out from their communities. Nevertheless, the records at the communities, health facilities and even at the district health directorates had not been updated. There was therefore the need to review and update the CBSVs records to enable me to decide on the sample size, have the list of the study population, get the sample frame as well as work out the attrition rate.

3. Health facility in-charges (also known as CBSV Sub-district coordinators)
4. CBSV district focal persons or coordinators
5. District directors of health services

Key informant interviews are interviews (ranging from unstructured to structured ones) carried out with people who have a special position in the community. They are looked upon as representatives of the opinions and experiences of the whole group. These range from government officials and non-governmental organizations (NGOs) employees, to community own resource persons and leaders of informal groups (Kruerger, 1990; Maier B et al, 1993; Swai 1993 and Henneh, 1998). Key informants can give valuable and independent information in a relatively short time without needing a large group in the study. However Annet and Rifkin (1988) pointed out that one needs to be careful with local leaders and some key informants. They may not represent the views of the vulnerable groups of the society (Henneh, 1998)



### 3.2: VARIABLES

Table 3.1a and b constitute the framework for defining variables of the study with their indicators/operational definitions and scale of measurement.

**Table 3.1a: Operational Definitions of Variables and Scales of Measurement**

| CONCEPTUAL DEFINITION OF VARIABLES | OPERATIONAL DEFINITION/ INDICATOR | SCALE OF MEASUREMENT |
|---|---|---|
| 1. Age | Age at last birthday | Continuous, in years |
| 2. Occupation | Occupation for which respondent is trained or work actually performed | Nominal e.g.<br>• Farmer<br>• Teacher<br>• Artisan<br>• Unemployed<br>• Retired |
| 3. Education | Type of educational institution last attended | Nominal e.g.<br>• None<br>• Primary<br>• Middle/JSS<br>• Secondary/ SSS<br>• Post-Secondary<br>• Tertiary |
| 4. Income | Average family income per member | Ordinal e.g.<br>• Low income<br>• Medium income<br>• High income |
| 5. Marital status | Marriage in terms of legal status | Nominal e.g.<br>• Single<br>• Married<br>• Widowed<br>• Divorced |
| 6. Sex | Sex of respondent | Nominal e.g.<br>• Male<br>• Female |
| 7. Expectation | What respondent expect to get from working as Community-Based Surveillance Volunteer (CBSV) | Nominal e.g.<br>• Money<br>• Bicycle<br>• Wellington boots<br>• Employ in GHS |
| 8. Volunteer Satisfaction | Response to a specific question put to a CBSV to illicit his/her level of satisfaction | Ordinal e.g.<br>• Very Satisfied<br>• Satisfied<br>• Somewhat dissatisfied<br>• Very dissatisfied<br>• Undecided |
| 9. Knowledge on the Job | Response to questions put to respondent on knowledge on CBSV activities | Ordinal e.g.<br>• Very Good<br>• Good<br>• Reasonable or Fair<br>• Poor |

**SOURCE: Author's Construct, March 2009**

**Table 3.1 b: Operational Definitions of Variables and Scales of Measurement**

| CONCEPTUAL DEFINITION OF VARIABLES | OPERATIONAL DEFINITION/ INDICATOR | SCALE OF MEASUREMENT |
|---|---|---|
| 10. Level of Motivation | The extent to which the respondent thinks he/she is motivated | Ordinal e.g.<br>• Highly Motivated<br>• Reasonably Motivated<br>• Poorly Motivated |
| 11. Kind of Motivation | Response to a specific question put to respondents on what is given to of done for CBSVs to motivate them | Nominal e.g<br>• Money<br>• Training/ Workshops<br>• Bicycles<br>• T-shirts<br>• Etc |
| 12. Attrition Rate | Proportion of cohort of CBSVs who have quitted within the last three years | Continuous e.g. percentages or Ordinal e.g.<br>• High<br>• Medium<br>• Low |
| 13. Supervision | Response to a specific question put to respondents on number of times visited by Health Worker(s) over the last one year | Ratio scale e.g. 0,1,2,3 etc or Ordinal e.g.<br>• 0-1= Low<br>• 2-3 = Medium<br>• >/= 4 = High |
| 14. Training | Number of training sessions or workshops a CBSV has attended within the last three years | Ratio scale e.g. 0,1,2,3, or Ordinal e.g.<br>• 0-2 = Low<br>• 3-4 = Medium<br>• >or =5 =High |
| 15. Capability & Willingness | Response to questions put to respondents on whether they have the natural ability, skill and competence and willingness to carry out all CBSV duties | Nominal /Ordinal e.g.<br>• Able and Willing<br>• Able but Not Willing<br>• Unable but Willing<br>• Unable and Unwilling |
| 16. Adequacy of Time | Response to question put to respondents on whether they have adequate time to carry out CBSV activities | Nominal e.g.<br>• Yes<br>• No |

**SOURCE: Author's Construct, March 2009**

### 3.3: STUDY POUPLATION

- Community-based surveillance volunteers (CBSVs) in Nkoranza North and South districts

- District Focal Person for CBSVs/ District Director of Health Services
- Sub-district CBSV Supervisors (i.e. the Health Facility In-charges)
- Community Leaders (Chiefs, Queen mothers, Assemblymen and Unit Committee members).

### 3.4: SAMPLE SIZE AND SAMPLING TECHNIQUE

The list of the CBSVs in the the Nkoranza North and Nkoranza South districts were updated. In all 310 out of the 420 CBSVs selected and trained were found to be active. This figure represented 73.8% of the original CBSVs recruited. Using table of random numbers and simple random sampling technique, 132 CBSVs representing 48.38% of the 310 active CBSVs in the two districts were selected. Data collectors who were staff of Kintampo Health Research Centre administered structured questionnaires to these 132CBSVs in their respective communities.



By rule of thumb, the district CBSVs Focal Persons for the two districts, the District Director of Health Services for Nkoranza North District, Subdistrict CBSV Supervisors for all the eleven Level B Clinics in the two districts who are the Health Facility In-charges were interviewed using key informant interview guide. In the same vein for want of time and logistics two chiefs, two queen mothers, two assemblymen and two unit committee chairmen who were familiar with the CBSVs scheme were selected for key informant/ in-depth interviews.

### 3.5: DATA COLLECTION METHODS AND TOOLS

As stated earlier the quantitative data was elicited through questionnaire administration using structured questionnaire (Appendix 1) whilst the qualitative data was obtained by an in-depth interview/key informant interview using interview guides. Historical data on the past village health volunteers was also collected from key informants using the snowball technique.

### 3.6: PRE-TESTING

The research tools were pre-tested in the Techiman District, a neighbouring district. The purpose was to

- Check on the clarity of the questions
- Fine tune the languages to be used for the study
- Check the logical sequence of the questions
- Find out if spaces for answers were enough
- See if there was the need to pre-categorize some answers or to change closed-ended questions into open-ended questions or vice versa, and
- See if it was necessary to add additional instructions or guidelines for the interviewers



### 3.7: PLAN FOR DATA HANDLING

- Questionnaires and other research tools were numbered based on the community, facility or individual from which the data was collected. This was done at the time of the interview.
- The principal investigator has been responsible for data storage both in and outside the DHMT offices. Data has been stored under lock and key. The questionnaires or interview record forms have also been kept in plastic files in the sequence they have been numbered.
- Data has been stored on a template designed using SPSS.

- The Health Information Officer in the Nkoranza South District Health Directorate helped with data cleaning and analyses.

### 3.8: ETHICAL CONSIDERATION

Ethical approval was sought from the Kintampo Health Research Centre – Institutional Ethics Committee (KHRC-IEC). Verbal and/or written consent for the study was sought from the Regional Director of Health Services, the District Health Management Team (DHMT), the District Chief Executive and the chiefs/ other opinion leaders of the selected communities. Individual consent for the interviews was finally sought before their participation took place.



### 3.9: DATA ANALYSIS

Two types of data namely Quantitative and Qualitative data were analyzed. Analysis of the quantitative data aimed at:

- **Describing the variables of the study.** They included respondents' age, sex occupation, educational background, level of motivation, their expectations and level of satisfaction.
- **Looking for differences between groups.** For example the kind of support the CBSVs were receiving from the community leaders compared with those received from the health workers, and
- **Determining the associations between level of motivation and level of satisfaction.**

Most of the questions used to illicit the data were pre-coded; however the few opened-ended questions were coded. The quantitative data was then edited and thereafter processed using SPSS and excel. Dummy tables for the descriptions of the variables were drawn where applicable. The relationships between variables established guided by the objectives of the study.

The quantitative data was described in terms of frequency distributions, percentages, averages or means and proportions. Statistical tools such as frequency distribution tables, bar charts and pie charts were used

to display analysed data. The Operational Definitions of variables and Scales of Measurement tables (Table 3a and b) were used to interpret the analyzed the quantitative data.

The qualitative data was also cleaned, edited and ordered. Ordering, that is presenting the data in the order that need them for analysis, was done in relation to the study objectives. The data was then summarized and presented in the form of narrative text, listing and quotations to support and/ or explain the findings from the quantitative data.

### 3.10: AVAILABLE FACILITIES FOR THE RESEARCH

Internet facility, data from the district, the University Library (KNUST), the Brong Ahafo Regional Health Directorate Library, Kintampo Rural Health Training School (KRHTS), Kintampo Health Research Centre (KHRC), and supervision by field and academic supervisors.

### 3.11: LIMITATIONS AND BIASES OF THE STUDY

1. The Oral history collected from the key informants could be adulterated due to recall bias.
2. Funding was a limitation to the study.

# CHAPTER FOUR

## 4.0 : DISCUSSIONS OF RESULTS

The findings from the study have been reported and possible reasons underlying the observed findings have been discussed. Where necessary the results have been compared with previous studies and observations as reviewed in the literature.

## 4.1: REVIEW OF PREVIOUS COMMUMITY HEALTH VOLUNTEERS (CHVs) SCHEMES

The study reviewed previous CHV or VHV schemes to identify the factors or reasons why those schemes were not sustainable. Some key informants/ experts knowledgeable on the previous CHV schemes were selected and interviewed using the Snowball technique. With this technique one key informant was identified, interviewed and thereafter made to direct the interviewer to someone he thought was also knowledgeable on the subject. The process continued until the interviewer realized that he had obtained adequate information on the subject or issue. The findings identified as key reasons or factors for non-viability of the CHV schemes included:

- Lack of or inadequate financial motivation/ other incentives
- Lack of community leaders' support
- Poor commitment from health workers/government
- Poor monitoring and supervision
- Inadequate training and capacity building
- No plan to ensure sustainability of the schemes

- Inequity in sharing of motivation package
- Unwillingness of communities to contribute to health programmes
- Poor health staff attitude towards the volunteers
- Ineffective communication
- Wrong perception that volunteers do the work of health workers and as such should be paid some allowances



## 4.2: UPDATE OF CBS VOLUNTEERS RECORDS

From the key informant interviews, 420 Community-based surveillance volunteers were trained in 2004 for the then Nkoranza District (now Nkoranza North & Nkoranza South districts). As at March 2009, the number had reduced to 310 (CBSVs) giving an attrition rate of 26.19%. Of the remaining 310 CBS volunteers, 190 were males whilst 120 were females (Table 4.1).

**Table 4.1a: Socio-demographic Characteristics of the Respondents (CBS Vs)**

| Variable | frequency | Percentage |
|---|---|---|
| | n=132 | 100 |
| **Age of Volunteers (years)** | | |
| Under 40 | 37 | 28.03 |
| Above 40 | 95 | 71.97 |
| **Sex of Respondents** | | |
| Female | 32 | 24.20 |
| Male | 100 | 75.80 |
| **Occupation** | | |
| Farmer | 107 | 81.10 |
| Trader | 7 | 5.30 |
| Civil/Public Servant | 12 | 9.1 |
| Others | 6 | 4.5 |
| **Educational Background** | | |
| None | 1 | 0.8 |
| Primary | 3 | 2.3 |
| Middle/JSS/JHS | 97 | 73.5 |
| Secondary/SSS/SHS | 21 | 15.9 |
| Post Secondary | 9 | 6.8 |
| Tertiary | 0 | 0.0 |
| Other | 1 | 0.80 |
| **Marital Status** | | |
| Single | 8 | 6.10 |
| Married | 115 | 87.10 |
| Widowed | 2 | 1.50 |
| Divorced | 7 | 5.30 |

**Table 4.1b: Socio-demographic Characteristics of the Respondents (CBS Vs)**

| | | |
|---|---|---|
| **Family Size** | | |
| 0-4 | 27 | 20.45 |
| 5-9 | 90 | 68.18 |
| 10-14 | 15 | 11.36 |
| **Average Annual Income (GH¢)** | | |
| Less than 500 | 60 | 45.45 |
| 500-1000 | 43 | 32.58 |
| More than 1000 | 17 | 12.80 |
| Not Known | 2 | 1.52 |
| **Number of years working as CBS Volunteer** | | |
| Less than 3 | 10 | 7.60 |
| 3-5 | 32 | 24.24 |
| 6-8 | 38 | 28.79 |
| More than 8 | 52 | 39.39 |

**SOURCE: FIELD SURVEY, MARCH 2009**



## 4.3: AGE OF VOLUNTEERS

The volunteers aged between 22 and 73 years with the mean age of 44 years. Majority of them 89(67.42%) were more than forty years. As high as 44 (33.33%) of the volunteers were above 50 years Table 4.1).

## 4.4: SEX DISTRIBUTION OF VOLUNTEERS

Majority of the CBS volunteers 100 (75.8%) were males whilst 32 (24.2%) were females (Table 4.1).

## 4.5: OCCUPATION

Most of the CBS volunteers 107 (81.1%) were farmers, 7(5.3%) were traders, 12(9.1%) were civil/public servants whilst the rest 6(4.5%) belonged to other occupations (Table 4.1).

## 4.6: EDUCATIONAL BACKGROUND

The highest educational level for most of the respondents (CBS volunteers) was Middle/Junior High School (73.5%). Only 1(0.6%) CBS volunteer had no formal education, 3 (2.3%) got up to primary or completed primary school, and 21 (15.9%) had secondary education (Table 4.1).



## 4.7: INTENTION TO WORK AS CBS VOLUNTEER

As high as 118 (89.4%) of the respondents intended to work as volunteer for good whilst the rest 14 (10.6%) intended to work as volunteers for at most three years.

## 4.8: DUTIES OF CBS VOLUNTEERS

The respondents were asked about what they do as CBS volunteers and multiple answers were allowed. Home visit/Home based care of malaria, neonates, etc was the most popular duty mentioned (102, 77.3%) whilst Ivermectin distribution was the least popular duty mentioned (Table 4.2).

**Table 4.2: Functions/ Duties of CBS Volunteers Among Respondents**

| Duties of CBSV | Frequency | Percentage |
|---|---|---|
| Surveillance | 67 | 50.8 |
| Taking part in National Immunisation Days (NIDs) | 62 | 47.0 |
| Home visit/Home based care | 102 | 77.3 |
| Assist in Child Welfare Clinic | 63 | 47.7 |
| Ivermectin distribution | 32 | 24.2 |
| Registration of births and deaths | 38 | 28.8 |

**SOURCE: FIELD SURVEY, MARCH 2009**



The study also analysed the number of duties or function each volunteer claimed he/she was performing. As high as 91 (68.9%) of the respondents (CBS volunteers) mentioned they were performing three or more duties (Table 4.3).

**Table 4.3: Number of duties performed by each volunteer**

| No. of Duties | Frequency (n=132) | Percentage % |
|---|---|---|
| 1 | 21 | 15.9 |
| 2 | 20 | 15.2 |
| 3 | 23 | 17.4 |
| 4 | 27 | 20.5 |
| 5 | 25 | 18.9 |
| 6 | 13 | 9.8 |
| 7 | 3 | 2.3 |

**SOURCE: FIELD SURVEY, MARCH 2007**

## 4.9: EXPECTATIONS OF CBS VOLUNTEERS

94 (71.2%) out of the 132 respondents wanted money as their first option for the voluntary work they do,

## 4.10: LEVEL OF SATISFACTION

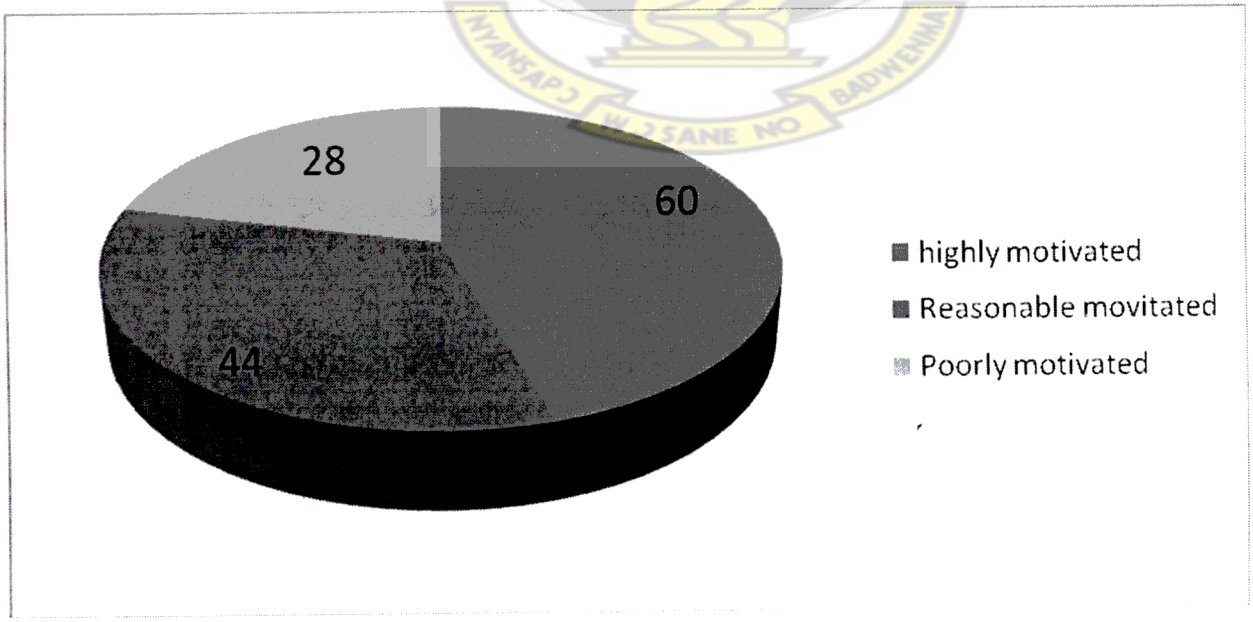
On level of satisfaction as a CBS volunteer, 105 (79.5%) of the respondents reported they were very satisfied, 21 (15.9%) said they were satisfied, and 6 (4.5%) indicated they were somewhat satisfied. None of the respondents said either dissatisfied or were undecided.



## 4.11: LEVEL OF MOTIVATION

As high as 60 (45.5%) of the respondents said they were highly motivated to do their job as health volunteers, 44 (33.3%) said they were reasonably motivated whilst 28 (21.2%) indicated that they were poorly motivated (Figure 4.1).

**Figure 4.1: Level of motivation among CBSVs**



## 4.12: STOPPAGE OR RESIGNATION FROM WORKING AS A VOLUNTEER

78 (59.1%) of the respondents claimed some of their colleague CBS volunteers had stopped or resigned from working as a volunteer whilst 51 (38.6%) contended that none of their colleagues had stopped or resigned. Three (2.3%) did not know whether some volunteers had resigned or stopped.

Table 4.4 assigns the reasons given by the respondents on why their colleagues CBS volunteers stopped voluntary work.



The qualitative data from the in-depth/key informant interviews also revealed the under-listed as causes of attrition:

- Leaving for school
- Transfers/moving out of the communities
- Travelled outside the country to look for greener pastures
- Going to school
- Employment outside the community
- Sickness, old age or incapacitation
- Death

**Table 4.4: Reasons for Resigning from the CBS Volunteers Scheme**

| Reason | Frequency | Percentage |
|---|---|---|
| | n=132 | 100 |
| No or Low Motivation | 16 | 12.1 |
| Moved out of community | 27 | 20.5 |
| Employment | 8 | 6.1 |
| Very busy/ No time | 16 | 12.1 |
| Pursuing Further Education | 2 | 1.5 |
| Other | 59 | 44.7 |
| 9 | 3 | 2.3 |
| 0 | 1 | 0.8 |

**SOURCE: FIELD SURVEY, MARCH 2009**



## 4.13: THINGS VOLUNTEERS HAVE RECEIVED FROM COMMUNITY LEADERS

Only 3 (2.3%) said they had been given money, 10 (7.6%) said they had been exempted from communal labour, 1 (0.8%) had been exempted from paying communal levy, 1(0.8%) had been given food stuff, whilst 1(0.8%) person claimed he had been given a cutlass. It was observed from the qualitative data (Key informant interviews for Community leaders and Health workers) the community leaders do not support the CBSVs.

The followings statements from the qualitative data will hit the hammer right on the nail:

***"Recognition as health workers and verbal encouragement"***

***From a health worker***

*"No support only that CBSVs have been exempted from communal labour"*

***From a health worker***

*"Nothing but we pray for them"* ***From a community leader***

## 4.14: VOLUNTEERS EXPECTATION FROM THEIR COMMUNITIES

The respondents (CBS volunteers) were asked to mention by way of priority things that they would have liked to receive from their communities/community leaders.

Table 4.5 shows the kind of material support the volunteers expected from their communities. Majority of them 57 wanted money as their topmost priority.



**Table 4.5: Volunteers expectations from their communities**

| Variable | Frequency | Percentage |
|---|---|---|
| | **n=132** | **100** |
| Money **(Monthly Allowance)** | 35 | 26.5 |
| Money **(Periodic Incentives)** | 22 | 16.7 |
| Rain coat | 7 | 5.3 |
| Wellington boot | 6 | 4.5 |
| Make farms for CBSVs | 17 | 12.9 |
| Exemption from communal labour/tax | 8 | 6.1 |
| Bicycle | 14 | 10.6 |
| Provision of food stuff to CBSVs | 4 | 3.0 |
| Certificate of Recognition/Appreciation | 3 | 2.3 |
| T-shirt | 1 | 0.8 |

| | | |
|---|---|---|
| Cutlass | 1 | 0.8 |
| Pay Health Insurance Premium | 1 | 0.8 |
| Motivation (Unspecified) | 4 | 3.0 |
| Moral support/Cooperation | 3 | 2.3 |
| Nothing | 7 | 5.0 |

**SOURCE: FIELD SURVEY, MARCH 2009**

## 4.15: RELATIONSHIP BETWEEN LEVEL OF SATISFACTION AND REMUNERATION



Table 4.6 is a cross-tabulation showing the relationship between level of satisfaction and remuneration that the volunteers had received.

**Table 4.6: Relationship between Level of Satisfaction and Quantity of items volunteers have received**

| No. of items received | Very satisfied | Satisfied | Somewhat satisfied | Very dissatisfied | Total |
|---|---|---|---|---|---|
| Nothing | 12 (85.7%) | 1 (7.1%) | 1 (7.1%) | 0 (0.0%) | 14 |
| 1 item | 16 (84.2%) | 3 (15.8%) | 0 (0.0%) | 0 (0.0%) | 19 |
| 2 items | 34 (72.3%) | 11 (23.4%) | 2(4.3%) | 0 (0.0%) | 47 |
| 3 items | 23 (76.7%) | 6 (20.0%) | 3 (3.3%) | 0 (0.0%) | 30 |
| 4 items | 14 (87.5%) | 1 (6.3 %) | 1 (6.3%) | 0 (0.0%) | 16 |
| > 4 items | 6 (100%) | 0 (100%) | 0 (0.0%) | 0 (0.0%) | 6 |

**SOURCE: FROM FIELD SURVEY, MARCH 2009**



## 4.16: THINGS VOLUNTEERS HAVE RECEIVED FROM HEALTH WORKERS

87 (65.9%) of the volunteers had received money from health workers as some form of motivation, 35 had received wellington boots, 97 had received T-shirts, 21 had received rain coats, 16 had received bicycles, 11 had received nothing, and 33 of them had received other items such as food stuff, soap, rice, bags, certificates, insecticide treated nets (ITNs), cutlasses, and cooking oil.

## 4.17: THINGS VOLUNTEERS WOULD HAVE LIKED TO RECEIVE FROM HEALTH WORKERS

It became obvious that several of the CBSVs (64.7%) would have liked to receive money from health workers (Table 4.7).

**Table 4.7: Things Volunteers would have liked to received from Health Workers**

| Item | Frequency | Percentage |
|---|---|---|
| | n=132 | 100 |
| Money | 89 | 67.4 |
| Recognition of work | 9 | 6.8 |
| Free medical care | 11 | 8.3 |
| Wellington boot | 10 | 7.6 |
| Bicycle | 10 | 7.6 |
| Others | 3 | 2.3 |

**SOURCE: FIELD SURVEY, MARCH 2009**



## 4.18: SUPERVISION OF CBS VOLUNTEERS

84 (63.6%) of the volunteers claimed they had been supervised by a health worker at least on four occasions within the past one year; 26 (18.9%) had been supervised between 3 and 4 times, 17 (12.9%) had been supervised 1-2 times, and only 5 (3.8%) said they had not been supervised for the past one year.

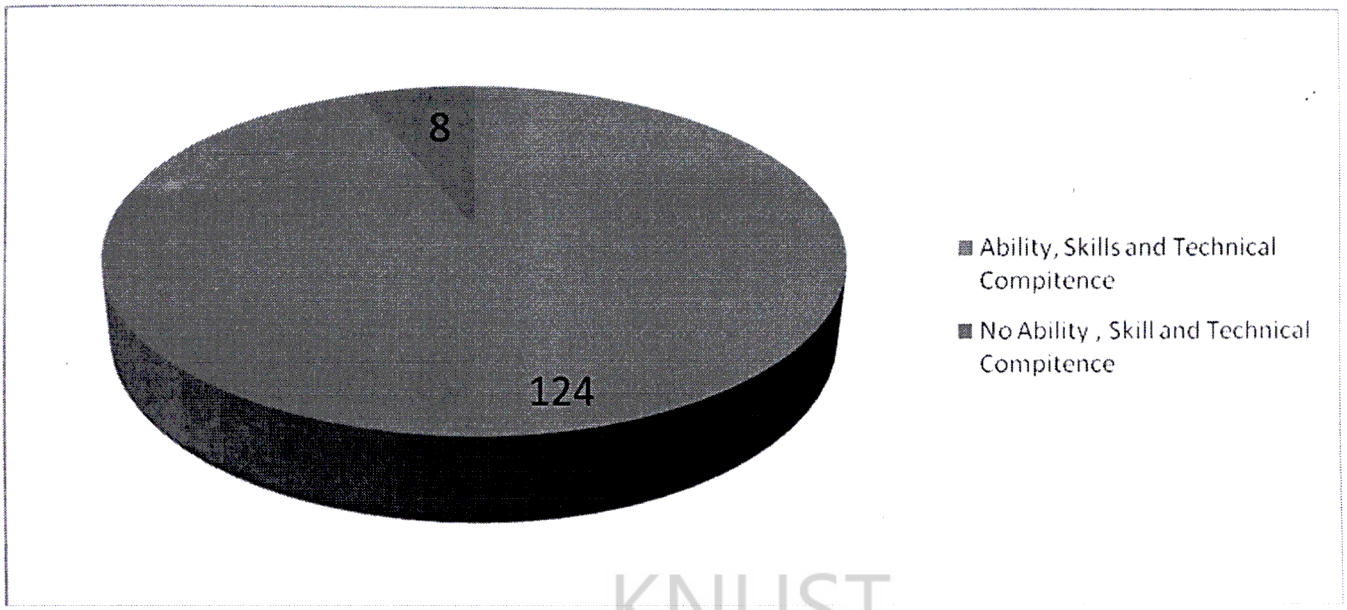
## 4.19: TRAINING OF VOLUNTEERS

As high as 91 (68.9%) of the respondents (CBS volunteers) claimed they had been trained by health workers more than four times within the last three years. 25 (18.9%) had been trained 3-4 times, 14 (10.6%) had been trained 1-2 times, and one volunteer (0.8%) had received no training. One volunteer response to the question was invalid.

## 4.20: NATURAL ABILITY, SKILL AND COMPETENCE TO WORK AS CBS VOLUNTEER

The respondents were asked whether they have the natural ability, skills and technical competence to carry out their numerous activities as CBS volunteers. 124 (93.9%) responded in an affirmative whilst 8 (6.1%) said they lacked the ability, skills and competence to carry out their numerous activities as volunteers (Figure 4.2).

**Figure 4.2: Ability, skills and competence of CBSVs**






**SOURCE: FIELD SURVEY, MARCH 2009**

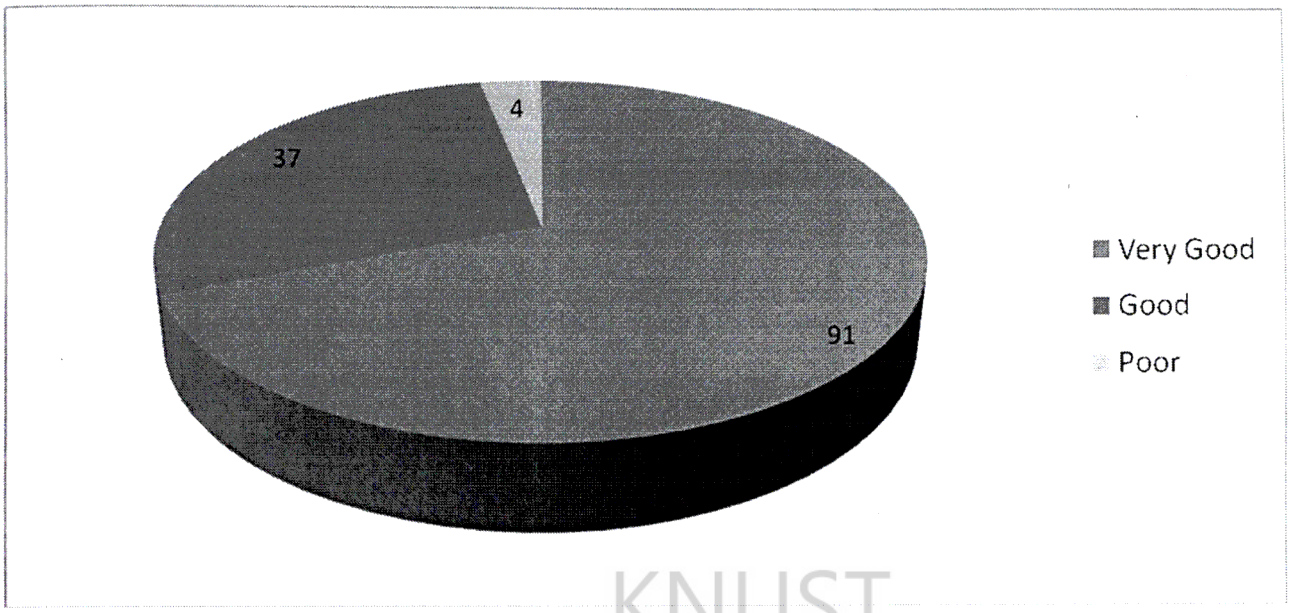
## 4.21: ADEQUATE TIME TO CARRY OUT CBSV ACTIVITIES

Almost all the respondents, 130 (98.5%) of the volunteers interviewed said that they had adequate time to carry out CBSV activities. Only 2 (1.5%) said they did not have adequate time for CBSV activities.

## 4.22: COMMUNITY LEADERS'/ HEALTH WORKERS' ATTITUDE TOWARDS CBSV ACTIVITIES

Fifty-three (40.2%) of the respondents (CBS volunteers) thought that their community leaders' attitude towards CBSV activities was very good, 46 (34.6%) said it was good whilst 31 (23.5%) thought it was poor. Two responses were invalid. Conversely 91 (68.9%) of the respondents thought the health workers' attitude towards CBSV activities was very good, 37 (28.0%) thought it was good and 4 (3.0%) said it was poor (Figure 4.3).

**Figure 4.3: Health Workers Attitude Towards CBSVs**






**SOURCE: FIELD SURVEY, MARCH 2009**

## 4.23: CHALLENGES THE CBSVs FACE IN THE PERFORMNACE OF THEIR DUTIES

The under-listed challenges were being faced by the CBS volunteers in the performance of their duties.

- Inadequate funds
- Transport
- Lack of community support
- Inadequate motivation
- CBSVs had to travel long distance to work
- Lack of logistics/working tools
- No or Lack of regular allowance

## 4.24: VIABILITY OF THE CBSV SCHEME

Out of the 132 CBS volunteers interviewed 124 (93.9%) believed that the CBSV scheme as being operated currently in the Brong Ahafo Region is viable. Only 8 (6.1%) thought the scheme is not viable.

## 4.25 REASONS FOR NON-VIABILTY OF THE PREVIOUS COMMUNITY HEALTH VOLUNTEERS SCHEMES

As mentioned in earlier in this chapter the underlined factors which negatively affected all the previous volunteers schemes leading to their dysfunction:

- Lack of or inadequate financial motivation/ other incentives. These led to dissatisfaction as the volunteers' expectations were not met. The spirit of volunteerism came to its lowest ebb eventually led to the collapse of these schemes.
- Lack of community leaders' support. Lack of community commitment to the CHV scheme demoralised/ demotivated the volunteers.
- Poor commitment from health workers/government. As a result the logistics and incentives could not be sustained.
- Poor monitoring and supervision. Volunteers were not doing their work as they were not being supervised or monitored.
- Inadequate training and capacity building. These made the volunteers incapable of performing their roles and also led to loss of interest in the voluntary work.

- No plan to ensure sustainability of the schemes. Because they did not plan, the scheme managers could not continue motivates and sustains the scheme when the initial resources got finished.

- Inequity in sharing of motivation package. This led to dissatisfaction in most of the volunteers which made them stop the voluntary work.

- Unwillingness of communities to contribute to health programmes. The volunteers depend mainly on their communities for survival in terms of material and moral support. They would stop the voluntary work if their community fail to support them.



- Ageing of the volunteers. The volunteers could work as a result of their age and they had to stop without being replaced.

- Poor health staff attitude towards the volunteers. This antagonistic behaviour from the health workers put the volunteers off since they were only doing free services.

- Ineffective communication. Because there were no free flow of information the volunteers were not informed about what to do and eventually had to stop the work they were doing.

- Wrong perception that volunteers are doing the work of health and as such should be paid some allowances. This led to the volunteers agitating for financial rewards which the scheme could not pay.

Most of these factors agreed with earlier observations by Gasper and Robinson 2004, and UNICEF Mozambique, 2001. Prominent among them was lack of motivation/financial incentives, training and capacity building. Ageing of volunteers was also identified by Townsend et al (1998) as a major factor undermining the viability of volunteer schemes. The key

informants used to generate the qualitative data for this study also mentioned some of the above factors as challenges facing the CBSVs scheme which invariably tend to threaten its variability.

## 4.26: MOTIVATION OF CBS VOLUNTEERS

One of the objectives of this study was to find out whether CBS volunteers are well-motivated to work. The study observed that about 104 (78.5%) of the volunteers claimed they were either highly motivated or reasonably motivated to work. Ironically it was found out that what the volunteers received as tangible motivation package was grossly inadequate. Besides, these incentives were not equitably distributed among the volunteers. Evidently lack of motivation coupled inequitable distribution of motivational packages could undermine the viability of the CBSV schemes.



Nevertheless the high proportion of volunteers who claimed they were motivated to work despite inadequate incentives conformed to the spirit of volunteerism as experienced in many countries. According to Wikipedia (2007), volunteerism is the willingness of people to work on behalf of others without being motivated by financial or material gains. When asked what they would have liked from the health workers or the community leaders as motivation 12 (9.1%) said they did not need anything. They just wanted to work as volunteers. Thus the real or dedicated volunteers are not motivated by financial or material incentives. As observed from the literature review the volunteers don't work for money, they work for less tangible but equally important forms of remuneration such as satisfaction, appreciation and the opportunity to build skills. This assertion agrees with observation from the present study where the fourteen (14) respondents (volunteers) who alleged they had received nothing since they were recruited as CBS volunteers; 10 (71.4%) of them claimed they were highly motivated, 12 (85.7%) claimed they were very satisfied, whilst 9 (64.3%) said they were both highly motivated and highly satisfied with voluntary work they were doing. Evidently all these respondents (volunteers) had at least 2 supervisions and 2 training sessions within the previous year which could be their source of motivation.

This study also agrees with other studies in Sudan, Pakistan, India, Indonesia and Malawi where volunteers were highly motivated to work without financial or material gains. The volunteers

worked independently from outside help and did not receive payment. The volunteers success and viability however depended on their motivation to work for their community, high spirit of volunteerism, regular meeting, training, supervision and team support.

Nonetheless, from the Zambezia community study in Mozambique and other studies elsewhere, one of the key aspect of sustainability or viability of CVH scheme is motivation including financial incentives (UNICEF Mozambique, 2001). Johnstone and Ranken (1994) had argued that CHVs need not be totally dependent on voluntary, unpaid work. They prescribed some form of small payment or gift, or one-off payment during workshops. On the contrary 89 (67.4%) of the respondents (volunteers) would have liked the health workers to give them regular financial incentives. In the same vein 37 (28.0%) of the respondents expected their community leaders to give them monthly allowance whilst 22 (16.7%) of them wanted periodic financial incentives.

Thus even though financial payment is contrary to the spirit of volunteerism, it is a necessary ingredient to ensure the viability of CBSVs scheme. The other material incentives such as the rain coat, wellington boots, bicycles, food stuff, certificate of recognition, etc as outlined in Table 4.4 should be promoted to ensure the viability of the scheme.



## 4.27: COMMUNITY SUPPORT TO THE CBSVs

According to the community opinion leaders as well as the CBSV Supervisors and Coordinators (health workers) the community virtually did not support the CBS volunteers financially or in kind. However few of the community leaders contended that they supported the CBS volunteers in the following ways:

- CBS volunteers are given recognition in their communities
- They are exempted from communal labour

- They pray for the CBS volunteers

In the quantitative study, out of the 132 CBS volunteers 116 (87.9%) of them said they had received nothing from their communities/community leaders. Nevertheless, these volunteers were given assurance during their selection by their respective communities that they would support them financially, in kind as well as helping them in their farms. Therefore with the breaking of the promise of the communities the moral of the spirit might go down and this would sloe down the performance of the volunteers.



## 4.28: EXPECTATIONS AND LEVEL OF SATISFACTION

The CBS volunteers on the whole expected their communities/ community leaders and health authorities to give them financial and material incentives. This is contrary to the spirit of volunteerism called for no financial or material gain in doing voluntary work. However looking at the fact that 107 (81.1%) of them were peasant farmers with low income (107, 81.1% received less than GHC1000 a year or GHC 83 a month), married with children, and most of them 95 (71.97%) were over 40 years, an occasional or regular remuneration would be necessary for them to ensure the viability of the CBSVs scheme. Nevertheless the level of satisfaction was very high, 105 (79.5%) despite the respondents' (volunteers') level of expectation not being met. No respondents said he or she was dissatisfied. Perhaps it is the recognition in the communities as para-health workers, the spirit of volunteerism, the benefits of training they have received, the facilitative supervision, the net- working and the desire to help their own people among others contributed to highly satisfaction and motivation of the volunteers but not the remuneration that they received.

## 4.29: VIABILITY OF THE CBS VOLUNTEERS SCHEME

The main objective of this study was to determine or forecast the viability of the current Community-based surveillance (CBS) volunteers' scheme as being operated in the Brong Ahafo Region of Ghana using the two Nkoranza districts as case studies. From all the key informants, both the health workers and the community leaders, the CBS volunteers are relevant to their communities and in their opinion they think the current CBSV scheme is viable. The community leaders admitted that they were not giving any incentive package to the volunteers now. They were however, willing to support the CBSVs programme.



In the quantitative data 124 (93.3%) of the CBS volunteers themselves believed that the CBSV scheme was viable. However, before the researcher will agree to this assertion or otherwise some key findings which favour viability of the scheme as well as those which hinder it will be discussed.

### 5.29.1 Observations which favoured the viability of the CBS volunteer scheme

All the key informants as well as majority, 124 out of 132 (93.3%) of respondent for the survey had a positive feeling or mental attitude towards the scheme. They believed that the scheme is viable. With this positive attitude they only need a calculated effort to make it viable.

The scheme currently has 310 volunteers which imply that the human resource base is strong enough to make the scheme viable.

Majority of the respondents (volunteers) claimed they were either highly motivated or reasonably motivated to work as volunteers. According to LeCouvie (2007) Motivation is defined as the

force that establishes the level, direction and persistence of effort expended at work. Level here refers to the amount of effort or intensity we put into the job; direction refers to our choice of where to put our effort: and persistence refers to our stamina or how long we are able to maintain our effort. Thus going by this definition if the volunteers are highly or reasonably motivated they can make the scheme viable.

The next observation is the desire or willingness to work as volunteers. As high as 90 (68.2%) of the respondents had worked as volunteers for 6 or more years but they were still motivated and committed to work. When the respondents were asked how long they intended to work as CBS volunteers, most of them 118 (89.4%) said they intended to work for good. The remarks they made included: ***"No fixed years","No intention to stop" ,"No limitation", "No time limit", "For life". "Until death","Till death", "Till I am asked to stop". "For ever" Non-stop and "Rest of my life"***



Simply put, the volunteers are willing to work, they are motivated to work, they are committed to work and they do not intend to stop the voluntary work.

The study revealed that at least 68.9% of the respondents (volunteers) were performing at least 3 core functions of the CBS volunteers. This is an indication that even after five years of doing volunteering work without adequate incentives the volunteers were still putting in much effort, energy and time. This is a good sign of viability of the scheme.

The key functions or duties of the volunteers are Surveillance, Participation in NID, Health education, Home visit/ Home based care (e.g. malaria), Assist in CWC, Ivermectin an distribution, Registration of birth and death. A very high proportion (93.9%) said that they were highly capable in carrying out these duties. Nevertheless, looking at the volunteers low

educational background (84.1% of them either no formal education or up to MSLC/JHS education), the fact that they were all engaged in their various jobs and the fact that they were ageing (mean age was 44 years and 67.42% of them above forty years), there is the limit that they can learn and do.

**4.29.2: Observations which did not favour the viability of the CBS volunteers' scheme**

Notwithstanding the numerous observations from the study which promote the viability of the current CBS Volunteers Scheme, there were some observations which were found to be detrimental to the sustainability of the scheme. First and foremost is lack of community support to the volunteers. Even though all the community leaders interviewed said they were prepared to support the CBS volunteers, they all admitted that they were not supporting the volunteers in any way. Likewise the remunerations from the health workers/health authorities were also found not to be enough. What were more serious are the inequitable distributions of these remunerations/ incentives by the health workers. Studies have demonstrated that, when individuals perceive that compensation and reward systems are inequitable they have lower level of job satisfaction and are unwilling to commit to organizational objectives (LeCouvie, 2007).

Another observation is the volunteers demand for financial benefit and other compensation and reward systems. As high as 43.3% of the volunteers wanted financial allowance (monthly or periodic) as their topmost priority whilst 51.5% demanded other forms of compensation and rewards such as bicycles, wellington boots, rain coats, etc. This is contrary to the spirit of volunteerism. Volunteerism is offering time, energy and skills of one's own free will without financial or material gains (Ontario's Good Neighbours Campaign Report, 2007, & en.wikipedia.org/wikivolunteerism). The study however agreed with that of Johnstone and Ranken (1994) who argued that community health volunteers (CHVs) need not to be totally

dependent on voluntary unpaid work. They suggested community leaders other than the health workers could arrange for a local fee-for service such as a small payment or gift. But as to whether the communities studied could afford this is another matter.

A literature review of White (1982) publication cited in Pappoe 1993; Philips (1990) publication cited in Henneh, 1998, and Rifkin (1988) had indicated that with good mobilization, community on its own has potential resources which can be utilized for the benefit of the majority ***including CBS volunteers***. However the researcher strongly believed that the communities for the study could not afford or sustain giving financial incentives to the CBS volunteers.



Another cardinal factor which would not ensure the viability of the CBSV volunteer scheme was the high attrition rate of the volunteers without replacement. Within the span of almost five year as many as 110 out of 420 volunteers had left the scheme giving an attrition rate of 26.2%. This is a recipe for a non-viable scheme.

Lastly the challenges which collapsed the previous Community Health Volunteers schemes were also identified in this study. They included lack of community/community leaders support, poor motivation/remuneration, lack of commitment from health authorities/government, and ageing of volunteers. These bottlenecks need to be addressed if one is to ensure that the CBS Volunteers scheme remains viable.

# CHAPTER FIVE

## 5.0 CONCLUSIONS AND RECOMMENDATIONS

Conclusions based on the findings of the study have been drawn on this chapter and recommendations to enhance viability of community-based surveillance volunteers (CBS) scheme.

## 5.1: CONCLUSIONS

1. This study has revealed that the previous Community Village Health Volunteers (CHVs or VHVs) scheme could not be sustained due to challenges such lack of community support to the volunteers, inadequate motivation, poor health staff attitude to the volunteers, inadequate training and capacity building ineffective communication, unwillingness of communities to contribute to health programmes, and the wrong perception that volunteers are doing the work of health workers and as such ought to be compensated. There was also no strategic plan to ensure the sustainability of the scheme.

2. The community leaders believed the CBSV scheme was viable, and even expressed their willingness to support the volunteers it was observed that they virtually doing nothing to support the scheme.

3. The volunteers were found to feel highly motivated, highly committed, and very satisfied to do their work irrespective of their expectations not being met in areas of remuneration or reward. Nevertheless, over 94% of the volunteers expected some financial/ material gains for the voluntary work they are doing, something which was found to be contrary to the spirit of volunteerism.

4. The present scheme was found to be an improvement over the previous ones in areas of supervision, communication, training and capacity building. These were positive features which could make the scheme viable.

5. Lastly this study observed that the schemes had a potential to be viable. There were adequate positive features which could make the scheme viable as already discussed. However the viability would only be a mirage if the challenges such as poor motivation, lack of community support, inequitable distribution of incentive, high attrition rate are not addressed.



## 5.2: RECOMMENDATIONS

1. The spirit of volunteerism where people use their time effort and energy to help their communities without asking for financial gain was found to be at its lowest ebb in the study area. It is therefore recommended that the Ministry of Health, Ghana Health Service, District Assemblies for Nkoranza North and South districts as well as other stakeholders should mobilize financial resources to support the CBS volunteers regularly.

2. The community support to the volunteers ought to improve. The communities can provide food stuff to the volunteers as well as assisting them in their farms. They should also exempt them from communal labour as well as from paying communal tax. Also the communities can pay the health insurance premium of the volunteers for them.

3. The health workers should continue to build the capacity of the CBS volunteers through training, monitoring and facilitative supervision.

4. The CBS volunteers should be given free medical care by the health authorities/ providers.

5. The volunteers are ageing and needed to be replaced occasionally by young and dynamic ones. There should be limited number of years to serve as volunteers.

6. Health Managers/ Authorities must ensure that the wards of volunteers who qualify to enter any of the health institutions such as Kintampo Rural Health Training School or Nurses Training Colleges should be given a priority.

7. There should be strategic plan for the CBS volunteers programme to be prepared by all the stakeholders – Community leaders, Health service providers and managers, District

8. Finally, there should be periodic operational researches on the volunteers' activities in order to improve the scheme.

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# APPENDICES

## APPENDIX 1: QUETIONNAIRE FOR THE CBS VOLUNTEERS

| KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY<br><br>INSTITUTE OF DISTANCE LEARNING<br><br>CSBVs FORM (13/02/09) | CSBVs FORM NO | FORMNO |
|---|---|---|



**CRITICAL ANALYSIS ON THE VIABILITY OF USING COMMUNITY BASED SURVEILLANCE VOLUNTEERS IN HEALTH DELIVERY SYSTEMS**

### 1.0: BACKGROUND INFORMATION

| | |
|---|---|
| 1.1. Interviewer Name and Code: ..... | **FW** |
| 1.2. Respondent's Current Household ID... | **HOUSEID** |
| 1.3. Respondent's Name: ..... | **RNAME** |
| 1.4. Respondent's Permanent ID | **PERMID** |
| 1.5. Date of visit: ..... | **DATEVISI** |
| 1.6. Age of respondent (in years)..... | **AGE** |
| 1.7. Respondent's sex ..... | **SEX** |

1.8. Respondent's occupation

| | 1. Farmer | 2. Trader | 3. Civil/ Public Servant | 4. Other (Specify)... | **OCCUP** |
|---|---|---|---|---|---|

1.9. Respondent's highest educational level completed

| | 1. None | 2. Primary | 3. Middle/ JHS | 4. Secondary/ SHS | 5. Post Secondary | **EDULEV** |
|---|---|---|---|---|---|---|

| | | | |
|---|---|---|---|
| | 6. Tertiary | 7. Other (Specify)… | |

1.10: Respondent's marital status?

| | | | | | |
|---|---|---|---|---|---|
| | 1. Single | 2. Married | 3. Widowed | 4. Divorced | **MARRY** |

| | | | |
|---|---|---|---|
| 1.11: Respondent's family size..... | | | **F_SIZE** |
| 1.12: Respondent's income per year..... | GH¢..... | | **INCOME** |

2.0: For how long have you been working as a CBS volunteer?

| | | | | |
|---|---|---|---|---|
| 1). < 3 years | 2). 3-5 years | 3). 6-8 years | 4). Over 8 years | **CVSLON** |



2.1: For how long do you intend to work as a CBSV volunteer?

| | | | | |
|---|---|---|---|---|
| 1. Next one year | 2. Next two years | 3. Next three years | 4. Other (Specify) | **INTEND** |

2.2: What are you supposed to do as CBS volunteer?

| | | | | |
|---|---|---|---|---|
| 1. Surveillance | 2.NID | 3.Health Education | 4.Home visit/ Home-based care | **DUTIES** |
| 5.Assist in CWC | 6.Ivermectin distribution | 7.Registration of birth and deaths | 8. Other (Specify) | |

2.3: What do you expect to get as a CBS Volunteer?

| | | | |
|---|---|---|---|
| 1.Money | 2.Recognition of work / certificate | 3.Free medical treatment | **EXPECT** |
| 4.Bicycle | 5.Wellington boot/Rain coat | 6. Other (specify): | |

2.4: Are you satisfied working as a CBS volunteer?

| | | | | | |
|---|---|---|---|---|---|
| 1. Very satisfied | 2. Satisfied | 3. Somewhat satisfied | 4. Very dissatisfied | 5. Undecided | **SATISFY** |

2.5 Are you motivated to do your work as a CBS volunteer?

| | | | |
|---|---|---|---|
| 1. Highly motivated | 2. Reasonably motivated | 3. Poorly motivated | **MOTIVA** |

2.6: Have some of your colleagues CBSVs stopped or resigned from working as a volunteer?

| 1. Yes | 2. No | 3. Don't know | STOPPED |
|---|---|---|---|

| 2.7 If your answer to Question 2.6 is yes, why did they stop? | | | |
|---|---|---|---|
| 1.No or Low Motivation | 2.Moved out of community | 3.Employment | WHY |
| 4.Very busy / No time | 5. Pursuing further education | 6. Other (specify): | |

| 2 8: Mention by way of priority things which you have received from community leaders since you became a CBSV | | | |
|---|---|---|---|
| 1.Money | 2.Wellington boot | 3.Bicycle | CRECEIVED |
| 4.Certificate of recognition | 5.T-shirts | 6. Other (specify): | |

| 2 9: Mention by way of priority things that you would have liked to receive from community leaders as a CBSV | | | |
|---|---|---|---|
| 1.Money/Monthly Allowance | 2.Periodic Money/ Incentives | 3.Rain coat | CEXPECTAT |
| 4.Wellington boot | 5.Bicycle | 6. Other (specify): | |
| | | | |

| 2 10: Mention by way of priority things which you have received from health workers since you became a CBSV | | | |
|---|---|---|---|
| 1.Money | 2.Wellington boot | 3. Bicycle | HRECEIVED |
| 4.Rain coat | 5.T-shirts | 6. Other (specify): | |

| 2 11: Mention by way of priority things that you would have liked to receive from health workers as a CBSV | | | |
|---|---|---|---|
| 1.Money | 2.Recognition of Work /certificate | 3.Free medical care | HRECEIVED |
| 4.Wellington boot | 5.Bicycle | 6. Other (specify): | |

| 2.12: How many times have you been supervised by a health worker (s) within the past one year? | | | |
|---|---|---|---|
| 1). 0-1 time | 2). 3-4 times | 3). >/=4 times | SUPERVISED |

| 2.13: How many times have you attended training sessions or workshops within the last three years? | | | | |
|---|---|---|---|---|
| 1). 0-2 times | 2). 3-4 times | 3).>/=4 times | 4).>/=5 times | TRAINING |

| 2.14: Do you have the natural ability, skill and competence to carry out all your numerous activities as a CBS volunteer? | | | |
|---|---|---|---|
| 1. Highly capable | 2. Somehow capable | 3. Not capable | ABILITY |

| | | | |
|---|---|---|---|
| 2.15: Do you have adequate time to carry out CBSV activities? | | | |
| | 1. Yes | 2. No | **TIME** |
| 2.16: In your opinion what is the community leader's attitude towards CBSV activities in your community? | | | |
| | 1. Very good | 2. Good | 3. Poor | **OPINIONC** |
| 2.17: In your opinion what is the health worker's attitude towards CBSV activities in your community? | | | |
| 1. Very good | 2. Good | 3. Poor | **OPINIONH** |
| 2.18:Do you think the CBSV scheme as being operated today is viable? | | | |
| 1. Yes | 2. No | 3. Undecided | **VIABLE** |
| 2.19: If yes, Give reasons for your answer? (multiple answers acceptable) | | | |
| 1.Regular Motivation | 2.Regular training & workshops | 3.Cooperation & support from health workers | **REASONSY** |
| 4.Adequate support/ cooperation from community leaders | 5. Have strong association and network | 6. Other (specify): | |
| 2.20: If NO, Give reasons for your answer? (multiple answers acceptable) | | | |
| 1.Low or no motivation | 2.Poor supervision / lack of support from health workers | 3. Lack of or inadequate support from community leaders | **REASONSN** |
| 4.CBSVs cannot be volunteers for ever | 5. High attrition rate | 6. Other (specify): | |

## APPENDIX 2: INTERVIEW GUIDE FOR TRADITIONAL/ COMMUNITY LEADERS

- ***CHIEFS & QUEEN MOTHERS***
- ***ASSEMBLYMEN & UNIT COMMITTEE MEMBERS***

1. Do you have Community-based Surveillance Volunteers (CBSVs) in your community?
2. How were the CBSVs selected?
3. How would you assess the performance of the CBSVs?
4. Is the communication between the community and CBSVs effective?
5. Do they provide feedback or report on their activities to the community?
6. If yes how is it done?
7. What support has the community been giving to the CBSVs?
8. Do you meet in the community to discuss the welfare of the CBSVs?
9. How relevant are the CBSVs to your community?
10. Is the community willing to contribute to health programmes?
11. Is the community willing to contribute to support CBSC scheme?
12. In your opinion do you think the current CBSVs scheme is viable? Give reason for your answer.

**APPENDIX 3: INTERVIEW GUIDE FOR HEALTH WORKERS**

- ***CBSV COORDINATORS***
- ***DISTRICT DIRECTORS***
- ***CBSV SUPERVISORS***

1. How many CBSVs have been trained in your district since the inception of the programme?
2. How many CBSVs do you have in your district now? Sex and age distributions.
3. What are the reasons for the attrition?
4. What support do the health sector gives to the CBSVs?
5. What support do the communities give to the CBSVs?
6. Are the communities willing to support the CBSVs programme?
7. Is the CBSV approach a more viable option to the previous Village Health Volunteer?
8. What is envisaged in the CBSVs?
9. Do you think the CBSVs have the capabilities to do the different things they have to do?
10. What are the challenges the CBSVs face in the performance of their duties?
11. Are they satisfied with their remunerations?
12. What do you think are the expectations of the CBSVs?