

VOLUNTEER RECRUITMENT AND RETENTION: A CASE STUDY OF THE
VANCOUVER PLANNED PARENTHOOD CLINIC

by

LISA ANNE PARSONS

B.A. Honours, The University of Western Ontario, 1990

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS

in

THE FACULTY OF GRADUATE STUDIES

Department of Sociology

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

September 1993

© Copyright Lisa Anne Parsons, 1993

In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

(Signature)

Department of Sociology

The University of British Columbia
Vancouver, Canada

Date Sept 28, 93

Abstract

The purpose of this project is to conduct a detailed evaluation of the Vancouver Planned Parenthood clinic volunteer program. The primary focus of this study is volunteer recruitment and retention. The simplicity of individual perspectives commonly employed in volunteer theories and research is rejected in this research project. A multi-leveled sociological analysis stemming from an organizational behaviour framework is used as an alternative approach to broaden the scope of this case study. The five levels of analysis used to examine the volunteer program in this study are: 1) individual level of analysis, 2) group behaviour, 3) interpersonal and organizational processes, 4) organizational structure and job design, and 5) organizational environment. Multiple factors are discussed under each level of analysis.

A triangulation of methods, comprised of interviews with volunteers, observational analysis, and document analysis, is used to provide a rich analysis of the volunteer program. Interpretations of the findings demonstrate that many factors beyond the individual level influence volunteer recruitment and retention. Results show that this particular volunteer program is operating below its maximum effectiveness, and that high volunteer turnover results in this atmosphere. Practical and theoretical implications of this case study are explored and recommendations are offered.

Table of Contents

Abstract.....	ii
Table of Contents	iii
Acknowledgements.....	v
CHAPTER ONE	
INTRODUCTION.....	1
1 The Planned Parenthood Association of British Columbia	5
1a Program Mandate	5
1b Planned Parenthood Services and Programs	6
1c Staff	7
1d The History of the Planned Parenthood Association of B.C.	8
Figure 1	
Funding for the Planned Parenthood Association of British	
Columbia 1993 Fiscal Year.....	11
2 The Vancouver Clinic.....	12
CHAPTER TWO	
LITERATURE REVIEW	17
1 Who Volunteers?	18
2 Why Volunteer?	21
3 Volunteer Recruitment	22
4 Volunteer Retention.....	24
5 Volunteer Theories	27
5a Volunteerism as Work	27
5b Volunteerism as Leisure.....	28
5c Organizational Behaviour	29
Figure 2	
Levels of Analysis.....	31
CHAPTER THREE	
METHODOLOGY	33
1 Individual Level of Analysis	34
2 Group Behaviour, Interpersonal and Organizational Processes and	
Organizational Structure and Job Design	41
3 Organizational Environment	42
CHAPTER FOUR	
RESULTS AND INTERPRETATIONS.....	44
1 Individual Level of Analysis	44
Figure 3	
Levels of Analysis: Outline Depicts Individual Level of	
Analysis	45
1a Situational Factors	45
1b Job Satisfaction	48
Figure 4	
Duties Performed Most Often Compared to Preferred Duties	49
1c Motivation	51
2 Group Behaviour Level Of Analysis.....	52
Figure 5	
Levels of Analysis: Outline Depicts Group Behaviour Level	
of Analysis	54
2a Cohesiveness	54
2b Group Inclusion	59
2c Leadership	60

3 Interpersonal and Organizational Processes.....	62
Figure 6	
Levels of Analysis: Outline Depicts Interpersonal and Organizational Processes.....	63
3a Autonomy.....	63
3b Communication.....	67
3c Recruitment.....	68
3d Training.....	70
3e Orientation.....	74
3f Scheduling.....	76
4 Organizational Structure and Job Design.....	78
Figure 7	
Levels of Analysis: Outline Depicts Organizational Structure and Job Design.....	79
4a Job Design.....	79
4b Volunteer Program.....	81
4c Clinic.....	85
4d Bureaucracy.....	87
Figure 8	
The Hierarchical Staffing of the Vancouver Clinic.....	88
5 Organizational Environment.....	89
Figure 9	
Levels of Analysis: Outline Depicts Organizational Environment.....	90
5a Accessibility.....	90
5b Funding.....	91
CHAPTER FIVE	
CONCLUSIONS AND RECOMMENDATIONS.....	93
1 Conclusions.....	93
1a Limitations.....	98
2 Recommendations.....	100
2a Recruitment.....	100
2b Training.....	101
2c Orientation.....	104
2d Scheduling.....	105
2e At the Clinic.....	107
2f Outside of Clinic.....	110
Bibliography.....	112
Appendix.....	119
Recruitment Notice.....	119
Letter of Consent.....	120
Interview Schedule.....	121
Interview Summary.....	124

Acknowledgements

I would like to thank Dr. Dawn Currie, Dr. Larry Moore, and Dr. Nancy Waxler-Morrison for graciously serving on my committee, and for guiding me through this project. I would also like to express my deepest appreciation to Ken for having faith in me and for being my source of inspiration and support over the long and lean years. Thanks also to Anthony for his infinite patience and technical support.

CHAPTER ONE

INTRODUCTION

The purpose of this research project is to examine volunteer recruitment and retention using the Vancouver Planned Parenthood clinic volunteer program as a case study. Specifically, I want to determine what factors influence volunteer retention and turnover. A multi-level analysis is used to investigate aspects of the volunteer program. Recommendations are generated from the findings to improve the effectiveness of the volunteer program and the clinic, especially as it pertains to the volunteer program.

My experiences as a volunteer reveal that the Vancouver Planned Parenthood clinic has little difficulty recruiting volunteers, but that volunteer retention is a serious and on-going problem. There is a small pocket of volunteers who are highly dedicated to regular long-term volunteering, but many of the newer volunteers drop out quickly. The volunteer program is integral to the operation of all Planned Parenthood clinics. The volunteers perform a wide variety of skilled functions, including nursing, pregnancy counselling, and presenting the contraceptive methods talk. The services provided by Planned Parenthood simply could not continue without volunteer labour.¹

New volunteers are easily recruited to supplement those who do not work regularly or replace those who drop out altogether. This continual recruitment enables the clinic to function. However, a tremendous amount of resources are spent on recruiting, training, and orienting volunteers. High volunteer turnover rates affect all aspects of the organization. For example, the clinic supervisors and educators must spend considerable time, money, and energy recruiting volunteers, arranging for them to take the training course, and conducting training and orientation sessions. Low volunteer commitment also means that

¹My observations and the literature reveal that the Vancouver clinic volunteer attrition rate is high. However, statistics are difficult to keep because 1) some people take the training course without ever intending to volunteer, because the course is a school or professional requirement for example 2) some volunteers volunteer at other clinics and 3) volunteer attrition rates and volunteer longevity rates are not recorded. My personal experiences serve as an estimate for attrition rates: there were about fourteen people in my training course, and six months later, only three or four volunteers (including me) were still volunteering at the Vancouver clinic.

the supervisors must continually contact volunteers to fill shifts for each clinic night. These demanding duties inevitably detract from other responsibilities to which the supervisors could devote themselves if they had the resources.

Low volunteer commitment and high turnover rates result because the volunteer program functions inefficiently. Management is aware of these problems, but lacks the resources necessary to evaluate the current volunteer program and implement a more effective one. Consequently, the ineffectiveness of the program is maintained. The clinic's resources could be used much more productively if they were not spent to preserve a minimally effective volunteer program.

A case study is the research strategy chosen to examine the Vancouver Planned Parenthood clinic volunteer program. In a case study, the volunteer program is looked upon as a unit and the analysis aims to retain a unitary nature of this individual case and to emphasize the relationship between its various attributes (Moser and Kalton, 1972). "A case study can provide a richly detailed 'portrait' of a particular social phenomenon" (Hakim, 1987:61).

A case-study involves the detailed study of a single example of whatever it is that the sociologist wishes to investigate. It may prompt further, more wide-ranging research, providing ideas to be followed up later, or it may be that some broad generalization is brought to life by a case-study. There is no claim to representativeness and the essence of the technique is that each subject, whether it be an individual, a group, an event, or an institution, is treated as a unit on its own (McNeill, 1985:87).

Case studies are probably the most flexible of all research designs (Hakim, 1987). "Case studies use a variety of data collection techniques and methods that allow a more rounded, holistic study than with any other design" (Hakim, 1987:61).

There is an extended range of case studies combining exploratory work, description and the testing out of hunches, hypotheses, and ideas in varying combinations. The case study is the social equivalent of the spotlight or the microscope: its value depends on how well the study is focused (Hakim, 1987:61).

I am not aware of any other case study that has been performed on a volunteer program. The exploratory and illustrative value of conducting a case study is evident: this research strategy yields a detailed analysis of the Vancouver Planned Parenthood volunteer program. There are significant sociological contributions to be derived from performing a case study. A case study focuses on all aspects of the volunteer program, and not simply on the individual level of analysis. In this way, a case study allows a more in depth and sociological understanding of this unit of analysis.

Some of the results of this study are applicable only to the specific conditions of the Vancouver clinic, while the remainder are relevant to any volunteer program. This research project is presented in a coherent manner by dividing it into five distinct, but related chapters. This introductory chapter provides an overview of this research project and explains my interest in this topic. It also gives detailed information on the Planned Parenthood Association of British Columbia and the Vancouver Planned Parenthood clinic. The second chapter reviews the major trends and theories in volunteerism in recent literature. In addition, it provides an overview of the approach I use in my analysis. The project's methodology is discussed in the third chapter. The results and interpretations of the study are presented in the fourth chapter. The fifth chapter contains concluding remarks, with research questions presented to guide further research. It also recommends ways to improve the clinic in general and the volunteer program specifically.

Project Goals: My project goal is two-fold. I want to write a sociologically sound paper to contribute to the scholarly knowledge of volunteers. Moreover, I want to conduct action research. In this case, action research entails studying the people who know the volunteer program best: the volunteers and staff. These workers realize that the clinic is not functioning efficiently, and they define the goals of this research accordingly. They will also take an active role in implementing the recommendations generated from this study. The practical aim of this research is to implement a more effective volunteer program. I have been one of the core volunteers at the Vancouver clinic for the past three years. As such, I

have witnessed clinic operations firsthand and wish to use my knowledge and research to help establish a better volunteer program.

The volunteers share their experiences and offer their suggestions through personal interviews about the volunteer program specifically, and clinic in general. Qualitative methods are used to collect data from the interviews and to highlight recurring patterns in the respondents' comments. My participation in the organization allows me to use my experiences as a volunteer to perform observational analysis. In addition, I analyze Planned Parenthood's documents to provide a rich analysis of the volunteer program, clinic and the organization.

A multi-leveled approach is used to critically examine each part of the volunteer program. We begin with analyzing individual behaviour. Using the knowledge gained at this level, we move on to the more complex levels of the group, interpersonal and organizational processes, then organizational structure and job design. Finally, we add a fifth level of complexity, the organizational environment, to arrive at the final destination: an understanding of the volunteer program. The five levels are analogous to building blocks- each level is constructed on the previous level(s) (Robbins, 1986).

Definition of Client: I use the term 'client' throughout this paper when referring to people who use the clinic's services. Client refers to a customer, or person who engages the services of a professional adviser. This is in contrast to the term 'patient' used in the clinic and in Planned Parenthood documents. Funk and Wagnall's definition of a patient is "a person undergoing treatment for disease or injury." This definition clearly does not accurately describe Planned Parenthood clientele. Furthermore, the term 'patient' connotes that the physician is the powerful one caring for the helpless person in his or her care. Planned Parenthood's clients are, in fact, seeking the organization's services. If they do not receive satisfactory service, like customers, they have the power to seek services elsewhere. I use the term 'patient' only when this terminology is used in volunteers' verbatim comments.

1 The Planned Parenthood Association of British Columbia

The Planned Parenthood Association of British Columbia is a member of the Planned Parenthood Federation of Canada (Planned Parenthood pamphlet, 1992). The Canadian Federation is affiliated with the International Planned Parenthood Federation, the largest voluntary organization in the world (Ibid.). The international agency operates in one hundred and fourteen countries worldwide.

1a Program Mandate

Planned Parenthood's program mandate asserts that

every couple and every individual has the right to decide freely and responsibly whether or not to have children as well as to determine their number and spacing, and to have information, education and means to do so (United Nations Human Rights Declaration of 1968. Planned Parenthood pamphlet, 1992).

To meet this mandate, Planned Parenthood strives

- 1) to provide non-judgmental confidential counselling and birth control services
- 2) to increase awareness of all possible methods of contraception to enable individual, appropriate choices about family planning
- 3) to encourage planned pregnancies
- 4) to promote the development of family life and sex education programs for children and adults
- 5) to help individuals seek appropriate professional health care
- 6) to provide work experience for nurses and physicians in training
- 7) to provide training for volunteers interested in working with people (Ibid.).

Planned Parenthood also believes that

- 1) deciding whether and when to have children is a basic human right and access to family planning services is an integral part of that right
- 2) early and continuing education in human sexuality encourages the development of positive healthy attitudes and responsible sexual behaviour
- 3) everyone has the right to a healthy reproductive life through preventative health care services

- 4) parents are and should be the primary educators of their children about sexuality. In this responsibility, parents should be supported by teachers, health and social services, education and religious institutions
- 5) every child has the right to be nurtured and given the best possible chance in life (Planned Parenthood pamphlet, 1992).

Each clinic acts as a microcosm of this mandate and these beliefs and applies these principles to the clinic setting.

1b Planned Parenthood Services and Programs

Planned Parenthood offers a wide variety of services, which include

- 1) birth control information and counselling services
- 2) confidential testing for sexually transmitted diseases
- 3) confidential pregnancy tests and counselling
- 4) fertility and infertility counselling
- 5) pamphlets on sexuality, birth control, infertility and a variety of other topics, in several languages
- 6) resource library including rental of videotapes and teaching materials
- 7) speakers and workshops for schools, youth, community and parent groups, and professionals. Topics of discussion include sexual decision making, birth control, talking to children about sex and sexuality, teenage pregnancy, infertility and menopause
- 8) infant car seat rental (Planned Parenthood pamphlet, 1992).

Planned Parenthood also offers educational programs among their services designed to meet the program's mandate. Diverse groups are targeted for the educational programs that are offered in British Columbia, including students at all levels of the school system (Primary, Elementary, Secondary, Post secondary: including the professions of Teaching, Nursing, Medicine and Social Work), parent groups (pre-school and school-aged children), teachers and counsellors, community health workers, and community groups (Planned Parenthood pamphlet, 1992).

Program topics include human sexuality and development throughout the life-span; human sexual anatomy and physiology; birth control; sexually transmitted diseases, including AIDS; sexual health and hygiene; fertility awareness; preconception health; pregnancy; teen pregnancy and parenthood; healthy sexual decision making; communication and counselling skills; and teaching techniques regarding sexuality, decision making, birth control, values clarification; and prevention of sexual abuse (Ibid.).

1c Staff

The Planned Parenthood Association of British Columbia is governed by a voluntary Board of Directors who have a broad range of experience and interest in reproductive health care. Physicians, nurses and volunteers provide services, such as health care, counselling, and education. Planned Parenthood depends on its volunteers. Two hundred and fifty volunteers donated 6723 hours of their time in British Columbia clinics over the past year (Planned Parenthood, Association of B.C., 1993:14). These hours would represent a monetary value of \$47,061 if calculated using minimum wage as an extremely conservative estimate (Ibid.). Training programs in education and clinical services are given by professional staff, educators, and medical personnel. The elected volunteer Board members set policy for the agency each year.

Organizational Membership: Planned Parenthood membership is required to receive any of the services offered by the organization. The annual B.C. Associate membership fee is currently ten dollars. This fee allows members to vote at their branch and to pick up a newsletter there. This is the minimum membership required to receive any clinic services. Full members pay twenty-five dollars for voting rights and full services. Sponsors pay one hundred dollars annually for full services, voting rights and for recognition in the annual general meeting report. A patron contributes five hundred dollars or more annually, and receives full services, voting rights, and special recognition at the annual general meeting (Planned Parenthood Association of British Columbia, 1993). Membership is also open to residents of B.C. who are not clients, but who wish to uphold

the objectives of the association. All interested parties are encouraged to participate in basic volunteer training and advanced training programs.

1d The History of the Planned Parenthood Association of B.C.

The first family planning clinic in British Columbia was opened by the Family Planning Association (FPA) of B.C. on February 4, 1965, in the basement of a house at 10th Avenue and Laurel Street, Vancouver (Family Planning Association of British Columbia, 1973). During the remainder of that year there were one hundred and seventy-six clients and a total of two hundred and forty client visits (Ibid.). In 1966 there were also two hundred and forty client visits (Ibid.). In these early years, the clinic was staffed by a core group of nurses who strongly believed in the program's mandate. They ran several clinics every week, wore their nursing uniforms, and were paid an honorarium for their services (Ibid.). Mrs. Caroline Porter was the Vancouver clinic coordinator in 1974. In that year, the Vancouver clinic had approximately thirty nurses on staff and was training more to work relief positions in the summer (Family Planning Association of B.C., 1974). At that time, nurses staffed positions which are now filled by volunteers. Nurses continued to receive an honorarium for their services to cover such expenses as transportation and child care costs. A grant was also established to pay a pregnancy counsellor for her services.

Funding: The clinic was financed through donations and a modest charge for services until 1967. In this year, the United Community Services of Greater Vancouver accepted the FPA as an agency, and allocated its first annual grant (\$2,595.00) to Planned Parenthood in 1968 (Family Planning Association of B.C., 1973). That year there were 465 new clients with a total of 1107 client visits (Ibid.). Committed individuals have offered family planning services in Canada since 1932 (Planned Parenthood Federation of Canada, 1989).

However, until 1969, the dissemination of birth control information and the sale of contraceptives was a criminal offense in Canada. However, the law was largely ignored and tended to favour the highly motivated and more informed members of society. Family planning was available to married upper- and middle-class women

who could afford the services of a private physician. Unfortunately, for those least able to support large families, birth control information and services were not usually accessible (Planned Parenthood Federation of Canada, 1989:1).

In February of 1969, six months before the amendment of the Canadian Criminal Code, the Government of British Columbia granted its first annual grant of \$4,000.00 to the Family Planning Association of B.C. (Family Planning Association of British Columbia, 1973). Various grants enabled many more clinics to open in Vancouver and the surrounding area over the next few years. By January 1973, there were eleven clinics operating in the province with a combined client load of 8,000 (Family Planning Association of British Columbia, 1973). The Provincial Government helped support Planned Parenthood with progressively larger annual grants until 1982 when the grant totalled \$166,800.00 (Family Planning Association of B.C., 1974). In 1983, the Provincial Government grant was discontinued. This loss of funding inevitably led to many changes within the organization. For example, the Vancouver branch was forced to share space with the provincial office, resulting in the amalgamation of many services (Ibid.).

There are now twenty-one branches of Planned Parenthood operating in the province (Planned Parenthood Association of British Columbia, 1993). The Planned Parenthood Head office is located on West Broadway in Vancouver. In British Columbia, there was a total of 13,481 client visits in 1992-93, and of these 1,757 were new clients and 11,724 returning clients (Ibid.). Forty-five percent of new clients in 1992-1993 were aged 15-19 years old, thirty-six percent 20-29 years old, nine percent 30-39 years old, eight percent under 15 years old, and one percent over 40 years old. The bulk of returning clients came for pill pick-up (58.4%), oral contraceptive follow-up (17.3%), or for annual examinations (13.6%). The majority of new clients came for oral contraceptives (40.7%), pregnancy counselling (28.4%), or other counselling (18%) (Ibid.).

The Planned Parenthood Association of British Columbia had three sources of revenue in the 1993 fiscal year: 1) fund raising, 2) services, and 3) investment income. Fund raising generated United Way contributions (\$79, 557.00); research grants

(\$17,322.00); other grants (\$27,847.00); donations and memberships (\$18,619.00); and casinos, bingo and other (\$99,231.00). The following services generated the bulk of the association's revenue: medical service commission (\$208,076.00); clinic services (\$15,356.00); medical supplies-sales (\$215,899.00); educational supplies-sales (\$9,913.00); educational fees (\$17,585.00); and conference fees (\$8,360.00). Investment income also generated a small amount of money for the organization (\$2,595.00). The total of these three sources of revenue is \$720,261.00. Fund raising is ongoing, or revenue is contributed annually in the case of grants. All sources of revenue fluctuate regularly. None of the revenues is guaranteed. Operation costs for each clinic vary, so allocations to clinics vary accordingly. Allocations are dependent on such factors as projected expenses (rent and salaries), and on-going expenses (equipment and supplies)(All information in this paragraph from the Planned Parenthood Association of British Columbia, 1993).

Four types of expenses were incurred to operate the organization: 1) human resources, 2) services, 3) promotion, and 4) administration. Human resource expenses include honoraria (\$10,024.00); salaries and benefits (\$367,569.00); and physicians' services (\$110,945.00). Service expenses include medical supplies-costs (\$73,152.00); educational supplies-costs (\$9,640.00); and conference costs (\$5,884.00). Travel (\$7,572.00) and publicity costs (\$17,499.00) comprise promotional expenses. Administration expenses are composed of building occupancy (\$44,359.00), telephone and postage bills (\$15,111.00), office fees (\$34,286.00); equipment (\$18,918.00); and audit expenses (\$7,885.00). The total of these expenses is \$722,844.00. The resulting deficit of the 1993 fiscal year is \$2,583.00 (All information in this paragraph from the Planned Parenthood Association of British Columbia, 1993). These figures demonstrate the financial hardship experienced by the organization. The following chart details the types of revenue generated and expenses incurred in the 1993 fiscal year.

Figure 1

**Funding for the Planned Parenthood Association of British Columbia
1993 Fiscal Year**

REVENUE

	Amount \$
1) Fund raising:	
a) United Way Contributions	79,557.00
b) Grants: Research grants	17,322.00
Other	27,847.00
c) Donations and memberships	18,619.00
d) Casinos, bingo and other	99,231.00
2) Services:	
a) Medical services commission	208,076.00
b) Clinic services	15,256.00
c) Medical supplies- sales	215,899.00
d) Educational supplies- sales	9,913.00
e) Education fees	17,585.00
f) Conference fees	8,360.00
3) Investment income:	2,596.00
Total Revenue	720,261.00

EXPENSES

1) Human resources	
a) Honoraria	10,024.00
b) Salaries and benefits	367,569.00
c) Physicians' services	110,945.00
2) Services	
a) Medical supplies- costs	73,152.00
b) Educational supplies- costs	9,640.00
c) Conference costs	5,884.00
3) Promotion	
a) Travel	7,572.00
b) Publicity	17,499.00
4) Administration	
a) Building occupancy	44,359.00
b) Telephone and postage	15,111.00
c) Office	34,286.00
d) Equipment	18,918.00
e) Audit	7,885.00
Total Expenses	722,844.00

DEFICIT FOR THE 1993 FISCAL YEAR: \$2,583.00

It is important to note that the clinics vary widely in the clientele they serve and the services they provide. The success of the volunteer program also differs in various clinics. This project is exclusively a case study of the Vancouver clinic. Some of the observations are applicable to all Planned Parenthood volunteer programs, while others are peculiar to the Vancouver clinic. Therefore, generalizations based on the observations of the Vancouver clinic must be made with caution.

2 The Vancouver Clinic

The Vancouver branch borrows space from the Women's Clinic at Vancouver General Hospital to operate the clinic. The Vancouver clinic has two small storage rooms containing all of their files, filing cabinets, contraceptive devices, medical tests and other supplies. All clinic supplies must be transferred from the storage space to their appropriate places for the clinic, then returned to storage at the end of the evening. The clinic is open every Tuesday and Thursday evening and the second and fourth Wednesday every month. Tuesday and Thursday clinics focus on all contraceptive methods, and Wednesday clinics are designated as cap clinics. Wednesday clinics focus on caps and diaphragms because learning to use these methods requires more time than other contraceptive methods.

The first appointments are at 6:30 p.m. for pregnancy counselling clients and at 6:45 p.m. for clients who wish to attend the methods talk. Regular appointments start at 7:00 p.m. and finish at 8:30 p.m. Clients are required to make appointments for every visit to the clinic, including pill pick up. However, many clients fail to keep their appointments or clients without appointments show up, so it is difficult to predict the client load on any night. Sometimes there are too many clients, creating a huge backlog. At other times, there are too few clients so there is insufficient work for the volunteers. Operations continue until all clients have received the necessary services, so this means that the clinic sometimes operates until 10 o'clock in the evening or later. Activity is greatest at the beginning of the evening when the methods talk and interviewing take place. The pace typically slows down toward

the middle of the evening when clients meet with the physicians, and workers await the last few appointments. There is then a flurry of activity as clean-up occurs at the end of the evening.

Two supervisors work together to operate the clinic. They are both Registered Nurses and have been working at the clinic for approximately two and a half years. They work well together and have been striving to improve the clinic since adopting their posts. Both have paid half-time positions. The supervisors' duties include ordering supplies; orienting new volunteers, physicians and other staff; liaising with the office to determine client load and to obtain test results; scheduling volunteers for shifts; conducting follow up with clients; and doing whatever is necessary to run the clinic efficiently.

There is a paid staff person who operates the front desk every clinic night. There are several people who are trained to perform these duties and they negotiate who will work when. The front desk person is usually the first to arrive at the clinic to begin setting up for the night. She answers the phone, greets clients and does the necessary paper work, dispenses birth control and collects payment, organizes new files, and liaises with the supervisors and volunteers to make sure everything is operating well.

Two physicians work on each clinic night. There is a pool of seventeen physicians who work at the clinic. Most of the physicians in the pool are female, so there are most frequently two female physicians or one male and one female physician working. Supervisors try to avoid booking two male physicians on the same night because some clients prefer female physicians. Physicians arrive about 7 o'clock and remain until they see the last client. The clinic process is frequently modified so that the physicians are not idle. Physicians spend as much time as necessary with each client and every physician sets her or his own pace and approach. Physicians are paid for their services through the Medical Services Plan. Many work for Planned Parenthood because they strongly believe in the program's mandate and/or because they want more experience in the field of women's health and reproductive care.

Volunteers comprise the largest number of workers at the clinic. They donate numerous hours to the organization with no financial compensation. All are female. Volunteers are required to take a twelve hour training course before beginning to volunteer. This course costs forty dollars and is offered one evening per week, three hours per night, for four consecutive weeks. The pregnancy counselling training course is optional, lasts twelve hours and also costs forty dollars. It is offered in a single week end, with classes on Friday night, then all day the following Saturday. Course fees are sometimes subsidized or waived if a volunteer cannot afford the fee. Volunteers perform a wide variety of duties for the organization, including: performing nursing, the methods talk, interviewing, pregnancy counselling, making new files, filing, and helping out wherever else they are needed. Like the physicians, there is a large pool of volunteers, but only a small pocket of volunteers work regularly.

The following are descriptions of the main volunteer duties. The main component of each duty is bolded.

Nursing:

- **Assist physicians to physically examine clients**
- hand physicians all test apparatus
- collect and prepare specimens for analysis
- complete all documentation and attach to appropriate sample
- comfort client
- prepare examination room for next client

Methods talk:

- **Present a synopsis of all contraceptive methods to new or interested clients**
- describe use of each method
- highlight pros and cons of each method
- state failure rates
- promote discussion of each method
- respond to clients' questions and comments

Interviewing:

- **Complete standardized interview form**
- collect information on clients (biographical, sexual, medical history) to include in client's file
- address clients questions and concerns in a one on one environment
- brief clients on clinic procedures
- go over details of client's chosen contraceptive method using a check-list

Pregnancy Counselling:

- **Provide information regarding options and services for women who have suspected or confirmed pregnancies**
- complete interview schedule if client is new
- complete pregnancy counselling form to collect such information as life circumstances, goals, support network and contraceptive use
- explore feelings about different options
- perform pregnancy test and discuss results
- refer client to services that may be useful to them
- discuss contraceptive choice and use
- explain abortion and adoption procedures if appropriate
- encourage client to have a physical exam to confirm test results

Volunteers arrive between 6:20 p.m. and 7:00 p.m. depending on what duties they have signed up to do. Although volunteers sign up to do a specific duty, duties are reevaluated at the beginning of each clinic when client load and volunteer staffing are determined. Complicating factors are that unscheduled volunteers frequently show up, while scheduled ones do not, or that volunteers have limited skills or prefer to do only one duty. Volunteers are advised to be flexible and most are happy to help out wherever they are needed. Volunteers leave throughout the evening depending on what duties they were performing, client load, and volunteer staffing, as well as personal commitments elsewhere. Some volunteers plan on staying to help clean up and close the clinic, but most leave when all clients have been serviced.

In conclusion, Planned Parenthood is a non-profit organization which relies heavily on its volunteers. Volunteers deliver most of the clinic services and donate invaluable skills and numerous hours to the organization. Volunteer recruitment and retention are paramount issues to countless organizations world wide, because they are essential to the success of a volunteer program. There is, therefore, substantial theory and research on these topics in the literature.

Most literature on volunteers adopts a highly individualistic perspective. For this reason, I take elements of analysis that appear in organizational behaviour literature to provide a broader and more sociological approach to understanding volunteer recruitment and retention. The theoretical component is to add to volunteer literature by demonstrating

the need to use a multi-levelled analysis to analyze the complexity of a volunteer program. Individual variables such as situational factors, job satisfaction, and motivation are important issues in volunteer recruitment and retention, but they illuminate only a small part of the whole picture. A case study is, therefore, an appropriate sociological research strategy to examine group processes such as cohesiveness, leadership, communication, job design, and accessibility. These sociological factors are integral to a holistic understanding of the Vancouver Planned Parenthood clinic volunteer program. The practical component of this study is to generate recommendations to improve the volunteer program.

An analysis of volunteer recruitment and retention is the focus of this study. The ensuing chapters comprise the diverse, but integrated components of this case study. The literature review is necessary to lay the groundwork for this research, while the methodology chapter describes the research design. The results chapter presents the findings and discusses the implications of this study. The final chapter presents conclusions and recommendations resulting from this research.

This case study examines the main components of the volunteer program. An organizational behaviour approach is used in this case study. This approach involves five levels of analysis, each of which builds upon the preceding one(s). These levels are individual; group behaviour; interpersonal and organizational processes; organizational structure and job design; and organizational environment. There are multiple processes within each of these levels of analysis and these processes are discussed accordingly. Interviews, observational analysis, and document analysis are the three types of data collection used to evaluate the volunteer program.

CHAPTER TWO

LITERATURE REVIEW

The purpose of this chapter is to provide a concise summary of the literature on volunteers. The recent literature on volunteers acknowledges the complexity of volunteerism. The difficulty in recruiting and retaining volunteers in order to maintain an effective volunteer program is a primary concern in the literature. This newer literature challenges the over-simplification of these issues in the past, such as identifying altruism as the primary volunteer motivator. However, as the following discussion demonstrates, a strong tendency persists to analyze volunteerism at an individual level. This trend is typified by concentrating on the individualistic aspects of the volunteer theories of work and leisure. Although these theories can be seen as sociological, much of the literature simply describes at an individual level who volunteers are and why they volunteer, rather than examining the sociological factors which influence recruitment and retention. Looking at the individual is important, but it is equally important to examine other levels to obtain a thorough understanding of volunteer recruitment and retention. An organizational behaviour approach is offered as an alternative to these individual, thus limited, approaches.

What is a Volunteer?: To avoid any ambiguity about the meaning of this term, I define a volunteer as a person who gives time, energy, skills, or knowledge voluntarily (freely) to a cause or activity without monetary profit (Schindler and Rainman, 1982-83). Similarly, Jenner defines a volunteer as someone who works out of free will for a non-profit organization which serves someone or something other than its membership (Jenner, 1982). Volunteerism pertains to the act of volunteering, while voluntary refers to doing something from one's free will.

1 Who Volunteers?

This section reviews the literature to determine who volunteers. Socio-demographic characteristics are highlighted since it is these characteristics which are most frequently used to explain propensity to volunteer. Although there is a growing literature on volunteers, few studies have acknowledged or examined diversity among volunteers in order to explain who volunteers for which organizations and for different types of volunteer work. When differences between volunteers are ignored, potential important differences among patterns in volunteering are indiscernible (Ellis, 1984-86). Ellis argues that until we have clearly described who volunteers for what, we cannot move on to more in-depth studies of other issues relating to volunteers (Ibid.). Until an organization knows who volunteers for its programs, it cannot tailor its recruitment, training and orientation programs to meet its individual needs.

Propensity to Volunteer: Studies show that many people volunteer, although the statistics differ depending on the study and the researcher. O'Connell finds that "approximately half of all adult Americans are active volunteers, and they give an average of 4.7. hours a week" (O'Connell, 1989:487). Hayghe writes that from May 1988 to May 1989 "about 1 out of every 5 persons in the civilian noninstitutional population 16 years old and over volunteered for an institution or organisation" (Hayghe, 1991:17). His figures show that twenty-two percent of women and nineteen percent of men did some work as a volunteer during this time period (Hayghe, 1991). His survey data also show that while most volunteers spend less than five hours a week at their main volunteer activity, more than forty percent of his sample engage in some kind of volunteer activity in over half the weeks of the year (Ibid.). In addition, fully thirty percent of the volunteers in his sample volunteer every week (Ibid.).

My review of the literature shows that there are readily discernible and recurring patterns in voluntary action. Numerous studies find that sex, age, ethnic background, education, and marital status are all related to volunteer rates, time spent volunteering, as

well as to the reasons people give for doing volunteer work (Gillespie and King, 1985). Hayghe finds that those most likely to volunteer are women, people in their thirties or forties, whites, highly educated people, and married people (Hayghe, 1991).

Gender: Historically, upper to middle class white women have provided volunteer labour to numerous causes. This is because these women tended not to seek employment, particularly while there were children in the home. To give their lives additional purpose and to contribute to important causes, they spent a significant segment of their work lives as volunteers (Jenner, 1981).

In more recent times, even though women with young children are far more likely to work outside of the home, they make up a larger proportion of both part-time workers and people not in the labour force than do men (Hayghe, 1991). However, the gender gap persists even when males and females in these groups are compared: women in these groups are more likely to do volunteer work than their male counterparts (Ibid.). One of the reasons for this is that women tend to be the primary care givers for their children. As such, many become involved in volunteer work through their children's school, recreation or religious activities (Ibid.). Fathers also have opportunities for volunteer activity through their children, but to a lesser extent (Ibid.).

Age: People aged thirty-five to forty-four years old are more likely to volunteer than people of any other age group (Hayghe, 1991; Vaillancourt and Payette, 1984-86). Parenthood may also account for this trend. People in this age group are likely to have children in the home and get involved with volunteer activities through them. Another reason is that people in this age group may have more time, energy and financial resources, enabling them to volunteer more than younger or older groups. Yet another reason may be that people in this age group have been more strongly socialized to see volunteering as a part of a complete life than other age groups.

Ethnic Differences: White people are more likely to volunteer than any other ethnic/racial group (Hayghe, 1991). This may be because whites tend to be more affluent than other groups, giving them the resources to volunteer. For example, they may be more likely to have reliable transportation, regular work hours so that they can plan activities during their time off, and the money to pay for child care while they volunteer. Other factors could be that whites are targeted for volunteer programs more than people from other origins, or that white culture more strongly encourages volunteer activity as a part of a complete life. Another possibility is that most research focuses on white volunteers, resulting in an over representation of white volunteers in the literature.

Education: Highly educated people are more likely to volunteer than less educated ones (Hayghe, 1991). Hayghe reports that "roughly 4 out of 10 college graduates 25 years old or over-both men and women- participated in unpaid volunteer work, compared with fewer than 1 in 10 among high school dropouts" (Hayghe, 1991:18). Because education and income are positively correlated, "the higher their income, the more likely persons are to engage in volunteer work" (Hayghe, 1991:20). The reasons for these trends may be explained by the differential access to resources explained above. There are two kinds of costs associated with volunteering. The first are monetary costs such as transportation and child care costs. The second, and most important, are time costs. Time costs depend on the alternative uses of the time devoted to volunteer work" (Vaillancourt and Payette, 1984-86). More highly educated people and higher income groups may be better able to absorb these costs than other groups.

Marital Status: Married people are more likely to do volunteer work than unmarried persons (Hayghe, 1991). One of the reasons for this trend is that married people are more likely than other groups to have children living with them (Ibid.). As already explained, parents are likely to get involved in volunteer activities through their children.

Many researchers find that the "propensity to volunteer has been noted as a function of availability of discretionary time" (Unger, 1987:524). However, recent literature on

volunteerism indicates that although they are very busy, volunteers simply find the time to volunteer (Unger, 1987). Unger concludes that the perceived availability of time may be as important as actual availability of time in determining volunteer behaviour (Ibid.). In fact, Unger finds that it is actually those people who perceived themselves to have the least amount of time who volunteered the most (Ibid.). Of course, it may be that the respondents perceived themselves to have so little leisure time precisely because they spent a substantial amount of time volunteering.

2 Why Volunteer?

Socio-demographic characteristics are related to propensity to volunteer as outlined in the preceding section. These characteristics are also related to the reasons people give for volunteering. For example, learning is the most frequently cited reason for volunteering by those under twenty-five years of age, who are primarily students (Jenner, 1981). Those over fifty-five said they volunteered because they wanted to help others and because they felt an obligation to their community (Ibid.).

The next section focuses on why people volunteer. Because of the diversity of volunteers, it is essential to examine what motivates people to volunteer in general, and what motivates them to join a specific organization or to do particular volunteer work. Only then can the organization evolve to ensure that these expectations are met by the volunteer experience (Gillespie and King, 1985). The results of better meeting volunteers' needs and expectations will result in a more effective volunteer program with improved volunteer recruitment and retention.

Some common reasons for volunteering are belief in the organization's purpose, the chance to do interesting work, because a friend or acquaintance asked the respondent to join, respect for the people in the organization (Jenner, 1982), to help others, to contribute to the community, out of a sense of obligation (Unger, 1987), and to obtain skills and training (Gillespie and King, 1985). Luks finds that people who volunteer experience the positive

physical benefit of feeling calm and the psychological benefit of enhanced self-worth (Luks, 1988). These levels of calm may decrease morbidity and delay mortality among people who participate in helping behaviour (Ibid). Most research focuses on the individualistic reasons for volunteering. Few studies examine the higher-level needs that can be met by volunteering. Knoke is one of the few researchers who examines these other levels and concludes that volunteers typically exhibit much higher levels of morale, self esteem, political efficacy, and community orientation as well as lower levels of alienation, apathy, and social withdrawal than non-volunteers (Knoke, 1981). These results show that not only do volunteers do valuable work, but that there is much to be gained from the volunteer experience.

3 Volunteer Recruitment

Many researchers study recruitment to determine how best to attract volunteers. Watts and Edwards note that "it is essential in developing recruiting strategies to understand how potential volunteers obtain information concerning opportunities for participation" (Watts and Edwards, 1982:10). Direct contact is arguably the most popular and most effective approach (Watts and Edwards, 1982). This includes the word of mouth approach, organizational membership, or knowing a friend or family member who benefits from a particular service (Ibid.). These direct contact techniques can be facilitated by encouraging volunteers to interact with prospective volunteers, asking volunteers to share their positive volunteer experiences, and inviting prospective volunteers to social or educational events so they can get to know some of the volunteers and to learn more about volunteering. Another effective recruitment method is to advertise for volunteers using newspaper ads, campus recruitment offices or billboards for example.

Once candidates express an interest in volunteering, screening techniques similar to those used in the recruitment process for paid employees may be used to make hiring decisions. For example, some agencies have a volunteer coordinator or committee who interviews candidates in order to consider their personality, commitment, motivation, and

available time and schedule to help in hiring decisions (Holmes et al., 1979). Candidates' skills, education, and work experience can also be explored during an interview to determine if the person is a suitable candidate for the volunteer position. Personality tests may also be used to see if a candidate is suited to a particular role (McLennan, 1985). Sometimes a recruit is accepted into the training program, but realizes that his or her aspirations are not going to be met by the volunteer role. Such people can and do screen themselves out (Holmes et al., 1979).

A thorough training program is also an excellent way to ensure that volunteers learn to perform their duties well. These programs must be tailored to specific volunteer roles and must cover all relevant information. For example, a program may cover time-setting, confidentiality, handling termination and the uses of supervision (Holmes et al., 1979). A variety of teaching techniques can also be used. For example, lectures, question and answer sessions, and role-playing (Ibid.).

Despite all the measures that can be taken to improve volunteer retention, the recruitment methods used by most organizations are rarely elaborate. Selection criteria often include simply the willingness and availability of the volunteer (Allen, 1987). Allen gives three reasons why this situation occurs:

The first involves, once again, the agency's role as the 'grateful recipient.' Turning down an individual's sincere offer to help is extremely difficult-particularly when the agency has made widespread appeals for that help. Second, the demand for volunteers usually exceeds the supply. Agencies requiring volunteers, therefore, resemble employers in a tight labor market-they cannot afford to be as 'choosy' as they might otherwise prefer. Furthermore, because the rewards of the volunteer are presumed to be intrinsic, he or she is perceived-probably quite accurately-as someone with a genuine interest in the clients being served. The agency may feel reluctant to establish a policy which appears to question the value of the efforts which this interest inspires (Allen, 1987:258).

Allen notes that most agencies provide training to volunteers before they assume the full volunteer role, but that this training is seldom adequate. The focus is often on the organizational set-up of the agency rather than learning about the operation and goal of the program and/or having volunteers practice some of skills they will need and duties they will

perform (Allen, 1987). To remedy this situation, Allen suggests that more detailed training sessions be offered as well as continued training to upgrade volunteers' skills (Ibid.). Not only would volunteers better perform their roles, benefiting the clients, other workers and the organization, but would be more strongly integrated into the organization, thereby increasing volunteer retention. Allen advises that the important role of volunteers warrants their involvement in all discussions of changes and improvements regarding the organization (Ibid.).

Maentz echoes many of Allen's sentiments. Maentz writes that there are more volunteer positions to choose from now than there ever were, so that organizations have to compete among each other to attract the best volunteers. Volunteers themselves have less discretionary time, so that puts even more pressure on organizations to offer rewarding volunteer positions. Agencies who are willing to review and tailor their program to best meet volunteers' needs will be at an advantage over other agencies in securing volunteer resources (Maentz, 1987; Netting, 1987). Maentz finds that successful organizations provide a rewarding role for volunteers so that they may learn and grow in their roles (Maentz, 1987). Successful organizations are "flexible in structure and opportunities, and yet they are organized and efficient. They have measurable goals to provide volunteers with a sense of accomplishment, and they provide training and support to allow the volunteers to become a motivator and enabler of others" (Maentz, 1987:79).

4 Volunteer Retention

Volunteer retention is currently a very popular topic in the volunteer literature. However, until recently, little attention had been given to turnover rates and the longevity of volunteers' participation in an organization after entry (Gidron, 1984; Rubin and Thorelli, 1984). It is crucial to recruit volunteers successfully, because successful recruitment hinders volunteer turnover rates. A high turnover rate can have such adverse effects as disrupting the program (McLennan, 1985) and disrupting the planned expenditures for recruiting, training, and orienting replacements (Gidron, 1985). Turnover rates can be high

because leaving a volunteer job does not involve a loss of pay, and positions are readily available, so there is a high potential mobility within the labour pool (Jenner, 1981).

Retention is a tremendously complex issue which warrants a brief overview.

Gidron identifies variables related to volunteer retention in his study and profiles characteristics of stayers and leavers.

A typical 'stayer' was reportedly well prepared for his job; given a task which he considered interesting, challenging, and well-suited to his skills and knowledge; derived sense of accomplishment and achievement from his work; and performed in an environment of meaningful interaction with peers (Gidron, 1984:14-15).

Many researchers find that the reasons given for joining an organization are not the same as those given for maintaining the volunteer role. For example, Jenner found that the appeal of rewarding work was more often cited as a reason for staying than for joining, while people-oriented responses were most often chosen for joining (Jenner, 1982).

An organization must clearly state the purpose of its volunteer program in order to successfully recruit and retain volunteers (Phillips, 1982). By doing this, the organization can clearly show how volunteers are important to the organization and that they have something valuable to contribute by volunteering. Furthermore, stating the purpose sets the limits of the task so that candidates can determine if they have the necessary skills, time, etc. to serve the volunteer role (Ibid.). Interviews and training sessions can be used to gather this information (Ibid.).

In order for any relationship to be sustained over time, the rewards must exceed, or at least balance the costs. This principle is known as social exchange. Phillips adopts this theory as the best explanation as to why people volunteer initially and why they dis/continue volunteering (Phillips, 1982). Jenner cautions against over-simplifying retention. She argues that volunteers are motivated to volunteer for different reasons. Consequently, longevity is predicted and determined by different sets of ambitions, needs and values (Jenner, 1981). Since there are diverse reasons for volunteering initially, no program can meet everyone's goals (Gidron, 1984). The success of a program using volunteers is

dependent upon the program's professional staff clearly understanding and supporting the motivations which lead people to volunteer. It is important to realize that the efforts to recruit volunteers must have a different focus from those efforts designed to keep the volunteers in the program (Phillips, 1982).

Women-dominated agencies tend to be less aggressive in recruiting and retaining volunteers. Interestingly, agencies totally dependent on female volunteers were found to be less likely to offer training than those with a more equal distribution of the sexes or where men outnumber women. Further, female-dominated organizations were less likely to offer training, flexible scheduling, and increased responsibility as inducements to retain volunteers than agencies with both female and male volunteers (Watts and Edwards, 1982). Women-dominated agencies tended to rely on word of mouth advertising for volunteer positions and received minimal exposure from the media (Ibid.).

5 Volunteer Theories

Two theories of volunteer motivation are discussed here. These theories are a theory of work and a theory of leisure. The former is by far the theory used most often in the literature to explain volunteerism. The latter is a newer approach to understanding why people volunteer. These theories have some commonalities despite their contradictory names. One of the fundamental similarities between the two theories is that they both adopt a psychological perspective. The underlying argument of both is that volunteering is an activity which individuals engage in to meet individual needs. When these needs are no longer met, volunteers move onto something else. The focus is on the individual and how she or he fits into the volunteer role in that organization. Little else about volunteers' experiences is taken into account. Both theories reject the idea that people volunteer for purely altruistic reasons. Again, as the names of the theories imply, people are seen to volunteer to fulfill their own needs, whether they are work- or leisure-related needs.

5a Volunteerism as Work

According to the work theory of volunteerism, volunteering meets work-related needs. Volunteer work is seen as identical to paid work other than the lack of monetary reward associated with volunteer work. Volunteering, like paid work, provides work-related satisfaction, consumes energy and time, provides a variety of intrinsic and extrinsic rewards, and has a significant impact on self-concept (Jenner, 1981). Women and men are thought to use volunteer work as a means of career preparation, or to maintain skills and contacts during a break in an employment because their work lives are interrupted, unfulfilled or pre-empted by child bearing and raising (Gidron, 1978; Jenner, 1981).

This theory stipulates that a person will be motivated to volunteer when primary interest, obligations, and needs can be met comfortably while giving service to others (Henderson, 1981). Similarly, Knoke and Prensky write that participants will continue their participation in the organization only so long as the inducements offered to them are as great

or greater (measured in terms of their values and in terms of alternatives open to them) than the contribution they are asked to make (Knoke and Prenskey, 1984). Note that Knoke and Prenskey's definition of the benefits and liabilities of volunteering parallel the explanation of staff turnover in paid employment.

Jenner notes that volunteer activity serves different purposes for different women (Jenner, 1981). Recent theories examining the determinants of volunteerism have focused on the altruistic and egoistic motives (Rubin and Thorelli, 1984). However, some researchers show that no one volunteers entirely for altruistic reasons. In fact, even the most altruistic acts are motivated by the anticipation of psychic rewards derived from knowing that ones acts helped someone else or contributed to the attainment of a valued end (Ibid.).

Jenner writes that

for many women, volunteer work is an element in the life-long progression of jobs that makes up a career. To ignore its place in that progression is to lose a bit of understanding about careers. To ignore the impact of all other jobs on the availability and commitment of the volunteer is to lose sight of a major influence on what is always a luxury-the opportunity and energy to do work which does not contribute to the survival needs of the individual or her dependents (Jenner, 1981:313-14).

As this description of the work theory of volunteerism shows, volunteerism is seen as an adjunct to, or a substitute for, paid work. The motivations to pursue volunteer work and the rewards expected to be derived from this work parallel those associated with paid work. Attainment of individual work needs through volunteerism is positively correlated to volunteer retention.

5b Volunteerism as Leisure

The volunteer theory of leisure stipulates that volunteering meets leisure needs. According to this theory, leisure activities like volunteering meet the higher level psychological needs of self-esteem, belonging, and self actualization (Henderson, 1984-86). Volunteers and leisuers seek common benefits from their experiences, such as being of service to others, using time constructively, feeling needed, receiving enjoyment, learning

something, interacting with others, and being with particular people or meeting people (Ibid.). In a study by Henderson, volunteers likened volunteering to a leisure activity, lending credence to the parallel between volunteering and leisure proposed above (Henderson, 1981). Henderson argues that the volunteer experience is beneficial when the volunteer receives through the volunteer role the same kinds of rewards which would be achieved through leisure activities (Henderson, 1984-86). Volunteering and leisure are both freely chosen. Leisure is generally associated with enjoyment and it is particularly important that the elements of enjoyment are manifested in volunteering in order for the role to be continued (Ibid.).

5c Organizational Behaviour

I want to know who volunteers at the Vancouver Planned Parenthood clinic, and why people volunteer there. In addition, I want to know about volunteers' experiences in recruitment, retention, training, orientation, and experiences inside and outside the clinic to enable us to understand why some volunteers become regular, long-term volunteers, while others do not. Volunteers' behaviour at the clinic is also examined. Observational analysis and interviews are used to conduct the analysis of the volunteer program. Much of the information presented thus far shows that there is much more to volunteering than the individual level of analysis which is employed by the volunteer theories of work and leisure. Without negating the importance of individual factors, it is necessary to acknowledge that there are many issues that go beyond the individual to explain volunteer recruitment, retention and the overall effectiveness of a volunteer program. Example of such factors are cohesiveness, autonomy, leadership, and communication. These important factors can be investigated when this multi-leveled analysis of organizational behaviour is adopted as an investigative approach. This framework can be applied to the organizational behaviour of a small unit of analysis. In this case, this unit is the volunteer program of the Vancouver Planned Parenthood clinic. This volunteer program is examined from five levels of analysis which together comprise organizational behaviour. These levels and components

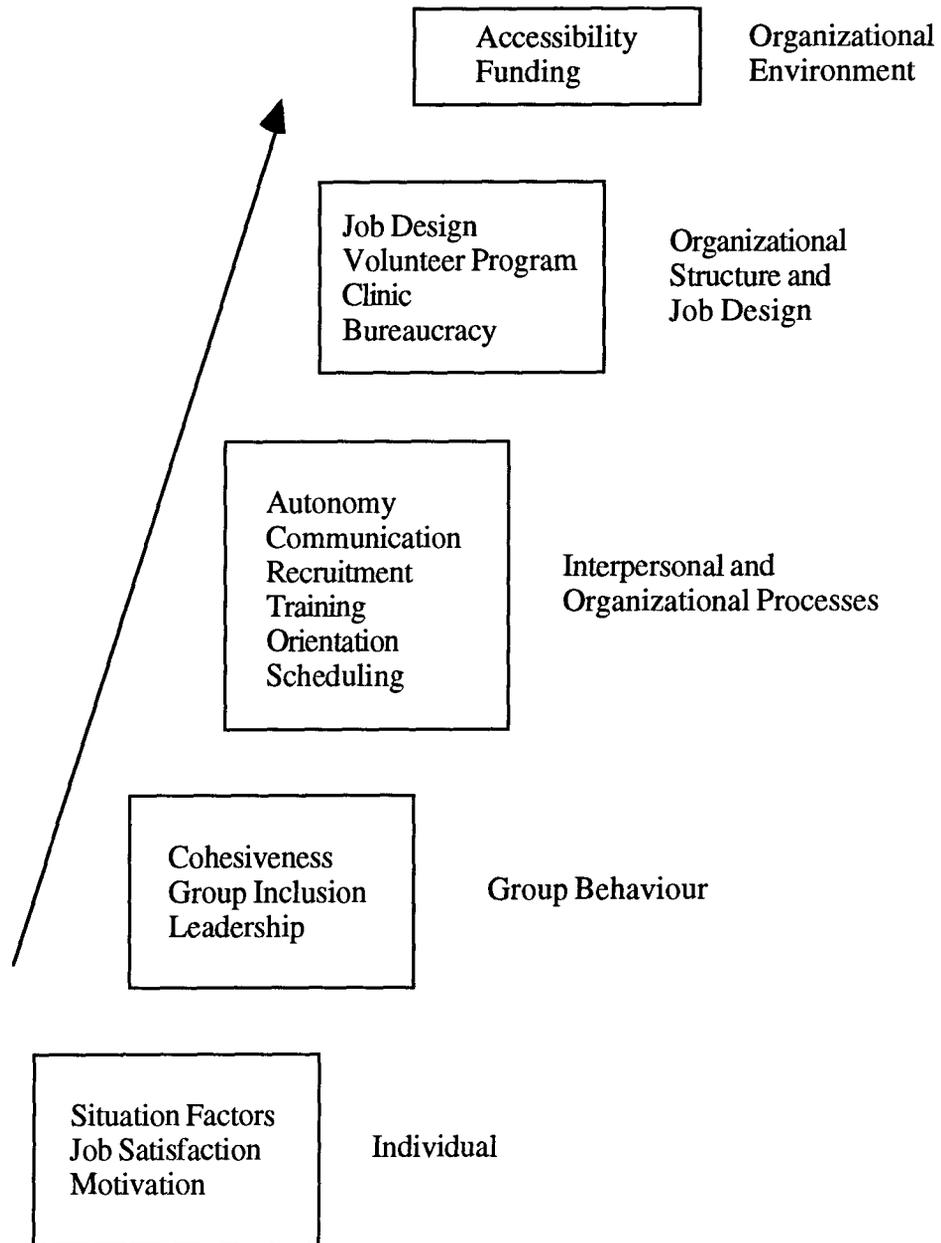
have been adopted from Arnold, Feldman, and Hunt and modified to meet the distinctive requirements of this study. The levels of analysis I employ are:

- 1) **the individual:** this level focuses on psychological factors and individual level processes. The individual level of analysis includes situational factors, job satisfaction, and motivation (Arnold, Feldman, and Hunt, 1992);
- 2) **group behaviour:** this level refers to how people work together in committees, teams or groups. It goes beyond the individual to examine the interactive processes that affect volunteers' experiences. This level examines factors that determine whether a group will be cohesive and productive, as opposed to fragmented and unproductive. Such factors include cohesiveness, group inclusion, and leadership (Ibid.);
- 3) **interpersonal and organizational processes:** this level includes the interpersonal and organizational processes that keep individual groups and the overall organization operating smoothly and efficiently; and the activities and processes organizations use to integrate and solidify the whole, such as autonomy, communication, recruitment, training, orientation, and scheduling (Ibid.);
- 4) **organizational structure and job design:** This level includes the way in which organizations are formally structured and the way in which jobs are designed; an emphasis on understanding how organizational structures and job design influence program effectiveness; and also takes into account the informal arrangements that characterize and influence the relationship among members that can have an impact on its effectiveness. Job design, the volunteer program, the clinic, and bureaucracy are discussed in this section (Ibid.);
- 5) **organizational environment:** this level is comprised of the macro-level environment in which Planned Parenthood operates and analyzes the relationship between the organization and its environment. Accessibility and funding are the two components which comprise this level of analysis. This level goes beyond the four levels of organizational behaviour framework proposed by Arnold, Feldman, and Hunt. I include it because it completes a holistic framework, thus providing a complete analysis of organizational behaviour. When volunteering is examined as an organizational activity, sociologists draw parallels to work or leisure. Examination of volunteering as an activity highlights the need to study the context and process of organizational behaviour.

The following figure illustrates the five levels of analysis that are examined in this case study. The components of these levels are also included to illustrate what kinds of issues will be discussed under each heading. This figure is presented again in the Results and Interpretations chapter at the beginning of each level of analysis. In these sections the

level of analysis that is being discussed is heavily outlined to show where the section falls in this model. This figure is intended to serve as a useful road map of the levels of analysis and the topics that are investigated in this research.

Figure 2
Levels of Analysis



I contend that a researcher must look far beyond individual factors to explain the complex issues of organizational effectiveness and volunteer recruitment and retention. The

analytical framework of organizational behaviour as presented by Arnold, Feldman, and Hunt permits us a much more profound understanding of these issues. A rich and detailed analysis results when the volunteer program is examined from these five distinct, yet interrelated levels of analysis.

Unlike many other studies that focus solely on the individual volunteer to explain retention, Gidron's study adopts a holistic approach in explaining volunteer retention (Gidron, 1984). However, Gidron does not formally acknowledge an organizational behaviour framework in his study. According to Gidron's study, the major predictors of volunteer retention are good preparation for the volunteer role, placement in a job where the volunteers can use their self expression and where they can see the results of their work, and have positive interaction with their peers (Ibid.). Similarly, organizational flexibility and efficiency, sociability and friendship, self-development and increased volunteer responsibility, community impact and personal gain are all strongly related to retention rates (Jenner, 1982; Watts and Edwards, 1982). Jenner concludes that people volunteer to meet needs that are not met by other facets of their lives (Jenner, 1982). These needs go beyond individual characteristics.

A definition of a volunteer, a description of who volunteers and an explanation as to why people volunteer have been among the issues addressed in the foregoing discussion. A theory of work and a theory of leisure have been presented here as two popular explanations of volunteerism in recent literature. I have explained that these theories are inadequate because they fail to recognize that there are many variables beyond the individual level which contribute to the success of a volunteer program. Organizational behaviour has been offered as a more holistic approach to understanding and analyzing these complex issues.

CHAPTER THREE

METHODOLOGY

This chapter describes the methodology used to gather the information presented in subsequent chapters of this research project. In the following discussion I outline the details surrounding the choice, format, implementation and application of each of the methods.

Using an organizational behaviour approach for this study necessitates methods different from those usually used to study volunteer recruitment and retention. Most studies focus on interviews with individual volunteers. Questions relate to what motivates people to volunteer, what they get out of volunteering, as well as other individual level questions. Seldom do these studies look beyond the individual to other aspects of the volunteer experience. For example, questions about interaction with other volunteers, leadership, autonomy, and orientation are frequently neglected. Furthermore, methods other than personal interviews and self-administered questionnaires are seldom employed. There is a wealth of information to be investigated beyond the individual level. Interviews and questionnaires only gather part of this information.

Organizational behaviour directs us to look beyond volunteers' experiences. This involves utilizing other methods of data collection which together with largely individual level data provided by interviews, provide a more holistic understanding of volunteer recruitment and retention. For this reason, I conduct interviews, perform observational analysis, and analyze Planned Parenthood's documents to give a detailed understanding of these issues. These methods are typically used when conducting a case study. A case study is "based on condensed field experience involving observation (rather than the classic participant observer strategy), tape-recorded interviews and the collection of documents" (Burgess, 1984:2). The need for multiple methods is apparent when conducting a case study.

Data Collection Methods: As already noted, three methods of data collection are used in this study. These methods are 1) interviews with former and current Planned Parenthood volunteers as well as informal interviews with paid staff, 2) on-site observational methods, and 3) analysis of Planned Parenthood's documents. These three methods were chosen because they interrelate well to examine the multiple levels of analysis proposed by organizational behaviour. Each of these methods of data analysis yields valuable information which contributes to the understanding of the five levels of organizational behaviour which were described in the previous chapter. This triangulation of methods yields the richest possible data.

Rich data mean, ideally, a wide and diverse range of information collected over a relatively long period of time...the collection is achieved through direct, face-to-face contact with, and prolonged immersion in, some social location or circumstance (Lofland and Lofland, 1984:11).

The advantage of this multidimensional analysis is that it allows a realistic picture of the complex organizational behaviour at the Vancouver Planned Parenthood clinic volunteer program.

1 Individual Level of Analysis

Interviews: The largest component of data collection consists of surveying former and current volunteers using interviews. I interviewed thirty-two volunteers. In general, "interviews permit us to measure the prevalence of attitudes, beliefs, and behaviors" (Weisberg, Krosnick, and Bowen, 1989:20). The reason for conducting interviews is that when "it is possible to ask people questions, we can gain much information about what they are thinking-and why they do things" (Weisberg, Krosnick, and Bowen, 1989:19). Specifically, in this study, interviews provide us with a snapshot of the volunteer program and clinic operations from an individual level of analysis. The target population is the volunteers themselves. The purpose of the interviews is to survey volunteers' experiences at the clinic and to garner their suggestions for improving the volunteer program and the clinic. The volunteers are very knowledgeable and articulate. The value of asking them to share

their experiences, perspectives and ideas cannot be understated. Respondents' answers are compiled and the information is used to generate recommendations to improve the volunteer program and clinic effectiveness.

The Sample: The average age of volunteers in my sample was thirty years old. The majority of respondents worked full-time as professionals at the time of interviewing (18). Four worked part-time or as relief staff, and three worked part-time as they attended school full- or part-time. Seven did not work and most of these were full-time students. All of the respondents were post-secondary school graduates (twenty-three at University level, two at college level) or working on a post-secondary degree graduate or undergraduate degree (five at University level, two at college level). Fifteen respondents were single, fifteen were married, and two were divorced. Only five of the respondents had children, while twenty-seven did not. Ten respondents described their racial/ethnic background as WASP Canadian, nine as Canadian of European descent, five as white/Caucasian, four as Canadian, three as Jewish Canadian, and one as a Canadian of Chinese ancestry. These statistics portray a relatively homogeneous picture of the Vancouver Planned Parenthood clinic volunteers on socio-demographic characteristics.

Access to former and current volunteers was facilitated by the clinic supervisors. The supervisors compiled a list of former and current volunteers who they felt would be good candidates for the research project. A phone number for each volunteer was included on this list so that I could telephone potential respondents. All regular volunteers were included on the volunteer list. I wanted to interview as many current core volunteers as possible because I thought they would have the most to say about the volunteer program and clinic. The candidate list also included former core volunteers, new volunteers who had recently completed the training course, and non-committed volunteers. The data collection yielded the following types and description of volunteers:

- 1) **Current Core Volunteers:** There are twelve volunteers in this category. All volunteer regularly, typically two to four times per month. All have volunteered for one year or more and are currently active. The supervisors rely on these volunteers when they need to fill shifts.

- 2) **Former Core Volunteers:** There are nine volunteers in this category. These volunteers volunteered regularly, typically two to four times per month. All volunteered for at least one year. None of these volunteers are active. They quit volunteering at Planned Parenthood because they felt they received all they could from volunteering or because they had a change in life circumstances which prevented them from continuing the volunteer role e.g. having a baby.
- 3) **New Active Volunteers:** There are five volunteers in this category. These volunteers have been coming very frequently, about once per week, since completing the training course. They have all volunteered for less than one year, and some are still orienting.
- 4) **Non-committed Volunteers:** There are six volunteers in this category. These volunteers tended to volunteer frequently for a short period of time, typically two to six months. They were not satisfied with the volunteer experience and discontinued the volunteer role relatively quickly.

I caution that not all volunteers at the Vancouver clinic fit into these categories. Most notable are those volunteers who took the training course but never volunteered, those who failed to complete orientation, and those who volunteered only one or two times. The supervisors and I agreed that it would not be useful to interview those volunteers who did not give the volunteer experience a fair chance before discontinuing the role. Furthermore, I decided that it would be difficult to contact these potential respondents and get them to agree to an interview. Even if an interview was scheduled, I doubted that volunteers with so little interaction with the organization would have many experiences to share.

Groups three and four in the above descriptions are of most concern to this study because the third group may not commit to volunteering, while the fourth group definitely did not. The supervisors and I wanted to develop strategies to ensure that members of group three continue volunteering by learning from the experiences and comments generated from the other groups, especially group four.

The current core volunteers are also important because these are highly dedicated and experienced, therefore the organization cannot bear to lose them. The former core volunteers are important because most of them volunteered at the clinic before or around the time the current supervisors adopted their posts. Many of them, therefore, had comments about how

the clinic operated when they were volunteers. Many volunteers dropped out soon after the new supervisors began working, partly because they were dissatisfied with the way the clinic and volunteer program were being handled. We have much to learn from these former core volunteers who have a very different perspective from the other groups.

I wanted to interview some volunteers from each of these groups, but anticipated difficulty in contacting potential respondents from the latter three groups and securing their participation in the study. I, therefore, decided I would interview all willing participants. I simply wanted to interview as many volunteers as possible, with a maximum diversity of respondents. For example, I wanted to interview volunteers from all ranges of experience, active and non-active volunteers, and regular and sporadic volunteers. The supervisors kept this in mind when they drew up the list of potential respondents. I called everyone on the list. I was not concerned with obtaining a random sample because the purpose of the interviews was to hear a selection of volunteers' experiences and suggestions.

The supervisors and I informed the active volunteers of my impending study in the months preceding data collection, so all were aware they would be asked to participate. I also put up a recruitment notice in the clinic so that volunteers could learn the details of the study. Participation was completely voluntary, and interviews were anonymous and confidential. These features were noted on recruitment notices and reviewed at the beginning of interviews.

I began recruiting respondents in March of 1993 by personal or telephone contact. I completed the first four interviews, then made minor revisions of the interview schedule. I then completed twenty-eight additional interviews to yield a total of thirty-two interviews. I made contact with most of the regular volunteers at the clinic and interviewed them there before the clinic began, when it was over, or when there was a lull in activity. I did these interviews first because I anticipated that the regular volunteers would be the easiest to contact and would be the most willing to participate in the study. I attended every clinic for three weeks and interviewed nearly all of the regular volunteers on those clinic nights. I also

pitched in to help as a regular volunteer or pregnancy counsellor when it was particularly busy, or when the clinic was short-staffed.

When I determined that my interview schedule was working well and I had more interview experience, I began calling the potential respondents on my volunteer list. I explained who I was, why I was calling, and asked potential respondents to participate in the study. I was expecting a lot of resistance and a number of refusals, and was delighted when nearly everyone happily agreed to participate. In fact, many people even offered to come to my home to be interviewed. I made appointments with others to interview them at their home or work place. Interestingly, I made several appointments with non-active volunteers to meet them at the clinic because they were contemplating resuming their volunteer work. My call was what gave them the incentive to become active again. I scheduled many shifts for regular and non-regular volunteers alike as a result of the recruitment calls I made. All interviews were complete by the third week of April, 1993.

No one I made contact with flatly refused to participate in the study. One volunteer was unable to participate because her spring schedule was incredibly hectic and she could not participate in the spring or summer. This respondent offered to arrange an interview in the fall. Another respondent cancelled her interview when she realized how far behind she was in studying for her final exams. I planned to complete my data collection by the time these two respondents would be available, and because I already had sufficient respondents, I did not set up other appointments with them. A few volunteers did not return my calls, a few had moved, a few phone numbers were no longer active, and a few consented to participate, but I was unable to contact them again to set up an appointment. I was highly satisfied at completing thirty-two interviews, an extremely high success rate considering there were only forty-three potential respondents on my list. I was particularly happy to interview seventeen non-active volunteers since I had anticipated that they would not only be difficult to contact, but would hesitate to participate in a study associated with an organization with which they are no longer involved.

Respondents were asked to read and sign a letter of consent regarding their participation in the study. Each respondent and I received a copy of this letter for our records. The interviews were between twenty and sixty minutes long, with an average length of thirty minutes. I debated about whether or not to tape record interviews because doing so gives an air of formality and tension to the interview that I would have preferred to avoid. However, after reviewing the literature, I decided that the advantages of tape-recording outweighed the disadvantages. Therefore, all interviews were tape-recorded with the respondent's permission. According to Lofland and Lofland,

it is imperative that you tape record the interview itself. Since there is no strict order of questioning and since probing is an important part of the process, you must be very alert to what the interviewee is saying. If you have to write everything down at the same time you are unlikely to be able adequately to attend to the interviewee. Your full attention must be focused upon the informant. You must be thinking about probing for further explication or clarification of what is now being said; formulating probes that link current talk with what has already been said; thinking ahead to asking a new question that has now arisen and was not accounted for in the guide (plus making a note so you won't forget the question); and attending to the interviewee in a manner that communicates to her or him that you are indeed listening (Lofland and Lofland, 1984:60-61).

As it turned out, few respondents mentioned the tape recorder and all seemed oblivious to it once the interview started. Perhaps tape recording did not present any problems because I explained specifically why I preferred to record the interviews, then placed the tape recorder in an inconspicuous place out of the respondent's vision. I took some notes during lulls in the interview and filled out a summary describing how each interview went immediately following the interview. I listened to each of the tapes as soon as possible following the interview and recorded any additional information that came up, clarified information, and recorded any interesting quotes verbatim.

The Interview Schedule: The interview schedule contains twenty-eight items. Some questions have sub-items, and not all questions are relevant to all respondents. The interview schedule was constructed to measure situational factors (such as volunteer longevity and status), job satisfaction (such as volunteer frequency and preferred duties), and motivation for volunteering initially. There are two sections in the questionnaire: qualitative

and quantitative. The first contains questions designed to elicit the respondents' perspectives and ideas regarding their volunteer experiences and clinic operations. These questions are open-ended because "open-ended questions are usually the most interesting (and possibly the most valuable) questions in a survey. Respondents say whatever they wish in response to these questions, and interviewers record their answers verbatim. These questions allow respondents to express themselves; if respondents give inconsistent, bigoted, witty, dumb, sophisticated, or knowledgeable answers, all that is preserved on the questionnaire" (Weisberg, Krosnick, and Bowen, 1989:105). The second section is designed to gather socio-demographic and behavioural information about the respondents. Some of these questions are open-ended because I could not anticipate responses. This allowed me to develop answer categories once the interviews were complete. The other questions in this section are close-ended when the categories are mutually exclusive and exhaustive, for example, the question on marital status.

Most interview topics relate primarily to the individual level of analysis, yet the answers generated from the questions also strongly relate to group behaviour; interpersonal and organizational processes; organizational structure and job design; and organizational environment. Respondents' insights and experiences contributed to our understanding of volunteer recruitment and retention. Respondents used their own observations and experiences as participants to address these other sociological levels of the organizational behaviour of the volunteer program.

I asked respondents if there was anything not covered by the interview schedule. No one had anything to add. I also asked the first dozen respondents for their input regarding the questionnaire and was told that the questions were clear, and the schedule was in a logical order and covered everything it should. Nonetheless, I changed a couple of things for the subsequent interview schedules. Namely, I decided to ask about pregnancy counselling training and orientation individually rather than amalgamating it with the regular volunteer course and training. I also decided to ask non-active volunteers why they

continued to volunteer at Planned Parenthood as long as they did as well as why they stopped volunteering. I found that the interview schedule worked well to initiate discussion and gather detailed information. As anticipated, respondents were very willing to talk and all contributed to the study with their respective experiences, and invaluable comments and ideas.

I also informally interviewed both supervisors to obtain their impressions of the clinic operations and the volunteer program. Discussions with the supervisors have taken place over the past year and have yielded all sorts of interesting ideas. The supervisors are fully aware that the Vancouver clinic is not operating at optimum efficiency and have been working on strategies to improve the situation since they adopted their posts two and a half years ago. Both supervisors were instrumental in getting this study off the ground. In fact, it was through a discussion about the volunteer program with one of the supervisors that I came up with the idea to do a case study of the Vancouver clinic for my thesis.

2 Group Behaviour, Interpersonal and Organizational Processes and Organizational Structure and Job Design

Group behaviour, interpersonal and organizational processes, and organizational structure and job design are all explored through observational techniques, in addition to interviews. My participation in the organization as a volunteer has accorded me tremendous insight into the volunteer program and clinic.

Observational Analysis: I have been a regular volunteer at the Vancouver clinic for almost three years and have been a Planned Parenthood client for seven years. I have witnessed the negative and positive aspects of the clinic workings and the volunteer program first hand. I began observing goings-on at the clinic long before I thought of studying the organization formally. Throughout the years I have experienced a wide range of situations and developed many ideas and recommendations. Numerous discussions with my co-workers have also yielded a wealth of information, as have discussions with clients. All of

these aspects of participation are employed in order to examine the organizational behaviour of the clinic from the group behaviour, interpersonal and organizational processes, and organizational structure and job design levels of analysis.

As an insider researcher, I had the advantage of already knowing my subjects.

Known investigators-whether doing intensive interviewing or participant observation-enjoy the tremendous advantage of being able to move around, observe, and/or question in a relatively unrestricted way...Only common standards of decorum, tact, courtesy, and circumspection-that is, only the necessity of getting along with the participants-need interfere with their 'snooping' and 'prying.' And note taking is generally not problematic (Lofland and Lofland, 1984:49-50).

I did my research openly, made my intentions known, gained cooperation from the setting participants, and depended on the characters of the setting. I also sought formal permission from the subjects, the supervisors, and the organization. According to Lofland and Lofland,

it seems quite typical for outside researchers to gain access to settings or persons through contacts they have already established...In short, wherever possible, you should try to use preexisting relations of trust to remove barriers to entrance (Lofland and Lofland, 1984:25).

I am certain that an outsider could not have conducted as successful a study as someone with my insider status. I had the full support of the clinic staff and volunteers as well as the Head office staff. I am one of the most experienced and regular volunteers and as such possessed helpful insider knowledge. In addition, I already had the respect of the people with whom I was working.

3 Organizational Environment

Document Analysis: The last and smallest component of data collection is document analysis. An analysis of Planned Parenthood's literature is performed in order to review documents including the distribution pamphlet, annual reports, conference publications, clinic newsletters, and historical publications. These analyses provide the information necessary to complete the understanding of the organizational behaviour of the Vancouver clinic. This data collection technique is used in part to study organizational

behaviour from the organizational environment level. The results of this data collection method are presented primarily in the introductory chapter of this project.

The materials I examined were all published by the Planned Parenthood Federation of Canada, the Planned Parenthood Association of British Columbia, or the Vancouver clinic. Specifically, these documents were composed of the Planned Parenthood distribution pamphlet; the 1992 and 1993 Planned Parenthood Association of British Columbia annual reports; Community Responses, Needs and Priorities; a Vancouver branch newsletter; and the 20th Anniversary Pioneer Address book. These documents span from 1973 to 1993. I seek detailed information regarding the Vancouver clinic and the provincial and federal organizations from these materials. Program mandate, services and programs offered by the organization, staffing, the history of the organization, funding, and clientele are among the issues explored through document analysis. This form of analysis takes us beyond the clinic level and permits us to understand how the clinic is affected by its relationship to the Planned Parenthood Association of British Columbia. This information is integral to understanding of the Vancouver clinic and the volunteer program.

The triangulation of interviews, observational analysis, and document analysis allows us to examine all five levels of the organization proposed by the organizational behaviour framework. The results of this complex analysis will not only yield practical recommendations for Planned Parenthood, but will have theoretical implications as well. Recommendations which Planned Parenthood can use to develop a more effective volunteer program, especially in regards to volunteer recruitment and retention, comprise the practical component of this project. Contributions to the volunteer literature and to sociology comprise the theoretical component of this project. The multi-levelled analysis demonstrates that the individual level of analysis is only one of the many levels of analysis which affects the success of a volunteer program. This approach also shows that the volunteer theories of leisure and work both contribute to our understanding of volunteer recruitment and retention. The next chapter discusses the results and interpretations of this multi-level analysis.

CHAPTER FOUR

RESULTS AND INTERPRETATIONS

The purpose of this chapter is to present the results and interpretations of this study. The results are reported sequentially from a micro to a macro level of analysis. Hence, results are discussed in order of individual level, group behaviour, interpersonal and organizational processes, organizational structure and job design, and organizational environment. The data have been organized into subheaded categories that are discussed under the appropriate level of analysis.

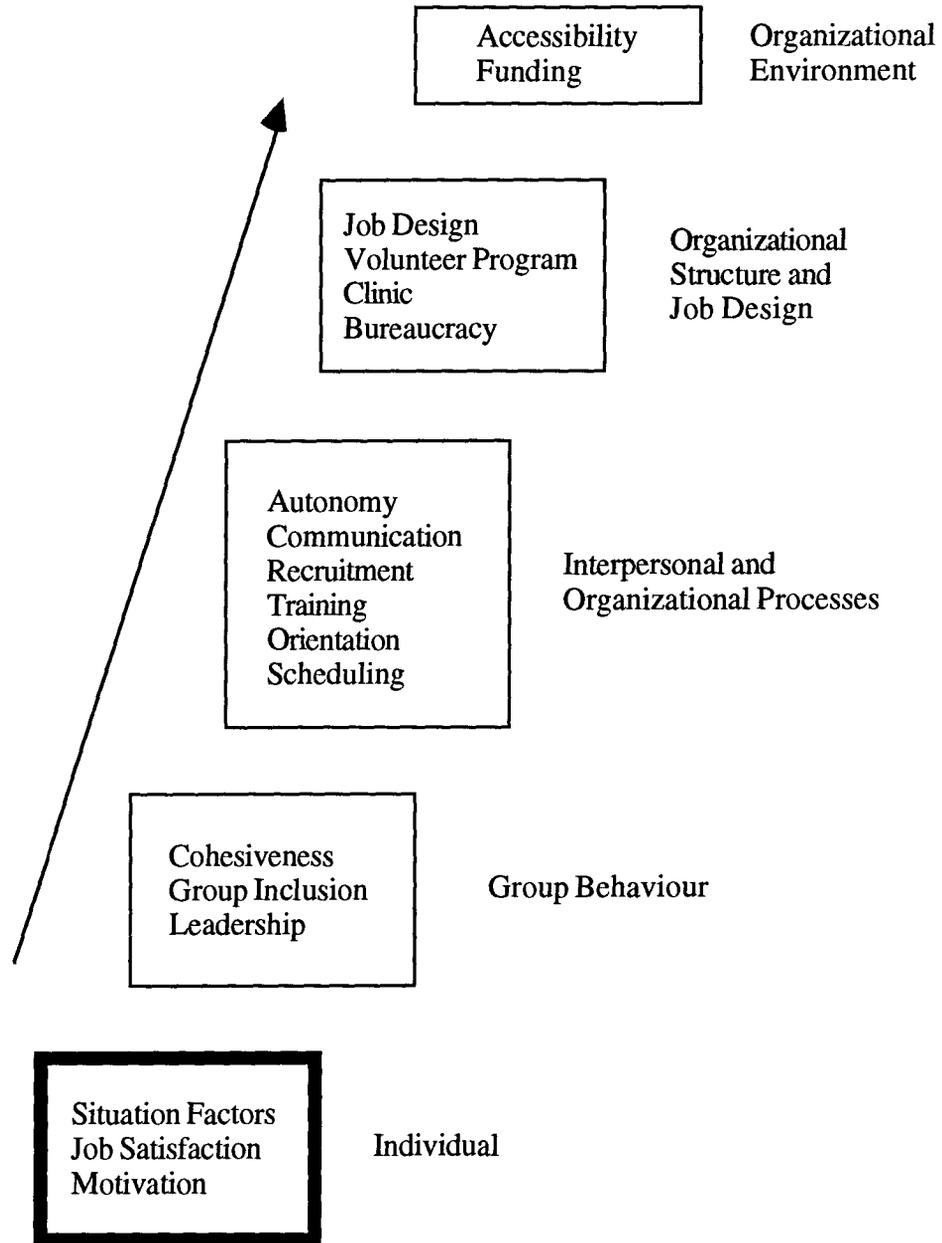
Most of the volunteers had multiple comments. For this reason, the number of responses exceeds the number of respondents for many questions.

1 Individual Level of Analysis

I have identified situational factors, job satisfaction, and motivation as the three central components of the individual level of analysis. The following discussion examines each of these elements by integrating and presenting the interview data.

Figure 3

Levels of Analysis: Outline Depicts Individual Level of Analysis



1a Situational Factors

Situational factors refer to a combination of circumstances which influence volunteerism. The situational factors which emerged from the interview data are volunteer status, longevity, prior interaction with Planned Parenthood, explanations for ceasing to

volunteer, and prior volunteer involvement. All of these factors interact to define and determine volunteerism.

Volunteer Status: Seventeen of the thirty-two volunteers were active Planned Parenthood volunteers, while the remaining fifteen were not. All volunteers were easily able to claim membership to one of these groups. Volunteer status results from a cumulation of volunteers' experiences within the organization. I include it as a situational factor because status is not necessarily a result of job satisfaction, so it seems to fit best under this category.

Volunteer Longevity: Average volunteer longevity at the Vancouver Planned Parenthood clinic is twenty-two months. The average longevity for active versus non-active volunteers is seventeen months and twenty-seven months respectively. Average longevity is higher for non-active volunteers because they have completed their volunteer role, whereas active volunteers are continuing theirs. In addition, many of the non-active volunteers volunteered when supervisors demanded long-term volunteering. Some of the active volunteers took the volunteer training course offered immediately prior to the data collection. Consequently, these volunteers had very little experience since they had volunteered for only a short period of time. It is difficult to anticipate how long they will retain their active status. The volunteer program would be highly successful if volunteer longevity approached this average. However, this average is skewed because it excludes the many volunteers who dropped out even before I could interview them. Hence, the experiences of these volunteers were precluded from the sample.

Prior Contact: Fourteen of the respondents had interaction with Planned Parenthood before volunteering, while eighteen did not. The reason I asked this question is because I suspected that some respondents had been clients before becoming volunteers. As anticipated, ten volunteers were former Planned Parenthood clients. Four other respondents had prior interaction with Planned Parenthood in various ways. One worked with the clinic director, one interacted with a friend who raved about Planned Parenthood, one had a friend

who supervised another clinic, and another received sex education from Planned Parenthood in another country.

Reasons for Quitting: The following discussion is central to an analysis of volunteer retention because it focuses on non-active volunteers and their explanations for discontinuing their volunteer status. There were two types of reasons why non-active volunteers ceased to volunteer at Planned Parenthood. These reasons are crucial to our understanding of volunteer retention. The first explanations involve volunteer-related factors. The second and most predominate reasons reflect clinic-related factors. There were two volunteer-related reasons offered by volunteers. These factors consist of becoming too busy with other things in their lives to continue volunteering (9), and school or employment conflicted with volunteering (4).

The remaining answers are more diverse, but they all reflect clinic factors that dissuaded volunteers from volunteering. There are seventeen explanations in this category. For example, one volunteer didn't feel useful, one had problems getting shifts at the clinic, and another found the environment at the clinic non-stimulating. One volunteer succinctly describes her reasons for quitting this way:

A lot of stuff I did at Planned Parenthood was menial, repetitive, and routine. I felt no rapport with the patients or doctors. Planned Parenthood was too much like my work, but I didn't get paid for it. I felt like if I didn't show up it wouldn't make any difference. I wanted one-on-one interaction and to feel like I was having a positive effect on patients. I felt like I was having a negative effect on nursing patients because doctors were interacting with patients and I felt invisible. I felt like most patients didn't want volunteers around (#32).

This articulate volunteer was clearly dissatisfied with the volunteer experience. All of the reasons she gave are clinic-related factors. Like other respondents who offered this type of answer, the respondent would have continued to volunteer if the volunteer experience had been more fulfilling.

Volunteer-related reasons for quitting cannot be accepted at face value. Although respondents were very open about their experiences, some likely offered socially accepted

responses rather than attributing quitting to unsatisfactory clinic factors. Some volunteers were likely not even aware that clinic-related factors may have contributed to their decision to quit. Also, many volunteers may have continued to volunteer if the clinic-related factors were more favourable. Because these volunteers were not deriving maximum satisfaction from their volunteer experience, volunteer-related factors became more important and were perceived by volunteers as good reasons to quit.

Other Volunteer Experiences: Prior volunteer involvement was also assessed through interviews. These experiences help shape volunteers' perceptions of the Planned Parenthood volunteer program by allowing them to compare their multiple volunteer experiences. Nineteen respondents said they had done volunteer work regularly and on a long-term basis in the past. Five had some volunteer experience, but only for a short term or irregularly. Only eight respondents had no volunteer experience prior to volunteering at Planned Parenthood. This means that Planned Parenthood's volunteers are an experienced group. Prior experience may help account for volunteers' critical comments and multiple suggestions. Volunteers who had current or past volunteer experiences tended to analyze their experiences at the Vancouver clinic much more critically than those who did not. In addition, they offered much more constructive criticisms.

1b Job Satisfaction

Job satisfaction is the next element of individual level of analysis to be discussed. The components of job satisfaction are volunteer frequency, performed duties, preferred duties, reasons for enjoying duties, reasons for continuing to volunteer, obstacles to increasing volunteer frequency, and barriers to volunteering in general. All of these variables interact to become antecedents or determinants of job satisfaction. It is crucial to understand job satisfaction because of its close link to volunteer retention.

Volunteer Frequency: Almost all of the volunteers volunteered at least once per month. Most active and non-active volunteers volunteered between two and four times per

month. Satisfied volunteers tend to volunteer more often and more regularly than dissatisfied ones. Most volunteers tended to volunteer frequently initially, but dissatisfied ones gradually came less frequently until they dropped out altogether. Many volunteers were dissatisfied with volunteering from the beginning, but continued to volunteer for a while hoping that the situation would improve. Some volunteers purposely came sporadically or failed to honour their volunteer commitments to test the waters for quitting. When the supervisors failed to react, they ceased volunteering altogether.

Performed and Preferred Duties: Some volunteers stated that they usually performed one duty at the clinic, but most stated a couple of duties.

Table 1 illustrates the duties performed most frequently compared to volunteers' preferred duties.

Figure 4

Duties Performed Most Often Compared to Preferred Duties

<u>Duties</u>	<u>Most often</u>	<u>Preferred</u>
Nursing	21	12
Methods Talk	13	15
Interviewing	12	15
Pregnancy Counselling	9	10
Other: e.g. filing, set up, clean up, urine tests	7	0
Does whatever needs to be done	1	0
Still orienting	5	N/A
Nurse practitioner	2	2
Reception	1	1

Some trends are that few volunteers who chose pregnancy counselling did other duties, only one volunteer claimed she did all duties equally, and a few others did all duties except for pregnancy counselling. Nursing is by far the duty performed most often, followed by methods talk and interviewing. Fifteen volunteers chose interviewing and fifteen chose the methods talk as their preferred activity. Twelve chose nursing, and ten chose pregnancy counselling. The visual representation shows that for most categories, the numbers in the two columns match, with the exception of nursing and other. In both of these categories, far more respondents say they do these duties most often than say they

prefer these duties. This discrepancy is alarming because the comments made by the respondents show that they frequently end up doing duties other than the ones they enjoy the most. In the words of one non-committed volunteer,

I got stuck with nursing every time, but didn't particularly like it. I never observed or participated in a methods talk or interview and didn't know how to go about doing so (#32).

Regardless of what duty was most preferred, similar reasons emerged for liking the duty. In descending order, one on one interaction, learning and educating, making a contribution to the client's life, supporting the client, and obtaining additional clinic or volunteer experience were the most frequently cited reasons for enjoying the volunteer duties.

Continued Volunteering: Active and non-active volunteers were asked why they continued to volunteer. The two types of responses that emerged from this question can be classified as altruistic and instrumental. Altruism refers to selfless devotion to the welfare of others. Instrumental rewards satisfy the volunteers' personal needs. These two components are inextricably related, therefore the categorization of these comments is somewhat arbitrary. Even the most relatively altruistic act satisfies the actor's needs, for example, by making her feel good about herself. Fifty-three of the comments can be interpreted as altruistic motives. These include making a difference to clients' lives (17), belief in the program's mandate (11), commitment to volunteerism (7), and commitment to women's health care (6). Sixty-three comments can be classified as instrumental rewards. Examples of instrumental rewards include enjoying interaction with volunteers and staff (12), enjoying interaction with the clients (11), liking the educational component (11), and enjoying volunteering in general (11). All volunteers cited both types of rewards. This demonstrates that satisfied volunteers derive a combination of altruistic and instrumental rewards from volunteering.

Increasing Frequency: Volunteers explain what would make them volunteer more often in the following discussion. The obstacles mentioned most frequently by volunteers

are volunteer-related. Twenty-two volunteers said that they come as frequently as possible given their other obligations. The remaining thirteen obstacles are clinic-related. Four volunteers said they would come more often if the clinic was open earlier in the day or on different nights. Four respondents said they would come more often if they could be sure that they would be needed. Two said they would come more often if they had been more strongly encouraged by the supervisors to do so. One would come more often if she could be guaranteed regular hours at the clinic. One volunteer said she would come more often if she felt closer to the organization and another said if there were other opportunities, such as sitting on the board.

If the volunteer experience provided more fulfillment and growth, perhaps the volunteer-related reasons for increasing frequency would be less important. Satisfied volunteers would be more likely to find the time to volunteer regularly and frequently despite their other obligations.

Barriers to Volunteering: All volunteers were asked to share the general barriers to volunteering they have experienced. The answers fall into the same two categories as the previous question: volunteer- and clinic-related. Thirty-three of the comments can be interpreted as volunteer-related. The principle answers are other priorities/time constraints (22), geographical inaccessibility of clinic (3), and lethargy (3). Clinic-related barriers include frustration with the inappropriate number of volunteers compared to the number of clients (7), disorganized approach of clinic (5), inaccessibility of training course (3), and not being able to perform preferred duties (3). The same cautionary note presented in the preceding paragraph applies here. Volunteers would simply find the time to volunteer regardless of obstacles if the volunteer experience was sufficiently rewarding.

1c Motivation

Volunteers decided to volunteer initially for diverse reasons. These reasons fall into two camps: altruistic and instrumental, the same categories used in the explanations for

continuing to volunteer. Forty-six motives can be classified as altruistic and twenty-two as instrumental. The two major altruistic motives are belief in the mandate of the program (21), belief in the worthiness of volunteering (11), and interest in women's health and reproduction. Among the instrumental motives are desire to enter the medical profession (9), and desire to obtain additional career experience (6). Most volunteers had multiple motives for volunteering, and some of these were altruistic and some instrumental. The combination of factors given by each volunteer demonstrates the complexity of volunteer motivations.

The information presented in the previous discussion contributes to our understanding of the micro level of analysis. Situational factors, job satisfaction and motivation are the three components which interact to comprise this individual level of understanding. Examination of the individual level of analysis is a crucial part of understanding volunteer recruitment and retention. Volunteers' reports show that they have a combination of altruistic and instrumental motives for volunteering. Both types of needs must be met in order for the volunteer relationship to continue. Retention occurs when a volunteer's expectations are met by volunteering at the Vancouver clinic, when the situational factors are favourable, and when the volunteer is satisfied with the personal and clinic-related factors. The interrelationship between these three factors means that if the volunteer is dissatisfied with one aspect of volunteering, she will likely quit. These individual factors must be met for volunteer retention to occur, but these factors are not sufficient to ensure retention. Favourable group dynamics and higher level processes are also essential to volunteer retention.

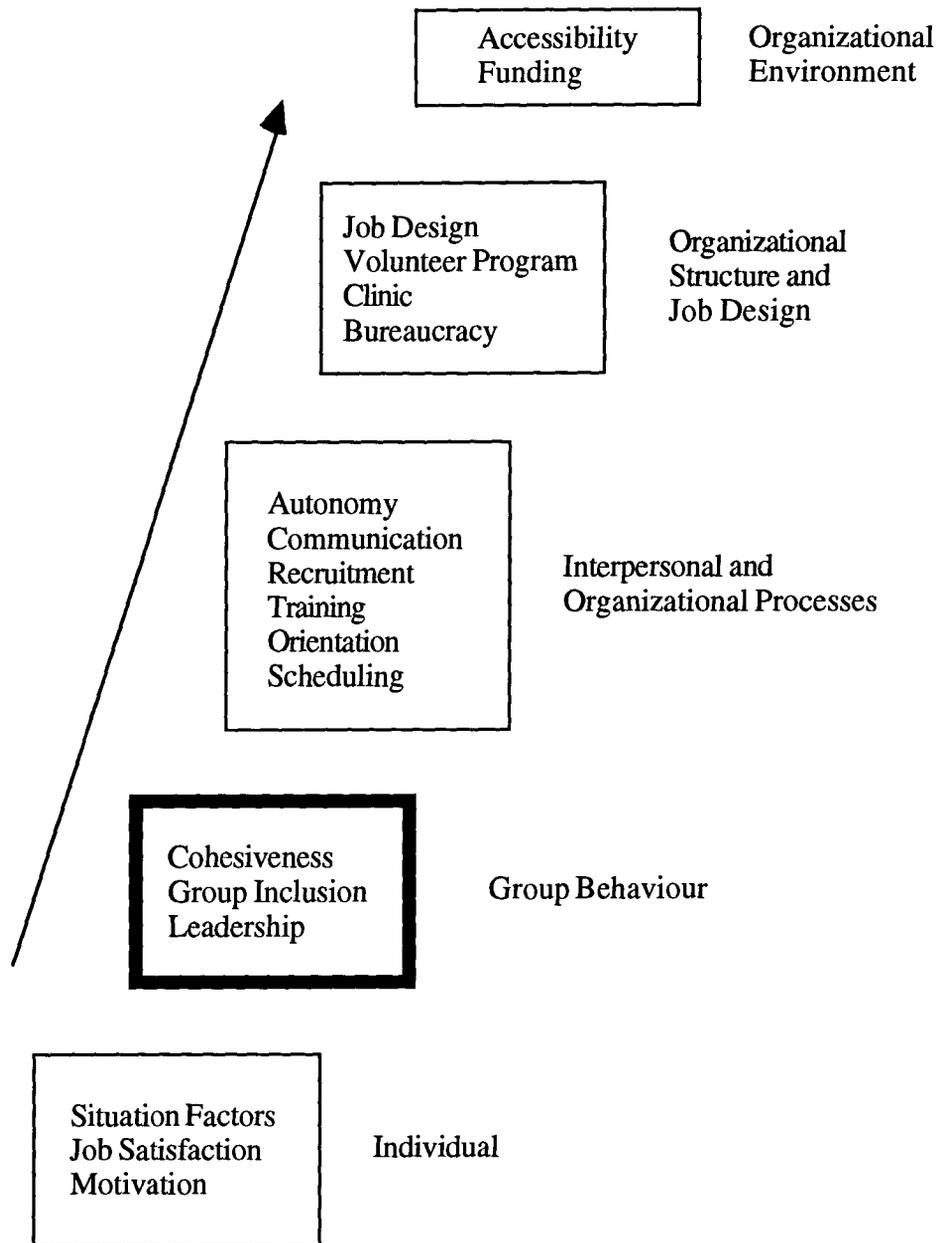
2 Group Behaviour Level Of Analysis

Group behaviour is the next level of analysis to be explored. Group behaviour goes beyond the individual to examine the interactive processes which affect volunteers' experiences. Group behaviour focuses on the informal arrangements that characterize and influence the relationship among group members that can have an impact on the group's

effectiveness and volunteer retention. Cohesiveness, group inclusion and leadership are the three dimensions of group behaviour to be discussed. These components affect the ways volunteers perceive and interpret their experiences. These factors in turn affect volunteer retention and are therefore a crucial aspect of this research project.

Figure 5

Levels of Analysis: Outline Depicts Group Behaviour Level of Analysis



2a Cohesiveness

Cohesiveness refers to the feeling that you belong to a group (Arnold, Feldman, and Hunt, 1992). The opposite of cohesion is alienation. The cohesiveness of a group affects both productivity and job satisfaction. Cohesiveness is extremely important for this reason. Structural factors and extra-curricular events are the two facets of cohesion to be explored

here. A scenario of volunteer cohesion is described in order to illustrate how cohesiveness is integral to satisfied volunteers, an essential criterion of volunteer retention.

Structural Factors: There are many structural factors at the Vancouver clinic which dissuade cohesion between volunteers. Some of these structural factors are addressed in the ensuing discussion. I readily observed that cohesiveness was a central issue to many of the volunteers. I met over a dozen people as a result of doing this research project. Some of these volunteers were new. Others had been there for as long as me, but I had never met them before because we always worked different shifts. Still others I had seen around, but so rarely that I had yet to learn their names. I know that I am not the only one in this position since many volunteers asked me to identify other volunteers because they knew that I had met them through interviewing. Many of the volunteers do not know each other, even after having volunteered for a long time. Newer volunteers know even fewer co-workers. There is a fairly large pool of volunteers and only a few volunteers work each clinic night. In addition, most volunteers tend to volunteer on the same evening each time they work. These factors interact to decrease the likelihood of volunteers crossing each other's paths regularly, if at all.

It is extremely difficult to feel you are a team member when you do not even know who is on your team. Volunteers become very frustrated when they do not know their co-workers and when their co-workers do not know them. I have regularly observed confusion at the clinic over whether a person is a volunteer, physician, or a client. None of the volunteers wants to embarrass herself by admitting her ignorance, so the volunteers mill about hoping that the unknown party will identify herself. One of the primary reasons for volunteering is to meet people. Clearly this goal is not being met by the current volunteer program.

Another complicating factor is that most duties, including nursing, interviewing, pregnancy counselling and the methods talk, require a volunteer to be secluded in a room, sometimes for the entire evening. This means that there is little interaction among the

volunteers, especially on busier nights. It is understandably difficult to feel you are a part of a group when you know few of your co-workers because you rarely see them. Further complication arises when there is a high volunteer turnover rate resulting in a constant change of faces.

Seclusion is frustrating for volunteers, especially those who are motivated to volunteer primarily for interactive reasons. Even when volunteers purposely schedule their shifts with a favourite co-worker, the two frequently end up working apart and scarcely see each other. Nursing often requires a volunteer to assist the physician continually throughout the evening, which confines the volunteer to the examination room. Seclusion largely explains why nursing is the least liked volunteer activity.

All duties are concentrated at a specific time point within the evening. Many volunteers sign up for a particular duty and want to do only that duty. Some of these volunteers expect to leave once they have accomplished their duties. This means that they can arrive early, begin the methods talk before other volunteers arrive, and complete the methods talk and clean up, then leave while the other volunteers are performing separate duties, such as nursing. This means it is possible to volunteer with minimal interaction with co-workers. Many of the volunteers do not see their contributions as part of a group effort. It is easy to feel alienated from other volunteers, the clinic, and the organization when volunteers do not feel that they are part of a group.

There is frequently tension between the small group of volunteers who see volunteering is part of a group effort and those who do not. I regularly observed a volunteer leaving after performing her assigned duties, leaving her co-workers to complete the other duties, such as filing and clean up. The fewer workers there are, the longer it takes to close the clinic. Therefore, a volunteer who does not pull her weight affects the cohesiveness of the other volunteers and negatively affects clinic operations. When one volunteer leaves, other volunteers often feel that they too can leave. This further minimizes any volunteer cohesion which could occur after servicing the clients. New volunteers quickly adopt the

pattern established by the more experienced volunteers and so they too fail to establish cohesiveness with their co-workers under these conditions. Volunteer turnover is much more likely to occur under these circumstances than in a cohesive environment. In addition, the clinic fails to function as smoothly as it could when volunteer involvement is fragmented.

Extra-curricular Events: There is also a lack of social events. This further dissuades group cohesion. The first Vancouver clinic in-service in recent times took place in April, 1993. There was a pot-luck in the summer of 1992, and a restaurant Christmas party for the past two years. There was substantial volunteer interest in all of these events, particularly by the current core and newer volunteers. Unfortunately, volunteers who work less regularly are frequently unaware that these events are taking place, and so they miss out. Some new volunteers are hesitant to attend social events when they know few people there.

When I interviewed respondents I told them that there was an in-service coming up in April, and was surprised that few people knew about it. Furthermore, some volunteers were interested in attending, but notice was so short that they had already made plans. Many volunteers were upset that no one had notified them about the in-service, and my telling them about it seemed to increase their feelings of alienation. The failure to tell every volunteer of this in-service is particularly tragic because nearly all volunteers suggested continued training as the best way to improve the volunteer program. Many volunteers who were just taking a little time out from volunteering because they recently had a baby, or because they were taking a night course on clinic nights, still considered themselves active volunteers. They were very hurt that no one notified them about the in-service. These feelings of exclusion are difficult to overcome. A couple of volunteers who were contemplating quitting probably did so when their volunteer involvement with the organization was treated with little regard over this issue.

The Christmas parties are notorious for being organized at the last moment. The events are typically scheduled for just before Christmas. The result is that most of the

volunteers have already made plans, such as leaving town to visit family and friends for Christmas, attending office parties, or writing final exams. The attendance is, therefore, poor and the supervisors question the interest in the event. The problem, however, is not lack of interest, but poor organization.

Most volunteers expressed a desire to be more strongly integrated into the organization. Better organization and greater consideration of volunteers is necessary to make this occur. An extremely successful pot-luck dinner was held at one of the supervisor's homes in the summer of 1992. Attendance was excellent. The reason why the event worked so well was because it was scheduled far in advance at an appropriate time of year, all volunteers were strongly encouraged to attend by other volunteers and the supervisors, and cost was minimal. The supervisors were amazed at the volunteer turn out, but the volunteers all knew why the event was successful. The pot luck dinner is an excellent example of what can be achieved by careful planning and consideration to volunteers. An event of this calibre takes a lot of work, but the demonstrated benefits are worth the effort. Much bonding took place at the dinner which carried over into the clinic environment.

An Example of Cohesiveness: The scenarios I have just described are not indicative of all volunteers. A cohesive scenario is described in the following discussion. The regular, more experienced volunteers tend to sign up on the same night with the same people every week. Because they enjoy working together, they seek to work successfully as a team. Most of these volunteers discussed their duties and personal lives when things were slow at the clinic and all had a good idea of what was occurring in all parts of the clinic that session. These volunteers showed concern for their co-workers by making sure everyone could get home safely, and performing a co-worker's duties if she had to leave early. These volunteers would normally stay to the clinic's end to clean things up so everyone could go home sooner.

The structural and social alienation scenarios versus the cohesive scenario represent two ends of the continuum, the least cohesive and the most cohesive groups. Cohesion is a central factor of group behaviour. Cohesion helps explain why volunteers tend to volunteer regularly over a long period of time, or drop out very quickly when they feel they are not a valuable member of the group.

2b Group Inclusion

Inclusion is another component of group behaviour. Group inclusion is closely related to cohesiveness, yet merits specific attention because of its special characteristics. There are multiple groups within the culture of the clinic. Among these is an elite group comprised of the most experienced volunteers. The characteristics of this group are discussed here. One of the issues brought up by many volunteers was the fact that the clinic seemed very cliquish. By this I mean that volunteers, particularly newer ones, felt that the more experienced volunteers and the supervisors were close friends. They perceived that they were not welcome to enter this impenetrable group. The result was that volunteers often felt like outsiders and could not overcome this feeling of exclusion. This atmosphere often predisposed volunteers to drop out. Some volunteers volunteered for many months, hoping that they would eventually be welcomed into the group, but this never happened.

It seems that some volunteers are accepted into the group either because they are around for a long time or, more likely, because they meet the informal criterion of medical association. The clinic supervisors are Registered Nurses and many of the most dedicated volunteers have a medical interest or background, or are married to physicians. These characteristics foster inclusion to this group. Some long-term volunteers experience little interaction with their co-workers and are satisfied with this situation. Most of the volunteers, however, want more out of the volunteer experience than just performing their duties. Most want to feel included as a group member and feel a connection with their co-workers, and they volunteer in part to meet these interactive needs.

2c Leadership

The leaders referred to in this section are the supervisors of the Vancouver Planned Parenthood clinic. The supervisors are the clinic leaders and among their responsibilities are the physicians, desk staff, volunteers, clients, and all clinic operations. The supervisors are hired specifically for this position of leadership. Both supervisors are Registered Nurses and have a solid background in reproductive and contraceptive issues. Furthermore, they strongly believe in the program's mandate and are very interested in this area of health care. The supervisors largely train on-site by apprenticing with departing staff. They also receive some training through the Head office before assuming full responsibilities. The current supervisors received little formal training because the previous supervisor left very abruptly, leaving insufficient time for thorough training. This means that the supervisors were inadequately prepared for this leadership role and were forced to learn their new duties in less than ideal conditions.

Many of the issues described in the preceding discussion are related to leadership. Leadership is another integral aspect of group behaviour. Just as a band requires an excellent conductor to coordinate the band members' efforts, a volunteer program needs a leader to coordinate volunteers' efforts in order to inspire optimum performance. The leadership at Planned Parenthood is weak. This weakness can be explained by the leaders' inaccessibility to volunteers and their remoteness. The dual components of inaccessibility and remoteness are the focus of the ensuing discussion.

Inaccessibility: Inaccessibility is a continual concern at the clinic. Supervisors are too busy assisting the physicians and concentrating on other duties to focus on leadership. These other activities make it difficult for volunteers to access the supervisors. Indeed, there are evenings when the volunteers scarcely see the supervisor. It is impossible for volunteers to develop a relationship with supervisors they scarcely see. Minor crises frequently occur at the clinic and volunteers become very frustrated when they do not know how to handle the situation and have no one to turn to for assistance. Volunteers often feel

that they must muddle through the situation on their own. This is especially frustrating when volunteers do the wrong thing. The supervisors are very understanding, but volunteers still resent being chastised after being forced to resolve complicated situations. Some interaction must occur in order for effective leadership to be established and maintained.

Remoteness: The other component of weak leadership is remoteness. The supervisors highly value the volunteers' contributions and do not want to discourage volunteers by appearing too rigid or demanding. Many volunteer organizations feel so grateful to volunteers that they feel strong leadership should be avoided (Allen, 1987). Remoteness is typical of the supervisors who want to be seen more as friends and not as bosses who must give their subordinates direction. This is not to degrade the personal approach used by the supervisors. Indeed, this approach is often what initially attracts clients and volunteers to the organization. However, nearly every volunteer wanted more guidance. Increased structure was not perceived as restrictive, but as liberating since it would define such job components as duties, scheduling, and team work. For example, volunteers wanted to know when to arrive, what they would be doing that night, how to resolve any problems or questions, where else they could pitch in (if their clients did not show up for example) and when to leave. It is up to the supervisors to clarify these issues to the volunteers by writing job descriptions, organizing a better method of scheduling, and meeting with the volunteers regularly to go over questions, policy, and procedure.

Strong leadership is essential to a successful volunteer program. The volunteers become frustrated when there is little guidance from supervisors. Lack of leadership also results in volunteers feeling unappreciated when they perceive that their contributions are ignored. Volunteers often feel alienated from the clinic operations because they have little interaction with the supervisors, feedback from them, or the opportunity to discuss their questions, concerns and suggestions.

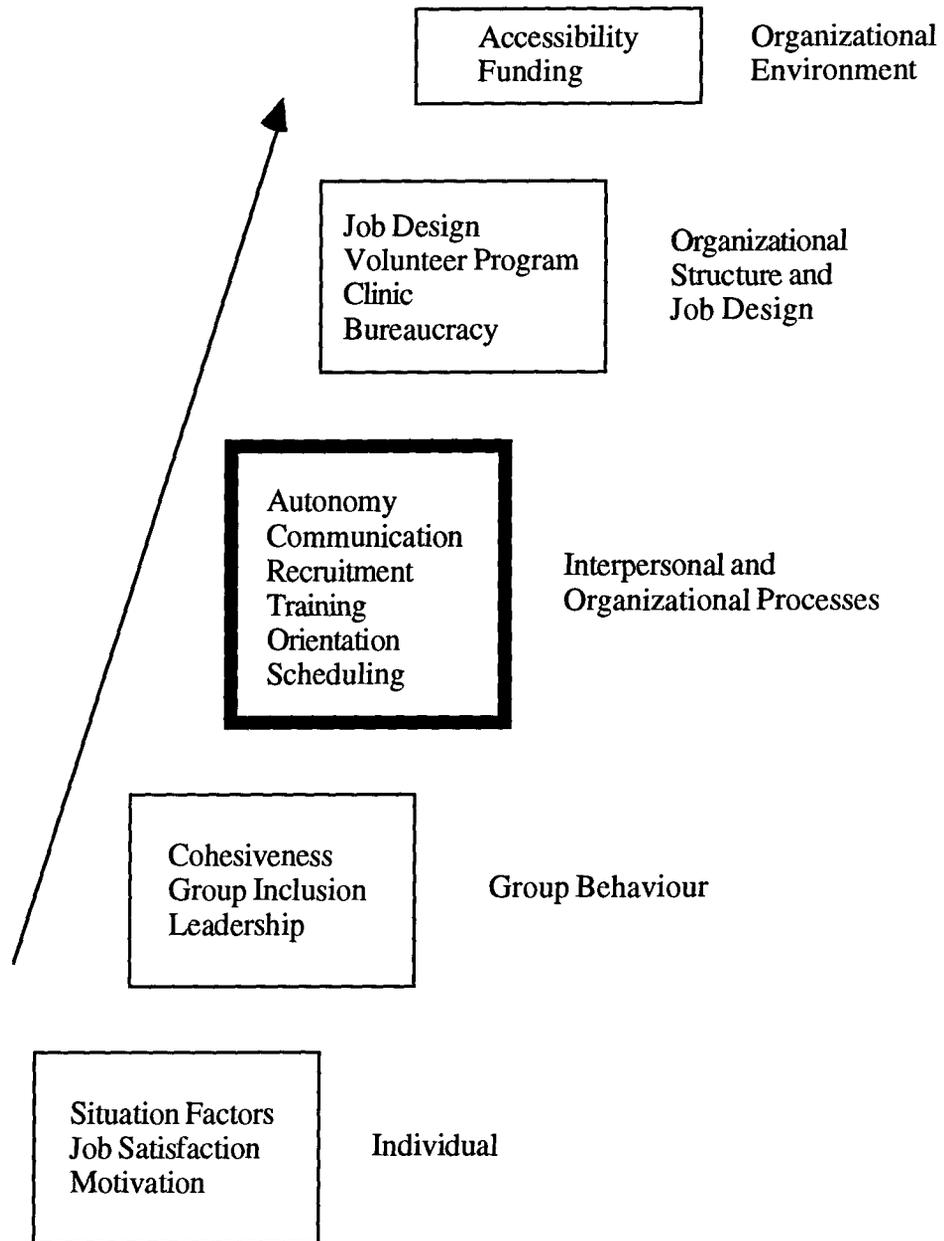
When cohesiveness, group inclusion, and leadership are examined, these interactive processes are shown to strongly influence volunteers' experiences. Group cohesion, inclusion, and leadership are all aspects of group behaviour which are essential to volunteer retention. It is these factors which influence the responses reported in the individual level of analysis. No matter how satisfied volunteers are with their volunteer duties for example, they will not continue to volunteer unless the group level factors are satisfactory. Volunteers who do not feel that they are valuable contributing members of a group have little incentive to continue volunteering. Likewise, volunteers who do not feel they are a part of a team have scant reason to continue when they feel they are on the fringes of the volunteer program. When leadership is weak, volunteers will not struggle to guide themselves, but will look for other opportunities where they can meet their altruistic and instrumental goals with minimal frustration.

3 Interpersonal and Organizational Processes

Interpersonal and organizational processes go beyond the individual and group levels of analysis. These processes refer to the operations that keep individuals, groups and the overall organization operating smoothly and efficiently. These operations also refer to the activities and processes organizations use to integrate and solidify the whole. Autonomy, communication, recruitment, training, orientation, and scheduling are the components of interpersonal and organizational processes examined in the ensuing discussion.

Figure 6

Levels of Analysis: Outline Depicts Interpersonal and Organizational Processes



3a Autonomy

Autonomy refers to the ability to think and act independently. Autonomy as it relates to volunteers and supervisors is examined in the following discussion.

Volunteer Autonomy: Volunteers have some autonomy in their duties. For example, volunteers are encouraged to develop their own approach to their jobs. However, they must work within the confines of the clinic and the organization. For example, they must present non-biased, and accurate information in a professional manner. These regulations rightfully limit volunteers' ability to make decisions regarding this aspect of their volunteer role. Volunteers can usually choose what duties they prefer to do, but are frequently asked to do other duties, so they must be flexible. Some volunteers will only do certain duties and refuse to volunteer unless they can perform their preferred duties. A prime example of this is pregnancy counselling. Some volunteers will only do pregnancy counselling and once they have finished counselling their clients they expect to (and usually do) go home.

Many volunteers enjoy this limited autonomy, yet they want greater autonomy within their volunteer responsibilities. Volunteers want to take on more responsibility to prove their worth and they want recognition for their efforts. Volunteers can decide how often they prefer to volunteer and can choose shifts that are suitable to them. Volunteers are rarely pressured to work more often than they do. Supervisors sometimes phone volunteers to recruit for specific shifts, but there is little pressure for volunteers to accept these shifts unless the supervisors are desperately short of volunteers. There is also little pressure to volunteer over a long period of time. Many volunteers drop out very quickly, with little or no follow up by the supervisors. Quitting when they are dissatisfied with the volunteer experience is the strongest way volunteers can assert their independence. There is little incentive to stay, especially with low cohesiveness and weak leadership. Lack of follow up makes it particularly easy for volunteers to quit with few consequences. Commitment to volunteering for Planned Parenthood takes a low priority in the environment described above.

Volunteers have very little autonomy beyond the capacity to quit volunteering. The ways of doing things have already been established and there is little a volunteer can do to

instigate change under present conditions. Volunteers frequently think of excellent ideas, but have no way to express these ideas or to implement change. This powerlessness often results in dissatisfaction with volunteering and makes volunteers feel their contributions are futile. Many volunteers stated in the interviews that they wanted to contribute to the organization in different sorts of ways, but did not know how to accomplish this.

For example, one volunteer said that she can not volunteer regularly because her job requires regular and impromptu travelling. She noted that the literature circulated by Planned Parenthood (such as brochures) and the documents used (interview forms, descriptions of contraceptive methods) desperately need updating. Professional layout and printing are also required. She works with computers professionally and has free time on week ends. She said she would love to get involved in these and any other projects involving computers that would allow her to volunteer her computer skills during her time off. Volunteers could also develop visual aids and documents for clients who attend the methods talk. These are excellent examples of projects suggested by volunteers, but volunteers need some guidance and coordination from the staff to make them happen. The volunteers have extensive resources that the organization need only tap to develop a more effective volunteer and clinic program.

Most physicians like to be the boss in the examination room and there is little room for the volunteers to make decisions there. Appointments are relatively short and the volunteers frequently do not get to spend as much time with the clients as they would like. Volunteers often feel they must rush through a counselling or education session so that physicians (who are paid for their services) do not remain idle. This atmosphere seems to contradict the program's mandate of quality service in the eyes of many volunteers. This organizational process frequently dismays volunteers and is counter-productive for the clients.

Volunteers are dismayed when they perceive the greater consideration accorded to paid workers. They also become upset when the structure of the clinic is seen as more

important than the volunteers' autonomy. For example, when I do the methods talk, I do a thorough job. I discuss each method in depth and encourage discussion. I feel that the methods talk is a safe environment for clients to talk about their experiences, and raise questions and concerns. Many clients have much to say. I believe the methods talk is extremely important because it introduces clients to the mandate of the program. It also educates clients about the contraceptive methods and encourages a matter-of-factness attitude toward contraception. Many of my co-workers agree with these ideas and we become frustrated when we are pressured to process clients as quickly as possible. Clients have little to gain from a perfunctory methods talk. Clients who attend a good methods talk tend to be more relaxed and educated, making the physician's job easier. Therefore, volunteers must be given more autonomy to modify the methods talk appropriately for each client. Volunteers would then be more satisfied with this duty and retention would be improved.

Supervisor Autonomy: The supervisors have considerably more power than the volunteers. The supervisors can decide, within the organizational guide-lines, how to operate the clinic. The major inhibitor to change is that the supervisors are so pressed for resources that it is difficult for them to implement all but minor changes. Moreover, they are so close to the subject matter every day that it becomes difficult for them to see new and improved ways of doing things. As a consequence, changes are few and far between, but they have been occurring gradually since the hiring of the two supervisors.

Most of the situations addressed in this discussion could be remedied with increased volunteer input and responsibility. The volunteer program and clinic would be greatly improved if volunteers were more autonomous both individually and collectively. Paid workers and volunteers alike enjoy having some power to create, interpret, and perform their jobs. Autonomy is essential to volunteer retention and for this reason autonomy is an important component of interpersonal and organizational processes.

3b Communication

Communication is another important aspect of interpersonal and organizational processes. It is crucial that volunteers be able to communicate their ideas to each other and to the supervisors. Communication between the supervisors and the Head office is also important. Communication allows for the interchange of ideas. This interchange is essential to all components of the organization. Poor communication prevents cohesion from occurring. It also increases feelings of alienation among volunteers. Alienation makes it very easy for volunteers to cease volunteering because of the lack of repercussions.

Communication Between Volunteers: As already mentioned, there is little communication between the volunteers because they rarely see each other inside or outside the clinic. There is little time to socialize even when volunteers do see each other in the clinic. Volunteers gather for few extracurricular activities of either a social nature, such as pot-lucks and parties, or of a work-oriented nature, such as in-services or field trips to an abortion clinic or maternity ward for example. Indeed, as previously mentioned, many volunteers do not even know their fellow volunteers. Volunteers have no vehicle to discuss their experiences at the clinic, to offer suggestions, to ask questions, or to get feedback about their performance. All of this provides an atmosphere conducive to poor communication among volunteers.

Communication Between Volunteers and Supervisors: There is also poor communication between the supervisors and the volunteers. Volunteers who come infrequently never develop a relationship with the supervisors. Even those who come often may work every shift with the same supervisor. When the volunteer or the supervisor changes their usual shift, the volunteer ends up working with a different supervisor. Volunteers tend to prefer the procedures to which they have become accustomed. Nearly all of the volunteers noted that each supervisor has a different way of doing things. All expressed a preference for one supervisor and tended to sign up for shifts with their preferred supervisor. Volunteers, therefore, become frustrated and tense when the rules

depend on who is supervising. Supervisors are usually too busy to interact much with volunteers in any case. The inaccessibility of volunteers to supervisors automatically precludes communication between these parties.

Communication Between Supervisors and Head Office: The communication between the supervisors and the Head office is good since the supervisors liaise with the office nearly every day to find out how many clients are scheduled, to order supplies, check test results and so on. Other than setting clinic budget, deciding which tests to administer in the clinic, and determining salaries, the Head office has a limited role in clinic operations. The supervisors are the acting managers and once trained, they are the ones who make and implement the day to day decisions and procedures. There is little liaison between the volunteers and the Head office because the supervisors act as a direct link between these two groups.

The interchange of ideas is stifled in an environment with poor communication. No change can be implemented unless the lines of communication are open. Therefore, communication is a central feature of all interpersonal and organizational processes. Communication is essential to an effective volunteer program and clinic operations as illustrated in the preceding discussion. Volunteers and supervisors frequently feel that their concerns and ideas are not acknowledged or considered seriously. This lack of communication is very frustrating to volunteers and supervisors and affects their interactions with others. Volunteer turnover occurs when volunteers rarely communicate with their co-workers and supervisors. Lack of communication facilitates alienation from the clinic. In this situation, other factors, such as cohesiveness and effective leadership, are negatively affected.

3c Recruitment

It is crucial to examine recruitment techniques in order to understand how the organization markets the volunteer program and attracts volunteers. As noted in the

literature review chapter, unless we understand why and how volunteers became attracted to an organization, we cannot analyze retention. Planned Parenthood does not actively recruit volunteers. The onus of volunteering is left to the potential volunteer. However, the organization is always receptive and encouraging to interested parties. Volunteers found out about volunteer experiences in four different ways: personal contact; self-initiated searches; prior knowledge; and through advertisement.

Personal contact: Twelve volunteers found out about volunteer opportunities through a friend, relative, or a current or former volunteer. Two people found out about the volunteer program through speeches at school.

Self-initiated search: Seven volunteers were looking for a volunteer experience and found out about volunteer opportunities at Planned Parenthood. Four were motivated to volunteer to fulfill the practicum requirements of their school program. Two were looking for paid work and when they found there was none with Planned Parenthood, they decided to pursue volunteer activities with the organization.

Prior knowledge: Ten volunteers were former Planned Parenthood clients and found out about volunteer opportunities this way. Another four said they had always known about Planned Parenthood or were unable to specify. One worked with Planned Parenthood through the pharmaceutical industry and found out about volunteer opportunities this way.

Advertisement: Five volunteers found out about volunteer opportunities through advertisements. However, these advertisements focus on the organization itself, and not on volunteer opportunities. Three found volunteer postings at the Greater Vancouver Volunteer Centre, and one heard about opportunities through the CBC drive for volunteers. One person saw a volunteer brochure at U.B.C. Advertisements by Planned Parenthood through brochures, postings on volunteer boards, and speeches by Planned Parenthood all facilitated these searches for volunteer opportunities. These responses paint an interesting picture because they are all indirect ways of finding out about volunteer opportunities. Planned

Parenthood rarely advertises for volunteers, so many people stumble upon volunteer opportunities by accident. Many people, including clients, are unaware that Planned Parenthood even has a volunteer program until they come across this knowledge in the ways described above.

3d Training

Training is a crucial aspect of any volunteer program. The success of a training program can greatly influence volunteers' performance, their job satisfaction and their commitment to the organization. The ensuing discussion focuses on volunteers' suggestions to improve training. Regular volunteer training and pregnancy counselling training are discussed.

Regular Volunteer Training: Twenty-eight of the respondents completed the regular volunteer training course. The remaining volunteers started volunteering without taking the training course because of accessibility complications. It is policy that volunteers complete the training course prior to volunteering. However, three did not take the training course and another one did not complete it because volunteers were desperately needed. Therefore, the policy was waived. One of these volunteers had volunteered at another clinic for three years and she and the clinic supervisors decided that she could easily learn the clinic procedures on the job. However, the remaining three volunteers all stated that they were at a disadvantage from not taking the course and that this negatively affected their performance on the job, as well as their impression of the clinic and Planned Parenthood. All said that the training course should be mandatory, and should be completed prior to volunteering.

Seventeen volunteers said that the training course adequately prepared them for their duties at the clinic. Nine said that it did not. Three had no opinion, and three did not take the course. All respondents had many ideas on how to improve the training course, including those who said it adequately prepared them for their duties. Three types of suggestions to improve training emerged from the volunteers. Volunteers stated that the course should be

more practical; that there should be continued training; and that there be preliminary screening. The following discussion presents the most frequently recurring suggestions to improve volunteer training.

Practical issues: Twelve volunteers suggested a tour of the clinic along with some on-site training as part of training. Eight wanted to know more about the organization of the clinic, a process easily facilitated by on-site training. Five wanted a well-developed buddy system as a part of the training course, and five suggested that role and group play be used more extensively to approximate actual clinic duties and scenarios. Five volunteers suggested that copies of job descriptions be circulated to inform potential volunteers of what job duties will entail. These descriptions could also be used as guides during orientation. Five said that there should be an increased focus on interpersonal, counselling, and education skills to complement the information taught. Five volunteers said that there should be increased exposure to paperwork; for example, practice filling out nursing forms and learning which forms go with which tests. This suggestion could be met either in the classroom setting, or at the on-site clinic orientation that many volunteers would like to see become part of training. Four people thought that a more extensive training program was required involving more thorough discussions and preparations.

Three respondents thought that there should be increased attention to practical issues to complement the largely theoretical course. Two volunteers thought that more objective and thorough information on contraceptives should be given. Two people suggested that a session focusing exclusively on the clinic should be offered to those who plan to volunteer. This is because some people take the training course for reasons other than the intent to volunteer, therefore, clinic routines are not applicable to them.

The more experienced volunteers all know about the many practical issues that need to be addressed during training. Newer volunteers fill out a course assessment on the last day of training, but the usefulness of doing this is limited because only when volunteers begin orientation are they able to assess the volunteer training. Newer volunteers verbalize

their views of the training course during interaction at the clinic. Unfortunately, because communication is poor, this information rarely filters back to the educator.

Continued training: Five volunteers wanted regular training updates regarding such topics as birth control, abortion, adoption and keeping the baby, as well as education on sexually transmitted diseases. Continued training would provide current and accurate information on these topics. One volunteer suggested that there be a volunteer follow-up session, perhaps six months after the course, so that everyone can discuss issues that are of concern to them.

Many volunteers are distressed that they are not kept abreast of the latest contraceptive and reproductive issues. Volunteers are frequently unable to answer client's questions adequately because volunteers lack sufficient knowledge and resources. Volunteers who are involved in the medical, legal, or social services have greater access to information they can use on the job. Those who do not have access to continued training tend to know less about current issues. Lack of continued training can affect volunteers' feelings of adequacy and job performance. Those volunteers who have access to continued training are the core volunteers. Their work at the clinic complements their paid work and vice versa. This link gives the core volunteers extra incentive to continue volunteering.

Volunteer screening: Two volunteers suggested that interviews be conducted to screen volunteers before they begin training. One suggested that a sense of commitment be obtained from the volunteers during screening, for example, signing a document promising they will contribute a specific number of volunteer hours to the organization. One volunteer said that volunteer motivations should be explored during screening.

The core volunteers intuitively know which new volunteers are not suitable for clinic volunteer roles. For example, some volunteers lack the interpersonal skills essential to working with clients, or are interested in political activism which has no place in the clinics. Volunteer screening could redirect these volunteers to more appropriate volunteer

opportunities rather than investing considerable resources in training and orienting these volunteers.

Pregnancy Counselling Training: Fifteen of the respondents took the pregnancy counselling training course, and seventeen did not. Seven volunteers stated they plan to take the course in the future or would have taken it had they continued to volunteer. Six of the fifteen respondents said that the pregnancy counselling training course adequately prepared them for those duties, four said it did not, two were undecided, and three were still orienting so they withheld judgement. Once again, all volunteers had many suggestions to improve the pregnancy counselling training course, whether or not they said it adequately prepared them for their duties. The most frequent suggestions were again related to practical issues.

Practical issues: Six volunteers stated explicitly that there should be more practical components, such as more role playing and visual aids; for example, a video of a pregnancy counselling session. Five stated that the course should be more extensive and longer. Five volunteers suggested that the options available to pregnant women be covered more fully. Some suggested that a resource book would be useful to achieve this goal. Four suggested that there be a more extensive buddy system as a part of training. This buddy system would entail including more observation by an experienced counsellor, and feedback from this buddy during counselling orientation, and monitoring and feedback following the first few counselling sessions attended by the experienced volunteer.

Three volunteers suggested that they should, as a group, tour an abortion clinic to see exactly what occurs there. By doing so, they could better explain the procedures to clients, empathize with clients, and better deal with their feelings, questions, and concerns. Two thought they should not have to pay for the pregnancy counselling course, or perhaps pay for it, then get reimbursed once they have fulfilled a specified volunteer requirement. Two respondents suggested that there be more information and long- and short-term planning documents that clients can take home with them to help them make their decision. Two said that there should be more structure and guide-lines in counselling to follow, and that they

should go over the sequence to follow and the paperwork that needs to be completed during training.

Continued training: Three volunteers suggested that regular information updates and on-going training be a volunteer requirement. In-services were suggested as the best way to establish on-going training. Continued training is particularly important for pregnancy counsellors because abortion and adoption legislation change regularly. In addition, procedures and services also change. Pregnancy counsellors must keep up to date on all of these issues to maximize their usefulness and personal feelings of fulfillment. The preceding discussion of training illustrates the volunteers' numerous ideas for improving volunteer training. The practicality of these suggestions is remarkable. The implementation of most of these ideas could be achieved quite easily with the combined efforts of the educator, supervisors, and volunteers.

3e Orientation

The focus of the next discussion is the orientation process. This process occurs over the first couple of sessions at the clinic, whether or not the volunteer has taken the training course. All of the volunteers had much to share about their experiences orienting at the clinic and had many suggestions to improve orientation.

Only seven respondents said that there were no major problems relating to orientation. Sixteen respondents said that orientation was insufficient, disorganized, sporadic, and that there was too little supervision. Nine volunteers stated they did not know what to expect in regards to the process of the clinic: for example, what to do when you get there, and when the clinic starts and ends. Eight jumped right into their duties and learned quickly despite the insufficient preparation. Five respondents said that there were too many or too few volunteers for the number of clients, resulting in either a boring or hectic environment, neither of which is an ideal learning environment for new volunteers. Five respondents did not know what the duties were and had no idea how to go about performing

them. Four respondents did not remember anything about the orientation process. Four recalled that the volunteers and staff were helpful and friendly. Three said that they gradually got into the swing of things, but it took a long time before they were comfortable. Three liked the buddy system and two were overwhelmed in the nursing room and elsewhere because they received an information overload.

The volunteers had many ideas to improve the orientation process. These suggestions are based both on their own experiences and their observations of other orienting volunteers. Their suggestions include such practical ideas as a slower, more thorough and progressive orientation (15) (including step-by-step instruction, observation, guidance, and feedback). The implementation of a better buddy system was the primary suggestion to achieve this goal. Specific suggestions include a process whereby the new volunteer observes the buddy, the buddy observes the newer volunteer, continually giving feedback to the newer volunteer until she is confident and capable of taking on full volunteer duties. Another component of this idea was to have the same buddy pal around with the new volunteer for the entire night and perhaps for future sessions as well if necessary.

Six volunteers said that volunteers should learn all duties systematically in orientation so that they can get a taste of everything and learn what duties they are most interested in pursuing. Six respondents said that there should be an appropriate number of volunteers compared to the number of clients so that new volunteers can be exposed to all of the duties and learn in an environment that is not too chaotic or too slow. Six suggested that a list of standardized procedures be developed so the volunteers can see what the duties consist of and use this list to ensure they do everything correctly. Five stated that there should be sufficient experienced volunteers to orient new volunteers properly, and that there should not be too many new volunteers orienting each night. Five suggested that the new volunteers meet with a supervisor following orientation so that they can discuss and resolve issues as they come up. Five suggested that there be more emphasis on what the client

experiences as she moves through the clinic so that volunteers can better understand procedures from the client's perspective.

Four said that there should be increased exposure to the various medical tests, such as the pelvic, glucose, pregnancy tests, and blood pressure checks. Four said that more structure would be useful: for example, learning the clinic routine to follow. Three respondents said that volunteers should wear name tags to distinguish them from the clients. Three stated that the experienced volunteers should be trained to orient new volunteers and that they should be warned beforehand that this is what their function will be that night. Two said it would be useful to meet the physicians formally and learn about their role. Two respondents said it would be helpful to work with several volunteers over the course of orientation to learn from their different styles. Two volunteers said there should be more volunteer follow-up.

Volunteers' orientation experiences and suggestions closely approximate the ones noted in regular and pregnancy counselling training. Orientation is evidently a very stressful time for volunteers. Many volunteers are so distressed with the experience that they never return. Experiences at orientation are almost wholly dependent on the circumstances that night. Core volunteers are those who are integrated with the other volunteers and the supervisor, and who are given much guidance and support during orientation. Those who feel ignored, rushed, and who do not get to know anyone drop out immediately or very quickly. It would be easy to implement the majority of ideas offered by the volunteers and to at least consider gradually adopting the more complex, but feasible ones.

3f Scheduling

Scheduling was the most frequently recurring subject in volunteers' dialogues. Remedial action must quickly be taken to prevent further volunteer turnover from this tremendous source of aggravation. Scheduling was a constant source of grief for volunteers and many of them became very worked up when they discussed it. Volunteers want to feel

their contributions are valuable, but they do not feel their clinic duties should exhaust them. Therefore, an inappropriate number of volunteers compared to the number of clients was perceived by volunteers as a significant problem. When there are too many volunteers compared to the number of clients, volunteers feel that they have wasted their time by coming since there is little for them to do. Many volunteers stated it was very unprofessional to have volunteers milling around the clinic gossiping and disrupting the clinic operations and the volunteers who are working. They suggested that until scheduling problems are resolved, supervisors should send surplus volunteers home. Often times a supervisor called a volunteer at the last minute to beg a volunteer to take a shift that night, then the volunteer consents to doing so, only to find that too many volunteers were scheduled. This situation arises frequently when one supervisor schedules volunteers without telling the other supervisor.

Volunteers found it very aggravating when they signed up and prepared for a particular duty, then were asked to do something different upon arriving at the clinic. This was particularly annoying when a volunteer wanted to get experience doing something new, but repeatedly ended up doing the same duty every night. Many pregnancy counsellors only wanted to counsel and felt cheated when they were asked to do something different because two counsellors were booked. Complications also arose when pregnancy counsellors arrived at the clinic only to find that there were no clients scheduled that night. When there are too few volunteers, the situation also becomes stressful and volunteers resent having to do so much work. Another source of frustration was having too many new volunteers orienting on one night, causing severe disruptions in clinic operations. Volunteers become particularly annoyed when, with little warning or no preparation, they are asked to orient one or more new volunteers.

Interpersonal and organizational processes is a fruitful aspect of organizational behaviour. Autonomy, communication, recruitment, training, orientation and scheduling are the components of this complex level of analysis which were discussed in the preceding

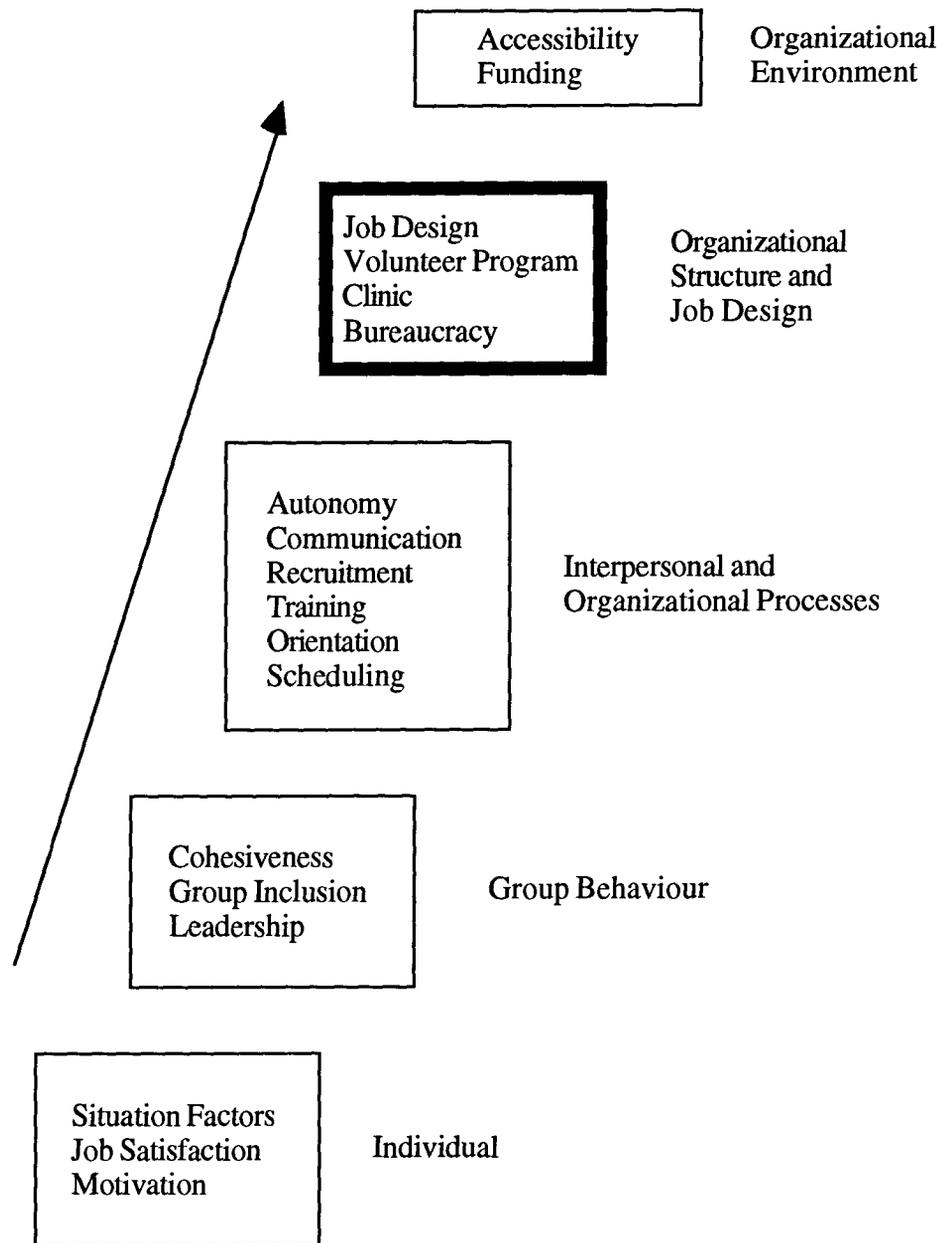
pages. These interpersonal and organizational processes contribute much to our understanding of volunteer retention.

4 Organizational Structure and Job Design

Organizational structure and job design represents yet a wider level analysis than the ones previously described. Structure refers to the arrangement of parts of an organization. Job design refers to the arrangement of job duties. Job design, the volunteer program and clinic in general, as well as the bureaucratic nature of the organization are the components of this level of analysis that are examined in the ensuing discussion. An explanation of how organizational structure and job design influence program effectiveness is discussed. In addition, a description of how the informal arrangements that characterize and influence the relationship among members can have an impact on the program's effectiveness are explored.

Figure 7

Levels of Analysis: Outline Depicts Organizational Structure and Job Design



4a Job Design

Two aspects of job design are discussed here: duty hierarchy and job structure.

Duty Hierarchy: Newer volunteers felt they had little autonomy to engage in their preferred duties. When more experienced volunteers were present, newer volunteers tended

to assume whatever duties no one else wanted to do, or the duty they had already had some training in. In practice this meant duties such as filing and nursing. No one likes filing, but volunteers regard it as a necessary evil that should be distributed equally among workers. Some volunteers wanted medical experience, so they were content to nurse every time they volunteered. Most of the volunteers however, were not happy to nurse every shift. Many volunteers mentioned spontaneously that they dislike nursing and that they were frequently coerced into it.

Many volunteers felt that there was a hierarchy between the pregnancy counsellors and the regular volunteers. Nearly all volunteers who volunteer for more than one year take the pregnancy counselling course. Consequently, the pregnancy counsellors are more experienced than most of the regular volunteers. This experience sometimes translates into some of the pregnancy counsellors acting superior to the regular volunteers. Interestingly, none of the pregnancy counsellors mentioned this dichotomy, but nearly all of the regular volunteers did. Many regular volunteers resented the fact that the pregnancy counsellors secured the most preferred duties each night. The pregnancy counsellors also received more of the supervisors' attention according to some of the regular volunteers. There is no formal admission that pregnancy counsellors are more prestigious than non-counsellors, but many of the regular volunteers felt that a preferential tendency existed. The regular volunteers claimed that all of the duties were equally important and resented the dichotomy between the counsellors and non-counsellors.

Job Structure: Job design affects clinic effectiveness in various ways. Job design inevitably has an impact on volunteer recruitment and retention. Many volunteers, particularly the non-active ones, stated that the duties were boring, repetitious and menial. No wonder volunteers are dissatisfied with the volunteer experience when they see their duties this way. Jobs are very fragmented. There is little room for innovation and change. Every volunteer does a job differently because there is little standardization and guidance. It

is not unusual for a volunteer to perform a position for a year, then find to her surprise that she has been doing it wrong all along.

The fragmentation of jobs means that lag times affect clients. For example, if one volunteer does the methods talk which is attended by several clients, and other volunteers are busy performing other duties, the clients must wait for an interviewer to become available before they can see the physician. Frequently the client has already discussed her case with the volunteer who gave the methods talk, then must repeat it all to the interviewer, then to the physician. This is a very fragmented approach that creates backlogs and repetitiveness, both of which can be very frustrating to volunteers and clients.

Many volunteers claimed that there was nowhere to go once you have learned all of the clinic duties. Volunteer growth and development are thus stunted. Many volunteers said that they would enjoy learning how to set up and clean up the clinic to increase their usefulness. The check ups are performed by the physicians and the blood pressures are performed by the physicians or the supervisors (who are Registered Nurses). Many volunteers, some of whom are nurses, said that there was no reason why the volunteers could not learn to do these duties. Others said that the volunteers could learn to check blood pressure and conduct the three and six month check ups with clients. If they encountered any problems, the volunteer could refer the client to the physician. This way, the volunteers could take on more varied and challenging duties, and the clients would prosper by not having to wait so long to undergo simple procedures. The physicians would also profit by being able to spend more quality time with the clients whenever necessary.

4b Volunteer Program

This section presents volunteers' insights on the volunteer program in general. Their suggestions to improve the volunteer program are reported in the following discussion. The recurring themes that emerged in this question and previous ones illustrate volunteers' concerns.

As previously noted, the supervisors are in charge of all clinic happenings. However, as already noted, the supervisors work within the structure of the organization. Supervisors and clinic operations are closely monitored by the Head office. The Planned Parenthood Association of British Columbia assesses the financial requirements of each clinic. Their decisions also include determining staff's salaries, setting prices for contraceptives, and deciding where and when to operate each clinic. The Planned Parenthood Association determines operating costs for each clinic. The supervisors do have some input regarding clinic-related issues, but they must adhere to the policies and procedures developed by the provincial organization. The Vancouver clinic is only one of numerous Planned Parenthood clinics in the province and the Head office does its best to oversee each of these clinics, despite scant resources available to do so. Because Planned Parenthood is a non-profit organization operating in very tough economic times, there is very little money to go around. Money is spent on the essentials only, and even then, not all needs are met.

The supervisors do their best with what little they have. They cannot be blamed for not implementing a more effective volunteer program when most resources are required simply to provide client services. The supervisors often feel as helpless as the volunteers in making changes to the clinic and the volunteer program. The two current supervisors have been at the clinic for approximately two and a half years. In this time, they have learned to work together quite well and have implemented many changes to the clinic to improve operations. A new educator has been hired within the past year and she too has implemented many positive changes. Change comes about slowly, especially in large organizations with few resources. The supervisors would certainly like to see many more changes come about, but they simply do not have the resources to implement them. Quite simply, there is more work to be done than two half-time workers can reasonably accomplish.

The volunteers were very aware of the constraints governing supervisors. Many volunteers suggested that a volunteer committee be formed, and a volunteer coordinator be hired to focus exclusively on establishing and maintaining a more effective volunteer program. A volunteer committee could work together to discuss all issues relating to volunteers, come up with a plan to respond to suggestions and complaints, and take necessary action. The volunteer coordinator would then liaise with the supervisors and the Head office to work together on these issues along with other Planned Parenthood clinics across the province. The supervisors could then devote themselves to all aspects of client care.

Although the notion of hiring a volunteer coordinator is excellent, I am not so optimistic to believe that it will occur any time soon. There is not enough money to hire another person to coordinate the volunteer program. The organization cannot pay its bills as it is, and the hiring of an additional person would be seen as luxurious, even though the merits of doing so are apparent. Admittedly, an organization cannot spend money it does not have to implement change, no matter how positive the implications would be. The next best thing is to offer the Head office and supervisors an analysis of the volunteer program and a statement of volunteers' suggestions for improvements, such as the development of a volunteer committee. Once the research aspect is complete, the implementation of change can occur gradually, and in order of priority.

On a clinic level, the supervisors have little autonomy over the volunteer program because another staff member conducts the training sessions. This means that the supervisors do not usually meet the volunteers until they attend the clinic for orientation. Sometimes the supervisors know that the volunteers are not suitable as soon as they meet them, but volunteers have already completed the training course and expect to begin volunteering. It is very difficult for the supervisors to ask a volunteer not to come again, and since the volunteer turnover rate is so high, this may in fact be counter-productive. The organization's informal policy to embrace any person who shows an interest in volunteering

is problematic. Some volunteers noted that if volunteers were better screened initially, then the training course could be more thorough, there would be fewer new volunteers to orient, and volunteer productivity, commitment, and retention would all be greatly improved. Once again, however, this means that the educator or supervisors would have to find the time in their busy schedules to screen and interview volunteers, another time consuming process that is unlikely to happen.

Nearly all of the volunteers I interviewed were white (with the exception of one woman of Chinese descent), aged early twenties to forties, with a post-secondary education. This sample represents a very select group of people. The volunteers do not match the diversity of clients the Vancouver clinic serves. Although I did not survey the clients, I suspect that having such a select group of volunteers affects the care that the clinic gives clients as well as the clientele it attracts. Even with instruction in listening, empathizing, and educating skills, the volunteers and clients often have completely different perspectives. It is difficult to understand the client's experiences and choices when there is a culture or language difference, or the client is a teenage high school drop out, or is poor. There is little attention to the wide variety of clients that use the clinic services, and how we can best meet their needs. Our ability to serve some of the clients we see, especially in a single session setting is minimal. Better training is necessary, as is better access to resources so that we can refer the client to an organization which may better serve her needs.

The most frequently mentioned idea to improve the volunteer program was to increase extracurricular activities for volunteers to make them feel more involved in the organization and their volunteer role (10). Suggestions for achieving this are having on-going education through in-services, more fun activities such as parties and pot lucks, and creating and distributing informative news letters. Better scheduling procedures were also recommended by respondents (6). Respondents also thought that the staff and volunteers should know who is doing what on any specific night. Another suggestion was having the appropriate number of volunteers for the number of clients so that all volunteers are kept

busy, but are not run off their feet (6). Five respondents said there should be better communication between the supervisors and volunteers so that all are aware of clinic happenings. Five said that there should be increased volunteer recognition and support by supervisors, including rewards for outstanding volunteers.

Four volunteers suggested there be increased volunteer follow-up, through phone contact for example. Many volunteers thought that volunteers should be called if they fail to meet an appointment or if they have not signed up for a long time for example. Four volunteers said that they had no ideas because they volunteered for a very short term or because they volunteered a long time ago. Four respondents wanted assigned areas of responsibility so that they could be assured a specific job. Three suggested that written instructions be developed to standardize all duties. Instructions for setting up and cleaning up the clinic and developing cue cards for the methods talk were deemed especially important. Three thought there should be a thorough, structured buddy program. Three said there should be more publicity about volunteer opportunities to increase the awareness of this facet of Planned Parenthood. Two said that staff should better understand the needs of volunteers and try to meet them. Two suggested that clients be solicited to give their ideas about the volunteer aspect of the clinic, and two respondents suggested that supervisors send some volunteers home when there are too many of them. Two respondents said that the volunteer program would be improved if there was a meeting about the clinic, Planned Parenthood and the volunteer program before training begins to weed out unsuitable applicants.

4c Clinic

Client backlog is a major problem. A system should be worked out to better meet clients' needs. Some suggestions to achieve this goal are to stagger multiple methods talks throughout the evening when there are many clients; conduct interviews before the methods talk(s); warn clients of the time commitment required for their appointment and explain why it takes so long (especially if they are new); space out annual exams differently by having

short appointments at the beginning of the night and longer ones later on or vice versa. Eight respondents said that scheduling should be improved by having better communication between the supervisors and between the volunteers and supervisors. Suggestions to achieve this are to have a master schedule in the office, and have pre-assigned duties so that everyone knows what she will be doing and can start immediately when she gets to the clinic rather than waiting to be told what to do. Eight volunteers said a better filing system would improve the clinic. The most obvious suggestions were to develop a computerized system, or at the very least to get the cabinets in order and develop a better way of marking and filing files.

Seven said the clinic runs pretty well, or better than it used to. Four said the clinic would run better if there was the appropriate number of volunteers compared to the number of clients. Four said that volunteers should receive additional training so that they can contribute more to the clinic, for example, learn to take blood pressure, read urine tests and how to file properly. Three respondents said increased volunteer follow-up would increase volunteer retention, thereby making the clinic function better. Three suggested that volunteers wear name tags to distinguish them from the clients and to help volunteers get to know each other. Two said the clinic would function better if the physicians and volunteers knew each other better and knew what to expect from the other. Two said that standardization would improve the clinic: making sure all new clients give a urine sample, ensuring that all samples are tested and that the answers are recorded on the client's file for example. Two respondents said that having nurse practitioners would be an improvement because they can do all duties, thus providing more continuity for the clients. Two said that the Vancouver clinic should have its own facilities so that everything could have its own place and the clinic would not have to be set up and torn down every night. Finally, two said the clinic would operate better if there were more paid staff.

4d Bureaucracy

Another issue that emerged repeatedly can be identified as the bureaucratic nature of the clinic. "Bureaucracy refers to a certain organization system that exists in modern industrial societies to provide efficient, skilled management. Every large organization has a bureaucracy" (Riddell and Lynch, 1973:7). There are six features of a bureaucracy. These are: 1) a functionally specialized division of labour; 2) an explicit hierarchy or authority; 3) rules which describe the duties and rights of individuals; 4) a set of standard operating procedures; 5) impersonal relations between officials; and 6) employment and promotion based on merit (Brown et al., 1979). The degree to which these features are present in an organization serve as a measure of the extent of its bureaucratization (Ibid.).

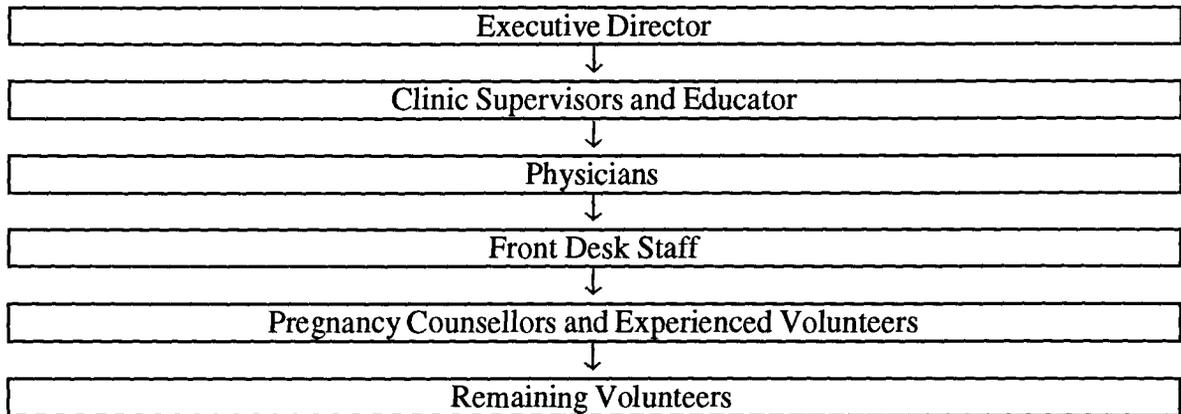
Regardless of where they operate, bureaucracies have an organized hierarchy. Some people have more status and authority than others, and their authority comes with their position. This hierarchical structure also sets the pattern for formal communication within bureaucracies (Riddell and Lynch, 1973:7).

Bureaucracies also have informal levels of communication. This communication tends to be of a hierarchical nature, as people associate with people in their own bureaucratic level. Bureaucrats are subjected to many rules. There are rules about what their job entails and what their job does not entail. There are rules about communication within and outside of the bureaucracy. There are rules about managing conflicts of interest, about use of experts, about the requisition of supplies and just about anything a bureaucrat might think of.

There is an extensive chain of command involved in operating a huge organization like Planned Parenthood at the international, federal, or even provincial level. The organization of these larger organizations has little bearing on the volunteer program, and are therefore, beyond the scope of this study. However, the staffing structure of the clinic is very important to the operation of the volunteer program. The following diagram illustrates the organizational structure of the clinic according to my research.

Figure 8

The Hierarchical Staffing of the Vancouver Clinic



The hierarchical and specialized nature of jobs is part of what makes the Vancouver clinic a bureaucracy. This bureaucratic nature affects all aspects of clinic operations, including cohesion and communication. Specialized division of labour, differences in status and authority, multiple rules and regulations, and standard operations and procedures are the four components which are the most important bureaucratic factors at the Vancouver clinic. These bureaucratic processes affect all components of the five levels of analysis examined in this case study. Bureaucracy is in this way a crucial factor of volunteer recruitment and retention.

The bureaucratic nature of the clinic often interferes with program improvements. For example, the volunteers were overflowing with suggestions, but many implied that there was little hope of improving the volunteer program and clinic because of the bureaucratic difficulties involved. For example, many volunteers stated the current filing system is absurd and suggested that the files and other information be computerized. This excellent suggestion was often prefaced or followed by a disclaimer that it would not be done because it would never filter back to the people who could implement this change. Many volunteers offered to contribute to projects such as this one, but were understandably hesitant to devote the time and energy necessary to undertake it single-handedly. A coordinated effort is needed and this effort must be initiated and overseen by the supervisors. Most of the

volunteers were extremely happy to share their experiences and suggestions. For many of them, it was the first time anyone had listened to their experiences and suggestions. Contributing practical suggestions helped to alleviate some of the volunteers' feelings of helplessness. Many of them were very interested in my project and are excitedly anticipating the implementation of some of their ideas.

Many volunteers disliked the hierarchical nature of the clinic. They often felt that they were the least important workers at the clinic and that their contributions pass unappreciated. For example, volunteers are frequently interrupted while performing such duties as the methods talk. They are asked to hurry the client along because the physician is idle. This upsets volunteers because they feel that some clients need more time than others and that to hurry them along compromises the principle of quality care inherent in the program's mandate. Furthermore, the physicians are paid for their work while volunteers are not, yet the concern is that the physician not be bored. Some volunteers feel that this demonstrates the low value ascribed to volunteers. The concern should first be for the client, followed by the volunteer who receives little tangible reward for their efforts.

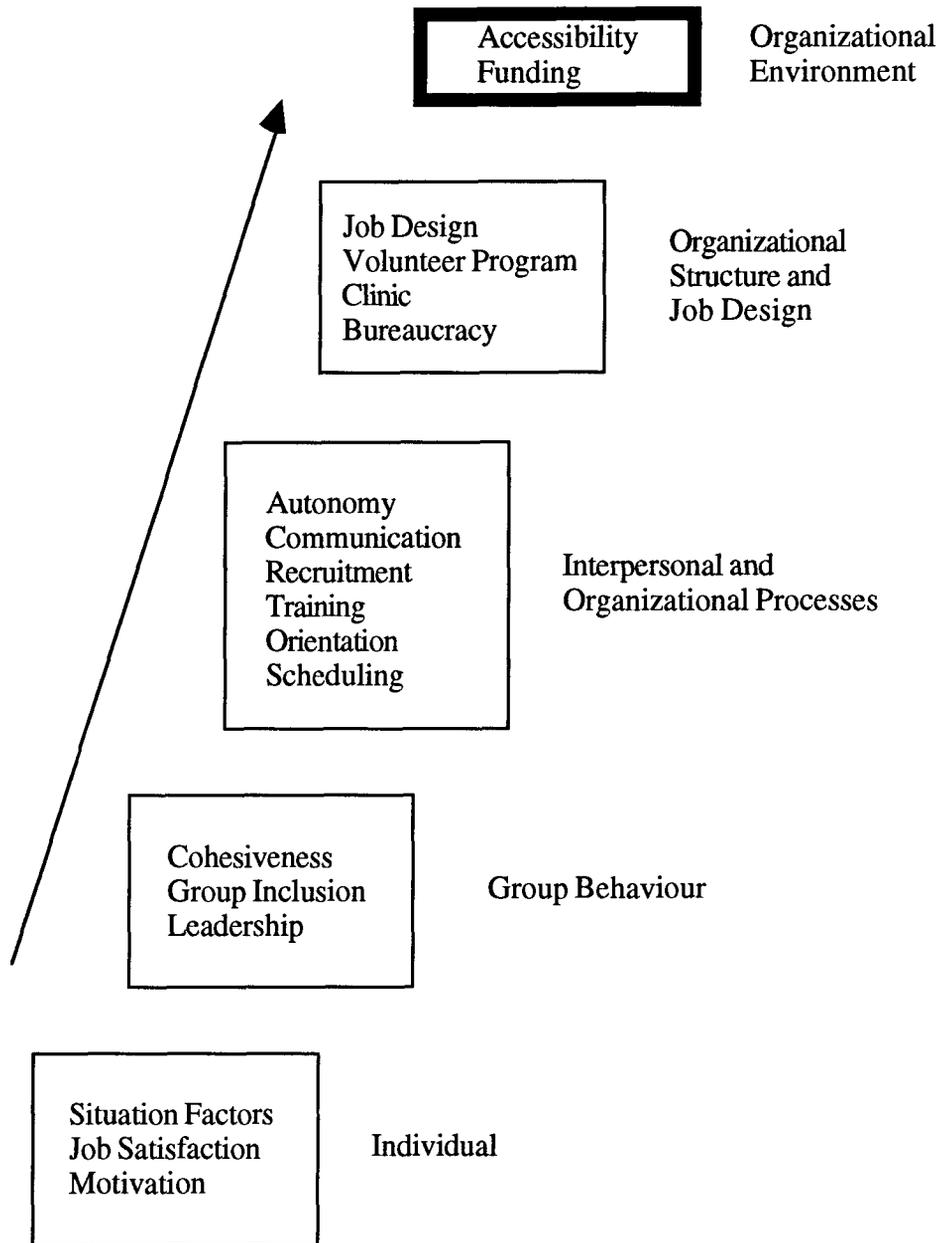
An examination of organizational structure and job design reveals diverse issues. Job design, scheduling and general suggestions to improve the organizational structure of the volunteer program and clinic all interact to influence volunteer retention. These components are therefore a necessary aspect of this macro level of analysis.

5 Organizational Environment

I will not spend too much time on this section because the focus of this project is on the volunteer program, and not Planned Parenthood's existence within the wider community. However, there are a few issues which need to be discussed here to complete the analysis. The issues which relate to the organizational and its environment are accessibility and funding.

Figure 9

Levels of Analysis: Outline Depicts Organizational Environment



5a Accessibility

Geography: The clinic is located in the north central area of Vancouver, a relatively rich area of the city. As already noted, the clinic operates out of the Women's Clinic at the Vancouver General Hospital. This is the only Planned Parenthood clinic in Vancouver proper. It is opened two evenings each week, plus one additional evening twice/month. The

geography of the clinic limits accessibility for the volunteers and the clients. Many people from both groups cannot get to the clinic easily. For example, some people have to spend an hour on the bus to get to the clinic. Many are afraid to attend the clinic in the winter darkness. The hospital is isolated and does tend to be secluded in the evenings, and especially in the winter. It is also poorly lit, and the nearest bus stop is two blocks away. Getting to the clinic from the nearest bus stop requires walking from one side of the hospital to another across a paved compound, a dangerous situation at the best of times. These factors were mentioned by many of the volunteers who perceived this as a risky situation they wished to avoid. My experiences as a client and continual interaction with clients show that clients feel the same way. These conditions may dissuade people from attending the clinic as volunteers or clients.

Clinic Hours: The other factor is clinic hours. The hours that the clinic is open also gives limited opportunities for volunteers to contribute their efforts at the clinic. Many of the volunteers work, or have school or child care responsibilities in the evenings which prohibit them from volunteering. Some volunteers could not work in the evenings at all and so were forced to drop their active volunteer status. My observations reveal that many of the clients also experience these complications. A large proportion of the clinic's clients are in their teens and have trouble getting out in the evenings. Many have curfews and do not want their parents to know where they are. They are nervous all evening because they are seeking contraceptive services (often for the first time). In addition, they often have to leave by a certain time and they do not want to choose between obtaining contraceptive services or getting home on time. Sometimes clients have to leave mid-way through their clinic rounds. This is very frustrating for the volunteers too, who hope that the client will get a reliable method of birth control before they start (continue) to have unprotected intercourse.

5b Funding

Funding is an issue that has been alluded to repeatedly in this paper. The Planned Parenthood Association of British Columbia has been operating in the red for many years

and there is very little money available for improvements of any sort. The government currently provides no funding to Planned Parenthood, although the demonstrated need for its services is great. Problems are often recognized by the Head office, supervisors, volunteers and clients, but since money is usually required to resolve these problems, remedial action is not taken. There are no Planned Parenthood clinics in Central or Northern B.C., areas that desperately need these services. If funding could be increased, many of the recommended changes could occur, as could the opening of full-time clinics in locations throughout the province to make volunteer involvement in reproductive services more readily available to all women.

Planned Parenthood works very hard to solicit public support through the provision of quality care and through limited advertisement. The organization also conducts many fund-raising events, such as casinos, to enable them to meet operating costs. These fund-raising efforts do not generate enough funds to give volunteers' remuneration for the basic costs of volunteering, such as transportation and child care costs. Current spending by the organization should be examined to determine if other spending could be reduced to allow more attention to the volunteer program.

This chapter had addressed a wide realm of issues and has reported many data relevant to each of the levels of analysis. Five distinct, yet interrelated, levels of analysis have been explored. Each of these wider areas of analysis have been broken down into smaller categories in order to present the information more coherently.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

1 Conclusions

The purpose of this research project has been to evaluate the Vancouver Planned Parenthood clinic volunteer program. The focus of the foregoing discussion has been volunteer recruitment and retention. A multi-leveled approach was adopted from organizational behaviour, then modified accordingly. Five levels of analysis were used to conduct this case study. These were: individual; group behaviour; interpersonal and organizational processes; organizational structure and job design; and organizational environment. Each level of analysis builds on the preceding one(s). This complex, multi-leveled model depicts the complexity of a volunteer program and highlights the many factors which influence volunteer recruitment and retention. It also shows that an individual perspective yields only a partial analysis of these issues. Each level of analysis is necessary to illuminate one dimension of our understanding of the Vancouver clinic volunteer program.

This case study entailed examining each aspect of the Vancouver Planned Parenthood clinic volunteer program. I used a combination of interviews, observational analysis, and document analysis to conduct this case study. I went beyond the individual level of analysis of situational factors, job satisfaction, and motivation which are typically the focus of volunteer studies. I examined the more sociological aspects of a volunteer program, including cohesiveness, group inclusion and leadership at the group behaviour level; autonomy, communication, recruitment, training, orientation, and scheduling at the interpersonal and organizational processes level; job design, volunteer program, clinic and bureaucracy at the organizational structure and job design level; and accessibility and funding at the organizational environment level. The latter four levels of analysis see volunteers in

relation to the organization, thereby acknowledging that group processes are integral to the sociological understanding of volunteer recruitment and retention.

When we examine the volunteer program, three primary processes emerge: 1) funding, 2) volunteer training and orientation, and 3) lack of cohesion among volunteers. These issues are crucial in explaining volunteer recruitment and retention, as well as the efficient operation of the clinic. These three processes involve macro levels of analysis and are, therefore, sociologically important.

These three processes emerged as the most important factors that influence volunteer recruitment and retention. Funding affects nearly every issue discussed in this paper and therefore has tremendous and multiple implications for the volunteer program. Volunteer training and orientation are also extremely important in influencing volunteer recruitment and retention. Satisfactory training and orientation are essential to the success of a volunteer program. Cohesion is also integral to the Vancouver Planned Parenthood clinic volunteer program. Integration into the program is crucial to sustain volunteers. Otherwise, volunteer turnover will occur as volunteers seek to fulfill interactive needs elsewhere.

Practical Component: This research project has two purposes. The first is to conduct action research. Action research involves pursuing a practical research project by having the subjects determine the aims and goals of the research. Practical results are then generated so that the organization can implement improvements. The study is intended to teach Planned Parenthood about its volunteers and every aspect of the volunteer program. This knowledge can be used to improve volunteer recruitment strategies and to improve volunteer retention. Even though some details are applicable only to the Vancouver Planned Parenthood volunteer program, most information is relevant to the analysis of any organization.

Volunteers' experiences were the primary source of information. The results of this study allowed me to identify four categories of volunteers. These categories were

described in the methodology chapter. The factors discussed in this multi-leveled analysis explain why and how volunteers become members of one of these groups. The current core volunteers had much in common as reflected by their similar experiences. Most notable is the core volunteers' feelings of cohesion and inclusion as valuable group members. These feelings allowed volunteers to get more out of volunteering than altruistic and instrumental rewards. These volunteers felt that volunteering served an important role in their lives. Their feelings of belonging allowed them to constructively criticize (and commend) the volunteer program even while being a satisfied volunteer. The experiences of former core volunteers were very similar to current core volunteers if they dropped out because of volunteer-related factors. If they dropped out because of clinic-related factors however, they tended to have had poor experiences at the clinic and had many scathing remarks.

It is critical that new active volunteers develop cohesion with their co-workers and feel they are included in the volunteer group. Otherwise, they will drop out regardless of favourable individual level characteristics. These volunteers have successfully completed the critical stage of orientation, but it is too soon to assume that these volunteers will become part of the core group. If new active volunteers are not satisfied with volunteering, they will quickly manifest their dissatisfaction by becoming non-committed volunteers and dropping out. Integration into the volunteer program must occur quickly to establish cohesion, thereby improving retention. Volunteer turnover in these two latter groups represents an obvious waste of resources. Improved retention will result as the recommendations of this study are implemented.

More resources must be invested in volunteers to establish and maintain a more effective volunteer program. A haphazard approach to running a volunteer program obviously does not work. Volunteers have less discretionary time than ever before and there are numerous rewarding volunteer positions around the city. These factors create an environment of competition. The organizations that are willing to tailor their volunteer

program in the ways I have proposed are the ones who will recruit and retain the best volunteers.

Theoretical Component: There is an extensive literature on volunteers, yet large gaps exist in this literature. Specifically, most volunteer literature deals mainly with individual level data. Socio-demographic characteristics of volunteers, motivations for volunteering, and feeling of satisfaction derived from volunteering are among the topics examined in most volunteer literature. These components are important, but they reveal only part of the story. Volunteers do not live in a vacuum and this is why it is crucial to look beyond individual level data to explain volunteer recruitment and retention.

Work and leisure needs are important regardless of volunteers' motivations for volunteering. However, the leisure aspects are more important to the Vancouver clinic because the limited volunteer hours and opportunities there preclude volunteering as an alternative to work. Furthermore, most of the volunteers have careers and seek to meet different needs by volunteering. Indeed, most volunteers likened a satisfactory volunteer experience to leisure more so than to work. Volunteers who cited work-related needs as motivating them to volunteer did not continue to volunteer unless leisure-related needs were also met.

These factors go beyond the volunteers themselves to explain interaction among volunteers, and the volunteers and supervisors. Regular, long-term volunteering occurs when volunteers' work and leisure needs are met. Both types of needs are examined using an individual perspective in the volunteer literature. However, in the literature on paid work, it is well-accepted that the multi-levels I have discussed are integral aspects of workers' satisfaction and the overall effectiveness of an organization. Longevity for core volunteers was achieved when volunteers perceived volunteering as a leisure activity. They saw volunteering as an experience that would meet such needs as self-esteem, belonging, and self-actualization. Those who received the same kinds of rewards which would be derived through other leisure activities found volunteering enjoyable and became core volunteers.

Those who did not have these positive experiences failed to commit to volunteering at the clinic. New active volunteers are still captivated with the work-related experiences, but will soon seek to fulfill leisure-related experiences. If these needs are not met, these volunteers will drop out regardless of their enjoyment of other individualistic factors.

The second purpose of this project is, therefore, to contribute to the volunteer literature. Volunteers come to volunteering with diverse expectations, contributions and needs. Work and leisure needs are sought and obtained from satisfactory volunteer experiences. It is not enough to study individual volunteer factors to assess a volunteer program. The other levels of analysis are at least as important in explaining volunteer recruitment and retention, and must therefore be critically examined. Satisfaction with individual level needs only comes with satisfaction with the other aspects of volunteering. For example, cohesiveness, communication, leadership, and autonomy are among the multiple factors that interact to influence the success of a volunteer program, including volunteer recruitment and retention.

The five levels of analysis employed in this study have been adopted from the organizational behaviour literature, then modified to meet the requirement of a sociological approach to this case study. Organizational behaviour is typically used to examine the effectiveness of agencies with paid staff. However, it is equally suitable to the investigation of a non-profit organization, a social relationship or a volunteer program. All five levels of analysis along with their numerous sub-sections must be employed to examine any complex network. This project shows that organizational behaviour has much to contribute to the volunteer literature and can be widely interpreted to accommodate new areas of research.

As far as I know, I am the first person to use organizational behaviour to examine a volunteer program. Further, I modified the organizational behaviour model proposed by Arnold, Feldman, and Hunt to address the sociological perspective of this study. This dual approach must be used in other research to demonstrate how well these divergent perspectives work together. These authors readily acknowledge that the factors I have

introduced in each level of analysis are crucial to the understanding of the organizational behaviour of the volunteer program. Since there are some differences between this volunteer program and paid employment, such as no financial remuneration and fewer time demands in the former, I tailored the organizational behaviour model to the examination of this specific volunteer program. I emphasized sociological rather than psychological factors and added the highest level of organizational environment to the model to address the sociological dimension of organizational behaviour.

1a Limitations

The triangulation of methods used in this case study provide a detailed analysis of the volunteer program. However, the choice of tape-recorded interviews, observational analysis, and document analysis necessarily shapes the perspective of this study, thereby affecting the data collected, the results, and the interpretations. All methods are limited in different ways.

Using ethnography as a research strategy and observational analysis as a research method would adopt a different perspective resulting in an alternative type of study with different results. An ethnography involves describing the

culture and life style of the group of people being studied in a way that is as faithful as possible to the way they see it themselves. The idea is not so much to seek causes and explanations, as is often the case with survey-style research, but rather to 'tell it like it is' (McNeill, 1985:54-5).

Ethnography would in this way allow a more detailed analysis of volunteers' experiences, with minimal focus on cause and effect relationships.

Participant observation has always been the central method of ethnographers. It is often combined with data from other sources, especially informal or unstructured interviewing. Participant observation is just one method of collecting data, not complete strategy for social research (McNeill, 1985:58).

Participant observation involves observing people in their natural habitat by "watching, listening, talking, taking life-histories, and recording" (McNeill, 1985:59). "Such a

perspective suggests that the social world is not objective, but involves subjective meanings and experiences of social actors, a task that can only be achieved through participation with the individuals involved" (Burgess, 1984:78). Using participant observation as a research method would take a more subjective perspective of the volunteers and would subsequently yield a completely different type of study.

It would be fruitful to use ethnography as a research strategy and participant observation as a research method to examine volunteer programs in future research. These methods would provide a more detailed understanding of the subjective meanings of volunteering and experiences of volunteers not broached by the methodology used in this case study.

The scope of this study is limited not only in methodological ways, but in its subject matter as well. This study is limited to the volunteer program at the clinic level. Ways to widen the scope of this study include increasing the focus on the paid staff at the organization's clinic, provincial and federal level; clients' subjective experiences; longitudinal analysis of volunteers; funding issues within the clinic, provincial and federal associations; as well as increased attention to physicians' experiences.

Future Research: Many ideas for further research have emerged from this research project. On a theoretical level, one of most notable research possibilities is the use of an organizational behaviour framework to examine voluntary organizations. At the clinic level, other fruitful areas of study would be to interview clients to assess their impressions of the clinic. Clients' experiences are not formally solicited. Better client care would result if clients were asked to share their experiences at the clinic and their suggestions for improving client services. The clinic operates in part for one-time crisis services, but services could be extended to more returning clients. Unfortunately, because many clients do not return, we have no way of following up on them. We cannot know if their needs were well-served by the clinic.

It would also be enormously productive to review the volunteer program at regular intervals to examine the effects of the implementation of my recommendations in regards to volunteer recruitment and retention, as well as to clinic operations. It would be especially useful to increase follow-up with volunteers with the aim of improving retention. Only when follow up research is conducted can we say with some certainty that this action research has yielded positive results or that the organizational perspective has contributed to our understanding of this or other volunteer programs.

2 Recommendations

The purpose of this section is to recommend ways to improve the volunteer program based on the information presented in the preceding chapters. I noted radical changes in the preceding chapter. These changes are not discussed in this chapter because implementation is highly unlikely due to factors beyond the clinic's control. Here I take a practical stance and concentrate on improvements that can conceivably be accomplished. Six sections are reported sequentially to provide maximum coherence and utility. Recruitment, training, orientation, scheduling, and factors inside the clinic and outside the clinic are discussed.

2a Recruitment

Planned Parenthood must be more assertive in their quest for quality volunteers. This means they must more actively recruit volunteers. Volunteer job listings should be generated for distribution to interested parties. These listings should include descriptions of volunteer duties and opportunities at Planned Parenthood, as well as an overview of the altruistic and instrumental needs which volunteering can fulfill.

The most likely way to recruit volunteers is to advertise at such places as the Greater Vancouver Volunteer Centre, Canada Employment Centres, Student Placement Offices, Community Centres, at the clinic and on bill boards. Volunteers and clinic staff can make appeals for help at Planned Parenthood functions, during community education, and fund-raising events. In addition, direct contact techniques, such as word of mouth methods, can

be used by current volunteers. When a wider variety of methods are used to recruit volunteers, more diverse volunteers than the current homogeneous group will inevitably volunteer. The volunteers would then more closely match the diversity of the clinic clientele.

Volunteers must be screened before taking the training course. Screening would help ensure that volunteers want the job and that Planned Parenthood wants them. Screening could be accomplished either by having telephone or personal interviews with potential volunteers, and/or by having volunteers complete an application form. The volunteer committee, volunteer coordinator, or educator could determine which volunteers are most suitable, and invite them to attend the pre-training session.

The pre-training session would clarify volunteer requirements, as well as the components of training and orientation. Volunteer duties would be defined, a commitment to fulfill a specific volunteer requirement would be established, and the shift and time demands would be clarified for volunteers. Candidates who are still interested in volunteering after attending the pre-training session could then sign up to attend the volunteer training program.

2b Training

Regular and Pregnancy Counselling Training: Training must be mandatory for all volunteers. Training should be offered more often, at varying times, to increase its accessibility to volunteers. Training should be more extensive to ensure volunteers have a basic grasp of all volunteer and clinic operations before undergoing orientation. Potential volunteers should meet at the clinic on an off-clinic night to visualize and examine the clinic, see how the clinic process works, and to practice duties in the clinic setting.

Volunteers should learn about different contraceptive methods, sexually transmitted diseases and medical tests during training. Many volunteers thought that far more attention should be given to sexually transmitted diseases and medical tests during training to highlight their importance. A physician should attend a training session to explain her or his

duties at the clinic, as well as why and how physicians require assistance from the volunteers. Volunteers should also complete the paper work that accompanies the medical tests and interviews during training to help them become comfortable with this aspect of the job.

Job descriptions should be distributed to volunteers so that they can understand and begin to memorize the components of their duties. These descriptions can be used during on-site training to guide volunteers through the duties. Volunteers can also use these descriptions during and following training to verify that they are following procedures correctly. Volunteers should meet the supervisors during the on-site clinic training. Supervisors and volunteers can then get to know each other. Moreover, the supervisors can walk the volunteers through the clinic, explaining the clinic process through the volunteers' and clients' perspective. The educator and supervisor should establish and maintain close ties to ensure that training needs are understood and met by both parties.

Volunteers should complete a statement promising that they will contribute a specified number of volunteer hours to the organization. If a volunteer volunteered one shift (four hours) every second week, this would amount to ninety-six hours over the year. The supervisors would be very happy if all volunteers fulfilled this commitment. Such a statement would formalize their commitment to the organization and would help ensure that it is worth the organization's efforts to train these volunteers. If volunteers fulfill this commitment, the course fee could be reimbursed. This policy would give further incentive to volunteers to complete their commitment.

More role- and group-playing, and visual aids should be used in training. These strategies would help volunteers absorb information, as well as expose volunteers to all types of situations that occur at the clinic. Training should also focus more on interpersonal, counselling and educating skills in addition to the information taught. This would help volunteers share the information they have learned in a helpful, productive and non-biased manner. Issues relevant to different social classes, ages, education and ethnic groups should

be examined to help volunteers cope with clients in all sorts of situations and from all backgrounds. Documentation on specialized organizations that are better adapted to meet clients' needs should also be distributed so that volunteers can refer clients to the most appropriate sources of help.

It is essential that volunteers receive on-going training. This training would help them to brush up on duties, policies and procedures. The newest information on contraceptives, sexually transmitted disease, abortion and adoption laws and procedures, and staff and volunteer changes could be discussed for example. There should also be regular follow-up of new volunteers so that volunteers from a training course can get together periodically, perhaps three and six months after training, to discuss any issues which are of concern or interest to them.

Pregnancy Counselling Training: The above recommendations are relevant to the regular and pregnancy counselling volunteer training courses. There are some additional recommendations relevant only to the pregnancy counselling training course. The pregnancy counselling course should be staggered so that it is never offered two days in a row. It is too overwhelming for volunteers to learn so much so quickly. Volunteers tend not to absorb much of the course content in this situation. In addition, volunteers tend to form questions and ideas when they have time to let information sink in. The course would then be more productive if there was a week between sessions.

Resource books should be distributed to volunteers during the first session so that they can begin learning the information and come prepared with questions the next session. These resources would also enable volunteers to learn more about issues relevant to counselling clients and the options and resources available to pregnant women. This book could be consulted every time the volunteer counsels and would also be a useful tool to volunteers both inside and outside the clinic. Examination of the resources that are available for clients to take home should also be incorporated into training. This would allow volunteers to know what resources are available for them to distribute to clients.

An experienced pregnancy counsellor should attend the training course to share her knowledge and experience with the new volunteers. A field trip to an abortion clinic should be a part of the pregnancy counselling course. Volunteers could then learn exactly what happens at the clinic, thereby enabling them to be more supportive and helpful to women who are considering termination. It would also be helpful to have guest speakers during training, such as an official from an adoption agency, to explain adoption procedures to volunteers. Males often accompany their female partners during clinic appointments. It would therefore be useful to both clients and volunteers to learn more about the males' perspective and role in reproductive issues.

2c Orientation

Orientation should be standardized, slower, and more thorough and progressive. Orientation should entail step-by-step instruction, observation, guidance, and feedback. A better buddy system should be developed to facilitate improved orientation. Buddies (experienced volunteers) should receive some training so that they can orient new volunteers competently. Buddies should always be warned that they will be orienting so that they can prepare for those duties. A buddy system would allow an experienced volunteer to develop rapport with a newer volunteer, introduce that volunteer to her co-workers and monitor the progression of the new volunteer. The buddy would ensure that the new volunteer has someone to observe, befriend, and from whom to obtain feedback. There should be sufficient experienced volunteers so that the buddy and newer volunteer can exclusively orient that shift and not be concerned with actually performing duties.

It is best to orient on a slower night so that the newer volunteer can become comfortable with the clinic operations and routines without being overwhelmed. A maximum of one or two volunteers should be oriented each night to provide an optimum learning environment and minimize disruption of clinic operations. All duties should be taught to all volunteers during orientation so that volunteers would be equipped to perform every duty. Duties should also be taught systematically during orientation so that volunteers

start with easier duties and progress to the more difficult ones. A booking system should be created to allow volunteers to record their progression, questions, and comments. If orientation is not completed during one shift, an experienced volunteer could use this book the next shift to easily pick up where the first buddy left off.

The concept of team-work should be promoted during orientation. The running of the clinic should be seen as a team project and not one of isolated individuals performing alienating duties. Team work can be emphasized verbally by supervisors and volunteers. Better yet, the newer recruits can learn from the example set by the more experienced volunteers. All volunteers should wear name tags to identify themselves to the clients and to ensure that volunteers get to know each other. Arrival and departure times should be clarified to volunteers so that there is no confusion about this matter. The new volunteers should meet with the supervisor following orientation to discuss any questions or concerns. Together the supervisor and volunteer can decide if the volunteer requires another session devoted completely to orientation, or if she can begin performing duties under the buddy's supervision the next session. The next shift can also be booked at this time.

2d Scheduling

It is essential to have the appropriate number of volunteers compared to the number of clients so that volunteers are not bored or run off their feet. If the supervisor notices that too many volunteers are scheduled, then a volunteer should be contacted and asked not to come. This would prevent volunteers from travelling to the clinic, finding that there is a surplus of volunteers, then going home frustrated. Duties can tentatively be assigned during scheduling, but it must be made explicit to volunteers that flexibility is a requirement of all volunteers. At the same time, volunteers' preferences and choices must be honoured whenever possible.

In addition, all volunteers must be treated equally to reduce tension among volunteers both during and following orientation. This means that if two volunteers want to

perform the same duty, they must decide who will perform it this shift and who will perform it the next. Team-work can be promoted by having the same team of volunteers work every shift. The team can then develop its own routines, duty assignment and car pooling. Volunteers, especially new ones, should be cautioned against coming very frequently because this tends to result in quick burn out. Volunteers should be encouraged to commit to volunteering regularly, the first and third Tuesday of every month for example. Volunteers could then plan on volunteering over a long term, and develop a routine which would help them remember their shifts.

Planned Parenthood must also keep track of who volunteers how often and for what duties. A binder can be created so that volunteers can record these vital statistics. Supervisors can ensure that duties are distributed fairly by referring to this information. In addition, a recording system would allow easier follow up of volunteers who have been coming less often.

2e At the Clinic

More duties must be assumed by volunteers to diversify their jobs, and render them more challenging and rewarding. Increased responsibility would result in greater job satisfaction, which would in turn lead to improved retention. Volunteer growth and development would then be inherent in the volunteer role. Volunteers are interested in pursuing new projects such as updating the filing system, developing better interview forms and creating more visual aids for the methods talk. The volunteers need to know that their ideas and contributions are valuable and that a supervisor will guide and oversee the implementation of suggested projects. Some of these projects can be set up and pursued during clinic time when there is a surplus of volunteers or during slow times. These projects would be beneficial to clients, and to volunteers who would have a constructive way to use their excess time and energy.

Volunteers should be exposed to the way several volunteers perform their duties so that they can learn from these different methods and develop their personal style. Even though duties should be standardized, volunteers should be encouraged to use their autonomy and discretion to develop the style that suits them best. Part of this autonomy would be to decide how much time they need to spend with each client, rather than adhering to the one short term appointment standard. This is especially relevant in pregnancy counselling when sometimes a half hour appointment is simply insufficient. If enough volunteers were available to staff other positions, the volunteer could lengthen the appointment when required. Otherwise, she could schedule a second appointment with the client for another shift or continue the appointment outside of the clinic.

Scheduling a meeting with all clinic workers at the beginning of the evening would be enormously beneficial. Attendance at a pre-clinic meeting could be mandatory for all volunteers, and could be scheduled at six o'clock. A meeting would allow client load and composition to be relayed, duties to be assigned to everyone's satisfaction, new volunteers to be introduced, and questions and concerns to be aired. These meetings would serve as a

forum for discussion, increasing the communication between volunteers and the volunteers and supervisors. These meetings would reinforce the concepts of leadership, team-work and cohesion. They would also benefit clients because volunteers would arrive well before clients, and be prepared to begin their duties immediately. Consequently, clients would be processed much more efficiently. Supervisors could use the meeting time to ensure that volunteers know what they are doing, respond to any questions and concerns, and show volunteers that they care about the volunteers' performance and job satisfaction. Volunteers could work on on-going clinic projects until their duties begin. A suggestion box should be set up for volunteers who are hesitant to bring issues up during meetings. A suggestion box should also be set up for clients. Clients could then give workers feedback which would be instrumental to improving client care.

Planned Parenthood is a client-based program. The organization must ensure that client needs are met, even if this means implementing program changes or inconveniencing staff. Volunteers and clients become frustrated when supervisors have different methods. Therefore, procedures must be standardized between supervisors to establish consistency of service. Clinic services must also be standardized so that all clients receive the same quality care. For example, all clients with appointments for annual check ups must give a urine sample. This sample must then be tested, the results entered in the client's file, and the client must be notified of any abnormalities. A haphazard approach to these tests results in inconsistent client care. Such care could be construed as neglectful if a client is not informed she has a sexually transmitted disease for example.

Clients frequently become frustrated because their appointment takes a long time. It is essential that clients be warned of the time commitment involved, especially if they are new, so that they can anticipate the wait. Most volunteers are content to wait when they have been told to expect delays because physicians and volunteers spend as much time as necessary with clients. The positive results of this universal policy are that clients always receive quality care. Volunteers and supervisors must be more respectful and

accommodating of clients with special needs. A common example of this is when a teenager comes to the clinic to obtain contraceptives. She states that she must be home by a certain time because she has a curfew and does not want her parents to know where she is. Staff must do their best to ensure that she gets served quickly, even if it means altering appointment order.

Appointments and order of duties can also be juggled so that client backlog is decreased. For example, multiple method talks can be staggered so that all clients do not have to wait together for interviews and physicians. Multiple talks would also mean that as soon as a client arrives, the methods talk could begin. This is in contrast to waiting for all clients to arrive before beginning the methods talk, when clients regularly do not keep their appointments. Interviews can also be conducted before the methods talk when clients arrive early, thereby speeding up client services. Volunteers would then be kept busy and would have the autonomy to alter clinic procedures when appropriate.

It is extremely important that a better filing system be established. Computerization is the best way to achieve this. Files could be located much more easily, information could be more easily accessed, new information could easily be entered, and files would rarely be lost if they were computerized. Unfortunately, computerization is prohibitively expensive. Failing a complete system overhaul like this one, filing cabinets could at least be arranged in order, and file identification could be better affixed to files to prevent file loss. Volunteers must learn to file properly and to have respect for this extremely important component of client care. All too often files and information are lost, an inexcusable occurrence in a health care organization.

Lastly, an escort service should be created to help clients get to their cars or transit safely. Volunteers could provide this service whenever it is dark and a woman is alone, or when a client requests it. Volunteers could take advantage of the same type of service when they close up the clinic. Car pooling can be arranged to make sure all workers get home safely.

2f Outside of Clinic

It is essential to have extracurricular activities of both a social- and clinic-related nature. In fact, these two purposes could be met by the same gathering in most instances. For example, volunteers could have a staff meeting at one of their homes or the office, then follow it with a pot luck dinner. Events like these would promote cohesion by allowing volunteers get to know each other, and the supervisors better. Team-work and commitment to the clinic could be promoted at these activities by increasing involvement in the organization. Continued education, and comment and question sessions could be a component of these meetings, as could volunteer recognition and rewards. Plaques, ribbons, or buttons could be awarded to the best and most dedicated volunteers to formally recognize their achievement and contributions to the organization.

It is crucial to have a systematic method of volunteer follow up. Volunteers should be periodically solicited for their experiences and suggestions. This is especially important when volunteers drop out or begin to come less frequently for no apparent reason. With follow up, reasons for quitting can be established and steps can be taken to improve the volunteer program. Some non active volunteers could be convinced to resume their duties. Some volunteers who have been coming less frequently could be encouraged to continue volunteering after they have aired their concerns. Some volunteers would undoubtedly return to volunteering more regularly under these circumstances. As the results chapter demonstrated, even when volunteers are satisfied with the volunteer experience, they have many suggestions. This is why it is important not to overlook active volunteers when conducting follow up.

A clinic newsletter should be established to inform volunteers of clinic happenings and changes; social events; new rules, laws or regulations; welcome new volunteers; say farewell to departing staff and so on. Such a newsletter would keep volunteers more in-tune with organizational concerns and clinic happenings. Volunteers who are taking a temporary

leave from the clinic, to have a baby or take a night course for example, could maintain contact with the organization in this way.

The last point to be made is the volunteer program requires more attention. The supervisors are simply too occupied with running the clinic to devote themselves to the volunteer program. A volunteer coordinator could be hired to handle all aspects of the volunteer program. Unfortunately, this is unlikely to happen because of financial constraints.

The next best thing would be to establish a volunteer committee who could also perform these duties. Volunteers could volunteer to serve on this committee as part of their duties. They would volunteer often enough to know what is going on at the clinic, but would devote most of their time to committee duties. This committee could recruit and screen volunteers; create a newsletter; liaise between the educator, supervisors and the volunteers; organize intra-clinic projects; conduct volunteer follow up; and arrange field trips and social events among other things. The hiring of a volunteer coordinator or the establishment of a volunteer committee would alleviate the pressure on the supervisors. The clinic would run better, which would benefit clients. In addition, it would be a perfect opportunity for the more dedicated volunteers to take on new and more challenging duties. This would result in greater volunteer satisfaction for both the committee and non committee volunteers. Recruitment and retention would, therefore, be improved.

The purpose of this chapter has been to make feasible recommendations to improve the volunteer program. Some of these recommendations have already been adopted by the educator and supervisors. The merits of considering and pursuing these changes is apparent and I am optimistic that most of my recommendations will eventually be implemented. Improved volunteer recruitment and retention will be a direct result of following these recommendations. These improvements will benefit the clients, volunteers, supervisors and the organization.

Bibliography

- Abbey-Livingston, Diane, and Doreen Sears
1984 "The Changing Role of Volunteers." *Leisurability* 10(3):4-12
- Agar, Michael H.
1986 *Speaking of Ethnography*. Qualitative Research Methods Series 2. Sage Publications
- Allen, Natalie J.
1987 "The Role of Social and Organizational Factors in the Evaluation of Volunteer Programs." *Evaluation and Program Planning* 10:257-62
- Arnold, Hugh J., Daniel C. Feldman, and Gerry Hunt
1992 *Organizational Behaviour: A Canadian Perspective*. McGraw-Hill Ryerson Limited
- Athey, Timothy R.
1987 "The Dynamics of Volunteer Participation in Futures Research." *Futures* 19(2):168-83
- Beachell, Laurie, and Brian Law
1984 "Changing Perspectives in Volunteerism." Editors' Comments. *Journal of Leisurability* 10(3):3
- Brewer, John, and Albert Hunter
1989 *Multimethod Research: A Synthesis of Styles*. Sage Publications
- Brotchie, Jane
1989 "Voluntary Sector: Mixed Blessings." *New Statesman Society* 2(August):24
- Brown, Robert, Eugene Komenka, Martin Krygier, and Alice Erh-Soon Tay
1979 *Bureaucracy: The Career of a Concept*. Ideas and Ideologies Series. Edited by Eugene Komenka and Martine Krygier. Edward Arnold
- Burgess, Robert G.
1984 *In the Field: An Introduction to Field Research*. Contemporary Social Research:8. Series Editor: Martin Bulmer. Routledge
- Campbell, Jean
1984 "The Changing Role of Volunteer Centres: A Case Study." *Leisurability* 10(3):17-18
- Clary, E. Gil, and Jude Miller
1986 "Socialization and Situational Influences on Sustained Altruism." *Child Development* 57(December):1358-69
- Coleman, James S.
1986 "Social Theory, Social Research, and a Theory of Action." *American Journal of Sociology* 91(May):1309-35

- Curtis, James E., Steven D. Brown, Ronald D. Lambert, and Barry J. Kay
1989 "Affiliating with Voluntary Associations: Canadian-American Comparisons."
Canadian Journal of Sociology 14(2):143-61
- Daniels, Arlene Kaplan
1985 "Good Times and Good Works: The Place of Sociability in the Work of Women
Volunteers." Social Problems 32(April):363-74
- Daniels, Arlene Kaplan
1987 "Invisible Work." Social Problems 34:403-15
- Distefano, M. K. Jr., and Margaret W. Pryer
1982 "Ability, Training Performance, and Demographic Factors in Voluntary Turnover
Among Psychiatric Aides." Psychological Reports 51(October):619-22
- Denzin, Norman K.
1970 Sociological Methods: A Sourcebook. Aldine Publishing Company
- Ellis, Susan J
1984- "Research on Volunteerism: What Needs to be
1986 Done." Journal of Voluntary Action Research 13-15:11-14
- Family Planning Association of British Columbia
1973 "Community Responses Needs and Priorities." First Provincial Conference.
Sponsored by the Family Planning Association of B.C. May 21-24, U.B.C.
- Family Planning Association of British Columbia
1974 "Vancouver Branch Newsletter." April
- Funk and Wagnall's
1977 Standard Desk Dictionary. Lippincott, Crowell, Publishers, U.S.
- Gidron, Benjamin
1984 "Predictors of Retention and Turnover Among Service Volunteer Workers." Journal
of Social Science Research 8(1):1-16
- Gillespie, David F. and Anthony E.O. King I.
1985 "Demographic Understanding of Volunteerism." Journal of Sociology and Social
Welfare 12(4):798-815
- Gladwin, Christina H.
1989 Ethnographic Decision Tree Modeling. Qualitative Research Methods Series 19.
Sage Publications
- Guzzo, Richard A.
1979 "Types of Rewards, Cognitions, and Work Motivations." Academy of Management
Review 4(1):75-86

Hakim, Catherine

1987 *Research Design: Strategies and Choices in the Design of Social Research.*
Contemporary Social Research:13. Series Editor: Martin Bulmer. Allen and Unwin
Ltd.

Hanks, Michael

1981 "Youth, Voluntary Associations and Political Socialization." *Social Forces*
60(Summer):211-23

Hawrylyshyn, Oli

1978 "The Economic Nature and Value of Volunteer Activity in Canada." *Social Indicators*
Research 5(Jan):1-71

Hayghe, Howard V.

1991 "Volunteers in the U.S.: Who Donates the Time?" *Monthly Labor Review*
114(February):17-23

Henderson, Karla

1981 "Motivations and Perceptions of Volunteerism as a Leisure Activity." *Journal of*
Leisure Research 13(3):208-18

Henderson, Karla

1984- "Volunteerism as Leisure." *Journal of Voluntary*
1986 *Action Research* 13-15:55-63

Hodgkinson, Virginia A., Richard W. Lyman and Associates

1989 *The Future of the Nonprofit Sector: Challenges, Changes, and Policy Considerations.*
Jossey-Bass Publishers

Holmes, Joanne, Patricia B. Nemic, and Catherine Weisbrod

1979 "Four Ways to Attract as Many Volunteers as You Can Use." *Practice Digest*
2(2):10-11

Ilsley, Paul J.

1990 *Enhancing the Volunteer Experience: New Insights on Strengthening Volunteer*
Participation, Learning, and Commitment. Jossey-Bass Publishers

Jenner, Jessica Reynolds

1981 "Volunteerism as an Aspect of Women's Work Lives." *Journal of Vocational*
Behavior 19(3):302-14

Jenner, Jessica Reynolds

1982 "Participation, Leadership, and the Role of Volunteerism Among Selected Women

Volunteers." *Journal of Voluntary Action Research* 11(4):27-38

Jenner, Jessica Reynolds

1983 "Correlates of Career Choices of Women Volunteers." *Psychological Reports*
53(December):1135-42

Jenner, Jessica Reynolds

1984 "Organizational Commitment Among Women Volunteers: Meaning and Measurement." *Psychological Reports* 54(January):991-96

Kelen, Andras

1985 "Making Pledges and Requirements: Historical Variants of 'Voluntary Labor'." *International Journal of Comparative Sociology* 26:209-19

Knoke, David

1981 "Commitment and Detachment in Voluntary Associations." *American Sociological Review* 46(April):141-58

Knoke, David, and David Prenskey

1984 "What Relevance Do Organization Theories Have for Voluntary Associations?" *Social Science Quarterly* 65(1):3-20

L., Alice (of Families Anonymous)

1990 "Increasing Men's Participation." *Social Policy* 20(Winter):64-5

Levine, Donald N.

1991 "Simmel and Parsons Reconsidered." *American Journal of Sociology* 96(March):1097-116

Lipset, Seymour Martin

1989 "Voluntary Activities: More Canadian-American Comparisons- A Reply." *Canadian Journal of Sociology* 14:377-81

Lofland, John, and Lyn H. Lofland

1984 *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis.* Wadsworth Publishing Company, California

Luks, Allan

1988 "Helper's High." *Psychology Today* 22(October): 39-40

Maentz, Ashley M.

1987 "Taking Charge: How to Make a Difference. The Volunteer-Agent for Action." *Public Health Reports* 102(summer):78-80

Maslow, Abraham H.

1943 "A Theory of Human Motivation." *Psychological Review* 50(July):370-96

McCroskey, Jan, Cilla Brown, and Susan Reid Greene

1983 "Are Volunteers Worth the Effort?" *Public Welfare* 41(Winter):5-6

McLennan, James P.

1985 "Helping Beliefs Inventory: Brief Screening Measure for Training Volunteer Applicants in Counseling." *Psychological Reports* 56(January):843-86

McNeill, Patrick

1985 *Research Methods.* Tavistock Publications

McPherson, J. Miller

1981 "A Dynamic Model of Voluntary Affiliation." *Social Forces* 59(March):705-28

McPherson, J. Miller, and Lynn Smith-Lovin

1982 "Women and Weak Ties: Differences by Sex in the Size of Voluntary Organizations." *American Journal of Sociology* 87(January):883-904

Moore, Larry F., editor

1985 *Motivating Volunteers: How the Rewards of Unpaid Work Can Meet People's Needs.* Vancouver Volunteer Centre.

Moser, C.A., and G. Kalton

1972 *Survey Methods in Social Investigation.* Second Edition. Basis Books, Inc.

Moyer, Mel S.

1984- "Voluntary Action Research: A View from

1986 Canada." *Journal of Voluntary Action Research* 13-15:15-16

Netting, F. Ellen

1987 "Ethical Issues in Volunteer Management and Accountability." *Social Work* 32(May/June):250-52

O'Connell, Brian

1989 "What Voluntary Activity Can and Cannot Do for America." *Public Administration Review* 49(September/October):486-91)

O'Neill, Michael

1989 *The Third America: The Emergence of the Nonprofit Sector in the United States.* Jossey-Bass Publishers

Pearce, Jone L.

1983 "Job Attitude and Motivation Differences Between Volunteers and Employees from Comparable Organizations." *Journal of Applied Psychology* 68(November):646-52

Perkins, Kenneth B., and Carole W. Metz

1988 "Note on Commitment and Community Among Volunteer Firefighters." *Sociological Inquiry* 58:117-21

Phillips, Michael

1982 "Motivation and Expectation in Successful Volunteerism." *Journal of Voluntary Action Research* 11:118-25

Planned Parenthood Association of B.C.

1992 Annual Report. Presented by the Board of Directors

Planned Parenthood Association Of B.C.

1993 Annual Report. Presented by the Board of Directors

Planned Parenthood Association of British Columbia

1993 Planned Parenthood Association of British Columbia, distribution pamphlet.

Planned Parenthood Federation of Canada
1989 20th Anniversary Family Planning Pioneer Address Book

Riddell, Barry, and John Lynch
1973 Bureaucracy. Maclean-Hunter

Robbins, Stephen P.
1986 Organizational Behavior: Concepts, Controversies, and Applications. 3d edition.
Prentice-Hall, U.S.A.

Rubin, Allen, and Irene M. Thorelli
1984 "Egoistic Motives and Longevity of Participation by Social Service Volunteers."
Journal of Applied Behavioural Science 20(3):223-35

Sadik, Nafis
1986 "The Importance of Voluntarism." Populi 13(4):14-22

Schindler-Rainman, Eva
1982- "Trends and Changes in the Volunteer World."
1983 Journal of Voluntary Action Research 11-12:157-163

Sciulli, David
1986 "Voluntaristic Action as a Distinct Concept: Theoretical Foundations of Societal
Constitutionalism." American Sociological Review 51(December):743-66

Serow, Robert C. and Julia I. Dreyden
1990 "Community Service Among College and University Students: Individual and
Institutional Relationships." Adolescence 25:553-66

Skloot, Edward, editor
1988 The Nonprofit Entrepreneur: Creating Ventures to Earn Income. The Foundation
Center.

Smith, David Horton
1975 "Voluntary Action and Voluntary Groups." Annual Review of Psychology 1:247-70

Smith, David Horton, and Frederick Elkin
1980 "Volunteers, Voluntary Associations, and Development: an Introduction."
International Journal of Comparative Sociology 21:151-301

Strauss, George, Raymond E. Miles, Charles C. Snow, and Arnold S Taunnenbaum, Eds.
1976 Organizational Behavior: Research and Issues. Wadsworth Publishing Company
Inc. California

Sundeen, Richard A.
1988 "Explaining Participation in Coproduction: A Study of Volunteers." Social Science
Quarterly 69(Summer):547-68

Tomeh, Aida K., and David W. Chilson
1982 "Predictors of Voluntary Group Participation Among Females and Males." Phylon
43(Summer):262-75

Turabian, Kate L.

1987 *A Manual for Writers of Term Papers, Theses and Dissertations*. 5th edition. The University of Chicago Press, Chicago

Unger, Lynette S.

1987 "Effect of Actual and Perceived Availability of Time on Volunteerism." *Perceptual Motor Skills* 65(October):524-6

Vaillancourt, Francois, and Micheline Payette

1984- "The Supply of Volunteer Work: The Case of
1986 Canada." *The Journal of Voluntary Action Research* 13-15:45-56

VanBuren, Michael P.

1990 *Reaching Out: America's Volunteer Heritage*. Published by the W.K. Kellogg Foundation Battle Creek, Michigan

Van Till, Jon

1985 "Voluntarism and Social Policy." *Social Policy* 15(Spring):28-31

Watts, Ann DeWitt, and Patricia Klobus Edwards

1982 "Recruiting and Retaining Human Service Volunteers: An Empirical Analysis." *Journal of Voluntary Action Research* 11(4):9-22

Weisberg, Herbert F., Jon A. Krosnick, and Bruce D. Bowen

1989 *An Introduction to Survey Research and Data Analysis*. Published by Scott, Foresman and Company, U.S.A.

Appendix

Recruitment Notice

The University of British Columbia
Department of Anthropology and Sociology
6303 N.W. Marine Drive
Vancouver, B.C. Canada V6T 2B2

TITLE OF PROJECT:
VOLUNTEER RECRUITMENT AND RETENTION:
A CASE STUDY OF THE VANCOUVER PLANNED PARENTHOOD CLINIC

Investigator: Lisa Parsons, M.A. student
Dr. Dawn Currie, thesis advisor
Department of Anthropology and Sociology
University of British Columbia
phone: 733-0478

I am conducting a case study of the volunteer program at the Vancouver Planned Parenthood Clinic. The goal of my study is to examine the organization in order to determine how to develop a more successful volunteer program. The focus of the project will be volunteer recruitment and retention. Therefore, the insights of the volunteers are essential to the success of the study.

Planned Parenthood has provided a current list of volunteers which I will use to select and contact potential respondents. Participation is voluntary and will involve one session of approximately 1- 1 1/2 hours. This session will consist of an interview exploring respondents' experiences as volunteers. All interviews are confidential and the names of participants will not be used when materials are published and will not be discussed in public. Anyone participating in an interview has the right to change her mind at any point.

Although I value your participation very much since the research cannot be conducted otherwise, I am not able to compensate participants in any way. However, most people enjoy the opportunity to discuss these types of issues which are important to them. In addition, there is the added pleasure of helping Planned Parenthood implement a more effective volunteer program.

Please feel free to contact me if you have any questions or comments about this research project.

Lisa Parsons 733-0478

Letter of Consent

The University of British Columbia
Department of Anthropology and Sociology
6303 N.W. Marine Drive
Vancouver, B.C. Canada V6T 2B2

**TITLE OF PROJECT:
VOLUNTEER RECRUITMENT AND RETENTION:
A CASE STUDY OF THE VANCOUVER PLANNED PARENTHOOD CLINIC**

Investigator: Lisa Parsons, M.A. student
Dr. Dawn Currie, thesis advisor
Department of Anthropology and Sociology
University of British Columbia
phone: 733-0478

Despite the importance of volunteers in many organizations, little research has been conducted to identify who volunteers for what kinds of work. Furthermore, strategies to recruit and retain volunteers more successfully have largely been neglected. This study is designed to explore the personal characteristics, motivations, and experiences of the Vancouver clinic Planned Parenthood volunteers, and to explore volunteer recruitment and retention. The purpose of the study is to interview long- and short-term volunteers to determine how Planned Parenthood can improve its volunteer program.

While these are topics which can be very personal, all interviews are confidential and the names of participants will not be used when materials are published or discussed in public. The interviews require about one to one and a half hours and will be tape-recorded. Anyone participating in an interview has the right to end the interview at any point. Although I value your participation very much because the research cannot be conducted otherwise, I am not able to compensate participants in any way. However, most people enjoy the opportunity to discuss these types of issues which are important to them.

Having read and understood the above purposes and conditions of the research, I hereby consent my participation in this study:

(signature)

(date)

This acknowledges receipt of a copy of this completed consent form.

Interview Schedule

Case #

How long have you been volunteering at the Vancouver Planned Parenthood clinic?

Do you consider yourself an active Planned Parenthood volunteer?

Yes How often do you typically volunteer? _____

No How often did you volunteer and for how long?

Have you volunteered at any other Planned Parenthood clinic?

Yes Which clinic and for how long? _____

No

How did you find out about volunteer opportunities at Planned Parenthood?

What made you decide to volunteer initially? _____

Did you have any interaction/involvement with Planned Parenthood before volunteering?

No

Yes (describe) _____

Did you take the regular volunteer training course?

Yes When (approx.) _____

No Do you plan to/would you like to? _____

Did you find that the training course adequately prepared you for your duties at the clinic?

Yes _____

No _____

What ideas do you have for improving the training course?

Did you take the pregnancy counselling training course?

Yes When (approx.) _____

No Do you plan to/would you like to? _____

Did you find that the pregnancy counselling training course adequately prepared you for your duties at the clinic?

Yes _____
 No _____

What ideas do you have for improving the pregnancy counselling training course?

What do/did you usually do?

Nursing _____
 Interviewing _____
 Methods Talk _____
 Pregnancy Counselling _____
 Other _____

What duties do/did you like best and why?

Nursing _____
 Interviewing _____
 Methods Talk _____
 Pr. Counselling _____
 Other _____

How did orientation at the clinic go? Describe your experiences.

What ideas do you have for improving the orientation process (regular and pregnancy counselling if applicable)?

Why do you continue to volunteer at Planned Parenthood (or why did you stop volunteering at Planned Parenthood)?

What would make you volunteer more often? _____

What barriers to volunteering have you encountered? _____

How do you think the volunteer program could be improved?

What do you think could be done to make the clinic function more smoothly?

Have you done any other volunteer work?
__ Yes Where, when and for how long? _____
__ No

What is your date of birth? _____

Are you employed:

- No: __ Unemployed?
 __ Student: Part-time/ Full-time?
 __ Home-maker?
 __ Other (specify _____)?
Yes: __ Full time (specify _____)?
 __ Part-time (specify _____)?
 __ Other (specify _____)?

What is the highest level of education you have completed?

What was your field of study?

- Are you: __ Single/Never Married?
 __ Married?
 __ Separated?
 __ Divorced?
 __ Widowed?

Do you have any children? __ Yes How many? _____
 __ No

How would you describe your ethnic/racial background?
