VOLUNTEERING AND MUTUAL AID IN HEALTH AND SOCIAL CARE IN THE CZECH REPUBLIC AS AN EXAMPLE OF ACTIVE CITIZENSHIP

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SUMMARY

This article informs about recent research findings on voluntary and mutual aid in the Czech Republic with a special attention paid to formal volunteering in health and social care. The data suggest that public involvement is comparable to middle-frequency experienced in European countries. In this respect, volunteering is higher in the Czech Republic than in other former Eastern European countries and is an evidence of a successful and rapid restoration of the civic sector. New patterns of volunteering featured by planning, coordination, and contracting have spread out being strongly supported by national and EU policy measures. Managerial patterns of volunteering are dominating in health and social care institutions. Volunteering in health and social care is firmly motivated by emotional altruism; however, reciprocal (instrumental) and normative motivations are also present, though to a lesser extent compared to other sectors of volunteer activities. In the managerial pattern of volunteering altruism is balanced with personal gains and benefits for those who volunteer. Volunteering is deeply embedded in a civic, humanitarian paradigm instead of a religious faith and duty.

Key words: civic sector, health and social services, formal and informal volunteering, altruism, motivation

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INTRODUCTION

General Remarks on the Civic Sector

The tradition of mutual help and civic activities has been interrupted by the political changes after the World War II which led to the complete state control over the economy, politics, culture and civic activities (socialist period 1948–1989). Only a few associations existed during the socialism which were exposed to political intrusion of the Communist Party, the monopolistic leading power in the society. Huntsmen, firemen, bee keepers and handicapped persons were rare examples of non-governmental associations which were tolerated by the state but which were also directly controlled by the state. Only in the late 80's, during the Perestroyka period limited number of new associations were established, especially in the field of self-help for chronically ill patients. One example of these new associations was the Association of Parents to Children with the Down syndrome. Thus, one of the most remarkable elements and consequences of the social, economic and political transformation from the totalitarian regime towards a pluralistic democracy was a rapid and enormous prosperity of the third sector represented by civic/voluntary associations and non-governmental organisations. Although some of the patients' self-help organisations have existed in a limited way shortly before the political change the civic movement has spontaneously and massively proliferated only after the Velvet Revolution. In a short period, the non-governmental sector has been restored with an extensive financial and organisational support of the state and international organisations. To build up a civic association is easy from the legal point of view since only three founding members are necessary. The civic associations must be registered at the Ministry of Interior.

Hundreds of associations have emerged since to represent chronically ill patients, their families, carers, sick children, etc. (e.g. cancer patients, Alzheimer patients and their carers, multiple sclerosis patients, renal dialysis patients, and many others). Also, church assistance in social and health services has been restored (Diakonia, Charita, and other churches like Adventists, etc.). In May 1990 the first umbrella organisation – The Czech Council of the Humanitarian Organisations – was established. It works as a coalition of the NGOs around the social and health services/area and provides subsidies for about 20 humanitarian projects every year. Additionally, the Foundation for the Civic Development has a large grant system to support various projects on non-professional and voluntary services as well as the state and municipalities support these activities.

General Overview of the Social and Health Care System

In 1991, the state-run tax funded health care system was replaced by compulsory public health insurance for all Czech citizens. The system is prevailingly based on the solidarity principle and provides a large scope of comprehensive health services ranging from the primary to the tertiary level. The accessibility and health care quality of services is good, though doubts

increase about the sustainability of the system in the future. Due to economic shortages, some reduction in the scope of services and increments in patients co-payments are expected in the near future. Unemployed, homeless people and ethnic minorities have the equal access to health services, but in practice some restrictions in care have been documented (due to administrative reasons in case of homeless, who are not registered with a health insurance company or with their general practitioners). No discrimination of ethnic minorities or unemployed has been recorded, but increasingly adverse health effects of social deprivation, poverty and exclusion have been observed in vulnerable groups. One of the aims of the health care system transformation was to re-establish and boost individual and community responsibility for health and to reduce the overall state intrusion and direct control over human health. That is why the state has adopted social policy measures to subsidise families in caring for their relatives giving some financial amounts as a compensation of salary, financial allowances for food and accommodation, financial vouchers to purchase tailor made social services. Due to economic constraints in the recent years many of those progressive rules have been cancelled or significantly reduced so that the economic situation of chronically ill and disabled has deteriorated. Positively, the society has invested resources to remove physical, social and mental barriers of disabled persons and to support their integration into society.

In 1992, The Charter on Patients Rights was adopted as a morally binding document. In 2001, The European Convention on Human Rights and Biomedicine was approved by the Czech Parliament, which led to amendments of the health legislation. Despite some relicts of paternalism and lacking responsiveness to weak and vulnerable populations the situation in health and social services has improved significantly.

Modalities of Voluntary and Mutual Aid

The phenomenon of voluntary and mutual aid embraces a broad range of diverse activities. They share in common the voluntary, basically unprofessional and unpaid work in a non-hierarchical arrangement in favour of other persons may they be family and/or community members, general public or persons in need (homeless, migrants, disabled). Both informal and formal patterns coexist, although formal volunteering in terms of planned and contracted activities coordinated by civic organisations is increasingly popularised. Self-help groups (breast cancer patients, crime victims, parents of drug addicted etc.) may also be involved. Concerning health and social care, most informal care is provided within the families and kinship.

During the socialist period, many traditional duties of families have been replaced by a broad range of institutional care provided by the state free of charge or with only low payments (day nurseries, kindergartens, school clubs, sport, youth and cultural organisations, orphan asylums, elderly homes). This process of "expropriation" of the family care was linked to the mass employment of women. After the Velvet Revolution, some effort was undertaken to rehabilitate the family role and support families in their natural caring assistance to their family members. Projects on family caring aim to educate and qualify motivated family members to participate in extramural health and social care. Also, mobile hospice care units exist to support families in care for their dying family members. The extent and volume of health and social assistance provided informally within the families is not precisely calculated. A conclusion can be drawn that even though the role of family was deliberately reduced by the socialist regime, informal mutual care has always been practiced and paradoxically has compensated for shortages in provision of scarce goods and services or low quality in services during the socialist period (1). Both cultural patterns can be identified today – on one hand families have restored again their caring commitments, on the other hand some families keep in placing their elderly to the professional institutions.

In the recent period, a new pattern of voluntary aid has been systematically implemented in advanced industrial societies. The formal/managerial model of volunteering in health and social services is characterised by high level of bureaucratic and rational arrangement, contractual culture, transparency and increasing balance between altruism and personal benefits reached through volunteering.

The managerial model was deliberately supported by the national and international non-governmental sector and by the Czech state and public authorities as well. In 2002, the Act on Volunteering Service was adopted which in congruence with the Act on Social Service (entered into force in 2006) creates the legal framework for formal volunteering and mutual aid activities. The Act on Volunteering distinguishes two modalities; the short-term and long-term volunteering. Short-term volunteering usually includes irregular occasional activities shorter than three month, whereas the long-term volunteering exceeds four months in duration and has a prevailingly regular schedule. The Act on Volunteering focuses especially on the long-term volunteering and tries to produce favourable conditions to protect all stakeholders. Students, retired, unemployed and housewives are the main candidates. Extensive and regular volunteering above 20 hours a week qualifies for free public social and health insurance and entitles for retirement benefits and unemployment allowances. Volunteering is viewed as a means of social inclusion. The managerial model is rooted in contracting the competences, scope and extent of activities. It usually involves formal recruitment/admission procedure, introductory training, indemnity insurance, coordination and supervision provided by volunteering centres or a coordinating person. Often, some rewards beyond the receipt of expenses and insurance are identifiable (new skills, career, sociability, recreation, self-esteem, access to services, etc.).

Today, volunteers provide their services also in hospitals and/or social care institutions. By the end of 2009, more than 40 hospitals have been engaged in the volunteering project. This is a remarkable number considering the fact that in the beginning of this movement Czech hospitals were rigidly against the admittance of lay persons and the majority of experts were highly sceptical. Thanks to enthusiastic persons a guide to volunteering in hospitals has been elaborated (2). Apart from this, volunteers perform their activities also in social care institutions, hospices, day-care centres, civic associations and households. Volunteers are not allowed to replace professional health services like patients feeding or washing. They are entitled to organise leisure time activities and supplement professional care. Volunteers in health and social services usually arrange social activities (reading, listening, accompanying, trips, visits to cultural events, manual work, crafts etc.). They also provide

counselling and crisis intervention (help lines). Often, they accompany patients to medical consultancies, assist in some procedures, assist in bureaucratic affairs like paper work with insurance companies or provide some entertainment or social activities, e.g. reminiscence therapy. They can also help with translations and charities campaigns, but they are never allowed to assist with the direct client's care (feeding, washing, etc.) in a professional health and social care facility.

MATERIALS AND METHODS

The oldest empirical research surveys on motivation for volunteering refer back to the 1970s (3, 4, 5). In the following decade the two or three factor models have been discussed. The two-factor model has distinguished between altruistic (i.e. feeling good about helping others) and egoistic motives (i.e. tangible rewards) (6). The three factor model contained altruistic, egoistic and social obligation motives (7) or altruistic, social or material motivation for volunteering (8). On the contrary, Cnaan and Goldberg-Glen (9) have concluded that volunteers have both altruistic and egoistic motivations for volunteering and do not act on just one motive or a single category of motives (10, 11). In the 1990s the multifactor model was developed by Clary, Snyder and their colleagues (12, 13). Primary functions or motivations of volunteering included the traditional belief about the importance of helping others, conforming to the normative influence of significant others and enhancing the person's sense of esteem, newly also the opportunity to learn, explore job opportunities or advance in the work environment. Based on their approach, a Volunteer Motivation Inventory has been validated which comprises 44 items representing 10 domains. In the Australian survey, the moral values for helping others, recognition and reciprocity ranked highest in the motivation structure (10).

Motivation for volunteering is obviously mixed up and does not refer only to altruistic feelings. The motivation is not static and evolves also during the volunteering activities as their result. Some authors consider altruism as the umbrella notion and distinguish among its different subcategories like: reciprocal (based on mutual benefits), normative (based on duty and expectations laid on social role in the community or society) and emotional (based on inner emotional satisfaction resulting from the volunteering activity) (14) whereas other authors exclude emotionally laden altruism from instrumental and obligatory motivations to volunteering (15, 16, 17).

Our theoretical approach was based on separation of emotionally conceived altruism from other motivations since we have identified altruism rather with affective contents (positive self-esteem, intrinsic values). The reciprocal (i.e. instrumental) motivation presumes mutual exchange of gifts and gains between the volunteer and the client/recipient (or community). This gain can be represented by new experiences, knowledge, skills, social contacts, social capital, recognition, access to services, trips, computer equipment, health insurance or unemployment allowances, CV references, career development and by the expectation to be helped in a similar situation. Some authors speak about volunteering as a copying strategy with negative life issues (especially in self-help movement).

Differently, normative (i.e. obligatory) motivation means that a volunteer seeks to conform to normative influences of significant others (e.g. friends, family, unity, society or mankind). It is a feeling of duty or an external societal expectation, not the internal stimulus which drives people to volunteering. Very often, traditional denominations may exert certain social expectations to work as a volunteer in a community. Not only Christianity, but also other religions involve this implicit or explicit expectation to help people in need.

Emotional motivation in this model is the genuinely altruistic motivation (orientation to the needs of others) which frames the volunteering activity with positive feelings and emotions of doing things well and being here for others. Feelings of solidarity, sympathy with suffering or disadvantaged, respect to dignity, justice and human life under any conditions speak for this emotionally driven component. Volunteers may also draw positive feelings from personal autonomy they receive and responsibility they have. Self-actualization, in Maslow's terms can also be considered.

Additionally, the fourth dimension has been called hedonic since some authors speak about hedonic stimuli. These may be manifested as a personal pleasure, adventure, amusement and fun perceived as the main drive for volunteering. Each of the items in the battery used in our interviews was deduced from one of the four presumable motivations (reciprocal, normative, emotional, and hedonic) (Table 2).

In frame of the research "The Patterns and Values of Volunteering in the Czech and Norwegian society" a representative population sample of 3,811 persons above 15 years was interviewed face-to-face (a structured interview) in autumn 2009 (Table 1)[1]. 1,132 (29.5%) persons of 3,811 people reported voluntary work through civic organisations; 170 of them have reported formal voluntary work in health and social services; 1,430 persons (37.5%) have reported informal mutual aid without any assistance of civic organisations. In this article, we focus on the motivation structure and compare different motivation patterns between particular groups of volunteers.

Table 1. *Research sample (N=3811 adult persons)*

Men	49.2%
Women	50.8%
Min age	15 years
Max age	92 years
Average age	47 years
Informal volunteers	37.5%
Formal volunteers via civic organisations	29.7%
Formal volunteers via civic organisations in health and social care	4.5%

[1]Between Oct 10–Dec 2 2009 the agency Factum Invenio has collected the data using a form developed by the research team. A stratified multiple stage random sampling was used. The general population of the Czech Republic was divided into 57 strata in each of them 3 stage random sampling was performed in terms of randomisation of residential units-households-individuals.

Table 2. *14 motivation items in 4 dimensions (emotional, reciprocal, normative and hedonic)*

E: I feel that people who I know need my help
E: I feel that it is important to help others
E: I sympathise with people who were less fortunate than I was
R: Opportunity to make useful contacts
R: I can contribute to something that is personally important to me
R: Opportunity to show my capabilities
R: Opportunity to gain new skills and experience
N: Confidence of my civic duty (commitment)
N: People who are close to me expected me to do volunteering
N: Opportunity to redeem my debt to the community of people I belong to
N: Religious faith
H: Amusement/fun for me
H: I want to dedicate to interesting activities in my leisure time
H: I want to relax from the everyday haste

RESULTS

More than one third of respondents (37.5%) reported informal voluntary activity in their neighbourhood and community. Women were significantly more active ($p<0.001$). Most common was "the mutual aid to neighbours" which probably also included "help provided to sick or needed persons". Most likely the mutual help is provided once in a month.

People who reported informal voluntary activities identified strongly with the emotionally laden altruistic motivation since most emotional reasons ranked higher than reciprocal, normative or hedonic motivations. As the weakest motivation religious faith was mentioned. This demonstrates a strong civic principle being fundamental for the motivation to do mutual aid which is not necessarily embedded in the religious paradigm.

The number of formal volunteers who are linked to an organisation mainly to a civic association is slightly smaller. 29.7% of our sample reported voluntary activity in different branches – leisure time, culture and sport, firemen, advocacy, human rights, support to vulnerable groups of population, etc. Out of them 170 persons (15% of all formal volunteers and 4.5% of the whole sample) reported formal voluntary work in health and social services. In this group, women were again significantly over-represented and also a higher average age was found. Significantly more health and social care volunteers were recruited in big cities, mainly from Prague. Almost two thirds were coordinated by a volunteering centre (64%) and participated in a preparatory training course (61%), though only 9% were directly commissioned by a volunteering centre. More than a half (54%) has passed an admission interview and 38% received a written description of the volunteering competences and activities. One fourth had concluded a written contract (25%) and was requested to provide the evidence of no criminal record (26%). Our data confirm that a new model of volunteering called contractual or managerial has been successfully established especially in the field of health and social services. This managerial model of volunteering was predominant in health and social services compared to other kinds of volunteering.

Table 3. *Motivation structure in two groups of formal volunteers: "How important were the following reasons for your decision to do the individual volunteering?"*

1 = I agree very much 4 = I disagree completely	Health and social care (N=170) Average on the scale 1–4	Other areas (N=1008) Average on the scale 1–4	t-test
Reciprocal			
I can contribute to something that is personally important to me	1.6	1.7	Not significant
Opportunity to gain new skills and experience	2.3	2.1	Not significant
Opportunity to make useful contacts	2.5	2.3	$p<0.05$
Opportunity to show my capabilities	1.9	1.9	Not significant
Emotional			
I feel that people who I know need my help	1.8	2.1	$p<0.01$
I feel that it is important to help others	1.5	2.0	$p<0.001$
I sympathise with people who were less fortunate than I was	1.9	2.7	$p<0.001$
Normative			
Religious faith	3.2	3.3	Not significant
People who are close to me expected me to do volunteering	2.5	2.4	Not significant
Opportunity to redeem my debt to the community of people I belong to	2.6	2.7	Not significant
Confidence of my civic duty (commitment)	2.0	2.5	$p<0.001$
Hedonic			
Amusement/fun for me	2.0	1.6	$p<0.001$
I want to dedicate to interesting activities in my leisure time	2.3	2.0	$p<0.001$
I want to relax from the everyday haste	2.9	2.5	$p<0.001$

Table 4. *Factor analysis of the battery of motivation items*

N=1,178 all volunteers who provide mutual aid via a civic organisation	Item dimension	Factor R	Factor E	Factor N
Opportunity to gain new skills and experience	R	0.675		
I want to relax from the everyday haste	H	0.634		
Opportunity to make useful contacts	R	0.597		
Opportunity to show my capabilities	R	0.738		
I want to dedicate to interesting activities in my leisure time	H	0.663		
Amusement/fun for me	H	0.542		
I can contribute to something that is personally important to me	R		0.541	
Confidence of my civic duty (commitment)	N		0.637	
Feeling that people who I know need my help	E		0.687	
I feel that it is important to help others	E		0.825	
I sympathise with people who were less fortunate than I was	E		0.617	
Religious faith	N			0.743
People who are close to me expected me to do volunteering	N			0.544
Opportunity to redeem my debt to the community of people I belong to	N			0.669
Rotated Component Matrix Rotation converged in 5 iterations Extraction Method: Principal Component Analysis Rotation Method: Varimax with Kaiser Normalization Values less than 0.400 suppressed				

Item dimension: R – reciprocal, N – normative, E – emotional, H – hedonic

Table 5. *Comparison of factors in two groups of volunteers by the use of t-test*

Mean factor values	Reciprocal	Emotional	Normative
Volunteers in health and social services, N=159	0.45	−0,58	0.03
Other volunteers, N=889	−0.08*	0.10	0.00
Statistically significant difference	yes, p<0.001	yes, p<0.001	no

* Lower mean factor values indicate its higher importance

The motivation structure is different in formal volunteers in health and social care and those in other areas (sport, culture, education, etc.). The emotional item "I feel that it is important to help others" was the most frequent in health and social care whereas the hedonic item "Amusement/fun for me" ranked highest in the volunteers of other areas (Table 3). All emotional items were significantly stronger supported in health and social care compared to a greater support of all hedonic items by volunteers in other areas.

Factor analysis transformed the 14 battery items differently from our theoretical presumptions and mixed them up across 4 theoretical motivation stimuli (Table 4). Only three factors were generated and none of them is fully identical with our theoretical expectations. Though, we still interpret the factors within our theoretical framework and call them according to the predominant items with the highest strength. Hedonic items did not create their own factor and merged mostly with the reciprocal (R) ones showing thus the closeness between the reciprocal and hedonic motivation. The emotional factor (E) embraces in addition one normative and one reciprocal motivation, whereas the only unmixed factor is the normative factor (N), though not complete (one normative item is placed in the emotional factor).

We have compared motivation for volunteering in two groups of formal volunteers (all active via an association). One was represented by volunteers in health or social care (170 persons,) whereas the other sub-sample gathered volunteers in all other areas (1,088 persons). Our presumption about higher emotional motivation for volunteering in health and social services was verified since the emotional factor was significantly stronger in volunteers in health and social services whereas the reciprocal factor (merging with hedonic items) was remarkably lower compared to the group of other volunteers (Table 5). The normative factor had similar values in both sub-samples and did not distinguish between groups.

DISCUSSION

Similarly to other volunteers, volunteering in health and social services gradually adopts a formal pattern which is featured by coordination, transparency, flexibility and symmetrical balance between the personal investments and gains. Our findings are very similar to a representative Czech research from 2004, which has reported 32% of volunteers (18). Czech data correspond to middle-frequency European countries reporting between 30–45% of adult population active in formal volunteering (Sweden, Denmark, UK, Slovenia, Spain, Belgium, Portugal) (1). In the USA, Norway, Switzerland, Austria, Netherlands and Germany the engagement of public is higher (between 45–70% of adult population) (19). Positively, the Czech Republic has successfully reduced the lag which is still persisting in the former Eastern European countries and in the literature is considered as a historical consequence of enforced volunteering by the totalitarian state and economic collapse after 1990 (1). Similarly to foreign surveys, women were over-represented among informal and formal volunteers who practised in the health and social care.

The prevailing motivation for formal volunteers in health and social services was emotional (altruistic) whereas hedonic and reciprocal motives ranked higher in the volunteers in other areas. Our data confirm that volunteers in health and social services are a specific group, since they are more affiliated with the altruistic emotional factor linked to feelings of solidarity, respect to human dignity, justice, sympathy. Religious faith was the least motivation for volunteering in all types of volunteers which allows us to say that motivation for volunteering is in our society deeply rooted on a civic principle. Motivation for mutual aid is thus fundamentally embedded in a humanitarian but not necessarily religious paradigm. This again is congruent with conclusions drawn by Ruiter Stijn who found only minor differences between religious and non religious volunteers (20).

Today, public opinion about volunteering is positive whereas the scepticism (21, 22) has been substantially eliminated in the recent years. The civic sector, which has been oppressed by the socialist state and has proliferated recently, offers new values, which are attractive and relevant to people. Volunteering is also viewed as a means of social inclusion and humanisation of institutional care. New legislation on volunteering and social services has stimulated the growth of mutual aid. Political measures were undertaken to restore the role of families, communities and civic associations in provision of health and social care. This has not only a financial, but also an ethical effect. There is a big interference between the legislation, state administration, public (municipal) bodies, and non-governmental associations. The state supports informal voluntary health and social care within families and subsidies volunteering projects also in Czech hospitals. Many of them have been stimulated by recommendations and decisions made by the EU institutions (23).

As an effect, a massive growth of civic associations also in health and social care has occurred in the recent decades and represents a very important part of the overall societal democratisation. Voluntary and mutual aid has proliferated also in an atheistic society and this can be positively evaluated as an evidence of active citizenship.

Acknowledgement

The theoretical framework was elaborated and the data have been gathered from an original questionnaire within the research project The Patterns and Values of Volunteering in the Czech and Norwegian society which was co-funded by the Norwegian Financial Funds (EEA and NFF) in 2009–2010 and led by Pavol Fric from the Charles University/Faculty of Social Sciences.

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Received July 19, 2011
Accepted in revised form February 27, 2012