Episode 103: Kenny Maes

# KL: Katie Linder

# KM: Kenny Maes

# KL: You’re listening to “Research in Action”: episode one hundred and three.

# [intro music]

# Segment 1:

# KL: Welcome to “Research in Action,” a weekly podcast where you can hear about topics and issues related to research in higher education from experts across a range of disciplines. I’m your host, Dr. Katie Linder, director of research at Oregon State University Ecampus. Along with every episode, we post show notes with links to resources mentioned in the episode, full transcript, and an instructor guide for incorporating the episode into your courses. Check out the shows website at ecampus.oregonstate.edu/podcast to find all of these resources.

On this episode, I am joined by Dr. Kenny Maes, an assistant professor and Graduate Program Director for the Anthropology program in the College of Liberal Arts, and the School of Language, Culture and Society and an adjunct faculty member in Humanitarian Engineering, Global Health, and Public Policy at Oregon State University. Prior to joining OSU, Kenny was a postdoctoral fellow at Brown University’s Population Studies & Training Center, an interdisciplinary demography center specializing in the study of population, health and development. As a biocultural medical anthropologist, he teaches courses on human health that explore the links between what goes on inside human bodies and what happens outside, with a focus on social inequalities, and political and economic determinants of health. Kenny’s research focuses on community health workers: women and men who engage in healthcare, community organizing, and advocacy at the community level, both inside and outside of clinics and hospitals. Since 2006, his research has focused on health and healthcare in Ethiopia. Since coming to OSU in 2012, Kenny has begun to work with colleagues in Oregon to understand the experiences of community health workers in our home state. In his free time, he surfs.

Thanks for joining me, Kenny.

**KM:** Yeah it’s great to be here.

**KL**: So I am really curious you call yourself a biocultural medical anthropologist. Which is kind of a mouth full, can you unpack for us what that means?

**KM**: Sure, well the medical part means um that the primary focus of my research is in health, human health. And the biocultural part means, just think like wholeism, we don’t want to leave out human biology, genetics, you know how the immune system works and so on and even from an evolutionary perspective. And we also don’t want to leave out the world of culture social structure political and economic. And ecological detriments of human health you know these things often times get separated in universities and the academic world. And biocultural anthropology is all about trying to bring them together. Um so it’s a very interdisciplinary kind of approach. Big focus on how the world we create socially and politically and economically leads to health problems that are not distributed equally. So big focus on health and equality’s that result from histories of oppression, racism, sexism, homophobia, what have you. And the topics that biocultural anthropologist focus on run the gamut from interest in infectious disease and how that impacts human populations, non-communicable health problems as well, big focus on human development and how culture write large and also within the home shapes human development child development and has impact on health and later life. Yeah I could go on and on [laughs].

**KL**: This is a huge area and I am always really interested especially with people who work in interdisciplinary fields. Um because it can get very niche in terms of once you add these, as you add more words to your title what it is you do [**KM:** Sure] you are kind of niching down into these areas. So I am curious what lead you into this particular area? Like you clearly see the importance in combining these things, but not everybody does. So what kind of lead you into this particular piece?

**KM**: Well, I mean anthropology is a discipline in the U.S. and I will try and make this brief. In many places many universities across the country try’s to bridge these subdivisions within our own discipline cultural anthropology and biological anthropology being the primary to. But there is also archology within our discipline and linguist is a fourth sub discipline. So in the United States there is a tendency to try and bridge the bio and the cultural. Where as in European or UK anthropology programs maybe not as much as this attempt to do this holistic, we can it four field like four sub field anthropology. People understand each other and can do collaborative work and avoid the divisions that have been present in a lot of anthropology programs at the same time in the United States and else were. So part of it just has to do with the way anthropology is and has been taught as a dripline in the 20th century and into the 21st century in the United States. And the other short answer to your question how I got into it was as an undergraduate student the first professor who really gave me an opportunity to get research experience and work in his lab and so forth. He was a bio archaeologist, someone who was putting together human health and archaeology to understand health and equalities in the past primarily. And I got really into bio archaeology I really wanted to study health in the past in Africa, and not a lot of people had done that. Basically as a bio archaeologist you are excavating human remains bones, teeth and reading the signs of health problems, disease, nutritional deficiencies, infectious diseases, injury, violence, and what have you that leave traces on the bones. And putting that in the context of what archaeologist know about social structure and change and social inequalities and so forth in the past. To understand what is driving health differences between men and women, between generations, between classes as classes start to develop in the Neolithic and agricultural period. Right, so that’s how I got into it. Was in this bio archaeology focus, but then in graduate school I decided that I was really even more passionate about the health of people who were living and how the world works and why we see so much suffering and health inequalities in the world today. And anthropology provides for that sort of kind of transition with continuity looking at health inequalities in the past and prehistory to all the way to the present.

**KL**: So as you are describing this field it sounds highly evolved to me [laughs]. In the fact that people are so collaborative working together working across these sub fields. So much of academia doesn’t necessarily do that everyone is kind of in their own turf. So that is a really interesting component of what you are talking about. I am wondering what are some of the primary methodologies that you are using in you research? What are some of the things you are using to gather the data and answer the questions you are asking?

**KM**: Sure. So as a bio cultural anthropologist I should be using like a mix of methods to get at the bio to get at the cultural and social and all that. And for sure bio cultural anthropologists um you know will take saliva and cheek swabs or blood spots or other human tissues. And extract bio markers to study you know outcomes how the world and social structure and culture gets under the skin. Shapes physiology, shapes health at the micro level. For me I have the kind of I haven’t actually taken blood from people and saliva and all that kind of stuff to stuff to study biomarkers. But I have done nutritional anthropometric measurements. Where you know you are measuring height and weight and arm circumference or skin fold thickness. Looking at the body composition of individuals within a population. Looking at nutrition status basically and how food prices is one thing I focus on as a doctoral student. How sky rocketing food prices lead to reduced access to food in an urban setting and how that can have impacts on nutrition and wellbeing more generally. Yeah the focus on food and security also lead me to measure with a scale. And food and security is also being measured with like a survey scale. Where you are basically asking someone nine questions in the last 30 days did you have to cut back in this way with regards to food, cutting meals, cutting diversity not eating the foods you wanted to going a whole day without food. So you get a sort of a measure of how serve the food security situation is in a household. Been doing that kind of survey work and also using like a check list of psychological stress symptoms. Like common depression and anxiety symptoms, to get at a measure of someone’s psychological distress loads. Looking for correlations between the experience of something like food insecurity as an aspect of poverty and mental health outcomes. A lot of research has been looking at that in different populations around the world, demonstrating over and over again that there is this tight connection. Between having secure access to basic resources like food and having a lot of psychological distress. That can actually become a diagnosable mental disorder and require mental health services in addition to addressing those underlining problems that are rooted in poverty and inequality. So there is the bio marker stuff, there’s like survey measures of things like food and security and mental health, we measure in the surveys we do with folks social support also, assets other measures of poverty. But I am skipping over a really important method we use as an anthropologist and that is a participate observation. So participate observation from example when I did my doctoral research in Ethiopia in the capital city of Addis Ababa. It was focusing on unpaid Ethiopian care givers, people who are volunteering to check on people with HIV/AIDs. Make sure they are getting what they needed taking there medicine, but also getting the food support they needed. And these where impoverished Ethiopians in an urban setting, and they were being recruited by local non-profit organizations and that local non-profit organization that would recruit and train and supervise these volunteers had partnerships with the public hospitals that was offering the anti-retroviral HIV/AIDS treatment to this expanding number of patients. And there is funding coming in from abroad, donors in the United States and Europe and elsewhere. And there is this huge field really that you have to sort of wrap your head around to understand how our policies at a high level are effecting the experiences of these unpaid caregivers at the ground level and the patients they are trying to take care of. And so this is along answer to say it is really important as a method to just spend the requisite amount of time embedded so to speak in the situation. The daily situations of these care givers and patients and clinicians and non-profit officials are living out their lives working in, learning the language. You know for my disorientation work I spend almost two years in Addis Ababa to hang out and observe, and go around with these volunteer care givers. Just being a part of their trainings, being a part of their interactions with patients, being a part of the ceremonies the non-profits put on to shower them with recognitions to thank them for the difficult work they were doing. And all of that is participate observation, hanging out trying to be as much as a participate as possible given the distance between me and the folks I am trying to get near to. I am a white man going to Ethiopia, I don’t speak the language, but learned how to speak it in the course of a couple years so that you can build the relationships of trust. So you can be in those situations where people are just being themselves and working out the struggles that they confront on a daily basis. And getting a deeper knowledge of folk’s motivations and what’s constraining their behavior what’s driving their behavior. So you can say something that is really meaningful and shaped by a deep understanding of the context. Say something that can help improve the situation. The kind of research is that I do is aimed at bringing some recommendations to improve um health care in this particular situation.

**KL**: We are going to take a brief break when we come back we are going to hear a little bit more about Kenny’s work with community health workers. Back in a moment.

[Music plays in the background]

**KL:** The “Research in Action” podcast is definitely a team effort, and I wanted to give kudos to our Oregon State University Ecampus multimedia team who ensures the podcast is the high quality production that it is. OSU Ecampus is home to national, award-winning multimedia developers and instructional designers facilitating the highest level of student engagement in OSU’s online courses. See what else the team is up to by previewing what it’s like to learn online with Oregon State by visiting ecampus.oregonstate.edu/demo.

# Segment 2:

**KL**: Kenny your recent research has focused on community health workers. I am wondering if you can share some of the questions you are exploring in this area?

**KM**: Sure. So community health workers just real briefly they are trained minimally and they are not necessarily considered health professionals some might get a month of training a year of training and refresher training as they are working. But there is sort of at the bottom of this health worker hierarchy in terms of how much training they are getting and also how much pay they are getting. What’s really unique about them and why health system, policy makers and so forth in the United States and all around the world low income countries especially included. Why they are interested to work with community health workers. Is that by definition they are supposed to come from the communities they are serving they are supposed to have that intimate understanding of health problems social problems of the folks they are trying to help are experiencing. They are supposed to have those relationships to with folks, that the trust is hopefully already there or easy to build with folks. Whereas nurses and doctors are kind of not always this is a generalization but distance socially because of their status and don’t always have an easy rapport with patients and can’t know what their lives are like on a day to day bases like a community health worker can. So given that definition of community health workers some of the main questions I ask are: What’s the wellbeing of the community health workers themselves? They are coming from communities that are typically impoverished and marginalized. So by definition they are probably experiencing some forms of depravation, marginality. And that’s why I have been asking them questions and doing surveys to assess their psychological wellbeing, the levels of social support they have, their experiences of depravation with regards to basic resources like food and water more recently. Also one of the main questions is how do they build relationships with their patients? And how do they establish that trust? And how does that important connection that they are supposed to have with folks translate to better health outcomes for people? And then better health outcomes for populations and reductions in health inequalities. Another really important set of question is: Okay how are health officials (policy makers people who make funding decisions about health systems and what we are going to spend money on). How are they relating to community health workers? How are they making decisions about what they should be paid? Whether they should be paid or not? Because there is a lot of expectations of unpaid volunteer work. Which is really problematic when we are talking about impoverished people, people who could in most cases are looking for decent work and a good job. And it’s pretty clear from lots of research in public health that decent work and a good job leads to better population health. So by not paying these community health workers well or not paying them at all there is a huge missed opportunity for improving public health. Just using them unpaid to do a health project that might be focused on HIV treatment and support or reducing the amount of emergency room usage in the United States by marginalized folks who have a lot of health problems. You can have some impact, but you are missing again this opportunity to have a bigger broader impact by giving people who don’t have access to good jobs, good jobs with good pay. And then finally the last question is: How are community health workers themselves organizing their own ranks, becoming conscious of the health system around them and these health care discussions that often channel funding away from them. Even though they are talked about as so important the work that they do is talked about as so important. How are they organizing how to push for improved job conditions for themselves? And change policies that are leading to health problems in their communities? So there is a tendency for doctors and health experts to think of community health workers roles as mainly just about having a relationship with one patient and helping that one patient get better and reducing cost for the health system one patient at a time. So that population health gets better and costs are reduced, that’s a big focus in the United States as elsewhere. There is not a lot of attention to what community health workers are doing as like community organizers. Building relationships, building capacity in their communities, links between different organizations who have maybe some shared interest in social justice, environmental justice, policies that are keeping people poor or keeping people sick. Whether they are public policies or the ways that private corporations operate or pollute the environment or what have you. One interest of mine is in seeing how attention to those kind of roles as community health workers is evolving. How community health workers are taking on that kind of community activist and organizer role and how other in the health system are encouraging them to do that or ignoring that or in some cases lets be real like discouraging them from taking on that kind of work.

**KL:** So I know that some of this work for you is still happening in Ethiopia. But some of it is also here in Oregon, so I am wondering if you can talk a little bit about…I am imagining that there is some pretty significate differences between the two areas. But maybe some similarities as well that some people would consider a little unexpected. And so can you kind of compare and contrast what that is?

**KM**: Yeah I mean there are a lot of similarities. Ethiopia is one of the lowest income countries in the world and the United States is like one of the highest income countries in the world. But in the United States, we have great income and inequality. We have huge inequality to access in power, basic detriments of health: environment, housing, food. Plenty of folks in our own state in our own country because of their economic status, because of their immigration status because of their prescribed race and so on. They are experiencing a lot of hardship and that’s where community health workers in the United States and in Oregon come in. There has been community health workers in this country for decades going by different names, and so forth. But they have been around because poverty and inequality has been around for a long time. There has been more interest in community health workers in the last few years after the pass of ObamaCare of the affordable care act. That act specifically said you know to help reduce cost in the health care system and to help reduce health and inequalities we need to use community health workers more. So there has been some movement to make that happen. Although again in Ethiopia there isn’t a lot of money behind this rhetoric on how important community health workers are. And money ends up getting spent on other parts of the health system and so that means community health workers here also in Oregon are struggling to have secure jobs and be there over the median term/ long term. Not just be there for a few years because of a grant then disappear when that grant period is over or something like that. Um very similarities that come from these structural similarities there inequality there is poverty in Ethiopia, there is inequality and poverty here in the United States. Differences though real briefly in Ethiopia there is very little kind of community health worker organizing that I mentioned before. Where they are autonomously organizing their ranks developing an association or something like that. Really tiny movements towards that that I have been able to pick up on in the last few years. Whereas in Oregon we have had for years in Oregon community health worker association and in many states around this country we can have community health worker alliances and what have you. That are trying to advance their own role, trying to convince policy makers and other experts in the health systems to put their money and policy change where rhetoric has been. So that community health workers are being better integrated into health systems and better respected so that their multiple roles are being respected as well. So, a lot more organization here and power and voice, collective voice, but still up against um a lot of challenges. So that’s gotten me really interested in work with my colleagues who have studied community health workers in different parts of the global. How are community health workers in different places organizing? How are they trying to get their voices heard and advocate for policy changes? Whether that is policies that govern their own jobs and the ways that they are remunerated or not. Or policies that are impacting the wellbeing of the communities that they live in. So, moving towards some like cross country comparative work or community health worker labor relations. Labor movements that have emerged in some places were community health workers are even going on strike and demanding better pay and conditions. And being very clear if they have better pay and better job conditions that will translate them being able to do better job for the people they are caring for which translates to better health outcomes. One thing that has been really interesting that I noticed is that its community health workers are vulnerable to criticism when they start to advocate for their own improved job conditions. Other health experts and policy makers and payers and so forth can say you know we are trying to save lives we have a limited budget don’t be selfish and think of your job conditions and your level of pay let’s just try and get it out there and save some lives from HIV or diabetes or what have you. And community health workers have to navigate that moral landscape. Which is different than how low level workers in a different industry that is just like for profit or something like that how they are navigating their own labor movements. So it’s an interesting question for me and the goal of this kind of research which is not just to see community health workers becoming more antagonist with others in the health system. But really how they are trying to find some mutual understandings and solidary with others in the health system. Get people to understand investing in the health workers is an investment in the population health. It doesn’t have to be either or. Do we pay the community health workers or do we pay for the medicines and the other parts of the health system. If we find ways to grow that pie of funding we can pay for it all. And that would be great in this country just as it would be in a place like Ethiopia.

**KL**: Okay…these are big, big ideas. Big questions especially the cross country analysis. You eluded to this a little bit, but I am wondering what’s next for you with this project?

**KM**: Yeah so um. Here in Oregon and the United States I have gotten involved with a network of colleagues we are trying to do is develop a set of common indicators or common metric or common things that we want community health worker programs across the whole country to measure on a regular basis. So, that evidence based for the impact of community health workers is growing and growing and growing. Because this has been lacking programs around the country are measuring different things and then you can’t put that data together into really big and convincing studies that are convincing for payers and policy makers and so forth. And then some community health worker programs aren’t paying much attention at all to evaluating the impacts of community health workers. So, we have heard from donors from folks in the federal government and so on that they need more evidence. And on the one hand there is already a good deal of evidence for how effective community health workers can be, how to use the language of economics. Which unfortunately dominates the health care discussion. How the return on investment for community health care workers can be quite favorable, right? You put in a dollar get two dollars back or something like that. On the one hand there is evidence there, but on the other hand if the demand is for more evidence then we have to respond to that demand. Get these common metrics out to programs around the country so everybody is measuring the same things. Basically what community health workers are doing in different aspects of their work conditions of their jobs of how they are being integrated into health care teams. These things need to be measured in outcomes. Like how are health indicators of the populations that community health workers are serving how do they get measured? Food and security and the people that they are serving. Transportation security, housing security those kinds of determinants of health too. We want folks everywhere to want to measure. So this isn’t necessarily a research project although it will blend into evaluation research. It’s more of a project in moving this field, making sure that a whole bunch of other folks are gathering the data, gathering the information doing the analysis that are going to convince policy makers and payers.

**KL**: Well this work sounds incredibly impactful. I want to thank you again for coming and giving us a glimpse a very small glimpse into what your work looks like with community health workers and also in biocultural medical anthropology. Thanks so much!

**KM:** Yeah. Great! thanks for having me!

**KL**: Thanks also to our listeners for joining us for this week’s episode of Research in Action. I am Katie Linder and we will be back next week for a new episode.

[Music plays]

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# Bonus Clip:

# KL: In this bonus clip for episode 103 of the “Research in Action” podcast, Dr. Kenny Maes shares strategies for building trust as a researcher. Take a listen:

**KL:** So I would imagine that, that trust piece is huge. And particularly for a population that, in the past, has been abused for things like medical research or they, you know, may be like very skeptical of why you’re wanting to measure things. Or why you’re embedding yourself into their community. Um, I’m wondering if you can speak to that just a little bit more. You mention things like spending time, you know, and really being there, learning the language. You know, were there other things you found that really allowed you to build that trust to allow you to have a successful project?

**KM:** Yeah, absolutely. I mean, as a, and going back still to the research that I did as a doctoral student in the capital, it really helped that I was a student because students in Ethiopia, historically/traditionally are, are seen as sacrificing, you know, an income by getting some education to improve themselves. And students are seen as relatively poor and in need of support. So there’s a generally positive, sort of, conception of students in Ethiopia and even though I’m not at all from Ethiopia, and I’m a total outsider for being a student as opposed to being another non-profit official or government official or donor official, or something like that was really important. Like I mentioned, you know, trying to learn the language was really important. At that time, being in my twenties, and a lot of these unpaid women and men who were doing this volunteer caregiver work were also in their twenties. That helped. I mean, that youth that we shared, they wanted to get to know me. They wanted to, they were pretty open about telling me what they were going through.

More recently, the work that I’ve done in Ethiopia, in rural parts of the country where I’m not a student, it’s been a challenge to develop that trust that is so important to claim a positive role as a researcher to learning something meaningful that’s going to help improve the situation. And, all along, in my more recent projects in the rural parts of the country, in the city previously, it has been hugely important to work with really fantastic Ethiopia research assistants. They’ve, I can’t, I can’t say enough about how much they’ve helped me establish trust with the other people that we want to collect information from, how much they’ve helped me understand these complex social situations that we’re trying to navigate to collect the information that we’re seeking. So, I’ve always been really fortunate to work with, um, a few women and a couple of men as well, who are and have been, just wonderful interviewers, really great with people, compassionate people, and that compassion can go a long way to building that trust. Yeah, one of those, um, one of those research assistants who’s worked with me since I was just starting out as the doctoral student in Ethiopia, he’s now a Ph.D. student of mine here at Oregon State University getting his Ph.D. in applied anthropology. He’s in Ethiopia right now doing his Ph.D. research, um, and he works closely with his wife actually because a lot of the folks that we’re interviewing are women and the gender factor is really important, too. His wife does such a wonderful job of building relationships, interviewing the women that we want to talk to. And so, yeah, like I said, local research assistants are so crucial and I’m always thinking about, “how do I really give back to these folks who have done so much to make these research projects successful?” Yeah. And just as an aside, the one thing that’s really important is that these, like I mentioned, these health workers who are not getting paid or getting paid very little who are at the very bottom of the health care hierarchy, they’re, like ninety percent of them are women. And that’s for a number of reasons, I mean, women have a harder time finding paid work in low income countries and in high income countries there is a gender gap in pay as well. And so, women are having trouble getting jobs in other sectors, these low-level health care jobs kind of end up being one of the only thing that’s available to them. And there’s also these cultural and social norms about women being just naturally better and designed for this kind of care work, and being more compassionate and willing to work for free also. Those kind of gender norms are not accurate—they’re norms, right? And they partly explain why there’s so many women in these roles, um, but they don’t explain why—actually, even if officials in Ethiopia say that women don’t really want money, why some of them actually really do for this work that they’re doing. And it doesn’t explain the fact that some men who take on this work and do a really wonderful job, too, and are compassionate and I think these things are really important to recognize.

**KL:** Okay, well there are so many layers here. Thank you for helping us to understand at least some of them.

**KL:** You’ve just heard a bonus clip from episode 103 of the “Research in Action” podcast with Dr. Kenney Maes sharing strategies for building trust as a researcher. Thanks for listening!

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