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Kenneth C. Maes Date

Examining social determinants of food insecurity, common mental disorders, and motivations among AIDS care volunteers in urban Ethiopia during the 2008 food crisis

By

Kenneth C. Maes
Doctor of Philosophy

Anthropology

____
Craig Hadley
Advisor

____
Ronald Barrett
Committee Member

____
Peter J. Brown
Committee Member

____
Joyce Murray
Committee Member

Accepted:

____
Lisa A. Tedesco, Ph.D.
Dean of the James T. Laney School of Graduate Studies

____
Date

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By

Kenneth C. Maes
Master of Arts, Emory University, 2007
Bachelor of Arts, University of California, Santa Barbara, 2002

Advisor: Craig Hadley, Ph.D.

An abstract of

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James T. Laney School of Graduate Studies of Emory University

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Abstract

Examining social determinants of food insecurity, common mental disorders, and motivations among AIDS care volunteers in urban Ethiopia during the 2008 food crisis

By Kenneth C. Maes

By mixing ethnographic and community-based epidemiological methods, this dissertation aims to illuminate the challenges facing AIDS care volunteers in urban Ethiopia, a setting characterized by low income, high rates of food insecurity, and ongoing scale-up of highly-active antiretroviral therapy programs. Shortages of health workers – widely recognized as the greatest threat to global health – are addressed throughout sub-Saharan Africa by using community volunteers. Whether it is unjust and/or unsustainable to rely on volunteerism in such settings has become a major concern for a widening group of social scientists and global health practitioners. This dissertation demonstrates that acute-on-chronic food insecurity during the 2008 global food crisis impacted psychosocial health and motivations to continue volunteering among AIDS care volunteers serving local non-governmental organizations in Addis Ababa, Ethiopia. This dissertation also proposes a theory of how volunteers' pro-social motivations are shaped and sustained by local norms of reciprocity and empathy, as well as by global group rituals organized by the institutions that rely on volunteer labor in rolling out antiretroviral therapies in settings of chronic food insecurity.

Participant observation was conducted in neighborhoods adjacent to a large public hospital in southwest Addis Ababa, including attendance at volunteer trainings, caregiver and care recipient homes, volunteers' reporting and planning meetings, and volunteer recognition ceremonies, over 20 months between May 2007 and January 2009. A purposive sample of 13 volunteer caregivers was recruited to complete a series of semi-structured open-ended interviews. In addition, a random sample of 110 volunteers from two local NGOs was surveyed 3 times over 11 months in 2008. Surveys included measures of food insecurity and common mental disorders, care relationship quality, and motivations for being an AIDS care volunteer. Text analyses, regression analyses, and cultural consensus analyses were triangulated to test hypotheses and interpret results.

Results indicate that volunteers faced unrelenting poverty, but they also built positive, empathic relationships with others in their communities. They also expected divine rewards as Orthodox Christians caring for marginalized people. Nevertheless, this dissertation concludes that "volunteerism" is an optimistic and loaded term that over-simplifies the motivations of low-income individuals and potentially masks a system of unsustainable labor exploitation within AIDS treatment and other development-focused movements.

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CHAPTER 1 – INTRODUCTION

Examining health care volunteerism in a food-insecure world[1]

On May 17, 2008, a sunny Saturday before the rainy season, I attended the second annual Ethiopian Volunteers Day celebration. The event was organized primarily by the Ethiopian Association of Voluntary Services (EAVOS) and the *Hiwot* HIV/AIDS Prevention, Control and Support Organization, an Ethiopian NGO and "local implementing partner" of a prominent global NGO, Family Health International (FHI). The roughly two-hour-long celebration was located in Volunteer Square, which had been dedicated the previous year at the first annual Ethiopian Volunteers Day. Volunteer Square is actually a small, unremarkable traffic circle located on the ring road, on the southwest outskirts of Addis Ababa, not far from the capital city's major landfill. The "square," unlike other monument-surrounding plazas in the heart of Addis Ababa, is anything but a historical gathering place or space of collective imagination. The location provided the opportunity for drivers of passing trucks, buses and autos to look in on the action as they skirted around the small circle.

When I walked up to the event (the bus on which I arrived dropped me a couple hundred meters away), a group of community-based AIDS care volunteers whom I knew came to greet me, followed by a few of their supervisors, and then the director of the

[1] A shorter version of this introductory chapter is forthcoming as a roundtable discussion base article in the *Bulletin of the World Health Organization*.

Hiwot NGO. The latter led me by the hand into the crowded traffic circle, and seated me under the "VIP" tent, where I saw the director of EAVOS and other guest speakers for the event. I was told after the fact that approximately 500 volunteers were packed into the roundabout, seated in the sun or under temporary tents colored red, green and yellow (the colors of the federal Ethiopian flag).

At the beginning of the program a sheet was passed out by EAVOS that provided a short background (in Amharic) on Ethiopia Volunteers Day as well as an overview of this year's theme: "Let us protect youth from HIV by involving them in volunteer service." A similar message was printed in Amharic on the white cotton t-shirts and cardboard sun-visors that were passed out and worn by the vast majority of volunteers and others present: "Let us protect children from HIV/AIDS and spread volunteer service" and "Everyone should give volunteer service in order to improve the country." Ethiopian Volunteers Day unfolded with a series of speeches by organization elites, and dances and songs performed by youths affiliated with the *Hiwot* NGO, all taking place in the center of the roundabout and making use of a basic public address system and electronic synthesizer. Though the volunteers present were active audience members, ululating, applauding, and waving their visors at times in response to the speeches and performers, not a single volunteer caregiver addressed the crowd.

The final speech of the day was delivered in Amharic by the Ethiopia Country Representative of the International Foundation for Education and Self-Help (IFESH). Wearing one of the sun-visors distributed to the volunteers present, the representative joked about his old age, generating laughter and applause from the audience. He noted that the ceremony was much "warmer" than in the previous year, because it was attended

this time by so many volunteers. After thanking many of the other organizations involved, and more or less reiterating many of the messages of the day, the representative expressed how happy the volunteers made him feel, and highlighted that they, too, have the advantage of experiencing "mental satisfaction" through their service: "Therefore, don't keep this activity for yourself, but try to pass it on to your children as well…"

A revealing epilogue to this brief description of the second annual Ethiopian Volunteers Day (EVD) is provided by an in-depth interview that I conducted just a few days after the event with a volunteer from the *Hiwot* NGO. At the end of our interview, I asked the respondent if she had anything she wanted to add. She brought up EVD, and said that many of the volunteers from her district were complaining amongst themselves during the celebration, and even talking about quitting, because they had heard that *Hiwot* NGO volunteers in other districts were getting more substantial food aid packages as remuneration for their services. Neither I nor my respondent knew whether this was true, but she clarified that the person who began the rumor at the event was notorious for such "talk," so it was possible that the idea (i.e. inter-district inequity among volunteers) was fabricated. And yet the existence of such gossip within the context of EVD illustrates 1) the ambivalence of volunteers' motivations and the inability of rituals like EVD to resolve this ambivalence; and 2) the importance of food as a key "ingredient" in sustaining the motivations of volunteers in Addis Ababa. Would such "talk" have occurred at EVD if there had been a free meal involved in the celebration that day (cf. Rödlach, 2009)? And given the chronic food insecurity experienced by the majority of AIDS care volunteers in Addis Ababa, would such talk have occurred if volunteers were paid regular wages that would allow them to afford sufficient food, instead of expecting

them to "sacrifice" their time and resources in the service of donor-funded HIV/AIDS programs?

By mixing ethnographic and community-based epidemiological methods, this dissertation aims to illuminate the challenges facing AIDS care volunteers in urban Ethiopia, a setting characterized by low income, high rates of food insecurity, and ongoing scale-up of highly-active antiretroviral therapy (HAART) programs. The World Health Organization asserts that health worker shortages are the greatest threat to global health, but that "essential health services cannot be provided by people working on a voluntary basis if they are to be sustainable. While volunteers can make a valuable contribution on a short term or part time basis, trained health workers…should receive adequate wages and/or other appropriate and commensurate incentives" (World Health Organization, 2008).[2] In other words, volunteerism in itself is not a sustainable practice in low-income settings, in particular because the lack of regular, predictable remuneration leads to high turnover rates in volunteer workforces, and thus wastes substantial resources on recruitment and training.

And yet community volunteers are used in large numbers to fill gaps in health workforces in Ethiopia and throughout sub-Saharan Africa (SSA). Whether it is unjust and/or unsustainable to rely on volunteerism in such settings has become a major concern for a widening group of researchers and global health practitioners. The recent global food and financial "crises"[3] have created a crossroads on this question. Will various

[2] Global Recommendations and Guidelines, Recommendation 14.
See: http://data.unaids.org/pub/Manual/2007/ttr_taskshifting_en.pdf [accessed on 9 November 2009].
[3] I have trouble with the term "crisis" as applied to the phenomena of skyrocketing food prices and the failures of financial institutions of recent years. Crisis suggests that these phenomena came out of

players in global health attempt to adhere to the WHO's recommendation – particularly in SSA where the use of volunteers appears to be accelerating[4]?

This dissertation argues that for the recommendation to be effective, policy-makers and practitioners will need to do (at least) three things: first, recognize that volunteerism is never politically neutral; second, examine the myth of the humble, selfless volunteer spirit in settings characterized by high rates of chronic food insecurity and unemployment; and third, come to some consensus on what is meant by sustainable. Of course, not all volunteers are alike – and neither are the programs they serve. While this dissertation focuses on urban Ethiopia, these issues must be considered in various contexts in the wake of recent global food and financial crises.

VOLUNTEERISM IS NEVER POLITICALLY NEUTRAL

The inherent inequality in AIDS treatment and care programs in sub-Saharan Africa that rely simultaneously on international donor funding and local volunteer labor reminds us that forms of volunteerism must be situated within their broader sociopolitical contexts. While it is not my intention to delve deeply, it is helpful to understand a few basic elements regarding the political economy of global health today. The first is that an enormous amount of money is currently invested in global health, and that amount has been growing rapidly over the past two decades (Ravishankar, et al. 2009). In general, the growing billions of dollars invested in global health flow from wealthy donor countries to

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"nowhere" and are "out of control" – but both phenomena were years in the making and predictable, in other words came out of the interaction of specific structural features and social forces of our global economy.

[4] Unfortunately it is difficult to longitudinally quantify the rates at which people are volunteering for health and development programs in sub-Saharan Africa. My assertion that the rate appears to be accelerating is based on a personal, qualitative assessment of the issue of global health care volunteerism. Quantitative data are obviously needed to confirm this, but would require sampling from an array of governmental, private sector, and non-governmental organizations across Africa.

low-income and middle-income countries. As Ravishankar and colleagues (2009) point out, funds are increasingly channeled through non-governmental organizations as well as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization (GAVI). Furthermore, the world has witnessed increases in donor dollars from both public institutions, particularly in the USA, and private philanthropic corporations. And yet there is reluctance among wealthy donors to allow funds to be used for creating health care jobs in low-income countries and paying steady wages and salaries (Ooms, et al. 2007). This reluctance seems strange given that shortages of health workers in such countries have been identified by the WHO (2006) as a critical bottleneck in turning donor funds into positive population health outcomes.

To make sense of this complex issue, it helps to understand why experts and laypersons alike have begun in the past few years to refer to "global health" instead of "international health." Basically, the fundamental shift in terminology reflects a cognitive shift: from interest in the *different* health practices and problems found in various countries and regions of the world to interest in the *shared* aspects of health challenges across borders and other geographic and socioeconomic dividing lines.[5] Accordingly, in the arena of so-called *global* health, donors, policymakers and practitioners put an emphasis on *partnerships* between different countries, agencies and organizations, and populations. The question that immediately arises is how to define partnership, and specifically how partnerships are "operationalized" when one partner is essentially a wealthy donor and the other is a resource-strapped low-income nation's Ministry of Health. What will each "partner" bring to the table? One answer to this question is that

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[5] See the Global Health Education Consortium website: http://globalhealthedu.org/Pages/GlobalvsInt.aspx [Accessed 16 April 2010].

while wealthy donors may provide large amounts of money and medical technologies, low-income recipients may be able to provide unemployed and underemployed laborers, resources which are both abundant within their own borders and critical to the success of many community health projects in countries like Ethiopia (Peter J. Brown, personal communication).

How such arrangements play out is of course variable in different contexts,[6] but it is important to first understand the underlying model of "partnering" wealthy donor dollars with local low-income labor. But when and where local health care laborers are not paid, a legal problem presents itself, as Ethiopia and other countries in sub-Saharan Africa do in fact uphold labor laws within their borders. An apparently convenient way out of this dilemma is to fill labor needs by promoting volunteerism – whether this refers simply to families caring for family members or to full-fledged community-based volunteer programs (Akintola, 2008b). It is also convenient, I think, that the work of community health in settings of health crisis tends to tug at heartstrings and arouse feelings of duty and inclinations to donate one's labor to care for others. At least in comparison to an industrial or manufacturing endeavor like assembling automobiles, community health work lends itself to the promotion of volunteerism in lieu of job creation. But even so, there is no guarantee that reliance on volunteer labor is sustainable in either situation. And if indeed it is not sustainable, what does this mean for the future of global health "partnerships"? Thus, while the question of global health care volunteerism in settings of extreme poverty and chronic food insecurity is apparently a question of sustainability, it is necessary to understand that certain political and structural

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[6] For instance, the extent to which local and international NGOs are involved, either partnering with local public health agencies or not, varies in different locales.

arrangements within low-income countries and with wealthy donors may support an unsustainable model until convinced by evidence and argument that changes are needed.

Social historian Theodore Roszak affirms that "[V]olunteerism is not politically neutral; it has always been closely linked to conservative values as the glowing alternative to mandatory government programs" (Roszak, 2001: p. 125). Recent policies associated with the new Obama administration as well as the 2008 financial crisis and ongoing recession make it clear that volunteerism is very much in line with "liberal" Democratic as well as "conservative" agendas – witness the ongoing "United We Serve" campaign that was rolled-out in late 2008.[7]

Simon Biggs has examined discourses promoting paid and unpaid work among elders in the UK, which also shed light on the promotion of volunteerism in settings in sub-Saharan Africa characterized by poverty and widespread unemployment:

> "We are told a story of autonomous older people, actively involved in their communities, achieving joy through the return of work and voluntary activities… Work-like activities are presented as a sort of social therapy that capitalizes on postmodern aging and simultaneously draws older people back into the social mainstream. Another marginalized group is saved!" (Biggs, 2001: p. 311).

Martinson and Minkler (2006), in examining recent pushes in North America for civic engagement and volunteerism among the elderly, note that older Americans have been called a growing and "untapped" civic resource. This is no accident, according to

[7] See http://www.serve.gov/ and the Spanish-language equivalent http://www.servir.gov/ [Accessed 19 March 2010].

these authors, given diminished public funding for many social services and programs in the U.S., which "places greater responsibilities on already deficit-ridden states and municipalities, which in turn often call on individuals, families, and volunteerism to help take up the slack" (Martinson and Minkler, 2006: p. 320). This raises a fundamental question that can be broadened to address volunteerism in various sociopolitical contexts: if governments and public-private partnerships are failing to provide resources and services that support community wellbeing, "is the answer to have older people [or socioeconomically marginalized people] step in to fill those unmet needs, thereby releasing government of long-term responsibility?" (Martison and Minkler 2006: p. 321).

Ramakrishnan and Baldassare (2004) expand the focus on civic volunteerism from the elderly to diverse communities in California, pointing to the effect that socioeconomic marginalization may have on the kinds of activities – in particular, political versus apolitical activities – in which people choose to engage as volunteers:

> "[A]lthough civic engagement may involve acts of individual choice, these choices are often structured by various social, economic, and institutional factors. Thus, for instance, poverty and lack of education mean fewer skills that are relevant to political participation and fewer opportunities to be mobilized into participation in political activities and volunteerism" (Ramakrishnan and Baldassare, 2004: p. 1).

Global AIDS treatment and care, and indeed primary health care in general, are endeavors that demand massive human resources amid often crumbling public health systems in low-income countries. The promotion of volunteerism in these contexts, too, does not take place in a political vacuum. The international NGO Partners in Health

(PIH) devoted its 2009 annual symposium to the theme of "accompaniment," the community health model that commits to training and modestly paying health *accompagnateurs* or community health workers who, besides the fact that they are paid a modest monthly salary, are much like the AIDS care volunteers I encountered in my doctoral research in Ethiopia's capital city, Addis Ababa. The Public Broadcasting Service in the U.S. recently produced an incisive documentary focusing on PIH's cooperation with the government of Rwanda and the Clinton Foundation in rolling out this model, to the apparent benefit of community health and economy.[8] In testimony before the U.S. Senate Committee on Foreign Relations on January 27, 2010, Paul Farmer mentioned that PIH's Rwandan community health workers contributed $7000 in donations for victims of the January 2010 earthquakes in Haiti, reflecting both their ability to donate (because of their adequate salaries) and willingness to do so in solidarity with Haitians experiencing chronic economic insecurity. In his testimony Farmer also emphasized the absurdity of arguing "that volunteerism and food-for-work programs will create sustainable jobs [for Haitians]." [9]

Acknowledging the shared social determinants of the "co-crises" of AIDS, primary health care system failure, and human resource scarcity in sub-Saharan Africa, Farmer and others have argued that community health workers who serve on a volunteer basis should be incorporated into the public sector and remunerated. This policy measure is meant to be just one aspect of wider efforts to strengthen public health systems and ensure human rights to health and economic security in poor countries, which were threatened by structural adjustment programs imposed by the International Monetary

[8] Available at http://www.pbs.org/now/shows/537/index.html [accessed on 4 February 2010].
[9] Available at http://standwithhaiti.org/haiti/news-entry/pih-co-founder-paul-farmer-testifies-at-senate-foreign-relations-committee [accessed on 8 February 2010].

Fund and World Bank in the 1980s and 1990s (Irwin & Scali, 2007; Kim & Farmer, 2006; Pfeiffer et al., 2008). An important outcome of structural adjustment in Ethiopia and other African countries is the large-scale elimination of jobs in the public – including public health – sector. In Ethiopia this was accomplished post-1991 (Mains, 2007). This period has also witnessed strong growth in the number of international and local NGOs in Ethiopia (Iliffe, 2006; Kloos, 1998), institutions that often call on community volunteer labor. From this perspective, current rates of volunteerism are an essential aspect of the thinning of the state in Ethiopia.

Though advocates of HAART roll-out in low-income countries envisioned drug access as a "wedge issue" to usher in more broad-based strengthening of public health systems and to help governments provide health care as a human right, João Biehl (2007) argues that objectives have shifted: health systems have become more oriented toward marketing and distributing drugs, technologies, and services to the poor, thus benefitting pharmaceutical corporations.

According to this model of "pharmaceutical humanitarianism," partnerships between public and private institutions, including NGOs involved in the health sector, attempt to save lives by developing new medical technologies and cost-effective ways to deliver care without confronting the overall dismal state of public health infrastructures. Structural violence and inequity that engenders disease is effectively ignored, and historical "economic injustices reflected in barely functioning health care systems are depoliticized" (Biehl, 2007: p. 384). The idea that health care systems in many African countries are barely functioning because of historical political-economic injustices

Biehl describes the remarkable resilience of pharmaceutical companies during the past two decades, in adapting to both the global AIDS treatment movement while influencing the definition of global trade-related aspects of intellectual property rights (TRIPS), which are meant to protect pharmaceutical patents and thus profitability:

> The [pharmaceutical] industry's capacity to neutralize and redirect any form of counter-reaction to its advantage is indeed remarkable. Just as big pharma has played a key role in setting global trade rules (through TRIPS, for example), it has also helped to shape the international health agenda….
>
> In the past few years, following the consolidation of the Brazilian [AIDS] policy and other treatment initiatives (by organizations such as Partners in Health, Doctors Without Borders, and the Clinton Foundation, for example), an international consensus has emerged over the feasibility of delivering ARVs to the neediest in resource-poor settings. The [pharmaceutical] industry is again exercising its flexibility and turning these unexpected fields of medical action into market opportunities.
>
> By juxtaposing the arguments of both corporate actors and policy makers one can identify the logic of such a pharmaceutical form of governance… Once a government designates a disease like AIDS the "country's disease," a therapeutic market takes shape – a captive market. As this government addresses the needs of its population...the financial operations of pharmaceutical companies are taken in new directions and enlarged, particularly as older lines of [HAART] lose their efficacy, necessitating the introduction of newer and more expensive treatments

> (still under patent protection) that are demanded by mobilized patients… Development agencies (such as the WHO, UNAIDS, and the World Bank) assist this process, which has crucial ramifications for the nature and scope of national and local public health interventions (Biehl, 2007: pp. 82-3).

Meanwhile, as Biehl shows through ethnographic work, people living with AIDS struggle to translate expensive and vertical medical investments into social capital and livelihood security.[10] Though his focus is on people accessing AIDS treatments, Biehl's analysis paves the way for an understanding of the struggles of economically insecure volunteers and other low-level laborers associated with the distribution of AIDS treatment and care:

> The political economy of AIDS, spanning both national and international institutions, creates an environment within which individuals and local AIDS organizations are codependent... Their transactions are legitimated by a humanitarian and pharmaceutical discourse of lifesaving and civic empowerment. In adhering to drug regimens and making new and productive lives for themselves, patients are – in this discourse – saved. However, merely guaranteeing existence in such dire contexts, amid the dismantling of institutions of care, involves a constant calculus that goes well beyond numbers of pills and the timing of their intake.

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[10] It must be kept in mind that Biehl primarily addresses Brazil, which in the past decade has become one of the largest economies in the world and a political leader in Latin America, as well as on the world stage – particularly in regards to pioneering an AIDS treatment policy based on "universal" drug access in the late 1990s. Thus Brazil stands in stark contrast to Ethiopia, one of the poorest countries in the world, despite the latter's attempt at rolling out universal access to first-line AIDS treatments starting in 2004.

> Even as they search for employment, AIDS survivors work hard to remain eligible for whatever [resources] the state's paternalistic politics have made available… Being adopted by a doctor and becoming a model patient (by complying with treatment in spite of a miserable situation) greatly facilitates this (Biehl, 2007: p.48).

Biehl's notion of pharmaceutical humanitarianism can be extended to encompass the volunteers who support the distribution of and adherence to AIDS drugs in sub-Saharan Africa. Doing so leads, I think, to the realization that volunteers effectively underwrite the consolidation of new markets in low-income areas for pharmaceuticals, helping to turn impoverished people who cannot afford food into consumers of drugs and medical technologies that are sometimes, but not always, provided at reduced prices or even free. Reduced prices for these drugs and technologies prevail in part because the labor needed to ensure their proper prescription is cheap or even free. And while the issue of labor is for the most part ignored, for-profit drug companies may enjoy good public relations in response to reducing the costs of *some* of their products. Whether or not the cost of local laborers in various NGOs and community-based programs enter into the accounting of donors, drug companies, and their partners, the roll-out of drugs and other medical technologies occurs in a context in which labor is cheap. And regardless of the human rights question of whether poor people in countries like Ethiopia should be paid for their valuable health care labor, cheap labor is essential to the sustainability of health programs modeled on Biehl's notion of pharmaceutical humanitarianism.

Thus, volunteer caregivers in SSA, like the patients for whom they care, occupy an uncertain position amidst the roll-out of HAART. Their continued participation raises

key questions: will this medical investment and their decisions to volunteer alongside its distribution translate into socioeconomic change for themselves? And from the perspectives of AIDS care programmers, should volunteers be encouraged or discouraged to ask this question and to desire remuneration for their labor? Neither patients nor AIDS care volunteers have much say in the design of new regulations and in reconfiguring global and national health infrastructures. If their stories filter up to policy makers, it is usually to reinforce the myth of the humble, selfless volunteer, which I describe in the next section. Despite the importance of volunteer labor for the success and sustainability of AIDS treatment – a key part of equitable development goals in SSA – very little micro-level research has been conducted that inquires deeply into 1) the motivations and values of volunteer caregivers and 2) the political-economic structures that define and constrain their role in providing care for poor people living with HIV/AIDS (but see Akintola, 2008b; Rödlach, 2009; Swidler & Watkins, 2009). The primary aim of this dissertation is to address these gaps, in order to advance an applied anthropological approach to confronting linkages among HIV/AIDS, food insecurity, and growing dependency on unpaid labor in community health projects in developing countries.

THE MYTH OF THE SELFLESS VOLUNTEER

A myth, according to anthropologists, is a narrative that provides a foundation justifying the "way things are" in a social group (Shore, 1996). Myths often narrate origins, for instance the origins of the group and of their interactions with other groups and natural environments. In *Global AIDS: Myths and Facts*, Paul Farmer lays out a definition of myth as intellectual confusion and unsubstantiated beliefs that "constitute a stock of

conventional wisdom about [HIV/AIDS]" (Irwin, et al., 2003: p. xix). This definition is not inconsistent with a more classic definition of myth, and yet Farmer's definition bends towards an obvious agenda of criticizing and dispelling what are seen as harmful myths that "often dominate discussions among the experts themselves, as well as among political leaders and ordinary citizens in wealthy countries" (Irwin, et al., 2003: p. xviii). These myths include

> "the belief that the HIV/AIDS pandemic is driven primarily by promiscuity; that endemic corruption in poor countries dooms AIDS control efforts to failure; that developing countries must view AIDS prevention and treatment as mutually exclusive options; or that AIDS treatment with antiretroviral medications is not feasible in resource-poor settings" (p. xviii-xix).

According to Farmer, such myths are "expedient to those who wish to hide the real reasons that these life-saving [anti-retroviral] medications are not more readily available" (p. xix).

Volunteer AIDS care projects in low-income settings rest on expedient yet oversimplified beliefs as well. One is the assumption that local communities are full of "untapped" moral and social energy, producing an abundance of individuals ready to donate their labor to make their communities healthier. Armed with this convenient assumption, the question of *why* one does not have to pay for labor is easily answered – because locals are simply willing to do it for free. This myth is apparent in discourses of major international NGOs: for instance, in its 2007 Ethiopia report to USAID, Family Health International boasted that it had trained over 11000 volunteers for home-based

care (HBC) and antiretroviral treatment support, and wrote, "The level of interest and commitment of volunteers to the [HBC] program has been overwhelming…. The program has shown the untapped spirit of volunteerism that exists within Ethiopian communities despite such pervasive poverty" (Family Health International/Ethiopia, 2007: p. 52).[11] The Secretary General of the United Nations noted in his statement on International Volunteer Day 2008 that "The altruistic spirit of volunteerism is immense and renewable. On this International Volunteer Day, I urge all members of our global community to tap this great reserve of energy and initiative."[12]

How should we interpret this "spirit" that international NGO, public health, and donor communities are so keen to tap? Underlying this question is the issue of whether a loaded term like volunteer spirit is a veneer for labor exploitation. Choosing a stance on this issue depends on one's perspective.

On the one hand, lay persons who have been affected by HIV/AIDS are often uniquely capable of providing compassionate chronic disease care (Hermann et al., 2009; Kim & Farmer, 2006). Volunteers may be particularly well positioned to understand "what really matters" for patients: what would improve their lives, their illness experiences, and their experiences of uncertainty and vulnerability. In other words, volunteers may often be people who are able to deliver highly culturally-competent care (Kleinman & Benson 2006). Further, many volunteers serving on the front lines of the struggle to roll out antiretroviral therapies say that they derive spiritual satisfaction and

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[11] Family Health International. Ethiopia Final Report (September 2001 to September 2006): USAID's Implementing AIDS Prevention and Care (IMPACT) Project. Arlington, VA: USAID IMPACT Project; 2007. See: http://www.fhi.org/en/HIVAIDS/pub/res_Ethiopia_Final_Report_IMPACT.htm [accessed on 8 November 2009].

[12] See http://www.worldvolunteerweb.org/fileadmin/docdb/pdf/2008/World_Volunteer_Web_stuff/IVD_reports_2008/Ethiopia_IVD_2008_report.pdf [accessed 2 March 2010].

meaningful relationships by helping others. Thus, from this perspective, community health programs have the potential to generate psychosocial and health "capital" derived from volunteers' pro-social motivations. This is a far cry from straightforward labor exploitation. In fact this perspective echoes two popular proclamations of positive psychology, namely that "being good is good for you" and that the economy of positive emotions is not "zero-sum" but instead comprised of "renewable" and perhaps limitless resources (cf. Borgonovi, 2008; Goleman, 2006; Haidt, 2006; Piliavin, 2003).

However, the scientifically testable idea that being good (i.e. volunteering altruistically) is good for you has not been critically examined in the context of SSA. Martinson and Minkler (2006), who have pioneered a critical approach to the promotion of volunteerism and "civic engagement" among elders in North America, note that three decades of research on the link between formal volunteering and health – including mental and cardiovascular health, immune function, and longevity – have led to over-generalized conclusions despite a lack of well-designed research in culturally- and socioeconomically-diverse populations. My doctoral research suggests a possible buffering effect of volunteering on mental health and reported household food insecurity among impoverished Ethiopian AIDS caregivers during the 2008 food crisis (see Chapters 2 and 3; Maes, Hadley, Tesfaye, & Shifferaw, 2010; Maes, Hadley, Tesfaye, Shifferaw, & Tesfaye, 2009). However, alternative explanations for this finding are plausible. For instance, participants in my study may have altered their responses to surveys based on expectations that the researchers would use their answers to determine eligibility to receive aid. This is a complication that is particularly relevant to contexts in urban SSA, characterized by unrelenting poverty and inequity, as well as substantial

presences of international humanitarians and researchers (which local people may sometimes find difficult to differentiate).

Further, even if volunteering appears to be "good for you," recognizing the production of such psychosocial benefits suggests that the pro-social "spirit" of volunteers – not just their physical labor – is usurped by the programs that they serve.

From this perspective, the organizers of volunteer workforces attempt (with success varying by program and context) to generate and maintain Durkheimian solidarity or "shared emotional energies" (Collins, 2004; Durkheim, 1915 [1965]) among volunteers and the communities they serve. The ritual reinforcement of religious and pro-social values among volunteers occurs in situations ranging from training programs and "appreciation" ceremonies like the one I briefly described at the beginning of this chapter, to every-day interactions between supervisors, patients, and volunteers. Matching t-shirts, group songs, and shared expectations of spiritual rewards are common ingredients in such situations. The psychosocial capital that these activities seek to generate is certainly valuable for sustaining volunteers' motivations and the programs that rely on them. Health programmers in Africa and other resource-scarce settings certainly recognize this economy of psychosocial capital.

As volunteer workforce supervisors also know, pro-social and self-interested motivations co-exist among volunteers (and are sometimes difficult to differentiate). A handful of anthropologists and sociologists have recently gathered information about the lives' of community volunteers upon whose labor so many AIDS care programs in SSA depend (e.g., Akintola, 2008b). The work of these scholars has gone some way towards dispelling the myth of the volunteer spirit by talking with volunteers, and recording their

discontents: unemployment (or landlessness in rural areas), lack of remuneration, low social status, inability to meet household needs, and, in the case of HBC, being unable to help patients who receive drugs but are not able to afford the health benefits of adequate food (Maes, Forthcoming).

Even with occasional remuneration in kind, trainings, and per diems, what is lacking for these volunteers is the certainty of remuneration that comes with regular wage payments. Uncertainty is at the heart of the economic insecurity that many volunteers voice. I argue in this dissertation that volunteerism is neither simply a case of donated kindness and labor nor simply a euphemism for labor exploitation. Instead, AIDS care volunteerism is a network of situations across Africa defined by two key features: 1) poor but often resilient and relatively pro-social community members building social solidarity and care relationships (with variable success) and receiving in return a mix of potential forms of “rewards” – except formal wages; and 2) the valuable socio-emotional solidarity and altruistic motives of volunteers being usurped, along with their physical labor, by a mix of organizations attempting to sustain the AIDS care movement, including local and international NGOs, governments, and for-profit biomedical entities. Elites in these organizations tend to imagine African communities as full of individuals containing “untapped” emotional energy and physical labor (i.e. “volunteers”). Thus this dissertation aims to show that the motivations of real volunteers in an urban setting in SSA – and the socioeconomic contexts in which they exist – are often inaccurately represented in the minds and documents of volunteer programmers.

THE MEANING OF SUSTAINABILITY

High rates of antiretroviral therapy adherence in sub-Saharan Africa have been at least partly attributed to the contributions of volunteers as treatment supporters, counselors, *accompagnateurs*, and mediators of patients' access to clinical and NGO resources (Coetzee et al., 2004; Hardon et al., 2007). However, the quality of their services is not guaranteed, and this poses a major problem. Insufficient training and monitoring of *paid* health care workers is considered to be one of the main reasons behind the often poor quality of health services in SSA (World Health Organization, 2008). If health systems are failing to effectively train and supervise paid health care workers, how can we expect those same systems to monitor volunteers and hold them accountable for their adherence to quality guidelines? Answers to these questions must engage with the troublesome concept of sustainability in global health workforce strengthening.

Unfortunately, policy-makers and practitioners in global health do not agree upon what is meant by sustainable. Sustainability theorists assess sustainability in terms of the "triple bottom line" by asking what are a program's economic, social, and environmental impacts (Hacking & Guthrie, 2008). Under this definition, the wellbeing and satisfaction of the labor force are key issues for sustainability of national and community health programs. But in the conventional and much narrower global health definition, a health/development project is said to be sustainable if it can be "taken over" by local organizations when the donors and implementers that financed the start-up pull their resources out (Ooms, Van Damme, & Temmerman, 2007). According to critics, this definition is associated with a set of health/development practices – such as relying on unpaid labor – that give rise not only to unsustainable programs, but also to unintended

social consequences in African communities (D. J. Smith, 2003; Swidler & Watkins, 2009).

Further, there is little basis for the contention that volunteerism is actually more cost-effective or sustainable than clinic-based care. Olagoke Akintola (2008b) provides a review of existing literature on unpaid AIDS care in sub-Saharan Africa, concluding that available data are inadequate to determine the financial cost-effectiveness of various models of home- and community-based care, let alone the psychosocial costs of such care borne by unpaid caregivers in settings of high unemployment and food insecurity (see also Ogden, Esim, & Grown, 2006; Schneider, Hlophe, & van Rensburg, 2008).

There is another definition of “sustainable” that refers to a health intervention that is backed by a commitment to sustained funding by global donors such as the Global Fund (Ooms et al., 2007). This conceptual shift is used to advocate for a transformation in practices – from reluctance to commitment – in hiring and paying health workers in low-income countries battling AIDS, tuberculosis, and malaria. This definition of sustainability is arguably more consistent with a global health system that puts African people in a position to exercise their entitlement to fair and regular remuneration for the important labor they provide.

Since its inception, the Global Fund has become more attuned to the benefits of strengthened health workforces. But a tension exists between any potential Global Fund mandate to implement “sustainable” workforce funding in cooperation with African governments on the one hand, and on the other hand, the International Monetary Fund’s practice of imposing government expenditure ceilings on health workforces (Dräger, Gedik, & Dal Poz, 2006). According to Ooms and colleagues (2007), without flexibility

about these IMF-imposed ceilings, bilateral donors continue to be unwilling to support health worker salaries; the Global Fund is willing but unable to break through this "vicious circle." These authors contend that the Global Fund has an "explicit endorsement from the international community" to practice an approach to sustainability that does away with idea that health system strengthening initiatives can simply be taken over by local governments and organizations after a brief injection of global funding.

Contested approaches to sustainability are at the heart of the policy tension between the Global Fund and the IMF on the issue of workforce expenditures. As this dissertation will show, the idea that volunteerism can simply alleviate this tension is clearly challenged by the economic insecurities that push volunteers to question their capacity and willingness to continue serving.

ACUTE-ON-CHRONIC FOOD INSECURITY

Particularly in the wake of the 2008 global food crisis, a focus on chronic food insecurity highlights the tension between a volunteer's spirit and her desires for economic security. Insecure access to food is increasingly recognized as a major contributor to cycles of poverty and HIV/AIDS in SSA (Ivers et al., 2009). However, there is a lack of micro-level studies that seek to understand the dynamic patterns of vulnerability and resilience in regards to food insecurity, its determinants, and its psychosocial and nutritional outcomes among urban and rural communities affected by the HIV/AIDS pandemic. For instance, most studies of the determinants and outcomes of the recent 2008 food crisis make use of national and regional level population data; thus conclusions are made at the national and regional (e.g. rural vs. urban) level, ignoring possible exceptions to these

broad patterns, and what such exceptions might teach us about preventing and alleviating household food insecurity. Thus examining the experiences of food insecurity among AIDS care volunteers is an opportunity to extend research on food crisis into the micro-level ethnographic realm, and to do so among a sub-population of increasing importance to health and development programs in sub-Saharan Africa (see Chapter 3). In urban Ethiopia, as I will show in this dissertation, AIDS care volunteers had household incomes well below conventional poverty lines and experienced high rates of food insecurity even prior to the peak of the 2008 food crisis. In this context, volunteers negotiated their desires for economic "progress" amidst a mix of other pro-social and self-interested motivations to be volunteer AIDS caregivers. For these volunteers, food insecurity was particularly de-motivating. Food crisis on top of chronic food insecurity pushed them to reconsider what they deemed as appropriate compensation for their efforts. Given that food insecurity is likely to remain problematic in many countries in SSA and elsewhere, volunteers will continue to face severe constraints that may impact on their capacity and willingness to be effective health workers and caregivers. Ironically, volunteers in such contexts may often be poorer than their clients.

Ideally, effective and resilient community health workers (CHW) derive mental satisfaction *and* fair remuneration from their labor. The ability of socioeconomically marginalized people to carry out their volunteer role emphasizes the *value* of their labor, which in a fair market would command decent remuneration. While volunteers may derive satisfaction from helping, it must be recognized that they face enormous challenges in other areas of their lives. The question for policy makers then becomes how

to generate the spiritual benefits of altruistic, compassionate care as well as a level of remuneration that allows for secure livelihoods among volunteers.

The WHO's recent recommendation challenges various public and private entities to adapt to a system in which funding and other measures are used to create fairly-paid and secure healthcare jobs in low-income countries facing pervasive food insecurity and high burdens of chronic and infectious disease. In the context of sub-Saharan Africa, hiring, training, and paying CHW may be a win-win situation: people get secure jobs that allow their households and communities to attain food security, and health care systems get strengthened, to the benefit of those in need of care and treatment for chronic and acute conditions ranging from undernutrition to HIV/AIDS. Given substantial global diversity in programs, contexts, and volunteers (e.g. retired and affluent versus underemployed and poor volunteers), it is problematic to make general statements about volunteerism in global health. This highlights the need to hear from experts who are familiar with successful and less-successful volunteer programs around the world. Importantly, we also need to listen to what volunteers themselves – and the people whom they serve – say about the benefits *and costs* of volunteering.

LOCAL SETTING

Ethiopia prepared to launch free HAART programs country-wide in 2004. At that time, home-based care, which by definition relies on unpaid volunteer and household labor, was recognized by national policy makers as a cost-effective way to support the "scaling-up" of treatment (Ministry of Health, 2005). In the face of a large and late-maturing HIV/AIDS epidemic (Iliffe, 2006; National Intelligence Council, 2002) and

poorly distributed public health services, volunteerism in community health care has grown substantially over the past decade in Ethiopia. Addis Ababa, the capital of Ethiopia, has an estimated population well exceeding three million (UN-HABITAT, 2008), a high rate of unemployment (Serneels, 2007) and food insecurity (Gebre-Egziabher et al., 1994; L. C. Smith, Alderman, & Aduayom, 2006). Addis Ababa, like many other cities around the world, also experienced high food price inflation over the course of 2007-2008 (International Monetary Fund, 2008; Ulimwengu, Workneh, & Paulos, 2009).

Here, community health volunteers number in the thousands. Public health facilities rely heavily on the training of volunteers, who provide home-based palliative care and counseling, support drug adherence, and mediate patients' access to clinical treatment and NGO assistance. In Addis Ababa, volunteers for these programs typically come from local households with per capita incomes well under one USD/day. Volunteers are not government health personnel; they are typically organized under NGOs, part of a civic society toward which Ethiopian governments past and present have been cooperative and antagonistic (Kloos, 1998). Volunteers serve for a period of 18 months, caring for at least five non-kin patients. They develop close relationships with one or two patients, but maintain regular interaction with all of their assigned patients. After 18 months, patients are re-assigned to a new group of volunteer recruits, and "graduating" volunteers either leave the service with unknown prospects for employment or continue for another service period. A select few continue for another service term; an even smaller proportion gets promoted to modestly-salaried NGO positions. Volunteers receive about 5-10 USD/month to reimburse their transportation and telecommunications

expenses. Some volunteers received food aid (usually wheat and cooking oil) as a stipend from their NGO. However, this practice was suspended in early-mid 2008.

I conducted my doctoral research with community AIDS care volunteers from two local NGOs: *Hiwot* HIV/AIDS Prevention, Control and Support Organization and *Medhen* Social Center. Both of these organizations provide home-based care for people with AIDS accessing treatment at the Ministry of Health's ALERT Hospital, located at the top of a small hill overlooking the Akaki River, on the southwest outskirts of Addis Ababa. ALERT Hospital's HIV/AIDS Department clinic attempts to provide universal treatment access to 2 out of Addis Ababa's 10 sub-cities. The *Hiwot* NGO runs an Addis Ababa-wide AIDS care program, with hundreds of volunteers; the bulk of its funding and support during the study period came from Family Health International, which in turn received much of its funding from USAID. In contrast, *Medhen* is a small organization under the auspices of the Ethiopian Catholic Church, which focuses on a few very impoverished neighborhoods adjacent to ALERT Hospital. *Medhen* receives funding from a mix of smaller international donors (both individuals and organizations). By including these two organizations, I intended that the sample of volunteers and my observations would be more representative of community health volunteers in Addis Ababa.

CHAPTER OVERVIEW

The remainder of this dissertation is organized as follows. **Chapter 2** reports on an assessment of the validity and dependability of the Household Food Insecurity Access Scale (HFIAS), which was developed for international use in measuring household food

insecurity. The validation of the HFIAS in an urban setting in SSA is a major contribution, as over half the world now lives in cities; indeed, rates of urbanization are increasing in sub-Saharan Africa (UN-HABITAT, 2008). The HFIAS performed well according to validation standards in the field; and yet my research also revealed a slight amelioration in reported food insecurity status over time, which seems paradoxical given the increasing inaccessibility of food over the same time period due to local effects of the 2008 global food crisis. Thus the results reported in this chapter are important not only for the validation of food insecurity tools, but also for the sustainability of community health programs reliant on volunteerism in sub-Saharan Africa, a region characterized by chronic food insecurity. A version of Chapter 2 was published in *The Journal of Nutrition* (Maes, et al., 2009).

Chapter 3 extends the findings reported in Chapter 2 by including analysis of the relationship between food insecurity and mental health, as well as the unexpected finding that neither food insecurity nor depression/anxiety symptom loads worsened along with increasing food prices and disappearing food aid associated with the 2008 food crisis. Chapter 3 also introduces qualitative data highlighting the "mental satisfaction" that many AIDS care volunteers claim to derive from their service. Thus I argue that understandings of the impact of food crises can be extended by conducting micro-level ethnographic studies. Policy researchers have attempted to *predict* the impact that a sharp rise in food prices might have on population wellbeing by performing simulations on population-level datasets, thereby estimating the proportion of households that drop below conventional poverty lines given a set increase in prices. My analyses presented in Chapter 3 show that food insecurity was highly prevalent among Ethiopian AIDS care

volunteers in Addis Ababa; that food insecurity was associated with household economic factors; and that it was also linked to common mental disorders (CMD, a debilitating mix of depression and anxiety symptoms). That the volunteers in this urban sample did not report increasingly severe food insecurity or CMD during the peak of the 2008 food crisis is a counter-intuitive result that would not be predicted in analyses of population-level data. But when these results are linked to real people in specific urban ecologies, they can improve our understanding of the psycho-social consequences of food price shocks. Chapter 3 concludes by calling for future studies that address links among food insecurity, psychosocial health, and the potential benefits of altruism. A version of Chapter 3 is published in *Social Science & Medicine* (Maes, et al., 2010).

Chapter 4 presents ethnographic and epidemiological research documenting how the 2008 food crisis in Addis Ababa affected AIDS care volunteers' care relationships and motivations. The qualitative data reported in this chapter highlight the distress and de-motivation that rising food costs created for caregivers by contributing to their own and their care recipients' experiences of food insecurity and HIV-related stigmatization. Epidemiologic results underscore the high prevalence of food insecurity reported by volunteers even prior to the peak of food prices. Results also show that new volunteers recruited in early 2008 by the larger NGO involved in my doctoral research (the *Hiwot* organization) were more likely to be dependents within their households, and that these participants reported lower rates of food insecurity and higher household income. While this shift in volunteer recruitment may help sustain volunteer care programs in the face of widespread poverty and underemployment, food insecurity was still highly prevalent among this sub-group. Thus, given the inability of the local NGOs that organize

volunteers to address the challenge of food insecurity for program sustainability, this chapter raises important policy questions regarding compensation for volunteers' valuable labor and poverty-reduction through public health sector job-creation. A version of Chapter 4 will be published in *Health Policy & Planning* in 2010 (Maes, Shifferaw, Hadley, & Tesfaye, In Press).

Chapter 5 presents short ethnographic case studies of two HIV-positive AIDS care volunteers. This chapter also presents epidemiologic findings, further documenting how acute-on-chronic FI during the 2008 food crisis affected AIDS care volunteers' psychosocial health, in terms of both restricted social participation and common mental disorder (CMD) symptoms. These findings include that positive HIV serostatus among volunteers was related to restricted social participation, but not to food insecurity, and to high CMD symptom loads only among those volunteers who were food-secure. These results reveal a widely-overlooked way in which food insecurity threatens to undermine AIDS care and treatment efforts in sub-Saharan Africa, and contributes new insights into synergies among food insecurity, HIV/AIDS, culture and structural inequalities. A version of Chapter 5 will be published in the *Bulletin of the National Association for the Practice of Anthropology*'s special thematic issue on "Anthropological Approaches to Confronting HIV/AIDS and Food Insecurity in Sub-Saharan Africa."

Chapter 6 presents two longer ethnographic case studies of AIDS care volunteers in Addis Ababa, as well as the results of cultural consensus analyses conducted on the motivations of the full sample of AIDS care volunteers involved in my doctoral research. This chapter argues that a person-centered ethnographic analysis of the motivations and experiences of these volunteer caregivers – people who uniquely link HAART patients to

the world of NGO and public health services – allows us to re-politicize the state of health care systems and unemployment, and to understand the micro-political (as opposed to strictly medical) consequences of HAART roll-out in low-income countries. With these two representative – but in some ways unique – case studies, I evaluate how volunteers and their supervisors deal with questions of remuneration and volunteerism itself. Such an analysis encourages policy-makers and broader audiences to confront the culturally- and socioeconomically-loaded concept of volunteerism amidst widespread unemployment and household economic insecurity in settings like Addis Ababa. Importantly, this inquiry gives volunteer caregivers a chance to explain their various motives in their own words, through narratives of their lives before, during, and after volunteering for such a daunting task.

These case studies also provide a frame of reference for interpreting the results of cognitive-motivational rankings that were collected from a larger sample of volunteers and subjected to cultural consensus analyses. As the case studies show, in the course of their day-to-day activities involving NGO supervisors, patients, and health professionals, volunteers experience subtle and not-so-subtle reinforcement of their pro-social motivations and control of self-interested motivations. Such processes appear to shape the way that volunteers rank the personal importance of various motivations for being an AIDS care volunteer, producing consensus among volunteers in which pro-social motivations (such as reducing the burden of care in the community) are ranked high while self-interested motivations (particularly receiving material benefits from the NGO) are ranked low. This chapter thus makes a second argument: that in conducting cultural consensus analyses of these data, it is necessary to keep in mind how social desirability

bias may have influenced participants' responses. Different conclusions can be drawn from these data when one assumes that a face-value interpretation is warranted, and alternatively when one assumes that the data reflect both what respondents "prefer" and what they think they "ought to" prefer. Such an analysis offers a preliminary understanding of how volunteer AIDS caregivers' motivations – particularly their desire for personal socioeconomic progress – are shaped by the cultural, economic, and micro-political environment. Thus I emphasize the importance of mixed ethnographic and cognitive survey-based methods in a critical examination of volunteer motivations. Collecting these different kinds of data together leads to a much richer analysis and understanding of both socially "desirable" and "undesirable" volunteer motivations. A version of Chapter 6 received the 2nd Prize in the 2010 Peter Kong-ming New competition of the *Society for Applied Anthropology*.

Chapter 7 examines how rituals function – with variable success – to sustain the motivations of AIDS care volunteers serving the HIV/AIDS treatment program of ALERT Hospital in Addis Ababa. I apply a Durkheimian theory of macro- and micro-level rituals, including volunteer recognition ceremonies, shared meals and coffee, and every-day interactions, to the activities of the two internationally-funded Ethiopian NGOs involved in my research. The goal of this analysis is to understand how a ritual economy – involving songs, dances, matching t-shirts and hats, occasional meals and "coffee ceremonies," as well as discursive symbols such as the selfless volunteer and the drug-adherent patient – attempts to sustain the motivations of volunteers and thus the antiretroviral therapy programs they serve in an environment of chronic resource scarcity. I argue that more comprehensive understandings of the sustainability of many kinds of

development and population health programs in Ethiopia and elsewhere in sub-Saharan Africa must explicitly account for the role that rituals play in garnering both material and psychosocial resources for the motivation of unpaid and underpaid laborers.

The strictly ethnographic approach employed in this chapter prevents a more empirical understanding of how various ritual ingredients and structures lead to variable outcomes in terms of individual and group solidarity and pro-social motivation. Thus I argue that a next step is to develop mixed quantitative and qualitative methods that combine predictions from interaction ritual theory (Collins, 2004) with formal tools for the measure of individual and social level variables, such as social network analysis, cultural consensus analysis, and multilevel modeling. Such an effort would allow for a rigorous ritual analysis focusing on testing competing hypotheses about the relationships between ritual inputs and outcomes in various development-related and other contexts. This approach to ritual analysis could potentially be applied by NGOs and other organizations to a more systematic promotion of social solidarity and individual motivation to volunteer in various health and development projects in sub-Saharan Africa. From a critical medical anthropological perspective, such analyses would serve to broaden notions of sustainability of donor-funded health and development programs that rely on unpaid and underpaid labor.

Chapter 8 concludes this dissertation by summarizing findings and outlining how they contribute to an applied anthropological approach to confronting links between HIV/AIDS, food insecurity, and a growing reliance on volunteer labor in global health programs in sub-Saharan Africa. This dissertation is particularly timely given that the issue of volunteer labor in (increasingly integrated) HIV/AIDS, family planning, and

primary health care programs in sub-Saharan Africa is increasingly seen as absolutely critical to the sustainability of these massive population health programs. And yet, though links between HIV/AIDS and food insecurity are investigated by anthropologists and others (e.g., Himmelgreen et al., 2009; Ivers et al., 2009), there is a complete lack of rigorous research that asks how food insecurity and general economic uncertainty amongst volunteers threatens to undermine AIDS prevention, treatment, and care programs in sub-Saharan Africa. This is unfortunate, because HIV/AIDS prevention and control, and indeed family planning and primary health care in general, are fundamental aspects of equitable development goals in sub-Saharan Africa.

Chapter 8 makes explicit what I show using mixed methods throughout this dissertation: an applied anthropological approach to confronting the use of volunteer labor in health and development projects in sub-Saharan Africa must engage with local and global discourses that aim to promote volunteerism, as well as with volunteers' own experiences of economic insecurity, psychosocial distress, and "mental satisfaction." Addressing these issues means first questioning and then rigorously assessing the sustainability of relying on unpaid labor to fill gaps in global health workforces.

This dissertation shows that a powerful set of assumptions, as well as a practice of using group rituals to motivate volunteers, encourage policymakers and NGOs to continue relying on volunteer labor without questioning the sustainability and fairness of this model. Future ethnographic and epidemiological research should continue to confront these issues. But it is clear that volunteers face enormous socioeconomic challenges. As this dissertation shows, volunteers enjoy serving their fellow community members, but they also desire secure jobs for themselves and for many of their care

recipients, as a primary way to achieve economic security. Thus creating and ensuring health care jobs, while rolling-back a reliance on unpaid labor, has already emerged as a policy that both helps households and communities to attain food security and strengthens public health care systems on which millions of people in Africa depend. Clearly, future anthropological research that investigates these linkages between community health, food insecurity, and labor in sub-Saharan Africa must continue to engage directly with global health policy makers, donors, and practitioners.

CHAPTER 2

Food insecurity among volunteer AIDS caregivers in Addis Ababa, Ethiopia: Highly prevalent but buffered from the 2008 food crisis[13]

INTRODUCTION

Household food security is defined by the Food and Agriculture Organization of the United Nations as access to a diet of sufficient quantity and quality for all household members at all times, through socially acceptable ways, in order to maximize the likelihood of healthy and active living (Food and Agriculture Organization of the United Nations, 2004). As defined by USAID, food security has three components: availability, access, and utilization (USAID, 1992). In the past two decades, researchers have sought to develop tools for measuring food insecurity (FI)[14] that directly assess the experience of the phenomenon at the household level; though a standard FI module has been available for use in the U.S. for several years (Kendall, Olson, & Frongillo, 1995), a standard FI scale proposed for international use was published only as recently as 2006 (Swindale & Bilinsky, 2006). The Household Food Insecurity Access Scale (HFIAS) was deemed by its developers to capture the "universal experience of the access component of household food insecurity across countries and cultures," and to require only minor adaptation to local contexts.

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[13] A version of this article was published in *The Journal of Nutrition* in 2009.

[14] Abbreviations used: ALERT, All-Africa Leprosy and Tuberculosis Research and Training Hospital; FI, food insecurity; GEE, generalized estimating equation; HAART, highly-active antiretroviral therapy; HFIAS, Household Food Insecurity Access Scale; NGO, non-governmental organization; USD, United States Dollar.

According to Frongillo (Frongillo, 1999), dependability in a food insecurity measure, or the extent to which differences in the measure consistently reflect differences in the phenomenon, “might be [an issue] for short time spans if, for example, transient events in people’s lives influence assessment of their food security status” (p. 508S). In other words, when the ecology of household food access is changing, we would expect a sensitive food insecurity scale to reflect these changes. Thus, the objectives of this chapter are to 1) briefly describe the process of adaptation and validation of an Amharic-language version of the Household Food Insecurity Access Scale (HFIAS), and 2) to present evidence that the HFIAS provides a valid and dependable (as defined above) measurement of food insecurity in Addis Ababa, Ethiopia. The analysis follows the proposed validation criteria of FI scales outlined by Frongillo (1999), which have provided a model methodology for the validation of other FI modules by researchers working in other settings (e.g., Perez-Escamilla et al., 2004). Here, these criteria are extended to include the dimension of dependability of repeated FI measures at three data collection rounds over the course of eleven months in 2008 (during a time of steep food price inflation and disappearing food support).

SUBJECTS AND PROCEDURES

Ethical treatment of participants. The study protocol was approved by the Ethics Committees of the Addis Ababa University Faculty of Medicine and the Armauer Hansen Research Institute / ALERT Hospital (Addis Ababa), and by the Institutional Review Board of Emory University.

Instrument adaptation and qualitative validation. I based the adaptation of the HFIAS on the premise that the content of the English-language tool was developed for international use (Coates, Swindale, & Bilinsky, 2007; Swindale & Bilinsky, 2006). The HFIAS includes the following nine items, all of which are asked with a recall period of 30 days:

1) Did you worry that your household would not have enough food?
2) Were you or any household member not able to eat the kinds of food you preferred because of a lack of resources?
3) Did you or any household member eat just a few kinds of food day after day because of a lack of resources?
4) Did you or any household member eat food that you did not want to eat because of a lack of resources to obtain other types of food?
5) Did you or any household member eat a smaller meal than you felt you needed because there was not enough food?
6) Did you or any household member eat fewer meals in a day because there was not enough food?
7) Was there ever no food at all in your household because there were no resources to get more?
8) Did you or any household member to sleep at night hungry because there was not enough food?
9) Did you or any household member go a whole day without eating because there was not enough food?

These nine items were translated into Amharic, the lingua franca of Addis Ababa and other urban centers in Ethiopia, by an Ethiopian expert in community nutrition (Fikru Tesfaye, MD, MPH, PhD). The translated instrument was then back-translated and the Amharic translation was revised (by Selamawit Shifferaw, MPH and Kenneth Maes). The revised Amharic tool was then pre-tested for face validity among a convenience sample of six community health volunteers who were not included in the subsequent quantitative study sample. Respondents with whom the HFIAS was pre-tested had no trouble understanding the items and responded clearly for each item. In addition, diet and the experience of food insecurity were focal domains during a twenty-month parallel ethnographic study of volunteer HIV/AIDS caregivers in Addis Ababa, which provided additional support to the appropriateness of the content of the HFIAS.

Quantitative validation study sample. The revised Amharic-language instrument was applied to a representative sample of community HIV/AIDS volunteer caregivers from two local NGOs, *Hiwot* HIV/AIDS Prevention, Control and Support Organization and *Medhin* Social Center, which cooperate with ALERT Hospital to provide home-based care for people with AIDS accessing treatment at the hospital. The full sample included 110 volunteer home-based caregivers (99 women and 11 men) of adult patients receiving treatment at ALERT Hospital. For the present analyses, we excluded male respondents on the assumption that they are not adequately familiar with their households' food economies to respond to the HFIAS. This left a full sample of 99 women, incorporating the following sub-groups: 48 randomly-chosen participants who had been volunteering with *Hiwot* organization for 12 months at the time of the first data collection round; 32 randomly-chosen participants who had just begun volunteering with

Hiwot organization at the time of the first round survey; all 19 female volunteer caregivers from *Medhin* organization, with a mean service length of 12 months at the time of the first round survey. The majority, but not all, of the participants in the study were heads-of-household "in charge of" daily meal preparation and food acquisition. Based on ethnographic evidence I believe that even those among the sample who were dependents within their households were nonetheless adequately engaged with their household food economy to respond to the HFIAS, given that they were adult women with substantial responsibilities in regards to their household food economy.

99 participants were surveyed at round 1 (February/March 2008). At round 2 (July/August 2008), 96 of the original 99 participants were surveyed, and at round 3 (November/December), 96 of the original 99 were again surveyed, giving a 97% follow-up rate. Four Ethiopian research assistants were trained for data collection methods at rounds 1, 2, and 3. Data collection was conducted in pairs. Initial training, refresher training, and the data collection "buddy system" aimed to maximize data quality.[15]

Household income. At rounds 2 and 3 (but not round 1), participants reported household composition (i.e. people sleeping and eating on a regular basis in the house). Monthly incomes (in Ethiopian Birr) from all income-generating members of the household were also collected at rounds 2 and 3, and the incomes of all income-generators were added to calculate a total household income. This total was then divided by the total number of people in the household (adults and children) to yield a monthly

[15] I invested research funds in having two data collectors conduct each survey together, and in training the data collectors to 1) be friendly to each other and to the respondent (making the respondent more comfortable); 2) keep an eye on each others' questioning and data recording; and 3) share the questioning and data recording within each survey interview (to avoid tedium). My reasoning was that this investment would pay off in terms of data quality and in keeping both the data collectors and the respondents engaged and upbeat. I was also fortunate to have generally friendly, engaged and upbeat data collectors.

household per capita income (Birr/month). At all rounds, participants also estimated an overall household income; at rounds 2 and 3, this was done *prior to* itemizing income by household member. On average, when participants itemized household income by member, total household income was about 15% greater than when participants estimated an overall household income. Since member-itemized household income was not reported at round 1, we adjusted round 1 incomes by adding 10% (a more conservative adjustment) to the reported value. Household composition was not reported at Round 1, so we assumed that it had not changed from round 1 to round 2. Therefore we divided the adjusted total monthly household income (in Birr) reported at round 1 by the total number of people in the household at round 2 to yield a monthly household per capita income for round 1. Finally, we categorized monthly per capita incomes at all three rounds according to USD/day, after dividing the raw data by 10 (1 USD was about 10 Birr during the study period) and then by 30 (the number of days in a month).

Organizational food support. At each round, respondents reported whether they were receiving food aid from governmental or non-governmental organizations, and what kinds of foods they were receiving as food aid. Since wheat grain or flour is the most common type of food available and accessed in large quantities as food aid, and because it is often traded for cash by recipients, we categorized respondents based on whether they were receiving free wheat as food aid at the time of the interview.

Food intake. A 24-hour food recall questionnaire, previously used with an urban Ethiopian population (Seifu, 2007), was used to record the consumption of twelve local food categories during *yesterday day and night*: meats, fish, eggs, dairy, vegetables, fruits, beans, cereals/bread, potatoes and other roots/tubers, oil/butter, sugar/honey, and

coffee and other drinks. Respondents indicated whether or not they consumed each item, but not the quantity they consumed. The 12 dichotomous items yielded a continuous variable ranging from 0 to 12, indicating increasing dietary diversity. Because many Ethiopians observe fasting days at various times throughout the year, respondents were also asked if they were fasting from meat, fish, eggs, and/or dairy on the day before the interview. This was taken into account during analyses of intake for these types of food by excluding respondents who reported that they were fasting. In addition, participants rated the desirability of each of the twelve food categories as “not at all desirable” (scored as 0), “somewhat desirable” (scored as 1), or “very desirable” (scored as 2).

Validity criteria. As recommended by Frongillo (1990), and following Perez-Escamilla and colleagues (2004), there were four validity criteria established a priori: 1) an expected Chronbach α approaching 0.85; 2) parallelism on item response curves across income strata; 3) a clear-cut dose-response relationship between income strata and level of FI; 4) a clear-cut dose-response relationship between level of FI and consumption of fruits, vegetables, meat, and dairy. We also sought to demonstrate a clear-cut dose-response relationship between FI level and dietary diversity score. Finally, we addressed the dependability (as defined above) of HFIAS results across multiple assessment rounds.

Data analyses. SAS (version 9.2) was used to conduct all analyses. Participants were presented with ‘yes’ or ‘no’ response categories for each item of the HFIAS. Affirmative responses (pointing towards food insecurity) were coded as 1 and negative responses were coded as 0. Items were then summed to create a HFIAS score ranging from 0 to 9. Chronbach’s α internal consistency tests were run at all three rounds. In order to minimize respondents’ distress in responding to sensitive questions and to save time (the HFIAS was administered amidst a series of other surveys), the sub-questions

related to frequency of occurrence in Swindale and Bilinsky's protocol were not included in the surveys and subsequent analyses. This may bias results, since in general it is helpful to distinguish whether specific conditions of food insecurity are experienced one or two times versus several times over the course of a month. Based on the very low income levels of the sample's respondents, we feel it is safe to assume that affirmative responses indicate that the specific food-insecure condition occurred more than just one or two days in the past 30 days.

Households were thus classified into four levels of food insecurity according to the following scheme, which closely parallels the categorization scheme outlined in the published HFIAS protocol guide despite my elimination of the sub-questions related to frequency of occurrence. This scheme allows the reporting of household food insecurity (access) prevalence for each level of food insecurity:

1) Food secure (respondent answers 'yes' to none of the items)
2) Mild FI (respondent answers 'yes' to item 1 or 2 or 3 or 4, but not items 5-9)
3) Moderate FI (respondent answers 'yes' to item 5 or 6, but not items 7-9)
4) Severe FI (respondent answers 'yes' to item 7 or 8 or 9).

To test the parallelism of the item response curves at all three rounds, we plotted the percentage of 'yes' responses to each of the nine FI scale items across the four household per capita income strata. The associations of FI severity level with household per capita income level and other covariates were tested with extended Mantel-Haenszel Chi-square statistics using the CMH option in the FREQ procedure, invoking modified ridit scores for unequally spaced response levels and controlling for round where

appropriate (Stokes, Davis, & Koch, 1995). Cochran-Armitage trend test was used to test for change in the percentage of households receiving free wheat as food support, using the TREND option in the FREQ procedure. Generalized estimating equations (GEE) accounting for intra-individual correlation of repeated measures, using the GENMOD procedure, were also used to observe the associations of measured covariates and data collection round with food insecurity. Statistical significance was based on a two-sided probability value ≤ 0.05. Values in the text are means ± SEM and percentages.

RESULTS

Sample characteristics. Respondents in the sample ranged in age from 18 to 45 years (mean: 28 ± 6 years). Length of schooling was 10 ± 2.6 years. The percentage of respondents who reported receiving free wheat as food support decreased over rounds 1, 2 and 3 ($P < 0.0001$), from 41% to 21% to 9%, respectively (**Table 2.1**).

Gross household income, in Birr, ranged from 476/month at round 1 to 571/month at round 3. Per capita income, in Birr, ranged from 110/month at round 1 to 127/month at round 3. Using an exchange rate of 1 USD=10 Birr, this corresponds roughly to per capita incomes of 0.37 USD/day at round 1 and 0.42 USD/day at round 3. Respondents were categorized based on their daily per capita income (in USD) into the following levels:

< 0.167 USD (poorest = 1);

0.167 – 0.333 USD (more poor = 2);

0.333 – 0.667 USD (less poor = 3);

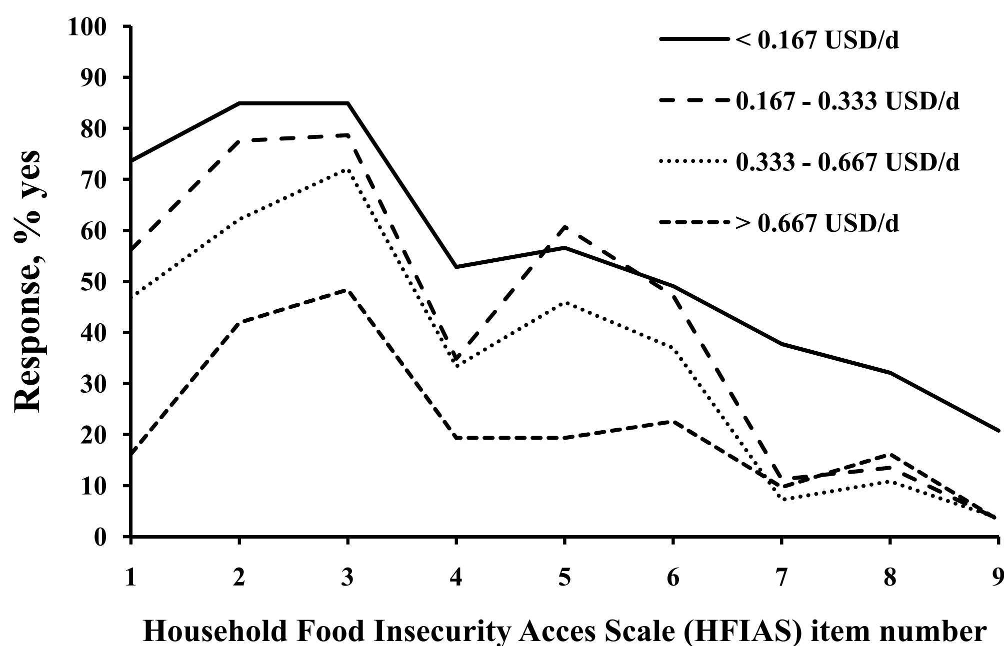
> 0.667 USD (least poor = 4).

TABLE 2.1: Sample descriptive characteristics of 99 female volunteer HIV/AIDS caregivers in Addis Ababa, Ethiopia, by round of data collection. Values are % or means ± SEM.

	Round		
	1 n=99	2 n=96	3 n=96
Respondent's age, %			
18-24 years	29.3	-	-
25-31 years	39.4	-	-
32 + years	31.3	-	-
Schooling, years	10.2 ± 2.6	-	-
Marital status, %			
Married	45.5	-	-
Unmarried	26.3	-	-
Separated/divorced/widowed	28.3	-	-
Gross household income, Birr/mo	476.3 ± 391.3	485.9 ± 388.0	571.1 ± 482.7
Per capita household income, Birr/mo	110.3 ± 90.8	109.8 ± 72.8	127.3 ± 91.3
Per capita household income, %			
< 0.167 USD/d	20.7	16.7	18.8
0.167 - 0.333 USD/d	37.0	34.4	22.9
0.333 - 0.667 USD/d	32.6	39.6	44.8
> 0.667 USD/d	9.8	9.4	13.5
Food insecurity level, %			
Food-Secure	16.2	21.9	18.8
Mild Food Insecurity	22.2	25.0	31.3
Moderate Food Insecurity	38.4	35.4	30.2
Severe Food Insecurity	23.2	17.7	19.8
Receiving wheat as food support, %	41.4	20.8	9.4
HFIAS score	3.8 ± 2.7	3.5 ± 2.5	3.3 ± 2.5
Dietary diversity score (0-12)	6.2 ± 1.2	6.3 ± 1.5	6.4 ± 1.2

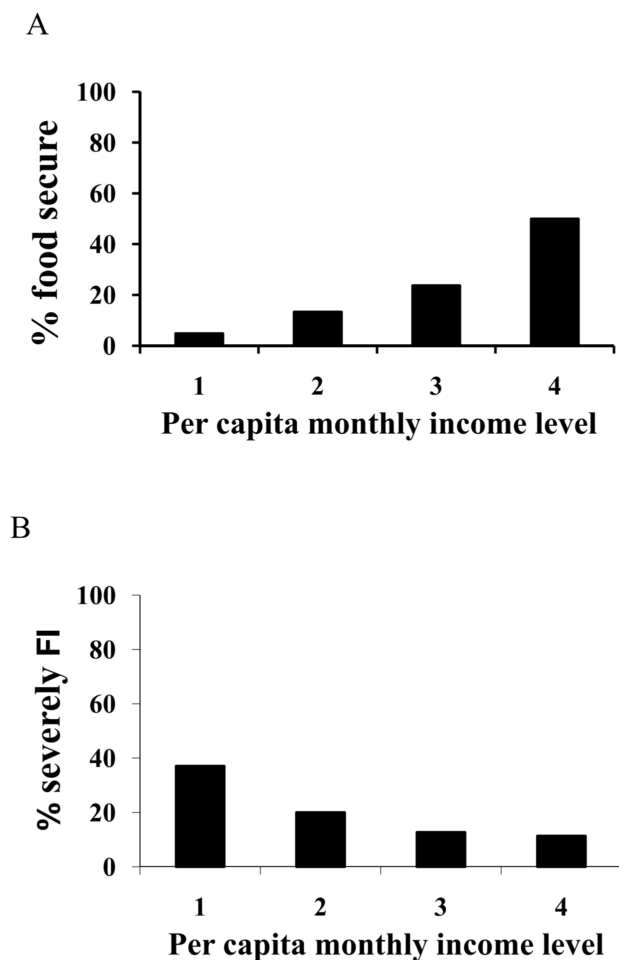
Internal consistency and parallelism. Chronbach's α at rounds 1, 2 and 3 were 0.85 (n=99), 0.84 (n=96), and 0.83 (n=96), respectively. With very minor exceptions, the HFIAS item response curves were parallel across per capita income strata, indicating that the likelihood of an affirmative response to most items increased as monthly per capita income decreased (**Figure 2.1**). The trends for all items across per capita income strata were significant ($P<0.02$, n=284).

FIGURE 2.1: HFIAS item response curves across household per capita income strata among 99 female volunteer HIV/AIDS home-based caregivers in Addis Ababa, Ethiopia. Observations across three data collection rounds (Feb/Mar 2008, July/Aug 2008, Nov/Dec 2008) are pooled (combined n = 284). HFIAS items are listed in the text.



Food insecurity severity and household per capita income. With food security as the outcome, a clear-cut dose-response trend was observed in relation to per capita income level. This trend was significant when controlled for round (P < 0.0001, n = 284). With severe food insecurity as the outcome, a dose-response trend was observed in the opposite direction in relation to per capita income level, with minor deviation between the two highest ("less poor" and "least poor") per capita income levels (**Figure 2.2**). This trend was significant when controlled for round (P = 0.0006, n = 284).

FIGURE 2.2: Food security (A) and severe food insecurity (B) as a function of per capita income among 99 female volunteer HIV/AIDS home-based caregivers in Addis Ababa, Ethiopia. Observations across three data collection rounds (Feb/Mar 2008, July/Aug 2008, Nov/Dec 2008) are pooled (combined n = 284).



In a linear GEE model accounting for repeated measures on participants, household per capita income was inversely associated ($P < 0.0001$) with HFIAS score. Further, the parameter estimates for the various per capita income strata revealed a clear

dose-response relationship with food insecurity, with each level having a significant (P < 0.02) effect on HFIAS score in the expected manner (**Table 2.2**).

TABLE 2.2: Analysis of GEE parameter estimates for per capita income strata linearly regressed on HFIAS score, accounting for repeated measurements (all rounds, n=284). Generalized estimating equations (GEE) pool observations across data collection rounds and account for intra-individual correlation in repeated measures.

Parameter	Estimate	SE	Z	Pr > |Z|
Intercept	2.3385	0.4148	5.64	<0.0001
Poorest	2.1263	0.6042	3.52	0.0004
More poor	1.3173	0.4686	2.81	0.0049
Less poor	1.0415	0.4151	2.51	0.0121
Least poor (ref)	0.0000	0.0000	.	.

Food insecurity level and food intake. Because the food intake items used to generate the food diversity score were qualitative (i.e. yes/no) and not quantitative, it is not possible to address the possibility that participants reduced the amounts of foods they ate. However, specific qualitative differences were observed in diet between participants reporting food security and food insecurity. Dose-response trends between food insecurity level and likelihood of previous-day consumption of various foods were observed for meats (not including fish), vegetables, and fruits, with minor deviations between moderate and severe levels of FI. For example, among respondent households

that were severely food insecure, the likelihood of previous-day consumption of meat was 8.3% aggregated over the data collection rounds, compared to 26.3% for food secure households. Controlling for round, the observed trends were significant for meats ($P < 0.04$, $n = 236$), vegetables ($P < 0.02$, $n = 291$), and fruits ($P < 0.001$, $n=291$).

The analyses also detected foods that were insensitive to food insecurity level, such as beans, which are a staple of local diets, and dairy, which is much less commonly consumed. For cereals, the likelihood of previous-day consumption was 100% for all food insecurity levels at all three rounds; this is because the cereals category included *teff*, a staple grain of local diets, as well as wheat, which has become nearly ubiquitous in Addis Ababa.

Increasingly severe food insecurity was associated with lower dietary diversity according to a GEE modeling the 4-level ordinal outcome of FI level ($P < 0.001$, $n=236$). We did not observe any difference in mean dietary diversity scores over time (6.2 ± 1.2, 6.3 ± 1.5, 6.4 ± 1.2 at rounds 1, 2, and 3, respectively). Participants reporting food insecurity were also less likely to be fasting ($P<0.05$).

Table 2.3 disaggregates consumption rates of the twelve food types by food insecurity status (i.e. food security vs. combined mild, moderate, and severe food insecurity) and round of measurement for the total study sample. Food-secure and food-insecure participants reported differences in terms of changing consumption rates over time. Rates of religious fasting involving avoidance of animal source foods (ASF) were much higher at Round 1. While food-secure participants were able to add animal source foods to their diets at Round 2 (after the major religious fasting season), food-insecure

participants only maintained the rates of meat and other ASF reported at Round 1 (P<0.05).

Regarding non-ASF, food-secure participants reported fairly steady consumption rates for each food type. In contrast, food-insecure participants reduced their consumption of fruits (P=0.03), beans and pulses (P=0.05), and edible oil (P=0.03), as well as *increased* their consumption of potatoes (P=0.02), over time. Interestingly, as shown in **Table 2.4**, participants ranked potatoes lower in comparison to the food types that were reduced by those participants reporting food insecurity. Thus, among food-insecure participants we observe a pattern of reduced consumption of higher-ranked foods with substitution of potatoes, a lower-ranked, albeit still nutritious, food.

TABLE 2.3: Consumption rates of 12 food types during "yesterday day and night," by food insecurity status and round of measurement. Note: these data were contributed by the complete study sample (n = 110 at Round 1).

	All				**Food Insecure**				**Food Secure**				
	Round				Round				Round				
Food type consumed yesterday, % yes	1 n=110	2 n=106	3 n=107	P † [a]	1 n=91	2 n=82	3 n=84	P * [a]	1 n=19	2 n=24	3 n=23	P ‡ [a]	P † [b]
Grains, breads	100	100	100	n/a	100	100	100	n/a	100	100	100	n/a	n/a
Potato, roots	35.5	35.9	46.7	0.08	29.7	34.2	46.4	0.02	63.2	41.7	47.8	0.36	0.04
Vegetables	40.9	43.4	45.8	0.43	37.4	41.5	40.5	0.6	57.9	50	65.2	0.61	0.01
Fruits	36.4	24.5	23.4	0.01	33	17.1	19.1	0.03	52.6	50	39.1	0.32	<0.001
Beans, legumes, pulses	88.2	82.1	80.4	0.1	91.2	82.9	81	0.05	73.7	79.2	78.3	0.77	0.14
Oil, butter	95.5	98.1	99.1	0.11	94.5	98.8	100	0.03	100	95.8	95.7	0.31	0.76
Sugar, honey	89.1	96.2	92.5	0.1	91.2	95.1	91.7	0.82	79	100	95.7	0.18	0.57
Coffee, tea	95.5	95.3	93.5	0.49	94.5	95.1	94.1	0.92	100	95.8	91.3	0.14	0.87
Meat (where fasting = 0)	14.5	21.9	22.6	0.18	15.3	16.7	21.3	0.34	10	44.4	27.8	0.63	0.07
Eggs (where fasting = 0)	11.6	7.3	9.7	0.72	10.2	5.1	9.3	0.9	20	16.7	11.1	0.48	0.08
Fish (where fasting = 0)	0	2.1	1.1	0.42	0	1.3	1.3	0.32	0	5.6	0	0.08	0.51
Dairy (where fasting = 0)	13	14.6	17.2	0.27	11.9	14.1	17.3	0.33	20	16.7	16.7	0.68	0.53
ASF (where fasting = 0)	34.8	38.5	38.7	0.53	35.6	32.1	38.7	0.64	30	66.7	38.9	0.78	0.12**

† For animal source foods (meat, eggs, fish, dairy), n = 258; for all other food types, n = 323.
* For animal source foods, n = 212; for all other food types, n = 257.
‡ For animal source foods, n = 46; for all other food types, n = 66.
[a] Generalized estimating equations (GEE) were used to test the effect of round of measurement on the frequencies of consumption of each food type.
[b] GEE were used to compare overall frequencies of consumption of food types between food insecure and food secure households.
** Excluding Round 3 data, there is a significant ($P<0.05$) interaction between food insecurity status and round for the consumption of ASF.

TABLE 2.4: Desirability of 12 food items, ranked according to the percentage of respondents who said that each item was "very desirable" (all measurement rounds combined, n = 323).

Food type	Desirability = very, %	Rank*
Grains, breads	76.5	1
Potato, roots	72.1	6
Vegetables	74.6	2
Fruits	73.7	4
Beans, legumes, pulses	72.5	5
Oil, butter	74.6	3
Sugar, honey	58.5	8
Coffee, tea	52.3	10
Meat	51.4	11
Eggs	56.7	9
Fish	45.5	12
Dairy	59.4	7

* Rank is based on comparing the percentage of respondents who said each food type was "very desirable"

Food insecurity severity and food support. Wheat as food support was concentrated on respondent households that were moderately or severely food insecure, which accounted for 65% of households receiving free wheat (P = 0.01, n = 291). HFIAS score was also a significant predictor (P = 0.02) of receiving wheat as food support in a GEE model accounting for repeated measures on participants and controlling for per capita income.

Food insecurity over time. The mean HFIAS score decreased slightly over the three data collection rounds, going from 3.8 ± 2.7 at round 1 to 3.5 ± 2.5 (round 2) to 3.3 ± 2.5 (round 3) (P = 0.04). The combined prevalence of moderate and severe food insecurity decreased from 61.6% at round 1 to 50.0% at round 3 (P = 0.02, **Figure 2.3**).

DISCUSSION

Findings from this study indicate that an adapted version of the HFIAS is a valid tool for assessing food insecurity among community health volunteers in Addis Ababa, Ethiopia. The content of the scale did not need to be changed during the translation process, and the face validity was assessed in pre-test interviews with target community members. The internal consistency of the scale was very good, with Chronbach's α at or approaching a commonly accepted cut-off for judging the level of consistency (Frongillo, 1999).

Very minor deviations from parallelism among affirmative scale item response curves across per capita income strata were observed for some items in the scale, but these deviations do not necessarily suggest that interpretations of these HFIAS items

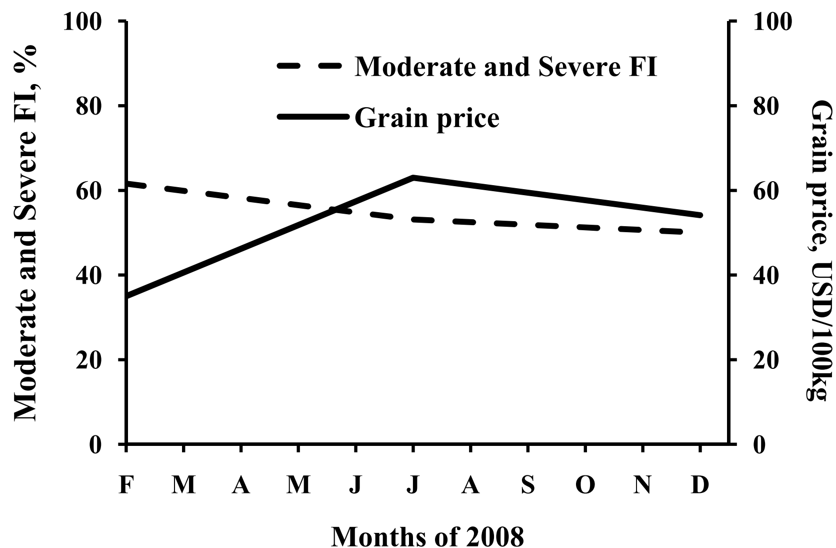
were different across the socioeconomic spectrum. This is partly because the daily per capita income strata into which respondents were categorized indicated such small real differences that they had minor consequences in terms of accessing a sufficient diet. In other words, the strata only designated gradations of extreme poverty. Even among the least poor stratum, the mean per capita household income was on the order of about 1 USD per day. That the HFIAS was still able to discriminate between these income strata in the current sample bolsters confidence that it is a valid tool for the assessment of FI.

The stability in mean dietary diversity score over time seems to suggest that the food crisis didn't affect respondents' diets. Because the food intake items used to generate the food diversity score were qualitative (i.e. yes/no) and not quantitative, however, we are unable to address the possibility that participants reduced the amounts of foods they ate if not the diversity of their diets, in response to the food crisis. However, data indicate that over the course of 2008, food-insecure volunteers reduced their consumption of higher-ranked foods and substituted potatoes, a lower-ranked food. Also, while food secure participants added animal source foods to their diets at Round 2 (after the major religious fasting season), food insecure participants only maintained the rates of meat and other ASF reported at Round 1.

There was, nonetheless, a significantly *improving* trend in FI observed over the three data collection rounds (**Figure 2.3**). Dependability as defined by Frongillo (1999) means that any temporal change or lack thereof in reported food insecurity should be explained by pertinent ecological factors in the context of validating a food insecurity scale. In the present study setting, such factors include change in 1) local food prices

(which respond to global food and fuel prices as well as local seasonal cycles), 2) per capita income, and 3) availability and distribution of food aid.

FIGURE 2.3. Trends of moderate and severe food insecurity prevalence and mean prices of seven grains in Addis Ababa across three data collection rounds (Feb/Mar 2008, July/Aug 2008, Nov/Dec 2008). Mean grain prices were computed using data from the Ethiopian Grain Trade Enterprise.



Changing food prices. Following a general trend of increasing food prices during 2005-2007 in Ethiopia, the year 2008 was characterized by record highs during the first 8 months, followed by somewhat attenuated prices during the latter part of the year (Ulimwengu, et al., 2009). **Figure 2.3** illustrates the mismatch between the trends in prices of seven grains in Addis Ababa wholesale markets and volunteer caregivers' reports of moderate and severe FI in the present study. In July 2008, mean prices of

sorghum (white and red), wheat (white), *teff* (red), barley (white and mixed), and maize had risen roughly 80% over their February 2008 levels, and during December 2008 were lower but still 54% over their February 2008 levels.[16] Thus, we might expect the prevalence and severity of FI to be lowest at round 1 and highest at round 2, with levels at round 3 intermediate. However, this was not the pattern observed.

Changing per capita income. This mismatch between food prices and FI severity is not explained by change in per capita income. The change in per capita income over the study period (on the order of 0.07 USD/d) was not significant. One limitation of this study, however, was that respondents reported their household compositions at rounds 2 and 3 only; thus I had to assume that household composition at round 1 was the same as at round 2 in order to calculate per capita incomes at round 1, after adjusting round 1 incomes by adding 10% to self-reports.

Availability and distribution of food aid. Rising food prices also had indirect effects on respondents' access to sufficient diets. As a result of high global food and fuel prices, which peaked during the northern hemisphere's summer (the local rainy season) of 2008, food "aid" supplies dwindled globally and in Addis Ababa. This situation prompted the government of Ethiopia to purchase wheat on the world market and provide it to urban households and millers at a subsidized price, starting in mid-2008. A limitation of this study is that I did not assess the distribution of government-subsidized wheat access in the sample, which could have helped to buffer some households from increasing food insecurity. Nevertheless, I found that the percentage of respondent households receiving free wheat as food aid from non-governmental organizations

[16] Ethiopian Grain Trade Enterprise. (2009). Market Statistics. Retrieved January 25, 2009, from http://www.egtemis.com/pricetrend.asp

dropped steeply, from 41.4% at round 1 to 9.4% at round 3. This trend might also lead us to expect an increase in the prevalence and severity of food insecurity over the three data collection rounds.

The fact that the HFIAS performed well according to validation standards, yet ostensibly "failed" to dependably reflect changes in the ecology of household food insecurity over 2008, presents a paradox. We suggest this paradox can be resolved by appealing to two self-report-related phenomena that arise in longitudinal studies: 1) observation bias, in which respondents change (a) their reports according to changing perceptions of the observer-respondent relationship or (b) their behavior in ways that ameliorate food insecurity status according to their reports at baseline; and 2) "response shift" (Sprangers & Schwartz, 1999), in which respondents change their reports according to reassessment of internal standards related to food security.

Observer Bias. It is possible that at round 1, participants in the study had stronger expectations that their answers to the HFIAS would bear on their eligibility to receive money or food from the researchers; participants may then have become more convinced at rounds 2 and 3 that their responses would not have any bearing on their eligibility for food or monetary support. Of course, we attempted to minimize such expectations in the process of obtaining informed consent for the research prior to the first round survey.

Another potential issue is that of stochastic time-varying covariates that respondents can voluntarily alter, which are an issue in many longitudinal observational studies (Fitzmaurice, Laird, & Ware, 2004; Robins, Greenland, & Hu, 1999). For instance, the assumption of stochasticity is violated if subjects with high HFIAS scores at baseline subsequently change their behavior so as to mitigate their food insecurity

situation, while subjects with the same propensity to FI-mitigating behaviors at baseline, but with low HFIAS scores, maintain their usual levels of FI-mitigating behaviors. Theoretically speaking, FI-mitigating behaviors (i.e. behaviors that improve food access) are not simply voluntary, but are heavily constrained by socio-economic factors. Therefore, this phenomenon probably does not play a major role in explaining the results from this study, but it cannot be ruled out.

Response shift. The observed trend in reported FI may be explained in part by recognizing the potential impact of coming into contact with people who are perceived to be hungrier, more marginalized, and more vulnerable, which is at the heart of the volunteer caregiver role, as indicated by my ethnographic work. I hypothesize that this role has a strong impact on volunteers' assessments of their own households' FI situation. This hypothesis is supported in part by the lack of an observed change in dietary diversity despite the significant improvement in reported FI. This is consistent with the idea of a "response shift" effect that comes from engaging in peer support, as described by Sprangers and Schwartz (1999). In the case of food insecurity, response shift can be defined as a psychological aspect of adaptation, which involves shifting internal standards, values, social comparisons, and concept definitions regarding food insecurity.

Researchers in the social and health sciences studying subjective measures of well-being, including food insecurity, must recognize 1) the systematic role that response shifts potentially play in a particular study, and 2) the scientific or inferential implications of such response shifts according to study goals. For example, if the goal of a study is to assess the prevalence of different levels of FI severity to indicate nutritional risk, then response shifts in reported food insecurity may lead to misclassifications and under-

estimates of nutritional risk. Yet if the goal is to determine the association of food insecurity and common mental disorders, which is increasingly of interest in international health research (Casey et al., 2004; Desjarlais, Esienberg, Good, & Kleinman, 1995; Craig Hadley & Patil, 2006; Craig Hadley et al., 2008; Hamelin, Habicht, & Beaudry, 1999; Heflin, Siefert, & Williams, 2005; Menon, Ruel, Arimond, & Frongillo, 2004; Quandt & Rao, 1999; Weinreb et al., 2002), then response shifts may reflect actual decreases in experienced insecurity, depression, and anxiety. Future research is needed to determine to what extent the relationship between FI and common mental disorder is mediated by social comparisons.

Response shift may also be important in designing food insecurity interventions. On the one hand, response shifts may lead to misclassification of some (but not necessarily all) households, confounding interventions to reduce exposure to food insecurity and diverting resources away from those who need them. On the other hand, response shifts may be a *goal* of interventions designed to reduce the anxiety associated with food insecurity and thus reduce the risk of common mental disorders.

Keeping in mind the limitations of this study, it appears that the HFIAS performed well in terms of classifying household food insecurity, while the surprising longitudinal results can be explained according to the biases and response shift process discussed above. Additionally, it is possible that rising food prices in Ethiopia over the three years prior to 2008 led to high prevalence of moderate and severe food insecurity among households in the sample. Against this historical backdrop, the food price spike of 2008, though striking to observers, may not have had commensurate added effects on the experience of food insecurity for these households. Future research should address these

issues by comparing multiple objective and subjective measures of food insecurity, including food intake and dietary diversity, in order to understand how different measures of the same construct vary and co-vary over time.

Some may regard the focus on community health volunteers as a limitation to a study of FI scale validity, since members of the sample are not representative of the general population of Ethiopia's capital city. This study of FI was in fact only one aspect of ethnographic and epidemiologic investigation of mental health among volunteer caregivers for people living with AIDS in Addis Ababa, which aims to highlight the theoretical and practical importance of applied understandings of this urban sub-group. As highly-active antiretroviral therapy (HAART) has become available in areas of sub-Saharan Africa that lack the infrastructure, health professionals, and resources to ensure its effective prescription, home-based care programs have evolved to rely on volunteer workforces (Ogden, et al., 2006). These same settings often bear a high prevalence of food insecurity; important links among health disparities related to food insecurity, nutrition, and HIV/AIDS are increasingly recognized (Gillespie, 2006; Himmelgreen et al., 2009; Ivers, et al., 2009).

I conclude this chapter by highlighting the high prevalence of food insecurity in this urban sample of volunteer caregivers, and call for future inquiries into this novel perspective on HIV-food insecurity interactions. I also note the intriguing possibility that food insecurity instruments may be prone to response shifts in situations where individuals repeatedly interact with those less fortunate. Response shifts may lead to misclassification of food insecure households as food secure. As low-income volunteer health workers become an increasing part of the African, and indeed global health work

force, situations that are prone to induce response shifts will become increasingly common. More research is needed to ensure that existing instruments accurately and dependably assess the food insecurity situation of these individuals. This is important for ensuring the well-being of not only volunteers but also those for whom they care.

CHAPTER 3

Food insecurity and mental health: surprising trends among community health volunteers in Addis Ababa, Ethiopia during the 2008 food crisis[17]

INTRODUCTION

The 2008 food crisis was the largest shock to the global economy since a similar food price shock occurred in the early 1970s. In mid-2008, global food prices had escalated rapidly to 150% of their 2006 prices, driven by a "perfect storm" of increased demand for food and biofuel crops, harvest shortfalls, rising petroleum costs, climate change, depreciation of the US dollar, and perhaps food price speculation (Dawe, 2008a, 2008b; Headey & Fan, 2008; Robles, Torero, & von Braun, 2009). While price increases were seen globally, the impact was predicted to be greater in low-income countries where poverty is combined with high spending on food as a proportion of total household expenditures (Ivanic & Martin, 2008; Zezza et al., 2008). This was true for Ethiopia, one of the world's poorest countries, where food prices had been increasing since 2004, culminating in the 2008 spike. In fact, the available data led Ulimwengu and colleagues (2009) to conclude, "it is obvious…that since August 2004 the Ethiopia food price index has been consistently higher than the world index" (cf. International Monetary Fund, 2008; Loening, Durevall, & Birru, 2009). This situation prompted the government of

[17] A version of this chapter will be published in 2010 in *Social Science & Medicine*.

Ethiopia to purchase wheat on the world market and provide it to urban households and millers at subsidized prices, starting in mid-2008.

A sharp rise in food prices may increase household food insecurity and cause distress among impoverished populations in low-income countries. Heady and Fan (2008) have reviewed the work of researchers who attempted to predict the impact on population wellbeing by asking what proportion of households drop below conventional poverty lines given a set increase in grain prices (cf. Deaton, 1989). Using existing national datasets, policy researchers attempt to model population heterogeneity in the impact of food price increases by stratifying according to urban and rural distinctions (food buying versus food producing and consuming) and income/asset levels. These policy studies often, but not always, predict that poor urban populations are hardest hit (contra Ivanic & Martin, 2008).

These modeling approaches have yielded influential policy-relevant insights about the links between rapid price increases, vulnerability, and poverty, but our understanding of the impact of food crises can be extended in three important ways. First, previous work notes but does not explore differential response or impact in unique samples. To say that urban populations are at risk says little about potentially substantial variation within urban populations. Such "hidden heterogeneity," in regard to social ties, culture and behavior (e.g. livelihood), is typically ignored in econometrics predictions of food crisis outcomes that make use of population-level data (Headey & Fan, 2008).

Second, prior work does not capture how individuals *actually* experience food crises, but rather makes statistical predictions about what *might* happen in the face of rapid price increases. Thus, an important next step is to examine the lives of people as

they negotiate rapid food price escalation. This approach requires the use of validated screening tools and ethnographic methods to document the psychosocially-mediated effects of food price shocks.

Third, existing studies of the 2008 food crisis have modeled the impact of food price increases on caloric intakes (Food and Agriculture Organization of the United Nations, 2008) or "welfare effects," while media reports focused on urban food protests. While these are important outcomes, ethnographic studies suggest that mental health is also associated with food insecurity, and that this is driven in part by the uncertainty that is introduced into people's lives as they struggle to meet their food needs. Such uncertainty is understood as a major contributor to anxiety and depression, which account for massive shares of the global disease burden (Craig Hadley & Patil, 2006; Murray & Lopez, 1997b; Pike, 2004). Coping strategies that buffer caloric intake might come with costs to mental health.

This chapter attempts to complement and extend existing research that assesses the impact of the 2008 food crisis by using qualitative and quantitative methods to examine the wellbeing of a cohort of poor community health volunteers living in Addis Ababa during the height of the crisis. In my quantitative analyses, we model two outcomes, household food insecurity (FI) and common mental disorders (CMD). FI is defined as insecure access to sufficient food for a healthy and active life (Food and Agriculture Organization of the United Nations, 2004). CMD is a syndrome characterized by depression, anxiety, panic, and somatic symptoms (Hanlon, Medhin, Alem, Araya, Abdulahi, Tesfaye, et al., 2008).

The individuals targeted here volunteer to fill critical human resource gaps in public health systems. Thus they differ from fellow urbanites in terms of livelihood. The AIDS care volunteer role in Addis Ababa positions these study participants amidst unique social networks of interaction and support, involving extremely deprived care recipients, other volunteers, and, as we will show, divine beings.

Based on the above definitions of FI and CMD, this chapter addresses several core questions. First, did rising food prices in Addis Ababa in 2008 lead to greater experience of FI and concomitant rise in CMD among volunteers in the sample? Second, do factors such as food aid, per capita income, or participation in microfinance clubs explain the observed patterns of self-reported FI and CMD symptoms? In answering these questions, I used generalized estimating equations that account for associations between responses given by the same participants over 3 survey rounds (February, July, and November 2008) to model longitudinal response profiles of FI, CMD symptoms, and covariates. I also analyzed qualitative data that contextualize the cognition and reporting behavior of caregivers in regard to FI and CMD. Although this study lacks data from a control group of non-volunteers, I exploit a key feature of the study design: the stratification of the sample according to whether a participant was a "newcomer" or "veteran" volunteer at baseline. Thus I addressed a third question: Is there a difference between newcomers and veterans in FI and CMD response profiles? This question is important for understanding how the uniqueness of the targeted population is potentially responsible for the results, and how conclusions from this study might generalize to community health volunteers in similar settings.

METHODS

Sample

The sample included 110 volunteer caregivers (99 women and 11 men) of adult patients receiving treatment at ALERT Hospital. This gender ratio reflects the overwhelming proportion of women in the volunteer population. A random sample of 90 participants was drawn from the *Hiwot* NGO's volunteer rosters, stratified by newcomer versus veteran status: 40 (out of 60) 'newcomers' who had just begun volunteering at the time of the baseline survey, and 50 (out of 70) 'veterans' who had all been volunteering for 12 months at the time of the baseline survey. All 20 volunteer caregivers from the *Medhin* NGO are also included, with an average service length of 11.7 months (±4.6, range: 4–22) at baseline. In the analyses that follow, veterans from *Hiwot* and *Medhin* were combined as a sub-group of 'Veterans' (n=70) to compare to the sub-group of 'Newcomers' (n=40). A very small number of participants missed one or more survey rounds. 110 participants were surveyed at Round 1. At Round 2, 106 of the original 110 participants were surveyed, and at Round 3, 107 of the original 110 were again surveyed.

Outcome measures

An Amharic version of The Household Food Insecurity Access Scale (HFIAS), described in Chapter 2, was used in this study (cf. Coates, et al., 2007; Maes, et al., 2009; Swindale & Bilinsky, 2006). Thus participants' households were classified into four levels of FI according to a scheme that closely parallels the published HFIAS protocol: 1) food-secure; 2) mild FI; 3) moderate FI; and 4) severe FI.

To assess the distribution of CMD symptoms, we used a 29-item version of the WHO Self-Reporting Questionnaire (World Health Organization, 1994), which

incorporates 8 items derived from Amharic idioms of distress (e.g. feeling that someone has cursed you; feeling that your heart is beating too fast). The SRQF has been translated to Amharic, tested for content, construct and criterion validity (Zilber, Youngmann, Workneh, & Giel, 2004), and used in previous population research in Ethiopia (Hanlon, Medhin, Alem, Araya, Abdulahi, Hughes, et al., 2008). Participants were presented with 'yes' or 'no' response categories for each SRQF item/symptom. Affirmative responses were coded as 1 and negative responses as 0. The number of affirmative responses was summed to create a SRQF score (out of 29) for each individual at each round. Though the SRQF is not a diagnostic tool, a cutoff of 7/8 was determined by Zilber and colleagues (2004) to be optimal for screening CMD cases from urban Ethiopian populations, and is used in the present analysis.

Covariates

Participants reported age, gender, marital status (single, married, divorced/separated/widowed), and years of formal schooling. Participants were categorized according to whether they had major responsibilities in their household food economy: that is, I distinguished between dependents living with parents or guardians, versus male and female heads of household and females living with parents but sharing food economy responsibilities (shopping and cooking). Participants reported whether they were members of traditional finance-pooling clubs called *ïqub*. An *ïqub* typically comprises a group of friends or co-workers who pool an amount of money monthly, and one member takes the sum in turn.

Participants estimated monthly household incomes at all three rounds. At Rounds 2 and 3, participants reported household composition (i.e. adults and children regularly

sleeping and eating in the house). At each round, estimated household incomes were divided by the total number of people in the household to yield monthly household per capita incomes in Ethiopian Birr/mo (converted to USD/mo using a rounded exchange rate of 10 Birr to 1 USD current at the time of the study). Household composition was not reported at Round 1. Since average household composition did not change between Rounds 2 and 3, we assumed that it also had not changed from Round 1 to Round 2. Thus we divided household incomes reported at Round 1 by the total number of people in the household at Round 2.

Participants answered three dichotomous questions addressing household economic coping "to fulfill basic needs" in the past three months: 1) starting a new income-generating activity, 2) selling household goods, and 3) keeping students home from school to help in income-generation or food preparation. Participants were categorized according to whether they or anyone in their households engaged in one or more of these coping measures versus none in the three months prior to survey.

At each round, participants reported whether they were receiving free food aid from non-governmental organizations, and what kinds of foods they were receiving. Wheat grain or flour was the most common type of food aid reported; in 2007 and the first part of 2008, free wheat was accessed often from NGOs like *Hiwot* and *Medhin*, and was commonly traded for cash by recipients. Participants were categorized based on whether they were receiving free wheat at the time of the survey.

At each round, participants reported their total number of care recipients, whether they were caring for at least one bedridden care recipient, and the total number of hours per week spent in volunteer activities.

Data Analysis

Generalized estimating equations (GEE) accounting for intra-individual association of repeated measures, using the GENMOD procedure in SAS, were used to observe the bivariate and multivariate associations of independent variables and round of measurement with dichotomous outcomes (food insecurity and SRQF score $\geq$8). For multivariate analyses of both outcomes, I first determined whether a significant difference existed in the FI and CMD response profiles of newcomer versus veteran volunteers, i.e. an interaction between group and time. If the interaction term was not significant, I dropped it and examined the main effect of round. I then included per capita income and other covariates to examine whether they were associated with the outcome, and how they affected the parameter estimate for the interaction between newcomer status and round or the main effect of round. In modeling the outcome SRQF score $\geq$8, we included FI severity level as an independent variable. SAS (v 9.2) was used to conduct all analyses.

Ethnographic methods

Participant observation was conducted in neighborhoods adjacent to ALERT Hospital, including attendance at volunteer trainings, caregiver and care recipient homes, and volunteers' reporting and planning meetings, over 20 months between May 2007 and January 2009. A purposive sample of 13 volunteer caregivers (7 newcomers [5 female and 2 male], and 6 veterans [5 female and 1 male]) were recruited to complete a series of up to seven semi-structured interviews assessing motivations, costs and benefits of volunteering, food insecurity, care relationships, and wellbeing. Interviews occurred over 8 months in 2008. Analysis involved an iterative process of identifying emergent themes

and grouping data into *a priori* and *in vivo* coded categories. Here, I limit the presentation of qualitative data to quotes from in-depth interviews that illustrate themes helpful to the interpretation of quantitative findings on FI and CMD response profiles.

FINDINGS

Qualitative findings

Participants in the sample clearly recognized that they and their care recipients suffer from an array of experiences subsumed under the construct of food insecurity. As one caregiver, a single mother, said, "The thing that only God and I know [is that] yesterday my children went without taking any food – nothing. I had some shoes in my house. I wanted to sell the shoes [in order to] prepare some lunch for them." Another caregiver referred to the food insecurity and distress of one of his care recipients: "[T]here is a woman who [only] boils beans [for her family's meals]. She is raising two children without a father… Because life now gets expensive, that troubles her mind."

Qualitative results also pointed to positive effects on wellbeing that come with being an AIDS care volunteer, a role that positioned informants within unique social networks involving other volunteers, patients, and divine beings. The representative quotes from informants listed in **Table 1** highlight cultural values that emphasize 1) empathy for those "lower" or more vulnerable, 2) reciprocity involving humans and divine entities (God, saints), and 3) mental satisfaction with helping others.

TABLE 3.1: Quotes from in-depth semi-structured interviews highlighting empathy, human and divine reciprocity, and mental satisfaction.

Profile	Quote
Single man, age 35, veteran volunteer caregiver	"[Being] a volunteer caregiver… will get you to think something good for human beings…and you will sympathize with human beings… Sometimes I will get aid from NGOs [in return for volunteering]; but you have to forget this thing. By believing in God...and doing God's work, you can live." (May 8, 2008)
Single mother, age , veteran volunteer caregiver	"In all my life, what makes me the happiest…is [to see those patients] being human – being able to work and feed themselves. He is now selling second-hand clothes. She is now sewing. We are now good sisters and brothers, and I am very happy." (October 7, 2008)
Young wife and mother, HIV+, newcomer volunteer caregiver	"What motivated me to be a caregiver? First, I myself am, of course, a patient [i.e. living with HIV/AIDS]. And second, to see others' pains like my own [and] understand how many hurt people there are. If I am not benefiting in my own way, I will get something from God. God will pay me [back for] my weariness." (May 20, 2008)
Young woman from wealthier background, newcomer volunteer caregiver	"I am working with happiness – I convinced myself for that. And because [other volunteer caregivers] are of lower economic status [than I am]…I make myself lower [i.e. humble myself]… and work together with them. That makes me very happy. It is also good for my mind." (Oct. 17, 2008)

As "followers" of Christianity, the religion with which 97% of participants self-identified (the vast majority of Ethiopian Orthodox denomination), volunteers often expressed expectations of divine rewards for helping others as an important motivation to volunteer. All informants expressed mental satisfaction in reaction to improvement in the health of care recipients. In the discussion, I address how these findings inform the interpretation of the quantitative results that follow.

Quantitative findings

Cronbach's alpha (raw) for the HFIAS was 0.85, 0.84, and 0.83 at Rounds 1, 2, and 3, respectively. For the SRQF, Chronbach's alpha was 0.89, 0.90, and 0.90. As illustrated in **Table 3.2**, at baseline, average age was 27.7 years (±6.2, range: 18–45) and average schooling was 10.3 years (±2.6). Newcomers were significantly more likely to be male (P<0.01), due in part to recent recruiting practices that target men. Compared to veterans, newcomers were also significantly more likely to be unmarried (P=0.04).

TABLE 3.2: Sample descriptive statistics, by newcomer status

	All n=110	**Veterans** n=70	**Newcomers** n=40	P
Age at baseline, years	27.7 ± 6.2	28.2 ±5.9	26.9 ±6.6	0.31
Female gender, %	90.0	95.7	80.0	<0.01
Schooling at baseline, years	10.3 ± 2.6	10.1 ±2.3	10.7 ±2.6	0.20
Marital status at baseline, %				0.04
Married	40.9	42.9	37.5	
Unmarried	33.6	25.7	47.5	
Separated/divorced/widowed	25.5	31.4	15.0	

Summary statistics are listed by round of measurement in **Table 3.3**. Average monthly per capita income was $11.31 (±$12.49) at Round 1 and $12.49 (±$10.14) at Round 3, a statistically non-significant gain of about $0.04 USD/day. The average number of people living in participant households at Rounds 2 and 3, when data were collected, was 4.6 (±2.1) and 4.5 (±2.0), respectively. The percentage of participants whose households received free wheat as aid dropped from 38% at Round 1 to 8% by Round 3 (P<0.0001). Participating in *ïqub* was fairly steady over the three rounds (8.5–

10%), as was engaging in at least one economic coping measure (19–25%); the most common of these coping measures was starting a new income-generating activity. The percentage of participants who held major responsibilities in the household food economy was 77.6%. The average number of care recipients per participant was fairly constant (12–14), as was the percentage of participants who cared for at least one bedridden care recipient (20-30%). Hours/week spent volunteering was 13.4 (±6.0) at Round 1 and about 16 at Rounds 2 and 3. Because workload statistics at Round 1 did not include newcomers (they had just begun the service), I did not calculate p-values for these variables.

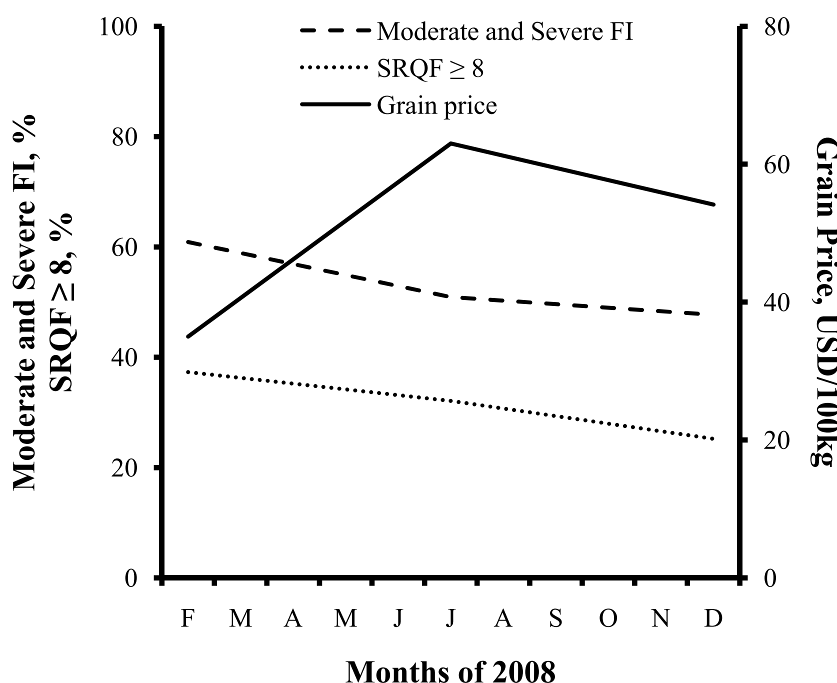
TABLE 3.3: Selected summary statistics, by round of data collection.

	Round			
	1 n=110	2 n=106	3 n=107	P
Estimated per capita household income, USD/Month	11.31 ± 12.49	11.38 ± 10.63	12.49 ± 10.14	0.3
Household composition, people	-	4.6 ± 2.1	4.5 ± 2.0	0.6
Food-secure	17.3	22.6	21.5	0.4
Food-insecure – mild	21.8	26.4	30.8	0.1
Food-insecure – moderate	39.1	34.0	29.9	0.1
Food-insecure – severe	21.8	17.0	17.8	0.3
Engaged in one or more economic coping measures in past 3 months, %	24.6	18.9	22.4	0.7
Started new income-generating activity, %	18.2	8.5	16.8	0.8
Sold household goods, %	6.4	8.5	7.5	0.7
Kept students home to help prepare food, %	0.9	5.7	2.8	0.3
In charge of household food economy, %	77.6	-	-	-
Receiving wheat as food support, %	38.2	18.9	8.4	<0.0001
Member of *ïqub*, %	10.0	8.5	10.4	0.9
SRQF score	6.9 ± 5.9	6.2 ± 5.9	5.0 ± 5.5	0.004
Number of care recipients	11.7 ± 5.1	13.2 ± 6.2	14.0 ± 7.8	-
At least one bedridden care recipient, %	19.7	28.6	20.4	-
Hours per week	13.4 ± 6.0	16.1 ± 8.1	16.2 ± 9.8	-

In July 2008, the average prices of sorghum (white and red), wheat (white), maize, *teff* (red), and barley (white and mixed) had risen roughly 80% over their February 2008 levels, and during December 2008 were lower but still 54% over their February 2008 levels (calculations from data provided by the Ethiopian Commodity Exchange).[18] Despite this marked increase in food prices over and above any seasonal cycles to which city-dwellers might be accustomed, at Round 2 the prevalence of moderate and severe FI had dropped to 50.9% from its Round 1 level of 60.9%, and dropped again slightly at Round 3 to 47.7% (P<0.01). Thus, over time, participants were less likely to report moderate and severe FI and more likely to report mild FI and food security. The percentage of participants who reported at least 8 SRQF symptoms dropped over the study period, from 37.3% at Round 1 to 25.2% at Round 3 (P=0.03). SRQF scores decreased from 6.9 (±5.9) at Round 1 to 5.0 (±5.5) at Round 3 (P=0.004). **Figure 3.1** illustrates the important mismatch between the trends in average market price of seven grains in Addis Ababa and participants' reports of moderate and severe FI and CMD symptoms. **Figure 3.1** also illustrates the link between FI and CMD.

[18] Ethiopian Grain Trade Enterprise. (2009). Market Statistics. Retrieved January 25, 2009, from http://www.egtemis.com/pricetrend.asp

FIGURE 3.1: Combined moderate and severe FI prevalence (%), SRQF ≥ 8 (%) and average grain prices (USD/100kg) in Addis Ababa.

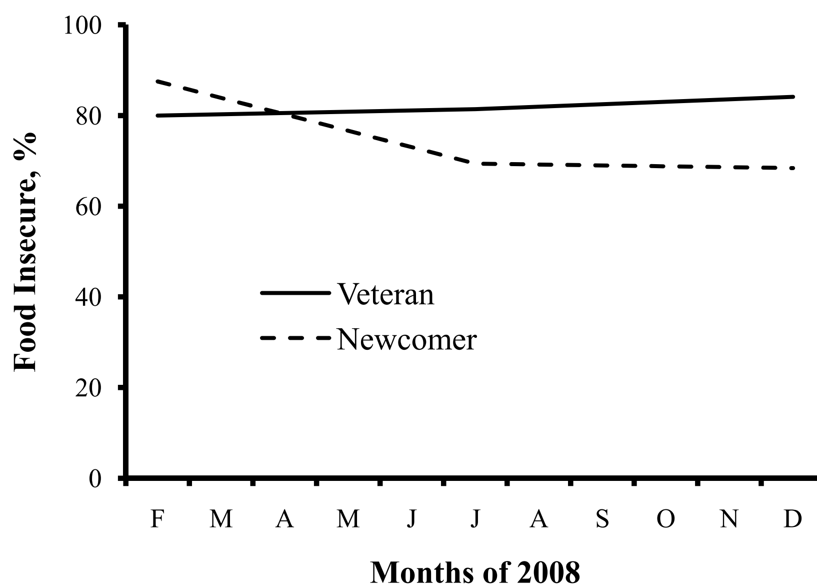


Regression outcomes

Food Insecurity (FI) Household per capita income was inversely associated with FI (P<0.001). Not having major responsibilities in the household food economy (P<0.05) independently reduced the likelihood of FI. Round of measurement was not associated with FI after the inclusion of covariates. **Figure 3.2** illustrates the difference between newcomer and veteran volunteers in combined mild, moderate, and severe FI prevalence. At baseline, newcomers and veterans did not differ in their reports of FI (P=0.15). Yet by Round 2, newcomers were less likely to report FI (P<0.05); therefore, the interaction term was included in the multivariate model summarized in **Table 3.4**.

The interaction between round and newcomer status remained significant (P<0.05) after the inclusion of covariates.

FIGURE 3.2: Combined mild, moderate and severe FI prevalence (%) as a function of Newcomer status and round of measurement.



Common Mental Disorder (CMD) Symptoms The most important result from this model is that FI severity was associated with SRQF score in a dose-response manner: participants reporting mild, moderate, and severe FI were increasingly likely to report SRQF scores ≥8 (**Table 3.5**). Participants that engaged in economic coping measures were more likely to report SRQF scores ≥8. At baseline, newcomers and veterans did not differ in the percentage of participants who reported SRQF scores ≥8. The apparently stronger improvement among newcomers in **Figure 3.3** was not significant; therefore, the interaction term was dropped from the model. No caregiver workload variable was associated with the outcome.

FIGURE 3.3: SRQF ≥ 8 as a function of Newcomer status and round of measurement.

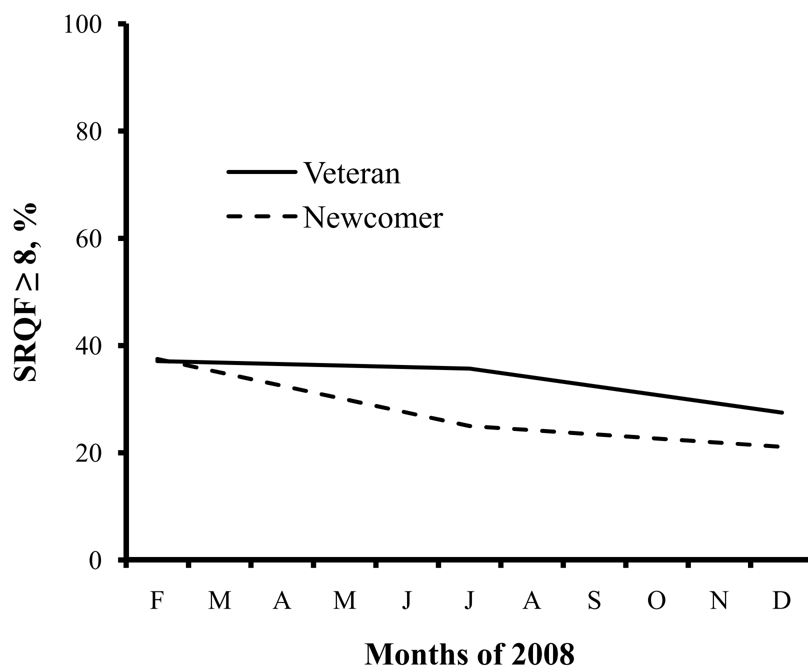


TABLE 3.4: Multivariate GEE results predicting dichotomous outcome of food insecurity (standard errors in parentheses).

	Model 1		Model 2	
Intercept	2.21	(0.55)****	3.57	(2.14)
Newcomer x Round	−0.66	(0.27)*	−0.74	(0.36)*
Newcomer	−0.98	(0.68)	−1.69	(0.91)†
Round	−0.52	(0.12)**	−0.42	(0.26)
Household per cap income (Birr/month)			−0.01	(0.00)***
Male gender			0.60	(0.74)
Education, years			0.03	(0.09)
Age, years			0.03	(0.06)
No economic coping measures			−0.14	(0.32)
No wheat as food support			−0.21	(0.42)
Single			−0.77	(0.94)
Married			−1.69	(1.00)†
Divorced/separated/widowed (ref)				.
Not member of *ïqub*			0.48	(0.43)
Not in charge of household food econ			−1.86	(0.74)*

† indicates $p < 0.10$, * indicates p < 0.05, ** indicates p < 0.01
*** indicates $p < 0.001$, **** indicates p < 0.0001

Table 3.5: Multivariate GEE results predicting dichotomous outcome SRQF score ≥ 8 (standard errors in parentheses).

	Model 1		Model 2	
Intercept	−0.37	(0.37)	1.87	(1.84)
Newcomer x Round		.		.
Newcomer	−0.20	(0.36)	0.16	(0.48)
Round	−0.26	(0.12)*	−0.20	(0.18)
Food-secure			−4.31	(0.83)****
Food-insecure – Mild			−1.93	(0.47)****
Food-insecure – Moderate			−0.86	(0.33)**
Food-insecure – Severe (ref)				.
Household per cap income, Birr/month			0.00	(0.00)
Male gender			−0.07	(0.82)
Education, years			0.02	(0.07)
Age, years			−0.00	(0.04)
No economic coping measures			−1.21	(0.36)***
No wheat as food support			−0.06	(0.40)
Single			0.18	(0.57)
Married			0.32	(0.42)
Divorced/separated/widowed (ref)				.
Not member of *ïqub*			−0.05	(0.50)
Not in charge of household food econ			0.27	(0.69)
Number of care recipients			−0.00	(0.03)
No bedridden care recipients			−0.47	(0.34)
Hours per week			−0.01	(0.02)

* indicates $p < 0.05$, ** indicates $p < 0.01$

*** indicates $p < 0.001$, **** indicates $p < 0.0001$

DISCUSSION

This longitudinal observational study took place in deprived neighborhoods of Addis Ababa during the 2008 food crisis, when the economic status of already poor people hypothetically deteriorated in the face of rising food costs and disappearing food aid (International Monetary Fund, 2008; Ulimwengu et al., 2009). Data clearly show that food insecurity was highly prevalent among AIDS care volunteers, and that FI was associated with household economic factors and mental health. Chapter 2 showed that FI in this sample was associated with lower dietary diversity (cf. Maes, et al., 2009). Importantly, these findings demonstrate that FI is not only a rural issue. Addis Ababa is just one example of an urban center with a large class of underemployed (Serneels, 2007), chronically food-insecure (Gebre-Egziabher, et al., 1994; L. C. Smith, et al., 2006), and resource-strapped households. In general, households experience food insecurity not because food is unavailable, but because they cannot afford to buy food (cf. Sen, 1981). The data presented in this dissertation clearly have implications that extend to urban settings in Africa with large community health volunteer workforces, and the more than 50% of the global population that now lives in urban centers (UN-HABITAT, 2008).

And yet, this urban sample did not report increasingly severe FI or CMD during the peak of the 2008 food crisis. This is a counter-intuitive result that would not be predicted in econometrics simulations using population-level data. But when linked to real people in specific urban ecologies, these results improve our understanding of the consequences of food price shocks.

Why did participants in this poor urban sample seem buffered from the local food crisis?

Food insecurity is a key sub-domain of the quality-of-life construct (QOL). Response shifts in QOL measures are expected in longitudinally-repeated self-report surveys – if and when participants are undergoing experiences that encourage re-evaluations of personal health and/or social status (Sprangers & Schwartz, 1999). Response shift is considered a marker of cognitive and affective adaptation in which meanings, standards, and social comparisons change along with the practice of altruistic care (Gibbons, 1999; Schwartz & Sendor, 1999; Schwartz & Sprangers, 1999; Sprangers & Schwartz, 1999). The sufficiency of accessible food is a potentially subjective assessment, sensitive to shifting internal standards and social comparisons. I argue that since volunteer caregivers repeatedly interact with care recipients (and other volunteers) who are perceived to be poorer and hungrier, FI is prone to response shifts in this sample.

That response shift at least partly explains the trend in FI in this sample is supported by the observation that newcomers were more likely than were veterans to report improved FI status at Rounds 2 and 3, because newcomers are expected to be affected more strongly by their new role. Additional support for the response shift hypothesis comes from semi-structured interviews, which allowed me to probe participants' experiences and values related to volunteer caregiving, poverty, and FI. Narratives provided insights into the material and psychological costs and rewards involved in volunteer caregiving, and the mechanisms (including divine) by which costs are exacted and rewards are meted. The shifting of internal standards and social comparisons related to FI is not necessarily a conscious process (Sprangers & Schwartz,

1999), but it is implied in statements about empathizing with the struggles of patients and other volunteers, an emotional habit that was reinforced by expectations of divine reward and ongoing interaction between volunteers and care recipients.

Is it possible to unite theories of volunteerism, FI, and CMD to explain why volunteer caregivers in Addis Ababa did not report worsening food insecurity and mental distress during the worst food crisis in recent history? Recently, regression analysis of data on self-reported health and happiness of religious volunteers and non-volunteers in the USA provided evidence of a positive, causal influence of religious volunteering on happiness (Borgonovi, 2008). Volunteerism and altruistic behavior have been studied for their hypothesized effects on wellbeing, with longitudinal data showing that adult volunteers enjoy better physical health and lower risk of mortality (Piliavin, 2003; Post, 2005; Thoits & Hewitt, 2001). Oman, Thoreson, & McMahon (1999) suggest these outcomes stem from the reduction of destructive self-absorption by the altruistic features of volunteerism, mediated by supportive relationships (Holt-Lunstad, Uchino, Smith, & Hicks, 2007) in which empathy thrives (Mikulincer, Shaver, Gillath, & Nitzberg, 2005). Volunteer care relationships, like all relationships, are mediated by neuroendocrine mechanisms with links to cardiovascular and immune function (Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002; Seeman et al., 2004). There are probably bidirectional arrows among psychological altruism, empathy, and increased wellbeing (Batson & Shaw, 1991; Cohn & Fredrickson, 2006).

Perhaps this helps to explain why SRQF scores did not worsen over time in this sample. Mental health could have been buffered from stressors by the psychological benefits mediated by volunteers' unique social networks, while response shift, also

mediated by volunteers' social networks, at least partly explains the surprising pattern in FI. Importantly, this study found that FI severity was associated with high SRQF scores in a dose-response manner. Biocultural anthropologists employ a feedback model between FI and CMD, in which stressful experiences like FI lead to anxiety/depression, while the experience of more CMD symptoms prevents or inhibits individuals from engaging in FI-mitigating strategies (Weaver & Hadley, 2009). Some researchers have attempted to test these alternative pathways (e.g., Heflin, et al., 2005). However, the directionality of effects between FI and CMD is beyond the scope of this paper.

Alternative explanations

Ultimately alternative explanations for the FI response profiles observed here cannot be ruled out, in particular potential biases introduced by the longitudinal, community-based design. There are at least two plausible alternative explanations for these results. First, I considered the assumption of stochasticity in reported FI. FI is an example of a time-varying covariate that participants can intentionally alter – a potential source of bias in observational research (Fitzmaurice, et al., 2004). However, FI-mitigating behaviors are not totally voluntary; they are heavily constrained by socio-economic factors.

Bias would also be introduced if participants changed their responses according to changing expectations of the researcher-participant relationship. It is possible that at Round 1, participants expected that the researchers would use their answers to determine eligibility to receive aid. I attempted to minimize such expectations while obtaining informed consent from participants. Still, some may have maintained such expectations, leading them to report more severe FI at Round 1. After Round 1, participants may have

become convinced that the researchers would not give aid, and thus were less inclined to report FI in hopes of receiving aid.

Implications and future questions

Headey & Fan (2008) argued that policy researchers have provided useful but limited insights into which types of households are most vulnerable to rising food prices. This study suggests that social networks can buffer the full psychological effects of a food crisis if they include relationships that provide for downward social comparisons and/or mental satisfaction through giving care to non-kin. Keys limitations of this study are that it did not explore caregivers' social networks of resource exchange in greater depth, their patterns of borrowing or spending from personal savings, or their access to government-subsidized wheat; these could help differentiate the roles of material versus psychological resources in the processes that apparently buffered this population. Nevertheless, data support the conclusion that *social networks of psychological support and exchange matter*; policy-makers need to recognize this.

The longitudinal results reported in this chapter do not negate the important cross-sectional findings, which highlight the concrete socioeconomic challenges and high rate of food insecurity faced by urban-dwellers in the sample. The households of these AIDS care volunteers, who fill critical human resource gaps in public health systems, were often moderately to severely food-insecure even prior to the peak of the food crisis. Across SSA, AIDS care volunteers are crucial to local and global economies of care, especially in the age of HAART (Akintola, 2008b; Ogden, et al., 2006). They tend to have few opportunities for employment; nevertheless they engage in volunteer activities that do not ostensibly support their food security. They are usually women, who are often

socio-economically marginalized, at increased risk of HIV-related stigmatization (Bond, 2006), and at increased risk for CMD (Desjarlais, et al., 1995; Hanlon, Medhin, Alem, Araya, Abdulahi, Tesfaye, et al., 2008; Heflin, et al., 2005; Patel, Araya, de Lima, Ludermir, & Todd, 1999). In SSA, both family and volunteer caregivers for people with TB and AIDS may be over-burdened and at increased risk of CMD (Akintola, 2008a; Orner, 2006; World Health Organization, 2002). Future research will help to determine whether my results reflect a general pattern of FI and CMD among community health volunteers in other settings characterized by high rates of unemployment.

This discussion provokes important policy questions: should the apparent resilience of this study population be supported with food or other material aid? Should they be relieved of their duties with efforts to put care and support in the hands of paid professionals? Or should they become paid community health workers (cf. Kim & Farmer, 2006; Pfeiffer, et al., 2008; Swidler & Watkins, 2009)? Answers to these questions are beyond the scope of this chapter, but are addressed in following chapters. I emphasize that debate over the rights of food-insecure volunteers to receive remuneration for their labor and over the sustainability of volunteer-based programs will be aided by mixed ethnographic and quantitative research that characterizes the economic and psychosocial costs and benefits of the volunteer role in various settings.

Future studies should also address links among FI, food crisis, response shift, and the potential benefits of altruism. Response shift in this context is understood as adaptation to not only illness, but also poverty as a widespread condition of material deprivation that constrains the means to achieve health and socioeconomic goals. Future research should use rigorous, mixed-methods study designs, involving control groups and

longitudinally-repeated measures where possible, multiple measures of constructs such as FI, non-invasive biomarkers of distress, and control variables such as social networks of support, negative life events, self-efficacy, and adult attachment security. In-depth life history interviews, multilevel modeling and cultural consensus analysis will effectively contribute to this avenue of research.

CHAPTER 4

Volunteer home-based AIDS care: Sustainability in the face of chronic food insecurity[19]

INTRODUCTION

On the eve of the XVII International AIDS Conference in August 2008, the executive director of UNAIDS, Dr. Peter Piot, summed up the effect of the then current global food crisis on AIDS treatment efforts: "We have the paradoxical situation that some people have access to pretty expensive and sophisticated drugs but have no food to eat…or don't have the money to take the bus to go to the [medical] center, and have no jobs" (reported by Democracy Now August 1, 2008).[20]

In the context of economic development, an important policy focus is the synergistic threat to human productivity and nutrition posed by AIDS and food insecurity (Gillespie, 2006; World Food Programme, World Health Organization, & UNAIDS, 2008), the latter defined as insecure access to sufficient food for a healthy and active life (Food and Agriculture Organization of the United Nations, 2004). With the rollout of AIDS therapies, low-income volunteers have become a major part of African and global health workforces. Food insecurity among AIDS care volunteers, like other biosocial mechanisms linking FI and HIV/AIDS, underscores "cycles of poverty" that must be

[19] A version of this chapter will be published in 2010 in *Health Policy & Planning*.
[20] See http://www.democracynow.org/2008/8/1/headlines [Accessed 17 March 2010]

interrupted at programmatic levels (Ivers, et al., 2009). Thus it is imperative to question not only how food insecurity (FI) contributes to HIV infection, drug access and adherence, related comorbidities, and early mortality (e.g., Mukherjee, Ivers, Leandre, Farmer, & Behforouz, 2006), but also how FI among volunteers impacts their wellbeing and the important labor they provide. However, to date no studies have assessed how FI specifically affects AIDS care volunteers.

As several policy-oriented researchers have shown, the promotion of volunteer (or unpaid) AIDS care across sub-Saharan Africa (SSA) is based on the assumption that volunteerism is an economic imperative in settings that combine health professional scarcity with national policies imposed by the International Monetary Fund (IMF) requiring expenditure ceilings on human resources for public health (Akintola, 2008b; Apondi et al., 2007; Campbell, Gibbs, Maimane, & Nair, 2008; Dräger, et al., 2006; Hermann, et al., 2009; Ooms, et al., 2007; Schneider, et al., 2008). AIDS care volunteers in SSA, typically organized by local NGOs, help fill large human and material resource gaps in public health systems, which many scholars attribute to structural adjustment programs of the 1980s and 1990s (Irwin & Scali, 2007). Community volunteers, many of whom have been affected by HIV/AIDS, are often uniquely capable of providing compassionate chronic disease care (Hermann, et al., 2009; Kim & Farmer, 2006). High rates of successful HAART adherence in low-income settings have been at least partly attributed to the contributions of volunteers as treatment supporters, counselors, and mediators of patients' access to clinical and NGO resources (Coetzee, et al., 2004; Hardon, et al., 2007). However, there is no reason to believe that it is the volunteer status

per se that is responsible for these successes; instead it appears to be the important labor performed by volunteers.

Acknowledging the shared social and economic determinants of HIV/AIDS, FI, and health professional shortages in Africa, some have advocated that community health workers (CHW) who serve on a volunteer basis be incorporated into the public sector and fairly remunerated along with efforts to strengthen public health and social welfare systems in poor countries (Kim & Farmer, 2006; Pfeiffer, et al., 2008). For many, this policy aims to protect AIDS care workers' right to fair compensation. Remuneration of workers is also a question of sustainability of health programs, highlighting the trade-off between losing volunteers through attrition and affording to pay adequate wages (Swidler & Watkins, 2009). As national governments struggle to find funding to hire and pay the large numbers of CHW and health professionals demanded by huge burdens of infectious and chronic disease, many nations will find it very difficult to follow the WHO's recent recommendation: "Countries should recognize that essential health services cannot be provided by people working on a voluntary basis if they are to be sustainable. While volunteers can make a valuable contribution on a short term or part time basis, trained health workers…should receive adequate wages and/or other appropriate and commensurate incentives" (World Health Organization, 2008: p. 35). In this context, sustainability is largely a question of whether major international donors such as the Global Fund can promise to maintain adequate funding to strengthen public health workforces in Africa (Dräger, et al., 2006; Ooms, et al., 2007).

This chapter argues that food insecurity (FI) is particularly de-motivating for volunteers, contributes to cycles of poverty and HIV/AIDS (Ivers et al., 2009) and adds

strain to the important relationships volunteers maintain with their care recipients who struggle to adhere to highly-active anti-retroviral therapy (HAART). A focus on FI clarifies what is at stake in the ongoing debate over the appropriateness of volunteerism from both human rights and sustainability perspectives, particularly in the wake of the 2008 global food crisis.

The 2008 food crisis represented a major shock to economies at the global, national and household scales. In mid-2008, global food prices had escalated rapidly, driven by increased demand for food and biofuel crops, rising petroleum costs, climate change, harvest shortfalls, and perhaps financial factors (Headey & Fan, 2008; Robles, et al., 2009). In Ethiopia, one of the world's poorest countries, the 2008 food price spike was the culmination of a trend that began in 2004. The available data led Ulimwengu and colleagues (2009) to conclude that the Ethiopian food price index had been consistently higher than the world index since August 2004 (cf. Loening, et al., 2009). While food price inflation occurred throughout Ethiopia, since 2006 rates were particularly high in the capital city, Addis Ababa (Ulimwengu et al., 2009).

The beginning of the upward trend in food prices in Ethiopia in fact coincided with the much-anticipated launch of HAART programs country-wide in late 2004. At that time, home-based HIV/AIDS care was promoted at the national level (Ministry of Health, 2005). In the face of a late-maturing HIV/AIDS epidemic (Iliffe, 2006; National Intelligence Council, 2002), volunteerism in community health care has grown substantially over the past decade in Addis Ababa. However, the experiences of volunteer caregivers and CHW in general in Ethiopia have received very little attention, despite the debate on the sustainability of unpaid community health work in SSA (Hermann et al.,

2009). Recent literature on task-shifting and human resources for health challenges has focused on southern Africa (e.g., Schneider, et al., 2008). Hermann and colleagues (2009), in their appraisal of the sustainability of CHW programs in Uganda, Malawi, and Ethiopia, limited their focus to the experiences of salaried CHW in Ethiopia's national Health Extension Program, ignoring even the large number of volunteers who work alongside this program's extension workers.[21]

This chapter and subsequent chapters in this dissertation seek to address these gaps, and extend the focus on HIV/AIDS-FI interactions to AIDS care volunteers, given their importance in prevention and treatment efforts. In this chapter, I show that FI was highly prevalent among volunteers even prior to the 2008 food crisis, and that FI was associated with volunteer caregivers' household economic status. I then present qualitative evidence that rising food costs in Addis Ababa, on top of chronic FI, were a source of distress and de-motivation for volunteer caregivers, contributing to their own and their care recipients' experiences of economic insecurity in a setting of widespread unemployment. I argue that, while volunteers appear resilient to socioeconomic adversity, FI among unpaid volunteers and their care recipients threatens to undermine AIDS care in Addis Ababa and similar settings.

METHODS

Ethnographic methods

Ethnographic methods were used to determine how FI affected and was affected by participants' roles as volunteer AIDS caregivers. Ethnography comprised participant

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[21] See http://www.jsi.com/JSIInternet/FeatureStories/Stories/Ethiopia_-_Health_Extension_Workers_-_Ready_to_Train.cfm [Accessed 17 March 2010]

observation in neighborhoods in south-west Addis Ababa, including attendance at volunteer trainings, caregiver and care recipient homes, and volunteers' reporting and planning meetings, conducted over 20 months between May 2007 and January 2009. Informal conversations were held with volunteers and staff within the NGO and hospital administrations.

A purposive sample of 13 volunteer caregivers (10 women and 3 men) aimed to account for the preponderance of women in the volunteer population, as well as variation in length of service, age, education, and socioeconomic status. Informants were recruited to complete a series of semi-structured interviews assessing various domains, including volunteer caregiver motivations, costs and benefits, food insecurity, care relationships, and wellbeing. Interviews occurred over 8 months in 2008; each informant was interviewed up to seven times, until we had addressed each of the pre-determined domains. Analysis involved an iterative process of identifying emergent themes and grouping data into coded categories. Here, I focus on volunteers' narratives of how food insecurity intersected with their lives and roles as caregivers.

Epidemiological assessment

Surveys were administered to volunteer caregivers from *Hiwot* and *Medhin* NGOs at three rounds (February, July, and November 2008). Drawn from NGO rosters, the sample included 110 volunteer home-based caregivers (99 women and 11 men) of adult patients receiving treatment at ALERT Hospital, incorporating 40 randomly-chosen participants (out of 60) who had just begun volunteering with *Hiwot* at the time of the baseline survey; 50 randomly-chosen participants (out of 70) who had all been volunteering with *Hiwot* for 12 months at baseline; and all 20 volunteer caregivers from *Medhin*, with an

average service length of 12 (± 4.6) months at baseline. 110 participants were surveyed at Round 1; at Round 2, 106 of the original 110 participants were surveyed; at Round 3, 107 of the original 110 were again surveyed. Four Ethiopian research assistants were trained prior to each data collection round, and data collection was conducted in pairs. Refresher training and the data collection "buddy system" aimed to maximize data quality.

Study instruments

An Amharic version of The Household Food Insecurity Access Scale (HFIAS), described in Chapter 2, was used in this study (cf. Coates, et al., 2007; Maes, et al., 2009; Swindale & Bilinsky, 2006). Thus participants' households were classified into four levels of FI according to a scheme that closely parallels the published HFIAS protocol: 1) food-secure; 2) mild FI; 3) moderate FI; and 4) severe FI.

Participants estimated total monthly household incomes at each data collection round. At Rounds 2 and 3, participants reported household composition (i.e. adults and children regularly sleeping and eating in the house). At each round, total estimated household incomes were divided by the total number of people in the household to yield monthly household per capita incomes in Ethiopian Birr/mo (converted to USD/mo using a rounded exchange rate of 10 Birr to 1 USD). Household composition was not reported at Round 1. Since household composition did not change substantially between Rounds 2 and 3, we assumed that it also had not changed from Round 1 to Round 2. Thus we divided household incomes reported at Round 1 by the total number of people in the household at Round 2.

At each round, participants reported whether they were receiving free food aid from non-governmental organizations, and what kinds of foods they were receiving. Wheat grain was the most common type of food aid available over the study period; in 2007 and the first part of 2008, free wheat was accessed often from NGOs like *Hiwot* and *Medhin*. We categorized participants based on whether they received free wheat as food support at the time of the survey.

Participants reported age, gender, marital status (single, married, divorced/separated/widowed), and years of formal schooling. We also categorized participants according to whether they were in charge of their household food economy: that is, we distinguished between dependents living with parents or guardians, versus male and female heads of household and females living with older parents but sharing food economy responsibilities (shopping and cooking).

Analytic strategy

The first goal of this chapter is to demonstrate the prevalence, severity, and household economic correlates of FI among volunteer caregivers. Secondly, my ethnographic work suggested that an important factor in household food access was whether a volunteer caregiver was dependent or shared major responsibilities in the household food economy. Household heads who volunteer typically have limited means of generating income, whereas dependents who volunteer typically live with other income-generating adults. Further, it is possible that younger adult dependents, especially young men, are to some extent buffered from food insecurity within their households (cf. C. Hadley, Lindstrom, Tessema, & Belachew, 2008; Mains, 2007; Poluha, 2004). I also observed that volunteers who were newly-recruited by the *Hiwot* NGO and began the service in February 2008

were more likely to be young adult dependents. Given the potential importance of this trend among recruits for volunteer AIDS care sustainability, I compare dependents and non-dependents in terms of overall summary statistics related to food access and insecurity.

Multilevel linear models (MLM) and generalized estimating equations (GEE), both accounting for intra-individual association of repeated measures, using the MIXED and GENMOD procedures in SAS, respectively, were used to observe the bivariate associations of microeconomic variables and round of measurement with the dichotomous outcome of food insecurity. SAS version 9.2 (SAS Institute, Cary, NC) was used to conduct all analyses.

RESULTS

Epidemiology

Age at baseline was 27.7 (±6.2) years. Formal schooling was 10.3 (±2.6) years. 90% of participants were women. 40.9% of participants were married, 33.6% were unmarried, and 25.5% were separated, divorced, or widowed.

Household income in USD/mo was 45.6 (±38.7), 46.8 (±41.7), and 53.1 (±48.1) at Rounds 1, 2, and 3, respectively (**Table 4.1**). While this increase was significant ($P<0.05$), it does not account for household composition. In fact there was no significant change in per capita household income over time in the full sample (R1: 11.3 ±12.5, R3: 12.5 ±10.1). Nor was there change in the number of people per household between rounds 2 and 3, when data were collected (4.6 ±2.1 and 4.5 ± 2.0 people, respectively).

The proportion of households receiving free wheat as food aid decreased from 38.2% at Round 1 to 8.4% at Round 3 (P<0.0001).

Food insecurity (mild, moderate and severe) was reported by 82.7%, 77.4% and 78.5% of participants at Rounds 1, 2 and 3, respectively. Moderate or severe FI was reported by a majority of respondents (60.9%) at Round 1. This percentage had dropped to 47.7% by Round 3 (P<0.01).

TABLE 4.1: Household economic variables by round of data collection and food insecurity status.

	All				**Food-insecure**				**Food-secure**				
	Round				**Round**				**Round**				
	1 n=110	2 n=106	3 n=107	*P* *	1 n=91	2 n=82	3 n=84	*P* *	1 n=19	2 n=24	3 n=23	*P* *	*P* †
Household income, USD/month	45.6 ± 38.7	46.8 ± 41.7	53.1 ± 48.1	<0.05	38.9 ± 32.5	39.7 ± 36.5	45.7 ± 39.4	0.05	77.7 ± 49.7	70.8 ± 49.6	80.1 ± 65.8	0.33	<0.01
Per capita household income, USD/month	11.3 ± 12.5	11.4 ± 10.6	12.5 ± 10.1	0.34	9.0 ± 6.9	9.1 ± 6.5	10.6 ± 6.9	<0.05	22.0 ± 23.3	19.0 ± 17.0	19.6 ± 15.8	0.48	<0.0001
Household composition, people	‡	4.6 ± 2.1	4.5 ± 2.0	0.6	‡	4.6 ± 2.1	4.4 ± 2.0	0.33	‡	4.4 ± 2.2	4.7 ± 2.1	0.61	0.37
Food insecurity, %	82.7	77.4	78.5	0.36	-	-	-	n/a	-	-	-	n/a	n/a
Moderate and severe food insecurity, %	60.9	50.9	47.7	<0.01	-	-	-	n/a	-	-	-	n/a	n/a
In charge of household food economy, %	77.6	-	-	n/a	80.7	-	-	n/a	63.2	-	-	n/a	0.13 **
Receiving free wheat as aid, %	38.2	18.9	8.4	<0.0001	38.5	20.7	10.7	<0.0001	36.8	12.5	0	<0.001	0.41

* For continous variables, multilevel linear models were used to test the effect of round of measurement on household economic variables. For categorical variables, generalized estimating equations were used. Both of these methods account for repeated measures.
† For continuous variables, multilevel linear models were used to compare food-insecure and food-secure households. For categorical variables, generalized estimating equations were used. Both of these methods account for repeated measures.
‡ Household composition was not assessed at Round 1.
** Fisher's exact test; only 7 participants reported food security and dependent status.

TABLE 4.2: Household economic variables and food insecurity by round of data collection and dependent status.

	Heads/non-dependents n=83			**Dependents** n=24			
	Round			Round			
	1	2	3	1	2	3	*P* *
Household income, USD/month	39.2 ± 26.2	39.0 ± 25.0	43.4 ± 86.7	69.7 ± 63.1	74.6 ± 70.4	86.7 ± 73.4	<0.001
Per capita household income, USD/month	10.4 ± 8.8	10.5 ± 7.5	11.6 ± 8.9	15.1 ± 21.5	14.6 ± 17.9	15.5 ± 13.4	<0.05
Household composition, people	†	4.1 ± 1.7	4.0 ± 1.7	†	6.2 ± 2.6	6.1 ± 2.4	<0.0001
Receiving free wheat as food aid, %	45.8	22	10.8	16.7	8.7	0	<0.01
Food-insecure	85.5	82.9	84.3	70.8	56.5	58.3	<0.01

† Household composition was not assessed at Round 1.
* For continuous variables, multilevel linear models were used to compare those with and those without major responsibilities in the household food economy.
For categorical variables, generalized estimating equations were used. Both of these methods account for repeated measures.

Food-secure versus -insecure households

Important differences in household economic variables were observed between participants reporting food security and food insecurity (**Table 4.2**). At each round, food-secure volunteers reported household incomes (P<0.01) and per capita incomes (P<0.0001) that were about twice the levels of those reported by food-insecure volunteers. Participants reporting FI reported increasing income over the three data collection rounds (P<0.05). However, while statistically significant, the increase in per capita income for food-insecure households was on the order of only 0.05 USD/d.

Household dependency status and socioeconomic status among new volunteer recruits

77.6% of participants were in charge of or otherwise held major responsibilities in their household food economies; the rest of participants were so-called dependents. During fieldwork I made preliminary observations that volunteers who were newly-recruited by the *Hiwot* NGO and began the service in February 2008 were more likely to be young adult dependents. In fact, 34.2% of volunteers recruited by *Hiwot* in February 2008 were dependents; the corresponding proportion among the other volunteers in the sample, who were recruited by their respective NGOs in early 2007, was only 15.9% (P<0.05).

Characteristics of personal appearance (e.g. clothing and hairstyles) further suggested that these younger newcomers came from higher socioeconomic backgrounds. These observations were confirmed by quantitative analyses. Dependents reported higher household income (P<0.001) and per capita income (P<0.05), and were less likely to report FI (P<0.01) at each round (**Table 4.2**). In addition, dependents' households were

approximately 50% larger ($P<0.0001$) and were less likely to be receiving free wheat as food aid ($P<0.01$). We return to the significance of these findings in the discussion.

Ethnography

Food insecurity featured prominently in discussions of care relationships and (the lack of) NGO compensation for volunteers, with important implications for the sustainability of the volunteer AIDS care in this setting. We discuss these two domains in turn.

Compensation and motivation

Although transport allowances and food aid stipends were sometimes referred to as salary (*dämoz*) in the discourses of volunteers and their supervisors, the salary label was often actively avoided. As volunteers, all informants understood that even a modest salary was not forthcoming. And yet it was common for volunteer caregivers to express a desire for compensation from the NGO and/or opportunities to turn their volunteer experience into a paid position within the NGO, other NGOs, or local public hospitals, and to lament that such opportunities were not available. Interviews made it clear that this ambivalence was exacerbated by rising food prices.

> "[The NGO supervisors] give us 100 Birr [about 10 USD] as a monthly transport allowance. I take the 100 Birr and spend it on my food. There is nothing that I do other than spend it on food. Nobody can move without food. Yes, we will continue volunteering. But how can we live with this life condition? [The NGO supervisors] know how much a sack of wheat costs.

> Nowadays, it is only that life is expensive and there is no employment.” (Male caregiver, December 2008)

Some volunteers expressed that they did not expect compensation for their efforts. As followers of Ethiopian Orthodox Christianity (the religion with which the vast majority of participants identified), volunteers often described their expectations of divine rewards as an important mechanism that provided motivation to continue volunteering. The following statement is highly representative of informants’ views on the link between human and divine reciprocity: enjoying the gifts that God bestows on people who help others.

> “What motivated me to be a caregiver… To see others’ pains like my own [and] to understand how many hurt people there are. If I am not benefiting in my own way [by directly receiving benefits from the NGO], I will get something from God. God will pay me [back for] my weariness.” (Female caregiver, May 2008)

Despite the motivating power of such spiritual beliefs regarding human and divine reciprocity, all informants expressed some ambivalence in regards to volunteering amidst chronic food insecurity and rising food prices. This ambivalence was structured by genuine interests to continue helping fellow community members living with HIV/AIDS on the one hand, and on the other hand, the rising cost of living, high rates of underemployment in urban Ethiopia (Serneels, 2007), and the naïve yet understandable assumption that local NGOs or the Ministry of Health had the resources to pay volunteers a livable wage. In fact, the local NGOs were in similar positions, facing reduced support

from international NGOs and donors in 2007 and 2008. The male caregiver quoted above on the inadequacy of NGO compensation added, "We were given 45 kilos of wheat [by the NGO]. We entered the volunteer program in the first place depending on that. [The NGO supervisors] are reducing things [i.e. food aid]; but we volunteer caregivers are not reducing our love." The question on this informant's mind was how long volunteer caregivers can sustain their "love" (*fiqïr*) and motivation in the face of reduced access to needed resources.[22]

Finally, my ethnographic work showed that volunteer caregivers often depend on family, including spouses, and other social ties to meet their household food needs. Rising food prices put a strain on these social ties.

> "When I finish [the spice supply in my home], I go to my extended family. Previously, when they would prepare spice, they would give me some. Nowadays, when life becomes expensive, they become antagonistic. They say, 'Now you are asking us too much.' They do not satisfy you as previously. (Female caregiver, October 2008)

One informant's relational distress with her husband regarding the household food supply had implications for her motivation to continue volunteering, given her dependency on her husband for both material and moral support as a volunteer caregiver (a situation she shared with a large proportion of her fellow female volunteers).

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[4] The informant who offered these quotes was an exceptionally dedicated volunteer caregiver, according to observations and assurances of his peers and supervisors. This heightened the sense of ambivalence involved in wanting to volunteer and yet desiring more ample compensation.

> "When [a particular food in the house] is finished, and my husband wants that – we get into argument…. I never said I should quit volunteering. But sometimes, my husband says, 'I can give you what I have, but you should also work.' At first, he was willing. But nowadays, he says, 'Volunteering has no benefit, and it is tiresome. What are you doing? Why don't you find another job?'" (Female caregiver, October 2008)

Care relationships

Food insecurity also affected volunteer caregivers through their relationships with care recipients. I identified two sub-domains in which volunteers' comments demonstrated this connection: 1) volunteers' sympathies with the suffering of care recipients and mental satisfaction from the improved health and status of care recipients; and 2) antagonism that food-insecure care recipients sometimes directed at caregivers.

First, all informants expressed sympathy for their care recipients' distress in relation to poverty and FI. In their view, care recipients' distress was exacerbated by the rising cost of food and the reduction in food aid that occurred over the study period: in 2008 the World Food Program began to require that people living with HIV/AIDS also have a body mass index below a cutoff of 18.5 (kg/m^2) to be eligible for food aid that used to be distributed more generously.

> "Now I am beginning to feel awful. Almost half of [the care recipients who were previously receiving free wheat as food aid] are dropped from the food aid program. Enough – they have anger. Now you will go to a care recipient's home and all you see

> is crying. And they start to cry when they see you." (Male caregiver, June 2008)

Conversely, all caregivers expressed mental satisfaction in reaction to cases in which the health of a bedridden care recipient improved, allowing him or her to find employment or start an income-generating activity.

> "I persuaded a care recipient and he started [HAART]… Now he is walking and working as a daily laborer. And satisfaction means – this person, for example, thanks me every time we meet. He says, 'It is because of you that I stand up and start to feed myself.'" (Male caregiver, August 2008)

A second important theme was the distress that volunteers experienced when care recipients became antagonistic. This antagonism resulted from a mix of poverty, FI, and HIV-related stigmatization. For instance, some care recipients expected volunteer caregivers to provide food or money from their own pockets. These situations often arose when care recipients were relatively healthy (due to the biological effects of HAART), but still very poor and unable to generate income.

> "[Some care recipients] have a shortage of food. They say, 'With what can I take the medication?' They tell you, 'My insides are burning with medication only.'" (Male caregiver, November 2008)
>
> "[Some care recipients say,] 'We are hungry, we are thirsty.' These days, it is when you eat that you'll be healthy…. There are many patients, and you will sometimes be insulted. Forget the insults, but

> they might [physically harm] you. Volunteer caregiving is a sacrifice. It is a risk – when their stomachs are empty." (Female caregiver, July 2008)

The majority of volunteers interviewed explained that it was beyond their "capacity" (*aqïm*) to give money or food to such care recipients. This often resulted in the care recipient rejecting the psychosocial support, health education, and other services that volunteers were prepared to give. This rejection was partly motivated by the care recipient's fear of HIV-related stigmatization, which could be triggered when neighbors or a landlord observed volunteers associated with known AIDS NGOs visiting the care recipient. A female caregiver, who was herself living with HIV/AIDS while raising a young child with her husband, explained her view on these issues:

> "For me, it seems [some care recipients] don't want you as a volunteer caregiver because there is no benefit they get from you. The absence of any material benefits makes caregivers and care recipients to disagree. When they meet us on the road, they think there is something [e.g. food] in the backpacks we carry. But the backpack contains our [nursing] materials. 'What do you carry in this bag? Why do you have it if it is empty?' That is what they say…
>
> "Actually, the care recipients are victims. Let alone them, even we volunteer caregivers will be happy if we get some benefits. If they get some benefits, I think they will be satisfied. They say, 'What

we get from the NGO is only their name – there is no benefit.'"
(August 2008)

DISCUSSION

By mixing quantitative and qualitative methods, in this chapter I have shown that FI (including moderate and severe FI) was highly prevalent among volunteers, and that rising food costs in Addis Ababa, on top of chronic FI, were a source of added distress and de-motivation for volunteer caregivers, exacerbating their own and their care recipients' struggles with economic insecurity, HIV-related stigmatization, and HAART adherence. Epidemiological results highlight significant cross-sectional differences in income between food-secure and -insecure volunteers rather than changes over time, despite the crisis-level trend in local food prices that occurred during 2008. It is possible that rising food prices in Ethiopia over the three years prior to 2008 led to high prevalence of FI in this sample. Against this chronic backdrop, the food price spike of 2008, though striking on a graph, may not have had commensurate added effects on the experience of FI for these households. I discussed alternative explanations for these longitudinal findings in previous chapters. Here, I emphasize that FI was *already* very high among participants prior to the 2008 food crisis in Addis Ababa.

Qualitative data suggested that rising food prices and reduced access to food aid induced de-motivation and distress among volunteers by 1) prompting them to question their ability to provide for their own families and their capacity to help impoverished and hungry HAART recipients; 2) straining volunteers' relationships with family members who typically supported them; and 3) impairing care relationships that were already

beleaguered by HIV-related stigmatization. The chronic suffering and occasional antagonism of care recipients was distressful for volunteers – many wanted to help, but found it beyond their capacity to do so. According to one woman, volunteer caregiving was a “risk” to body and mind – “when [care recipients’] stomachs are empty. As explained by another female caregiver, many volunteers and care recipients shared similar desires for economic security: “Let alone them, even we volunteer caregivers will be happy if we get some benefits.” Thus for one man, persevering as a volunteer in the face of severe FI was partly a matter of recognizing the lack of other employment opportunities: “Nowadays, it is only that life is expensive and there is no employment.” For another of my female informants, the pressure to quit volunteering came not from within herself, but from her husband, who was unhappy that his wife was not being compensated for her tiresome efforts while he struggled to generate income.

In SSA, both family and volunteer caregivers for people with illnesses such as TB and AIDS may be psychosocially over-burdened (Akintola, 2008a; Kipp & Nkosi, 2008; Orner, 2006; World Health Organization, 2002). Volunteer caregivers are usually women, who are often socio-economically marginalized, and at increased risk of social stigmatization related to AIDS and other illnesses (Bond, 2006; Nyblade et al., 2003). Volunteers in SSA are critical to local and global economies of AIDS care, especially in the age of HAART (Ogden, et al., 2006). But as Escott and Walley (2005) and Akintola (2008b) report, AIDS caregivers in southern Africa have few opportunities to generate income. Kironde and Klassen (2002) found that hope for remuneration was the strongest factor motivating youth to volunteer for a TB control program. Their study also found high volunteer drop-out rates, with the majority reporting that they wanted to find paid

work. These studies have not, however, assessed how food insecurity specifically affects volunteer caregivers.

The findings reported here corroborate work that has shown how hunger and food insecurity act as barriers to HAART access and adherence (e.g., Hardon, et al., 2007). However, my results go beyond previous research by examining how food insecurity impacts AIDS care volunteers. Specifically, results suggest that food crisis on top of chronic food insecurity push 1) many low-income and underemployed volunteers and to reconsider what they deem as appropriate compensation; and push 2) many hungry and underemployed HAART patients to reject volunteers and the services they are prepared to provide.

I have also shown that volunteers who were dependents within their households reported lower rates of FI and higher income. As mentioned above, new volunteers recruited during the study period (February 2008) were more likely to be dependents. It is thus tempting to speculate that the households of dependent volunteer caregivers in effect subsidize the collective material and psychosocial burdens of AIDS care (cf. Akintola 2008b), with important implications for the sustainability of volunteerism in this setting. It is notable, however, that even among dependents' households, FI was highly prevalent and per capita income was less than 1 USD/d. Thus it is not clear that increasing numbers of household dependents among the ranks of volunteer caregivers in this setting will promote the sustainability of volunteer care programs in the face of FI.[23]

[23] It is also not clear that NGOs were attempting to target these younger volunteers. NGO administrators of the programs involved in this study explained that their recruitment practices focus on any community members who 1) have reputations for abiding by community norms and avoiding substance abuse, 2) have enough free time to devote to volunteer responsibilities, and 3) are willing to offer their time and efforts without expecting material benefits.

Though further research is needed to corroborate the results presented here, my findings constitute a major complement to existing research, because AIDS care volunteers are not only key witnesses to the paradoxical situation experienced by HAART recipients mentioned by Peter Piot at the opening of this paper, but are also key resources in the effort to sustain and scale-up AIDS care and treatment in SSA. Their continued participation in the face of widespread underemployment and food insecurity is very much in question, in terms of both the right to adequate compensation and program sustainability. Further, the narratives of my informants expose theoretical and practical problems regarding the practices of NGOs and other AIDS programmers and policy makers, which promote the harnessing not just of cheap labor but also of local peoples' religious values, norms of reciprocity, and social solidarities (cf. Collins, 2004; Swidler & Watkins, 2009).

CONCLUSIONS AND RECOMMENDATIONS

Future research might examine food insecurity as a determinant, among others, of volunteer attrition and reduced recruitment. But future studies should also consider the psychosocial impacts of volunteering on volunteers. Even if programs continue to recruit and retain volunteers, their apparent "sustainability" comes with a cost of overlooking the contextual problem of unemployment, as well as the potentially more invisible problem of insecurity among volunteers who persevere on the front lines of AIDS care and treatment programs.

My results reveal a widely-overlooked way in which food insecurity threatens to undermine AIDS care and treatment efforts in sub-Saharan Africa. I show elsewhere that FI among volunteers is associated with decreased dietary diversity (Chapter 2) and

depression/anxiety disorders (Chapter 3). The 2008 food crisis and its sociopolitical aftermath suggest that FI will remain very prevalent in urban Ethiopia and elsewhere unless major international and national policy initiatives are enacted. The local NGOs that organize the volunteer caregivers in this study recognized that FI among caregivers and care recipients undermines their HIV/AIDS programs. But because the NGOs were also dependent on donor and international NGO support, they were unable to adequately address this problem. FI is thus a serious threat to volunteer AIDS care in this context.

A focus on food insecurity emphasizes the importance of policy questions regarding compensation for volunteers' valuable labor and poverty-reduction through public health sector job-creation. Many (e.g. the international NGO Partners in Health) argue that remunerating CHW is a matter of the right to receive fair wages for one's labor, as a means to affording household income and food security. As policy measures addressing CHW remuneration are enacted, ethnographic and quantitative research will contribute to understanding the social and economic costs and benefits of volunteer health care labor from the perspectives of volunteers, their care recipients, and the wider public health system.

CHAPTER 5

"My stress is because I am not working" – HIV serostatus, food insecurity, and psychosocial health[24]

INTRODUCTION

In the context of economic development in sub-Saharan Africa (SSA), an important policy focus is the synergistic threat to human productivity and wellbeing posed by HIV/AIDS and food insecurity (Gillespie, 2006; Himmelgreen, et al., 2009; Ivers, et al., 2009; World Food Programme, et al., 2008). Ivers and colleagues (2009) point out that the physiological complications of HIV infection and progression are compounded by food insecurity, which taxes immune function and the body's resistance to the side-effects of antiretroviral therapy. This leads to a positive feedback between undernutrition and immunodeficiency, resulting in increasingly poor health and livelihood insecurity. In addition, a lack of food at the household level can lead to the adoption of risky coping strategies, including sale of assets, removal of children from school, and exchange of sex for money or food, which increase exposure to HIV, economic vulnerability, or both.

These processes comprise "cycles of poverty" with "ripple effects" extending beyond the individual to household and community (Ivers et al., 2009). Thus, while lack

[24] A version of this chapter will be published in a special thematic issue (Anthropological Approaches to Confronting HIV/AIDS and Food Insecurity in Sub-Saharan Africa) of the *Bulletin of the National Association for the Practice of Anthropology* (B. Brenton, J. Mazzeo, and A. Rodlach, editors).

of trained health care workers, neglected infrastructure, and scarce resources devoted to health are commonly identified as barriers to effective HIV/AIDS care in SSA, undernutrition and food insecurity can also comprise major barriers to effective care. With the growing weight of HIV/AIDS-food insecurity syndemics (Himmelgreen et al., 2009) and multiple barriers to prevention and treatment, "the development of evidence-based programmatic solutions to these issues becomes essential" (Ivers et al., 2009: 1097).

The 2008 food crisis represented a major shock to economies at the global, national and household scales. In mid-2008, global food prices had escalated rapidly, driven by increased demand for food and biofuel crops, rising petroleum costs, climate change, harvest shortfalls, and perhaps financial factors (Headey & Fan, 2008; Robles, et al., 2009). In Ethiopia, one of the world's poorest countries, the 2008 food price spike was the culmination of a trend that began in 2004. The available data led Ulimwengu and colleagues (2009) to conclude that since August 2004 the Ethiopian food price index had been consistently higher than the world index. While food price inflation occurred throughout Ethiopia, since 2006 rates were particularly high in the capital city, Addis Ababa (Ulimwengu, et al., 2009).

The beginning of the upward trend in food prices in Ethiopia in 2004 in fact coincided with the much-anticipated launch of highly-active antiretroviral therapy (HAART) programs country-wide. At that time, home-based HIV/AIDS care was promoted at the national level (Ministry of Health, 2005). In the face of a late-maturing HIV/AIDS epidemic (Iliffe, 2006; National Intelligence Council, 2002), volunteerism in community health care has grown substantially over the past decade in Addis Ababa.

With the rollout of AIDS therapies, low-income volunteers have indeed become a major part of health workforces throughout sub-Saharan Africa. However, the motivations and experiences of volunteer caregivers in SSA have received little attention, before or after the recent food crisis (but see Akintola, 2004, 2008a, 2008b; Escott & Walley, 2005; Hermann, et al., 2009; Kironde & Klaasen, 2002; Maes, Forthcoming; Maes, et al., 2010; Maes, et al., In Press; Rödlach, 2009; Swidler & Watkins, 2009). Akintola (2008b) provides a review of existing literature on unpaid AIDS care in sub-Saharan Africa, concluding that available data are inadequate to determine the financial cost-effectiveness of various models of home- and community-based care, let alone the psychosocial costs of such care borne by unpaid caregivers in settings of high unemployment and food insecurity (see also Ogden, et al., 2006; Schneider, et al., 2008).

Food insecurity (FI) among AIDS care volunteers, like other biosocial mechanisms linking undernutrition and HIV/AIDS, underscores “cycles of poverty” that must be interrupted at programmatic levels (Ivers et al., 2009). Thus it is imperative to question not only how food insecurity contributes to HIV infection, drug access and adherence, related comorbidities, and early mortality (Mukherjee, et al., 2006; Weiser et al., 2009), but also how FI among volunteers impacts their wellbeing. Further, while existing studies of the 2008 food crisis have modeled the impact of food price increases on caloric intakes (Food and Agriculture Organization of the United Nations, 2008) or “welfare effects,” ethnographic studies suggest that psychosocial health is also associated with food insecurity, and that this is driven in part by the uncertainty that is introduced into people’s lives as they struggle to meet their food needs (Craig Hadley & Maes, 2009; Weaver & Hadley, 2009). Such uncertainty is understood as a major contributor to

anxiety and depression, which account for massive shares of the global disease burden (Craig Hadley & Patil, 2006; Murray & Lopez, 1997a; Pike, 2004). Coping strategies that buffer caloric intake might come with costs to mental health. However, to date few studies have assessed how FI specifically affects AIDS care volunteers.

I have shown that food insecurity is associated with low income, decreased dietary diversity (Chapter 2), and high depression/anxiety symptom loads (Chapter 3) among AIDS care volunteers in Addis Ababa, Ethiopia, and that food insecurity plays a major role in generating strife between volunteer caregivers and their care recipients (Chapter 4). In this chapter, I further develop an understanding of

1. How acute-on-chronic FI during the 2008 food crisis affected AIDS care volunteers' psychosocial health, in terms of both restricted social participation and common mental disorder (CMD) symptoms; and
2. The relationship between positive HIV serostatus among volunteers and food insecurity, restricted social participation, and high CMD symptom loads.

While others have called for measures to encourage volunteers' motivations with increased "incentives," my focus emphasizes the potential of anthropological inquiries to inform underlying debates over poverty-reduction through sustainable health sector job-creation and volunteers' economic right to regular wage-remuneration for their labor.

METHODS

Ethnographic Methods

Ethnographic methods (participant observation and interviews) are described in previous chapters. Here, I examine brief case studies of the two in-depth interview participants in the study who openly disclosed their positive HIV serostatus prior to the beginning of the research, in order to identify themes that aid the analysis and interpretation of quantitative data on HIV serostatus, food insecurity, and psychosocial health among the epidemiologic study sample.

Epidemiologic Methods

Study Design and Sample

The sample included 110 volunteer caregivers (99 women and 11 men) of adult patients receiving treatment at ALERT Hospital. This gender ratio reflects the overwhelming proportion of women in the volunteer population. A random sample of 90 participants was drawn from the *Hiwot* NGO's volunteer rosters, stratified by newcomer versus veteran status: 40 (out of 60) 'newcomers' who had just begun volunteering at the time of the baseline survey, and 50 (out of 70) 'veterans' who had all been volunteering for 12 months at the time of the baseline survey. We also included all 20 volunteer caregivers from *Medhin*, with an average service length of 11.7 months (±4.6, range: 4–22) at baseline. The present analyses examine the entire sample (n=110) as a whole. A very small number of participants missed one or more survey rounds. At Round 2, 106 of the original 110 participants were surveyed, and at Round 3, 107 of the original 110 were again surveyed.

Food Insecurity (FI)

An Amharic version of the Household Food Insecurity Access Scale (HFIAS), described in Chapter 2, was used in this study (cf. Coates, et al., 2007; Maes, et al., 2009; Swindale & Bilinsky, 2006). Thus participants' households were classified into four levels of FI according to a scheme that closely parallels the published HFIAS protocol: 1) food-secure; 2) mild FI; 3) moderate FI; and 4) severe FI.

Common Mental Disorder (CMD) Symptoms

To assess the distribution of CMD symptoms, I used a 29-item version of the World Health Organization Self-Reporting Questionnaire, which incorporates 8 items derived from Amharic idioms of distress (e.g. feeling that someone has cursed you; feeling that your heart is beating too fast). As noted in Chapter 3, the SRQF is not a diagnostic tool, yet a cutoff of 7/8 was determined by Zilber and colleagues (2004) to be optimal for screening CMD cases from urban Ethiopian populations, and is used in the present analysis.

Social Participation Restriction

Following van Brakel and colleagues (van Brakel, Anderson, Mutatkar, Bakirtzief, & Nicholls, 2006), I operationalized restricted social participation with the Participation scale (**Table 5.1**). The published Participation scale consists of 18 items that ask a respondent to tell whether she engages in various social activities as much as her "peers" or local age-mates do. For each item, a 'yes' response is scored as '0', while a 'no' or 'sometimes' response is followed up with the question, How big a problem is it to you? 'No problem' is scored as 1, 'small' problem as 2, 'medium' problem as 3, and 'big' problem as 5. Thus, each item can range from a score of 0 to 5. The items are summed to

produce a Participation scale score, which can range from 0 (no participation restriction) to 90 (5x18 items, severe participation restriction).

Based on ethnographic work, I modified the Participation scale by adding two items, ‘Do you receive guests as much as your peers do?’ and ‘Do you have the capacity to treat guests (show hospitality) as much as your peers do?’ These items were found to correlate strongly with overall Participation scale scores. In the present analyses, I dropped seven items from the original Participation scale that had consistently low correlations (<0.15 at 2 or more data collection rounds) with overall scores. Thus the maximum possible score (denoting severe participation restriction) is 65. The resulting 13 items are listed in **Table 5.1**.

TABLE 5.1. Participation scale items used in the present analyses.

1) Do you have equal opportunity as your peers to find work?

2) Do you make visits outside your neighborhood as much as your peers do?

3) Do you help other people (e.g., neighbors, friends or relatives) as much as your peers do?

4) Do you take part in casual social activities (e.g., sports, chatting, meetings) as much as your peers do?

5) Are you as socially active (e.g., in church/community affairs) as your peers are?

6) Do you visit other people in the community as often as your peers do?

7) Do you have the same respect in the community as your peers?

8) Do you visit public places (e.g. schools, shops, offices, cafes) in your neighborhood as much as your peers do?

9) Do you have the opportunity to take care of yourself (e.g. appearance, nutrition, health) as well as your peers do?

10) Do you take part in major festivals and rituals (e.g. weddings, funerals, religious festivals) as much as your peers do?

11) Do you feel as confident as your peers to try to learn new things?

12) Do you receive guests as much as your peers do?

13) Do you have the capacity to treat guests (show hospitality) as much as your peers do?

Covariates

At baseline, participants reported age, gender, and years of formal schooling; at data collection round 3 participants reported HIV serostatus (positive, negative, or unknown). Participants estimated monthly household incomes at all three rounds. At Rounds 2 and 3, participants reported household composition (i.e. adults and children regularly sleeping and eating in the house). At each round, estimated household incomes were divided by the total number of people in the household to yield monthly household per capita incomes in Ethiopian Birr/mo (converted to USD/mo using a rounded exchange rate of 10 Birr to 1 USD at the time of the study). Household composition was not reported at Round 1. Since average household composition did not change between Rounds 2 and 3, we assumed that it also had not changed from Round 1 to Round 2. Thus household incomes reported at Round 1were divided by the total number of people in the household at Round 2. At each round, participants reported whether they were receiving free food aid from non-governmental organizations, and what kinds of foods they were receiving. Wheat grain or flour was the most common type of food aid reported; in 2007 and the first part of 2008, free wheat was accessed often from NGOs like *Hiwot* and *Medhin*, and was commonly traded for cash by recipients. Participants were thus categorized based on whether they were receiving free wheat at the time of the survey.

Statistical Analysis

Based on the qualitative data presented below, in general the analytic strategy of this chapter is to assess the prevalence and severity of food insecurity among AIDS care volunteers across data collection rounds, and how food insecurity status, CMD symptom

loads, and participation restriction varied between volunteers reporting positive and negative HIV serostatus. I further examine interactions between HIV serostatus and food insecurity on participation restriction and CMD symptom loads. Finally, I fit a multivariate regression model to examine whether participation restriction modifies a previously observed dose-response relationship between food insecurity severity and high CMD symptom load (Chapter 3). To account for the nonindependence of data contributed by volunteer caregivers at multiple survey rounds, multilevel linear models (MLM) and generalized estimating equations (GEE) were used to observe bivariate and multivariate associations of covariates and round of measurement with continuous outcomes (HFIAS score, SRQF score, Participation scale score) and dichotomous outcomes (FI status, SRQF score ≥8), using the MIXED and GENMOD procedures in SAS, respectively. SAS version 9.2 (SAS Institute, Cary, NC) was used to conduct all analyses.

RESULTS

Qualitative results

Eskinder[25]

Eskinder is a middle-aged man who began volunteering with the *Medhen* NGO in April 2007. About four years ago, he found out that he was HIV positive when he became critically sick and was hospitalized. But he has been close to the stigmatization of disease for his entire life. His mother, with whom he still lives, was infected with leprosy at a young age. His experiences with these illnesses have deeply affected his life in general, and specifically, his access to secure employment and his motivation to be an AIDS care

[25] All personal names in this chapter are pseudonyms.

volunteer. Eskinder began HAART at ALERT Hospital in 2005. Aside from his medicine, he identifies God and the prayers of his friends as key ingredients in his recovery from near-death. Eskinder suggests that he and all of his fellow volunteer caregivers are faithful to the promise they made upon entering the service at the *Medhen* NGO, which means doing the work for a full 18 months and being an advocate of anti-stigmatization.

> I got cured with God's help and peoples' prayers…. Now I am going around as a volunteer caregiver while carrying my anti-retroviral medication in my pocket. Patients will call for you. They fear that their neighbors, friends, and family will avoid them. The reason I see these matters deeply is that I have HIV inside me. In addition, I was trained.

I always interviewed Eskinder in the front room of his two-room shack located in the slum next to ALERT Hospital. He explained that, before he got sick, he used to be in a better socioeconomic position. He was able to work, furnish his house, and lead a decent life in mutual support with his family. Now living alone with his disabled mother, he has no substantial source of income, and depends on the NGO and neighbors for food. He uses the Amharic word for "change" (*läwt*), to describe both the process of furnishing the house in the past and improving his life in the future.[26] At present, however, he says that "change" is not possible, and it stresses him.

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[26] Dan Mains (2007) noted the use of this same terminology in his work among underemployed youth in the town of Jimma, Ethiopia. The desire to experience progress or change (*läwt*) is pervasive amongst urban Ethiopian youth.

> This chair is not edible. The television and these cupboards are not edible… I got all these things previously when I was healthy – when I was working…. My stress is because I am not working. I am not stressed because the HIV virus is inside me. I also worry about how long I will rely on the support of others. I have to work and I have to change myself. We volunteers [at *Medhen*] are left with only two or three months of service. After that, what will I do? That is inside me; that is stressing me.

> [The NGO supervisors] give us 100 Birr [about 10 USD] as a monthly transport allowance. I take the 100 Birr and spend it on my food. There is nothing that I do other than spend it on food. Nobody can move without food. Yes, we will continue volunteering. But how can we live with this life condition? [The NGO supervisors] know how much a sack of wheat costs. Nowadays, it is only that life is expensive and there is no employment.

Asayech

Asayech is a 30-year-old woman who began volunteers with the *Hiwot* NGO in early 2008. She was also living with HIV/AIDS and receiving HAART, and had suffered with TB in the past. Asayech feels that she is "peaceful" at present because she keeps herself

busy by volunteering, which gives her hope. She says that when she is busy, she rarely thinks about the fact that she is living with HIV/AIDS. Asayech used to work in a factory – before she became sick with TB: "After that, I was not able to do any job…because I have a fear that I will get sick [on the job]." Thus, like Eskinder, volunteering as an AIDS caregiver allows Asayech to be active in a space of confidence that her latent illness will not pose a problem.

> Most of the time, I forget about it – even that I have it [i.e. HIV]. My internal feeling is peaceful. Why? Because I am working and I am moving…. If you have your own work, you never think that you have a disease. If you are getting aid, you always think of your pain… [and] if you are just sitting in the house, waiting for what the [aid] organization is doing for you, it is very difficult.... Previously, I sat idle for a long time. I compare this [volunteer caregiving] with the previous time when I used to sit idle because of sickness…. Now, this [volunteer caregiving] gets me to go out, rather than sit idle at home. It gives me hope – it gives me a chance. If I want to work in the future, I can work; I can move. [But currently] I can't do another job.

In addition, during the study period Asayech was raising a young child. Importantly, her husband supports the family with a low-level position at an industrial firm located about 30 minutes outside Addis Ababa. Asayech has friends and neighbors who can look after her child while she is out of the house, and living with the support of her husband allows her to feel somewhat economically secure. However, when we asked

Asayech if she ever felt a longer sadness, a depression, she replied that she and her husband sometimes disagree over sex, which causes substantial emotional distress. According to her, these situations arise when Asayech thinks about her illness. Asayech said that if she were able to have her own regular income, she would be satisfied to leave her husband and raise her child on her own.

> Sometimes there is [a longer sadness]. But my being sad is when I have a fight with [my husband] at home... When I am thinking about my sickness, I am not comfortable to have sexual contact. I will be happy if he doesn't even touch my clothes. Sometimes he plans to have sexual contact, and I may not be ready, and we just fight because of that. We even say bad things to each other. That thing disturbs me for some time. Why? If I had my own [job], and if I could live alone, I would have freedom. Even if my child is [dependent on me], if I had a good income, I could live [apart from my husband].

Whether or not Asayech actually desires to leave her husband, it was clear that having her own income would resolve some of her marital strife and the need to support herself and avoid idleness.

> Sometimes, my husband says, "I can give you what I have, but you should also work." At first, he was willing. But nowadays, he says, "Volunteering has no benefit, and it is tiresome. What are you doing? Why don't you find another job?"

> I am ready to work whatever job that God gives me. I can even sell vegetables in my area – because I have to move. If I get a chance of employment in an organization [i.e. an NGO, government office, or private company], I can do that. I want to live, working. I don't want to think about the distant future and accumulating wealth, but only about my daily bread.

HIV/AIDS, stress, and mental health

During her first interview, Asayech disclosed her HIV serostatus and mentioned that she kept her status secret because she heard other AIDS care volunteers saying something like, "Those people living with AIDS have mental problems." When I asked her at a later interview whether she still heard such talk, she replied that she did not. She explained that such talk resulted from aversive interactions among volunteers and some care recipients, but that care recipients are only antagonistic when they are experiencing economic problems or physical illness. In other words, their "mental problems" are not due to HIV/AIDS itself, but to their experiences of livelihood insecurity and physical disability. This echoes what Eskinder said about his own experience, as well as Asayech's own distress about "sitting idle" and waiting for aid from an organization.

> [The care recipients who were previously antagonistic] are now working in income-generating associations. There are some who prepare cotton; there are some who do weaving, and they believe in work [i.e. they want to work, not sit idle and receive assistance].

> "Her mind is disturbed" – people sometimes say that [about care recipients]. But I do not know a person whose mind was disturbed [by HIV itself]. Sometimes, lack of health, not having a house – there are many things, and when all those things accumulate, [people] become angry and don't know what they are saying. When a care recipient is angry, she can say bad things to others – anybody can do that. Even a healthy person, if angry, can disturb others. But unless they have some [economic or social] problem, they are very peaceful. With a [social or economic] problem, anyone can face a mental problem. But I don't think the disease itself can disturb the mind.

What is clear in both Eskinder's and Asayech's narratives is that a preoccupation with wage work, as an essential means to food security and economic autonomy, causes more mental distress than does a positive HIV serostatus. For Eskinder, the prospect of unemployment and dependence on others creates stress, while his HIV status becomes a concern only in relation to how his health condition affects his prospects for paid employment. Similarly, Asayech clearly identifies wage work as a path to alleviate her frustrations with the confines of married/domestic life as well as her anxieties about receiving her "daily bread." Her principal stress derives from her financial dependence on her husband, with whom she experiences circumscribed personal freedom. In both cases, HIV status plays an indirect role in creating stress linked to inaccessibility of wage work. Additionally, both Eskinder and Asayech see volunteer AIDS care as a socially congruent, but not economically viable, activity. In the following sections, I examine how

the epidemiologic data on volunteers' experiences of food insecurity, HIV serostatus, and psychosocial stress further illuminate the themes raised by Eskinder and Asayech.

Quantitative results

Average Cronbach's alpha (raw) for the HFIAS at Rounds 1, 2, and 3 was 0.84. For the SRQF and Participation Scale, average Chronbach's alpha was 0.90 and 0.80, respectively.

AIDS care volunteer sociodemographics

At baseline, average age was 27.7 years (±6.2, range: 18–45) and average schooling was 10.3 years (±2.6). 72.6% of participants reported negative HIV serostatus, 17% reported positive HIV serostatus, and 10.4% said that their HIV serostatus was unknown (**Table 5.2**). Twenty-one out of 110 (19%) volunteers said they volunteered as home-based caregivers to learn how to care for a family member (including extended family) with HIV/AIDS. Thirty out of 110 (27%) said they volunteered because one of their friends or family members died of HIV/AIDS.

TABLE 5.2. HIV serostatus among AIDS care volunteers in Addis Ababa, Ethiopia. HIV serostatus was surveyed at data collection round 3.

HIV Serostatus	**Round 3** n=106
Negative, %	72.6
Positive, %	17
Unknown, %	10.4

Summary statistics are listed by round of measurement in **Table 5.3**. Average monthly per capita income was $11.31 (±$12.49) at Round 1 and $12.49 (±$10.14) at Round 3, a statistically non-significant gain of about $0.04 USD/day. The average number of people living in participant households at Rounds 2 and 3, when data were collected, was 4.6 (±2.1) and 4.5 (±2.0), respectively. The percentage of participants whose households received free wheat as aid dropped from 38% at Round 1 to 8% by Round 3 (P<0.0001).

TABLE 5.3: Selected summary statistics, by round of measurement

	Round			
	1	2	3	*P*
Estimated per capita household income, USD/Month	11.3 ± 12.5	11.4 ± 10.6	12.5 ± 10.1	0.3
Estimated household income, USD/Month	45.6 ± 38.7	46.8 ± 41.7	53.1 ± 48.1	<0.05
Household composition, people	-	4.6 ± 2.1	4.5 ± 2.0	0.6
Receiving wheat as food support, %	38.2	18.9	8.4	<0.0001
Raw HFIAS score	3.7 ± 2.7	3.4 ± 2.5	3.2 ± 2.5	0.04
Food-secure	17.3	22.6	21.5	0.4
Food-insecure – mild	21.8	26.4	30.8	0.1
Food-insecure – moderate	39.1	34.0	29.9	0.1
Food-insecure – severe	21.8	17.0	17.8	0.3
SRQF score	6.9 ± 5.9	6.2 ± 5.9	5.0 ± 5.5	0.004
Participation Scale score*	9.5 ± 9.1	7.0 ± 7.2	5.2 ± 6.8	<0.0001

*Excluding two individuals who were extreme outliers at data collection rounds 2 and 3.

Are AIDS care volunteers food-insecure and is the prevalence increasing?

Yes and no. As I have shown in previous chapters, more than 80% of AIDS care volunteers reported food insecurity at the data collection baseline, even prior to the peak of the 2008 food price spike. The present analyses further reveal that two-thirds (65.7%) of volunteers in the sample reported food insecurity at *all three* data collection rounds, whereas only 9.5% never reported food insecurity. However, the prevalence and severity of food insecurity did not rise over the course of 2008. Surprisingly – given the context of rising food prices and the observed drop in the percentage of participants receiving free wheat as food support – the prevalence and severity of food insecurity decreased. Specifically, only 21/107 (19.6%) reported more severe food insecurity at data collection round 3 compared to baseline, while 34/107 (31.8%) reported less severe food insecurity (Chi-sq P=0.001; 52/107 [48.6%] reported no change in food insecurity severity). I have hypothesized that the overall improving trend owes to the uniqueness of the volunteer

caregiver role itself. That is, volunteers develop unique social networks that allow for 1) the witnessing of improvement in some patients' physical health, 2) downward social comparisons (with patients who are perceived to be worse off as the primary reference group) and 3) the fulfillment of religious and pro-social duties. These processes likely contribute to the experience of mental or spiritual satisfaction (in Amharic, *mänfäsawi ïrkata*) among many AIDS care volunteers (see Chapter 3).

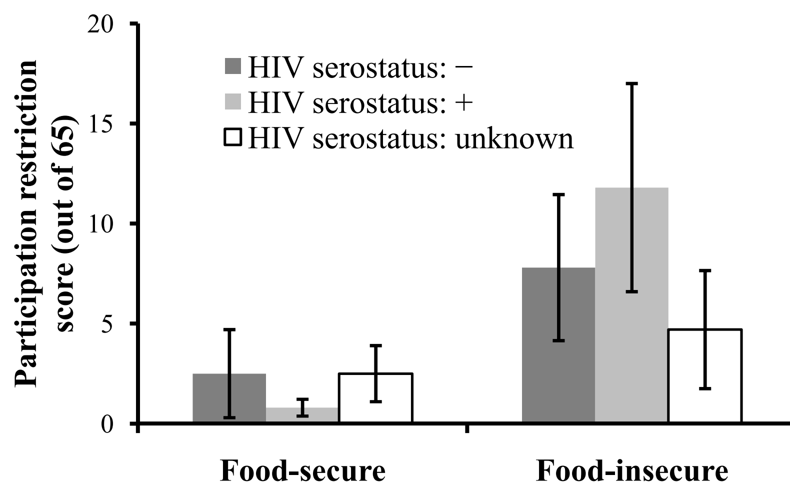
Does HIV serostatus among volunteers predict food insecurity status?

No. Across all three data collection rounds, FI was reported by 76% of volunteers with negative HIV serostatus, 81% of volunteers with unknown HIV serostatus, and 91% of volunteers with positive HIV serostatus. However, according to a GEE model accounting for repeated measures, the difference between those reporting positive and negative HIV serostatus was not significant (P=0.12). Furthermore, a different pattern was observed when taking into account FI severity. Across all three data collection rounds, moderate to severe FI was reported by 33% of volunteers with positive HIV serostatus, while 50% of volunteers with either negative or unknown HIV serostatus reported moderate to severe FI. Again, the difference between those reporting positive and negative HIV serostatus was not significant according to a GEE model (P=0.09). I further examined whether HIV serostatus was associated with change (improvement, worsening, or stasis) in FI severity between data collection rounds 1 and 3, but did not observe any significant interaction.

Does HIV serostatus predict participation restriction?

Yes. In a linear model accounting for repeated measures (and excluding those with unknown serostatus), positive HIV serostatus was associated with higher participation restriction scores (P=0.002). Positive HIV serostatus remained significant (P=0.005) after food insecurity was included as an independent variable; food insecurity was also strongly associated with higher participation restriction scores (P<0.0001). I next fit a logistic GEE model of food insecurity status, controlling for age, gender, years of education, and per capita income. In this model, which excluded those with unknown HIV serostatus, higher participation restriction scores were associated with increased likelihood of food insecurity (P<0.01); the interaction between positive HIV serostatus and participation restriction also increased the likelihood of food insecurity (P=0.005). **Figure 5.1** illustrates the pattern in which the highest participation restriction scores belong to volunteers who report both food insecurity and positive HIV serostatus.

FIGURE 5.1: Participation restriction as a function of food security and HIV serostatus (all data collection rounds combined, n = 310).

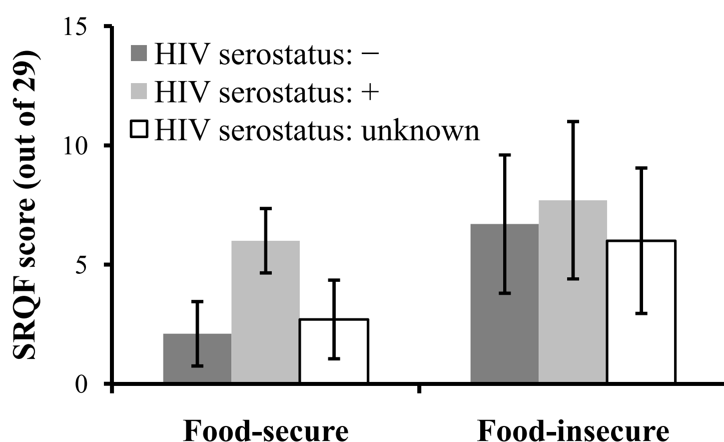


Does HIV serostatus predict mental health status?

A qualified yes. This was a focal question in the present study given the narratives provided by Eskinder and Asayech, in which HIV serostatus was believed to be at best indirectly related to mental disorder, while livelihood insecurity was believed to have a more direct influence. I first examined the relationship between serostatus and SRQF score. Across all data collection rounds, volunteers with positive HIV serostatus had slightly higher scores compared to those with negative and unknown status; however this was not significant (P=0.12) according to a linear model accounting for repeated measures. I further examined the interaction between food security status and HIV serostatus on SRQF scores ≥8 in a logistic GEE model controlling for age, gender, years of education, per capita income, and participation restriction. According to this model, food insecurity is highly predictive of SRQF scores ≥8 (P<0.0001); there is also a significant interaction between food security and HIV serostatus (P=0.02), in which

positive HIV serostatus is predictive of high depression/anxiety symptom loads *among food-secure volunteers*. **Figure 5.2** illustrates the pattern in which the lowest SRQF scores belong to volunteers who report both food security and negative HIV serostatus.

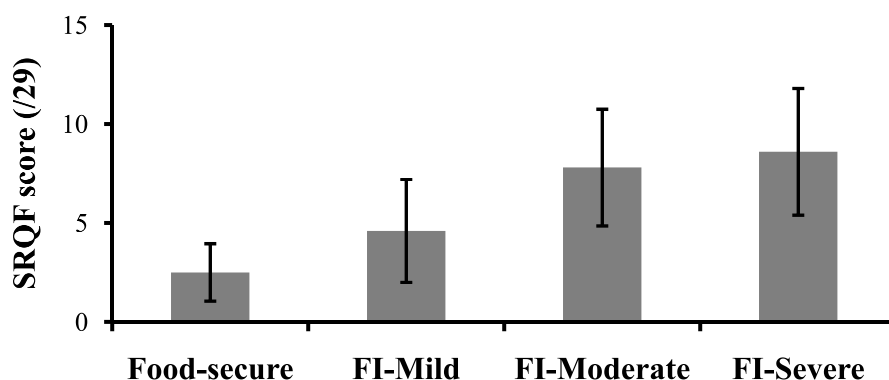
FIGURE 5.2: CMD symptom loads (SRQF scores) as a function of food insecurity and HIV serostatus (all data collection rounds combined, n = 316).



Does participation restriction account for the relationship between FI severity and mental health?

No. Chapter 3 reported a clear dose-response effect between food insecurity severity and high depression/anxiety symptom loads (**Figure 5.3**). In a GEE model of SRQF scores ≥8, this effect persisted after including Participation scale scores as an independent predictor. Participation restriction was not significantly associated with the outcome in this model (P>0.2), though participation restriction was correlated to SRQF scores in bivariate analyses (P<0.0001).

FIGURE 5.3: CMD symptom loads (SRQF scores) as a function of food insecurity severity (all data collection rounds combined, n = 323).



DISCUSSION

Quantitative analyses and interpretation of results from these analyses were guided by the open-ended narratives of Eskinder and Asayech, which in turn benefited from the establishment of strong rapport between the interviewer and respondents. This emphasizes the power of mixed qualitative and quantitative study designs in understanding interactions between FI, HIV/AIDS, and psychosocial wellbeing. Specifically, Eskinder and Asayech narrated a belief that "mental problems" are not due to HIV/AIDS itself, but to experiences of livelihood and food insecurity that result from a mix of factors, namely high urban unemployment, physical disability due to illness, and discrimination (including self-discrimination) of people living with HIV/AIDS within local labor markets. The epidemiologic portion of the study lends support to this first-hand "folk knowledge" but also adds nuances revealed by the interactions between food insecurity and HIV serostatus that were examined.

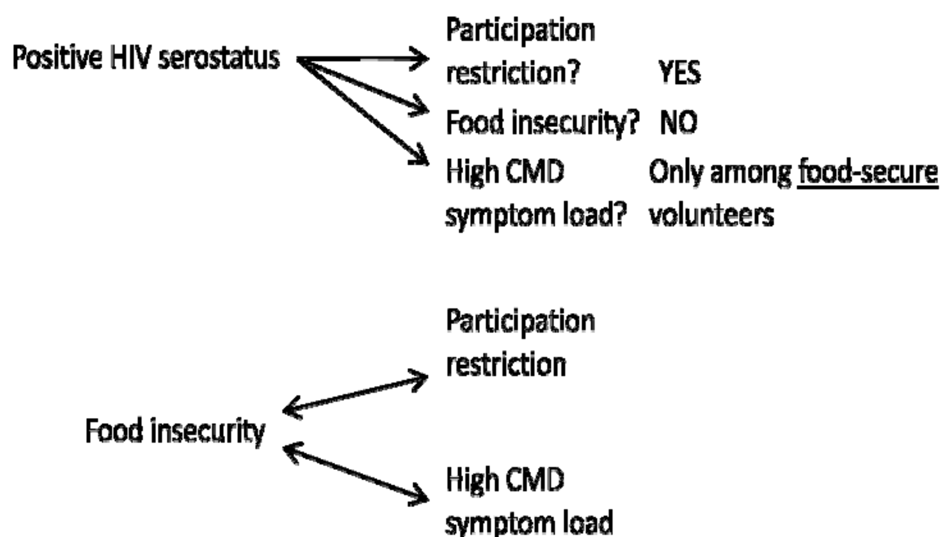
Results confirm that food insecurity is experienced by the majority of AIDS care volunteers in urban Ethiopia, and is negatively impacting their psychosocial health. Results also show that HIV serostatus among AIDS care volunteers does not predict food insecurity status. This particular finding may be unique to this urban sample of volunteers, many of whom depend on other household members for income (albeit very low income), as well as on social networks and organizational aid for food (see Chapters 3 and 4). Food insecurity and HIV serostatus appear to interact, however, revealing dynamic patterns of psychosocial vulnerability in terms of both social participation restriction and common mental disorder symptoms. Specifically, participation restriction is most severe among volunteers who are both food-insecure and living with HIV/AIDS, while HIV serostatus predicts high CMD symptom loads only among food-secure volunteers. Finally, I have shown that the dose-response effect between FI severity and high CMD symptom load is robust to the inclusion of social participation restriction, lending further support to the contention that food insecurity is a major contributor to psychosocial distress among urban populations in sub-Saharan Africa, and in particular among a sub-population that is increasingly important to economies of AIDS care.

A limitation of the analyses presented in this chapter is that most of the statistical tests performed did not directly test the direction of causality among these variables. The only direct test showed that HIV serostatus did not predict change (improvement, worsening, or stasis) in FI severity between data collection rounds 1 and 3. I do not have the qualitative or quantitative data to test the hypothesis that past food insecurity status led to HIV infection among the volunteers in the sample – via high-risk transactional sex, for example (Bryceson and Fonseca 2006; Weiser, et al. 2007). Positive HIV serostatus

appears to have a causal yet dynamic effect on high depression/anxiety symptom loads and participation restriction. Further analyses are needed to determine whether other factors mediate these relationships. For example, it is unclear how positive HIV serostatus leads to higher participation restriction – is it through physical disability, self-restriction, stigmatization and discrimination by others in the community, or all of these (Nyblade, et al. 2003; van Brakel 2006; van Brakel and Officer 2008)? Further analysis of the participation restriction data reported here may be able to answer this question; in particular, it will be helpful to know what specific kinds of social participation restriction are more common and problematic among volunteers in this sample.

In regards to common mental disorder symptoms, I have shown that positive HIV serostatus is associated with high SRQF scores only among those in the sample who reported food security. Although Participation scale and SRQF scores are positively correlated, participation restriction was not a significant predictor of high SRQF scores when FI severity was included in a GEE model. Future analyses may be able to determine the direction of causality among these three variables. However, it is plausible that bidirectional arrows exist among these constructs; in other words, food insecurity, participation restriction, and depression/anxiety may feed back on each other, creating a cycle of poverty and psychosocial vulnerability. **Figure 5.4** summarizes this model as well as findings on the effect of HIV serostatus on participation restriction, food insecurity, and mental health.

FIGURE 5.4: Summary of findings on food insecurity and HIV serostatus as predictors of psychosocial vulnerability among volunteer AIDS caregivers in Addis Ababa, Ethiopia.



Eskinder said that, "My stress is because I am not working… Nowadays, it is only that life is expensive and there is no employment." In contrast, Asayech said that she was content to be active as a volunteer. What sets them apart, first and foremost, is that Eskinder is a single man living with his elderly mother, while Asayech is a married woman whose husband is fortunate enough to be working in a low-wage but steady position. Thus for Eskinder, even if he is active as a volunteer, he is not content to be unemployed. However, Asayech also admits that she is often stressed by the fact that she is dependent on her husband, who wants to have sex when she would rather not. Thus for Asayech, having her own income would in fact be desirable, as it would change the dynamic of her married life and perhaps alleviate some stress.

The cases of Eskinder and Asayech illustrate the fundamental role that gender inequalities play in both food insecurity and HIV/AIDS epidemics in sub-Saharan Africa (Himmelgreen, et al., 2009). These short but rich case studies extend the body of empirical evidence on this theoretical framework into the under-studied realm of AIDS care volunteerism. While Akintola (2004, 2008a, 2008b) and others have pointed out that AIDS caregiving tends to be "women's work" in SSA, to my knowledge no studies have examined the specific ways in which gender and HIV/AIDS intersect with food insecurity and unemployment-related psychosocial distress among AIDS care volunteers. Unfortunately, the qualitative differences that emerge between the experiences of Asayech and Eskinder cannot be explored with quantitative analyses, because there are not enough men in the current study's sample in order to include gender as a factor in multivariate models. Thus I hope that this dissertation will be an impetus for further research on this challenging topic.

While others have called for measures to encourage AIDS care volunteers' motivations with increased incentives and recognition (e.g., Rödlach, 2009; World Health Organization, 2002), my focus emphasizes the potential of anthropological inquiries to inform underlying debates over poverty-reduction through sustainable health sector job-creation and volunteers' economic right to regular wage-remuneration for their labor. In Addis Ababa, food in the form of occasional group meals is often used as an incentive for volunteers. This is because, among humans, food is not simply a source of nutrition, but is also a symbolically powerful ingredient in rituals that NGOs and other groups use to maintain volunteer "spirit" and solidarity in the context of scarce resources. Both Eskinder and Asayech desired work that generated a steady income to afford food and

other basic necessities. Even with occasional incentives in kind, what is lacking for these volunteers is the certainty of remuneration that comes with regular wage payments. Uncertainty is at the heart of the livelihood insecurity that many volunteers voice.

Amartya Sen's work (1981) helped to bring about a conceptualization of food insecurity that focuses not on the availability of food, but on people's ability to afford regular access to sufficient food (cf. Maxwell, 1999). It is problematic to assume that food insecurity in sub-Saharan Africa is a totally different phenomenon than food insecurity in generally affluent settings like the United States – in other words, that in SSA the problem is underproduction, while in the US the problem is unaffordable food costs.[27] While underproduction is certainly an issue, this oversimplifies the situation in SSA, where urbanization is increasing at a faster rate than anywhere else in the world (UN-HABITAT, 2008), and where even rural farmers have to buy much of the food that they consume (Headey & Fan, 2008). For the urban-dwelling volunteers in this study, food insecurity is primarily linked to low income and underemployment.

Though Eskinder and Asayech wanted paid work, they faced an urban environment in which 1) unemployment was rampant (Serneels, 2007) and 2) volunteer AIDS care was socially congruent (i.e. it fulfilled their desires to help others affected by HIV/AIDS and to avoid potential discrimination in other labor markets). Volunteers, when asked, often say they want remuneration for their health labor, but of course the paradox is that they find no buyers, though their social landscapes are heavily populated with health programs in need of labor (Swidler & Watkins, 2009). Instead, they find

[27] See for example, Roger Thurow's recent blog on Global Food for Thought: "Can't lead abroad while losing at home." http://globalfoodforthought.typepad.com/global-food-for-thought/2010/02/roger-thurow-outrage-inspire_hungerinamerica.html [accessed 8 February 2010].

donor-funded programs seeking free labor, doled out in units of eighteen months (or more) of unpaid but certainly highly valuable home-based care (Akintola, 2008b).

The international NGO Partners in Health (PIH) devoted its 2009 annual symposium to the theme of "accompaniment," the community health model that commits to training and modestly paying health *accompagnateurs* or community health workers much like Eskinder and Asayech. The Public Broadcasting Service in the U.S. recently produced an incisive documentary focusing on PIH's cooperation with the Rwandan government and the Clinton Foundation in rolling out this model, to the apparent benefit of community health and economy.[28] In testimony before the U.S. Senate Committee on Foreign Relations on January 27, 2010, Paul Farmer mentioned that these Rwandan health workers contributed $7000 in donations for victims of the recent earthquakes in Haiti.[29] Though these health workers make less than 200 USD/month, that sum is sufficient to afford food security in places like Rwanda and Ethiopia, and to give donations rather than be donor-dependent.

In conclusion, given that acute-on-chronic food insecurity is likely to remain problematic in many countries in SSA, volunteers will continue to face severe constraints that may impact on their psychosocial health, and thus their capacity and willingness to be effective health workers and caregivers. Ironically, volunteers in such contexts may often be poorer than their clients. Though volunteers may derive satisfaction from their activities and see their roles as socially congruent, it must be recognized that they face enormous challenges in other areas of their lives. The question for policy makers then

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[28] Available at http://www.pbs.org/now/shows/537/index.html [accessed on 4 February 2010].
[29] Available at http://standwithhaiti.org/haiti/news-entry/pih-co-founder-paul-farmer-testifies-at-senate-foreign-relations-committee [accessed on 8 February 2010].

becomes how to generate the psychosocial benefits of compassionate care as well as a level and regularity of remuneration that allows for secure livelihoods among volunteers.

CHAPTER 6

"We will continue volunteering, but how can we live with this life condition?" Displacing the myth of the selfless community health volunteer[30]

INTRODUCTION

In the past decade, forms of volunteer and unpaid AIDS care have been promoted across eastern and southern Africa.[31] Many with an interest in development and public health assume that unpaid care is economically imperative when it comes to combating HIV/AIDS in settings of health professional and resource scarcity (Akintola, 2008b; Apondi, et al., 2007; Campbell, et al., 2008; Schneider, et al., 2008). Recruiting, training, and retaining people who are motivated to volunteer their time and labor have thus become key bottlenecks determining the sustainability of AIDS care programs in sub-Saharan Africa (SSA).

Meanwhile, debates over the unjust and/or unsustainable nature of volunteerism in low-income countries have emerged among a widening group of researchers and community health practitioners (Swidler & Watkins, 2009). A key question is whether a socio-economically and culturally loaded term like "volunteerism" is simply a veneer for labor exploitation. I argue in this chapter that volunteerism is neither simply a case of

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[30] A version of this chapter won Second Prize in the 2010 Peter Kong-ming New competition of the *Society for Applied Anthropology*.

[31] Unfortunately, estimates of the numbers of volunteers at regional and local levels are practically nonexistent. See Akintola (2008b).

donated kindness and labor nor simply a euphemism for labor exploitation. Instead, AIDS care volunteerism is a network of situations across Africa defined by two key features: 1) poor but often resilient and relatively pro-social community members building social solidarity and care relationships (with variable success) and receiving in return a mix of potential forms of "rewards" – except formal wages; and 2) the valuable socio-emotional solidarity and altruistic motives of volunteers being usurped, along with their physical labor, by a mix of organizations attempting to sustain the AIDS care movement, including local and international NGOs, governments, and for-profit biomedical entities. Elites in these organizations tend to imagine African communities as full of individuals containing "untapped" emotional energy and physical labor (i.e. "volunteers"). Thus a key question addressed by this chapter is whether the motivations of real volunteers in an urban setting in SSA – and the socioeconomic contexts in which they exist – are accurately represented in the minds and documents of volunteer programmers.

Objectives

In this chapter, I present two ethnographic case studies of AIDS care volunteers in Addis Ababa, Ethiopia. A person-centered ethnographic analysis of the motivations and experiences of these volunteer caregivers – people who uniquely link HAART patients to the world of NGO and public health services – allows us to re-politicize the state of health care systems and unemployment, and to understand the micro-political (as opposed to strictly medical) consequences of HAART roll-out in low-income countries (Biehl, 2007). With these two representative – but in some ways unique – case studies, I evaluate how volunteers and their supervisors deal with questions of remuneration and

volunteerism itself. Such an analysis encourages policy-makers and broader audiences to confront the culturally- and socioeconomically-loaded concept of volunteerism amidst widespread unemployment and household economic insecurity in settings like Addis Ababa. Importantly, this inquiry gives volunteer caregivers a chance to explain their various motives in their own words, through narratives of their lives before, during, and after volunteering for such a daunting task.

These case studies will also provide a frame of reference for interpreting the results of cognitive-motivational rankings that were collected from a larger sample of volunteers. As the case studies show, in the course of their day-to-day activities involving NGO supervisors, patients, and health professionals, volunteers experience subtle and not-so-subtle reinforcement of their pro-social motivations and control of self-interested motivations. Such processes appear to shape the way that volunteers rank the personal importance of various motivations for being an AIDS care volunteer, producing consensus among volunteers in which, as one might expect, pro-social motivations (such as reducing the burden of care in the community) are ranked high while self-interested motivations (particularly receiving compensation/material benefits from the NGO) are ranked low. In conducting analyses of these data, it is necessary to keep in mind how social desirability bias may have influenced participants' responses. Different conclusions can be drawn from these data when one assumes that a face-value interpretation is warranted, and alternatively when one assumes that the data reflect what respondents "prefer" *and* what they think they "ought to" prefer. Such an analysis offers a preliminary understanding of how volunteer AIDS caregivers' motivations – particularly their desire for personal socioeconomic progress – are shaped by the cultural,

economic, and micro-political environment. Thus I emphasize the importance of mixed ethnographic and cognitive survey-based methods in a critical examination of volunteer motivations. Collecting these different kinds of data together leads to a much richer analysis and understanding of both socially "desirable" and "undesirable" volunteer motivations.

Background

Advocates of highly-active antiretroviral therapy (HAART) roll-out in low-income countries envisioned drug access as a "wedge issue" to usher in more broad-based strengthening of public health systems and to help governments provide health care as a human right (Irwin, Millen, & Fallows, 2003; Kim & Farmer, 2006). However, as João Biehl (2007) argues, the objectives have shifted, and health systems are more oriented toward marketing and distributing drugs, technologies, and services to the poor, thus benefitting pharmaceutical corporations and other public-private partnerships.

According to this model of "pharmaceutical humanitarianism," public-private-NGO partnerships in the health sector attempt to save lives by developing new medical technologies and cost-effective ways to deliver care without confronting the overall dismal state of public health infrastructures. Structural violence and inequity that engenders disease is effectively ignored, and historical "economic injustices reflected in barely functioning health care systems are depoliticized" (Biehl, 2007: p. 384). Meanwhile, as Biehl shows through ethnographic work, people living with AIDS struggle to translate expensive and vertical medical investments into social capital and livelihood security.

Volunteer caregivers in SSA, like the patients for whom they care, occupy an uncertain position amidst the roll-out of HAART.[32] Their continued participation raises key questions: will this medical investment and their decisions to volunteer alongside its distribution translate into socioeconomic change for themselves? And from the perspectives of AIDS care programmers, should volunteers be encouraged or discouraged to ask this question and to desire remuneration for their labor?

Despite the importance of these questions for the success and sustainability of AIDS treatment – a key part of equitable development goals in SSA – very little micro-level research has been conducted that inquires deeply into 1) the motivations and values of volunteer caregivers and 2) the political-economic structures that define and constrain their role in providing care for poor people living with HIV/AIDS (but see Akintola, 2008b; Rödlach, 2009; Swidler & Watkins, 2009).

World Health Organization policy

The 2008 food and financial "crises" have presented a crossroads for the issue of health care volunteerism in low-income countries. The World Health Organization recently recommended that "essential health services cannot be provided by people working on a voluntary basis if they are to be sustainable. While volunteers can make a valuable contribution on a short term or part time basis, trained health workers…should receive adequate wages and/or other appropriate and commensurate incentives" (World Health Organization, 2008: p. 35). This is a significant shift from previous policy that *promoted* "community home-based care in resource-limited settings," asserted volunteers' universally shared motivation to help others, and recommended "honoring"

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[32] A substantial proportion of AIDS care volunteers (15-50% in my study, depending on the organization) are living with HIV/AIDS and potentially in need of or already taking HAART (see Chapter 5).

and “encouraging” such motivation with token gifts and payment in kind rather than with fair, predictable wages:

> “[V]olunteers have one thing in common – a desire and ability to help others…. [G]roup support, education, honoring volunteers and providing awards, honoraria and payment in kind are important sources of encouragement for volunteers... [G]roup celebrations, badges, uniforms, T-shirts, umbrellas and other forms of volunteer recognition [are] also important” (World Health Organization, 2002: p. 68).

The WHO's recent about-face on the viability of volunteerism leads me to question whether various players and global health organizations will follow suit. The older 2002 WHO rhetoric reflects a set of largely unquestioned guiding principles among donors and international non-governmental organizations (as well local governments and NGOs) that reinforce a reliance on volunteerism in low-income countries. For the WHO’s more recent recommendation to be effective, policy-makers and practitioners will need to examine at least two interlocking ideas.

(1) Paying labor is “not sustainable”

The idea that *paying* labor is not sustainable derives from an assumption that unpaid labor is economically imperative in settings of health professional and resource scarcity; a confused understanding of what sustainability means; as well as a principle among aid agencies that patients, and in particular the elderly and children living with or

orphaned by AIDS, are categorically the most vulnerable in society, and thus that scarce resources must go to them (cf. Gwatirisa & Manderson, 2009; Merten & Haller, 2009).

Sustainability theorists assess sustainability in terms of the "triple bottom line" by examining a program's economic, social, and environmental impacts (Hacking & Guthrie, 2008; O'Connor, 2006; Pope, Annandale, & Morrison-Saunders, 2004). Under this definition, the wellbeing of the labor force is a key issue for sustainability. But in the conventional and narrower global health definition, a health/development project is said to be sustainable if it can be "taken over" by local organizations when the donors that financed the start-up pull their resources out. According to critics, this definition is associated with a set of health/development practices – such as relying on unpaid labor – that give rise not only to unsustainable programs, but also to unintended and often negative social consequences in African communities (Swidler & Watkins, 2009).

There is another definition of "sustainable" that refers to a health intervention backed up by a commitment to sustained funding by global donors such as the Global Fund (Ooms, et al., 2007). This definitional shift is used to advocate for a transformation in practices – from reluctance to commitment – in hiring and paying health workforces. Since its inception, the Global Fund has become more attuned to the benefits of strengthened health workforces in the fight against AIDS, tuberculosis and malaria. But a tension exists between any potential Global Fund mandate to implement "sustainable" workforce funding in cooperation with African governments, and the International Monetary Fund's practice of imposing government expenditure caps on health workforces (Dräger, et al., 2006; Ooms, et al., 2007). This tension generates a fair

amount of interest among policy-makers, social scientists, and public health practitioners – hence the contested and evolving definition of sustainability.

Akintola (2008b) provides a review of existing literature on unpaid AIDS care in sub-Saharan Africa, concluding that available data are inadequate to determine the financial cost-effectiveness of various models of home- and community-based care, let alone the psychosocial costs of such care borne by unpaid caregivers in settings of high unemployment and food insecurity (Akintola, 2008a; Ogden, et al., 2006; Schneider, et al., 2008). Akintola (2008b) also provides a useful typology of the costs associated with various forms of unpaid or volunteer AIDS care, including financial costs, opportunity costs, and physical and emotional costs.

(2) "Being good is good for you"

The idea that "being good" (i.e. volunteering altruistically) is "good for you" (cf. Borgonovi, 2008; Piliavin, 2003) has not been critically examined in the context of SSA. Martinson and Minkler (2006), who have pioneered a critical approach to the promotion of volunteerism and "civic engagement" among elders in North America and Europe, note that three decades of research on the link between formal volunteering and health – including mental and cardiovascular health, immune function, and longevity – have led to over-generalized conclusions despite a lack of well-designed research in culturally- and socioeconomically-diverse populations. Though my research has suggested a possible buffering effect of volunteering on mental health and reported household food insecurity among impoverished Ethiopian AIDS caregivers during the 2008 food crisis (see Chapters 2 and 3), alternative explanations for this finding are plausible. For instance, participants in this study may have altered their responses to surveys based on

expectations that the researchers would use their answers to determine eligibility to receive aid. This is a complication that is particularly relevant to contexts in urban SSA, characterized by unrelenting poverty and inequity, as well as substantial presences of international humanitarians and researchers (which local people may sometimes find difficult to differentiate).

(3) Locals are simply willing to work for free

This is what I call the myth of the humble, selfless volunteer (see Chapter 1). Though the WHO seems to have moved away from supporting this myth with its recent recommendation, many volunteer projects arguably rest on the assumption that African communities are full of "untapped" moral and social energy, as well as norms of generalized reciprocity (Swidler and Watkins, 2009), producing an abundance of individuals ready to donate their labor to make their communities healthier. With this convenient perception, the question of *why* one does not have to pay for labor is easily answered – because locals are simply willing to do it for free.

The myth is apparent in discourses of major international NGOs: for example, in its 2007 Ethiopia report to USAID, Family Health International (FHI) boasted that it had trained over 11,000 volunteers for home-based care (HBC) and antiretroviral treatment support, and wrote, "The level of interest and commitment of volunteers to the [HBC] program has been overwhelming…. The program has shown the untapped spirit of volunteerism that exists within Ethiopian communities despite such pervasive poverty" (Family Health International/Ethiopia, 2007: p. 52). Elsewhere in the same report, we learn that during the early phases of the HBC program design, NGO and donor communities were "keen to harness the good will and generosity of [local]

communities…" (p.72). How should we interpret this "spirit" and "good will" that various players in the international NGO and donor communities are so keen to "tap" and "harness"?

Volunteers serving on the front lines of the struggle to roll out antiretroviral therapies indeed express mental satisfaction from helping others (see Chapter 3), and thus appear more resilient than others experiencing similar marginalization and insecurity. And despite their experiences of economic insecurity, they *are* capable of being effective caregivers and treatment-supporters, at least when adequately trained and supervised (Coetzee, et al., 2004; Hardon, et al., 2007). However, simply pointing out the apparent resilience of volunteers is not a good argument for discounting their needs as the demands and conditions of their service – and lives – shift.

Accepting the myth of the selfless volunteer also obscures the complex mix of values and emotions that motivate volunteers. The myth encourages programmers to ignore the co-existence of self-interest among so-called volunteers in order to downplay potential accusations of volunteer exploitation. As I show in this chapter, volunteers expressed multiple material and spiritual desires and rationales that defy the myth of the selfless volunteer.

Further, though it is anthropologically interesting to understand altruism and resilience among volunteers, this should not obscure the processes by which their altruism and resilience are usurped by programmers in the global health industry. Thus it is not only volunteers' labor that is usurped, but also their resilience and pro-social motivations. NGO and donor elites tend to envision this raw energy as "unharnessed," running wild among poor rural and urban communities in Africa. They simply have to

tame it, harness it, and encourage it through ritual celebrations involving t-shirts, group songs and occasional meals (see Chapter 7). Following microsociologist Randall Collins (2004), through the regular ritual reinforcement of religious and pro-social values and emotions, volunteer AIDS caregivers and their supervisors attempt to generate and maintain Durkheimian solidarity, "collective effervescence" or "shared emotional energy," which is certainly valuable when it comes to sustaining their motivations (Durkheim, 1915 [1965]). Despite the WHO's more recent recommendation, this logic continues to guide many international organizations and donors. In turn, local NGOs that remain dependent on finicky donors and international NGO support operate within this ethos: with varying degrees of success, they organize and even build social solidarity and capital, which they then "harness" in order to sustain their programs in contexts of material resource scarcity. On the ground, "encouraging" volunteer caregivers (instead of paying them) amounts to ritually reinforcing pro-social motivations and discouraging self-interest, which as local NGO supervisors rightly know, co-exist among volunteers.

While volunteers may derive satisfaction from helping, they face enormous challenges in other areas of their lives, and they seek to overcome these challenges. A handful of anthropologists and sociologists have recently gathered information about the motivations and lives' of community volunteers upon whose labor so many global health programs depend (e.g., Akintola, 2008b; Escott & Walley, 2005; Kironde & Klaasen, 2002; Rödlach, 2009). The work of these scholars challenges the myth of the volunteer spirit by talking with volunteers and recording their discontents: unemployment (or landlessness in rural areas), lack of remuneration, low social status, inability to meet household needs, and, in the case of HBC, being unable to help patients who receive

drugs but are not able to afford the health benefits of adequate food. Paradoxically, volunteers find no buyers for their labor, though their social landscapes are heavily populated with health programs in need of labor. Instead, they find donor-funded programs seeking free labor, doled out in units of eighteen months (or more) of unpaid home-based care. I have shown that the majority of AIDS care volunteers experienced moderate to severe insecurity in food access even prior to the 2008 food crisis (see Chapter 2), and that food insecurity severity was associated with depression/anxiety symptom loads in a dose-response manner (see Chapters 3 and 5). For these volunteers, food insecurity was particularly de-motivating: insecure access to food strained the relationships they maintained with care recipients who struggle to adhere to antiretroviral therapies and pushed volunteers to reconsider what they deemed as appropriate compensation for their efforts (see Chapter 4).

METHODS

Ethnography

Ethnography comprised participant observation in neighborhoods adjacent to ALERT Hospital and greater south-west Addis Ababa, including attendance at volunteer caregiver trainings and recognition ceremonies, volunteers' and care recipients' homes, and home-based care reporting and planning meetings, conducted over 20 months between May 2007 and January 2009. Dozens of informal conversations were also held with caregivers and staff within the NGO and hospital administrations.

Key volunteer informants were recruited from the *Hiwot* and *Medhen* NGOs. A purposive sample of 13 volunteer caregivers (10 women and 3 men) aimed to account for

the preponderance of women in the volunteer population, as well as variation in length of service, age, education, and socioeconomic status. Informants were recruited to complete a series of semi-structured interviews assessing various domains, including volunteer caregiver motivations, costs and benefits, food insecurity, care relationships, and wellbeing. Semi-structured, open-ended interviews occurred over 8 months in 2008; each informant was interviewed up to seven times, until we had addressed each of the pre-determined domains.[33] Interviews benefited from the build-up of rapport over the course of multiple hour-long meetings. Thus they provided a forum for volunteers to speak openly about their various motives and experiences.

Here I focus on two respondents and their views on what volunteerism means, how they balance their pro-social motivations with their desires for improvement in socioeconomic status, and why and how their motives as volunteer caregivers are subject to questioning, doubt, and ritualized control by their NGO supervisors, fellow volunteers, and patients. In the case studies that follow, we will meet Eskinder and Alemnesh.[34] Eskinder is a middle-aged man who volunteers with the *Medhen* NGO, which provides community health services in a few, very poor neighborhoods in Addis Ababa. Eskinder began volunteering in April 2007 with *Medhen*, which relies on the labor of a couple dozen volunteers and funding from a mix of international donors. Alemnesh is a young woman volunteer with the *Hiwot* NGO, which runs an Addis Ababa-wide AIDS care program that relies on hundreds of volunteer caregivers for labor and on Family Health International (FHI) for major funding and policy guidance.

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[33] Interviews were recorded, transcribed in Amharic, and translated by the author and native Amharic-speaking assistants. Texts and field-notes were coded in MAXQDA software using a coding scheme combining pre-determined and emergent codes.
[34] All personal names in this chapter are pseudonyms.

Ranking by pair comparison

A series of surveys were conducted with a larger sample of AIDS care volunteers from the *Hiwot* and *Medhen* organizations, which covered a range of domains, including socioeconomic status, food insecurity, care relationship quality, workload, motivations, and mental wellbeing (depression/anxiety symptoms). For the purposes of this chapter, I focus on data collected from participants' rankings (by paired-comparisons) of motivations for doing volunteer home-based care according to personal importance. This task comprised an attempt to describe volunteer caregiver motivations in terms of their importance, and to assess whether consensus existed among volunteers in the sample when it comes to ranking these motivations. Since this task was repeated at multiple data collection rounds (3 in total), the data also address change (or stability) over time in the rankings of volunteer caregiver motivations at the group level.

Pilot ethnographic research and literature review identified 10 key motivations that are relevant in the study setting (**Table 6.1**), which can be categorized from a Western perspective as self-interested or altruistic.[35] The random-order series of 45 paired comparisons were accompanied by the instruction to choose: "Which of the two motivations has been more important for you in the past 4 weeks?" For each participant, rankings were calculated by summing the total number of times (out of 9) that each

[35] There is much, though not perfect, overlap in what is considered "pro-social" and "self-interested" from emic and etic perspectives. However, it is beyond the scope of this paper to attempt to give an in-depth emic account of the target items and terms used in the ranking and semantic scaling tasks. The ethnographic case studies presented in this paper serve to provide some context for understanding the way that participants understood these target items. For one thing, from an emic perspective self-interest and pro-sociality are not incompatible, though many westerners tend to think they are.

motivation "won" a pair comparison. If two or more items "tied" with the same number of wins, their ranks were recorded as equal, and the next highest rank accounted for the number of ties. For example, if there was a tie between two items for the highest rank (1) for a particular participant, then the next highest rank possible was 3. These rankings (not raw pair comparisons) were used for the cultural consensus analyses described below.

TABLE 6.1: English translation of 10 pair comparison items denoting common motivations for being an AIDS care volunteer in Addis Ababa, Ethiopia.

Paired items
To see sick people get healthy
To help reduce stigma and discrimination
To reduce the burden of care in my community
To receive God's response/reward
To please God
To get job experience and opportunity
To get respect/appreciation from community
To please my family/parents
To get out of my house from time-to-time
To get income/materials from the NGO

Sample

The pair comparison task, along with a series of other questionnaires, was administered to volunteer caregivers from the *Hiwot* and *Medhen* NGOs at three rounds (Feb/Mar 2008, July/Aug 2008, and Nov/Dec 2008). Drawn from NGO rosters, the sample included 110 volunteer home-based caregivers (99 women and 11 men) of adult

patients receiving treatment at ALERT Hospital, incorporating 40 (out of 60) randomly-chosen participants who had just begun volunteering with the *Hiwot* organization at the time of the baseline survey ("*Hiwot* newcomers"); 50 (out of 70) randomly-chosen participants who had all been volunteering with the *Hiwot* organization for 12 months at the time of the baseline survey ("*Hiwot* veterans"); and all 20 volunteer caregivers from *Medhen*, with an average service length of 12 (± 4.6) months at the time of the baseline survey ("*Medhen* veterans").

110 participants were surveyed at Round 1. At Round 2, 106 of the original 110 participants were surveyed, and at Round 3, 107 of the original 110 were again surveyed. Four Ethiopian research assistants were trained prior to each data collection round, and data collection was conducted in pairs. Refresher training aimed to maximize data quality. Results are reported for each data collection round and are disaggregated by organization (*Medhen* and *Hiwot*) and newcomer/veteran status at baseline.

Cultural consensus analysis

Cognitive anthropologists view culture as a set of shared and socially distributed information or models, models which in turn motivate and therefore influence patterns in individual and group behavior (Weller, 2007; Hruschka, et al., 2008). But cultural models and their associated motivational "power" are not necessarily universally shared. Cultural consensus analysis is a set of statistical tools for studying "sharedness" as well as variation in the distribution of cultural information or models. According to Weller (2007), cultural consensus analysis estimates "culturally correct" answers to a series of questions as well as respondents' accuracies in answering those questions. A primary assumption of cultural consensus theory is

that there is a single, shared set of culturally correct answers to the questions asked: in other words, that there is a high degree of agreement among the responses of different individuals. By estimating the agreement matrix among a group of socially related individuals, one can test whether indeed there is a high degree of agreement on a single cultural model (Weller, 2007). I aim to illustrate how when combined with ethnography and a hypothesis-testing framework, cultural consensus analysis can be used to determine the processes by which knowledge in a cultural domain comes to be shared or not.

In the current study, individual respondents' rankings were subject to cultural consensus analyses performed separately for each sample sub-group (*Hiwot* newcomers, *Hiwot* veterans, *Medhen* veterans) and each of the three data collection rounds. All analyses were conducted in UCINET (v.6). Datasets were imported as respondent-by-respondent similarity matrices, which outputs individual competencies and eigenvalue ratios.[36] Answer keys were generated by performing separate consensus analyses invoking the interval/ordinal analytical model and inputting profile datasets.

Common criteria for consensus are 1) an eigenvalue ratio (largest to next) greater than or equal to three, indicating that a single factor is far more important than any others in accounting for systematic variation in the matrix of inter-individual agreement, and 2) the absence of negative individual loadings on the first factor (i.e. negative competencies). Using Excel, I calculated the mean and standard deviation of

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[36] Similarity matrices were produced using UCINET's Similarities Tool, invoking the correlation measure of respondent profile similarity. When using respondent-by-respondent similarity matrices at input datasets for consensus analysis, it is not necessary to choose one of the analytical models offered in UCINET. See Romney, Batchelder, and Weller (1987) and Weller (2007) on the informal data model for ranked data.

respondents' competencies. I also examined the stability of rank answer key arrays across data collection rounds and sample sub-groups, by calculating the correlation coefficients of rank arrays.

Social Desirability Bias

Examining the motivations of volunteer caregivers presents the well-known methodological issue of social desirability bias (SDB): the preference of good (socially desirable) behaviors and motivations and the under-reporting of bad (undesirable) behaviors and motivations. Basic social science theory (Furnham, 1986; Ones, Viswesvaran, & Reiss, 1996; Paulhus & John, 1998; Spector, 2006) says we should not be surprised that SDB posed a challenge at two stages of the data collection protocol: 1) the preliminary stage that involved compiling commonly identified (potentially normative) motivations and moral terms from the target population, and 2) the secondary stage that involved asking individuals to rank target items compiled from the preliminary stage, based on their values and preferences.

Important methodological issues must be taken into account when attempting to use free-lists and ranking exercises for a cultural domain that is strongly subject to social desirability bias. At the first stage of methods development, SDB would make it difficult to get respondents to "freely" list socially undesirable motivations for being a volunteer caregiver – motivations, in other words, that could be interpreted as self-interested or self-serving. Examples are "To get income/materials from the NGO," "To get respect/appreciation from the community," and "To get job experience and opportunity." The resulting free lists would therefore be biased to include pro-social or socially

desirable motivations, such as "To help reduce stigma and discrimination," "To see sick people get healthy," and "To reduce the burden of care in my community."

I dealt with this problem by relying not exclusively on potentially biased "free" lists but also on an ethnographic and theoretical understanding of both self-sacrificing/pro-social motivations *and* potentially self-interested motivations for being a volunteer AIDS caregiver. With this understanding I attempted to develop balanced, unbiased, and concise compilations of motivational target items for use in the secondary stage of individual-level data collection.

Most of the paired items listed in Table 1 are straightforward, but a few require brief explanation. "To please my family /parents" was included because many volunteers are young adults still living with parents; Ethiopians even in urban areas tend to feel a strong sense of responsibility towards pleasing and obeying their parents and family (Poluha, 2004). I have observed that many urban young adult Ethiopians facing widespread underemployment also have a desire to avoid "simply sitting" (cf. Mains, 2007). In this context, "To get out of the house from time-to-time" can be construed as one reason for becoming a volunteer. The items referencing "God" reflect the strong (but still variable) religiosity of Ethiopians, including my informants. A couple quotes are sufficient to illustrate this:

> "[Being] a volunteer caregiver… will get you to think something good for human beings…. Sometimes I will get aid from NGOs; but you have to forget this thing. By believing in God...and doing God's work, you can live." (Male caregiver, May 2008)

> "What motivated me to be a caregiver… To see others' pains like my own [and] to understand how many hurt people there are. If I am not benefiting in my own way [by receiving benefits from the NGO], I will get something from God. God will pay me [back for] my weariness." (Female caregiver, May 2008)

At the second stage of survey data collection, SDB may lead individual participants to mask their "genuine" preferences and to rank self-sacrificing motivations above ostensibly self-interested motivations. Data collectors reminded participants of the confidentiality of the interview and the importance of honest responses. Still, it is impossible to eliminate SDB at this point of the survey protocol. It is better to pay attention to SDB and, if possible, provide compelling evidence that it is at play. Drawing conclusions from face-value interpretations of these data alone may reify the same over-simplified myth of the selfless volunteer and the idea of pharmaceutical humanitarianism as a win-win situation. SDB does not render survey data on volunteer motivations completely useless. Rather, they are interesting if one assumes that the data reflect not simply the personal preferences of respondents, but also what they think they "ought to" prefer as participants in a ritually- and discursively-reinforced ethical system, and perhaps what they think the data collector or researcher prefers (cf. Weller, 2007: pp. 364-5). On the other hand, at some level respondents may have convinced themselves that they are volunteering for pro-social reasons. It seems difficult to tease apart what one "really thinks" and what one thinks others want to hear: to some extent these become the same thing, especially in a context of strong social pressure. Based on this discussion, one can posit 1) that there is a "culturally correct" answer key that may be the "socially

desirable" answer key, from which respondents draw or to which respondents attempt to approximate when asked about their personal preferences; and 2) that variation among individuals is determined by relative competence in that answer key, not simply by personal preferences. In the following section, I use ethnographic evidence to suggest that the first proposition is true. Subsequently, I present the results of the ranking exercises and cultural consensus analyses, and interpret them in light of ethnographic insights. This analysis depends on understanding *why* social desirability bias features strongly in volunteers' self-reports of motivational preferences – not just from a universal perspective but from a local micro-political view.

Case Studies

Both Alemnesh's and Eskinder's cases address the key issue of being a volunteer in a setting of rampant unemployment. Eskinder and Alemnesh are of different genders, age levels, and NGOs. They also have very different family and economic backgrounds, and divergent histories of volunteer service. Eskinder has himself been living with HIV/AIDS and began HAART prior to becoming a volunteer caregiver, while neither Alemnesh nor anyone in her immediate family was living with HIV/AIDS.

In addition to documenting the testimonies of Alemnesh and Eskinder, I was able to collect reflections from some of their supervisors and peers on their work ethic and, in Alemnesh's case, her decision to drop out and work in Dubai. These additional informants' perspectives allow for richer case studies of volunteer caregiver motivations in cultural and socioeconomic context.

Eskinder

About four years ago, Eskinder found out that he was HIV positive when he became critically sick and was hospitalized. But he has been close to the stigmatization of disease for his entire life. His mother, with whom he still lives, was infected with leprosy at a young age. His experiences with these illnesses have deeply affected his life in general, and specifically, his access to secure employment and his motivation to be an AIDS care volunteer.

> When we first entered the service, we volunteers promised that we would care for elders. The [NGO] staff told us that they had elders who were leprosy patients, and that we needed to care for them. Recently I found an elder with maggots on his body. He had nobody, and he was living in the cemetery. 'Who am I?' I said that to myself. 'From whom was I born?' Even if my father was a healthy person, my mother was a leprosy case. Because of these things, how can I avoid people with leprosy? I will be close with those people. I will turn them over in bed properly and I will clean them. I will brush away the maggots, and I will put some baby powder.

Eskinder began HAART at ALERT Hospital in 2005. Aside from his medicine, he identifies God and the prayers of his friends as key ingredients in his recovery from near-death. Eskinder suggests that he and all of his fellow volunteer caregivers are faithful to the promise they made upon entering the service at the *Medhen* NGO, which

means doing the work for a full 18 months and being an advocate of anti-stigmatization. In short, it means putting the patients first.

> I got cured with God's help and peoples' prayers…. Now I am going around as a volunteer caregiver while carrying my anti-retroviral medication in my pocket. Patients will call for you. They fear that their neighbors, friends, and family will avoid them. The reason I see these matters deeply is that I have HIV inside me. In addition, I was trained.

> Our [NGO] supervisors made us promise on the Bible when we entered this place. 'To serve and respect our fellow people… Not to make people sad; not to trouble people; to go even when you are called in the middle of the night.' We promised that.

Distressful turning points – the loss of employment and food stipend

We always interviewed Eskinder in the front room of his two-room shack located in the slum next to ALERT Hospital. He explained that, before he got sick, he used to be in a better socioeconomic position. He was able to work, furnish his house, and lead a decent life in mutual support with his family. Now living alone with his disabled mother, he has no substantial source of income, and depends on the NGO, extended family, and neighbors for food. He uses the Amharic word for "change" (*läwt*), to describe both the

process of furnishing the house in the past and "improving" his life in the future.[37] At present, however, he says that "change" is not possible, and it stresses him.

> This chair is not edible. The television and the cupboards are not edible… I got all these things previously when I was healthy – when I was working. It was because we worked – me, my sister and my brother – that we changed [i.e. improved] this house. My stress is because I am not working. I am not stressed because the HIV virus is inside me. I also worry about how long I will rely on the support of others. I have to work and I have to change myself. We volunteers [at *Medhen*] are left with only two or three months of service. After that, what will I do? That is inside me; that is stressing me.
>
> This is not only me. Many of my sisters [my fellow volunteers] are stressed about it. They say, 'What are we going to do?' We have a problem with the organization – especially after our food stipend was stopped. We used to be given 45 kilos of wheat and 3 liters of [cooking] oil as a stipend, and we depended on that. We entered in the first place depending on that. We don't have any other thing – no salary (*dämoz*).[38] I told the staff that the only

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[37] Dan Mains (2007) noted the use of this same terminology in his work among underemployed youth in the town of Jimma, Ethiopia. The desire to experience progress or change (*läwt*) is pervasive amongst urban Ethiopian youth.

[38] The Amharic word *dämoz*, translated often as "salary," is a combination of two words meaning "blood" and "sweat."

> thing I took from them was the wheat and 3 liters of oil. That was the thing that we changed into bread and ate. Otherwise, I don't have other income.

> Most of us volunteers were managing our household needs with that food stipend. We considered that as food… We considered that as a salary. But now, we are given a monthly stipend of only 100 Birr [approx. 10 USD]. What can I do with that? This is troubling my mind. It is not only me, but many of us…
> When the stipend was changed, everybody complained. We said, 'We will not [volunteer] if it is like that. Why do we work? Can a person work without eating?'

This provokes an obvious question, which Eskinder also addressed:

> Why do I continue volunteering? It is a promise. We respected our word, and the [NGO] supervisors should respect theirs [i.e. to support the volunteers]… They are reducing things; but we are not reducing our love.

A letter of recommendation, a chance to improve one's life

Eskinder explained that his prospects for employment are limited by HIV stigmatization as well as by the disabilities in his hand and lower limbs caused by HAART-related peripheral neuropathy. He previously worked as a welder and in other physically demanding labor, but doesn't think that this kind of work is appropriate for him anymore. According to Eskinder, what would be best for him is physically less demanding work in a setting where he can be open about his HIV status without fear of discrimination. He mentioned that a low-level position at ALERT Hospital would be ideal for him.

> We volunteers tell the [NGO] staff to write a letter of recommendation for us to ALERT Hospital. We were saying to the staff, 'You can write letters of recommendation to the hospital. The hospital is employing cleaners and [low-level office assistants]. We live around the hospital; we were raised around here – why don't we get hired in the hospital and work? Why? We were even giving good service [to patients] in the hospital. We were getting familiar with the doctors, the nurses, the health assistants, and the guards. We know all of them…'

> As long as we are volunteers, we are doing good things. Serving fellow people for one year and six months is not an easy thing. It is good if we get paid work, after we complete the service. So it is good if they can transfer us to work at the hospital. When we

> presented this idea [to the NGO staff], they told us, 'Why don't you compete for the job on your own?' We replied, 'We can compete when you give us a support letter. If you write us letters of recommendation, the people responsible for hiring at ALERT can give us priority.'

We asked Eskinder why his NGO staff hesitates to write letters of recommendation. He replied, "They don't want to go to that… I think the reason has to be related with their religion." In other words, according to Eskinder, his NGO supervisors want the volunteers to enjoy God's favor, but would prefer not to encourage them to seek "worldly" material benefits from their service – for instance, by recommending them for employment. Eskinder told us that he discussed these issues further with the NGO director, Sister Kidan.

> I said, 'Sister, there is one thing we should discuss alone – you and us.' She said, 'About what?' I replied, 'It is about what we are doing. We are doing good work. We are doing a good thing… Why don't you assign each of us volunteers for some job – some of us who do well as volunteers? If you send each of us, it can mean big thanks for you also – from God.'
>
> Sister Kidan looks towards God, right? You can get the greatest gratitude from God. Also, that person who is working – he and his family will thank you. I said, 'Sister, why don't you ask ALERT

> Hospital for us? ALERT is hiring workers – cleaners, gardeners, office assistants. Why don't we get priority?'
>
> [Sister Kidan replied,] 'I can't do this.' She said that.

"Information gap"

Near the end of October 2008, as the *Medhen* NGO was in the process of "graduating" their current volunteers (including Eskinder) and recruiting new volunteers, I spoke with Sister Kidan. She told me that they planned to keep a handful of the current volunteers (the ones enrolled in my study) to continue alongside the newcomers. She said they would select those who should continue based on 1) how impressive their record was in helping orphans and vulnerable children in the neighborhood; 2) how quickly they identified problems and reported them to the staff; 3) how much they went "out of their way"; and 4) whether they understood that they were volunteers as opposed to employees.

This last criterion was particularly salient. According to Sister Kidan, in general the present group of volunteers did not fully grasp that they were volunteers – they thought of their service like a job. She said there was an "information gap" between the volunteers and the organization.

She explained that the volunteers complained that they were doing very hard work for little pay. But she said this was beside the point, given that they were volunteers. She also noted that 100 Birr per month (the new stipend regime that began in June 2008,

replacing the 45 kilos of wheat and 3 liters of oil that Eskinder mentioned) was comparable to the wages of many low-paying jobs in the community. She told me that the volunteers complained, but that they would actually prefer to volunteer at the NGO, as opposed to working, say, as a house servant with slightly higher remuneration. Government and NGO jobs alike hold considerable prestige in Ethiopia. Another of *Medhen*'s staff, when I met with her in November 2009, almost a year after I had left the field, said that the number of new volunteer recruits was higher than ever before. She said that people want to be volunteers because they see that volunteers are upbeat and full of energy. In a sense, she was telling me that local people observe the volunteer "spirit" and want to participate in it. With urban unemployment in Ethiopia reaching 50% among young men (Serneels, 2007), however, it is not surprising that interest in volunteer positions is high.

In this regard, Eskinder is an interesting case. He did seem to be possessed by a volunteer spirit – he was often hopeful, very compassionate, and apparently admired by many of his peers and neighbors. He was one of the handful of volunteers who was asked to continue for another term of service. And yet, he clearly saw his volunteer service as a potential job and wished that he received better remuneration; thus he seemed to be on the other side of the "information gap" that Sister Kidan lamented.

Sister Kidan told me that during the "graduation" process for the volunteers in late 2008, she was trying to close the "information gap" in dialogue with the volunteers. This issue was important to her because she thought that the volunteers lacked ambition to improve their lives, and she wanted the volunteers to use their service as a way to "get

on with their lives," "fight for their lives," and "focus on what else they could do with their lives."

After I had this conversation with Sister Kidan, I interviewed Eskinder again and paraphrased what she had said. He focused less on the idea that he lacked ambition and more on the idea that the monetary stipend provided to the volunteers was inadequate. Eskinder seemed to take it for granted that he wanted to improve his life.

> What shall I do working with something that has no prospects for improvement? If there is means to make a living, then there is marriage. And if there is marriage… What can I do with 100 Birr? How can a woman accept me as a husband? When you are a house-to-house caregiver, how can you live with 100 Birr if they don't increase it?

It became clear that, to Eskinder, the ideal situation would be continuing as a volunteer caregiver while receiving a living wage either from the NGO or from parallel employment. He was adamant that he would continue to be a volunteer caregiver alongside whatever employment he could secure.

> Yes, we will continue volunteering. But how can we live with this life condition? The [NGO] supervisors know how much a sack of wheat costs. Nowadays, it is only that life is expensive and there is no employment…. If I have an income [from another job], I will be happy even serving [as a caregiver] for free. Why? If I have my own income, I will eat my own food and I will serve my fellow

> people… When you go to the hospital and visit them; when you help them; when you give them food; when they get up and thank you; and when you see them stand up and walk – it makes you happy.

In my final interview in mid-December 2008, I asked Eskinder if there were any things he wanted to tell us.

> Well, I think that I will improve. I will be changed. In the middle of my life, I became HIV positive, and I couldn't find work. So I couldn't get to the level that I could improve. Now my chance is here in this place [with the NGO]. I will do this [volunteer care] and serve as long as I live. I have a hope that I will work and be improved – through time, that is to say. If I can work, I can be changed.

Alemnesh

At age 26, Alemnesh is unmarried and living with her parents, whom she describes as giving and caring role models. Her father, an ex-soldier who served during the military "Marxist" regime (the *Derg*) that ruled Ethiopia from 1974-1991 (Donham, 1999), does not receive a pension. Her mother is the family's homemaker. In the past, Alemnesh was able to help support her family financially. She worked abroad in Saudi Arabia and Kuwait before becoming an AIDS care volunteer.

From the outset, the NGO supervisors who recruited Alemnesh doubted her dedication and capability to be a volunteer caregiver, an experience which Alemnesh

recounts with indignation. She proved the doubters wrong by being an outstanding and reliable volunteer. However, nine months after her recruitment, in November 2008, in a sense she proved them right. She dropped out from the volunteer program to work in Dubai.

Alemnesh recounts her initial interest to become a volunteer caregiver as a case of "spiritual envy" – she heard about others doing it, and desired to be like them.

> I heard on television and on the radio about those volunteers who do good deeds. When you hear that, you may have spiritual envy (*menfesawi qïnat*). I thought, 'What if I do something like them?'

Her ongoing motivation is very much a matter of fulfilling the desire to experience the spiritual satisfaction she imagined was the delight of those people she heard about on the radio. As voiced by all of my informants, this mental or spiritual satisfaction comes primarily from seeing patients that they have cared for and counseled become healthy and productive.

> There was a patient that I had. When she was told that she had HIV, she was crying on the road. But now she accepts it, and she is peaceful. She is changed a lot now. When you see that, you will become happy. That is what mental satisfaction is – even if you are not paid, when a fellow human gets well and walks, you say that is a result of your work.

Recruitment and resentment

During their recruitment interviews, Alemnesh and another of my informants – a young woman who also had previous experience working in the Middle East – were met with the suggestion that they were not fit to be volunteers because they were accustomed to a better standard of living and remuneration. Alemnesh recounted that the woman who would become their nurse supervisor, Sister Meheret, strongly emphasized that there was not a salary for the work that they would be expected to do. Apparently this was a ritualized interaction with which Sister Meheret, the recruiter, was familiar, but which only created resentment for Alemnesh, the recruit.

> I told Sister Meheret that I don't have any kind of work. She said to me, 'So if you don't have work, if you live with your family, how can you simply serve, without being compensated?' I answered, 'I will help my people with all my capacity – just that much.'

According to Alemnesh, Sister Meheret persisted. At the end of the interview, she again asked, "So without anything being paid to you, how can you work?" Alemnesh raised her voice when she recounted to us her response:

> I myself came with good will [*bäbägo fäqadäñanät*, i.e. voluntarily]. I knew that we were not going to get anything. At the time, I was very angry. If you came there to serve with good will, then they have to give you a kind face (*mälkam fit*)…. But they said, 'There is no money, there is nothing. The work is heavy and

> you will get tired.' They told us like this. They were frustrating me…

Tsehay, the other young woman recruited along with Alemnesh, had also worked abroad. Tsehay recounted her interview experience similarly. She added that the indignation (in Amharic, *ïllïh*) she experienced at recruitment only motivated her to work harder.

> At first, it didn't seem to them that we would work. They made this judgment by simply seeing us. They said, 'These people will not work.' But now, we are the ones who are working… That experience pushed me to work hard and show them. I thought, 'I have to do this thing and show them.' This kind of thing – *ïllïh* – will be inside you, so you will work even more.

As it turns out, Alemnesh and Tsehay became recognized by their peers and supervisors as outstanding and reliable volunteer caregivers. Months after the initial interview, Tsehay said:

> Their opinion towards us changed a lot. Sister Meheret told me, 'You are working more than the other caregivers. Keep it up. You are very strong; you are very good. We are even talking about you as an example at other neighborhoods [with different groups of volunteers].'

Working abroad – and dropping out – for a better life

Alemnesh had made two previous trips to work abroad for a total of four years in Saudi Arabia and Kuwait, with one year back in Ethiopia between those trips. I asked her how much money she made while working abroad, and if she was leading a good life when she was abroad – better than the life she was having in Ethiopia.

> I didn't have anything in Addis Ababa. Let alone 150 dollars, there is no job here that will pay you 50 dollars (per month)! Even if [working abroad] was difficult, it is after suffering that you get something.

Alemnesh described her experiences abroad as helpful in terms of financially supporting her family, but not as personally life-changing. Her previous work had financed her siblings' university attendance, which led to them securing very good jobs. Alemnesh was pleased to have helped her brother and sister achieve such progress. But Alemnesh's previous work had not brought about a qualitative "change" (or step up the socioeconomic scale) for herself, and she was not shy of admitting this.

> When I went abroad that time, well, back home there is family and there is the house rent. My father was a *Derg* soldier. He was retired and there was no pension… Then my brother passed the university entrance exam, and was assigned to Jimma University. [Then] my sister got into Addis Ababa University. And it was a must that I should fulfill their expenses… That pushed me to work abroad….

> I came back [from Saudi Arabia] after two years. After staying one year in Ethiopia, I went to Kuwait. At that time, my siblings were third year university students. When I went to Kuwait, it was also for them…. And thanks to God, even if I didn't do anything for myself, I supported my family. They have reached a good level now. They both graduated, and my brother is working for Ethiopian Airlines. And my sister is working in the Ministry of Agriculture. Even if I was so tired…it was for good. Otherwise, I didn't do anything for myself. And now, I joined this job [volunteering]. But if it is God's will, and if I get some other opportunity, I will not hold myself back.

After learning that her cousin in Dubai had arranged a job and visa for her there, Alemnesh dropped out of the volunteer caregiver program in November 2008. In our interview at the time, she claimed that she had promised to her recruiters to be a dedicated volunteer *as long as she was in Addis Ababa*. And they knew that she had been abroad twice before. She rationalized her decision to drop out and go to Dubai by emphasizing, primarily, that she was obliged to take the opportunity so as not to disappoint her cousin, who had arranged it. And secondly, the money she could make abroad would help her support her family and change her life.

> You have to do something for yourself, too. When they recruited me at first, I told them, 'I will volunteer as long as I am here.' I told them previously, 'In the middle, something can happen. But as

> long as I am here, I want to work.' I served eight months, and I am very, very close with the patients – with the children. And it is difficult [to leave]…but it is life.

Another of Alemnesh's fellow volunteers, Haimanot, also participated in interviews. She and Alemnesh were fairly close, and around the time of Alemnesh's departure for Dubai, Haimanot related her own impressions of her friend's decision to go abroad.

> Alemnesh said, 'I don't want to go,' but we fellow volunteers encouraged her not to reject the opportunity. Alemnesh's mother raised her with much effort. It is good if she changes [i.e. improves the life of] her mother, as her mother worked hard to raise her. It is good if she changes herself and changes her family, too.

I asked Haimanot why she thought Alemnesh waited until the day before her departure for Dubai to tell Sister Meheret that she was dropping out and leaving. Haimanot and Alemnesh were together on that day. Haimonot recounted,

> On that day, Alemnesh was saying [anxiously], 'Oh my, how can I tell Sister Meheret!?' We told Alemnesh to call her… [When she finally called her,] Alemnesh said to Sister Meheret, 'I am going to say goodbye.'
>
> Sister Meheret replied, 'What!? You shocked me! I depended on you!' Then Alemnesh said, 'I can't do anything – this opportunity

> to go abroad happened without my expectation.' Then Sister Meheret said, 'May God make you successful. May we meet peacefully.'

Sister Meheret's reaction to the last-minute news that Alemnesh was leaving, as reported by Haimanot, might seem surprisingly benevolent. It is understandable when we consider the relationship that she and Alemnesh had developed over the past nine months. Also, by all accounts and my own experience, this particular nurse supervisor was a very sympathetic person, the kind of person who is very quick to bestow blessings like the ones she gave to Alemnesh over the phone. I return to this matter in the discussion below.

In my final interview with Alemnesh, I asked her about her vision of the future – for herself, Addis Ababa, and Ethiopia.

> For our development and economy, the major thing is peace… [Ethiopia] could even donate rather than being donated to… And for me, as for any person – good income. And for my family and people who are in trouble – to live a good life. For me, a good life is when you have money with love and peace.

Motivational Rankings

I now turn to the results of the cognitive-motivational rankings that were collected from a larger sample of volunteers, including Alemnesh and Eskinder. The foregoing case studies, which unlike survey data benefit from the build-up of substantial rapport between researchers and respondents, provide an important frame of reference for interpreting the survey results. Collecting these different kinds of data together

(narratives and structured rankings), and interpreting them with social desirability bias in mind, produces a richer understanding of both socially "desirable" and "undesirable" volunteer motivations.

Do volunteers agree on how to rank their motivations for being AIDS caregivers?

Yes. A high degree of consensus (agreement) was observed among participants' motivational rankings (**Table 6.2**). Among the 110 volunteers involved in this study, there were no negative competency scores observed. Further, mean competencies were very high (around 0.9), standard deviations were quite low (around 0.1), and rankings (answer keys) were largely consistent across data collection rounds and across the organizational/newcomer sample sub-groups. Both inter-round and inter-group correlations of rank arrays ranged from 0.97 to 1.00 (mean: 0.99). Finally, all eigenvalue ratios well exceeded a cutoff of 3 (average: 17.4). Taken together, these results suggest strong consensus – and stability over time – in terms of ranking the relative importance of motivations for being an AIDS care volunteer.

There was one interesting exception to the overwhelming consistency in rankings across time and across the sample sub-groups. Among *Medhen* volunteers, at Round 3 the two God-related items were ranked higher than at Rounds 1 and 2, and thus displaced "To reduce stigma and discrimination" and "To reduce the burden of care." This pattern was not seen among *Hiwot* veterans or newcomers. *Medhen* volunteers also ranked "To get respect/appreciation from the community" somewhat lower than did *Hiwot* veterans. Ethnographic work provides a plausible explanation for these disparities. Data collection Round 3 coincided with the final month of service for the *Medhen* volunteers. During that time, the volunteers were engaged in exit discussions with their supervisors, which

were briefly mentioned in Eskinder's case study. These discussions focused to a large extent on the meaning of volunteer caregiving, with the supervisors making final attempts to assure the volunteers that their service had been especially valuable in the eyes of God, and that they should not have been interested in reaping more worldly rewards (e.g. material remuneration and social prestige). *Medhen* volunteers may have ranked religious motivations higher at Round 3 because they were affected by this discourse.

TABLE 6.2: Average rankings (answer keys) of motivations for being an AIDS care volunteer, by round and organization/newcomer status, and summary consensus analysis statistics.

	Hiwot Newcomers			**Hiwot Veterans**			**Medhin Veterans**		
	Round			**Round**			**Round**		
	1	**2**	**3**	**1**	**2**	**3**	**1**	**2**	**3**
Paired items	n = 40	n = 36	n = 36	n = 50	n = 50	n = 48	n = 20	n = 20	n = 20
To see sick people get healthy	1.5	1.3	1.3	1.4	1.4	1.5	1.4	1.5	1.7
To help reduce stigma and discrimination	2.4	2.3	2.8	2.6	2.9	2.3	2.6	2.6	3.2
To reduce the burden of care in my community	2.8	2.4	2.8	2.4	2.7	2.9	2.5	3.1	3.6
To receive God's reward	4.3	4.1	3.9	4.1	3.5	3.8	4.0	3.6	2.8
To please God	3.3	4.1	3.7	3.5	3.9	3.9	3.9	3.4	3.1
To get job experience and opportunity	6.2	6.2	5.9	6.5	6.2	6.3	5.9	6.4	6.6
To get respect/appreciation from community	6.9	7.7	8.1	6.8	7.3	7.4	7.8	7.8	7.9
To please my family/parents	7.6	7.6	7.5	7.7	7.5	7.5	7.0	7.6	7.0
To get out of my house from time-to-time	8.0	8.0	7.5	8.2	7.8	8.0	8.0	7.7	8.4
To get income/materials from the NGO	9.5	9.5	9.4	9.4	9.6	9.5	9.3	9.2	9.2
Summary consensus statistics									
Eigenvalue Ratio (largest to next)	21.8	37.8	17.1	12.4	14.0	12.9	9.0	18.9	13.1
Number of Negative Competencies	0	0	0	0	0	0	0	0	0
Mean Competency (SD in parentheses)	0.9 (0.1)	0.9 (0.1)	0.9 (0.1)	0.9 (0.1)	0.9 (0.1)	0.9 (0.1)	0.9 (0.1)	0.9 (0.1)	0.9 (0.1)
Correlation Coefficients of Rank Arrays	**Round 1**	**Round 2**	**Round 3**						
Hiwot Newcomers : Hiwot Veterans	1.00	0.99	0.99	--	--	--	--	--	--
Hiwot Veterans: Medhin Veterans	0.99	0.99	0.97	--	--	--	--	--	--
Hiwot Newcomers : Medhin Veterans	0.99	0.99	0.97	--	--	--	--	--	--
	Hiwot Newcomers			**Hiwot Veterans**			**Medhin Veterans**		
Round 1 : Round 2	0.99	--	--	0.99	--	--	0.99	--	--
Round 1 : Round 3	0.98	--	--	0.99	--	--	0.97	--	--
Round 2 : Round 3	0.99	--	--	1.00	--	--	0.98	--	--

Do volunteers' motivation ranks support the myth of the selfless volunteer?

Yes. In general, motivations that can be called "pro-social" or "selfless" from an *etic* perspective were ranked higher than motivations that can be called "self-interested" (**Table 6.2**). The three overall highest ranked motivations at all data collection rounds were "To see sick people get healthy," "To help reduce stigma and discrimination," and "To reduce the burden of care in my community." Further, the highest-ranked motivation that can be called "self-interested" was also spiritual/religious: "To receive God's reward." This was followed by the other self-interested motivations, with "To get income and materials from the NGO" being the lowest-ranked out of all motivations. At face value, these results confirm that participants believed altruistic and pro-social motivations to be the most important for being a volunteer AIDS caregiver. Consensus analyses also suggest that volunteers largely agree on these preferences. A high level of consensus was even observed among newcomer volunteers at the first round of data collection. One possible reason for this result is that volunteer recruits are self-selected and thus have similar pro-social values and preferences even before the experience of becoming a volunteer. These are results that those who seek to rely on volunteer labor, and on the myth of the selfless volunteer, would love to hear.

Is a face-value interpretation of these data warranted?

Probably not. An alternative, critical interpretation, supported by ethnographic evidence, is that these data are heavily biased by social desirability: they reflect what participants think they "ought to" prefer. The unexpected concordance between newcomers and veterans at Round 1 suggests that newcomers have already been effectively "socialized" in terms of their motivations by the time they finish initial

training and are deployed to their community roles. This interpretation is supported by qualitative evidence that the process of recruitment and training shapes (and is meant to shape) the motivations of volunteers by communicating what is socially desirable and what is frowned upon. We have seen this with the case of Alemnesh. And with the case of Eskinder, we have seen how this socialization can be sustained all the way up to the end of the service period, in particular when supervisors perceive a persistent "information gap" regarding the volunteer role.

Further, "To get income/materials from the NGO" is consistently ranked the lowest, and this item's average rank is associated with a smaller standard deviation in comparison to the other self-interested items (**Table 6.3**). This suggests, but of course does not prove, that social desirability shaped responses to the pair comparison task. It appears that regardless of volunteers' different organizational associations and the passage of time, nearly all completed the task according to a rule that precluded choosing this motivation over any of the other motivations. I argue that participants performed this task with such a rule in mind not simply because they all independently "believed" that getting income and materials from the NGO was unimportant or personally undesirable, but because they thought that this was socially undesirable. This makes sense given that this motivation in particular is highly contentious in the context of volunteerism, as suggested by the ethnographic case studies.[39]

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[39] In an in-depth interview conducted in May 2008, another female caregiver told me that some of her fellow volunteers had recently been complaining amongst themselves after hearing a rumor that volunteers in another Addis Ababa district were receiving more substantial food stipend packages. I asked her why some volunteers would complain like this when participants in the surveys say that getting a stipend and materials from the NGO is so unimportant. She responded, "What do you think? What we are answering [in the surveys] and what we are working is different. Don't think that there will not be an advantage [to volunteering]. There will be wheat and so forth on the side… Since we are doing the same job, if others get something better, [you will ask] "Why are we not getting that here?"

Table 6.3. Standard deviations (SD) of ranks of self-interest items, by round of data collection. Note that "To get income/materials from the NGO" consistently has the lowest SD.

	Round		
	1	2	3
To get job experience and opportunity	1.56	1.57	1.66
To get respect/appreciation from community	1.45	1.50	1.85
To receive God's reward	1.61	1.44	1.48
To get out of my house from time-to-time	1.42	1.47	1.35
To get income/materials from the NGO	1.34	1.27	0.99

DISCUSSION

I have examined how volunteers negotiate the desire for personal socioeconomic change or progress amongst a mix of motivations to be volunteer AIDS caregivers alongside the distribution of HAART. The portrayal of volunteers as exceptional altruists who do not subscribe to this pervasive desire is clearly over-simplified; such a portrayal contributes to the characterization of pharmaceutical humanitarianism as "a new way of doing business" in which everyone – including the selfless volunteer – is a winner.

I have also attempted to confront the challenge posed by social desirability bias in the examination of various volunteer motivations by mixing cognitive survey methods and ethnographic case studies developed through in-depth interviews. Important methodological issues must be taken into account when attempting to use free-lists and ranking exercises for a cultural domain that is strongly subject to social desirability bias. SDB can make it difficult to get respondents to "freely" list motivations for being a volunteer caregiver that may be locally interpreted as self-interested or self-serving. Thus I relied not exclusively on potentially biased "free" lists but also on an ethnographic

and theoretical understanding of both pro-social *and* potentially self-interested motivations for being a volunteer AIDS caregiver. This of course is a departure from standard free-list protocols in cognitive anthropology, which aim to compile responses commonly offered by locals, not by the foreign researcher. However, I felt that it was a necessary adjustment in the context of this particular research. It may also be necessary in similar research settings elsewhere (e.g., Hruschka, Sibley, Kalim, & Edmonds, 2008).

The main results from the consensus analyses are 1) that AIDS care volunteers overwhelmingly agreed about the relative importance of these motivations (regardless of organization or length of service); and 2) that the one exception to this pattern may be explained by ethnographic evidence, specifically that "graduation" or exit discussions among volunteers and supervisors at the *Medhen* organization may have led to higher rankings of motivations referencing God. A limitation of the results reported here is that there was no control group of non-volunteers to rule out or understand the potential self-selection of AIDS care volunteers. Future research should involve both longitudinal and case-control designs, and could attempt to validate a locally-tailored measure of individual social desirability bias, as well as compare consensus analyses within the same group of people between a domain that is hypothesized to be heavily biased by social desirability and another domain that is not. However, even if there is self-selection among volunteer recruits, it does not negate that volunteers' motivations are controlled, which is plainly evident from the ethnographic work.

New insight: Resource-scarcity, economic status, and the politics of volunteerism

Here I discuss Alemnesh's and Eskinder's case studies in order to summarize what their experiences reveal about the micro-politics of volunteering alongside the

distribution of HAART. Despite their different situations, Eskinder and Alemnesh shared a desire for socioeconomic progress, and this desire was at odds with their respective organizations' goal of maintaining next-to-nothing labor outlays. Alemnesh took advantage of an opportunity to work abroad and dropped out from the *Hiwot* NGO's volunteer program. Her multiple opportunities to work abroad – to improve her own and her family's socioeconomic status – required substantial amounts of money (for plane tickets, brokers, visas) and certain social connections (a friend in Jeddah, a cousin in Dubai). Alemnesh's family was better-off than those of most volunteers. While other volunteers may have been interested in remuneration for their service, she was more interested in the opportunity to work and gain substantial income abroad.

In general, Eskinder and his fellow volunteers at the *Medhen* NGO did not have access to the income and social connections that serve as initial investments in personal progress. They still wanted socioeconomic change, but they flat out could not afford it. The same could be said for many of *Hiwot*'s volunteers as well. Further, Eskinder and his peers experienced the loss of a substantial monthly food stipend during their volunteer service. Alemnesh and her cohort of volunteers at the *Hiwot* organization did not experience this loss. Since they started serving in early 2008, they never received such a food stipend, and had only heard that previous volunteer cohorts did (it was cut off at the end of 2007). The *Hiwot* NGO was now giving the volunteers in my study a monthly stipend of about 5 USD, which was said to reimburse transportation and other expenses. In effect, Eskinder and his cohort experienced a substantial reduction to their incomes; as Eskinder made clear, they all depended on that food stipend to get by. This loss, within the context of outrageous food price inflation in Addis Ababa in 2007-2008, produced a

salient ambivalence in Eskinder's motivation to continue volunteering without more substantial remuneration, and in his supervisors' efforts to sustain what they believed were desirable motivations among the volunteers.

The purpose of this analysis is not to criticize local NGO policies and the staff who implement them, but to question the higher level policy structures and guiding principles that constrain these NGOs and their volunteers. Comparing these case studies suggests that the problem of volunteer drop-out is actually not as salient as the problem of volunteer interest in NGO resources. Eskinder – and volunteers who were very poor like him – were seen by their NGO supervisors as more dependent on what resources they could garner from the NGO. They had openly voiced their grievances to their supervisors, who knew that the resources the volunteers wanted (and perhaps deserved) were unavailable in the current political-economic climate. Their supervisors were even reluctant to provide letters of recommendation, ostensibly (at least from Eskinder's perspective) because doing so would encourage volunteers to focus on the material rewards that their volunteer service could potentially generate, instead of spiritual rewards.

In contrast, to her supervisors Alemnesh was not likely to make a claim on NGO resources: though she desired remuneration and a chance to change her life, she sought it in Dubai. Alemnesh feared to reveal her plan to go abroad, but she did not really need to. If it had been another, less well-off and dedicated volunteer, or one who had complained about the lack of remuneration for volunteers, she may have been more strongly reprimanded, and perhaps gossiped about as an example to others of an unreliable or difficult volunteer. Instead, Alemnesh was given a blessing by her supervisor when she

finally revealed her plan to drop out. Nevertheless, Alemnesh waited until the last minute to reveal her plan precisely because she was aware that it was socially undesirable in the context of AIDS care volunteerism.

How the *Hiwot* NGO rewards volunteers helps to clarify these points regarding the micro-politics and social control of volunteer motivations. A select few volunteers who go out of their way to work hard without expecting NGO resources in return are admired and (seemingly ironically) rewarded with NGO resources at the end of their service. Rewards for outstanding volunteers are used to encourage both dedication to the cause of caring for patients and adherence to the unwritten law that volunteers should not seek or expect to receive NGO resources. The wellbeing of patients is used to keep volunteers from claiming NGO resources: whatever resources volunteers claim would have to be taken away from the patients. Thus volunteer complaints regarding the lack of remuneration or claims on resources can be characterized as selfish and hurtful to the patients. Whether or not volunteers always put patients' wellbeing before their own interests, no volunteer wants a reputation as someone who puts herself before her patients. Not only would this kill one's chances of receiving a reward, or perhaps being invited to volunteer again, but it would also humiliate the volunteer (and maybe his or her family).

Neither Eskinder's nor Alemnesh's local organization hierarchy supposed it possessed the resources or capacity to provide regularly remunerated employment to help their volunteers achieve the progress they desire. The idea that volunteers do not have such a desire, however, is clearly inaccurate. As these case studies illustrate, local NGO supervisors question the motives of would-be volunteers at recruitment and all the way

up to the end of the year-and-a-half service period. They do so not because they are insensitive to the lives of their volunteer caregivers, but because they know from the policy and donor-funding structures in which they are embedded that volunteers' self-interested motivations are threats to the bottom line: running a home-based care program with minimal labor outlays. Simply put, if an organization wants to run a "sustainable" program, it cannot pay for labor. The reproduction of the organization depends on cheap labor, and would be impossible if the job market in urban Ethiopia were to substantially improve. Like her counterparts at the *Hiwot* NGO, Sister Kidan has to question volunteers' motives and see their self-interest as potentially problematic. This is not a case of an "information gap" as much as it is a structural problem – a mismatch between the basic needs and desires of volunteers and the NGO, public health, and international donors who rely on their labor but deny them regular compensation. Unfortunately, this structural problem adds distress to already difficult work.

Acknowledging the shared social determinants of the "co-crises" of AIDS, primary health system failure, and human resource scarcity in SSA, many advocate that community health workers who serve on a volunteer basis be incorporated into the public sector and remunerated. This particular policy measure is meant to be just one aspect of wider efforts to strengthen public health systems and ensure human rights to health and economic security in poor countries, which were threatened by structural adjustment programs imposed by the International Monetary Fund and World Bank in the 1980s and 1990s (Irwin & Scali, 2007; Kim & Farmer, 2006; Pfeiffer, et al., 2008). An important outcome of structural adjustment in Ethiopia and other African countries is the large-scale elimination of jobs in the public – including public health – sector. In Ethiopia this

was accomplished post-1991 (Mains, 2007); this period has also witnessed strong growth in the number of international and local NGOs (Iliffe, 2006; Kloos, 1998). From this perspective, current rates of volunteerism are an essential aspect of the thinning of the state in Ethiopia. Further, a tension currently exists between any potential Global Fund mandate to implement "sustainable" workforce funding in cooperation with African governments on the one hand, and on the other hand, the International Monetary Fund's continued practice of imposing government expenditure ceilings on health workforces. According to Ooms and colleagues (2007), without flexibility about these IMF-imposed ceilings, bilateral donors must eschew supporting health worker salaries; the Global Fund is willing but unable to break through this "vicious circle." These authors contend that the Global Fund has an "explicit endorsement from the international community" to practice an approach to sustainability that does away with idea that health system strengthening initiatives can simply be taken over by local governments and organizations after a brief injection of global funding. Contested approaches to sustainability are at the heart of the policy tension between the Global Fund and the IMF on the issue of workforce expenditures. The idea that volunteerism can simply alleviate this tension is clearly challenged by the economic insecurities that push volunteers to question their capacity and willingness to continue serving.

Modest remuneration might not keep volunteers like Alemnesh from taking opportunities to work abroad. However, Eskinder, besides his male gender, is actually a better representative of poor and economically insecure AIDS care volunteers I encountered in Addis Ababa. Regular, predictable remuneration would certainly help these volunteers to achieve economic security. A policy of remunerating volunteers might

also alleviate the added stress that comes with having to downplay one's self-interested motivations (on the part of volunteers), and with having to worry about volunteers' making claims on scarce NGO resources (on the part of NGO supervisors).

Revisiting pharmaceutical humanitarianism – Is volunteerism simply a veneer for labor exploitation?

Recommending a policy of remuneration for AIDS caregivers and other community health workers would also begin to address the inherent inadequacies of a model of pharmaceutical humanitarianism. This model, which has solidified over the past few years with the roll-out of HAART in low-income countries, largely bypasses the underlying inequalities and health system failures that have threatened attempts to effectively control the AIDS pandemic (Biehl, 2007). Markets for medical technology in poor countries operate within a framework involving free or cheap labor from poor people in the NGO sector; thus companies do not have to completely sacrifice profits in the marketing of global health goods via public health systems.

How is it possible that pharmaceutical corporations market expensive AIDS drugs in poor countries? These markets did not exist until the Clinton Foundation, the WHO, and other organizations and governments negotiated price reductions from pharmaceutical corporations in return for stable, "captive" markets and good PR opportunities (Biehl, 2006; d'Almeida et al., 2008). The idea behind this political-economic reconfiguration is that this is a *win-win situation*: for the drug company CEO, the resource-strapped Ministry of Health, and even the poor mother with AIDS and her unpaid caregiver. Ira Magaziner, the Clinton Foundation's chairman, refers to this as "a new way of doing business" between governments, pharmaceutical corporations, and

other partners.[40] Meanwhile, volunteers have little say in the debate over new regulation and reconfiguring of global and national health infrastructure. If their stories filter up to policy makers, it is usually to reinforce the myth of the humble, sacrificing volunteer.[41]

On the surface, however, there is a difference between AIDS care volunteers and, say, Wal-Mart factory workers in China, Bangladesh, and Honduras. Wal-Mart factory workers are exploited so that corporate executives and shareholders can enrich themselves, and workers on the floor generally do not care to advance this particular outcome. In contrast, AIDS care volunteers are exploited so that poor people with a potentially deadly and stigmatized illness can get treatment and decent care, and volunteers tend to care very deeply about this outcome. But in fact, we are not dealing with the simple exploitation of labor; instead we are witnessing the *usurpation* of both the labor and the pro-social motivations that impoverished people maintain in the face of the social suffering and disruption wrought by HIV/AIDS, food crisis, and unemployment.

And yet this is not all that different from, for example, male mine workers in mid-20th century South Africa (Moodie & Ndatshe, 1994) or female office workers in turn-of-the-century Barbados (Freeman, 2000). In all of these cases, the psychosocial satisfaction that low-status people claim to derive from their work may distract an outsider from the inherent inequalities between laborers, supervisors, and capitalists. Like the mine workers and "pink collar" office-workers studied by Moodie and Freeman, respectively, AIDS

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[40] It is notable that Magaziner reportedly does not take a salary, as a way to instill a "volunteer ethic" among the foundations' employees. *The Atlantic*, October 2007. http://www.theatlantic.com/doc/200710/clinton-foundation.

[41] A comparison can be drawn to the "voluntary" labor of Ethiopian peasants in state-designed construction, conservation and other communal works, labor that is in fact compulsory in order to maintain good relations with the state apparatus, which controls the resources and services that peasants depend on. Lefort (2007) has found that this type of compulsory labor is largely accepted on principle among peasants in southeast Amhara State (north Shoa), and yet they contest the amount of labor they are expected to give and feel that the state's works do not bring about commensurate development.

care volunteers have values, emotions, and relationships with their colleagues, care recipients, and supervisors. They are not just pawns of the 21st century AIDS treatment movement. Community volunteers, many of whom have been affected by HIV/AIDS, are indeed uniquely capable of providing compassionate chronic disease care. But many face serious economic insecurity along with their care recipients, particularly in a time of rising food prices. Ideally, effective and resilient community health workers derive mental satisfaction *and* adequate, predictable remuneration from their labor. The remarkable ability of marginalized people to carry out their volunteer role emphasizes the *value* of their labor, which in a fair market would command decent remuneration. In order for NGO and public policy makers to appropriately address volunteerism as an integral part of AIDS treatment and development in SSA, it is necessary to understand both volunteer motivations and the economic context of their service. The question for policy makers becomes how to generate the spiritual benefits of altruistic, compassionate care and a level of remuneration that allows for secure livelihoods among volunteers like Alemnesh and Eskinder.

CHAPTER 7

The ritual basis of sustainability: Motivating the "untapped volunteer spirit" in HIV/AIDS treatment programs in urban Ethiopia

INTRODUCTION

This chapter examines how rituals function – with variable success – to sustain the motivations of volunteer caregivers serving an HIV/AIDS treatment program in Addis Ababa, Ethiopia, and thus the role that rituals play in sustaining such programs in this as well as other contexts. It applies a Durkheimian theory of macro-ritual (e.g. volunteer recognition ceremonies) and micro-ritual (e.g. shared meals and coffee, and every-day interactions) to the activities of two internationally-funded Ethiopian NGOs that support the HIV/AIDS treatment program of a large Ethiopian Ministry of Health hospital located on the southwest outskirts of Addis Ababa. The goal of this analysis is to understand how a social-ritual economy attempts to sustain the motivations of volunteers and the programs they serve in a (sustainability-threatening) context of material resource scarcity and economic insecurity. I argue that more comprehensive understandings of the sustainability of many kinds of development and population health programs in Ethiopia and elsewhere in sub-Saharan Africa (SSA) must explicitly account for the role that rituals play in garnering both material and psychosocial resources for the motivation of unpaid and underpaid laborers.

Volunteerism has recently attained increasing prominence in development and population health projects in sub-Saharan Africa (SSA), as well as in the critical awareness of social scientists studying health and development. With the rollout of AIDS therapies in particular, low-income volunteers have become a major part of health and development workforces throughout SSA. Three underlying assumptions have supported this evolution: 1) that volunteerism is "economically imperative" for the sustainability of public services in settings of human and material resource scarcity; 2) that volunteer or altruistic service and care can be beneficial to the psychosocial wellbeing of the giver; and 3) that local communities are full of "untapped" moral and social energy, producing an abundance of individuals ready to donate their labor to make their communities healthier. Together, these three assumptions powerfully motivate policy-makers and programmers to promote volunteerism in population health and development efforts in SSA. Furthermore, these three assumptions are often invoked in the context of various rituals that are meant to sustain the motivational energies of volunteers.

In the context of HIV/AIDS care in SSA, Olagoke Akintola (2008b) recently reviewed evidence for the first assumption (that relying on unpaid and volunteer labor is economically imperative), concluding that available data are inadequate to determine the financial cost-effectiveness of various models of home- and community-based care, let alone the psychosocial costs of such care borne by unpaid caregivers in settings of high unemployment and food insecurity. Akintola (2008b) also provides a useful typology of the costs associated with various forms of unpaid or volunteer AIDS care, including (1) financial costs ("direct dollar outlays…compared to what would have been incurred had the patient been in institutional care"); (2) opportunity costs ("the cost of time that

caregivers cannot spend on other activities" and "the value of opportunities that caregivers relinquish to provide home-based care"); and (3) physical and emotional costs ("the mental and practical difficulties that caregivers experience in carrying out their tasks") (p. 129).

The second assumption – that "being good" (i.e. volunteering altruistically) is "good for you" (cf. Borgonovi, 2008; Piliavin, 2003) – has not been critically examined in the context of SSA. Martinson and Minkler (2006), who have pioneered a critical approach to the promotion of volunteerism and "civic engagement" among elders in North America and Europe, note that three decades of research on the link between formal volunteering and health – including mental and cardiovascular health, immune function, and longevity – have led to over-generalized conclusions despite a lack of well-designed research in culturally- and socioeconomically-diverse populations. Though my dissertation research suggests a possible buffering effect of volunteering on mental health and reported household food insecurity among impoverished Ethiopian AIDS caregivers during the 2008 food crisis (see Chapters 2 and 3), alternative explanations for this finding are plausible. For instance, participants in this study may have altered their responses to surveys based on expectations that the researchers would use their answers to determine eligibility to receive aid. This is a complication that is particularly relevant to contexts in urban SSA, characterized by extreme poverty, uncertainty, and inequity, as well as substantial presences of international humanitarians and researchers (which locals may sometimes find difficult to differentiate). Further, the precise mechanism by which playing the role of volunteer caregiver might influence mental health remains unclear. As

I argue in this chapter, understanding ritual and its role in motivating volunteers is a necessary step towards elucidating such mechanisms.

The third assumption – that local African communities are full of "untapped" moral and social energy – is arguably a principal myth within global health and development circles. This myth is apparent in discourses of major international NGOs (see Chapters 1 and 6). Likewise, the Secretary General of the United Nations noted in his statement on International Volunteer Day 2008 that "The altruistic spirit of volunteerism is immense and renewable. On this International Volunteer Day, I urge all members of our global community to tap this great reserve of energy and initiative."[42]

As I have argued in this dissertation, there are multiple ways to interpret the so-called "spirit" and "good will" that international NGO, public health, and donor communities are so keen to "tap" and "harness." On the one hand, people who have been affected by HIV/AIDS are often uniquely capable of providing compassionate chronic disease care. Volunteers may be particularly well positioned to understand "what really matters" for patients: what would improve their lives, their illness experiences, and their experiences of uncertainty and vulnerability. In other words, volunteers may often be people who are able to deliver highly culturally-competent care (Kleinman & Benson 2006). And as I have shown in Chapter 3, many volunteers serving on the front lines of the struggle to roll out antiretroviral therapies say that they derive spiritual satisfaction and meaningful relationships by helping others (and see Rödlach, 2009). Thus from this perspective, community health programs appear to have the potential to generate psychosocial and health "capital" derived from volunteers' "good will."

[42] See http://www.worldvolunteerweb.org/fileadmin/docdb/pdf/2008/World_Volunteer_Web_stuff/IVD_reports_2008/ Ethiopia_IVD_2008_report.pdf [Accessed 2 March 2010].

On the other hand, the production of such psychosocial benefits could mean that the pro-social "spirit" of volunteers – not just their physical labor – is usurped by the programs that they serve. From this perspective, the organizers of volunteer workforces attempt to generate and maintain Durkheimian solidarity or "shared emotional energies" (Collins, 2004) among volunteers and the communities they serve. The main goal of this chapter is to show how the ritual reinforcement of pro-social values among volunteers occurs in situations ranging from appreciation and initiation ceremonies to every-day interactions between supervisors, patients, and volunteers. Matching t-shirts, group songs and photo-ops, food, and shared expectations of mental satisfaction and divine rewards are common ingredients in such situations. The psychosocial capital that these activities seek to generate through these rituals is apparently highly valuable for sustaining volunteers' motivations and the programs that rely on them. Health programmers in SSA recognize this ritualized economy of psychosocial capital, but it has gone unexamined by social scientists.

The remainder of this chapter is organized as follows. First, I review the work of anthropologists and sociologists examining the motivations of local volunteers and their fellow community members, vis-à-vis the expectations of international NGO programmers and funders associated with population health and development programs in SSA. These analyses have yielded useful insights that help to displace a narrow conceptualization of sustainability within population health and development programs. Yet I argue that these studies can be extended by focusing on the use of group ritual in attempting to produce social solidarity and pro-social motivations – key resources for program sustainability. Thus, I provide a brief overview of interaction ritual theory (IRT),

drawing on the Durkheimian micro-sociology of Randall Collins (2004). This overview provides the basic concepts and propositions needed to understand the role that rituals play in sustaining volunteers' motivations and the HIV/AIDS treatment programs that rely on them. Subsequently, I describe the HIV/AIDS programs in Addis Ababa and the data that inform my argument, and the methods that I employed in gathering these data. Thus the analytical core of this chapter describes and interprets an array of macro-rituals (e.g. volunteer recognition ceremonies) and micro-rituals (e.g. every-day domestic interactions between volunteer caregivers and patients), which I observed while conducting fieldwork with two internationally-funded local Ethiopian NGOs that support the HIV/AIDS treatment program of a large public hospital in Addis Ababa. I conclude by charting some future steps for advancing a fully-fledged analysis of how ritual produces variation in individual and group level motivation and solidarity in different development-related contexts bridging global and local processes and actors.

Motivation amid patron-clientism and economic insecurity

A handful of anthropologists and sociologists have examined the motivations of local volunteers vis-à-vis the expectations of governmental and NGO programmers and international funders associated with population health and development programs in SSA. These scholars have largely focused on how social traditions of patron-clientism and experiences of modern economic insecurity motivate local African elites and non-elite laborers and "beneficiaries" alike, and how the expectations of these individuals are often incongruent with the expectations and programmatic goals of international donors

and policy-makers, who tend to assume individualistic and prior intention-based models of motivation and behavior change (Johnson-Hanks, 2005).

For example, Daniel Jordan Smith (2003) situated the kin and non-kin networks of patronage (often referred to by outsiders as "corruption") within the local political economy and culture of southeastern Nigerian government officials involved in a family planning project funded by UNFPA. Smith pointed to the irony revealed by an in-depth understanding of how divergent priorities among local officials and international funders could harmonize when it came to carrying out training workshops: the locals could use the per diems and other resources made available through workshops to expand and satisfy their patron-client networks, while UNFPA could happily document the amounts of money it spent on these workshops, which were theoretically successful in regards to its Western notion of "knowledge-transfer."

Kaler and Watkins (2001) examined the goals of low to middle-income women who served as community-based distributors of family planning resources to rural beneficiaries in western Kenya, functioning as on-the-ground laborers for a joint program of the Kenyan Ministry of Health and the German government's international development agency (GTZ). They found that these "street-level bureaucrats" promoted the use of family planning methods while simultaneously seeking to become more prestigious patrons to networks of clients among their fellow community members and beneficiaries.

Jennifer Johnson-Hanks (2005), in seeking to understand the motivations of southern Cameroonian women in regards to "family planning," found that for her informants, "[t]he challenge is not to formulate a plan and implement it regardless of

what comes but to adapt to the moment, to be calm and supple, recognizing the difference between a promising and an unpromising offer." Johnson-Hanks refers to this model of motivation as "judicious opportunism" (an alternative to a Western rational choice model), which is "widespread in social action, both in sub-Saharan Africa and in the rich West, whenever the social structures that enable and enforce rational choice are absent or weak" (p. 370). In her analyses, she draws limited attention to bygone eras of Cameroonian life in which ritual helped to manage the uncertainty that has always been inherent in "vital conjunctures" – those specific instances in the lives of young women, such as finishing school, marrying, and reproducing, "when multiple alternative futures are available or under reconsideration" (p. 377). Johnson-Hanks sees vital conjunctures in modern African life as strikingly mundane; in other words, uncertainty is no longer experienced acutely, but rather chronically, or even as "acute-on-chronic" uncertainty. What seems missing is an understanding of how the rituals that used to help manage uncertainty no longer function in the context of severe economic insecurity, as well as how new ritual forms at the micro-level continue to function, if imperfectly, to help manage uncertainty.

More recently, Swidler and Watkins (2009) analyzed the social consequences of donor-funded AIDS programs in Malawi that operate within a narrow conceptualization of sustainability: namely, that a health/development project is "sustainable" if it can be taken over by local organizations when the donors and implementers that financed the start-up pull their resources out (as opposed to a broader "triple bottom line" notion of sustainability that asks what are a program's economic, social and environmental impacts) (cf. Hacking & Guthrie, 2008). Swidler and Watkins identified a reliance on

volunteers, training workshops, and income-generating projects as common ways in which international donors seek to promote community health and autonomy but often end up feeding interrelated experiences of economic insecurity, disempowerment, communal envy, and modern desires for economic status among local "beneficiaries" and elites alike. To quote Swidler and Watkins at length on the narrow logic of sustainability:

> If funders will not finance substantive projects ([voluntary counseling and testing], nutrition supplements, paid healthcare workers, paid teachers or counselors) on an on-going basis because they would not be sustainable, then "training" is one of the only fundable activities…. If the only way volunteers can legitimately receive material compensation in a sustainable program is through the [unpredictable] per diems and transportation money they receive for training, then training needs to come often to keep volunteers "motivated"… Training and workshops provide the occasions when like-minded aspiring elites can gather, soaking up authoritative wisdom and reinforcing modern identities. So sustainability both requires and reinforces not only the link between volunteering and the modest rewards of attending workshops and participating in training, but also the elaboration of complex truths which are taught and reinforced in those workshops. Belief in these complex truths in turn strengthens volunteers' commitment to identities that the trainings reinforce, as donors hold out hopes of funding, or even jobs, which all too rarely materialize. (p. 1190)

Alexander Rödlach (2009) has examined the motivations of HIV/AIDS care volunteers in Zimbabwe. As in other contexts in SSA, the Zimbabwe government has

promoted community- and NGO-based models of health care that rely on trained volunteers to provide basic material, social, and nursing support to AIDS-affected households. Rödlach echoes the key message that uncertainty in the day-to-day socioeconomic lives of volunteers and their care recipients threatens to undermine pro-social motivations and the under-funded programs that rely on them (and see Chapter 4). The volunteers he encountered claimed to be motivated by a mix of religious values and empathy for the suffering of others, as well as by desires for prestige, expanded social networks, and material benefits. Rödlach (2009) concludes that, in order to promote volunteers' commitments to caregiving, more integrated recognition for volunteers – including occasional *free meals* – is required from the public health system, NGOs, community leaders, and church groups. This conclusion suggests, but does not examine critically, the role that ritual can play in motivating volunteers. Meals after all constitute more than just physical nourishment; they are potent ingredients in fostering collective attention and solidarity among people (Farb & Armelagos, 1980; Mintz & DuBois, 2002).

The ethnographically-grounded analyses reviewed above have yielded useful insights into the ways that inherently hierarchical social networks and socioeconomic insecurities play key roles in shaping the motivations, hopes and behaviors of African men and women involved in population health and development programs as "beneficiaries," low-level laborers, or project coordinators. As Ann Swidler and Susan Watkins (Swidler, 2009; Swidler & Watkins, 2009) have argued, these insights are necessary in moving from narrow and counter-intuitive conceptualizations of sustainability in population health and development towards understandings that are more

consistent with the triple bottom line notion of sustainability theorists. But these studies can be extended by focusing on the use of social ritual in attempting to produce social solidarity and pro-social motivations – key resources for program sustainability in contexts of resource scarcity and economic insecurity.

INTERACTION RITUAL THEORY

Overview

Rituals can be defined in a broad sense as social acts, of small or large scale, that are to some extent stylized, repetitive, and stereotyped (Rappaport, 1974; Kottak, 2006). People often think of rituals as religious – but rituals happen all the time in secular life, whenever people come together with some degree of common purpose and shared attention. In fact the word *religion*, derived from Latin *religio*, simply means to "reconnect," to come together once more, perhaps repeatedly and on a regular basis. Thus people do not necessarily perform rituals in particularly sacred spaces and at set times. Though to some extent many rituals include what are called *liturgical orders* – "sequences of words and actions invented prior to the current performance of the ritual in which they occur" (Kottak, 2006, p. 474) – such liturgical orders need not be especially religious. Instead they often can be thought of as more secular cultural scripts. Ritual is in fact consistent with an epidemiological view of culture, which sees cultural knowledge as socially distributed in time and space rather than as a fixed stock of cultural knowledge and beliefs that are always universally shared within a group (Collins, 2004).

A functional approach to ritual has been emphasized by sociologists and anthropologists Emile Durkheim (1915 [1965]), Erving Goffman (1967), and Victor

Turner (1969). Whereas Durkheim focused mainly on the role of religious ritual in fostering social solidarity, Goffman applied a theory of ritual to everyday secular social interactions, including face-to-face conversations. For Turner, ritual is a space and time for the creation of novelty. Rituals occur in between mundane day-to-day action, which is by comparison to ritual severely restricted by individual and group tendencies to categorize and draw boundaries in an effort to keep chaos at bay (Turner, 1969, p. vii). Rituals also produce what Turner calls *communitas*, an intense group "spirit," or a "feeling of great social solidarity, equality, and togetherness" (Kottak, 2006, p. 276). The idea that religion and rituals can also function to reduce anxiety and dampen fears was proposed by Malinowski (1978/1931). And yet Radcliffe-Brown made a strong case that rituals and their associated beliefs can also *create* a sense of anxiety and insecurity: if such a sense of anxiety is alleviated at the *conclusion* of the ritual (for instance a group circumcision ritual), then anxiety may function to strengthen the bonds between those who undergo the tumult (Radcliffe-Brown, 1962/1965).

Interaction ritual theory (IRT) is a theory of rituals in the broadest sense, thus including large- and very small-scale ritualized behavior in religious and secular contexts. With this broad focus, IRT in fact attempts to explain the dynamics of individual and group motivation, cohesion, affect, devotion to shared symbols, and behavior (Collins, 2004). IRT thus defines a concrete mechanism for understanding when new cultural (i.e. shared) symbols are generated, and when old symbols either remain motivating or "fade away" as no longer meaningful or moving. However, IRT is not a teleological functionalist theory for why rituals are *always* successful in motivating people and promoting devotion to shared symbols (contra Comaroff & Comaroff, 1993); rather IRT

is a theory of dynamic social processes involving rituals that range from utter failure to overwhelming success (cf. P. Richards, 2005). IRT can thus be applied to many (perhaps all) realms of collective human experience, from conflict and consumerism to agriculture and addiction (e.g., A. Richards, 1939; P. Richards, 1993, 2005). My aim is to show that IRT can be applied from an objective standpoint to the realm of motivating volunteers and thus to the sustainability of HIV/AIDS treatment programs in SSA that rely on volunteers.

What ingredients go into successful interaction rituals?

The ingredients that go into various types of rituals that ideally function to sustain the pro-social motivations of AIDS care volunteers in Addis Ababa include the meeting quarters at which people congregate (public squares, homes, community centers, and NGO conference rooms), food and coffee and their accoutrements[43], antiretroviral pills and other medicines, songs and dances, matching t-shirts and hats, as well as shared discursive symbols such as the selfless volunteer and the drug-adherent patient.[44] In addition, the divine entities (God and saints) that protect and reward human endeavors are often invoked in everyday rituals experienced by volunteers – even those serving nominally secular NGOs.

According to Collins (2004), the central mechanism of IRT concerns assembling various essential ingredients – physical spaces, symbols, rhythmic patterns of movement and sound, and various kinds of material resources – in order to (ideally) provide for shared attention and emotional entrainment among subjects. Thus, occasions that

[43] Note that the consumption of coffee in northern Ethiopia is bound up to a great extent in long-standing but evolving rituals (see Pankhurst, 1997).
[44] The converses of these discursive symbols can also appear in rituals – the selfish and undedicated volunteer, the "difficult" and non-adherent patient.

"combine a high degree of…emotional entrainment – through bodily synchronization [and] mutual stimulation/arousal of participants' nervous systems – result in feelings of membership that are attached to cognitive symbols; and result also in the emotional energy of individual participants…" (Collins, 2004: p. 42).

Central to IRT is the proposition that the ingredients of rituals are *variables*; that is, they can either be present or not present, and present to varying degrees. The variable nature of the ingredients gives rise to the variable outcomes of rituals: more or less shared attention, emotion, and action (i.e. intersubjectivity), and thus higher and lower degrees of motivation or commitment to shared goals, as well as stronger or weaker shared attachments to (more or less sacred) symbols. Collins notes that, though Durkheim may have been averse to the idea, social solidarities or "collective conscience" can exist in pockets rather than across all segments of a society. This is consistent with an epidemiological or distributed understanding of culture, emotion, and motivation. In the context of the present study, these psychosocial resources may exist to varying degrees in different NGOs, and even in different sub-groups of volunteers and supervisors within a single NGO. While it may seem that availability of material resources determines such differences, IRT suggests that how such resources are used in the context of group rituals more directly influences the degree of shared motivation in a group.

What is shared emotional energy?

Shared emotional energy and social solidarity go hand-in-hand, and refer specifically to shared feelings of enthusiasm and confidence – the opposites of depression and isolation – as well as to shared desire to move along what is considered a morally proper path or towards a morally proper goal (Collins, 2004). Emotional energy thus

entails a general feature of social life and what an individual feels enthusiastic and confident about, the latter varying with one's experience of successful or unsuccessful rituals in a certain life domain (e.g. household, work, romance, school). Drawing on Durkheim (1915 [1965]), Collins notes that emotional energy is a "morally suffused energy," in that it produces collective feelings of not only enthusiasm, but also exaltation in doing what is believed to be important and valuable (cf. Haidt, 2007). Groups tend to hold periodic ritualized assemblies to sustain these feelings, because such feelings are not permanent, but rather naturally fade over time if they are not "resuscitated" by another ritual. The feeling of emotional energy "has a powerful motivating effect upon the individual; whoever has experienced this kind of moment wants to repeat it" (Collins, 2004: p. 39). Further, it is the experience of intersubjectivity and emotional energy in group rituals that generates conceptions and symbols of what is good, right, and true:

> For Durkheim, the touchstone of morality, and of the sacred, is that which is a value in itself, apart from its utilitarian value. Respect for sacred objects, and for the group sentiments behind them, is a higher value than the merely mundane, individual consideration of "useful or injurious effects." … [W]hat holds society together is not self-interest, and it is only where utilitarian exchanges are embedded in ritual solidarity that any sustained cooperation on practical matters can take place. (Collins, 2004: p.40)

Thus IRT claims to be capable of explaining altruism in many forms.[45] As I argue in this chapter, sustained cooperation between unpaid laborers (“volunteers”), supervisors, patients, and international donors on the practical matter of home-based HIV/AIDS care in Addis Ababa depends on ritually-infused “sacred” symbols such as the drug-adherent patient as well as the selfless volunteer caregiver. As individuals, AIDS care volunteers do not necessarily calculate consciously the emotional costs and benefits associated with various courses of action; rather, according to Collins (2004), emotional “attraction” or lack of attraction leads individuals into behaviors unconsciously. Rituals have the ability, but are not guaranteed, to motivate individuals to behave altruistically, by rewarding such behavior with positive emotional energy, a shared sense of moral purpose, and often boosted social status, which is also emotionally rewarding. IRT predicts that the higher the level of “success” in collective rituals, the more people will sacrifice to serve the interest of the group. “This…is well known to fund-raisers who time their collections just after the emotional high point at rallies and meetings, and who attempt to build up a rhythmic crescendo of gift-giving or pledge-making within the group.” Even risking one’s life, the ultimate sacrifice from the point of view of individual self-interest, “occurs regularly when well-integrated groups are mobilized against collective danger or for inter-group combat” (Collins, 2004: p. 169; cf. Richerson & Boyd, 2001). HIV/AIDS is often referred to as a sort of “collective danger” to households and nations, against which communities – and self-sacrificing individuals – must battle.

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[45] An in-depth appraisal of this claim is beyond the scope of this dissertation. See Brown and Brown (2006) and the commentaries accompanying that article.

How does IRT account for power and status hierarchies?

Collins (2004) asserts that IRT accounts for power and status differentials within organizational settings. This is an important aspect when it comes to explaining the obvious hierarchy in AIDS care NGOs in Addis Ababa and elsewhere: despite the fact that they are unpaid (or at best irregularly and meagerly remunerated), volunteers cooperate with the requests and demands of nurse supervisors, local NGO and government officials, hospital personnel, and international NGO partners and funders. Drawing on Goffman, Collins explains the generic context of cooperation and conflict between workers and managers on a factory floor:

> The everyday reality of…the supervisor trying to get the workers to work harder [and] the workers putting on a show of compliance during the moments when they are ceremonially confronted by the manager…is a kind of theatrical performance; both sides generally know what is real or unreal about the situation; both put up with it, as long as the show of respect is maintained. The show of cooperation is the situational performance through which conflicting interests are tacitly managed. (p. 21)

According to IRT, getting AIDS care volunteers to do what is asked of them is possible precisely because their day-to-day experiences as volunteers are a succession of ritualized situations that constrain both themselves and their supervisors to keep up a shared impression of reality. In the case of AIDS care and treatment support in Addis Ababa, the reality that volunteers and their superiors work to keep up is constituted by several fundamental beliefs that correspond to the assumptions outlined in the

introduction (that volunteerism is "economically imperative" for the sustainability of public services; that volunteer or altruistic service and care can be beneficial to the psychosocial wellbeing of the giver; and that local communities are full of "untapped" moral and social energy). Volunteers and their superiors put up with what they may know to be "unreal" about these beliefs. For instance, volunteers, supervisors, and international funders tend to downplay volunteers' desires for fair and predictable wages for their labor, as well as the paradox that highly sophisticated "life-saving" antiretroviral drugs are available while access to basics like food and employment remains very uncertain for volunteers and patients alike. As suggested by previous chapters in this dissertation, food is an essential ritual ingredient: its presence or absence can have significant effects on individual and group motivation (cf. Farb & Armelagos, 1980; Mintz & DuBois, 2002).

METHODS

I conducted participant observation in neighborhoods adjacent to ALERT hospital and within the compounds of ALERT, *Hiwot*, and *Medhin*, including attendance at volunteer trainings and other major volunteer-focused events, volunteers' and care recipients' homes, and volunteers' reporting and planning meetings, over 20 months between May 2007 and January 2009. I took extensive field notes, which I typed on a daily basis for subsequent coding. During participant observation, I was typically able to communicate with informants via a mix of English and Amharic (I developed a working proficiency in Amharic reading, writing and conversation). Field notes were recorded primarily in English; in addition I recorded important terms and phrases in Amharic script. I often

took digital photographs and short digital videos using a small dual-purpose camera, in particular at volunteer caregiver meetings, trainings, and major events. I usually did not use the camera at the homes of patients and volunteers.

Additional data come from a 2005 video-recorded "graduation" and "initiation" ceremony for a large group of out-going and in-coming volunteers serving the *Hiwot* organization, which was provided to me in VHS form by the organization's staff.[46] I also analyzed discourses of patients, volunteer caregivers, NGO and government officials, as well as interactions between volunteer caregivers and patients, portrayed in a 13-minute documentary film produced by Family Health International in 2005, available by request on their website.[47] Parts of the film include staged patient home visits by two female volunteers from the *Hiwot* organization whom I came to know through interviews and regular interaction over the course of my fieldwork.[48] Finally, a purposive sample of 13 volunteer caregivers (seven newcomers [five female and two male], and six veterans [five female and one male]) were recruited to complete a series of up to seven semi-structured

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[46] My host "mother," with whom I lived for over a year, viewed the VHS recording with me and helped to explain what was happening and being said at various points. The *Hiwot* NGO did not hold a similar ceremony during my fieldwork, even though they insisted that they were planning one. I was told that the delay was due in part to staff turnover in the home-based care coordinator position within the NGO.

[47] The video contains English subtitles during the interactions between patients and volunteers. From the FHI website: "Family Health International has produced a 13-minute documentary on the link between home-based care and safe and effective provision of antiretroviral therapy (ART). The digital film documents the work of volunteer caregivers in Ethiopia as they help clients initiate and adhere to complex ART regimens. The film focuses on clients at home with their families and discusses the challenges they face adhering to ART as they grapple with nutrition, child care, income generation and other day-to-day issues. In addition to interviews with clients and caregivers, the film includes interviews with Sister Tibebe Maco, executive director of the HIV/AIDS Prevention, Care and Support Organization; Dr. Ashenafi Haile, head of the HIV/AIDS Prevention and Control Office, Addis Ababa; Dr. Eyob Kamil, head of the Addis Ababa Regional Health Bureau; and Dr. Yigeremu Abebe, head of the ALERT Free ART Program. The documentary is of interest to HIV/AIDS programmers hoping to ensure adherence and minimize drug resistance as they expand ART provision. For a copy of the film on DVD or Video CD, please contact aidspubs@fhi.org." (http://www.fhi.org/en/HIVAIDS/Video/ethiopia.htm) [Accessed 17 March 2010]

[48] One of the young women had "graduated" from the service and became one of the select few who received a low-wage job from her NGO. The other young woman had remained a volunteer for a subsequent round of service, and was considered by her supervisors and peers to be an outstanding volunteer in terms of her willingness to take on an incredible (from my perspective at least) caseload.

interviews assessing motivations, costs and benefits of volunteering, food insecurity, care relationships, and wellbeing. Interviews occurred over eight months in 2008, and were conducted by the author with help from local research assistants. These interviews were digitally recorded, and texts were transcribed and translated by the author with local research assistants. Texts, as well as field notes, were then coded by the author using MAXQDA software (VERBI, Marburg, Germany), involving an iterative process of identifying emergent themes and grouping data into *a priori* and *in vivo* coded categories.

MACRO RITUAL

Volunteer Initiation and Graduation

In October 2007, I viewed a video-recording of the 2005 graduation and initiation ceremony for the *Hiwot* NGO's volunteer caregivers. The ceremony took place in a hall belonging to the Addis Ababa municipality, arranged in the familiar western fashion with a large, raised stage and expanding rows of seats. All the volunteers were seated towards the back of the hall, and officials from the *Hiwot* NGO, Family Health International (FHI), and the Federal HIV/AIDS Prevention and Control Office (HAPCO) and other guests were seated up front. A banner hung across the stage, and the white cotton t-shirts that all the caregivers were wearing, named the event as the "Home-based support and care-givers blessing ceremony" (*yäbet wïst dïgafïna ïnkïbïkabe agälgïlot sächïch yämäräqa bä'al*).

The ceremony started with a synthesizer-accompanied dance (of the well-known Gurage ethnic style) performed by a hired group of very good male and female dancers. Following this performance, the volunteers received a printed handout of lyrics to a song

which they were to sing together. It is notable that this is the same song performed at the Ethiopian Volunteers Day ceremony described in the next section, and was written by an office staff person within the *Hiwot* organization. The theme upon which the song is based is the "promise" or "covenant" (in Amharic, *qal kidan*) that volunteers make to serve people living with and children affected by HIV/AIDS. Three teenage girls on stage led the song, while all of the volunteers – both the initiates and graduates – sang along while remaining seated in the audience.[49] I noted that the volunteers looked less bored as they joined in the song (many were smiling), compared to their countenances during the dance performed previously. After the "promise" song, another traditional song and dance (this time of the Amhara regional style) was performed with synthesizer, a singer, and the same group of male and female dancers. Subsequently, the audience listened to a song performed by a dozen or so young boys and girls affiliated with the *Hiwot* NGO, the Amharic lyrics of which exhorted the volunteers to care for people living with HIV/AIDS as well as orphans and vulnerable children, and to confront and reduce HIV-related stigmatization, in order to minimize Ethiopia's loss of productive families to HIV/AIDS.

The Director of the *Hiwot* NGO then made her speech in Amharic. She thanked FHI, the Ethiopian North American Health Professionals Association (ENAHPA), and the head of HAPCO. She recounted that her organization had served over 1500 beneficiaries in the past year, and noted that, "Though the volunteer caregivers have worked very hard, today they renew their promise."

[49] It is also noteworthy that both times that I observed this song, it was not volunteers themselves who led it; rather they were expected to sing along as audience members while younger people performed the song. It makes me suspect that the song is viewed by the *Hiwot* NGO staff as a useful tool not only in motivating current volunteers, but in socializing youth into desiring to take up a similar role in the future.

Next, an unidentified official from FHI/Ethiopia made a speech in Amharic. She thanked the volunteers for sacrificing their time, and said she did not have words to express her appreciation, but that applause would do the trick. She said that the work of volunteers is the kind that gives mental satisfaction: "Your mind is satisfied from giving care and fulfilling your responsibility to the nation."

Next, the medical director of ALERT Hospital's HIV/AIDS Department and treatment program gave his speech in Amharic. He "bore witness" to the incredible job that the volunteers were doing, setting an example for their friends and sacrificing so much of their time. He described ALERT Hospital's antiretroviral therapy clinic as a pioneering program that depended on them, and lamented that many physicians do not respect the volunteers or realize the importance of their work.

A highlight of the event followed when a nurse supervisor from the *Hiwot* NGO took to the stage and instructed the volunteers to get out the candles that each of them had been given. Matches were passed around so that each volunteer could light her candle. All then stood up from their seats, placed their left hands over their hearts, and in unison chanted an oath. They promised, in God's name, to give proper care, putting the patients before themselves; to keep secret the HIV status of their patients until they die or choose to publicly disclose their status; and to prevent the spread of HIV.

Subsequently, the coordinator of the NGO's home-based care program took to the stage and called the volunteer graduates by name. As they approached the stage, some carried the umbrellas and backpacks that had been given to them by the NGO. They each received their certificates from the head of HAPCO, who was all smiles. He then made his speech, smiling naturally as he spoke. He, too, acknowledged that the work of the

volunteers is very difficult, and that they sacrifice themselves. He told the initiates that they will be satisfied when they see their patients improve. Finally, he reminded the volunteers to keep their promise, and vowed that he and his fellow officials were there to help and encourage them.

Ethiopian Volunteers Day

I attended the second annual Ethiopian Volunteers Day (EVD) celebration on May 17, 2008, a Saturday. The event was organized primarily by the Ethiopian Association of Voluntary Services (EAVOS) and the *Hiwot* NGO, with funding from Family Health International (FHI).[50] The roughly two-hour-long celebration was located in Volunteer Square, which had been dedicated the previous year at the first annual EVD.[51] It is notable that Volunteer Square is actually a small traffic circle located on the ring road, on the southwest outskirts of Addis Ababa, not far from the city's major landfill. The "square," unlike other monument-surrounding squares in the center of Addis Ababa, is anything but a central gathering place or space of collective imagination.[52]

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[50] Prior to the celebration, I had interviewed the head of EAVOS, who explained that May 17 was chosen for historical reasons – it is the day that humanitarian organizations "officially" started operations during the 1974 Ethiopian famine. International Volunteer Day (IVD, December 5), created by the UN General Assembly in 1985, was also celebrated in 2008 at Volunteer Square in Addis Ababa, with the theme "Volunteer for Change and Ethiopian Renaissance," but I did not attend as the focus was not on volunteer HIV/AIDS caregivers. See http://www.worldvolunteerweb.org/fileadmin/docdb/pdf/2008/World_Volunteer_Web_stuff/IVD_reports_2008/Ethiopia_IVD_2008_report.pdf [accessed 2 March 2010].

[51] The first annual EVD was timed just a few months before the nation-wide celebrations of the "Ethiopian Millennium." The Orthordox and state calendars in Ethiopia are ante-date the European calendar by roughly seven years. Thus on September 11, 2007, the Ethiopian calendar reached the first day of the first month (Meskerem) of the year 2000. This was cause for major state-led celebrations and development-focused initiatives, including the control of HIV/AIDS. The Ethiopian Calendar date of the second annual EVD that I attended was 9th of Genbot, 2000.

[52] The location provided the opportunity for drivers of passing trucks, buses and autos to look in on the action as they skirted around the circle. It is amusing to see so many vehicles going by in the background of all the video and photos I shot. Even though EVD was located on the periphery as opposed to the city center, many young men and boys had come to watch the event from the surrounding neighborhood. These low-status youths might be viewed as hoodlums, and thus the traffic police who were on duty at the circle

When I walked up to the circle (the bus on which I arrived dropped me a couple hundred meters away), a group of volunteers whom I knew came to greet me, followed by a few of their supervisors, and then the director of the *Hiwot* NGO. The latter led me by the hand into the crowded traffic circle, and seated me under the "VIP" tent, where I saw the director of EAVOS and other guest speakers for the event. I was told after the fact that approximately 500 volunteers were packed into the roundabout, seated in the sun or under temporary tents colored red, green and yellow (the colors of the federal Ethiopian flag). All of the volunteers, I later learned, were caregivers from the *Hiwot* NGO; none of the volunteers from the *Medhin* NGO, nor any other Addis Ababa NGO with substantial numbers of volunteers, took part in the event.[53]

At the beginning of the program a sheet was passed out by EAVOS that provided a short background on EVD as well as an overview (in Amharic) of this year's theme: "Let us protect youth from HIV by involving them in volunteer service." A similar message was printed in Amharic on the white cotton t-shirts and cardboard sun-visors that were passed out to and worn by the vast majority of volunteers and others present (including senior staff from the *Hiwot* NGO): "Let us protect children from HIV/AIDS and spread volunteer service" and "Everyone should give volunteer service in order to improve the country." EVD unfolded with a series of speeches by organization elites, and dances and songs performed by youths affiliated with the *Hiwot* NGO, all taking

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were also keeping a close eye on this particular group of onlookers. At one point some event organizers were pushing the youths back from encroaching too far into the circle. They did not cause any trouble, but it was interesting to see the virtually unchanging dead-pan expressions on all their faces throughout the event's many speeches and performances. Once in a while I saw a couple of the boys applaud, but in general they looked on with apparent contempt.

[53] The theme of the second annual EVD was HIV/AIDS; though the *Hiwot* NGO is the largest organization running volunteer-based HIV/AIDS care programs in Addis Ababa, there are several other prominent organizations, and it is not clear why none of them participated. The coordinator of the Medhin NGO's AIDS care program did not even know about EVD when I asked her about it during the week prior to the event.

place in the center of the roundabout and making use of a basic public address system and electronic synthesizer. As in the graduation/initiation ceremony described above, however, not a single volunteer caregiver addressed the crowd. Instead volunteers were merely audience members – applauding and exclaiming at times in response to the speeches and performers, and talking amongst themselves.[54]

Those in attendance were welcomed with a song performed by a young woman, who wore one of the t-shirts produced for EVD, accompanied by a male keyboardist and a familiar style of Ethiopian dance performed by four young women and men. Volunteers in the audience ululated and clapped with the beat, encouraged to do so by the singer.

The director of EAVOS then delivered an opening address in Amharic, in which he more or less reiterated the background and theme of the EVD celebration in the patriarchal vocal style of male Ethiopian politicians. Though he was not wearing one of the t-shirts or visors passed out, in the middle of his speech a man approached him and placed a visor on his head. The next speech was delivered in English by a non-Ethiopian African woman representing UNDP and the UN Volunteers program, which addressed "the need to promote voluntarism." She said that Ethiopians, like all Africans, value volunteering along with compassion, love, and care. She quoted an "African" proverb: "When an African cries, everybody comes running." She emphasized the need for more volunteering, and said that the joy that comes from volunteering is a great reward.

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[54] A couple days after EVD, I spoke with the director of the *Hiwot* NGO about the program. She informed me that the Federal HIV/AIDS Prevention and Control Office (HAPCO) Director was a no-show at EVD. The state-owned Ethiopian News Agency also did not show up to cover the event, though they apparently obtained footage from another news agency, and ran a 30-second story on Ethiopian Television on the Monday after EVD. Another *Hiwot* official joked about what the event would have been like if their own NGO had not participated: "It would have been just a meeting inside of a roundabout."

Subsequently, a woman whose organizational affiliation I was unable to determine recited a poem in Amharic that she had apparently authored. Wearing one of the paper visors, she energetically recited the poem with bodily gestures and vocal dynamism, generating a strong response of ululation and applause from volunteers in the audience. Roughly translated, her poem called attention to the empathy with which she views the suffering of fellow urban Ethiopians:

> …If I didn't feel your pain, how could I be called a human being?
> …If I didn't feel your sorrow, I am like the devil that only seems human.
> …I am restless for my people, who are lying on the street.
> Did you see the mother lying on the street with her children?
> …Don't give her a bad face, by saying, "Why did you bring these kids into the world?"
> ...Life by itself is punishing her, so don't help it.
> …The solution is on your hand. Fulfill her interest, fulfill her interest.
> I won't stand by, saying, "God help you."
> I will help you with the capacity that I have.
> Let God help us all to do this.

Following the poem, the director of the *Hiwot* NGO delivered a lengthy address in Amharic, in which she spoke about the history and current extent of her organization's home-based care programs, bestowed praise on her large cadre of hard-working volunteers, and thanked her organization's many donors. She wore the t-shirt and sun-visor that had also been distributed to the volunteers present, and she received applause at various points in her address. Of note was her use of a certain metaphor to illustrate the role of individual AIDS care volunteers: a volunteer caregiver is a candle, giving light and hope to her patients while herself melting away in self-sacrifice. This is particularly noteworthy for two reasons. First, it recalls the actual candle-lighting ritual in the volunteer graduation/initiation ceremony described above. And second, when I

interviewed one of my in-depth volunteer informants [ID #83] twelve days after EVD, about whether volunteering for her was like a "sacrifice," she agreed and recalled this metaphor: "[The metaphor] very much affected me internally."[55]

A Senior Technical Officer from FHI/Ethiopia then delivered a speech in Amharic. She first welcomed and congratulated all the volunteers who attended the celebration, receiving a round of applause in return. Acknowledging her organization's funders; their local implementing partner for five years, the *Hiwot* NGO; and the Ethiopian government for dedicating Volunteer Square, she expressed her deep happiness "from the bottom of my heart," which drew another round of applause from the audience. She recalled that, early on in the HIV/AIDS care and support program in Addis Ababa, the period of service for volunteers was lengthened by her organization from 12 months to 18 months: "What is the reason? The caregivers were very interested to serve more than a year." To quote her speech at length:

> "When [we office people] go to see what [the volunteer caregivers] are doing, we see that they walk through the back alleys – even if there is rain, mud, or bad smells… They have helped many of us who work in the office – we who are not volunteers – by encouraging us to look at ourselves and question what we are doing… And we understand that their day-to-day activities are full of ups and downs; and yet they don't give attention for themselves. They are happy with what they are doing. [We office people] want

[55] According to IRT, the metaphor was so salient for my informant not only because it was particularly visual, but also because it was conveyed in the setting of a major group ritual. Further, there is a strong tradition of highly sophisticated metaphorical poetry in orthodox Ethiopian culture (Levine, 1965).

> to look after ourselves when it is raining… But these [volunteers] are giving their time for the patients instead of taking care of themselves… They even help the patients with money from their own pockets. I would be pleased if all of us could do their job – I believe that it would be an important opportunity to learn a lesson.… Ethiopia is a poor country, and we have many people. Unless we do more with volunteers, we will not get rid of our problems – not only HIV, but also poverty and lack of education. I want to explain that FHI, the Royal Netherlands Embassy, USAID, and other organizations are very motivated to continue and sustain the program. For the future, I wish you the strength and the interest to continue your good work for your country and your society. God will help you. Thank you." [Applause]

The FHI representative's speech was followed by the same "promise" song described in the previous section, this time performed by a group of young boys and girls affiliated with the *Hiwot* NGO, accompanied by a beat and music from the electronic synthesizer. Throughout the rather repetitive song, volunteers in the audience clapped with the beat and waved their sun-visors back and forth in the air, more or less in unison.

The final speech of the day was delivered in Amharic by the Ethiopia Country Representative of the International Foundation for Education and Self-Help (IFESH). Wearing one of the sun-visors distributed to the volunteers present, the representative joked about his old age, generating several instances of laughter and applause from the audience. He noted that the ceremony was much "warmer" than in the previous year,

because it was attended this time by so many volunteers. After thanking many of the other organizations involved, and more or less reiterating many of the messages of the day, the representative expressed how happy the volunteers make him feel, and highlighted that they, too, have the advantage of experiencing "mental satisfaction" through their service: "Therefore, don't keep this activity for yourself, but try to pass it on to your children as well…"

A revealing epilogue to this description of EVD 2008 is provided by an in-depth interview that I conducted just a few days after the event with another volunteer informant. At the end of our interview, I asked the respondent if she had anything she wanted to add. She brought up EVD, and said that many of the volunteers from her district were complaining amongst themselves during the celebration, and even talking about quitting, because they had heard that the *Hiwot* NGO's volunteers in other districts were getting more substantial food aid packages as remuneration for their services. Neither I nor my respondent knew whether this was true, but she clarified that the person who began the rumor at the event was notorious for such "talk," so it was possible that the idea (i.e. inter-district inequity among volunteers) was fabricated. And yet the existence of such gossip within the context of EVD illustrates 1) the Goffmanian components of interaction ritual theory, and 2) the importance of food as a key ingredient in rituals that are meant to sustain the motivations of volunteers in Addis Ababa. In regards to interaction ritual theory, it is interesting to ask whether such "talk" would have occurred at EVD if there had been a free meal involved in the celebration that day (cf. Rödlach, 2009). In regards to the chronic food insecurity experienced by the majority of AIDS care volunteers in Addis Ababa, it is also important to question whether such talk

would have occurred if the volunteers were paid regular wages that would allow them to afford sufficient food, instead of expecting them to "sacrifice" their time and resources in the service of donor-funded HIV/AIDS programs.

MICRO RITUAL

Patient-Caregiver Interaction and Every-Day Coffee Ceremony

In this section I provide a partial running timeline of scenes from a 13-minute "documentary" film produced by FHI. The rituals depicted in this video are of course staged by its producers, but that is the point. The video portrays every-day positive interactions in which volunteers and their care recipients *should* be engaging, thereby constructing a certain reality that is meant to motivate volunteers, treatment recipients, and funders alike. Even if the film is not used regularly in the training or motivation of volunteers, its existence vividly illustrates the way that every-day ritual interactions *ideally* function (that is, when they are successful) to motivate individuals to "adhere to" morally-infused promises to give unpaid care (in the case of volunteers) and to take their antiretroviral medicines as prescribed (in the case of patients).

Of note is the preparation of sugar-laden coffee and stew in the scenes that unfold within the homes of the two care recipients chosen for interviews in the film, as well as the absence of scenes (or "behind-the-scenes" situations) depicting the hang-ups and interpersonal difficulties that often arise in home-based care in a context of widespread food insecurity and unemployment. The two patients in the film both refer to the importance of having food in order to stay healthy and feed their families. And yet it is as if the food and coffee have materialized quite matter-of-factly, when in reality, accessing

food, whether at the market, from a neighbor, or as aid from the NGO, is terribly uncertain in the day-to-day lives of the majority of volunteers and patients I came to know in Addis Ababa. According to IRT, food and coffee are readily available and prominently displayed in the film precisely because they are necessary ingredients in smooth, successful interaction rituals between volunteers and care recipients. Such interactions are precisely what the film "documents," with the caregivers and care recipients engaged in rhythmic back-and-forth monologues and dialogues that highlight their ostensibly smoothly-timed day-to-day coordination of self-sacrifice, drug adherence, and improving health.

Within the first 30 seconds of the film, we see and hear the sound of sugar being stirred with a metal spoon into hot porcelain cups of Ethiopian coffee, accompanied by incense and smoke from the charcoals. Adults and children are present. This is an every-day and widespread ritual in many Ethiopian households – that is, when sugar and coffee are accessible.

From 3:09 to 3:50, with the medical director of ALERT Hospital's HIV/AIDS Department speaking in the background, we see a group of caregivers helping a patient out of mud house and onto a stretcher; the scene then cuts to the group of caregivers carrying the patient on a stretcher as they approach the entrance of a local health center. The scene cuts again to the caregivers helping the patient out of the stretcher and into the doctor's office, and cuts once more to the patient having her breathing examined with a stethoscope by the doctor in the office. Note that there is no portrayal of the inevitable delays and difficulties that come with transporting a bedridden patient from a remote urban neighborhood to a health center, such as the gathering of money to pay for a taxi,

or waiting to see a doctor, nurse, or health officer at a health center. Instead, there is a steady rhythm to the process as depicted in the film.

From 5:17 to 7:47, we first see a female caregiver enter a patient's corrugated metal house. Abebech (real name), a volunteer caregiver, speaks in Amharic to the camera while seated in her patient Fikirte's home: "[Fikirte] is the first of my patients to start [antiretroviral] treatment. She had many complications. I was giving her simple medications, according to my training." Fikirte then speaks: "The [NGO staff] came and took me to the hospital. They referred me for treatment. They told me to take the pills at 8am and 8pm… They assigned Abebech to follow me closely." The scene cuts to Fikirte seated in her home knitting. Abebech is fanning a cook fire, and a couple children are looking on. (At 12:05, we again see this sequence of Fikirte knitting, with Abebech fanning the fire with stew cooking in a pot.) Fikirte again: "Sometimes when I feel healthy and am busy with my children I lose track of time… And then Abebech comes and asks, 'Have you taken your pills?'… That was the beginning, but now I'm serious. I don't forget." Abebech: "The treatment has done a great job. It has saved the children from going to [institutional care]. They are growing with their mother. That's what is needed." The scene cuts to Abebech interacting positively with Fikirte's kids in the house. The scene cuts once more to Fikirte playing with one of her children outside the house, and a neighbor coming to visit. Finally, Fikirte again:

> "If Abebech had not been with me there would be no life. I say this in all respects. She helps me when I have nothing at home, until I get food items like sugar and wheat from the home-based care program. You can't take the pills without food since it burns

the stomach and gives you a hard time. Sometimes I wake up in the middle of the night feeling hungry. At these times [Abebech] goes to the neighbors and says, 'There is this woman with three children who is very sick and has nothing to eat,' and she brings me food to eat. She is my life. Without her I would not have been alive."

From 8:32 to 9:51, another female volunteer, Zenebech (real name), is talking with her care recipient, Almaz, within the latter's smoky house, showing her the antiretroviral pill bottles.

Zenebech: "So how do you feel Almaz?"

Almaz: "What I feel is the cough. The other feelings are OK. I feel better.

Z: "Do you think the drugs are helping you?"

A: "Yes."

Z: "How do you take [these pills]?"

A: "This one at 8 in the evening."

Z: "At 8?"

A: "One pill."

Z: "You take one pill from this bottle?"

A: "Yes."

Z: "What time?"

A: "Evening 8 o'clock, morning 8 o'clock."

Z: "Have you ever lost track of time?"

A: "No."

Z: “How about the pills in this bottle?”

A: “10 o’clock, three pills.”

Z: “So you take three of these at one time, at 10 o’clock.”

A: “Yes.”

After this rhythmic dialogue regarding drug adherence, the scene cuts to Zenebech speaking in Amharic to the camera while seated in Almaz’s house: “It’s been three months since Almaz started treatment… I come here and follow up to see if she’s taking it regularly, on time, and give her advice not to miss a pill or delay the time, even a minute.” Again the scene cuts to a sequence of burning incense, stirring and serving coffee in the patient’s home. Unseen, Almaz says:

> “The caregivers are giving me good care. I’m here because of them. If they had not been giving me emotional support and visiting me time and again, what would have happened to me? What would I have given my children to eat? What would I have eaten to take the drugs? It would have been impossible to feel better.”

At 11:05, the Head of the Addis Ababa Regional Health Bureau, Dr. Eyob Kamil, provides an on-screen monologue:

> “In countries like Ethiopia – where poverty is very high; and where the health infrastructures are very poor; [and] the quality of health service is very low; [and] where there are very few health professionals and clinicians – to strengthen the community-based

> services is extremely important. We have a lot of community members who are unemployed – [and] who are literate – who can give this service… Therefore…to allocate them in the community to give the service *is not an option, but it is mandatory*." [original emphasis]

Prayer/Meditation Session

On October 24, 2007, I attended a meeting with the volunteer caregivers from the *Medhin* NGO, led by the program's coordinator, a Catholic nun with whom I came to enjoy strong rapport by the end of my fieldwork. The night before, the coordinator had called to invite me to the meeting, and so I arrived at 9am in the NGO's compound, located adjacent to ALERT Hospital, an Orthodox church, and a community-based organization focusing on services for people living with Hansen's disease (leprosy).

The program coordinator was with the NGO's volunteers in one of the makeshift classrooms within the NGO compound. The coordinator was seated in front of the blackboard, talking to the caregivers as they sat on wooden benches facing her. I sat down in the front of the room with the coordinator and her male assistant. The coordinator then began asking the volunteers about what to do in different difficult scenarios they might encounter in the course of their day-to-day service. The first person to respond was the one male volunteer (age 35) in the room. There were 19 other female volunteers in attendance, ranging from about 20 to 40 years old. A few of them also responded to the coordinator's questions, but some of them looked bored. They each

were holding papers, folders, and small notebooks, and some of them – the ones who did not look bored – were taking notes. This went on for about 30 minutes.

The coordinator then told everyone to put down their papers and pens, and sit up straight. She closed the window and the door of the classroom. The caregivers folded their hands, closed their eyes, and looked downwards. The coordinator led the meditation in Amharic. I could not understand everything she said, but much of the time she was repeating the words, "May I have peace, may I have love," and invoking God's favor. I was keeping my head down, though I wanted to study the faces of the caregivers. I also listened to the noises outside – the voices of people in the neighborhood, the voice on the megaphone of the Orthodox church just across the lane, and the occasional hacking cough of a couple of the volunteers. When the coordinator brought the meditation to a close, after about 10 minutes, many of the volunteers spent a few seconds rubbing their eyes.

The coordinator later told me that she herself translated parts of the meditation from words of the Dalai Lama. She told me that a major aspect of their meetings in the past involved discussions of how to deal with having "bad thoughts" about their care recipients. I determined after a year or so of fieldwork had passed that the meditation session I attended that day was not a regular activity, at least not in the form that I witnessed. Whether or not the meditation that day served its intended purpose for the volunteers present, as I noted in my field notes, it certainly made my day more upbeat.

CONCLUSION

This chapter argues that understanding ritual is a necessary step towards elucidating the mechanisms by which HIV/AIDS treatment and care programs in Addis Ababa and other contexts attempt to promote volunteerism – specifically, by shaping adherence to shared assumptions about the need for and benefits of volunteerism. The ritual reinforcement of pro-social values among volunteers occurs in situations ranging from appreciation and initiation ceremonies to every-day interactions between supervisors, patients, and volunteers. Rituals, even if they are not always maximally successful in sustaining pro-social motivations, must be understood in order to holistically address various threats to the sustainability of development and population health-related programs in contexts of chronic economic insecurity. Such an understanding is, however, relatively neglected, despite the insightful work of a handful of anthropologists and sociologists addressing how ritual shapes war and agriculture in Africa (P. Richards, 2005), as well as how traditions of patron-clientism and modern experiences of economic insecurity shape motivations of volunteers and other "stake-holders" in population health program (Smith, 2003; Kaler & Watkins, 2001; Johnson-Hanks, 2005; Swidler & Watkins, 2009; Rödlach, 2009).

According to interaction ritual theory (Collins, 2004), AIDS care volunteers do what is asked of them, generally speaking, because their day-to-day experiences as volunteers are a succession of ritualized situations that constrain both themselves and their supervisors to keep up a shared impression of reality – and ideally that shared reality keeps volunteers motivated. In examining the discourses pronounced within the various major and minor rituals described above, I note several fundamental beliefs that

constitute the reality that volunteers and their superiors work to keep up: 1) volunteerism is "economically imperative" for the sustainability of the program; 2) volunteer or altruistic service is beneficial to the psychosocial wellbeing of the giver, and such benefits are achieved through the mediation of divine entities; and 3) local men and women (predominantly the latter, including their children) are potentially overflowing with "untapped" moral and social energy, making them willing and able to donate their labor. A fourth fundamental belief of course concerns the beneficial effects of volunteer-based home care for the recipients, in which "seeing patients get healthy" through adherence to antiretroviral therapies becomes a sort of mantra motivating volunteers.

Volunteers and their superiors downplay what they may recognize as fallacies in these beliefs – at least when they are interacting "on-stage" as opposed to more privately. As I noted previously, the existence of gossip regarding inter-district inequity in food-based remuneration among volunteers within the context of EVD 2008 illustrates this Goffmanian aspect of interaction ritual theory, as well as the salience of food as a key ritual ingredient. The latter is also especially apparent in the "documentary" film produced by FHI, which stages ideal, ritual interactions among volunteers and care recipients, complete with sugar-laden coffee and cooked stew. Situations depicting the difficulties that often arise in home-based care in a context of widespread food insecurity and unemployment are unmistakably absent. Consistent with IRT, I have argued that food and coffee are readily available and prominently displayed in the film precisely because they are necessary but highly inaccessible ingredients in "successful" interactions between volunteers and care recipients. Successful interactions are precisely what the

film seeks to document, because only such a film could be used to sustain the motivations of volunteers, patients and funders alike.

At stake are the pro-social motivations of volunteers and the health/development programs that seek to rely on them in the midst of (sustainability-threatening) scarcities of material resources. In this context, IRT would certainly predict the spoken, sung, and chanted beliefs, the coordinated actions (applause, ululation, and the like), and the shared attention that underlies all of these intersubjective activities, which I witnessed in the context of the various rituals described above. Conversely, conducting rituals that seek to encourage volunteers to assert their rights to compensation would be the goal of human rights activists (or perhaps of volunteers themselves after being exposed to such "enlightenment"), who perhaps rightly view the use of volunteer and other underpaid labor in these programs as a form of exploitation. It is not my intention in this article to take a stance on this issue, but rather to describe the roll of ritual in consolidating meaning and motivation.

It is also not my intention to argue that the rituals described above were totally successful. IRT treats ritual not as an "all-purpose social glue" (contra Comaroff & Comaroff, 1993; cf. P. Richards, 2005; Collins, 2004). Instead, whether different rituals, and specifically the ingredients marshaled by their organizers and participants, lead to the intersubjectivity, social solidarity, and sacrifice on which these programs depend, is an empirical question.[56] A limitation of this chapter, then, is the strictly ethnographic approach employed, which prevents a more empirical understanding of how various ritual

[56] I do not mean to suggest that sustaining motivations through ritual or through regular wages are mutually exclusive. It should be possible, and is perhaps desirable, to pay community health laborers a living wage while producing the potential psychosocial benefits assumed to be the special reward of so-called volunteers.

ingredients and structures lead to variable outcomes in terms of individual and group solidarity and pro-social motivation. Thus a next step is to develop mixed quantitative and qualitative methods that combine predictions from interaction ritual theory with formal tools for the measure of individual and social level variables, such as social network analysis, cultural consensus analysis, and multilevel modeling. Such an effort would allow for a rigorous ritual analysis focusing on testing competing hypotheses about the relationships between ritual inputs and outcomes in various development-related and other contexts. This approach to ritual analysis could potentially be applied by NGOs and other organizations to a more systematic promotion of social solidarity and individual motivation to volunteer among men and women in various health and development projects in SSA. From a more sociological perspective, such analyses would serve to broaden notions of sustainability of donor-funded health and development programs that rely on unpaid and underpaid labor. With a focus on the mis-match between the motivations of African men and women experiencing chronic economic insecurity and the expectations of elites from non-profit and for-profit organizations that seek to rely on economically-insecure laborers, ritual analyses have the potential to integrate critical and applied approaches to the practice of community health and development in SSA. Both approaches can in fact agree on a fundamental point: that fair and regular remuneration for health care laborers is not necessarily incompatible with the performance of rituals aimed at producing and sustaining social solidarity and pro-social motivations.

CHAPTER 8 (CONCLUSION)

What future for global health volunteer labor in sub-Saharan Africa?

This dissertation is particularly timely. Though applied anthropologists and global health practitioners have recently begun to investigate threats to sustainable development posed by synergies among HIV/AIDS, economic uncertainty, and food insecurity (e.g., Himmelgreen et al., 2009; Ivers et al., 2009), this dissertation comprises the first rigorous study of how food insecurity and general economic uncertainty among volunteers threaten to undermine AIDS prevention and treatment programs in sub-Saharan Africa. This is important because HIV/AIDS control, and indeed family planning and primary health care in general, are fundamental aspects of equitable development goals in sub-Saharan Africa (WHO, 2006). As this dissertation hopefully makes clear, on-the-ground efforts towards meeting these goals often depend on volunteer labor.

As this dissertation confirms, volunteers can be effective health care laborers, and they often derive mental satisfaction from serving their fellow community members. But they also desire secure jobs for themselves and for many of their care recipients, as a fundamental means to achieve economic security. Anthropological approaches to this apparent conundrum posed by the loaded term “volunteerism” will clearly benefit from integrating multiple theories of altruism and cooperation, including those derived from

evolutionary biology, with its focus on shared reproductive interests at the genetic, individual, and group levels; positive psychology, with its rigorous focus on empathy and subjective wellbeing linking social and biopsychological processes; and sociology, with its focus on how solidarities can be forged through ritual and potentially usurped in hierarchical social formations.

Further, applied anthropological research that investigates the linkages between community wellbeing, food insecurity, and health care labor in sub-Saharan Africa must also continue to engage directly with global health policy makers, donors, and practitioners. Addressing these issues requires first questioning and then rigorously assessing the sustainability of relying on unpaid labor to fill gaps in global health workforces. The World Health Organization asserts that health workers shortages are a major threat to global health (WHO, 2006), but that relying on volunteerism is not a sustainable response to this threat (WHO, 2008). And yet community volunteers are used on a large scale to fill gaps in health workforces in Ethiopia and throughout sub-Saharan Africa. As I have shown, this is driven by a powerful set of assumptions shared by local and global discourses that promote volunteerism. Volunteerism is often assumed by policy makers, donors, and programmers to be 1) economically imperative; 2) good for the giver's spiritual and mental wellbeing; and 3) based on an "untapped" and "renewable" resource – the so-called "volunteer spirit." The perceived effectiveness of group rituals in reinforcing and maintaining volunteers' pro-social motivations also leads many local and global organizations to continue relying on volunteer labor without seriously questioning sustainability.

But aside from the question of sustainability, there is the question of justice. Is it fair that people lacking secure employment and therefore secure access to basics like food, housing, and water are not paid regular and adequate wages for their valuable health care labor? Is it possible to fund the creation of community health worker jobs for the large cadres of volunteers serving HIV/AIDS and other health/development programs throughout sub-Saharan Africa? The recent global food and financial "crises" have underscored the need to address these questions. In the wake of these crises, creating and ensuring health care jobs, while rolling-back a reliance on unpaid labor, has emerged as an economic rights-based policy that may help households and communities to attain food security while strengthening the public health care systems on which millions of people in Africa depend.

This dissertation highlights novel linkages among HIV/AIDS, food insecurity, and a growing dependency on unpaid labor in community health projects in developing countries issues by drawing on the voices of volunteers themselves. Given chronically high rates of urban unemployment and food insecurity, and the challenges of caring for stigmatized people who have access to AIDS drugs but not basics like food and water, being an AIDS care volunteer in Addis Ababa was often fraught with ambivalence towards the motivation to continue volunteering. Volunteers often desire to help their fellow community members become healthy, but they are also de-motivated by their own experiences of food insecurity as well as by their patients' inability to achieve good health and economic security. This research points to the need for new policies and practices that benefit the socioeconomic status of underemployed "volunteers," the health systems they buttress, and the marginalized urban and rural communities they are meant

to serve. Thus the primary goal of this brief concluding chapter is to review recent developments in policy and practices aimed specifically at this issue, and to pose important questions raised by these developments that demand future study.

Rights to secure jobs and fair pay: a quaint notion?

I return to the testimony given before the U.S. Senate Committee on Foreign Relations on January 27th, 2010, by Paul Farmer, anthropologist-physician and co-founder of the well-known international NGO Partners in Health (PIH):

> “If there is any silver lining to [the January 2010 earthquakes in Haiti], it is that we can push job creation. It is a strange irony that supporters of economic assistance to Haiti are now obliged to shill for “cash for work” programs—for the quaint notion that people should be paid for their labor. Let us at least be honest: it is absurd to argue that volunteerism and food-for-work programs will create sustainable jobs. But if we set the ground rules on reconstruction correctly, we will be able to create sustainable jobs. In other words, if we focus the reconstruction efforts appropriately, we can achieve long-term benefits for Haiti… Putting Haitians back to work and offering them the dignity that comes with having a job and its

basic protections is exactly what brought [the U.S.] out of the Great Depression." [57]

Farmer is in fact echoing a sentiment that extends beyond Haitian reconstruction to his organization's approach to community-based health care delivery in Haiti, Rwanda, and beyond. PIH was a key advocate in the global movement to make highly-active antiretroviral therapies (HAART) accessible to people in sub-Saharan Africa and other "resource-limited" countries. Advocates of HAART roll-out in such countries envisioned drug access as a "wedge issue" to usher in more broad-based strengthening of public health systems and to help governments provide health care as a human right, endeavors that were threatened by structural adjustment programs imposed by the International Monetary Fund and World Bank in the 1980s and 1990s (Irwin, et al., 2003; Kim & Farmer, 2006; Pfeiffer, et al., 2008). An important outcome of structural adjustment in Ethiopia and other African countries is the large-scale elimination of jobs in the public – including public health – sector. In Ethiopia this was accomplished post-1991 (Mains, 2007). Thus HAART roll-out was supposed to be a step towards remedying past policies that effectively dismantled and hindered the rebuilding of health systems (Biehl, 2007).

However, as João Biehl (2007) argues, objectives associated with HIV/AIDS treatment have shifted, and health systems are more oriented toward marketing and distributing drugs, technologies, and services to the poor, thus benefitting pharmaceutical corporations and other public-private partnerships without adequately addressing underlying social inequalities or under-funding of basic social services (see Chapter 6). One "sign" or outcome of this shift is the increasing reliance on unpaid labor in rolling-

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[57] Available at http://standwithhaiti.org/haiti/news-entry/pih-co-founder-paul-farmer-testifies-at-senate-foreign-relations-committee [accessed on 8 February 2010].

out HAART on a public health scale in sub-Saharan Africa, as opposed to committing resources to create and sustain public health jobs and to combat insecure access to basics like food along with sophisticated medical technologies.

Thus, by advocating that community health workers who serve on a volunteer basis be incorporated into the public sector and remunerated, Farmer and colleagues are reacting to what Biehl identifies as the remarkable capacity of the pharmaceutical industry to "to neutralize and redirect any form of counter-reaction to its advantage" (Biehl, 2007: p. 82). In other words, the pharmaceutical industry is resilient: it has adapted to the global movement to treat poor people living with HIV/AIDS in such a way that it can enjoy access to new "markets" as well as drug distribution systems that rely to some extent on underpaid labor. As I mentioned in previous chapters, PIH devoted its 2009 annual symposium to the theme of "accompaniment," the community health model that commits to training and modestly paying health *accompagnateurs* or community health workers. The Public Broadcasting Service in the U.S. recently produced an incisive documentary focusing on PIH's cooperation with the Rwandan government and the Clinton Foundation in rolling out this model, to the apparent benefit of community health and economy.[58] But how exactly do PIH and the Clinton Foundation manage to finance the salaries of their community health workers (CHW)?

One approach is to simply commit donor funds to paying modest CHW salaries. However, it appears that more "innovative" and "market-based" approaches are preferred, at least by the Clinton Foundation, which in the past few years has become a prime mover in global HIV/AIDS drug supply and health care delivery programs. The Clinton Foundation HIV/AIDS Initiative in Rwanda recently prepared a short document

[58] Available at http://www.pbs.org/now/shows/537/index.html [accessed on 4 February 2010].

on its model, entitled "Market Based Solutions to Community Health Worker Compensation in Rwanda." [59] The report emphasizes that the government of Rwanda has "mandated" that CHWs form cooperatives to undertake income generating activities. Profits from these income generating activities are to be shared among cooperative members as compensation for their service. In other words, a group of CHW is expected to divide their time between performing their health care work in the community and engaging in the cooperative's profit-making ventures. Additionally, under the government of Rwanda's "Community Performance Based Financing" system, the government promises to make quarterly contributions to each CHW cooperative, which can be used as capital to support the ongoing income-generating activities. Importantly, the size of the government's contribution is dependent on each cooperative's performance in regards to the quality and/or volume of its various health care services in the community – hence "performance-based financing."[60]

According to the Clinton Foundation document, it is anticipated that this performance-based model will "incentivize the CHWs to work hard and improve primary health care services in the community while accessing greater levels of working capital for their business, which will translate to improved individual compensation in the long run." The role of the Clinton Foundation HIV/AIDS Initiative is to partner with the Rwandan Ministry of Health to assist the CHW cooperatives with their "business ventures." That means 1) identifying (usually agriculture-based) schemes with which members have some experience; 2) developing capacity, particularly in regards to

[59] Unpublished document in possession of the author.
[60] Keep in mind that performance-based remuneration, like performance-based disbursement of donor funds, can be problematic. In particular, without careful monitoring this scheme may effectively incentivize the over-reporting of service delivery indicators (see Lim, et al., 2008).

management, market research and monitoring; and 3) mediating access to banking and other services that would help cooperatives to be profitable. In addition, the Clinton Foundation in Rwanda has provided seed grants of USD 1500 – 4000 to a “rich blend of [CHW cooperatives]…that include the sale of milk, eggs, fertilizers, and a variety of grains…”

The Clinton Foundation in Malawi is also considering options for following the lead of its counterpart in Rwanda. A document produced by the country director of the Clinton HIV/AIDS Initiative in Malawi, entitled “Community/Village Health Workers/Volunteers – Possible Way Forward for Malawi,” addresses the movement towards “Regular and Sustainable Compensation/Incentives/Motivation for [CHW] Services.”[61] The report assesses the current situation among various organizations operating in Malawi (not necessarily under the policy framework of the Clinton Foundation):

> “Most [Community Health Workers] are considered volunteers. Even with that, some receive refreshments during monthly or periodic training. Some have quarterly incentives like t-shirts, gumboots, umbrellas, notebooks that help in their work. Some partners pay their [CHWs] monthly salaries or cash incentives for certain activities.

In addition, the Clinton Foundation Malawi document presents a rationale for achieving “regular and sustainable” compensation for CHW services:

[61] Unpublished document in possession of the author.

> "[CHW] compensation schemes would reflect a desire to recognize the important role they play in bringing healthcare closer to the community. Motivation and compensation of [CHWs] is vital to ensure that investments made in training and supervision are fully utilized. It is also a human rights issue; [CHWs] should be compensated for whatever economic time they expend on the work they are assigned."

The report then presents options for implementing regular compensation for CHWs. Echoing the performance-based model in Rwanda, the report asserts that "ideally services that [CHWs] provide should be linked to outcomes." Illustrative examples of such outcomes, according to the report, include increasing the number of women giving birth at health centers. For instance, the number of pregnant women accompanied by community health workers to a health center for delivery could be tied to a set amount of compensation for those CHWs. Cooperatives, with initial or phased financial and credit support like in Rwanda, are also an option. The report admits, however, that "[r]ealistically, cooperatives…may not be able to generate sufficient amount of resources, at least not in the short to medium term."

Three questions

Three questions emerge from this short review of "innovative" CHW remuneration practices and their associated discourses. First, why are so-called "market-based" models apparently preferred over simply paying regular wages or salaries to low-level workers, and would this form of remuneration be acceptable to more elite public health practitioners and officials? Second, how is the resilient pharmaceutical industry

adapting to, and/or influencing, these shifts in community health worker investment and pay? And finally, how will continuing reliance on volunteer labor, as well as on "innovatively-remunerated" CHW labor, impact the provision of primary health care services and key population health indicators in sub-Saharan Africa?

It is beyond the scope of this dissertation to answer these questions. Answers will reflect the fact that global health is a dynamic system of public-private partnerships dependent on donor funding. Provisioning health care and other basic necessities like food and jobs is seen by some as a legitimately for-profit venture and by others as a public good that must be ensured in a rights-based framework. There is an obvious need for future research that can engage with these political-economic realities while testing hypotheses about the links between various forms of global health labor, health outcomes, and economic insecurities at the community level. I hope that this dissertation has paved the way for rigorous mixed-method study designs that will begin to address these questions, for they are of utmost importance to population health and sustainable development in 21st century sub-Saharan Africa.

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