Volunteering in Public Health: An Analysis of Volunteers' Characteristics and Activities

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Abstract

Despite current interest in social capital and health, little is known about volunteers in public health causes. This study describes public health areas and activities in which individuals volunteer, and assesses the volunteers' characteristics. Data were collected from a cross-sectional sample of Illinois residents (N = 605) through a random-digit-dialing telephone survey in 1999. Ninety-nine (16.3%) individuals volunteered for a health organization. The most common areas for volunteering included cancer and the elderly. The most frequent activities were fundraising and support to the sick. Higher income was the only significant predictor of volunteering after controlling for age, gender, race, marital status, and education. Public health-related organizations and volunteer administrators need to promote volunteerism among the disadvantaged.

Key Words:

volunteering, public health, volunteering, participation, community involvement

Introduction

Volunteering, as a form of social capital, has a two-fold critical role in public health (Putnam, 2000). First, via such organized action, individuals create change in their communities and make health interventions both culturally appropriate and sustainable (Kelly, 1999; Omoto, Snyder, & Berghois, 1993; Zimmerman, Ramirez-Valles, Suarez, De la Rosa, & Castro, 1997). Second, through their volunteer work in health-related organizations and efforts, individuals become educated about risk and preventive behaviors, develop and maintain a positive sense of themselves and their community, and mobilize their social networks to cope with stressors (Arno, 1986; Bellah, Madsen, Sullivan, Swidler, & Tipton, 1996; Chambre, 1991; Kobasa, 1991; Moen & Fields, 1999; Perrow & Guillen, 1990; Snyder & Omoto, 1999; Thoits and Hewitt, 2001; Weitzman & Kawachi, 2000; Wolfe, 1994; Youniss & Yates, 1997). Yet, little is known about volunteering in health-related endeavors, especially among ethnic minority communities.

The purpose of this study is to describe the public health areas and activities in which individuals volunteer, and assess the sociodemographic characteristics of volunteering. This study is especially significant for volunteer administrators and public health professionals because of their interest in both community mobilization and

social capital. The study may assist them in understanding who participates in community mobilization. In particular, this research informs the recruitment and involvement of communities by documenting what groups are likely to get involved and in what types of public health activities.

For the purpose of this study, volunteering refers to individuals' unpaid work on behalf of others or a collective good and in the context of a formal or semiformal organization, that is, outside the home and the family (Schondel, Shields, & Orel, 1992; Smith, 1997; Wilson & Musick, 1997). The term volunteer emerged in the 19th century in Britain and in a social class system (Taylor, 2005). At the height of industrialization, middle classes, mostly women, engaged in volunteer work as a charity, to "help those less fortunate," and fulfill their own class and gender roles. The working class and the poor, however, did not engage in that type of work. Their unpaid work was in the form of mutual aid, solidarity, and as a means of survival (Taylor, 2005).

The most recent national data, collected by the Independent Sector (2001) indicate that 44% of adults (i.e., 21 years and older) volunteered in 2000. Of those who volunteer, only about 7% do so in health and 10% in human services areas (Independent Sector, 1999). The most commonly reported volunteer activities were direct service (e.g., serving food), fundraising, and informal volunteering (e.g., helping neighbors). Regarding socio-demographic characteristics, volunteering is higher among older cohorts (e.g., >35 years), women, Caucasians, and those with higher education (e.g., college degree) and income (e.g., > $40,000) (ibid). African-American and Latino groups seem to volunteer less than White groups (Smith, 1997). Unfortunately, little is known about volunteering and civic involvement among non-White and low-income populations, and the available evidence is inconclusive. In some studies, racial differences disappear when social class is taken into account (Wilson & Musick, 1997). Other studies indicate that racial minorities do not participate less than White populations, but they participate in different types of organizations such as neighborhood-level organizations (Portney & Berry, 1997; Schondel et al., 1992).

In the area of HIV/AIDS, for example, Ferrer, Ramirez-Valles, Kegeles, and Rebehook, (2002) found that young white gay men in the southwest (i.e., Austin, Phoenix, and Albuquerque), volunteered at higher rates (26%) than their Latino peers (20%) in HIV/AIDS and gay issues. In another study based on a probabilistic sample of Latino gay men in Los Angeles, Miami, and New York City, the rates were higher, ranging from 37% in the first, to 63% in third city (Ramirez-Valles & Diaz, 2005). These differences could be attributed to measurement, besides the evident geographic variation. The study in the southwest assessed only volunteer work (e.g., *yes*, *no*) on HIV/AIDS and gay issues during the last 12 months. The study in the metropolitan areas included current level of involvement (e.g., *definitely yes* to *definitely no*) in gay and Latino organizations. In the latter study, being involved was associated with being bilingual (i.e., Spanish and English) and with experiences of homophobia and experiences with HIV/AIDS (e.g., people who are HIV-positive in one's social network). Education and income were not related to involvement. Furthermore, the involvement of those who are HIV-positive also seems to be higher than expected. About 60% of Latino gay men, who are HIV-positive, report participating in AIDS organizations in New

York City, while 40% report in Washington DC (Ramirez-Valles & Diaz , 2005).

Methods

Sample. Data for this study come from a random-digit-dialing telephone survey of households in the state of Illinois (Survey Research Laboratory, 1999). A dual frame design was used by which a reverse directory provided addresses of households with listed telephone numbers. Then, a letter was sent to these households to inform about the survey and solicit their cooperation. Telephone interviews were conducted during the spring of 1999. The final sample included 605 respondents for a response rate of 45.3%. Post-stratification weights were applied to adjust for biases in response. Data were weighted by gender, education, age, and race, following estimates in the 1998 Current Population Survey.

Measures. Data were collected on respondents' age, gender, race, marital status, education, income, and volunteer work. Education was measured with a 4-point scale (e.g., 1 = *Less than high school*; 4 = *College or higher*). Similarly, income was assessed as the total 1998 household income from all sources using a 6-point scale (e.g., 1 = *Less than $10,000,* 6= *More than $70,000*). For our outcome variable, volunteering, we asked participants: "During the past 12 months, did you do volunteer work for any health-related organization or event, not including donating money?" Those who answered "yes" were then asked for the health-related issue addressed by the organization in which they volunteered (e.g., cancer, HIV/AIDS, violence). In addition, we asked for the types of volunteer work done (e.g., counseling, outreach, fundraising). In the latter two questions, respondents had the option to report up to three volunteer areas and activities.

Analysis. In descriptive analyses, volunteers were compared to nonvolunteers on study variables of interest using *t*-tests for continuous variables, Mann-Whitney tests for ordered categorical variables, and chi-square tests for unordered categorical variables. A series of three logistic multiple regressions was conducted to evaluate the additive effects of the study variables (e.g., education and income) on the outcome variable, volunteering (yes/no). Logistic regression is the most appropriate statistic modeling for these data given the dichotomous nature of the outcome variable. Model 1 consisted of age, gender, race, and marital status. Models 2 and 3 added the variables of education and income, respectively. Interaction effects were assessed for each model (e.g., race and income) as well as nonlinear associations. All analyses were conducted on weighted data and then verified on non-weighted data. No significant differences were found on those analyses, hence I only present those based on weighted data.

Findings

Table 1 shows the socio-demographic characteristics of the sample by volunteering. Ninety-nine (16.3%) participants reported volunteering in the previous year. The volunteer areas most commonly cited include cancer (n = 18), elderly (n = 18), disabilities (n = 12), hospitals (n = 11), heart conditions (n = 9), diabetes (n = 8), homelessness (n = 7), and HIV/AIDS and blood drives (n = 6, respectively). The activities most frequently reported are fundraising (n = 39), support services to the sick or the elderly (n = 19), office help and health fairs (n = 12, respectively), organizing meetings and events (n = 11), housekeeping tasks (n = 8), and health education and outreach/recruitment (n = 5, respectively).

In bivariate analyses, no significant correlations were found between volunteering and age, gender, race, and marital status. Education and income were positively correlated with volunteering.

The results of the logistic multiple regressions are presented in Table 2. In Model 1, which included four demographic variables, race (e.g., White) was the only statistically significant predictor of volunteering (OR = 1.81; $p < .05$). In Model 2, education was added to the equation and no variable was found to be statistically associated with volunteering. Notably, the effect of race on volunteering became non-significant. Finally, in Model 3, the addition of income was significant. Individuals with higher incomes were more likely to volunteer (OR = 1.22; $p < .05$). This final model also fitted the data well, as indicated by the significant chi-square value. No interactions or nonlinear (e.g., inverted u-shapes) effects were found.

Conclusions

The intent of this study was to assess which public health areas and activities attract volunteers, and the socio-demographic characteristics of volunteers. Compared to national data (Independent Sector, 1999), I found a larger percentage of volunteers in health-related areas (i.e., 16%). This discrepancy may be due to a couple of factors. First, the Independent Sector survey (which collects national data on volunteering), does not ask directly about volunteering in health-related organizations, as it was done in this study. Furthermore, in this study, respondents were not asked about their volunteer work in general, as the Independent Sector does. This could have increased reporting of volunteering in health-related areas in this study. Second, the difference could reflect actual regional variations.

In regard to the socio-demographic attributes of volunteering, the findings from this study are consistent with previous research. Education and income were found positively correlated with volunteering in bivariate analyses. National surveys and small community studies have consistently found that individuals with higher education and income are more likely to be recruited for volunteer work than those with lower levels of formal education and income (Hodgkinson, 1995; Smith, 1994; Wilson & Musick, 1997). As noted previously, ethnic minorities seem to volunteer at lower rates than White populations (Smith, 1997). Here it was found that race differences disappear when education is controlled for statistically. Further, the only significant predictor in the final model was income. These results suggest that race difference may be explained by the overall higher income levels among the White population. Individuals with higher incomes may be more likely to volunteer in health-related organizations because (a) they may have technical and professional skills that organizations need, and (b) they may be more socially connected, therefore, more exposed to opportunities to volunteer. It is plausible, however, that individuals with lower income levels and who are members of racial minorities, channel their collective action through informal groups, nonissue-oriented organizations, or neighborhood groups (Portney & Berry, 1997). Moreover, and perhaps of most importance, their leisure time is very limited as to get involved in unpaid work with formal or semiformal organizations.

Consistent with the relationship between income and volunteer work, fundraising was among the most frequently reported activity, followed by the areas of cancer and the elderly. Notably missing are substance use and maternal and child health, among others.

Also, activities such as organizing groups and health education are rarely reported. These types of activities, while requiring more time and involvement than fundraising, are central to pubic health and to reach the working class and the poor.

A significant limitation of this study is the single dichotomous measure of volunteering. A more comprehensive measure should include length and frequency of involvement, and types of activities performed (Ramirez-Valles, 2002). In addition, the concept of volunteering, as measured in this study, may fall short in capturing the ways and extent to which minority and low income individuals work (unpaid) for others in health issues. For working class individuals, for instance, volunteering may be irrelevant because it denotes the upper and middle class notion of "giving back" (Abrahams, 1996; Boehmer, 2000).

The low percentage of volunteers in the sample precluded the analysis of differences in the kinds of volunteers who work for different types of organizations. In addition, the telephone interview used to collect data could have introduced social desirability bias in reporting volunteering (Acree, Ekstrand, Coates, & Stall, 1999). A data collection method that does not require participants to be identified (e.g., mail surveys and computer assisted-interviewing) may help avoid this bias in future research. In addition, the random digit sampling method could have systematically excluded those in the low-income categories. Our findings, however, are consistent with previous studies, suggesting that such biases were limited. A final shortcoming of this study is the fact that the data were collected in 1999. Yet, the data are unique and rarely collected, particularly at the state level, and changes in volunteering trends might take longer than six years to take place.

Implications for Practice

This study corroborates traditional tendencies in volunteering. The current pool of volunteers in public health endeavors is comprised of individuals with higher incomes, working in cancer and elderly-related organizations, and fundraising. Public health initiatives may need to promote collective mobilization, such as volunteering, and in the context of organizations (as opposed to informal helping behaviors), among disadvantaged groups to increase their social capital (Arno, 1998). This may be accomplished in several ways. First, organizations and volunteer administrators may need to get closer to the communities they serve, which tend to be low income. By getting closer, they can listen to those communities' concerns and incorporate them into the organizations' agendas and recruitment strategies. That is, the goal to attract low-income communities to volunteer may be to create a better fit between the organizations' agenda and needs and those of low-income communities.

Second, the concept of volunteer may not resonate among some low-income communities. Informal helping behaviors (which are common among poor communities) may provide a more meaningful experience than volunteering. Thus, administrators and their organizations may need to show the significance and meaningfulness (at both personal and societal levels) of volunteering so that it closely resembles informal helping behaviors. Third, and final, recruitment efforts may have to emphasize the social spaces in which that informal help takes place, such as social networks, churches, and neighborhood groups.

Those efforts, however, need to be broadened to include youth. Volunteerism, as a form of civic participation, is a cultural and social practice learned from childhood, in homes, neighborhoods, and schools (Independent Sector, 2001). There is an opportunity, thus, for local and federal governments and not-for-profit organizations to promote forms of volunteering and their importance to society in schools and neighborhoods among youth.

One last implication is the need to diversify the types of organizations and activities in which the current volunteer pool participates. Public health areas, other than cancer and the elderly, such as the environment, substance use, and HIV/AIDS seem to be in need of volunteers and are unable to attract significant numbers of them. Likewise, tasks, other than fundraising, need to be promoted by organizations and volunteer administrators. Although fundraising may be one of the most important activities for not-for-profit public health organizations, too much emphasis on it may be hampering opportunities to attract more volunteers to other activities such as organizing groups and meetings, advocacy, and organizing health promotion campaigns.

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Table 1.

Sample Characteristics (Means and Percentages) by Volunteering, Illinois 999 (N= 609).[a]

	Volunteers (n= 99; 16.3%)	Non-volunteers (n= 510; 87.7%)
Age	46.5	44.5
Gender		
Female	60%	52%
Male	40%	48%
Race		
White	81%	74%
Non-White	19%	26%
Marital Status		
Married	54%	55%
Single	46%	45%
Education[b]		
1. Less than High School	10%	16%
2. High School	23%	33%
3. Some College	37%	27%
4. College or More	30%	24%
Income[c]		
1. < $10, 000	4%	9%
2. $10,000-$19,000	12%	10%
3. $20,000-$29,000	17%	19%
4. $30,000-$49,000	21%	29%
5. $50,000-$70,000	13%	13%
6. > $70,000	33%	20%

a. Weighted data.
b. Mann-Whitney= 20290; Z= -3.157; p< .05.
c. Mann-Whitney= 16950; Z= -2.33; p< .05.

Table 2.

Logistic Regression Odd Ratios (and Confident Intervals) for Volunteering.[a]

Independent Variables	Model 1	Model 2	Model 3
Age	1.00 (0.99-1.02)	1.00 (0.99-1.02)	1.00 (0.99-1.02)
Gender (Women)	1.46 (0.91-2.35)	1.46 (0.91-2.34)	1.54 (0.95-2.50)
Race (White)	1.81[b] (1.00-3.29)	1.69 (0.93-3.09)	1.56 (0.85-2.86)
Marital Status (Married)	0.90 (0.57-1.44)	0.88 (0.56-1.42)	0.69 (0.41-1.16)
Education		1.04 (0.99-1.08)	1.02 (0.97-1.07)
Income			1.22[b] (1.01-1.49)
X^2	7.04; $p > .05$	9.78; $p > .05$	14.39; $p < .05$

a. n = 605 due to missing data.
b. Beta $p < .05$

About the Author
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