

# Volunteer responsibilities, motivations and challenges in implementation of the community-based health planning and services (CHPS) initiative in Ghana: qualitative evidence from two systems learning districts of the CHPS+ project

**MMargaret Kweku**

University of Health and Allied Sciences, Ho

**Emmanuel Manu** (✉ [emanu@uhas.edu.gh](mailto:emanu@uhas.edu.gh))

University of Health and Allied Sciences, Ho, Ghana <https://orcid.org/0000-0002-2724-3649>

**Hubert Amu**

University of Health and Allied Sciences, Ho

**Fortress Yayra Aku**

University of Health and Allied Sciences, Ho

**Martin Adjuik**

University of Health and Allied Sciences, Ho

**Elvis Enowbeyang Tarkang**

University of Health and Allied Sciences, Ho

**Joyce Komesuor**

University of Health and Allied Sciences, Ho

**Geoffery A Asalu**

University of Health and Allied Sciences, Ho

**Norbert N Amuna**

University of Health and Allied Sciences, Ho

**Laud A Boateng**

Volta Regional Health Directorate, Ghana Health Service, Ho

**Justine S Alomyo**

Volta Regional Health Directorate, Ghana Health Service, Ho

**Roland Glover**

Volta Regional Health Directorate, Ghana Health Service, Ho

**Bawah Ayagah**

Regional Institute of Population Studies, University of Ghana, Legon

**Timothy Letsa**

Volta Regional Health Directorate, Ghana Health Service, Ho

**Koku Awoonor-Williams**

Policy Planning, Evaluation and Monitoring Division, Ghana Health Service, Accra

**James F Phillips**

Mailman School of Public Health, Columbia University, USA

**John Owusu Gyapong**

Office of the Vice Chancellor, University of Health and Allied Sciences, Ho

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## Research article

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# Abstract

**Background** Community volunteerism is essential in the implementation of Community-based Health Planning and Services (CHPS) concept in Ghana. We explored the motivations, responsibilities and challenges of Community Health Management Committees (CHMC) in two CHPS+ project districts in Ghana.

**Methods** We used a qualitative approach to collect data through 4 focus group discussions among a purposive sample of Community Health Volunteers in December 2018 and analysed them thematically.

**Results** The value, self-enrichment and protective functions were found to be the key motivations for serving on CHMCs. The committees provide support in running the CHPS programme through resource mobilisation, monitoring of logistics, assisting the Community Health Officers (CHO) in the planning of CHPS activities, and resolution of conflicts between the CHOs and community members. Financial challenges, inadequate logistics, lack of support from community members, lack of motivation, poor telecommunication network and lack of frequent skill development training programmes for CHMC members who serve as traditional birth attendants (TBAs) were major challenges in CHMC volunteerism.

**Conclusion** Community health volunteerism needs to be prioritised by the Ghana Health Service and other health sector stakeholders to make it attractive for members to give off their best in the discharge of their responsibilities.

## Introduction

The 1978 international conference on primary healthcare held in Almaty, Kazakhstan, expressed the need for urgent action by governments, health and development workers as well as the international community to protect and promote health for all across the globe [1]. It was also affirmed at the conference that the existing gross inequality in the health status of people particularly between developed and developing countries as well as within countries was politically, socially, and economically unacceptable; hence, governments had to take the needed action to bridge the health inequality gap [1]. To achieve this, there is the need to make healthcare accessible to every citizen. The Ghana Health Service (GHS), therefore, implemented the Community-based Health Planning and Services (CHPS) Initiative as a nationwide health policy in 2000 after its successful experimentation at Navrongo in the Northern Region of Ghana [2, 3].

The CHPS concept aims at improving basic health care access for rural communities in Ghana. In CHPS implementation, a number of communities are put together based on geographical proximity and called CHPS zones. A CHPS Compound, manned by one to three Community Health Officers (CHOs) serves as the health post which serves the zone in terms of healthcare delivery [4]. CHPS also depends on Community Health Volunteers (CHVs), who support the CHOs with programme implementation [5]. The concept of community health volunteerism in the implementation of CHPS came from the realisation that communities can be active in the delivery of healthcare through the mobilisation of local resources to support health institutions in providing care as well as the design and mode of delivery of healthcare services [6]. It also emanates from the recognition that community health volunteers are key partners in health, particularly in villages across low and middle income countries [7].

There are two sets of community volunteers in CHPS implementation. These are Community Health Volunteers (CHV) and Community Health Management Committees (CHMCs) [6]. CHMCs are key health partners who play vital roles in the successful implementation of CHPS [5]. CHMCs for instance help in community participation and increase access to and utilisation of primary healthcare services through community mobilisation and education [7, 8]. Despite their immense contribution to healthcare delivery, community health volunteers face a myriad of challenges. They often face logistic and financial challenges and are often not given the needed recognition and support from their community members [6].

## **The CHPS+ Project**

The National Program for Strengthening the Implementation of the Community-based Health Planning and Services (CHPS) Initiative in Ghana (CHPS+) is a scale up of the Ghana Essential Health Interventions Programme (GEHIP) which was piloted in three administrative districts in the Upper East Region of Ghana [9] from 2011 to 2016. The objective of GEHIP was to provide an integrated response to challenges that would strengthen district capabilities towards facilitation of CHPS scale-up. The scale-up, CHPS+ was initiated in 2017 and was expanded to include the Volta and Northern Regions [9].

CHPS+ is a collaboration project by the Ghana Health Service (GHS), the Mailman School of Public Health of the Columbia University, USA, the University of Ghana's Regional Institute of Population Studies, Ghana, the University of Health and Allied Sciences' (UHAS) School of Public Health (SPH), and the University for Development Studies (UDS) with funding from the Doris Duke Charitable Foundation, USA. As part of the project implementation, UHAS serves as training partner tasked with the primary purpose of building the capacity of the frontline health workers especially the CHOs through the development of short and long term training modules in the Volta Region of Ghana. The region was selected due to its high under-five mortality (61/1000) and fertility (4.8) rates in Ghana [10]. Two administrative districts (Nkwanta South Municipality and Central Tongu District) were selected by the Volta Regional Health Directorate of the GHS and labeled 'Systems Learning Districts' (SLDs). This, therefore, influenced the choice of the two districts for the present study. UHAS was chosen as a project partner based on its focus on problem-based learning (PBL) approach (termed 'vocational training programme') adopted in training students upon its establishment in 2011 [11].

## **Conceptual issues (The functional approach to volunteerism)**

The concept of volunteerism and motivation has been explained under varied theories, including the functional approach to volunteerism [12]. The functional approach to volunteerism is based on the premise that volunteerism serves different function for different people [13]. Thus, when volunteers' essential motives for service are congruent with features of the environment that enable them to realise these motives, then volunteers will become more satisfied and are more likely to continue volunteering in future [12]. People often indulge in volunteerism to fulfill at least one of six functions; the value, the understanding, the career, the social, the protective and the esteem or enhancement. The value function deals with concerns for the welfare of others or society and contribution to society [13, 12]. Thus, the sole purpose for volunteerism is to help others. Some people also volunteer just because it will give them the opportunity to learn, practice and

apply skills and abilities, known as the understanding function. Thirdly, some people volunteer as they see it as an avenue to boost their career prospects, thus the career function; where volunteerism is seen as an opportunity to acquire and develop new skills or establish contacts to boost one's chances of getting employed in future [14]. Moreover, others accept volunteer jobs due to strong normative or social pressure, known as the social function. This class of people agrees to do so because they want to get along with people in their reference group [12]. With reference to the protective function, people offer to volunteer to reduce the feeling of guilt for being more fortunate than others or to escape from one's own problems. Thus one feels guilty for not giving back to society. Lastly, some people offer to volunteer with the aim of enhancing their self-esteem, self-confidence or to improve themselves, known as the enhancement function [12].

Considering the significance of the CHMC in the implementation of CHPS, there was the need to understand the motivations, responsibilities as well as the challenges that CHMCs in the 2 SLDs encounter and how these impact on the conduct of their responsibilities based on the tenets of the functional approach to volunteerism. Such challenges could affect their motivation that could influence volunteerism. Addressing the challenges therefore could effectively motivate CHMC members to enable them to play their role in the implementation of the CHPS concept in Ghana.

## **Figure 1: A functional approach to community health management volunteerism adapted from Clary et al. (1998)**

### **Methods**

#### **Study setting**

The study was conducted in the two CHPS+ Project Districts of the Volta Region of Ghana; Central Tongu District and Nkwanta South Municipality. The Volta Region is one of Ghana's ten administrative regions with Ho as its capital. The region has 25 administrative districts/municipalities and a population of 2,118,252 with a growth rate of 2.5% as projected from the 2010 Population and Housing Census [15]. In terms of health facilities, the region has 514 health facilities; 271 Community and Health Planning Services (CHPS), 40 Clinics, hospitals, 156 health centers, 16 maternity homes, 2 polyclinics and 1 regional hospital [16].

The Central Tongu District has a total population of 71,331, a growth rate of 2.4% and the population covered by the CHPS—38,874 (54.5%). There is one district hospital, 4 health centers, 15 functional CHPS zones and 1 private maternity home. Mafi Zongo was selected as the Model zone for Central Tongu District. The rest, though were trained, are non-model zones according to Central Tongu District Health Directorate [17]. The Nkwanta South Municipality has a population of 140,121. There are 216 communities, 2 hospitals, 2 health centers and 21 functional CHPS zones. Salifu was selected as the Model zone for Nkwanta Municipality. The rest though were trained, they non-model zones according to Nkwanta South Municipal Health Directorate [18].

# Figure 2: Map of Ghana, depicting the Nkwanta South and Central Tongu Districts of the Volta Region

## Study design and participants

A phenomenological qualitative approach, based on constructivists' assumptions, was used for this study. Phenomenological qualitative approach aided to describe the lived experiences of participants in relation to their motives for accepting to be CHMC members, the roles they play in the implementation of CHPS within their various zones as well as the challenges they face in carrying out their duties [19]. Our core research team consisted of nine faculty members from SPH, five GHS directors of health and three research consultants.

The study participants comprised adults aged 18 years and above who were members of their CHMCs. Those who had lived in their respective communities for up to six months prior the study were included. However, CHMC members who had traveled at the time of data collection or were seriously ill were excluded from the study. Two sampling strategies were used to recruit the participants for the study. First, purposive sampling was used to select the two SLDs, since they were the designated districts for the CHPS+ project by the Volta Regional Health Directorate. Secondly, simple random sampling techniques by balloting was used for the selection of the two CHPS zones per SLD. Purposive sampling method again was used for the selection of participants where all members of the CHMC from each of the two selected zones (from each SLD), Nkwanta South and Central Tongu, were selected. In all, 37 participants were sampled for the study.

## Interview guide

Focus Group Discussions (FGDs) were conducted for CHMC members using a semi-structured FGD guide constructed in English and translated verbatim into Ewe and Akan languages for the conduct of the interviews. The guide was developed by three research team members (MK, HA and EM). The guide was used to collect information on the socio-demographic characteristics of participants, their motivations for being CHMC members, the responsibilities of the CHMCs as well as their challenges.

## FGD interviews

The FGD interviews were facilitated by six research assistants (all staff of UHAS) and four supervisors who are faculty members constituting the core research team (MK, HA, EM and JK) from the School of Public Health (SPH-UHAS). The research assistants were trained for three days on the data collection instruments and a conceptualization of the CHPS+ project. This was done to ensure that all data collectors understood how to conduct the interviews in order to elicit appropriate responses from study participants. Pre-testing of the instrument was done at one of the CHPS zones in the Hohoe Municipality which is not an SLD. This was done to enable the research team know how the participants understood and responded to the questions. After the pre-testing the research team modified the questions and printed the final guide which was used for

the study. Data collection begun with an explanation of the purpose of the study to all participants. Participants were then organised into two focus groups per SLD, making a total of four. The first zone visited was coded Z1, the second Z2, the third Z3 and the fourth zone Z4. Responses were not linked to individuals to ensure anonymity and data collected was handled by only the research team to ensure confidentiality. In each focus group, alphabets were assigned to the participants and were used to identify them in relation to their bio-demographic characteristics and contributions during the discussions. Each discussion lasted for about one and half hours and was voice recorded with the permission of the participants. Handwritten notes were also taken during the interviews. After each interview, the facilitator and the PI made notes and discussed the preliminary observations. This preliminary analysis helped to improve the wording of the questions in subsequent interviews as well as in noting of areas that needed to be emphasized. Data collection was conducted in December, 2018.

## **Data analysis and data saturation**

Audio recordings from each CHMC interview were transcribed verbatim from the Akan and Ewe languages to English by a certified language translator. The transcripts were then manually analysed using the thematic content analysis approach. Content analysis describes an analytic process that applies intuitive and interpretive approaches to systematically summarise textual data [20]. We thoroughly read through the various transcripts to gain a general sense of the information. Each transcript was put into segments and codes, which were descriptive in nature, in terms of the subject matter in the transcript. Coding was done by writing the applicable codes in the margins of transcripts. The codes from the various transcripts were then compared and arranged under major topics. Sub-themes were then formed from the various topics by using the most expressive words for each set of codes. We then grouped related topics under various themes, based on the research objectives as well as those that emerged from the data analysis process. Data saturation was deemed to have been achieved when there were non-immersion of new codes or themes from the transcripts.

## **Trustworthiness of the study findings**

Credibility of the study findings was ensured through development of rapport between the research team and community and opinion leaders prior the study which opened participants up for interviewing without feeling hesitant to divulge sensitive but vital information. Dependability of the study findings was guaranteed through the input of professional qualitative researchers on the research team and from outside who studied and evaluated the study for perfection. Conformability was also ensured by seeing to it that participants went through the transcripts after to confirm that what we reported was what they actually said.

## **Results**

The results of the study were grouped under two headings, socio-demographic characteristics of participants and thematic results from the content analysis process. Three broad thematic results emerged from the study; motivations for becoming a CHMC, the roles and responsibilities of the CHMC, as well as the

challenges facing the CHMC in the conduct of their duties. Quotes from the participants were used in presenting the data and also informed the structure of the discussion section. A frequency table was, however, used to present the socio-demographic characteristics of the participants.

## **Socio-demographic characteristics of participants**

Table 1.0 presents the demographic characteristics by zone. Both Nkwanta and Central Tongu had 10 each (50.0%) in Z1 and Z3 zones, however, more, 9 (52.1%) participants were in Z2 in Nkwanta. Majority 9 (45.0%) of the participants in Z2 were aged 40–49 years and same in Z4 7 (41.2%). Overall, there were more 30 (81.1%) males who participated compared to females. Similarly, the main occupation of the participants was farming, 27 (73%). In terms of NHIS, there were more non-subscribers, 19 (51.4%) compared to subscribers.

### **Table 1: Socio-demographic characteristics of participants**

Variable	Frequency [Z1&Z3, N=20] n (%)	Frequency [Z2 &Z4, N=17] n (%)	Total [N=37] n (%)
<b>System Learning District</b>			
Nkwanta South	10 (50.0)	9 (52.9)	19 (51.4)
Central Tongu	10 (50.0)	8 (47.1)	18 (48.6)
<b>Age group (years)</b>			
Mean age (SD)			
<40	2 (10.0)	3 (17.6)	5 (13.5)
40-49	9 (45.0)	7 (41.2)	16 (43.2)
50-59	2 (10.0)	2 (11.8)	4 (10.8)
60+	7 (35.0)	5 (29.4)	12 (32.4)
<b>Sex</b>			
Male	19 (95.0)	11 (64.7)	30 (81.1)
Female	1 (5.0)	6 (35.3)	7 (18.9)
<b>Qualification</b>			
None	4 (20.0)	2 (11.8)	6 (16.2)
Primary	0 (0.0)	3 (17.6)	3 (8.1)
JHS	3 (15.0)	6 (35.3)	9 (24.3)
SHS/Vocational	11 (55.0)	4 (23.5)	15 (40.5)
Tertiary	2 (10.0)	2 (11.8)	4 (10.8)
<b>Religion</b>			
Christian	19 (95.0)	15 (88.2)	34 (91.9)
Muslim	0 (0.0)	1 (5.9)	1 (2.7)
Traditional	1 (5.0)	1 (5.9)	2 (5.4)
<b>Ethnicity</b>			
Ewe	10 (50.0)	10 (58.8)	20 (54.1)
Guan	10 (50.0)	7 (41.2)	17 (45.9)
<b>Marital status</b>			
Married or living together	20 (100)	16 (94.1)	36 (97.3)
Widowed	0 (0.0)	1 (5.9)	1 (2.7)
<b>Occupation</b>			
Public Servant	1 (5.0)	1 (5.9)	2 (5.4)
Farmer	13 (65.0)	14 (82.3)	27 (73.0)
Teacher	3 (15.0)	1 (5.9)	4 (10.8)
Trader	2 (10.0)	0 (0.0)	2 (5.4)
Tradesman	1 (5.0)	1 (5.9)	2 (5.4)
<b>National Health Insurance</b>			
<b>Subscription</b>			
Subscriber	9 (45.0)	9 (52.9)	18 (48.6)
Non-subscriber	11 (55.0)	8 (47.1)	19 (51.4)
<b>Average monthly income (GH₵)</b>			
Mean (SD)			
<100	2 (10.0)	5 (29.4)	7 (18.9)
100-400	12 (60.0)	7 (41.2)	19 (51.4)
500+	6 (30.0)	5 (29.4)	11 (29.7)

# Motivations for becoming a CHMC member

For the purpose of this study, only three constructs of the functional approach to volunteerism (value, self-improvement and protective), out of the six, were discussed. Discussants provided various reasons as to why they accepted to work as CHMC members in their various CHPS zones. Notable reasons cited were the desire to provide leadership in one's community to improve its health outcomes through effective needs assessment conduction (the value function), financial expectations for being a volunteer (self-improvement function) as well as the guilt of allowing committed CHOs to work in isolation in their communities (protective function).

## The value function

With reference to the value function, some discussants explained that they wanted their communities to progress; hence they saw volunteerism as an opportunity to improve the health needs of their communities. This, they said could be achieved through provision of good leadership to ensure an effective functional CHPS compound, as explained by a CHMC member from Z3; *"Every human institution needs people to lead them"*. The following quotes express the views of the participants:

*"We accepted the offer because we wanted an improvement in our health needs and service delivery. Nobody from outside will come and make it [CHPS compound] work better for us except ourselves so it is our duty to serve on the committee to help improve our own health" (CHMC member, Z1).*

*"If the majority of the members repose their trust in you, you do not need to reject it but accept it with happiness.....lead the community and help the clinic to deliver good services to the people" (CHMC member, Z3).*

## The self-improvement function

With reference to the self-improvement function, some participants revealed that although they voluntarily accepted to serve on their respective committees, they expecting some financial benefits in the end, as explained by the following discussants:

*"We thought from the beginning that, as time goes on there will be some financial reward but now we understand that is not the case and the community is looking up to us so we can't disappoint them" (CHMC member, Z3).*

*"Everybody want to progress in life, so I for instance thought that while we serve on the committee, there come be a time when the government would say ok, you have something [money] small for your efforts, even if to buy a soap. By the way, we are yet to receive anything like that" (CHMC member, Z2).*

## The protective function

The protective function was also found to be a motivation for CHMC volunteerism. In this regard, allowing a hard working CHO who was not even an indigene in the community to work in isolation made some CHMC members feel guilty and pledged to assist the CHO in any way they could, leading to volunteerism. Hence, they served on their respective CHMCs, as a way of dealing with the guilty conscience they had. They explained:

*"I accepted the work because of the hard working nature of the CHO. It will not be fair to refuse to assist him in his work looking at the way he cares about us even though he is not from here. I wouldn't have been able to sleep well if I had refused to serve" (CHMC member, Z1).*

## **Responsibilities of the CHMC**

Being a CHMC member comes with various responsibilities. Some of the responsibilities of the CHMC as identified by discussants were provision of support for the CHPS facility and the CHO in terms of needs assessment, conducting, overseeing the smooth running of the CHPS facility and mediating between the CHO and community members in disseminating information. They were also to be involved in planning of activities of the CHO for the CHPS zone. Thirdly, as CHMC they are supposed to be aware of the various activities undertaken by the CHO in their respective communities. Finally they are to assist in resolving conflicts between the CHO and community members.

## **Provision of support services to the CHPS facility and the CHO**

The CHMC provided services such as mobilisation of community resources in building and maintaining CHPS compounds, home visiting to conduct health needs assessment in the community, monitoring the wellbeing of the CHO and logistics availability and mobilising community members for health educational talks.

On mobilising resources for development and maintenance of respective CHPS compounds, the following quotes provide insight into the activities undertaken by the various CHMCs in that regard:

*"We mobilise our communities to help in putting up the building for the nurses" (CHMC member, Z1).*

*"We mobilise the women to be clearing the place [of weeds] once in a while and all communities in the catchment area also come to clean up the place" (CHMC member, Z3).*

With reference to helping in identification of community health needs assessment, the CHMC regularly paid home visits to identify the pressing health needs of the people and provide the necessary guidance and support and feedback to the CHO, as mentioned by a CHMC member from model zone 1:

*"Some of our responsibilities are that we visit communities to help fish out or identify sick persons. Also, when community members are sick, they come to us and we help them to the hospital" "when we see*

*pregnant women, we ask whether they have gone for check-ups. If they answer no, we show them the ways and the steps to the clinic. This is because some of the pregnant women are shy to and reluctant to go to the hospital so we check up on them and send them to the CHO” (CHMC member, Z2).*

*“The nurse cannot do everything by herself in all the communities. So [CHMC volunteers] we report cases and problems we find in our communities to the nurse during our home visits” (CHMC member, Z4).*

On their oversight responsibility, they plaid this by checking on the well-being and safety of the CHO and also monitored logistics availability at the facility in order to take the appropriate action, should the need be. A discussant narrated:

*“Sometimes, we group ourselves and visit the CHPS compound to check up on the nurse. We find out about their wellbeing. We also find out if they have drugs then we send a report to the district director” (CHMC member, Z1).*

*“These nurses are not from here, sacrificing to stay in this village to help us so as CHMC, it is our responsibility to ensure that they are safe” (CHMC member, Z4).*

The CHMC further assisted the CHOs in community mobilisation for health education activities by pre-informing community members of a health education or promotion programme to enable the CHO undertake such an activity with ease. A discussant recounted:

*“We also help the nurses by disseminating information to community members. Also, if the nurse wants to organise programmes, we first inform the community before the nurse goes ahead with the programme so that every community member can help or support the nurse” (CHMC member, Z2).*

*“We also inform the community not to go to their farms anytime the nurse wants to come and talk to us about any health issue. Sometimes we even arrange with the schools to wait for the nurses to go and talk to them” (CHMC member, Z3).*

## ***Assisting CHO with planning of activities***

Another salient responsibility of the CHMC was in assisting CHOs in the planning of activities for their various CHPS zones. All CHMCs noted that one of their core mandates was to be involved in the planning of activities for their respective zones. Hence, the CHOs were expected to be involving the committee in the planning their activities. This, they said was often the case as they often planned activities such as how to address challenges hampering the smooth running of CHPS compounds, drawing of action plans for the zones, strategies on treating of neglected tropical diseases, and on how to keep the CHPS compound clean. The following quotes sums discussants views:

*We also help with planning of activities for our zone, even our action plan, the CHO, the committee and the chief and members of the community sat together to draw our action plan (CHMC member, Z3).*

...For instance, the recent injection against measles and rubella, he informed us. What we do is that we have a communication centre, so if he wants to do any announcements, he comes to us then we go on to inform the chief before making the announcement to community members. Also in the distribution of the oncho [onchocerciasis] medication, we decided on the date and time together (CHMC member, model zone 2). CHMC member, Z1)

## Awareness on the services rendered by the CHO

Another key responsibility of the CHMC as mentioned by discussants was to be aware of the various services rendered by their respective CHOs in their communities. In this regard, discussants mentioned that they were fully aware of the activities undertaken by their respective CHOs as they were often involved in the planning of such activities. The following quotes explain their views:

*"Yes, we are aware of what they do in our communities. The nurse sometimes visits from house to house to take care of the elderly who are sick and could not come to the hospital and they check blood pressures for those that are not too sickly. The nurse also attends to children's health during home visits" (CHMC member, Z1).*

*"Because some of us are not educated, when the nurse tells us the prescription, we forget, so they are supposed to come to our homes to ensure we take the right dosage on time" (CHMC member, Z4).*

## Conflict resolution

The CHMC was also responsible for resolving conflict between health workers and community members. They are always on hand to quell tensions between a CHO and an aggrieved community member to ensure peaceful coexistence. They explained:

*"One of our responsibilities is that whenever there is any confusion between a nurse and a community member, we [the committee] sit down with them [the aggrieved parties] to resolve the problem" (CHMC member, Z4).*

*"Sometimes there can be a disagreement between the nurse and a community member, especially during weighing sessions, we ensure that there is peace before everybody goes home" (CHMC member, Z2).*

## Challenges faced by CHMCs

The data also revealed that CHMCs face some challenges that affect their operations. The most common challenges faced by the CHMCs included financial challenges, logistical challenges such as wellington boots and bicycles, lack of cooperation from community members, lack of motivation for members, unavailability of telephone communication network and lack of refresher training courses for traditional birth attendants (TBAs).

## Financial challenges

Discussants explained that they were peasant farmers who do not get much income from their farming activities, hence the decision by government for communities to solely finance CHPS compounds pose a challenge to the CHMC and the communities at large. They said:

*"We were here the last time when the district [health directorate] came and said that if we don't provide security for the nurse, they are taking her away. We know it is our duty to provide security put at least they [government] should help us in paying him since it is not easy to mobilise money every month to pay him. In such a case, it is us the committee members that suffer because people think we are receiving some form of remuneration from the government"* (CHMC member, Z1).

*"Our security officer just vacated his post because we weren't able to pay him for over five months so he got fed up with the job. We had to contribute some money to persuade him to come back to work since the nurse was feeling unsafe being alone at the facility. This affects us a lot since we are also not paid for what we do"* (CHMC member, Z3).

## Logistical challenges

The lack of logistics such as 'Wellington boots' bicycles, motor cycles for ease of movement and lack of mowing machines, hampered the activities of CHMC members. The following statement summarises their views:

*"Just as said earlier, bicycle and motorbike. If at least, each of the villages gets a bicycle and a motorbike each, it will enhance our work. A mowing machine to be weeding the CHPS compound will also be a very good motivation"* (CHMC member, Z1).

*"We live in a muddy and swampy area. The formal director supplied us with wellington boots to help protect us. For example, when you are walking late in the night and you even step on a snake you won't get bitten. That was the reason behind the former director giving us the Wellington boot and rain coat and some touch light to volunteers but for some time now, those things have not been coming again"*(CHMC member, Z4).

## Lack of cooperation from community

Another pressing challenge mentioned by the discussants was the lack of cooperation from community. They explained that community members were not willing to even clean CHPS compound for free, as narrated by model zone 1 member; *"We need a cleaner to be cleaning the floor but no one is willing to do so"*. Other forms of non-cooperation stated by discussants are include:

*"Some of the challenges we have faced are that some community members are reluctant when we call for some communal work to be done. But finally, we try hard to involve everybody"* (CHMC member, Z4).

## Lack of recognition

Lack of recognition for the CHMS was also mentioned as serious challenge facing the smooth running of CHMC activities. They received no reward or recognition for their voluntary work which affected the commitment levels. The following quotes represent their views:

*"We started working as a committee since 2012, till date the health directorate has not rewarded us in any form. If they could even give us GH₵ 1 every month as a reward, we can use it to buy soap to wash our clothes. I won't lie to you; this has made some of us relax a bit" (CHMC member, Z2).*

*"No one sees the importance or the sacrifice we are making in this community. Some people even insult us on top of our sacrifice, without offering us anything. It is very sad" (CHMC member, Z3).*

## Poor telecommunication network

The non-availability of telephone communication network in some communities served as a serious challenge in the performance of CHMC roles. Participants had these to say:

*"There is no telephone network for making calls to at least to report emergency cases, hence, the bicycle or motor cycle will be of important use to us" (CHMC member, Z1).*

*"Our network here is not always good so when you want to report a case to the nurse or even call people for meetings, it becomes difficult. I will say that is one of the challenges I wished could be solved" (CHMC member, Z3).*

## Lack of refresher course training

The lack of frequent skill development training programmes for traditional birth attendants served as a disincentive to TBAs who also served as CHMC members. They were frustrated that their skills have not been upgraded over the years, as explained by a participant from zone 2:

*"We the TBAs usually go for routine training at Nkwanta but for close to 2 years now, we have not been invited for training. We need to update our skills in skilled delivery" (CHMC member, Z2).*

*"The only motivation I used to get was the trainings they were organising for us [TBAs] but now there is nothing like that. I really don't know what the problem with them is [Health Directorate]. Maybe it could be because they have sent a midwife to us now" (CHMC member, Z 4).*

## Discussion

### Motivations for becoming a CHMC member

Although CHMCs are integral part of the successful implementation of the CHPS concept, membership is purely voluntary. As such, one must have a strong motivation to serve on such a committee, taking into consideration the challenges that are associated with community health volunteerism. Three main reasons (provision of leadership to improve community health needs, financial reward and being motivated by the dedication of CHOs), grouped into three thematic areas (the value function, the self-enrichment function and the protective function) under functional approach of volunteerism [12] were ascertained. We found that the desire to provide leadership in one's community in order to improve its health outcomes through effective needs assessment conduct (the value function), financial expectations for being a volunteer (self-improvement function) as well as the guilt of allowing committed CHOs to work in isolation (protective function) were the main reasons why members obliged to serve on their respective CHMCs. In other words, both intrinsic and extrinsic motivation [21] played a role in driving discussants to become community health volunteerism in our 2 SLDs.

The value function was found to be an important contributor to volunteerism in the 2 SLDs. Some CHMC members were of the view that they owed it to their communities to volunteer and provide the much needed leadership to help properly steer the affairs of their respective CHPS facilities in order to maximised their performance and improve the health status of their communities thereby reducing the burden of existing health disparities in the country. This, they said, could be achieved through the conduction of proper community health needs assessment guided by effective leadership. Hence, some CHMC members were of the belief that their presence on their respective CHMCs would enrich the performance of the committees to enable effective primary healthcare delivery in their zones by maximising the performance of their various CHPS compounds. Thus, they were concerned for the welfare of their society and therefore decided to contribute to societal development. This assertion has been supported by a study in United States of America [22] and United Kingdom [23].

The self-improvement function was also found to be another motivating variable for some CHMC members to volunteer on their respective CHMCs. Though members were ready to work as volunteers to help steer the affairs of their various CHPS compounds, they were hoping to improve their financial standing by being financially rewarded should they agree to serve on their respective CHMCs. They were of the view that being on the CHMC would come with some form of financial incentive, hence were not expecting the job to be purely voluntary. Such volunteers have however come to terms with the fact that being a CHMC member is purely voluntary, devoid of any financial gain. Studies conducted in Ghana [24] and elsewhere in Africa [25] reported similar findings. Furthermore, [26] found that while volunteers may not wish to receive some form of incentive for their work, most volunteers are more likely to give off their time when they perceive they are being paid for the work done. It could therefore be argued that although volunteers may wish to contribute their quota to the development of communities, they have personal goals and aspirations to achieve and therefore expect some form of financial reward, for their efforts in order to achieve these personal aspirations even if they do not state so.

Furthermore, the protective function, borne out of the feeling of guilt, motivated some discussants to serve on their various CHMCs. The commitment and dedication of non-indigenes CHOs towards their work, motivated indigene community members to volunteer and join their various CHMCs. Thus, they felt guilty of

sitting idle for an outsider to be solely responsible for their health. This function was supported by similar studies by [27] and [28].

## Responsibilities of the CHMC

We probed further to ascertain whether the respective CHMCs were aware of their responsibilities as CHMC members in the implementation of CHPS in their various zones and whether they were actually carrying out those responsibilities. We found that the CHMC had four key responsibilities: providing support to the CHO through resource mobilisation, home visiting, conducting health needs assessment, monitoring logistics availability and ensuring the wellbeing of CHO, assisting the CHOs in planning of CHPS activities, ensuring that they were aware of the activities undertaken by their respective CHOs; and helping in amicable resolution of conflicts between the CHO and community members.

The responsibilities performed by the CHMCs in the SLDs for the effective functioning of their respective CHPS compounds were in line with the requirements of the CHMC per the community health volunteers training manual developed by the [6]. Again, the roles and responsibilities of the CHMCs in the 2 SLDs were similar to the roles of community health committees in some African countries such as Zimbabwe. In the case of Zimbabwe, the role of community health committees include; identification of priority health problems within communities, planning how to help communities raise their own resources, organising and managing community input and advocating for the availability of resources for community health activities and inputs [29].

As an essential component of their responsibilities, the discussants were always aware of the various services rendered by their respective CHOs. Home visits, educational talks (in communities and schools), disease control programmes, home deliveries, treatment of minor ailments and conduction of child welfare clinics (CWC) were some of the activities that were known to be conducted by CHOs in the various CHPS zones by the CHMCs. To the discussants, being aware of the various activities of the CHO did not only serve as an indicator of their own performance, but also served as a measure to keep their respective CHOs on their toes to deliver on their mandate. The finding was in line with the [6] expectations of the CHMC, who are expected to perform an oversight responsibility. A study by [30], supports this finding.

We found that the CHMC was always involved in the planning and undertaking of health activities in their respective zones. Some of the activities the CHMC planned in unison with the CHOS include; how to run the health facility, development of action plan, planning on treatment of neglected tropical diseases, and how to keep the CHPS compound tidy. Working together with people (team work) in order to improve the health status of the community is a skill that every CHO is supposed to acquire under the CHPS concept [6]. As such, they are supposed to involve the CHMC in the planning of their activities. This element has been affirmed by the [31]. Hence, the involvement of the CHMCs in planning activities of the CHO is likely to improve the health outcomes of the communities. Despite the fact that discussants did not receive any form of recognition from their community members, they went ahead to carry out their duties to the best of their abilities. It could be argued that, the opportunity to contribute to the improvement of individual and communal health outcomes through strengthening of the CHPS concept (the value function) is a strong

driving force to get community health committees to effectively do their work. Thus, the CHMCs in the two SLDs were effectively carrying out their expected responsibilities in line with the training manual of the [2] despite lack of recognition for volunteers.

## Challenges faced by the CHMC

A number of issues were raised; ranging from financial to logistical challenges, to lack of support from community members, to lack of motivation, to poor telecommunication network and lack of frequent skill development training programmes for traditional birth attendants (TBAs). The [6] posited that community health volunteers, including CHMC members, are to be motivated by their respective communities in order to keep up with their voluntary work. Thus, they need constant encouragement, support and recognition from their communities. Hence, the lack of remuneration for community health volunteers, as found in this study, can significantly demotivate health volunteers. For instance, it has been found that projects that offer minimal economic incentives to community health volunteers tend to limit their focus and their performance while those that offer some form of incentives maximise the potential of such workers [32, 33];

Logistical challenges such as unreliable supply of proper working gear, lack of bicycles and tricycles also served as a demotivation for some CHMC members. Studies have shown that lack of these supplies to volunteer health workers diminishes the effectiveness and seriousness they attach to their work [34, 35]

As part of the community health volunteers training manual, various suggestions were made as to how to motivate community volunteers by the GHS. To this end, communities are expected to assist CHMC members on their farms or businesses, or provide them with foodstuffs as well as pay their transportation costs to training programmes and other meetings. In addition, communities are expected to provide logistics such as working gear, bicycles and motor cycles as well as money to cover maintenance cost [6].

Unfortunately, we established that communities no longer offer these motivational and supportive services to community health volunteers, including the CHMC, leading to some form of apathy and anguish on the part of some CHMC members, thereby affecting their maximal cooperation and operations of their CHPS compounds for communal benefit.

Furthermore, lack of telecommunication services in some of the communities also hampered the work of CHMC members. As members are drawn from different communities and villages in the CHPS zone to form the CHMC, some members hail from communities where there is weak or no telecommunication signal at all, thus making contacts difficult. Moreover, valuable time is lost in situations where there is the need to report emergency cases to the CHO or when referrals need to be made as key stakeholders such as ambulance drivers, become unreachable. To effectively mobilise communities for positive health outcomes, there is need for effective communication network in these rural communities [36].

The last challenge, as stipulated by discussants, especially those who also served as traditional birth attendants (TBAs), was their disappointment in the lack of periodic refresher courses on their skills. To them, the joy of successfully delivering a baby alone served as a motivation, hence, not receiving frequent training in that regard to upgrade their skills was a significant challenge in the performance of their duties. The

importance of training courses as a source of motivation, capacity building and performance for volunteers has been highlighted by [32].

## Conclusion

Three forms of motivation were found to influence volunteerism; the value function (desire to serve in order to improve the health needs of their respective communities), self-enrichment function (expected financial reward) and guilt function (the commitment of CHOs to their work). The respective CHMCs performed their responsibilities in ensuring quality primary healthcare delivery in their communities. They helped in planning the activities of the CHO for the CHPS zone, conducted community health needs assessment, helped in the development of action plans, served as liaison officers between the community and the CHO, in treatment of neglected tropical diseases, in cleaning the CHPS compound and also resolved conflicts between the CHO and the community. Although logistical challenges were reported by the CHMCs, functional ambulance challenge was only reported in one health facility. Volunteers also faced other personal challenges including financial challenge, communal support, poor telecommunication network and lack of refresher training courses for CHMC members who are also TBAs.

Based on our findings, we conclude that although most CHMC members are intrinsically motivated to carry on with their responsibilities, the challenges they face demotivate them to give off their best. Consequently, this negatively impacts the performance of the CHPS zones, and affects healthcare delivery outcomes in the communities. We, therefore, recommend that volunteerism under the CHPS concept needs to be given more priority by the Ghana Health Service and other stakeholders in Ghana's health industry than is currently done to ensure that challenges are addressed to make it more attractive for volunteers to give off their best. This will consequently influence other community members to serve as volunteers in the implementation of CHPS.

## Abbreviations

CHMC: Community Health Management Committees; CHPS: Community-based Health Planning and Services; CHO: Community Health Officers; CHVs: Community Health Volunteers; CWC: Child Welfare Clinics; FGD: Focus Group Discussion; GEIHIP: Ghana Essential Health Intervention Programme; GHS: Ghana Health Service; PBL: Problem –based Learning; SLD: System Learning Districts; PSH: School of Public Health; TBAs: Traditional Birth Attendants; UDS: University of Development Studies; UHAS: University of Health and Allied Sciences; USA: United States of America

## Declarations

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## **Authors' contributions**

MK, HA, and JG conceived the study. MK, HA, and EM, did the data analysis and wrote the methods section. MK, EM, HA, MA, JK, FYA, ET, GAA, NNA, and JG were responsible for the initial draft of the manuscript. All authors reviewed and approved the final version of the manuscript.

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## **Availability of data and materials**

All the data used to this study are contained in the manuscript document and associated files.

## **Ethical approval and considerations**

Ethical approval for this study was obtained from the Ghana Health Service (GHS) Ethics Review Committee (ERC) (Number: GHS-ERC: 04/01/2017). Permission was also sought from the Volta Regional Health Directorate and the 2 district directorates before the commencement of the study. Participants were assured of their anonymity and confidentiality and gave their consent by signing or thumb printing an informed consent form. Participation in the study was purely voluntary as participants were free to withdraw from the study at any stage they felt uncomfortable without consequences.

## **Consent for publication**

Not applicable

## **Competing interests**

The authors declare that they have no conflicts of interest.

## **Authors' details**

- School of Public Health, University of Health and Allied Sciences, Hohoe, Ghana

- Volta Regional Health Directorate, Ghana Health Service, Ho, Ghana
- Regional Institute of Population Studies, University of Ghana, Legon, Ghana
- Policy Planning Monitoring and Evaluation Division, Ghana Health Service, Accra, Ghana
- Mailman School of Public Health, Columbia University, USA
- Office of the Vice Chancellor, University of Health and Allied Sciences, Ho, Ghana

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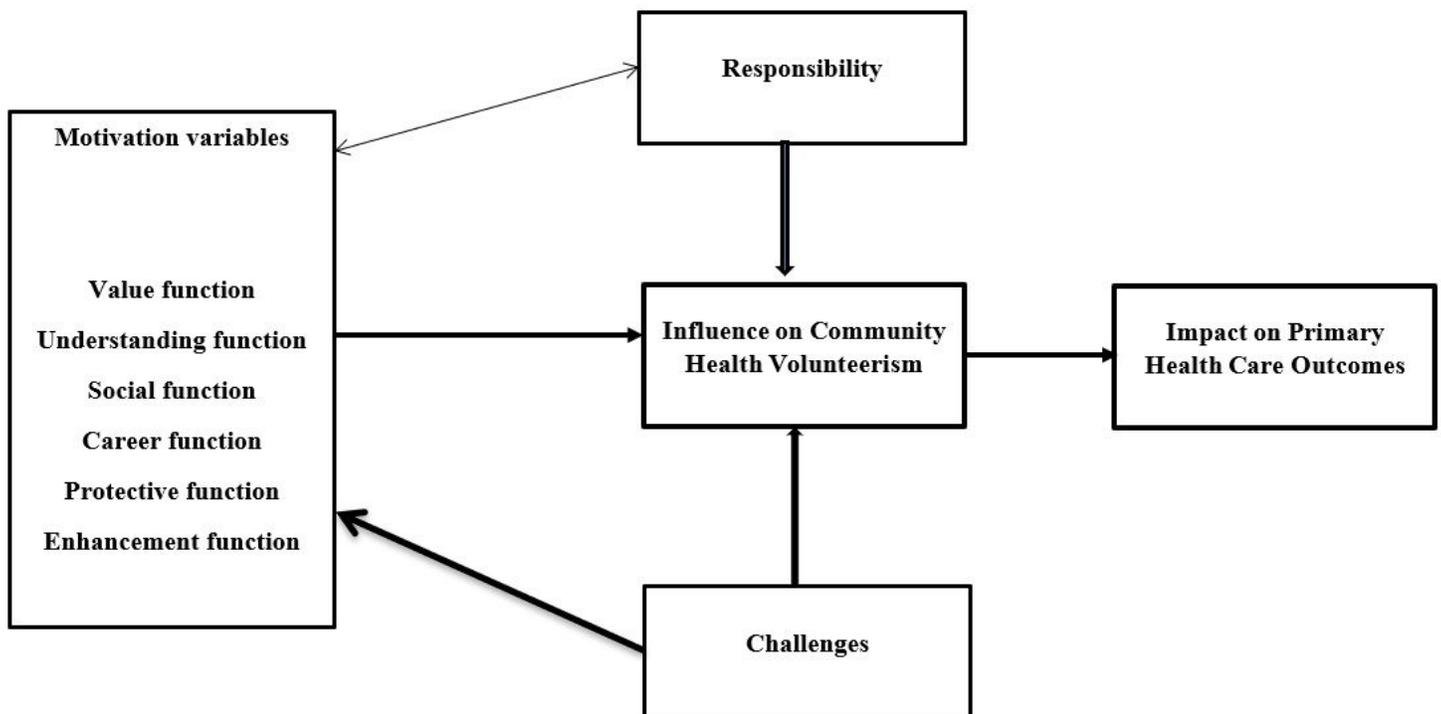
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## Figures



**Figure 1**

A functional approach to community health management volunteerism adapted from Clary et al. (1998)

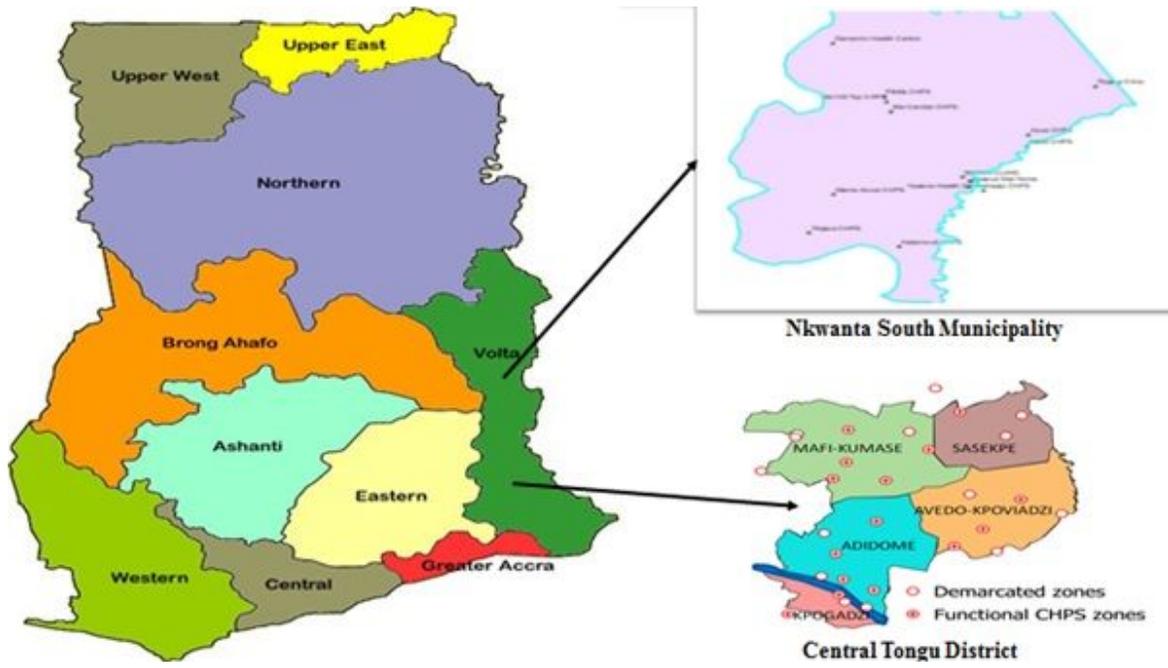


Figure 2

Map of Ghana, depicting the Nkwanta South and Central Tongu Districts of the Volta Region