

Examining health-care volunteerism in a food- and financially-insecure world

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Introduction

The problem of severe shortages in global health workforces is addressed in many places by using community volunteers. Whether it is unjust and/or unsustainable to rely on volunteerism in low-income settings, particularly in sub-Saharan Africa, has become a major concern for a widening group of researchers and community health practitioners, particularly in the wake of the 2008 food and financial crises.

The World Health Organization (WHO) recommends 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”.¹ In other words, volunteerism 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. But will various players in HIV/AIDS treatment and care attempt to adhere to WHO’s recommendation?

For the recommendation to be effective, policy-makers and practitioners will need to do (at least) three things: first, examine the myth of the humble, sacrificing volunteer spirit; second, determine how – and whether it is even possible – to hold volunteers accountable for the quality of the work that they do; and third, come to some consensus on what is meant by sustainable.

The myth of the selfless volunteer

Volunteer HIV/AIDS-care projects in low-income settings rest on the assumption that local communities are full of “untapped” moral and social energy, producing an abundance of individuals ready to donate their labour to make their

communities healthier. Armed with this convenient assumption, the question of *why* one does not have to pay for labour is easily answered – because locals are simply willing to do it for free. This myth is apparent in discourses of major international nongovernmental organizations: in its 2007 Ethiopia report, Family Health International boasted that it had trained more than 11 000 volunteers for home-based care and antiretroviral treatment support, and wrote, “The level of interest and commitment of volunteers to the program has been overwhelming.... The program has shown the untapped spirit of volunteerism that exists within Ethiopian communities despite such pervasive poverty”.²

How should we interpret this “spirit” that international organizations, 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 labour 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 culturally-congruent and compassionate chronic disease care.^{3,4} Further, many volunteers involved in the struggle to roll out antiretroviral therapies say that they derive spiritual satisfaction and meaningful relationships by helping others.⁵ Thus from this perspective, community health programmes have the potential to generate psychosocial and health “capital” derived from volunteers’ pro-social motivations. This is a far cry from straightforward labour exploitation.

On the other hand, recognizing the production of such psychosocial benefits suggests that the pro-social “spirit” of volunteers – not just their physical labour – is usurped by the programmes that they serve.

From this perspective, the organizers of volunteer workforces attempt to generate and maintain Durkheimian solidarity or “shared emotional energies”^{6,7}

among volunteers and the communities they serve. The ritual reinforcement of religious and pro-social values among volunteers occurs in training programmes, “appreciation” ceremonies and every-day interactions between supervisors, patients and volunteers. Matching t-shirts, group songs and shared expectations of spiritual rewards are common ingredients. The psychosocial capital that these activities seek to generate is certainly valuable for sustaining volunteers’ motivations and the programmes that rely on them.

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 labour so many HIV/AIDS programmes in sub-Saharan Africa depend.⁸ The work of these scholars has gone some way towards dispelling the myth of the volunteer spirit by talking with volunteers and recording their discontent: unemployment (or landlessness in rural areas), lack of remuneration, low social status, inability to meet household needs⁹ and, in the case of home-based care, being unable to help patients who receive drugs but are not able to afford adequate food.¹⁰

Even with occasional remuneration in kind, training and per diems, these volunteers lack the certainty of remuneration that comes with regular wage payments. Uncertainty is at the heart of the economic insecurity that many volunteers voice.

Holding volunteers accountable

High rates of antiretroviral therapy adherence in sub-Saharan Africa have been at least partly attributed to the contributions of volunteers as treatment supporters, counsellors and mediators of patients’ access to resources.^{11,12} However, the quality of their services is not guaranteed.

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Insufficient training and monitoring of *paid* health workers is one of the main reasons for poor quality of health services. If health systems are failing to effectively train and supervise paid health workers, how can we expect those same systems to monitor volunteers and hold them accountable for their adherence to quality guidelines? These questions demand that we deal with the troublesome concept of sustainability in global health workforce strengthening.

The meaning of sustainability

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 programme’s economic, social and environmental impacts.¹³ Under this definition, the well-being and satisfaction of the labour force are key issues for sustainability of national and community health programmes. But in the “conventional” and narrower global health definition, a health/development project is said to be sustainable if local organizations can “take it over” when the donors that financed the start-up withdraw their resources.¹⁴ According to critics, this definition is associated with a set of health/development practices – such as relying on unpaid labour – that create unsustainable programmes and also lead to unintended and often negative social consequences in African communities.^{9,15}

There is another definition of “sustainable” that refers to a health intervention backed by a commitment to sustained funding by global donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria.¹⁴ This conceptual shift calls for a transformation in practices – from reluctance to commitment – in hiring and paying health workers in low-income countries. 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 their important labour.

Since its inception, the Global Fund has become more attuned to the benefits

of strengthened health workforces. But tension exists between any potential Global Fund mandate to implement “sustainable” workforce funding and the International Monetary Fund (IMF)’s practice of imposing ceilings on government health workforce expenditure.¹⁶ According to Ooms et al.,¹⁴ without flexibility in these IMF-imposed ceilings, bilateral donors continue to be unwilling to support increased health worker salaries; the Global Fund is willing but unable to break through this “vicious circle”. Ooms et al. contend that the Global Fund has an “explicit endorsement from the international community” to practice an approach to sustainability that dismisses the idea that health initiatives can simply be taken over by local governments and organizations after a brief injection of funding.

The idea that volunteerism can simply alleviate this tension is clearly challenged by the economic insecurities that lead volunteers to question their capacity and willingness to continue serving. The international nongovernmental organization Partners in Health devoted its 2009 annual symposium to the theme of “accompaniment”, the community health model that more closely matches the triple bottom line notion of sustainability through commitment to training and modestly paying health *accompagnateurs*. The Public Broadcasting Service in the United States of America recently produced an incisive documentary focusing on Partners in Health’s cooperation with the Rwandan government and the Clinton Foundation in rolling out this model, to the apparent benefit of community health and the economy.¹⁷ These practices signal a nascent but welcomed shift to a broader definition of sustainability in global health.

Food insecurity

Insecure access to food is increasingly recognized as a major contributor to cycles of poverty and HIV/AIDS in sub-Saharan Africa.¹⁸ In Addis Ababa, Ethiopia, a recent study found that HIV/AIDS care volunteers had household incomes well below conventional poverty lines and experienced high

rates of food insecurity even before the peak of the 2008 food crisis.¹⁹ In this context, volunteers espouse desires for economic “progress” amid a mix of pro-social and self-interested motivations to be volunteer AIDS caregivers. For these volunteers, food insecurity was particularly demotivating. Food crisis on top of chronic food insecurity pushed them to reconsider what they deemed as appropriate compensation for their efforts.¹⁰ Ironically, volunteers in such contexts may often be poorer than their clients.

Ideally, effective and resilient community health workers should derive mental satisfaction *and* fair remuneration from their labour. The question for policy-makers is how to generate the spiritual benefits of altruistic, compassionate care as well as a level of remuneration that allows for secure livelihoods among volunteers who are often socioeconomically marginalized.

Conclusion

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 health-care jobs in low-income countries facing pervasive food insecurity and high burdens of chronic and infectious disease. In sub-Saharan Africa, hiring, training and paying community health workers may be a win-win situation: people receive secure jobs that provide food security for their families and communities, and their participation strengthens health-care systems and people in need of care. Given substantial global diversity in programmes, contexts and volunteers (e.g. retired and affluent versus under-employed and poor volunteers), it is difficult to generalize about volunteerism in global health. We need to hear from experts who are familiar with successful and less-successful volunteer programmes 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. ■

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