NIH Public Access
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Soc Sci Med. Author manuscript; available in PMC 2014 June 01.

Published in final edited form as:
Soc Sci Med. 2013 June ; 87: 52–59. doi:10.1016/j.socscimed.2013.03.026.

Becoming and remaining community health workers: Perspectives from Ethiopia and Mozambique

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Abstract

Many global health practitioners are currently reaffirming the importance of recruiting and retaining effective community health workers (CHWs) in order to achieve major public health goals. This raises policy-relevant questions about why people become and remain CHWs. This paper addresses these questions, drawing on ethnographic work in Addis Ababa, the capital of Ethiopia, between 2006 and 2009, and in Chimoio, a provincial town in central Mozambique, between 2003 and 2010. Participant observation and in-depth interviews were used to understand the life histories that lead people to become CHWs, their relationships with intended beneficiaries after becoming CHWs, and their social and economic aspirations. People in Ethiopia and Mozambique have faced similar political and economic challenges in the last few decades, involving war, structural adjustment, and food price inflation. Results suggest that these challenges, as well as the socio-moral values that people come to uphold through the example of parents and religious communities, influence why and how men and women become CHWs. Relationships with intended beneficiaries strongly influence why people remain CHWs, and why some may come to experience frustration and distress. There are complex reasons why CHWs come to seek greater compensation, including desires to escape poverty and to materially support families and other community members, a sense of deservingness given the emotional and social work involved in maintaining relationships with beneficiaries, and inequity vis-à-vis higher-salaried elites. Ethnographic work is needed to engage CHWs in the policy process, help shape new standards for CHW programs based on rooting out social and economic inequities, and develop appropriate solutions to complex CHW policy problems.

Keywords

community health workers; volunteers; HIV/AIDS; Ethiopia; Mozambique; motivations; care relationships

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Introduction

Currently, many actors in the field of global health are reaffirming the crucial importance of community health workers (CHWs)—lay workers trained to provide primary health care and promote healthy behaviors for their own communities—in achieving public health goals in the context of poverty and weak health systems. For instance, 2011 saw the emergence of the Frontline Health Workers Coalition, a coalition not of workers themselves, but of international organizations seeking to make better use of them. Though there is considerable debate over the value and activities that should be assigned to CHWs, major global health-development institutions proclaim "No Health Without Health Workers," identify massive global shortages of CHWs, and call for innovative and evidence-based policies that improve recruitment and retention of community health workforces (WHO 2006; Watt et al. 2011; Bhutta et al. 2010).

In the 1970s, the importance of community health workers was originally affirmed by the World Health Organization. After the Alma Ata Declaration of 1978, many countries in sub-Saharan Africa began to institutionalize CHW programs as a strategy to extend primary health care to impoverished rural and urban populations and to address the relationship between poverty, inequality and community health (Newell 1975; Standing and Chowdhury 2008; Cueto 2004). For example, Mozambique's newly independent government instituted a cadre of community health workers known as *Agentes Polivalentes Elementares* (APEs), and Ethiopia's military government called for a new cadre of Community Health Agents (CHAs). APEs have remained active to the present in Mozambique (Simon et al. 2009), while CHAs in Ethiopia were largely neglected and eventually abandoned (Kloos 1998). In the last few years, Mozambique has sought to re-invest in its APEs (Simon et al. 2009). And in 2003, the Ethiopian Ministry of Health created a new community health worker cadre of salaried, full-time Health Extension Workers (HEWs) (Donnelly 2011).

With renewed interest in CHWs, public and private health agencies have recently begun to partner with economists to carry out randomized controlled trials to build an evidence base for recruitment and mixed incentivization schemes that positively impact community health worker performance (for example, see http://www.povertyactionlab.org/evaluation/recruiting-and-motivating-community-health-workers-zambia). This approach may be helpful to policy makers, and increased attention to CHWs—rather than to specific diseases—is a welcome step towards a more humanistic approach to health policy making (Biehl 2011). However, the recruitment, retention and performance of CHWs may involve complex social and political processes linking CHWs' life histories, values and desires, and relationships with beneficiaries and the institutions that recruit them, and randomized controlled trials and other evaluations of interventions are usually not designed to adequately assess these processes (Christopher et al 2011).

Ethnographic work can address these processes and provide policy makers with a more holistic understanding of how and why people become and remain CHWs. In recent years a few ethnographic studies have examined the motivations and social relationships of community health workers. These studies suggest that CHWs have many motivations including desires for better compensation and other job opportunities, new knowledge, patron-client relationships, and more pro-social motivations such as reducing suffering and living up to civic and religious values of sacrifice and service (Akintola 2011; Kironde and Klaasen 2002; Rödlach 2009; Swidler and Watkins 2009; Kaler and Watkins 2001). The policy implications of CHWs' desires for better compensation are unclear, as fair compensation is a contentious issue for stakeholders interested in improving community health workforces. Leading global health bodies have recently affirmed that CHWs deserve fair wages to secure their livelihoods and ensure their commitments and effectiveness in

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serving public health institutions (Watt et al. 2011; WHO 2008). The international NGO Partners in Health has demonstrated that CHWs have an economic right to receive fair monetary compensation, and that providing fair compensation contributes to the goal of improving population health and social solidarity (Farmer 2010; Public Broadcasting Service 2009). But public health institutions and donors use several economic and moral arguments to justify the minimal compensation of CHWs and volunteers (Glenton et al. 2010; Maes et al. 2010). For instance, some argue that CHWs, even those that receive a salary, should have a "volunteer spirit," meaning that they should be less interested in monetary compensation and more committed to serving others (Maes 2012; WHO 2002; Kalofonos 2008). Meanwhile, CHWs in places as various as Massachusetts (Mason et al. 2010), Pakistan (Closser 2010), Nepal (Glenton et al. 2010), and South Africa (Kuppan 2005) have organized, developed leadership, and protested or pursued legislation to attain better work conditions.

We aim here to build on recent ethnographic studies of CHWs by more closely examining the life histories that lead people to become CHWs, the ways that relationships with intended beneficiaries influence CHWs' commitments, and the multiple reasons why many CHWs may desire better compensation for their contributions to community health. A better understanding of these processes can potentially inform positive policy changes to CHW programs in which stakeholders, including CHWs themselves, envision innovative policies that address goals of livelihood security and fulfillment for CHWs, improved work performance and population well-being, and greater solidarity between CHWs, health professionals and bureaucrats, and the communities they serve. We present narratives from CHWs in two study sites—Addis Ababa, Ethiopia and Chimoio, Mozambique—and contextualize these narratives within the political and economic histories of these sites. We show that processes by which people become and remain CHWs are rooted in past and present experiences of poverty and inequality. Comparing results from two different sites reveals that CHWs, communities, and health officials in different contexts face similar problems, yet underlines the importance of socio-political and cultural differences for community health workforce policy making.

We report on volunteer CHWs who have been crucial to HIV/AIDS treatment programs in sub-Saharan Africa, ensuring accessible and successful antiretroviral therapies for millions of new patients (Iliffe 2006; Akintola 2008; Simon et al. 2009). As lay persons, they provide drug adherence support and counseling. They also mediate patients' access to clinical care and social support, and collect data on their activities so that public health institutions can monitor their progress towards AIDS treatment and prevention goals.

In the mid-1990s, HIV-positive people in Ethiopia and Mozambique could generally access treatment only for opportunistic infections. Antiretroviral therapies were only available for those who could pay high prices. At this time, NGOs in both sites began implementing home-based care, defined by the WHO as "care including physical, psychosocial, palliative, and spiritual activities" aimed at helping family caregivers and the ill "to maintain their independence and achieve their best quality of life" (WHO 2002: 8; Iliffe 2006). As HIV became a priority of donors and international activists in the early 2000s, rapid testing centers opened in Mozambique and Ethiopia, and antiretroviral therapies began to be introduced. Clinical operations were carried out within these countries' public health systems. Home-based care was the responsibility of local NGOs, which received funding and support from foreign NGOs and donors. Combination antiretroviral drugs became more widely available after 2004 as the prices of first-line antiretrovirals plummeted and global donors—particularly PEPFAR, the U.S. President's Emergency Plan for AIDS Relief—began to prioritize HIV/AIDS treatment. Volunteers, organized by already-existing local NGOs and community institutions, were asked by funders and administrators to recruit

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patients for HIV testing and treatment and support their drug adherence while continuing to provide home-based care. In Ethiopia and Mozambique, then, the roles of these volunteer CHWs in antiretroviral drug roll-out look similar, due to similar health system weaknesses and to norms of HIV/AIDS home-based care, financing, drug prescription, and monitoring that are common throughout sub-Saharan Africa.

Organized by NGOs and focused on HIV/AIDS, these volunteer CHWs have operated somewhat independently from the more generalist, government-organized CHWs that exist in Mozambique and Ethiopia. In both locations, however, there are efforts underway to integrate the work of HIV/AIDS-focused and generalist CHWs through partnerships between health-development NGOs and government (Simon et al. 2009). While it is problematic to apply our findings to other cadres of CHWs, and comparative ethnographic research is needed, the CHW narratives reported here offer lessons for policy makers and practitioners involved in CHW programs beyond our study settings. Specifically, our research suggests that policy making should better address CHWs' (1) life histories, including the pro-social role models and hardships they have encountered; (2) relationships with intended beneficiaries, given that these relationships are the basis for achieving basic global public health goals and are important determinants of CHWs' own well-being; and (3) aspirations for socioeconomic progress and policy innovations.

Methods

Ethnographic research was carried out in Addis Ababa, the capital of Ethiopia, between 2006 and 2009, and in Chimoio, a provincial town in central Mozambique, between 2003 and 2010. Ethnographic research in Addis Ababa focused on the southwest outskirts of the city, including ALERT Hospital and two local NGOs that closely cooperated with the hospital's HIV/AIDS clinic. ALERT Hospital houses one of the largest HIV/AIDS treatment clinics in the country. *Medhin* Social Center is a small NGO located within the slums adjacent to ALERT Hospital. Operated by nuns of the Ethiopian Catholic Church, it was originally founded to support families affected by Hansen's disease (leprosy). At the time of the research, it employed 20 volunteers who focused on HIV/AIDS care and treatment support. The *Hiwot* NGO was a fairly large NGO founded by an Ethiopian nurse. Headquartered in an upscale neighborhood, it served as the "local implementing partner" of Family Health International, a major international NGO that received substantial funding from PEPFAR during the initial era of antiretroviral drug roll-out in Ethiopia. It organized one of the largest volunteer workforces in the city. In 2008, about 150 *Hiwot* volunteers worked in the urban districts served by ALERT Hospital. The first author conducted participant observation in the context of volunteer trainings, meetings, events, and activities in care recipient homes, and conducted in-depth, semi-structured interviews with a sample of thirteen volunteer caregivers (10 female and 3 male), purposively selected to reflect the preponderance of women in the volunteer population and variation in length of service, age, education, and socioeconomic status. Each respondent completed five to six interviews over eight months in 2008. Interviews were conducted in Amharic and translated by the first author with help from local assistants.

In Chimoio, the second author accompanied community health workers from five different organizations while on their regular visits to care recipients' homes, and conducted in depth, semi-structured interviews with a convenience sample of twenty-five volunteers. Convenience sampling was used because the ethnographic research in Chimoio focused more intently on people living with HIV/AIDS and their networks of care (Kalofonos 2008). Interviews ranged from 30 minutes to three hours; most were conducted in Portuguese, though a small number were conducted in Chiteve, a Shona-related language, with the aid of a translator. The CHW whose case is presented below belonged to one of the largest

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community-based organizations in the region at that time, *"Together for Life"* (a pseudonym). Founded in the mid-1990s by a Swedish missionary and eight local churches (4 Pentecostal, 3 Evangelical, and one Catholic), during the initial years of antiretroviral drug roll-out in Mozambique, *Together for Life* grew considerably as it received substantial PEPFAR funds as the local implementing partner of a U.S.-based NGO. At the time of the research, it specialized in HIV/AIDS outreach through local church communities and included over 90 churches. There were 130 *Together for Life* volunteers in Chimoio in 2006–2008, and 240 total for the province of Manica.

In both study sites, interviews addressed CHWs' motivations, life histories, well-being, spirituality, and relationships with patients. Ethical approval for the Ethiopia research was obtained from the IRBs of Emory University, Addis Ababa University Faculty of Medicine, and ALERT Hospital. Ethical approval for the Mozambique research was obtained from the University of California, San Francisco and the Mozambique Ministry of Health.

Comparing research settings: Addis Ababa and Chimoio

Addis Ababa, founded as the capital of Ethiopia in 1886 as the Ethiopian monarchy solidified its hold on lands to the south, has rapidly grown from a series of encampments into a city of several million inhabitants. Since the 1990s, municipal governments have struggled to keep up with rapid population growth through infrastructure and housing projects. Ethiopia today is a multi-ethnic federation in which ethnicity, religion, and party affiliation are significant social fault lines (Turton 2006). Amharic is spoken by most Ethiopians inhabiting Addis Ababa.

The second site is the town of Chimoio, capital of Mozambique's central province of Manica. Chimoio is linked to neighboring Zimbabwe by a shared Shona cultural history and by an international highway. Chimoio grew from a colonial railway stop into a city around a Portuguese textile factory built in 1944 (the *Sociedade Algodeira de Portugal* or Portuguese Cotton Society). Nationalized in 1975 and privatized in the late 1980s, the factory employed 2,500 to 5,000 residents before folding in 2000 (Guerreiro 2003; Magalhães personal e-mail communication February 20, 2006; Pitcher 2002). Chimoio's population has grown from 50 thousand at independence in 1975 to over 250 thousand in recent years (Instituto National de Estatística 2008). Most residents live in shantytowns called the "cane city," which ring the former colonial "cement city." Households in the cane city combine wages or income from the informal market with subsistence production on *machambas* (subsistence plots) outside the city. The dominant languages are Portuguese and Chiteve.

Ethiopia is unique in sub-Saharan Africa for having never been successfully colonized, though Italy attempted it and was an occupying force from 1935–41. In contrast, Mozambique was a Portuguese colony for nearly five centuries. In 1974–75, both countries saw major political changes. The Ethiopian monarchy fell in 1974 to a military junta known as the *Derg*. In 1975, after a ten-year armed struggle, Mozambique declared its independence from Portugal. In both countries, Marxist-inspired reforms followed, along with violence fueled by wider geopolitics.

After independence, Mozambique initiated ambitious social programs aimed at universal access to education, health care, and food. In 1977, however, a war of destabilization initiated by Rhodesian and South African-backed forces targeted communication, health, and education infrastructures. Over one-third of schools and clinics were destroyed or closed, roads became impassable, and local economies collapsed (Finnegan 1993; Hanlon 1990).

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In Ethiopia, the military government attempted to strengthen primary health care and reform land tenure. However, the government quickly became engulfed in costly civil war and conflict with neighboring Somalia, and little national or international funding was devoted to health care. Health services coverage declined to 1960s levels, and hundreds of rural health facilities were damaged or destroyed. Modern health care resources remained concentrated in Addis Ababa (Kloos 1998).

In the late 1980s and 90s, Marxism in both countries gave way to free market reforms and structural adjustment. Since this time, in both Ethiopia and Mozambique, NGOs have proliferated to fill gaps in health services, especially with the rise of the HIV/AIDS pandemic (Iliffe 2006).

In Ethiopia, a coalition of revolutionary guerillas overthrew the military government in 1991. Since then, a single coalition of parties has held power, instituting structural adjustment reforms and reducing the number of government workers. The federal government has issued a series of reforms aimed at health systems strengthening and equitable distribution of health services (Kloos 1998; Donnelly 2011). These reforms have preceded gains in many health statistics, but are threatened by scarce governmental revenues, debt, and donor-dependence.

The end of the civil war in Mozambique in 1992 ushered in an oligarchic single-party rule that continues today. Structural adjustment reforms initiated the transition to a free-market economy in 1986 and gained momentum with the 1992 ceasefire (Hanlon 1996; Pitcher 2002). Food subsidies were drastically cut (O'Laughlin 1996), and the public health sector was fragmented and "outsourced" to foreign NGOs (Eys 2002; Hanlon 1991; Pfeiffer 2003). In 2008, the number of health centers remained below prewar levels (Hanlon and Smart 2008: 73).

In recent years, urban populations in Ethiopia and Mozambique have endured considerable frustration and suffering due to hikes in food prices (Arndt et al. 2008; Loening, Durevall, and Birru 2009; Ulimwengu, Workneh, and Paulos 2009). In Mozambique, rising food, fuel, and utility costs sparked riots in cities throughout the country in 2008, prompting the introduction of subsidies. In 2010, the government announced that the price of bread, water, and electricity would increase by 11–25%, triggering more protests that escalated to riots (Africa Research Bulletin 2010). The government responded by backing down from the price increases. Violent food riots have been largely absent in urban Ethiopia despite widespread suffering and frustration (Hadley et al 2012).

In summary, while Ethiopia and Mozambique have very different political and cultural histories, they have faced similar political and economic challenges in the last few decades involving war and Marxist-inspired reforms in the 1970s and 80s, structural adjustment in the 90s, and food price inflation in the first decade of the new millennium. These jarring political and economic transitions shaped the lives and opportunities of CHWs in Addis Ababa and Chimoio.

AIDS care volunteers' perspectives on becoming and remaining CHWs

Linda – Chimoio

Linda (a pseudonym), a single mother of three in her late 40s, had been a *Together for Life* volunteer for over ten years and was responsible for overseeing the work of several other volunteers in her neighborhood. She also operated a neighborhood market stall and was well-respected in the Market Association. Having separated from her husband years before and never feeling the need to remarry, she lived behind her market stall with her daughters

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and frequently hosted visiting relatives. Her house was made of brick-and-mortar and had a zinc roof, a step up from the standard mud-and-wattle houses in the neighborhood.

Linda grew up in an *aldeia*, a colonial village north of Manica that was liberated by Frelimo (the Liberation Front of Mozambique) during the war of independence in the latter half of the 1960s. She recalled the uncertain days of her childhood: “We suffered the war out there in the bush, the war of our neighbor, Ian Smith [head of the Rhodesian government]. He came with airplanes, dropping bombs. We ran carrying whatever we could. My mother was pregnant, so I had to carry my baby brother.”

As conflict in Mozambique escalated, Linda’s family fled to Zimbabwe. In 1990, they returned to Mozambique, and settled in Chimoio a few years later. During this period, as much as 40% of the Mozambican population was displaced (Hanlon 1996). Soon after she moved to Chimoio, Linda converted to the Universal Church of the Kingdom of God, an international Pentecostal church: “My daughter had been sick with bronchitis for seven months. Nothing I could do seemed to help until my brother took me to his church and, with prayer, it passed. I joined the church, and our family has continued to be blessed ever since.” Pentecostal churches, popular particularly among women (Pfeiffer, Gimbel-Sherr, and Augusto 2007), surged during the postwar period in Chimoio.

Linda learned about *Together for Life* from a colleague in Chimoio’s market. She recalled initially hearing about ―this association where people come together from different countries and exchange opinions about religion, civilization, and these positive diseases [HIV/AIDS and opportunistic infections].‖ The concept reminded her of an association she had joined while a refugee in Zimbabwe: ―We studied ideas together, how to live with others, how to educate children…I was also introduced to different kinds of religion. That was a great experience and I thought it would be great to have it again.‖ Unsure that she would have time given her other responsibilities, Linda was finally convinced to join *Together for Life* by a fellow church member who belonged to the NGO.

When asked why she continued to do this work after many years despite the difficulties, Linda responded that she had a spiritual calling. Her father was a *curandeiro*, a traditional healer, and she grew up with sick and suffering visitors in her home.

> Sick people always came [to our house]. We always ate together. We were all one family. I once asked my father, ―*Papá*, why is our family always so full?‖ He answered, ―Another moment, you will find yourself in another country, another place, and those you helped will recognize you and open their homes.‖ So this work [AIDS caregiving] is nothing new. It is not difficult for me. My patients also come [to my home] and tell me their stories. There are things they can speak to me about that maybe they are too proud to share with their families.

One of Linda’s patients, Severino, spoke about Linda’s involvement in his care. His illness had sparked a quest for treatment, as he tried various medicines and visited many traditional healers, prophet-healers, and private biomedical practitioners. After none of these seemed to have lasting impacts, Linda guided him to the HIV testing center:

> I was living alone. I was at zero. I was sick and had nothing and felt I had tried everything. Linda is a neighbor, and she would visit and see how I was. On one of her visits she asked, “Have you gone to the Day Hospital [the AIDS clinic]?” I tried to get there in 2003, but they said, “No, you first have to get tested for HIV,” and I did not know where to get that done. So I went to get tested, but they said I had to go to the hospital first. I was confused. All these doors, papers, and places to go…I just went home. And that was it. Linda came and picked me up the next day. She said, “Let’s go [to the AIDS clinic].” And we went.

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After being on antiretroviral treatment for two years and still meeting regularly with Linda, Severino spoke fondly of her:

> She is my guide and my savior. When I had nowhere to turn to and nothing to eat, she took me to the proper place, and I received food [from *Together for Life*] and the treatment I needed. I am much better now, working more, eating more.

Despite the satisfaction and pride that Linda derived as a CHW, specifically from relationships she formed with patients like Severino, she expressed some frustrations. Like all the volunteers, Linda hoped her certifications and experience would translate into steady, formal employment. She recalled, "When we were trained, we were told we would be needed one day [as salaried workers]. Well, that day has not come." Furthermore, *Together for Life*'s incentives for their volunteers were inconsistently provided, and were felt to be inadequate. Initially, most volunteers received trainings and certificates, t-shirts, snacks and lunches, and allotments of rice, corn, oil, or soap. With the rapid scale-up of antiretroviral treatment, the Ministry of Health set an official incentive rate of around 60% of the minimum wage (about 24 USD /month) for CHWs working on HIV/AIDS interventions. This was a recommendation, however, and not a requirement. What Linda and her colleagues actually received depended on the flow of grant monies. After years of demands and appeals made by the *Together for Life* volunteers, they finally began receiving the recommended amount. After a year, however, the grant supplying this amount was set to expire.

Linda expressed her frustration by saying:

> We are expected to carry the burden of labor but not the benefits? Our organization has built a nice office. Those people who work in the office, they drive cars to work. But those of us who do the work in the neighborhoods? This is not our office, and that hurts. We built that office, we built the organization. We arrive at the homes of the sick, and they say, ah, *Together for Life* is here. Yes, we are *Together for Life*. But we [volunteers] are the last to receive and the first to lose. Perhaps we should discuss selling the office.

For Linda, the "work in the neighborhoods" was the difficult work of relating to patients and their families, which was the basis for her organization's existence. From her perspective, it was unfair that officers of the organization enjoyed elite status and materially benefited from her work while her aspirations for socioeconomic advancement went unfulfilled. Despite her frustration, Linda maintained that she and her fellow volunteers would continue volunteering: "We feel it, we know how to help one another, and we have our patients who rely on us."

Alemayehu – Addis Ababa

Alemayehu (a pseudonym), at 33 years of age, had not yet married and still lived with his parents. His sisters had married and migrated to the Middle East to work as domestic servants, and would send money to their parents every few months.

Alemayehu's father was a retired soldier who had served since the latter years of Emperor Haile Selassie's reign. This had implications for Alemayehu's life, including his eventual decision to become a CHW. After the overthrow of Haile Selassie that brought the *Derg* to power, Alemayehu's father was deployed to the Ogaden region of Ethiopia to battle Siad Barre's invading forces. Later he was deployed to Asmera to fight guerrillas seeking Eritrea's independence from Ethiopia. During his time on the frontlines of these wars, he would send part of his paychecks to his wife and family. Eventually he was shot and wounded, and returned to Addis Ababa. With the fall of the *Derg* in 1991, he retired from the military and found low-paid work as a house guard in an upscale neighborhood.

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Two years later, Alemayehu dropped out of secondary school because he wanted to contribute to the family income. He began working in cotton-processing factories and construction day labor. Though these jobs are highly desirable among a population facing up to 50 percent unemployment (Serneels 2007), for Alemayehu they were menial and meaningless. After working at them for several years, he stopped and shortly thereafter joined the *Medhin* NGO as a volunteer CHW. It was 2004, when the majority of people in need of antiretrovirals did not have access. "I was watching many people dying from HIV/AIDS, and I also saw when they were insulted and discriminated."

Alemayehu volunteered with the *Medhin* NGO for 18 months. After a short break, he joined the *Hiwot* NGO in late 2007. As a volunteer for *Medhin*, he had received a sizeable monthly allotment of wheat and cooking oil. "It was considered as a salary. 'This is your salary,' [our supervisors said]. I would bring it home. I would give it to my family one month, and I would sell it the next month [and keep the money] for myself… I never sold the oil. I always brought it home." Now that he was volunteering for the *Hiwot* NGO amid much higher food prices and diminished support from the World Food Programme, Alemayehu did not receive food as remuneration. He only received 5 USD per month to offset transportation and telecommunication costs.

Alemayehu's father reflected on the dramatic rise in the cost of living over the past half-century. "During the Emperor's time, you could do daily labor and eat with just 25 cents. When you compare that time with the present, it seems like a fairy tale. During the *Derg* time, conditions deteriorated. Then the present comes, which is even worse. I don't understand why. I don't know whether it is development or what."

Nevertheless, Alemayehu's parents remained supportive of his volunteer efforts, though he was not bringing in substantial income. Like his father's military service, his service as a volunteer CHW was understood to address a basic need of the country. As Orthodox Christians, Alemayehu and his parents also saw volunteering as consonant with their religious values.

However, Alemayehu was stressed about being unable to provide for his family. He said that since he had begun volunteering for *Hiwot*, he had been experiencing a "sleeping problem":

> Now at least three times in a week, I wake up [in the middle of the night]. I think about my family…about supporting them with a good job. I will not sleep until the next day. There is no happiness with me. When I can't sleep, I will feel depressed all day.

A fellow volunteer, Markos, provided his perspective on Alemayehu's distress. "At his age, Alemayehu should build a house and support his mother. Instead of supporting her, she is supporting him, because he doesn't have any income. He just works with us as a volunteer."

Alemayehu was also struggling with the emotional difficulties of helping patients whose main concern was obtaining employment and other basic necessities. He was currently visiting a dozen patients.

> When I wake up [in the night], I also think about what they tell me in the day about their problems …. Yesterday there was one woman who was lying on the ground. She had nothing to eat. The [antiretroviral] medication was there in her room, unused. Now they get food aid only when their body mass [index] is less than 18.5 [kg/m^2]. And I can see these things… So these things worry me.

Alemayehu said that he really wanted to be able to financially support both his family and other community members in need. When asked how people can avoid negative emotions

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like anxiety, anger, and sadness, he replied, “I think that if you work, then the pressure of life can decrease and you will not be worried by anything. And if you do good things for human beings, then you will not worry. You will get mental rest (*aimero ereft*).” When asked why he did not stop volunteering to find another job, he responded, “I have an obligation to the people for whom I care, for one year and six months—even if I am in trouble. I consider this as an obligation…as citizenship.”

Discussion

Creating jobs in health and other social services remains a highly contested way to improve well-being in low-income countries (Ferguson 2010). This has clearly been the case in the arena of volunteer-dependent HIV/AIDS treatment roll-out in sub-Saharan Africa. In global health more generally, there is a lack of commitment among donors and governments to pay for salaries over the longer term, though this may be changing (Dräger, Gedik, and Dal Poz 2006; Ooms, Van Damme, and Temmerman 2007; Swidler and Watkins 2009). Leading global health institutions affirm that CHWs are crucial, in short supply, and deserving of fair wages (Watt et al. 2011; WHO 2008), and there is growing interest in using controlled experiments to establish the cost-effectiveness of recruitment and mixed incentivization schemes. Although our methods have important limitations, we have aimed here to demonstrate that ethnography can play an important complementary role in CHW policy making by improving our understanding of CHW recruitment and retention processes.

Our goal to compare two field sites limits our ability to describe the socio-political and cultural particularities of each site in greater detail. Our decision to present only one narrative from each site also compels us to clarify that not all CHWs in Chimoio eloquently expressed a sense of inequity like Linda did, and not all CHWs in Addis Ababa suffered “sleeping problems” and psychological distress like Alemayehu did (Maes et al. 2010). However, we can assert that all of the CHWs we interviewed were very poor, and each of them had life histories involving significant challenges related to larger political and economic forces. In addition, it was common for them to identify pro-social and caring role models in their lives, especially parents. And for all CHWs, their relationships with intended beneficiaries appeared to have important impacts on their own well-being and sense of commitment to the CHW role.

By comparing contextualized narratives from two sites, our work reveals several striking similarities in the processes by which people become and remain CHWs. On a structural level, war, regime change, and structural adjustment play important roles in how and why people become CHWs. Wars exacerbated local epidemics even as they weakened health care systems in Ethiopia and Mozambique (Collins 2006; Kloos 1998). Regime changes in the early 1990s in Ethiopia and Mozambique put an end to violent conflicts but gave way to cuts in health expenditures, “outsourcing” of social services from government to NGOs, and reduction in the availability of public sector jobs. These processes help explain why Alemayehu and Linda ended up volunteering for NGOs for minimal and irregular pay while HIV/AIDS epidemics raged.

The narratives presented here also show that becoming a CHW is influenced in complex ways by both gender norms and the moral values that people come to uphold through the example of parents and religious communities. Community health work, paid or unpaid, clearly provides a way to live up to ideals of religious and civic duty. Women predominate in unpaid healthcare roles in sub-Saharan Africa, due to biases that caregiving is “women’s work” and to fewer formal employment opportunities for women (Akintola 2008; Friedemann-Sanchez and Griffin 2011). Linda had separated from her husband and was the primary source of support for her children, pursuing multiple informal economic

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opportunities simultaneously. One of her primary role models was not another woman but instead her father, a *curandeiro*. Facing limited work opportunities within urban Ethiopia, many women, including Alemayehu's sisters, brave the difficulties of migrating to the Middle East to gain an income as domestic servants. For some women in Addis Ababa, becoming CHWs happened after returning from stints in the Middle East, and for some it preceded this sort of labor migration (Maes 2012). Alemayehu's case also illustrates a common experience of urban young men in Ethiopia: the lack of good jobs that would allow them to start families and become adults who support rather than depend on others, particularly parents (Gurmu and Mace 2008; Sibanda et al. 2003; Mains 2011). Becoming CHWs allows men like Alemayehu to take on an ambiguous status, providing social and emotional support to others while still materially depending on parents.

The research reported here also highlights the importance of CHWs' relationships with intended beneficiaries. The participants in our research were more than front-line health workers; they often brokered conflicts within the social networks that constitute therapy management groups (Janzen 1978), taking time to become familiar with the competing priorities, agendas, and conflicts within families. The CHWs we encountered experienced positive relationships with their intended beneficiaries, leading to progress towards public health goals, greater well-being, and shared hope. This was highly motivating for CHWs like Linda and Alemayehu, and helps to explain why CHWs stay committed to their positions. However, volunteer CHWs were not always welcomed in homes of the sick. When their patients were disappointed or when things went poorly, volunteers frequently bore the brunt of their frustrations. Volunteers told stories of being accused of causing disease in neighbors so that they could be paid for visiting them and of hoarding benefits that were meant for patients. Feeling unable to help people whose main complaint was lack of food was distressing (Kalofonos 2010; Maes et al. 2011). For Alemayehu, witnessing the dejection of patients at the height of the 2008 food crisis apparently contributed to his sleeping problem and related depressive symptoms.

We find that there are complex reasons why CHWs come to desire greater compensation and better job opportunities. For instance, CHWs may develop a sense of deservingness, based on their awareness of the intense social and emotional work involved in relating to patients. In addition, desires for better compensation may be related to a sense of inequity vis-à-vis salaried elites in government, NGOs, and donor countries and foundations, even if CHW positions may sometimes confer some prestige (Swidler and Watkins 2009). Linda came to express that the volunteers' efforts in relating to patients and families were unfairly exploited, and she related this exploitation to the country's colonial past. It is also important to recognize that CHWs' desires for greater income go well beyond narrow self-interest. CHWs desire to move beyond difficult pasts involving poverty and conflict; to avoid exposure to poverty, rising food prices, and other stressful experiences in the present; to support families, including parents and children (and in some cases to *start* families); and to have the means to be community benefactors in terms of providing psycho-social and *material* assistance to the poor.

Finally, we noted several unique socio-political and cultural aspects of our study cites, including the specific nature of the conflicts, regime changes, and economic reforms through which CHWs in Ethiopia and Mozambique have lived. Recent food price increases have led to great distress in both settings, yet violent food protests have been absent from urban Ethiopia. Another important difference between our field sites is the prominence in Chimoio of Pentecostal and Evangelical churches (see Pfeiffer 2002), which exist but are not as prominent as Orthodox Christian churches in Addis Ababa. These differences remind us of the importance of identifying locally specific challenges and opportunities for partnerships

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and innovative practices aimed at better recruiting and retaining CHWs and securing their livelihoods.

Renewed interest in the contributions of CHWs, and new efforts in evaluating CHW remuneration and mixed incentivization schemes against rubrics of worker performance, are welcome developments in community health policy making. However, our research suggests that CHW recruitment and retention are highly complex socio-political processes, and that policies aimed at improving CHW programs should also set goals of livelihood security and fulfillment for CHWs, and of solidarity between CHWs, health professionals and bureaucrats, and the communities they serve. CHWs' relationships with intended beneficiaries and aspirations for socioeconomic progress are arguably the basis for achieving several global public health goals, as well as important determinants of CHWs' own well-being, and thus demand attention.

Future research should use ethnographic and other methods to uncover the processes by which people become and remain CHWs. We recognize a need for research that more systematically compares these processes across different localities, highlighting common aspects of social life amid intense globalization and inequality, as well as the diversity of meanings, values, and labor negotiations surrounding CHWs. Comparative analysis should also focus on change over time, and specifically how evolving syndemics (Singer 2011) and the desires of donors, local governments, and global public health institutions interact with CHWs' attempts to improve their lives and serve their communities amid shifting economic and cultural contexts. Such research may also shed light on how complex socio-economic and biocultural processes influence population health (Hirsch et al. 2009).

Importantly, such work can engage CHWs themselves in the process of policy innovation and assessment, help to shape new standards of global health intervention based on rooting out social and economic inequities, and thus go beyond searching for technical and theoretical quick-fixes to complex health policy questions (Biehl 2011; Farmer 2008). Ultimately, community health worker programs may be unique opportunities to improve health and reduce poverty and unemployment, and to generate emotional, health, and material returns in which workers and communities can share.

Acknowledgments

KM was supported during data collection by the National Science Foundation (Cultural Anthropology Dissertation Improvement Grant #0752966) and Emory University's AIDS International Training and Research Program (NIH/FIC D43 TW01042). IK was supported during data collection by a Fulbright-Hayes Doctoral Dissertation Research Award, the UC Berkeley Rocca Research Award, and a UCSF School of Medicine International Program Grant. We are grateful to all in Ethiopia and Mozambique who shared their experiences with us. We also extend thanks to the organizations and individuals who supported this work.

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Research highlights

- Life histories of economic insecurity and resilience help explain why people become CHWs.
- Relationships with beneficiaries help explain why people remain CHWs.
- CHWs come to desire greater compensation for complex reasons beyond narrow self-interest.
- Ethnography offers insights for strengthening community health workforces.
- Policies should also set goals of livelihood security and fulfillment for CHWs.