MOTIVATIONS FOR ENTERING VOLUNTEER SERVICE AND FACTORS AFFECTING PRODUCTIVITY: A MIXED METHOD SURVEY OF STEPS-OVC VOLUNTEER HIV CAREGIVERS IN ZAMBIA

ZAMBIA-LED PREVENTION INITIATIVE

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Zambia-led Prevention Initiative

Investigators
Jessica Price, Population Council
Tina Moyo, Population Council
Stephanie Topp, Independent Consultant
Drosin Mulenga, Population Council
Mardieh Dennis, Population Council
Mathew Ngunga, Futures Group

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Cover photo by Mathew Ngunga. Caregivers singing during a mobile voluntary counseling and testing activity.

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ACRONYMS

BCS	Basic care and support
HIV	Human immunodeficiency virus
HRH	Human resources for health
NGO/INGO	Non-governmental organization/International non-governmental organization
OVC	Orphans and vulnerable children
PLHIV	Persons living with HIV
SOL	Standard of living
STEPS-OVC	Sustainability Through Economic Strengthening, Prevention and Support for Orphans and Vulnerable Children Project
USAID	United States Agency for International Development
ZPI	Zambia-led Prevention Initiative

BACKGROUND

The STEPS-OVC Project and a Need for Informed Transition

Over the last several years, the United States Agency for International Development (USAID) has invested in large volunteer projects to support caregiving for HIV-infected and -affected adults and children in Zambia. In 2011, two of these projects—RAPIDS and SUCCESS—were "closed out" and later consolidated into one new project, STEPS-OVC (Sustainability Through Economic Strengthening, Prevention, and Support for Orphans and Vulnerable Children). STEPS-OVC is a consortium of NGOs, led by World Vision International. Other consortium partners include Africare, CARE International, Catholic Relief Services, Expanded Church Response, the Salvation Army, and the Futures Group. Together, these organizations and their local collaborating partners provide a range of HIV prevention, care, and support services for community members in need, especially children. At the heart of STEPS-OVC is a network of over 30,000 volunteers who are trained in various caregiving areas and working in 72 districts throughout the country. (See Annex 1 for a description of the STEPS-OVC project.)

Reflecting recent emphasis in US development assistance policy to promote sustainability and country ownership, and to do more direct contracting with local institutions,[1] the USAID Zambia Mission has confined the implementation period for STEPS-OVC to three years and included a mandate to transition the activities to local institutions by the end of this period. Given STEPS-OVC's imminent closure in 2013 and USAID's transition imperative, understanding how best to recruit and retain volunteer workers has become a matter of pressing concern. This study was undertaken to address this concern.

Orientation to the Study and the Report

The study was designed to examine the motivations of individuals volunteering as STEPS-OVC caregivers; to explore their experiences in service, including perceived barriers to carrying out their volunteer work and if, and how, their expectations for volunteering had been met or not; to assess individuals' intent to continue caregiving; and to ascertain factors associated with volunteer productivity. To these ends, we applied a multi-staged, mixed-method survey of 758 active caregivers who were selected using a quota-purposive sampling frame. We collected data from fixed-choice and open-ended questions via the same survey instrument and mixed methods at the research design, analysis, and interpretation stages.

Understanding of volunteer motivations in Africa is founded principally on data from small, convenience samples (Leech and Onwuegbuzie 2009). With its relatively large sample size and fully mixed-method approach, the present study brings an important addition to existing knowledge. Combined quantitative and qualitative data provide new insights on volunteer motivations and incentives, work barriers and facilitators, and retention and attrition. No less important, however, is that the results support and confirm key findings previously reported.

[1]US Department of State (2010). Leading Through Civilian Power: The First Quadrennial Diplomacy and Development Review.

In so doing, it adds to the volume and consistency of data that can inform changes in policy and programming. As a starting point, we need to be clear about what we mean by "volunteer" and "volunteerism."

Volunteer and volunteerism defined

Conventional wisdom

Formal volunteerism is typically characterized as helping behavior that is *(i)* planned and enduring, and thus distinct from spontaneous helping, *(ii)* non-obligated, and thus distinct from family caregiving or compelled social service, and *(iii)* neither economically necessitated nor impelled by monetary rewards, and thus distinct from compensated labor (Finkelstien 2009, Omoto and Snyder 1995, Penner 2002, Smith 1981). Following these assumptions, individuals tend to be categorized either as volunteers (distinct from family caretakers) or paid workers.

Such definitional clarity, however, is often absent in reality. In particular, in volunteer-related research and programs in Africa, compensated community health workers are frequently not distinguished from volunteer workers. At the same time, many volunteer workers receive material or cash incentives for their time, while others do not (Lehmann and Sanders 2007, Sunkutu and Nampanya-Serpell 2009). Further complicating conceptual matters is the fact that many individuals in Africa enlist in volunteer programs explicitly in the hope of future employment or, at the very least, with an expectation to receive material benefits from being a volunteer (Kironde and Klaasen 2002, Schneider et al. 2008). As the findings presented later in this report show, these definitional complexities are pertinent to this STEPS-OVC study population. To acknowledge and respond to definitional ambiguity, a more nuanced understanding of what it means to be a volunteer is needed.

Being a volunteer as a matter of degree

Earlier work by Smith (1981) provides help in this regard. Smith defines a volunteer as an individual engaging in behavior that is motivated by an "expectation of psychic benefits"—rather than financial rewards—which result from work that has a market value exceeding any compensation received for the work. Because workers' market values vary greatly, when defined in this way being a volunteer becomes a matter of degree. Smith illustrates with the following example:

> By this definition, a low skilled Peace Corp 'Volunteer' receiving both expenses and a 'stipend' may indeed not be a volunteer at all, but merely a low paid worker. In contrast, a law school professor who forgoes private practice, whether totally or partially, because of dedication to teach and research on the law may be viewed as a quasi-volunteer, assuming an average academic salary (p 23).

Smith emphasizes that the degree of volunteer[ism]—from a "pure" volunteer receiving no compensation to a compensated worker based on market value—is an empirical question, rather than a definitional matter. This conceptualization shifts the interest and focus from an *either/or* (volunteer/paid worker) question to a matter of *how much* (voluntariness).

We draw on but adapt Smith's concept of *volunteer in degree*. Later in the report we propose an empirically-derived typology of STEPS-OVC caregivers reflecting three distinct degrees of *voluntariness* found in the study population. In lieu of Smith's uncompensated labor as a marker of volunteer degree, we use our study participants' self-perceived labor value as a means of differentiation. Identifying STEPS-OVC caregivers by different degrees of voluntariness serves a twofold purpose. In a conceptual sense, the voluntariness categories partially address the definitional ambiguity described above. In a practical sense, differentiating caregivers by their voluntariness provides us a person-level variable, through which we can understand volunteer motivations and commitment to and productivity in services.

Outline of the Report

The remainder of this report is organized as follows:

- Section 2 summarizes the study methods and analytic procedures.
- Section 3 presents the study's findings following the main areas of interest explored in the survey instrument. In six sub-sections we:
  - i) review the sample population characteristics and present descriptive findings on the volunteers' work
  - ii) present reasons individuals cited for entering volunteer service
  - iii) describe participants' experiences in volunteer caregiving, including barriers to performing their volunteer work and expectations met and not met through volunteering
  - iv) summarize motivators (volunteer desires) cited for continuing to volunteer in the future
  - v) describe and present findings about degrees of voluntariness at the individual caregiver level
  - vi) summarize findings on various factors affecting caregiver productivity
- Section 4 discusses the methodological, programmatic, and ethical implications of the study's key findings.

STUDY DESIGN: A MULTI-STAGE, MIXED-METHOD APPROACH

Studies on volunteer motivations seem to fall along a geographic divide. Research conducted in wealthier countries (and in wealthier volunteer populations) in the "North" are heavily influenced by concepts and methods used in social psychology. These studies have robust theoretical grounding and apply rigorously tested psychometric measures for fine-grained assessment of volunteers' attitudinal, experiential, and motivational states. Psychological scales and measures—e.g., of personality type, motivation fulfillment, and satisfaction in service—are in turn used to examine their relative importance for volunteer program outcomes, such as longevity in service (see for example, Clary et al. 1998, Omoto and Snyder 1995, Penner 2002).

On the other hand, research conducted in the less well-resourced countries in Africa, whose volunteer populations are among the world's poorest, tends to be purely descriptive. Most apply exploratory procedures only, such as focus group discussions and, less often, in-depth interviews, in small samples of volunteers (Akintola 2008a, Akintola 2010, Kaseke and Dhemba 2007, Kironde and Klaasen 2002, Wilson 2007). While valuable insight on many issues affecting volunteer motivation and productivity has been gained through this exploratory research, the knowledge-base on volunteerism in Africa is constrained due to a lack of diversity in research methods used to date.

To partially address this limitation in the literature from Africa, we enrolled a large number of volunteers in the sample and used a fully mixed-method approach (Leech and Onwuegbuzie 2009). As outlined in detail below, the study involved a multi-staged process applying qualitative and quantitative methods sequentially and concurrently, producing a final survey instrument comprised of forced-choice items and open-ended questions. Method mixing continued from the study design and instrument development to the data analysis and final interpretations presented in this report.

Study Objectives

The overall aim of the study was to advance understanding of factors related to individuals becoming and remaining STEPS-OVC caregivers. Following models framing volunteerism as a process (Clary et al. 1998, Omoto and Snyder 1995), the specific objectives were to *(i)* discern and describe different motivations for entering service, *(ii)* ascertain if, and how, motivations and expectations were fulfilled in the volunteer experience, and *(iii)* identify and describe factors associated with volunteer retention. As synthesized in Table 1, the initial study approach, key outcome measures, and specific data collection techniques were modified through an iterative and multi-step process.

A Four-Step Process

The research process included four main phases:

Phase One—Study Design (February–April 2012): The initial study design and draft one instrument was developed during this period. Questions were developed based on prior studies of volunteerism, globally and in Africa, in combination with our knowledge of the local context. Ethics review applications were also completed and submitted during this phase.

Phase Two—Initial Instrument Development (May–July 2012): Following recommended procedures for translating and adapting instruments for cross-cultural research (Alegria et al. 2004, Canino and Bravo 1994), in phase two of the research process we focused on instrument preparation and pretesting. This step involved professional translation, question-by-question review in focus group discussions with STEPS-OVC caregivers, pretesting, back translation to English, and instrument modification.

Prior to pretesting, interviewers were trained on the study objectives and the intended purpose of each question. They were given clear instructions on interviewing techniques and probing parameters for open-ended questions. Interviewers were fully engaged in the process of reviewing and modifying questions and translations. Through this involvement, interviewers were generally well-equipped to handle situations and questions from respondents.

Phase Three—Validation Study (August 2012): Following the instrument preparation phase, we conducted a validation study with 200 volunteers in Kafue District to field test the draft one instrument. Results from this validation study informed changes in the study design and in specific questions (Table 1). Experience from the fieldwork, especially around managing volunteer enrollment, also informed field management procedures.

The final step in producing the main study instrument involved a question-by-question review by a multi-lingual group comprising research team members knowledgeable of the topic and the study design. Guided by core concepts in cultural equivalence (Bowden and Fox-Rushby 2003, Kirkpatrick and van Teijlingen 2009), the multi-lingual group assessed linguistic, semantic, and contextual equivalence and recommended final changes to questions and translations.

Phase Four—Main Study (September–October 2012): The main study involved a mixed-method survey of volunteer caregivers in Lusaka, Chongwe, and Mpika districts. The findings presented in this report are from the main study phase of the research process.

Table 1: Validation and main study concepts and question types

Concepts and intended measures	Validation study instrument	Main study instrument (based on validation study findings)
Motivations		
Individuals' reasons for becoming a volunteer and remaining in service	Method: 32-item motivation scale comprising 8 subconstructs, each measured by 4 items. Items were framed as statements with 4 response categories ("strongly disagree" to "strongly agree"). Two open-ended questions probed volunteer motivations. Validation study findings: Some individual scale items were effective but the overall scale was not; no clear clustering patterns were evident from exploratory factor analysis. Replies to open-ended questions revealed a few issues and themes that we had not initially considered.	Revised method: We reduced the number of items from 32 to 16. Some of the original 32 items were retained and we introduced several new ones based on issues discovered in free-text data. After pretesting both a 10-point Likert-type scale (with a visual aide) and a dichotomized ("agree"/"disagree") response category, we opted for the latter. We revised open-ended motivation questions to elicit other motivations, not reflected in the fixed-choice statements and the main motivation for volunteering.
Experiences in service		
Barriers	Method: One open-ended question eliciting three things that prevented caregivers from carrying out their volunteer work. Validation study findings: The original open-ended barriers question was productive, revealing widely shared issues affecting volunteer performance and morale as well as very specific contexts and concerns for different volunteers.	Revised method: Replies to this barriers question were used to develop nine fixed-choice barriers statements with dichotomized response categories ("never or rarely" / "sometimes or frequently") for the main study. The barriers to service section of the interview begins with the open-ended elicitation question (unchanged) followed by the nine fixed-choice barriers items.
Satisfaction (removed from the final instrument)	Method: One fixed-choice item focused on overall positivity of the experience and a second one focused on individuals' personal satisfaction with the work. Validation study findings: Out of 200 respondents, very few expressed disagreement with the satisfaction statements.	Revised method: The lack of variability in responses made these items unproductive. They were removed from the instrument.
Expectations (not) met	Method: Two open-ended questions asked volunteers to describe how their expectations were met and not met. Validation study findings: Replies to both questions provided useful understanding of volunteers' experiences.	Revised method: Both questions were retained.

Concepts and intended measures	Validation study instrument	Main study instrument (based on validation study findings)
Outcome measures		
Intent to continue (transformed to a screening question in the final instrument)	Method: Two fixed-choice items were designed to measure individuals' intent to continue volunteering in the future. Validation study findings: Out of 200 respondents, all 200 "agreed" or "strongly agreed" that whether or not anything changed in the current volunteer program, they would continue to volunteer in the coming year and 198 "agreed" or "strongly agreed" that they would continue volunteering.	Revised method: We retained one fixed-choice intent-to-continue question as a screening question for an open-ended follow on question: "List three things that would make you willing and able to *do more volunteer work / continue working as a volunteer* in the future." As intent to continue proved ineffective as an outcome variable, we replaced it with two measures of productivity: OVC visitation rate and BCS visitation rate.
Longevity in service (removed an outcome variable in the final study design)	Method: We asked respondents to indicate whether they started volunteering as a caregiver with STEPS-OVC, RAPIDS, or SUCCESS project and then asked them to indicate the year and month they began volunteering. Validation study findings: Many of the respondents did not recognize the project names, but they did know the name of the partner organization they were affiliated with (e.g., Africare, CRS, or The Salvation Army)	Revised method: We retained the year and month question and expanded the list of options to include project names and partner organization names.

Main Study Instrument

The final instrument was divided into four sections and included 49 fixed-choice and seven open-ended questions.

Section I—Background: Section I includes questions on demographic background and standard of living indicators. Given the methodological challenges in assessing socioeconomic status (for example with household income data), we opted to use a household standard of living (SOL) measure instead based on nine proxy indicators tested in various developing country contexts (Montgomery et al. 2000). Assessing the presence or absence of indicative household features and possessions, a value of "9" indicates the highest possible SOL and "0" the lowest (Table 2).

Table 2: Standard of living indicators and measure

	Question	Response category
1	In the house you live in now, what is the main source of your drinking water?	1 (river/lake) indicating lowest SOL to 5 (private piped) indicating highest
2	In the house you live in now, what type of toilet do you have?	1 (none) to 5 (private flush)
3	In the house you live in now, what type of flooring is there?	1 (mud floor) to 4 (tiles)
4	Does the house you live in now have electricity?	1 (yes) and 0 (no)
5	Do you or any member of your household own a functioning TV?	1 (yes) and 0 (no)
6	Do you or any member of your household own a functioning bicycle?	1 (yes) and 0 (no)
7	Do you or any member of your household own a functioning refrigerator?	1 (yes) and 0 (no)
8	Do you or any member of your household own a functioning cell phone?	1 (yes) and 0 (no)
9	Do you or any member of your household own a functioning car?	1 (yes) and 0 (no)

This section also includes questions on recruitment, project affiliation, length of service and information on beneficiaries. Beneficiaries included orphans and vulnerable children (OVC), people living with HIV/AIDS (PLHIV) receiving basic care and support (BCS), or both. For each category of beneficiary we asked respondents to indicate the number they currently supported. Later in the interview we asked the volunteers to indicate how many beneficiaries in each category they visited last month. We use the ratio of OVC visited last month to total OVC supported and BCS clients visited last month to total number of BCS clients supported as indicators of volunteer productivity.

Section II—Motivations for Entering Service: Section II included 16 fixed-choice motivation questions with dichotomized "agree"/"disagree" response categories. Motivation statements were inspired by prior research in volunteer populations (Akintola 2010, Clary et al. 1998, Omoto and Snyder 1995) and based on results from pretesting and the validation study (Table 1). Two open-ended motivation questions follow the 16 fixed-choice statements, one probing for additional motivations not yet cited and the other the main motivation for becoming a caregiver.

Section III—Experience in Service: Focusing on experience in volunteer service, Section III also combines fixed-choice statements and open-ended questions. Nine fixed-choice statements on barriers to volunteer service were devised through pretesting and the validation study. Barriers statements were prefaced with an open-ended elicitation question asking respondents to cite three things that prevent them from carrying out their volunteer work.

Section IV—Expectations and Motivation to Continue: The final section comprises open-ended questions exploring whether or not, and how, caregivers' expectations from volunteering have been met and what would enable and motivate them to continue and increase their volunteer work in the future.

Data Management

Fixed-choice data

Fixed-choice data were entered manually into an SPSS program. Data entry for each interview was checked for accuracy at a later date and by two data entry clerks. Descriptive and inferential analyses were performed in SPSS.

Free-text data

Given the large sample and the large number of open-ended questions, all of the open-ended questions were designed intentionally and pretested to deliver short-answer replies. To facilitate later transcription and coding, interviewers wrote respondent replies on the paper survey instrument and translated them directly into English in the process. Replies were transcribed in full and uploaded to Nvivo version 10 for coding.

Pre-ordered by question in Nvivo, free-text replies were reviewed to devise an initial coding scheme. This initial scheme was elaborated and refined during a three-day joint coding session attended by three study team members. Responses were coded to all pertinent categories and sub-categories such that one reply could be assigned simultaneously to multiple codes. (Annexes 2 and 3 show sample quotes for each of the main coding categories.)

To facilitate their use in quantitative analysis, thematically-coded text data were then transformed into numeric variables. Involving a multi-step process, we created a nominal variable for each coded theme in the text data and assigned binary values to indicate the presence (=1) or absence (=0) of the theme in the respondents' replies. Transforming themes into dichotomous variables allowed us to: *(i)* examine patterns in free-text data for each of the open-ended questions, *(ii)* examine the presence or absence of themes in individuals' responses across multiple questions, and *(iii)* combine free-text and fixed-choice data types in various analyses.

Data Collection

Sampling

Using a quota/purposive sampling frame, we first purposefully selected three districts for inclusion in the study based on: *(i)* ability to access a mix of new volunteers who started with STEPS-OVC and those who started under either the SUCCESS and RAPIDS predecessor projects, *(ii)* logistical and financial feasibility, and *(iii)* proportionate representation of volunteers working in urban and rural areas.

Initially we attempted to draw our sample of respondents from volunteer rosters maintained by STEPS-OVC and its partners. We abandoned this recruitment approach, however, due to difficulty in obtaining complete and updated rosters. Instead, we worked directly with STEPS-OVC coordinators to announce the study and proposed interview dates to eligible volunteers in their areas. Volunteers who were 18 years old or older, who were recognized by the STEPS-OVC coordinator as an active caregiver, and who had been in STEPS-OVC volunteer service for six months or more were eligible to participate in the study.

All eligible volunteers were scheduled for interviews until district quotas were met or the fieldwork schedule came to an end, whichever came first. Generally, between 10 and 30 volunteers presented on interview days at the different interview sites. A total of 802 individuals were interviewed, of which eight cases were removed for not meeting the inclusion criteria or not having any beneficiaries assigned to them at the time of the interview. An additional 36 individuals were excluded from the analysis due to what appeared to be intentional inflation of the reported number of beneficiaries assigned and recently visited.[2] The remaining 758 individuals constitute the evaluable population that is the subject of this report.

Fieldwork procedures

Data were collected in the three districts simultaneously by three fieldwork teams comprising a field supervisor and five interviewers. All three supervisors were members of the research team. After introducing the team to the STEPS-OVC coordinator, the coordinator and the field supervisor oriented the volunteers on the purpose of the study and the interview procedures. Volunteers who wished to participate were screened for eligibility, consented, assigned a unique identification number, and then interviewed in a private space. Each interview took approximately 30 minutes. Upon completion of each interview, supervisors conducted rapid quality control checks to ensure eligibility, identify potential problems with the data (e.g., inconsistency between beneficiaries supported and visited), quality of translations, and legibility of written responses.

[2]In carrying out data quality check procedures after the interview, the Mpika field supervisor noticed unusually high reports of beneficiaries supported and visited last month. In exploring the issue with interviewers she came to suspect intentional inflation of numbers by the participants. Statistical procedures performed on the dataset of 802 individuals supported this suspicion. We subsequently excluded data from all interviews (n = 36) conducted in Mpika on the date of this observation.

FINDINGS

Study Population Characteristics

Socio-demographics

As noted above, 758 individuals constitute the evaluable population for this study. The mean age of these 758 respondents was 43 years old. Seventy-six percent were women, 60 percent resided in Lusaka or a contiguous urban district, and 40 percent were from rural areas. Most respondents had between one and 12 years of formal education. Most of the volunteers were married (67 percent); 27 percent of women were widowed compared to less than one percent of men. Thirty-six percent of the study population was in the lowest of three SOL categories. Using Pearsons chi-square test, no significant differences were found in SOL between male and female respondents ($p > .05$) or between urban and rural residents ($p > .05$). Table 3 summarizes sample characteristics.

Project affiliation and length of service

Most of the respondents said that they started as volunteer caregivers with STEPS-OVC (24 percent) or one of its predecessor, RAPIDS or SUCCESS, projects (20 percent). Another 31 percent indicated that they started volunteering with one of the STEPS-OVC consortium partner organizations and 12 percent cited another project or organization.[3] The majority (54 percent) said that they entered volunteer service simply out of conviction, while others reported being encouraged by friends (17 percent) or at church (10 percent); 11 percent were approached by a project staff member.

Length of service ranged from six to 284 months.[4] On average, respondents indicated being volunteer caregivers for 58 months. Men reported being in service for 68 months compared to 56 months reported by women. While long length of service may indicate retention, it does not capture or address periods of inactivity which, as reported in another study in Zambia (Ashraf et al. 2009), are common in other community health worker populations. In follow-up or similar surveys, we recommend asking specific questions about periods of inactivity.

Volunteer productivity: Beneficiaries assigned and visited last month

All but five volunteers were assigned OVC beneficiaries and 654 (86 percent) provided basic care and support to PLHIV. As discussed above, we used the rate of beneficiaries (OVC and BCS clients separately) visited last month to the total number assigned to assess volunteer productivity (Table 4). Overall, volunteers reported visiting 80 percent of their assigned OVC and 84 percent of their assigned BCS beneficiaries last month.

[3]Many of the volunteers did not distinguish between STEPS-OVC and the predecessor projects. Many also were unable to identify the STEPS-OVC project but identified instead the partner organization in the consortium.

[4]Despite emphasizing that we were interested in volunteer start dates under STEPS-OVC and its predecessor projects, several volunteers insisted on start dates pre-dating the projects.

Table 3: Sample characteristics

					Total
Sex					
Male	Female				
184 (24%)	574 (76%)				758 (100%)
RESIDENCE					
Rural	Urban				
304 (40%)	454 (60%)				758 (100%)
DISTRICT					
Lusaka	Chongwe	Mpika			Total
406 (54%)	186 (24%)	166 (22%)			758 (100%)
AGE					
18–24 years	25–34 years	35–44 years	45–54 years	≥55 years	
46 (6%)	131 (17%)	236 (30%)	226 (30%)	126 (17%)	756 (99.7%)†
Mean (SD): 43 (11.7)					
Median: 43					
Min-Max: 18–81					
MARITAL STATUS					
Married/ cohabiting	Divorced/ separated	Widowed	Never married		
505 (67%)	55 (7%)	153 (20%)	45 (6%)		758 (100%)
EDUCATION					
None	1–6 years	7–12 years	≥13 years		
44 (6%)	143 (18%)	529 (70%)	42 (6%)		758 (100%)
Mean (SD): 8 (3.6)					
Median: 8					
Min-Max: 0–18					
STANDARD OF LIVING (9 item index)					
Lowest	Middle	Highest			
273 (36%)	340 (45%)	123 (16%)			736 (97%)‡
(values: 0–3)	(values: 4–6)	(values: 7–9)			
Mean (SD): 4.4 (1.85)					
Median: 4					
Min-Max: 1–9					

Percentages are on the evaluable population of individuals (n = 758)
†Excludes two individuals who did not know their age; ‡Excludes 22 cases with missing data on one or more SOL items

Table 4: Beneficiaries supported and visited last month

Overall	Mean (SD)	Min-Max	Total
OVC BENEFICIARIES			n = 753†
Supported	9.79 (7.84)	1–55	
Visited last month	7.24 (5.98)	0–45	
Visited:Supported	.80 (0.30)		
BCS BENEFICIARIES			n = 653‡
Supported	5.78 (4.68)	1–50	
Visited last month	4.48 (3.34)	0–27	
Visited:Supported	.84 (0.31)		

†Five individuals had no OVC beneficiaries assigned to them; ‡104 had no BCS beneficiaries assigned to them

A Spearman's Rank Order correlation was run between OVC supported and OVC visited last month. We found a weak, but statistically significant, inverse correlation between the two variables (r_s = -.262, p < .001), with visitation declining as the number of OVC supported goes up. This finding may indicate a possible threshold number of OVC beneficiaries supported beyond which the frequency and consistency of visitations decline. The same correlation analysis done on BCS data did not show a significant correlation between the two variables.

Motivations for Becoming a Volunteer Caregiver

We assessed motivations for entering service in two ways. First, 16 fixed-choice motivation statements with dichotomized "agree"/"disagree" response categories were intended to measure one of eight dimensions: *(i)* communitarian values, *(ii)* learning opportunity, *(iii)* religiosity, *(iv)* desire to influence social change, *(v)* empathy and reciprocity, *(vi)* opportunity for social engagement, *(vii)* potential for material gain, and *(viii)* potential paid employment. Two open-ended questions further probed motivations.

"A vocabulary of motives"

Normative helping values

> *I love to help others and being a volunteer created a platform for me (ID 1004)*
>
> *I wanted to bring development in my community (ID 2151)*
>
> *We are taught as Christians to look after the needy in our community (ID 1267)*

In research on volunteer motivations, communitarianism, religiosity, and helping values inevitably figure prominently in the findings (Ashraf et al. 2009, De Wet 2011, Kaseke and Dhemba 2007). This study is no exception. Out of the 16 fixed-choice motivation statements, seven were values-oriented, focusing on community concerns, religious faith, and desire to influence social change (see items 1–9 in Figure 1). We found almost universal agreement (94 to 99 percent) with each of these seven values-oriented motivations. Eighty-eight percent

(n = 666) of the respondents agreed with all seven values-oriented statements and another 10 percent (n = 74) agreed with six out of the seven. The remaining 20 individuals in the sample agreed with three, four, or five of the values-oriented statements.

Helping values and social concerns also dominated responses to open-ended motivation questions, which was consistent with findings from the fixed-choice questions presented above.

The predominance of helping values expressed in replies to open-ended and fixed-choice questions is striking but not surprising. Noting the tendency described in the volunteer literature, Smith (1981) explains the preponderance as a "vocabulary of motives" reflecting normative ideals and standards of how things *ought* to be, why one *ought* to volunteer. While clearly revealing socially acceptable reasons for volunteering, such a normative vocabulary tells us little about causative factors underlying individuals' decisions to become volunteer caregivers. While this is not to suggest that helping values have no influence on volunteer motivations, we must question their degree of influence. The universality of agreement with values-oriented motivation statements precludes us from using the responses in inference stages of this research and, as Smith argues, may also indicate that among a multitude of factors contributing to volunteer motivations, personal values play a relatively minor role.

HIV-specific helping motives

If you're not infected, you're affected (ID 2008)

The importance of personal values is more compelling when linked to a clear and present community need. As implied in the quote above, responding to the HIV epidemic represents such a need, and the STEPS-OVC project provides an opportunity for individuals to participate in the community's response.

Not only did virtually all of the respondents (99 percent) agree with the statement, "I became a volunteer to learn about HIV and take care of people" (Figure 1), the majority (617, 81 percent) also cited an HIV-related concern to one or both of the open-ended motivation questions. Some of the volunteers expressed HIV concerns in vague and higher order terms, such as *saving humanity [from HIV]* (ID 3086), *helping my country progress by reducing HIV* (ID 2088), and *helping people in my community with diseases like HIV* (ID 1003). Many, however, gave more specific HIV-related reasons for volunteering. These ranged from:

- promoting testing—

People . . . don't know about VCT and refuse to be tested (ID 1018)

- helping people accept their HIV-positive status—

People were dying due to stigma and denial of their status (ID 1051)

- supporting treatment adherence—

I really wanted to have knowledge to reach out to people who do not take their medication (ID 1031)

- reducing stigma—

Many people think being HIV-positive is a death penalty, so I wanted to help people see that despite being positive one can live a long life (ID 1085)

- changing knowledge and behaviors—

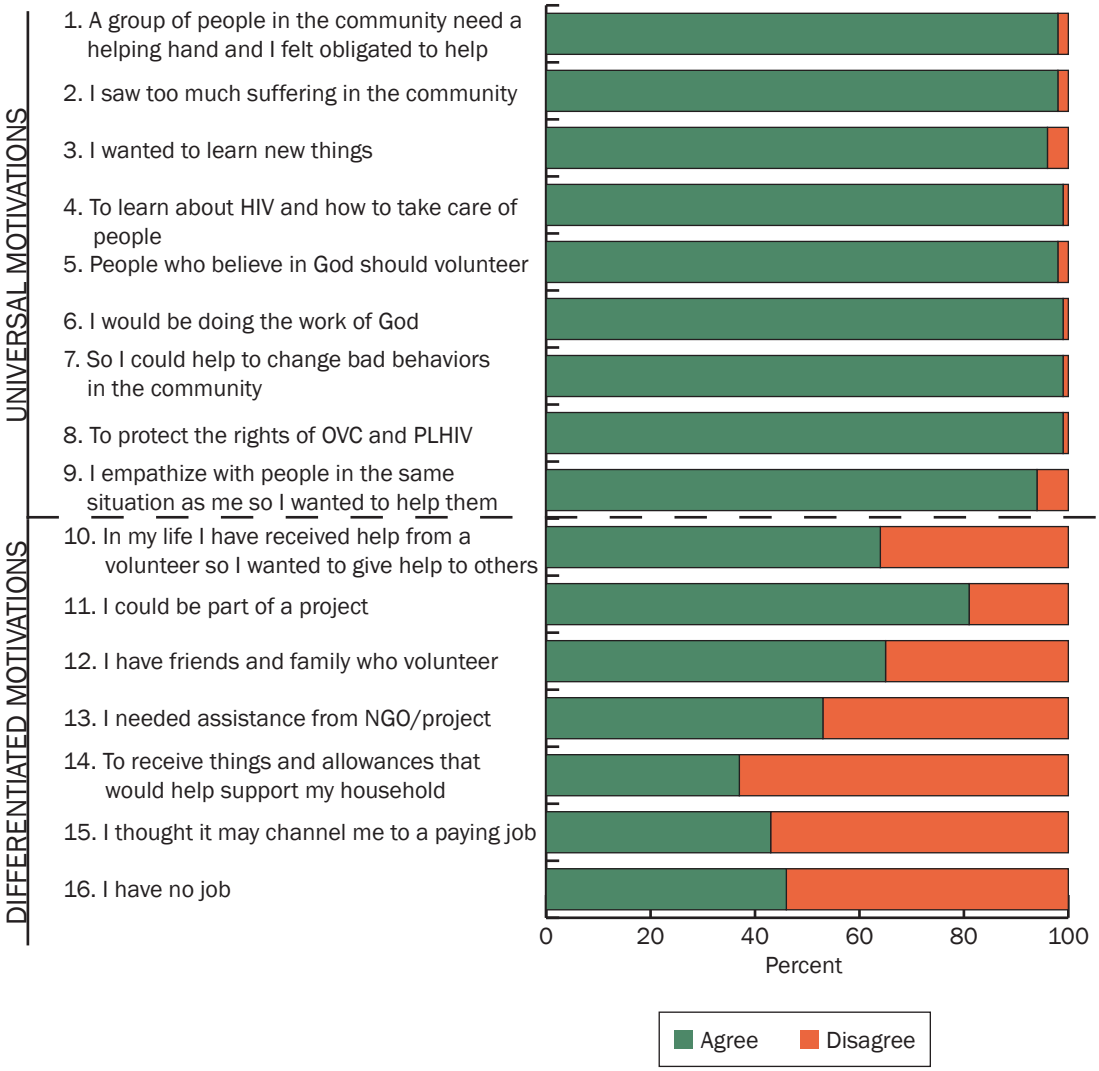
I wanted to change the myth that a man gets HIV after having sex with a woman who has had an abortion (ID 1097)

Many people believe in traditional medicine. I wanted to help them know the importance of seeking medical attention (ID 1168)

- advocating for the rights of OVC and PLHIV—

To help abused OVC and women, and counsel OVC about their education (ID 1181)

Figure 1: Replies to fixed-choice motivation statements: "I wanted to become a volunteer (because) . . ." (n = 758)



Especially impressive in the respondents' replies is the specificity in knowledge and awareness about core issues for an effective response to HIV. Beyond reflecting the social experience living in a community with a high HIV burden, this specificity may also attest to the tremendous effort and resources dedicated to scaling-up comprehensive HIV care and treatment services in Zambia. As the funding landscape changes and HIV programming priorities are redefined, it will be useful to consider carefully how to draw and build upon prior investments in this volunteer workforce in revised programs and approaches.

Beyond normative values and community needs: Self-interested motives

It is at the personal level of caregivers' lives that we begin to see diversity in volunteer replies and are able to understand motivations in a more nuanced way. Basic economic needs and direct, personal experience with HIV are two of the main reasons offered by many of the respondents for becoming volunteer HIV caregivers.

Caregivers' economic and household needs

Unlike universal agreement with the values-oriented motivation statements, responses to seven other fixed-choice statements showed substantially greater variability (see items 10 to 16 in Figure 1). One of these "differentiated" motivations focused on reciprocity (item 10 in Figure 1), two on opportunity for social engagement (items 11–12), and four on the potential for material gain (items 13–16).

Seventy percent of the respondents in the sample agreed to at least one of the four material motivation statements and 23 percent agreed to all four. Notably, in response to the statement, *I wanted to become a volunteer because I needed assistance from the project/NGO*, 398 (53 percent) of the respondents agreed. For each of the four material motivation statements we tested for significant associations with respondents' sex, residence, and SOL. Using Pearsons chi-square test we found women to be significantly more likely than men to agree that they wanted to become a volunteer: *(i)* "to receive things and allowances that would help me support my household" (item 14) ($p < .001$); *(ii)* "because I thought it may channel me to a paying job" (item 15) ($p < .001$); and *(iii)* "because I have no job" (item 16) ($p < .001$). Compared to rural residents, urban residents were also more likely to agree that they became a volunteer *(i)* "to receive things and allowances" ($p = .03$) and *(ii)* to get a "paying job" ($p < .001$). Individuals with lower SOL were significantly ($p < .001$) more likely to agree with one, two, or all three of the material motivation statements (Table 5).

Table 5: Agreed to material self-interest motivation statements

SEX	Male	Female		n=758	p-value
Agreed to:					
None of the statements	76 (41%)	198 (35%)			
At least one statement	77 (42%)	202 (35%)			.002
All three statements	31 (17%)	174 (30%)			
RESIDENCE	**Rural**	**Urban**		**n=758**	**p-value**
Agreed to:					
None of the statements	115 (38%)	159 (35%)			
At least one statement	119 (39%)	160 (35%)			.124
All three statements	70 (23%)	135 (30%)			
STANDARD OF LIVING	**Lowest**	**Mid-level**	**Highest**	**n=736†**	**p-value**
Agreed to:					
None of the statements	94 (34%)	110 (32%)	64 (52%)		
At least one statement	97 (36%)	137 (40%)	26 (21%)		.002
All three statements	82 (30%)	93 (27%)	26 (21%)		

Percentages within socio-demographic categories; used Pearsons chi-square to test for significant differences
†22 cases had missing data on standard of living indicators and are excluded from this analysis

In response to open-ended motivation questions, however, few respondents (5 percent) cited similar material self-interest. We coded as material motives such replies as:

Being a widow, I thought if I offer my services as a caregiver maybe I'd get something like a monthly allowance to assist me and my family (ID 1164)

I also wanted to obtain some help by becoming a caregiver (ID 1269)

Altruistic reasons for volunteering, such as wanting to help the less fortunate and to better society, are commonly reported in other qualitative studies in Africa (Ashraf et al. 2009). In this study, however, the differences in responses from fixed-choice and open-ended questions forces us to question the explanatory completeness of either of the methods. Whereas open-ended questions permitted respondents to demonstrate their alignment with normative helping values, the forced-choice statements seemed to offer a non-threatening way for caregivers to express self-interested motives for volunteering. The findings together provide a more complete picture of volunteer motivations.

Caregivers' HIV-related needs

Reciprocity and empathy were other important personal reasons for individuals to become volunteer caregivers. Almost all of the respondents agreed that they became a volunteer out of empathy for others in similar situations to their own (item 9 in Figure 1) and 485 (64 percent) agreed with the more precise statement: *In my life I have received help from a volunteer so I wanted to give help to others* (item 10, Figure 1).

To the open-ended questions, 22 percent of the respondents cited very specific personal circumstances which motivated them to become volunteer caregivers. For example:

- having received help in the past, typically from a volunteer caregiver—

One of my relatives was sick [with HIV] in 2001 and the caregivers were a great help in his recovery, so I decided to help others who needed it (ID 1077)

- having themselves suffered—

I suffered so much when my parents died . . . so I volunteered to help people who were going through what I went through (ID 2079)

- wanting to learn caregiving skills in order to help oneself or a personal relation—

This disease is in my family . . . I joined the group to be able to help my family members who are in the same situation (ID 1066)

My son was sick. I wanted to learn how I could help him, so I became a caregiver (ID 1388)

It was my own health problems, that's why I became a volunteer (ID 3061)

In contrast to conventional definitions of volunteerism, which assume non-obligated helping, caring for sick spouses, children, parents, siblings, nieces, nephews, aunts, uncles, and friends were all cited as an important motivation for volunteering. These same volunteers tended to express their improved ability to care for themselves and their loved ones as an expectation met through their volunteer work.

Experience in Volunteer Service

Volunteers' experiences in service were also assessed through a mix of question types focused on perceived barriers to carrying out caregiving work and expectations met (and not met) from volunteering. As with motivations, mixed question types produced mixed, or complementary, results, allowing us to perceive a complex range of issues potentially affecting volunteer productivity and morale.

Perceived barriers

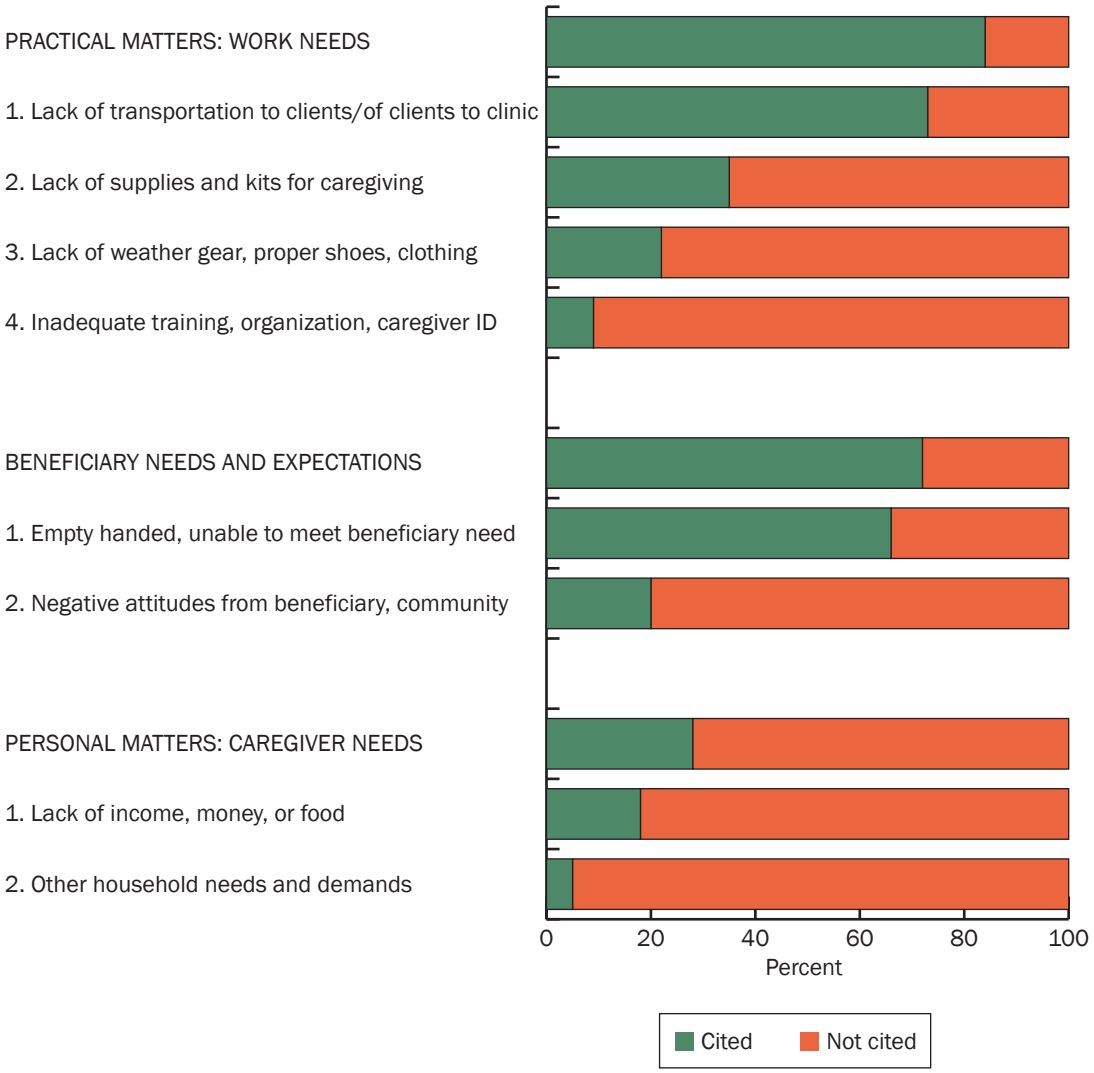
We began our exploration of volunteering barriers with an open-ended elicitation: *List three things that prevent you from carrying out voluntary caregiving work*. This question was followed by nine fixed-choice barriers statements. Barriers statements were framed as *I have failed to visit my clients because* . . . and had two response options: "never or rarely" or "sometimes of frequently" (Table 6).

Analysis of free-text replies to the barriers elicitation question revealed three broad areas of concern for volunteers: *(i)* practical, work-related matters, *(ii)* beneficiary needs and expectations, and *(iii)* caregivers' personal interests and needs. We use these three categories to structure the presentation of findings.

Practical, work-related needs

The largest category of barriers identified in the free-text data was related to practical, work-related impediments (Figure 2). Overall, lack of transportation—to make home visits and to take beneficiaries to clinics—was the most frequently cited barrier (73 percent). Replies typically made general reference to a lack of transportation, but some volunteers made specific mention of not having a bicycle (67, 9 percent) or a cash allowance (14, 2 percent) for transport.

Figure 2: List three things that prevent you from carrying out your volunteer work: Main categories from coded responses of text data (n = 758)



The absence of homecare kits, incomplete kits, and lack of work-related supplies (35 percent) were also frequently cited. Not having "safety gloves" was a particular concern and many respondents reported having to make do with plastic bags in their absence. Lack of weather gear and appropriate clothing and shoes (22 percent), followed by various other organizational issues (9 percent), including inadequate training, lack of formal volunteer identification, and management and supervisory matters, were other notable barriers reported by the volunteers.

The nine fixed-choice barriers statements were read after the open-ended elicitation. Consistent with replies to the open-ended elicitation, many of the volunteers also indicated "sometimes or frequently" failing to conduct home visits due to a lack of transportation, caregiving supplies and kits, and weather gear in response to fixed-choice barriers statements. As shown in Table 6, more females compared to males, urban residents compared to rural

residents, and volunteers with higher SOL compared to lower SOL were more likely to reply "sometimes or frequently" failing to visit clients on several of the barriers statements.

Table 6: Respondents indicating "sometimes or frequently" to fixed-choice barriers statements (n = 758)

	"I have failed to . . .	"Sometimes or frequently" n (%)	p < .05
1	visit my clients because I don't have transport"	207 (28%)	
2	help transport my clients to the clinic"	349 (46%)	(1) (2) (3)
3	visit clients because I felt bad about going empty handed"	306 (41%)	(1) (2)
4	visit clients because I lacked the supplies and kits to do the job"	280 (37%)	(1) (2) (3)
5	visit clients because I never receive money for my work"	72 (10%)	(2)
6	visit clients because I don't have enough food or money at my own home"	83 (11%)	(1) (2)
7	visit clients because I am sick"	16 (2%)	
8	visit my clients because people think that I keep things provided by the project for myself instead of giving them to clients"	149 (20%)	(1) (2)
9	visit clients because I don't have rain gear"	292 (39%)	(2)

Used chi-square test; (1) females more often than males, (2) urban residents more often than rural residents, (3) individuals with higher SOL more often than those with lower SOL

Beneficiary needs and expectations

A second major constellation of barriers identified in the free-text data was around beneficiary needs and expectations (Figure 2). Many respondents indicated that the suffering of beneficiaries sometimes prevented them from making home visits, usually due to caregivers' inability to effectively help people with their material needs (509, 67 percent). This caused feelings of shame and discouragement for some of the caregivers:

> *I feel ashamed visiting a client knowing that she doesn't have anything to eat (ID 1251)*

> *When I find my OVC in a bad state and I can't help them I feel bad, like I'm not doing anything to better their lives (ID 1969)*

> *I get discouraged visiting people with problems, knowing that I can't offer solutions (ID 1155)*

> *It's painful for me when my clients complain that they have no food (ID 1126)*

Beneficiaries' expectations from the project generally, and from caregivers specifically, accentuated and compounded frustrations:

> *OVC and PLHIV want food, soap, clothes. They complain a lot but we have no means of helping them with these things (ID 1104)*

Our clients can't afford anything, especially food, and they expect a lot from us that we can't provide (ID 1324)

Clients are too demanding. They want me to give them things every time I visit. The OVC ask about why we take their names since they don't receive school sponsorship (ID 1568)

Many of the respondents made it clear that "health talk" and "psycho-social support" alone were not enough. Visiting beneficiaries "empty handed" was not only distressful, for some it was demotivating and directly linked to reduced productivity:

Because I keep visiting clients empty handed and only offer counseling, I feel discouraged and demotivated (ID 1697)

Sometimes if I don't have anything to give the OVC I choose not to visit them (ID 1561)

For other caregivers, failing to assist with basic material needs led to negative encounters with their clients. Twenty percent of the respondents specifically described such experiences. Beneficiaries "hiding," being "hidden by relatives," or "running away" from "empty handed" visiting caregivers was the most common negative experience described. But more dramatic interactions were also reported. A particularly poignant example was offered by this respondent:

Once I took a blouse [to a client] and she threw it back at me, yelling that she can't eat a blouse (ID 1053)

Beneficiaries generally expect and assume they will receive food, school fees, or other forms of material support from the project. When caregivers are unable to deliver they come under suspicion and are often subjected to accusation:

My clients think I take their money or food that comes from the project (ID 1229)

Clients shout at us when we go empty handed because they think we get things and keep for ourselves what is meant to be given to them (ID 1132)

Clients chase us away because they think we eat the food provided for them by the donors (ID 1137)

Responses to fixed-choice barriers statements are consistent with these qualitative findings (Table 6). Forty-one percent of the volunteers said that they "sometimes or frequently" failed to visit clients *because I felt bad about going empty handed* (item 4) and 20 percent said they "sometimes or frequently" failed to visit clients *because people think I keep things provided by the project for myself instead of giving them to the client* (item 8).

Personal, caregiver-related needs

Various personal barriers to volunteering emerged as an important theme in response to our open-ended elicitation question. While household demands, such as caring for family members and personal health, were mentioned by a few volunteers (5 percent), the most common personal barrier reported by the caregivers related to household economic and food needs (Figure 2). Twenty-four percent (184) of the volunteers said that a lack of food or money in their households sometimes prevented them from performing caregiver work. The replies below are examples of free-text coded to caregivers' household food and economic need barriers:

> *When I don't have food or money at my own home, I fail to do my work (ID 1021)*
>
> *When my family goes hungry, this affects my work (ID 1316)*
>
> *It's hard to work for another person when there is hunger at home (ID 2077)*
>
> *My family also has needs and I have to attend to them first, so I find it difficult to visit my clients (ID 3047)*

Several volunteers framed such barriers as a lack of volunteer "*motivation*," material *incentives*, or cash *compensation* for the time they spend caregiving. Most linked this lack of incentive barrier directly back to their household needs:

> *[Lack of] motivation for volunteers. I have a family and I need to leave something at home. An allowance would do (ID 1068)*
>
> *Balancing between working for our families and for the clients is a challenge. We [caregivers] need to be looked after too (ID 1085)*
>
> *As most of our time is spent visiting clients, a lack of incentives for caregivers to sustain our families [prevents me from working] (ID 1129)*
>
> *Apart from the volunteer work I do, I don't have a paying job to help me support my family (ID 1331)*

Only a few individuals indicated that their partners or other family members "want me to stop this work" (ID 1112) in order to find something more beneficial for the household.

Personal barriers to caregiving were also assessed through three fixed-choice barriers statements (items 5–7 in Table 6). We note a discrepancy in the responses to these fixed-choice items and the qualitative findings presented above. Out of the 184 respondents who explicitly indicated a household food or economic barrier in their replies to the open-ended elicitation, in the follow-up fixed-choice statements only 33 (18 percent, 33/184) said they "sometimes or frequently" *failed to visit clients because I don't have enough food or money at my own house*. Similarly, only 25 (14 percent, 25/184) of the 184 said they "sometimes or frequently" *failed to visit clients because I never get paid for my work*. It is difficult to interpret this apparent discrepancy, which again illustrates the value of using mixed question types in exploring volunteer motivations and experiences in service.

Expectations met and not met

Two open-ended questions addressed volunteer expectations, one asking respondents to tell us if and how their expectations of volunteering have been met or not. Similar themes were apparent in replies to our expectations met/not met questions.

A wide range of expectations met was offered, generating 30 unique codes. These were subsequently collapsed into eight broad categories shown in Table 7. By far, the most frequently met expectation from volunteering was being able to help individuals in need and the community generally (cited by 423, 56 percent, of the respondents). Exemplified by these caregivers' responses, encouraging individuals to accept their HIV diagnosis and seek treatment and helping OVC enroll and stay in school were especially prominent:

> *I expected to save people's lives because they used to die prematurely from staying in their houses. Now, most of the patients in my community get medical attention and stigma has become a thing of the past for people living with HIV (ID 1082)*

> *I've managed to help children remain in school and have counseled sick people, who are now free to seek medical help and stay on their treatment (ID 1010)*

> *I went in to volunteering with a heart and had high expectations. So far I've helped some people who were bedridden and now they are actually back home and taking medication. All I wanted was to help bring them out of this condition and so far I am happy (ID 1016)*

> *I've met some expectations in that some of my OVC are in school. I also advised their guardians to start gardening to help the children and even helped with my personal funds when I have them (ID 1097)*

The opportunity for learning was also cited by a large number of volunteers (242, 32 percent) as an expectation met. Beyond helping others, caregiving knowledge and skills were valued by many of the volunteers for their own personal lives and situations. In addition to practical skills, such as *how to keep my own home clean, for example the water supply and toilet* (ID 1038) and *how to take care of my own family* (ID 1013), respondents described other ways that caregiving was personally enhancing:

> *Going to workshops has given me the exposure I've always dreamt of (ID 1004)*

> *This job is a passion from my heart and all my expectations have come to pass. I'm a better person now that I help people in my community, especially those who are sick (ID 1059)*

> *After becoming a caregiver I came to have a free mind. I used to stigmatize people with diseases like TB. Through caregiving, though, I've acquired a lot of information which enables me to even handle difficult cases, even within my household. I'm able to counsel my children (ID 1128)*

Only 11 of the respondents said explicitly that none of their expectations have been met (Table 7).

Table 7: Replies to the question: Thinking about the things that made you become a volunteer, how has volunteering met your expectations?

	Total times cited	Number of volunteers who cited the theme
General helping (individuals who suffer, improving my community, responding to HIV)	434	423 (56%)
Learning opportunity (learning skills, new knowledge, personal growth)	242	242 (32%)
Work-related (caregiver identification, kits, weather gear, transport)	64	59 (8%)
Various caregiver interests (serve my faith, work with friends, keeps me occupied)	57	56 (7%)
Meeting clients material needs (food or monetary support, school fees, household needs)	72	38 (5%)
Caregivers material needs (allowance, school fees, provision of self-care or family care)	42	40 (5%)
Social change agent (alcohol and stigma reduction, human rights)	24	23 (3%)
None of my expectations has been met	11	11 (2%)

In response to the opposite question, *How have your expectations* not *been met?*, 142 respondents (19 percent) said that the question did not apply to them and that their expectations had been fully met. The remaining 616 individuals indicated various disappointments from their volunteer work, mainly work-related issues (244, 32 percent), especially lack of transportation, kits, and supplies; the absence of support for caregivers (121, 16 percent); and being unable to provide material help to beneficiaries (251, 33 percent). Dissatisfied by not having food, money, clothes, or other household supplies to give their clients, some of the volunteers expressed their frustration quite forcefully:

> *Sometimes I feel like a liar. At the beginning we told the children and their guardians that they will be given food and other things, but these things never come (ID 1099)*

> *They told us that clients would have food, so going to see them without food is very hard; it's not fair (ID 1070)*

Motivations to Continue as a Volunteer Caregiver

Our final question in the interview asked respondents to *List three things that would make you willing and able to perform more voluntary work in the future*. Familiar themes are apparent in the volunteers' responses to this question. Having access to transportation, complete kits and supplies, and more training were cited at least once respectively by 47 percent, 30 percent, and 18 percent of the volunteers (Table 8). Compared to response patterns for the barriers and expectations questions, however, many more of the volunteers (45 percent) said that receiving some form of material compensation would motivate them to continue their caregiving work in the future.

Table 8: Replies to the question: List three things that would make you willing and able to perform more voluntary work in the future?

	Number of volunteers who cited the theme
Access to transport (bike, cash allowance)	353 (47%)
Caregiver compensation or incentives (salary, job, regular cash stipend, food support)	341 (45%)
Client needs met (food support, school fees, cash and household support)	303 (40%)
Complete kits and supplies available	226 (30%)
Weather gear for caregivers provided	168 (22%)
More training provided	135 (18%)
Various work-related needs (uniforms, formal IDs, regular supervision)	93 (12%)

Being able to meet beneficiaries' material needs remained an important theme, cited by 40 percent of the volunteers. Within this broad theme, many individuals (184, 24 percent of the whole population) said they wanted to "be empowered" in order to help their clients better, expressed in terms of cash payment, food subsidies, or loans and training for income generation:

- receiving cash or food directly—

If I am provided money to give my clients (ID 1238)

Money to buy whatever the OVC need (ID 3108)

If I'm given things that I can take to clients, like food or money (ID 1403)

- generating income or growing food in order to meet client needs—

Caregivers should be empowered with income-generating activities that would enable us to look after our clients as well (ID 1033)

If we could be given some capital, a small business loan to start something up, because it doesn't feel right visiting our clients empty handed (ID 3108)

I want to receive help in my farming so that I can take food to the sick (ID 2024)

The idea of sharing with clients, or somehow benefitting mutually from cash allowances, food subsidies, or income generation, was also commonly expressed by the caregivers:

If we were given fertilizer we could farm our own food and that way also help our clients better (ID 2034)

Start-up income, like from a tailoring business, so we could sustain ourselves, our families, and our patients (ID 1361)

Fourteen percent of the volunteers cited virtually identical needs for themselves and for the beneficiaries they support. Replies below in response to our question, "What would make you willing and able to perform more voluntary work in the future?," illustrate this:

If I am provided for financially.

If I am given money to give to my clients.

(ID 2024)

Provision of a caregiver allowance.

If I am provided money so I can buy food for my clients.

Educational support for my children.

(ID 1150)

If I am paid monthly, this will help me meet my obligations as a caregiver.

If I can also benefit from the items that we give our clients, after everyone has gotten their share, this will motivate me.

(ID 1339)

However dissatisfied with the irregularity or insufficiency of the supply, as the last quote above suggests, material support for clients is part of the STEPS-OVC project and volunteer caregivers are responsible for their delivery. While we have no reason to doubt the sincerity of caregivers' desire to assist their clients materially, these replies suggest a potential conflict of interest in the uses of material resources. As we discuss later in the report, defining and clarifying a hybrid caregiver-beneficiary category is advisable.

Voluntariness: A Person-Level Indicator of Motivation

The findings presented thus far provide a population-level view of the distribution of responses concerning motivations, barriers, and expectations. Although useful, these findings do not tell us much about individual STEPS-OVC caregivers, whose responses across different questions and question types are complex and sometimes contradictory. Insight into individual volunteers and what motivates and discourages them requires a person-level measure that cross-cuts the study's key concept variables. For this we return to Smith's (1981) idea of being a volunteer as a matter of degree.

As a reminder, Smith (1981) conceptualizes "volunteer" and "volunteering" in terms of degrees. Volunteering, according to Smith, is the "expectation of psychic benefits" resulting from work that has market value which exceeds any compensation received for doing the work. The degree of voluntariness corresponds to the degree to which a person's labor goes uncompensated according to its market value. Freed from the conceptual confines of an either/or categorical state, Smith's matter-of-degree concept provides an alternative way to assess individual motivations for volunteering.

While the market value of volunteer caregiving in Zambia is not known, most of the respondents in our study did perceive their caregiving work as having value worthy of material or monetary compensation. Self-perceived labor value was expressed in terms of desired compensation and indicated across responses to questions on motivations, barriers, and expectations. As a proxy measure of degree of *voluntariness*, we use this self-perceived labor value—*desired compensation*—to empirically differentiate caregivers by volunteer type, or motivational profiles. Assuming that consistency in individual caregiver replies across different questions and question types is meaningful, our typology derives from an analysis of data collected at various points in the interview.

Below we describe the analytic process used to determine the three mutually exclusive caregiver profiles in a *voluntariness* variable and later in the report present findings on statistical examination of the relationship between voluntariness profiles and caregiver productivity.

Fully voluntary: The "pure" volunteer type

> *You see, this is why it is called 'voluntary'. You give yourself and you must be ready to sacrifice . . . I am self-motivated.*
>
> *(ID 1248, 54-year-old male in response to the question 120: Why did you continue volunteering during the period of programmatic lapse)*

The "pure" volunteer type produced from our data analysis best corresponds to conventional wisdom of volunteerism as unpaid helping behavior. Material self-interest is consistently absent in the responses from these caregivers. Respondents with the following response pattern were identified as having a "pure" volunteer profile:

Motivation statements: ***I became a volunteer caregiver because . . .***			
. . . I needed assistance from the project (item 13, Figure 1)	IF	=	"disagree"
. . . it would channel me to a paying job (item 15, Figure 1)	AND	=	"disagree"
Barriers statements: ***I fail to visit my clients . . .***			
. . . because I never get paid for my work (item 5, Table 5)	AND	=	"never or rarely"
Barriers elicitation: ***List three things that prevent you from caregiving***			
Absence of caregiver *(a)* income, *(b)* allowances, *(c)* food support	AND	=	not cited
Expectations: ***How has volunteer caregiving not met your expectations?***			
Absence of caregiver *(a)* income, *(b)* allowances, *(c)* food support	AND	=	not cited
Continuation: ***What would enable/motivate you to continue/do more work?***			
Caregiver *(a)* income, *(b)* allowances, *(c)* food support	AND	=	not cited

Voluntary with reservations: The "paid" volunteer type

> *We need to be employed like other workers so that we are able to support our families*
>
> *(ID 2008, 40-year-old widow with eight children at home to support)*

Although oxymoronic, a conceptual precedent of the "paid volunteer" exists from an early stocktaking of successes and failures of community health programs (Fendall 1984). For our purposes, caregivers assigned to this category expected or desired salaried employment or a monthly cash stipend for their caregiving work. A desire for food support did not indicate the paid volunteer type. Further, individuals assigned to this profile had to express a desire for regular payment in at least two different sections of the interview. Caregivers with the following response pattern were assigned to this category:

Motivation statements: ***I became a volunteer caregiver because . . .***			
. . . it would channel me to a paying job (item 15, Figure 1)	IF	=	"agree"
Barriers elicitation: ***List three things that prevent you from caregiving***			
Absence of caregiver salaried job or some form of *monthly* income	AND	=	cited
Expectations not met: ***How has volunteer caregiving not met your expectations?***			
Receiving a salary, a job, or some form of *monthly* income	OR	=	cited
Continuation: ***What would enable/motivate you to continue/do more work?***			
Receiving a salary, a job, or some form of *monthly* income	OR	=	cited

Partially voluntary: The "incentivized" volunteer type

> *If they [the project] could give me a little something that I can give to my family as well.*
>
> *(ID 2018, 54-year-old widow with no children living at home)*
>
> *If I could be helped with food because sometimes I make my home visits without having eaten anything.*
>
> *(ID 1255, 50-year-old married woman with five children at home)*

An intermediate type of respondents met neither all of the pure volunteer type nor all of the paid volunteer type criteria. Unlike those assigned to the pure profile, "incentivized" volunteers cited a desire for a salary, cash allowances, *or* food support at least once in the interview but did not indicate this desire in at least two sections of the interview. Individuals were assigned to this category according to the following criteria:

Motivation statements: *I became a volunteer caregiver because . . .*			
. . . it would channel me to a paying job (item 15, Figure 1)	*IF*	=	"agree"
. . . I wanted to receive things or allowances (item 15, Figure 1)	*OR*	=	"agree"
Barriers statements: *I fail to visit my clients . . .*			
. . . because I never get paid for my work (item 5, Table 5)	*OR*	=	"sometimes or frequently"
Barriers elicitation: *List three things that prevent you from caregiving*			
Absence of caregiver *(a)* income, *(b)* allowances, and *(c)* food support	*OR*	=	cited
Expectations: *How has volunteer caregiving not met your expectations?*			
Absence of caregiver *(a)* income, *(b)* allowances, and *(c)* food support	*OR*	=	cited
Continuation: *What would enable/motivate you to continue/do more work?*			
Caregiver *(a)* income, *(b)* allowances, and *(c)* food support	*OR*	=	cited

Figure 3 summarizes our assumptions about the voluntariness concept. We assume that different qualities and consistencies of caregivers' expressed desire for compensation indicate different degrees of voluntariness and, in turn, different levels of volunteer motivation.

Figure 3: Voluntariness: Key assumptions about the relationship between expressed desire for compensation, degree of voluntariness, and level of motivation

Expressed desire for compensation	Indicates	Degree of voluntariness	Indicates	Level of motivation
Desire for compensation consistently absent across the interview	→	Fully voluntary	→	High motivation
Desire for monthly payment or any incentive indicated once during the interview	→	Partially voluntary	→	Mid-range motivation
Desire for a salary indicated ≥2 times or salary + other incentive indicated ≥2 times	→	Voluntary with reservation	→	Low motivation

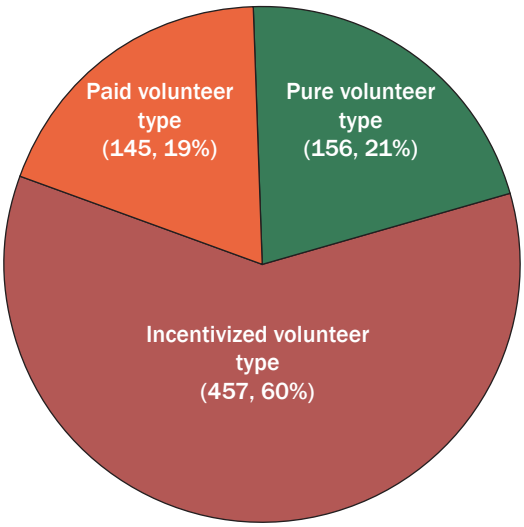
Descriptive findings on voluntariness profiles

Of the evaluable sample of 758 individuals, 156 (21 percent) met the "pure" volunteer criteria (Figure 4). Across different question types and throughout the interview, an expectation, need, or desire for material compensation was consistently absent in responses from these individuals. An almost equal number of volunteers (145, 19 percent) expressed a desire to be formally employed or to receive regular cash payment for being a caregiver. The majority of individuals (457, 60 percent), however, met the criteria for the intermediate, "incentivized" volunteer profile. These caregivers expressed a desire to receive some form of material compensation, sometimes including food, but they did not consistently (two or more times) indicate a need or desire for regular cash payment or other incentives.

As one would expect, caregivers with higher standard of living (SOL) were more likely to be meet the pure volunteer criteria. Of the 123 individuals in the highest SOL category, 30 percent (n=37) met the pure volunteer type criteria compared to 17 percent (58 out of 340) of volunteers in the mid-range SOL category and 21 percent (57 out of 273) of those in the

lowest SOL category. Using Pearsons chi square test, this difference was statistically significant (p = .022). On the other hand, urban volunteers were significantly (p = .002) more likely to meet the paid volunteer criteria (23 percent, 105 out of 454) compared to their rural counterparts (13 percent, 40 out of 304). No difference in volunteer profiles was found between female and male volunteers.

Figure 4: Frequency distribution of three voluntariness profiles (n = 758)



Factors Affecting Volunteer Productivity

As described earlier, in the validation study phase of the research our original outcome measures—*intent to continue and longevity in service*—proved ineffective. We thus replaced these variables with *productivity* measures for each type of STEPS-OVC beneficiary (Table 1). As described above, we calculated client visitation rates (number of beneficiaries visited last month:total number assigned) to indicate productivity, and calculated rates separately for OVC and BCS clients. For both types of beneficiaries, visitation rates spanned from 0 to 100 percent visited (with a few volunteers indicating visiting more individuals than the number of beneficiaries assigned to them). The overall visitation rate for OVC was 80 percent versus 83 percent for BCS clients.

Using OVC and BCS visitation rates as the dependent variables we are able to analyze the effect of various factors on volunteer productivity.

Socio-demographic factors

Using Mann-Whitney *U* test and the Kruskal Wallis *H* test accordingly, we compared mean OVC and BCS visitation rates between *(i)* male and female caregivers, *(ii)* rural and urban residents, and *(iii)* caregivers in the lowest, mid-range, and highest SOL categories. In the analysis we excluded cases where zero beneficiaries were assigned and a few cases with missing SOL data.

Compared to males, female volunteers had significantly higher visitation rates, both for their OVC and BCS clients. No significant differences were found between rural and urban volunteers. For both OVC and BCS clients, we also found no significant difference in visitation rates between the three SOL categories. However, in comparing means between all possible pairs of SOL categories we found that volunteers with the lowest SOL had a significantly ($p = .006$) higher OVC visitation rate than volunteers in the highest SOL; no other significant difference in OVC visitation was found in the other SOL pairs compared. No significant differences were found in BCS visitation rates by SOL.

Specific motivations and barriers

To explore the effect of specific motivations on OVC and BCS visitation rates, using the Mann-Whitney U test we compared means of volunteers "agreeing" and "disagreeing" with each of the differentiated motivations (Figure 1).[5] No significant differences in visitation rates were found between respondents who agreed and those who disagreed with these motivation statements. Again using the Mann-Whitney U test, we compared mean OVC and BCS visitation rates between volunteers who indicated that they "rarely or never" versus "sometimes or frequently" fail to visit clients due to various barriers. Comparisons were performed on each of the nine fixed choice barriers statements. Caregivers who said that they "sometimes or frequently" failed to visit clients due to a lack of transport also had significantly ($p < .001$) lower OVC visitation rates compared to those who responded "rarely or never"; the same trend was found for BCS visitation rates ($p < .001$). No other significant differences were found.

Voluntariness profile

Finally, we compared mean OVC and BCS visitation rates using the empirically-derived voluntariness profile as the independent variable using the Kruskal Wallis *H* test. No significant differences between volunteer types in BCS visitation ($p = .474$) were found. Results on OVC visitation, however, showed moderate significance ($p = .09$). To explore this latter finding further, we conducted post hoc comparisons of OVC visitation on all pairs of volunteer types. No significant difference in OVC visitation between *pure* and *incentivized* types ($p = .317$) was found, while the difference between *incentivized* and *paid* volunteer types trended towards significance ($p = .094$). Between *pure* and *paid* types, however, a significant difference was found ($p = .035$), with pure type volunteers having significantly higher OVC visitation rates compared to paid type volunteers.

[5]As described above, differentiated motivations refer to fixed-choice motivation statements that generated variable response patterns.

DISCUSSION AND CONCLUSION

Two main findings stand out from this study. The first—that communitarian and religious helping values were virtually universal in the study population (Table 9) —is not unexpected. Reflecting as much about social norms and expectations as about the individual volunteers under study (Smith 1981), such findings are common in volunteer research from Africa (Ashraf et al. 2009, De Wet 2011, Kaseke and Dhemba 2007). Nor is the second main finding—that a majority of the volunteers indicated economic and material interests and needs (Table 9)—surprising. However contrasting to conventional definitions of volunteer[ism] as non-obligated or economically driven behavior (Clary et al. 1998, Finkelstien 2009, Omoto and Snyder 1995, Penner 2002), the substantial need-based motivation found in our study is consistent with results from other studies in the region (e.g., Akintola 2008b, Ashraf et al. 2009, Lehmann and Sanders 2007, Wilson 2007).

Supporting and adding to the literature on volunteerism in Africa, our findings thus highlight the spectrum of "volunteering" individuals typical in low income settings. In the STEPS-OVC sample, the volunteers ranged from those with a socio-economic profile that is indistinguishable from project beneficiaries to others who make explicit their desires and expectations for payment in exchange for their work and others still who willingly give their time without compensation. We conclude this report by addressing the implications of this fact.

Definitions and Measures

That the category of "volunteer" is quite broad and resists easy definition became evident early on in our quantitative and qualitative data analysis. Our empirical determination of the degrees of voluntariness from the data and, in turn, differentiation of caregivers by volunteer type ("pure," "paid," and "incentivized") represents an *a posteriori* attempt to variegate the category. While heading in the right conceptual direction, the concept, methods, and measures all need further elaboration and refinement. In particular, although our inductive process and its results were enlightening, future studies should anticipate and theorize a more complex concept of "volunteer" at the design stage. This will ensure that more effective measures and questions will be developed and tested, thus advancing our descriptions and ability to distinguish between voluntary, necessitated, and self-interested dimensions of volunteering and volunteer motivations.

Table 9: Summary of key findings

Demographics:

- Female: 76%
- Urban: 60%
- Average age: 43 years
- Married/co-habiting: 67%
- Average education: 8 years
- Standard of living: overall very low, with 36% in lowest SOL, 45% in mid-range SOL, and 16% in the highest SOL category

Beneficiaries and volunteer productivity:

- Average number OVC clients supported: 9.8 (80% visited last month)
- Average number BCS clients supported: 5.8 (84% visited last month)

Motivations frequently indicated:

- Helping values: almost universal agreement (96% to 99%) on values-oriented motivation statements; helping values are equally dominant in open-ended replies
- Learning opportunity: almost universally (98%) expressed in fixed-choice statements and often indicated in open-ended replies
- Material self-interest and needs: prominent but more varied
  - 70% agreed to ≥1 fixed-choice material motivation statement
  - 23% agreed to all four material motivation statements
  - Women, urban residents, and volunteers with lower SOL agreed to material motivation statements more frequently than men, rural residents, and volunteers with higher SOL

Barriers:

- Most frequently cited in open-ended replies
  - Practical, work-related barriers (lack of supplies, kits, transportation)
  - Inability to meet beneficiary needs and expectations (food, money, school fees)
  - Lack of caregiver compensation (cash incentives, food support, regular stipend/salary)
- Top reasons for "sometimes or frequently" failing to perform caregiving work
  - Lack of transport for clients: 46%
  - Going "empty handed": 41%
  - Lack of rain gear: 39%
  - Lack of kits and supplies: 37%
  - Females, urban residents, and individuals with higher SOL reported significantly more barriers that males, rural residents, and individuals with lower SOL

Expectations:

- *Met*: Strongly aligned with normative helping values, being able to help people in need and one's community was a dominant theme in responses to the open-ended expectations met question
- *Not met*: Strongly aligned with perceived barriers, *(i)* practical, work-related barriers, *(ii)* inability to meet beneficiary needs and expectations, and *(iii)* lack of caregiver compensation were dominant themes in responses to the open-ended expectations not met question

Voluntariness:

- Most voluntary: "Pure" (no expressed compensation desire): 21%
- Least voluntary: "Paid" (repeatedly expressed desire for monthly compensation): 19%
- Mid-range voluntary: "Incentivized" (expressed desire for some form of incentive): 60%
- Volunteers with higher SOL were significantly more likely to meet the "pure" criteria than individuals with lower SOL

Factors effecting productivity (OVC and BCS visitation rates):

- *Demographics*: Females reported significantly higher OVC and BCS visitation compared to males; no significant differences were found for volunteer residence or SOL.
- *Motivations*: No significant differences were found between volunteers who agreed and disagreed to different motivation statements
- *Barriers*: Volunteers who said they "sometimes or frequently" failed to visit clients due to a lack of transportation had significantly lower OVC and BCS visitation rates compared to volunteers who indicated "never or rarely"; no other significant differences were found on other barriers
- *Voluntariness*: "Pure" volunteers had significantly higher OVC visitation rates compared to "paid" volunteers; no other significant differences between volunteer types were found

Better and more nuanced concepts, measures, and tools to differentiate volunteers according to their interests and material needs are even more pertinent for programming purposes. Fendall (1984) raised the issue 30 years ago: "To expect voluntary work from the leisured and comfortably off is one thing; to expect it from the indigent at subsistence level is entirely another. Hence I would advocate seeking volunteers from the elite. . . " (p 302). Admittedly, it may be neither practical nor desirable for contemporary volunteer programs to recruit exclusively from "the elite" classes. But the essence of Fendall's observation resonates well with findings from the present study, which suggest that more careful screening for economic and health-based vulnerability is in order.[6] Better defining and prospectively assessing material needs and socio-economic vulnerability of volunteers would help program implementers

[6]The most dramatic case that we encountered was in Chongwe, where a woman over 70 years old, frail, blind, and clearly in severe poverty presented to be interviewed. While she was identified in the volunteer organization's roster, her overall weak health and level of poverty made us question her ability to effectively care for others.

enroll and place individuals appropriately, including enrolling (or referring) the most vulnerable as beneficiaries.

An explicit hybrid volunteer-beneficiary category may be beneficial. Although the STEPS-OVC project recognizes the need and enrolls volunteers as beneficiaries,[7] such a mixed-status category is not explicit in project documentation (World Vision et al. 2012) nor was it evident in data derived from the caregivers. Hence, defining and clarifying the roles and benefits of a hybrid volunteer-beneficiary status is advisable.

A Matter of Ethics

> *Vol'untary, a. acting from choice; Vol'unteer, n. a voluntary soldier*
>
> From A Complete Etymology of the English Language, by William W. Smith (1873)

> *yozipereka (Nyanja), ukuipelesha (Bemba), kulyaaba (Tonga), to give oneself wholly, with passion and heart*

Our discussion thus far has focused on practical matters of methods, measures, and program application. Beyond such pragmatics, this study's findings underscore more challenging ethical questions for volunteer programs in low-income communities.

At a high-order level, the research highlights ethical issues for national policy and funding utilization. Reliance on uncompensated or minimally compensated voluntary labor has long been justified and defended as the "sustainable"—conflated with "low cost"—solution to shortages in human resources for health (HRH). To date, however, there is little evidence that volunteer programs can be sustained over the long-term. Contrary to the assumption of low cost, earlier (Berman et al. 1987, Skeet 1984) and more recent (Hermann et al. 2009, Lehmann and Sanders 2007) reviews show that successful integration of community health workers into national health programs requires substantial investment in worker selection, supplies, supervision, support, *and* proper remuneration. The STEPS-OVC caregivers' pleas for more training, materials, transport, and support from the project may indicate inadequate investment. To effectively help fill the HRH gap, volunteer programs must be properly funded and supported, short of which, as Berman and colleagues (1987) argued decades ago, they risk "merely extend[ing] inadequate services" (p 457). Alleviating burden on the health system through viable community and home-based services is ethical; extending inadequacy is not. Given the caregivers' complaints about material gaps in program support, understanding how the STEPS-OVC program is faring on this count merits deeper exploration.

The ethical issue at the person-level is more complex. With their emphases on behavior that is non-obligatory, non-compulsory, and not economically determined, contemporary concepts and definitions of volunteer[ism] manifest clearly the history and original meanings of the

[7]Written communication from Mathew Ngunga of The Futures Group seconded to the STEPS-OVC project.

word. Whether a soldier, a helper, a community health agent, or an HIV caregiver, to be a volunteer implies free will, that one is "acting from choice," rather than from a requirement to serve or out of economic necessity. In designing this study we accepted these meanings and took for granted that they applied to the STEPS-OVC caregivers. The caregivers themselves seemed to embrace the assumptions as well. Reacting to translations of the instrument, focus group discussants emphatically rejected the local language terms we initially proposed to refer to "volunteer"—*kugwira nchito mozipereka*, *ukuipela*, and *kucita ncito yakulitola* in Nyanja, Bemba, and Tonga respectively. In all three language groups, caregiver discussants offered alternative terms—*yozipereka*, *ukuipelesha*, and *kulyaaba*—which, for them, stress the importance of the individual's willfulness and commitment to volunteer, to give / bring / offer oneself fully, and voluntarily, to the work.

There is no doubt that the individuals interviewed for this study want to help people in need in their communities. With the STEPS-OVC project providing them a helping platform, the individuals we interviewed "acted from choice" to become HIV caregivers. If we accept, however, the tenets of voluntary action as non-obligated or economically necessitated, the key findings from this research compel us to ask: How much choice do volunteers in this study population actually have? To be sure, the relationship between freedom (to act from choice) and necessity (to react to need), is anything but straightforward (Harris 2005). We can nevertheless assume that exercise of choice and, hence, voluntary action is compromised for individuals who are faced with severe material needs and limited or absent livelihood options. From this perspective, we must examine the ethics of continued reliance on poor volunteer workforces to deliver basic public health services in the name of sustainability.

Different findings from this study could be used to support many different sides in the debate of these issues. Regardless of how they may be used, our hope is that they trigger reflection, advance understanding of the issues, and provoke critical deliberations about the future of volunteer health programs in low-income populations.

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ANNEXES

Annex 1: Overview of STEPS-OVC

1. WHAT IS STEPS-OVC?

STEPS-OVC stands for ***S**ustainability **T**hrough **E**conomic Strengthening, **P**revention and **S**upport for **O**rphans and **V**ulnerable **C**hildren, youth, and other vulnerable populations*. The grant is a three-year (2010–2013), $54 million dollar award under the United States Agency for International Development.

The overall goal of STEPS-OVC is to provide support for HIV prevention and behavior change initiatives in order to reduce HIV transmission, while simultaneously building the capacity of Zambian communities to care for and support OVC, at-risk youth and adults, and the general population more effectively, efficiently, and sustainably.

STEPS-OVC has 3 strategic objectives (SOs):

- SO1: Ensure that individuals and households affected by and vulnerable to HIV and AIDS access holistic, gender-sensitive, high-quality HIV prevention, care, and support.
- SO2: Strengthen the continuum of effective, efficient, and sustainable HIV prevention, care, and support.
- SO3: Improved efficiency, sustainability, and Zambian leadership of HIV- and AIDS-related services including engagement with the private sector.

2. WHO IS STEPS-OVC?

World Vision serves as the lead agency for STEPS-OVC and brings together the expertise and geographic coverage of six other leading international and local non-governmental organizations: Africare, CARE International, Catholic Relief Services (CRS), Expanded Church Response (ECR), Futures Group, and The Salvation Army. STEPS-OVC collaborates with the USAID-funded Zambian Prevention Initiative contract on designing prevention initiatives, capacity-building, and referral mechanisms.

3. WHERE DOES STEPS-OVC WORK?

STEPS-OVC will implement activities in all 72 districts of Zambia. In addition to the main office in Lusaka, three Transition Hubs offices, planned for Chipata, Choma, and Kitwe, will coordinate piloting of new interventions, support transition of activities, and gather information for learning.

At the end of this period, the program will mitigate the HIV epidemic by:

- Strengthening comprehensive support services for over 300,000 orphans and vulnerable children (OVC)
- Improving quality of life for 135,000 adults and children living with HIV (PLHIV)
- Delivering HIV prevention information and behavior change skills to 80,000 HIV- and HIV+ persons
- Providing HIV counseling and testing services to over 50,000 people

- Increasing livelihoods of 26,029 beneficiaries through economic strengthening activities
- Involving an organized network of over 20,000 trained, equipped caregivers and building capacity of over 300 Zambian-owned organizations to respond to communities and households affected by HIV and AIDS

4. WHO CAN WORK WITH STEPS-OVC?

The government of Zambia will be the main partner and will be involved in planning and transition of activities, with emphasis on district-level coordination of implementation. At the national level, STEPS-OVC will collaborate with various offices, including the Ministry of Health, National AIDS Council, Ministry of Sport Youth and Child Development, and Ministry of Community Development and Social Welfare, and will participate on National Technical Working Groups. Partnerships with non-governmental organizations (NGOs), faith-based organizations and churches, community-based organizations (CBOs), associations, and local informal and formal private sector entities will be used for planning, implementing, and monitoring the impact of activities. Their participation will be consolidated through capacity building, sub granting mechanisms and public-private partnerships (PPPs).

Annex 2: Motivations and Expectations Met – Sample Quotes

Main Categories and Example Replies Coded to Each Category MOTIVATIONS AND EXPECTATIONS MET	Global Theme	Open-Ended Question
Religiosity, faith-driven *I'm an evangelist, so I'm used to going out to win people to Christ. It's the same. I love people. (ID 1221)* *Volunteering gave me a chance to practice my Christian faith. (ID 3118)*	**Values**	**Background:** Q120 – Why did you continue volunteering during this time [period of project lapse]? Q121 – Why couldn't you continue volunteering during this time [period of project lapse]? **Motivations:** Q217 – Other than all of these reasons [in fixed-choice statements] for becoming a volunteer, are there any others that made you want to volunteer? Q218 – If you had to pick just one reason why you wanted to become a volunteer, what would you say it is?
Helping values *To help HIV-positive people accept their status and to live positively and I also thought I could eventually get a paying job from this voluntary work. (co-coded paid employment) (ID 1147)* *By volunteering I wanted to make the burden of people working in the clinic less burdensome. (ID 1162)* *I wanted to teach people that formal employment wasn't the only way to earn income. I wanted to teach them to earn income from gardening. (ID 2196)*	Values	
Want to effect social change *I saw that HIV-positive people were being stigmatized and so decided to help stop this evil. (ID 2072)* *Many people believe in traditional medicine . . . so I wanted to show the importance of seeking [professional] medical attention. (ID 1168)*	Values	
Obligation to clients (Questions 120 and121) *I had clients who depended on my help and I wanted to continue to monitor how they were doing. (ID 1143)* *I continued because our work wasn't initiated by RAPIDS; it was a community initiative so we just continue. (ID1323)*	Values	
Learning opportunity, personal growth *I wanted to learn a lot of things, like when people are sick I can help them in the right way. (ID 1138)* *I wanted to learn new things about livelihoods. (ID 2039)* *My younger sister was sick but we didn't know from what until she died. Her son was found to be HIV-positive, so I wanted to learn more. (co-coded with self, family care) (ID 1293)*	Learning	

Main Categories and Example Replies Coded to Each Category MOTIVATIONS AND EXPECTATIONS MET	Global Theme	Open-Ended Question
Need to care for self, family members *I wanted to help my family and friends. (ID 1396)* *I have orphans at home so I wanted to learn how to help raise them. (ID 2060)* *I didn't know how to take care of patients in my family, but now I have learned to do that and also to take care of others in the community. (ID 1361)*	Caregiver need	
Material benefits from the project *I was hoping to receive help. As you can see I am old and it is not easy. (ID 1148)* *To receive food for my household as I don't have a paying job. (ID 1139)*	Caregiver need	
Hope for salary, paid employment *I wanted to volunteer to find a paying job. (ID 2133)* *I volunteered because I thought I would be given things that would in turn help me help others, that is, a salary. (ID 2095)*	Caregiver need	
Reciprocity: received, giving back; giving to receive *I had problems when my husband died. I had no money. Through encouragement from caregivers I am now able to stand on my own and help others. I volunteered to strengthen others. (ID 1010)* *I fell ill and caregivers helped me a lot. I felt I owe it to the community. (ID 3104)* *The church folks really encourage us to help. If I help people here in Mpika I know other people will also help my family who live elsewhere. (co-coded to religiosity) (ID 2034)*	Reciprocity	
To be occupied, do something instead of being idle *I wanted to learn about HIV and how to care for OVC. We women tend to gossip, so I just wanted to keep myself busy. (co-coded with learning) (ID 1116)* *I looked at my life. I had nothing to do after being divorced so I decided to give myself to help others through volunteer work. (ID 1124)*	Other	
Want social connection *When my husband died, the HBC coordinator encouraged me to take up volunteering to mix with other people rather than being lonely. (ID 2029)* *I wanted to work with my friends to help those who need our help. (ID 3037)*	Other	

Main Categories and Example Replies Coded to Each Category MOTIVATIONS AND EXPECTATIONS MET	Global Theme	Open-Ended Question
Caregiver identity *Because I love what I do.* (ID 2071) *You see it is why it is called 'voluntary' – you give yourself and must be ready to sacrifice. . . I am self-motivated.* (ID 1248)	Other	
Hoped things would improve (Question 120) *We continued because we understood that when projects are starting up things are not smooth. We knew that things would stabilize and get better one day.* (ID 1128) *We had hope that one day the Lord would look down upon us and things would get better.* (ID 1012)	Other	
Habit of volunteering (Question 120) *My heart is used to helping others. It is now a habit. I do not feel content if I don't help or visit the sick . . that is why I continued the work.* (ID 1011) *We continued because we were used to working. The people we were caring for had gotten used to being with us too.* (ID 1048)	Other	

Annex 3: Experience in Services and Intent to Continue – Exemplary Quotes

Main Categories and Example Replies Coded to Each Category EXPERIENCES IN SERVICE AND INTENT TO CONTINUE Client-focused*	Global Theme	Open-Ended Question
Lack of/need of food support *Lack of food to take to clients. It's shameful to go empty handed so I become discouraged.* (ID 1024) *Taking food and clothes to our clients because they yell at us if we go with nothing. Once I took a blouse and she yelled at me, 'I can't eat a blouse', and threw it back.* (co-coded to general support and negative perceptions) (ID 1053) *Lack of money to buy food for my clients because I am also poor, so it becomes difficult for me.* (ID 1190)	Client need	**Experiences in Service:** Q301 – List three barriers that prevent you from carrying out your volunteer work. **Expectations and Intent to Continue:** Q401 – Thinking about the things that made you become a volunteer, how has volunteering met your expectations? Q402 – Again, thinking about the things that made you become a volunteer, how has volunteering *not* met your expectations? Q403 – List three things that would make you will and able to perform more volunteer work / continue volunteering in the future.
Lack of/need of support with money *Most of our clients don't have the money to afford food or transport in times when they have to go to the clinic.* (co-coded to food) (ID 1188) *Provision of income-generating activities for our clients and also for us caregivers would enable us to work better and help a lot of people.* (co-coded to caregiver needs) (ID 1286) *I expected assistance with money to help our families and clients.* (ID 1315)	Client need	
Lack of/need of school support *Although I have enrolled some OVC in community schools, I'm unable to supply other things, like shoes and books.* (ID 1304) *The educational support we used to give has been cut because of the free education policy. But we have OVC in secondary school who still have to pay fees and there are other needs: shoes, uniforms. I have not been able to help as many children as I would have wanted to.* (ID 1217)	Client need	
Lack of general support *Sponsorship for buying things for clients like food, school requirements, blankets, etc. would encourage us to visit and work better.* (co-coded to food and school support) (ID 1020) *I would like it if they would give me money so that I can help out some of my clients in terms of buying them food and other things they need.* (co-coded to food support) (ID 1334)	Client need	

EXPERIENCES IN SERVICE AND FUTURE DESIRES Caregiver-focused**	Global Theme	Open-Ended Question
Household situation and needs *When I don't have food or money at my own home I fail to do my [volunteer] work.* (ID 1021) *Provision of incentives for caregivers so we can leave something for the people at home as we go to visit our clients.* (ID 1045) *Lack of food at home makes it difficult to leave my family hungry, so sometimes I draw back [on volunteering].* (ID 1077) *Incentives for caregivers so that our children don't starve to death while we are visiting clients!* (co-coded to allowances, incentives) (ID 1117)	Caregiver need	
Lack of/need of allowances, incentives *A reasonable allowance for caregivers, anything to help us with our families would allow us to concentrate on our work rather than doing it part-time.* (co-coded to household needs) (ID 1094) *A small allowance for caregivers would motivate us to spend more time doing this work.* (ID 1115) *Provision of incentives in any form.* (ID 1113)	Caregiver need	
Lack of/need of formal employment, salary *Incentives in the form of a salary* (co-coded to allowances, incentives (ID 1116) *If [the organization] could find us employment, such as a washing or maid job.* (ID 1129) *I was hoping that I could be registered so that I could be employed at our clinic, but this isn't the case.* (ID 1092)	Caregiver need	
Personal issues *Mostly I get sick, so it hinders me to do my [volunteer] work as I should.* (ID 1035) *I'm caring for my elderly father-in-law, so this interferes with my volunteer caregiving.* (ID 2060) *My husband sometimes stops me from visiting my clients.* (ID 2002)	Caregiver need	

EXPERIENCES IN SERVICE AND FUTURE DESIRES Work-focused	Global Theme	Open-Ended Question
Transport **-specific mention of caregiver to client** *If you have five households it becomes a challenge to reach all of them as we don't have any form of transport.* (ID 1027)	Work need	
-specific mention of client to clinic *Transport for the sick, especially those who are on ARVs. This will help with treatment adherence.* (ID 1011) *Provision of a car for me to use to take my clients to the hospital.* (ID 1302) *Transport to take our clients to the clinic is a very big challenge; as a caregiver, you have to beg or borrow money to take the sick to the clinic.* (ID 1242)		
-specific mention of a bicycle *Some HIV-positive people prefer to send us to the clinics to get medicine for them. So, helping us with bicycles would help our work. The ones we were given are now broken.* (ID 1242) *I'm an old man and I don't have the strength to walk long distances. I thought I would at least be given a bicycle, but up to now that has not happened.* (ID 1177)		
Lack of/need of caregiver kits and supplies *When you get there, you find the patient is bedridden and there are no supplies – like gloves – to use.* (ID 1016) *We need a kit to use with out clients, with gloves, bandages, and other things. Their relatives don't bath them.* (ID 1066)	Work need	
Lack of/need of weather gear *The rainy season is hard. We need raincoats and boots so we can still reach our clients.* (ID 1031)	Work need	
Caregiver training, training certificates *We learn a lot in the trainings so we would like them as often as possible.* (ID 1041) *I would like a certificate if I complete a training.* (ID 1209)	Work need	

EXPERIENCES IN SERVICE AND FUTURE DESIRES Work-focused	Global Theme	Open-Ended Question
Negative perceptions by clients, community *Donors visiting the communities and explaining our work to people should clarify that they don't give us money. People think we keep things meant for them for our own personal use.* (ID 1027) *Most of my clients think I keep their things given to them by the project.* (ID 1264) *Our clients say bad things about us because we don't help them with food. We just counsel them.* (ID 1275) *Some people tell us to stop visiting them because we don't give them anything.* (ID 1265)	Work need	
Lack of/need of formal caregiver identification *Sometimes I fail to help people because they think I'm not a caregiver. We don't have IDs.* (ID 1023) *Provision of uniforms and other identity for caregivers and also register us with health centers in our areas.* (ID 1039)	Work need	
General resources *We need books to write progress of our clients and their needs.* (ID 2065) *Sometimes clients get sick at night. Without flashlights it is difficult for us to leave home at night and walk through the dark.* (ID 2079) *... phones (to communicate with clients), stationary, bags ...* (ID various)	Work need	
Organizational issues *When I started with STEPS they gave us food for our families and for the orphans. Now that it's a different organization they don't give us these things anymore so my expectations are slowly coming down.* (ID 1081) *I would like to receive money directly from the donor and not go through an in-between organization.* (ID 1228)	Other	
Other work-related challenges, barriers, needs *There should be a way to help us adopt OVC so we can help them closely.* (ID 2051) *... communication with clients, regular meetings with the organization, hostile OVC guardians, etc...* (ID various)	Other	
Community needs *Community schools, clinics, orphanages, etc.* (ID various)	Other	