Caring in crisis:

The experiences of local faith leaders meeting community food needs in the Philippines during the COVID-19 pandemic

by

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Author's Declaration

This thesis consists of material all of which I authored or co-authored: see Statement of Contributions included in the thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Statement of Contributions

I, Shoshannah Speers, authored Chapters 1, 2, and 4 of this thesis under the supervision of Dr. Warren Dodd. These chapters were prepared for the thesis and not for publication. Chapter 3 was prepared as a manuscript with the intent of publication. Co-authors of the manuscript are indicated in Chapter 3 and contributions to the work are described below in order of authorship.

Chapter 3

I, under the supervision of Dr. Dodd, have been the primary researcher and contributor to writing and preparing this manuscript to date. Contributions by co-authors have been primarily to the total research effort as members of the research team. Further contributions by co-authors to the written work is forthcoming.

Dr. Lincoln Leehang Lau is a member of this thesis committee and a collaborator on the study as the Director of Research at International Care Ministries (ICM), the partner organization for this research. Dr. Lau provided support with project development and coordination, liaison between the University of Waterloo and ICM, and research debrief sessions. Dr. Lau contributed to designing and conducting the study as well as to reviewing and revising the manuscript.

Dr. Hannah Tait Neufeld is a member of this thesis committee. Dr. Neufeld provided support as interim supervisor in the Fall 2020 term. Dr. Neufeld contributed to designing the study as well as to reviewing and revising the manuscript.

Danilo Servano Jr. is a member of the research team and the National Metrics Officer at ICM. Mr. Servano Jr. provided support with participant recruitment, interview facilitation, language interpretation, debrief sessions, and data transcription. Mr. Servano Jr. contributed to designing and conducting the study.

Daryn Go is a member of the research team and a Research Associate at ICM. Ms. Go provided support with project development, administration, interview preparation, participant recruitment, and debrief sessions. Ms. Go contributed to designing and conducting the study.

Dr. Warren Dodd is the supervisor of this thesis and research. Dr. Dodd is the primary and ongoing collaborator with Dr. Lau and provided support throughout all stages of the project. Dr. Dodd contributed to designing and conducting the study as well as to reviewing and revising the manuscript.

Abstract

Background: Unintended consequences from public health measures have inspired a wave of care during the COVID-19 pandemic. In the Philippines, where extensive and strict community quarantines exacerbated food insecurity, countless individuals, organizations, and institutions reached out to care for those most affected. International Care Ministries (ICM), a Philippines- and faith-based non-governmental organization (NGO), responded by mobilizing resources through its Rapid Emergencies and Disasters Intervention (REDI), a program which functions through a broad network of volunteer faith leaders local to the areas ICM works. The purpose of the study was to explore the experiences of faith leaders caring for their communities through REDI involvement during the pandemic with the aim to inform the program moving forward.

Methods: Semi-structured qualitative interviews were conducted with 25 REDI faith leaders remotely via Skype in Negros Occidental, Philippines between November 2020 and January 2021. Interviews were audio recorded, transcribed verbatim, and analyzed using an inductive thematic analysis approach. Ethics of care provided theoretical framing for the study. Thus, the efforts of faith leaders were understood as a type of care work, and ethics of care broadly informed study design, data analysis, and research presentation.

Results: Faith leaders practiced care for community members through REDI by navigating care responsibilities, leveraging relationships, and engaging holistically with the care work. That is, faith leaders were greatly motivated to meet community food needs, drew on a depth of

commitment and creativity to accomplish tasks, reached out to personal relations to elicit and provide support with care tasks, navigated a range of complex circumstances and emotions with optimism, and offered emotional and spiritual care alongside material aid.

Conclusion: Participant narratives emphasized the integral roles of responsibility, relationality, and emotion to the care work. The accounts of faith leaders also highlighted contextual elements of their care practice; namely, the humanitarian setting, partnership with ICM, positionality as local faith leaders, and locatedness in the Philippines. Further, their experiences revealed the inherently complex nature of care. This study expands and complicates our understanding of care by examining an under explored form of care work within ethics of care. In addition, findings bring visibility to the efforts of faith leaders in humanitarian crises.

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Finally, I extend my heartfelt gratitude to the 25 REDI faith leaders who participated in this study. Thank you for generously sharing your time and experiences with me. It was an honour to hear and be immersed in your stories; I hope I have done them justice through this work.

Dedication

To my late father, John L Speers, who cared deeply and lived fully.

To also the many Filipino faith leaders in the Rapid Emergencies and Disasters Intervention (REDI) network who cared for their communities in this crucial time. May this research contribute to your continued and valued efforts.

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List of Abbreviations

COVID-19	Coronavirus disease 2019
ICM	International Care Ministries
LGU	Local Government Unit
LMICs	Low- and middle-income countries
NGO	Non-governmental organization
REDI	Rapid Emergencies and Disasters Intervention
SSHRC	Social Sciences and Humanities Research Council
WHO	World Health Organization

"To be a caring person requires more than the right motives or dispositions. It requires the ability to engage in the practice of care, and the exercise of this ability."

Virginia Held

in *The Ethics of Care: Personal, Political, and Global*, 2006, p. 51

Chapter 1: Introduction

1.1 Preface

With the onset of the COVID-19 pandemic in early 2020, Dr. Warren Dodd of the University of Waterloo (Canada) and Dr. Lincoln Lau of International Care Ministries (ICM; Philippines) began to discuss opportunities to conduct research that would support ICM's pandemic response. ICM had recently employed its Rapid Emergencies and Disasters Intervention (REDI) program to meet critical food needs in the country exacerbated by the pandemic. Thus, the idea was born to investigate the experiences of ICM's partner volunteers who were implementing the program at the community level. A larger research team including members from the University of Waterloo and ICM was then formed, and further collaboration ensued. In addition to being grounded in partnership, the study was guided by an ethics of care (or care ethics) theoretical orientation. Accordingly, a broad concept of care was held, as "everything [done] to maintain, continue, and repair our 'world'" (Fisher & Tronto, 1990, p.40), which meant that the efforts of ICM's community volunteers were understood as a type of care work. Therefore, this research elucidates how ICM's volunteers, all of whom were local Filipino faith leaders, practiced care in their communities through participation with REDI. In doing so, this research identifies critical elements of their care work and highlights the complexity of practicing care in this context.

This thesis is divided into four sections: an introduction (Chapter 1), an account of research methods (Chapter 2), a manuscript that outlines and discusses study results (Chapter 3), and a conclusion (Chapter 4). In this introductory chapter, I provide framing for the study. First, I present background information, which includes an overview of ethics of care, a survey of faith

leader community-based roles and efforts in the Philippines and more broadly, and a review of sociocultural factors in the Philippines. Second, I describe the study context, which includes an outline of why the research took place and what it aimed to accomplish. Third, I explore my positionality and its potential intersections with and impacts on the research.

1.2 Background

1.2.1 Local faith leaders: Community-based roles and efforts

Community mobilization has widely been recognized as an effective means to bring about change among individuals. The World Health Organization (WHO) identifies community mobilization as a type of social mobilization characterized by involvement of local political, religious, social, and traditional leaders, groups, and organizations (World Health Organization: Regional Office for the Western Pacific, 2003). Social mobilization, according to the WHO, is "a process that engages and galvanizes people to take action towards the achievement of a goal for the common good" (World Health Organization: Regional Office for the Western Pacific, 2003, p.4). Community mobilization has been shown to be effective in addressing localized health promotion, behaviour change, social inequities, intervention participation, and emergency response (Blanchard et al., 2013; Grabe et al., 2014; Kaliwile et al., 2020; Lippman et al., 2018; Menon et al., 2016; Nkoghe et al., 2011; Okware et al., 2002; A. Wilkinson et al., 2017). During the COVID-19 pandemic, community engagement and mobilization have been abundant and essential around the globe as individuals have volunteered, in both spontaneous and organized capacities, to address local needs from grocery shopping, checking on well-being, medicine delivery, telephone helplines, packing and delivering food, supporting the public health system,

and assisting non-profits deliver various services (Dodd, Kipp, Bustos, et al., 2021; Mak & Fancourt, 2021; Marston et al., 2020; Roy & Ayalon, 2021; Trautwein et al., 2020).

Faith communities and leaders in particular can play a key role in promoting health and well-being. Importantly, some scholars have identified religion as a social determinant of health (Idler, 2014; Kawachi, 2020). Spirituality is a source of stability, meaning, and connectedness for individuals (del Castillo et al., 2020; Rovers & Kocum, 2010) and previous research has found positive health outcomes to be associated with regular participation in a faith community (Cohen-Dar & Obeid, 2017; Ellison & Levin, 1998; Harrigan, 2011; Sørensen et al., 2011). Further, faith leaders provide support, comfort, and guidance in their communities (World Health Organization, 2020a) and have been shown to be significant stakeholders due to their cultural, spiritual, and physical embeddedness within communities and comprehensive understanding of local networks and historical context (Lau, Dodd, et al., 2020; Oyo-Ita et al., 2021; Powell, 2014). Relationships between faith-based groups and leaders and their communities can be characterized by trust, and faith leaders may be seen as reputable sources of information by their communities (Harr & Yancey, 2014; Lau, Dodd, et al., 2020; Powell, 2014). Accordingly, existing evidence has revealed religious leaders to be valuable social agents for change in some contexts, particularly regarding health and well-being promotion (Adedini et al., 2018; Cohen-Dar & Obeid, 2017; Lau, Dodd, et al., 2020; Oyo-Ita et al., 2021; Rivera-Hernandez, 2015).

In emergency response settings, religious individuals, groups, and organizations have also been particularly effective, especially in religious societies (Ager et al., 2014; O. Wilkinson, 2018). In the context of the COVID-19 pandemic, studies found that faith leaders were instrumental in both disseminating public health information, encouraging disease prevention activities, and promoting health and safety measures as well as dissuading adherence to public health measures

and fostering mistrust among members (Osei-Tutu et al., 2021; Wijesinghe et al., 2022; Yoosefi Lebni et al., 2021). Beyond disease prevention, faith leaders worldwide have been active in addressing a range of needs – physical, mental, emotional, spiritual, and relational – which have arisen during the pandemic. Accordingly, faith leaders have mobilized food, hygiene items, clothes, and financials; offered psychological support, counselling, prayer, and spiritual support; provided shelter; found creative ways to foster belonging and resilience despite isolation measures; and shared messages of hope and faith to congregants (Arruda, 2020; del Castillo et al., 2020; Frei-Landau, 2020; Osei-Tutu et al., 2021). Indeed, concern has been raised regarding the well-being of faith leaders as their roles and responsibilities have expanded during the pandemic (Greene et al., 2020).

1.2.2 The Philippines: Calamities, faith leaders, and sociocultural factors

Due to its archipelagic nature and geographical location, the Philippines is exposed to a range of climate hazards, resulting in its status as one of the most disaster-prone nations and most vulnerable to the effects of climate change globally (Center for Excellence in Disaster Management and Humanitarian Assistance, 2019; Center for Research on the Epidemiology of Disasters, 2019; Day et al., 2019; Global Facility for Disaster Reduction and Recovery, 2016; United Nations Office for Disaster Risk Reduction, 2019; Valenzuela et al., 2020). Its frequent calamities exacerbate poverty in the nation, which was at an incidence rate of 16.7% of the population in 2018, equating to 17.7 million people (Philippine Statistics Authority, 2020a; United Nations Office for Disaster Risk Reduction, 2019). Importantly, hunger and food insecurity persist as major concerns in the country and are also exacerbated by exposure to climate hazards and armed conflict in some settings (Briones et al., 2017; World Food

Programme, 2020). At the same time, the Philippines has seen steady economic growth over the past decade, causing an anticipated advancement to classification as an upper middle-income country (World Bank Group, 2019). However, the income gap remains large, and growth is uneven across the population (World Bank Group, 2019).

A multiplicity of sociocultural and ethnolinguistic features exist across the nation, contributing to a highly diverse population of over 109 million residents located in over 7,000 islands grouped by Luzon (north), Visayas (central), and Mindanao (south) (Boquet, 2017; Philippine Statistics Authority, 2021b). Despite its vast diversity, a shared feature includes an inclination toward spirituality with over 90% of the population identifying as religious (predominantly Catholic, in addition to Protestant and Muslim) (Boquet, 2017; Philippine Statistics Authority, 2019a, 2019b). Accordingly, religion is an integral part of the daily lives of Filipinos (Boquet, 2017; del Castillo et al., 2020; Marshall, 2018), and support grounded in spirituality is both culturally appropriate and meaningful in the context of humanitarian emergencies. For example, Typhoon Haiyan (2013) victims reported faith-based disaster relief more favorably than secular disaster relief, as these individuals found faith-based disaster relief to be relational and holistic, meeting not only physical needs, but emotional and spiritual needs as well (O. Wilkinson, 2018). In the context of the COVID-19 pandemic, faith leaders have played a crucial role in providing stability and hope for Filipinos as they have not only shifted to provide services online typically offered in person, but have also mobilized to supply food, shelter, and supplies to frontline workers and individuals in need across the country (Calleja, 2020; CNN Philippines Staff, 2020; Corpuz, 2021; del Castillo et al., 2020; Guadalquiver, 2021; Hilario, 2020; International Care Ministries, 2020, 2021). In doing so, faith leaders have been recognized by the Philippine government for filling an essential gap since government aid alone had not been sufficient (Calleja, 2020).

Further, it has long been recognized that a commonly held cultural norm of Filipino society is a value for relationships; thus, previous research has shown the presence of strong 'bonding' social capital (i.e., between family members, friends, neighbours) among Filipinos (Abad, 2005; Eadie & Su, 2018; Marshall, 2018; Morais, 1981; Pal, 1966; Turgo, 2016). From this, a widely held traditional concept in the country is *bayanihan*, a sentiment which signifies communal effort for the common good (Ang, 1979; Aruta et al., 2022; Bankoff, 2020; Eadie & Su, 2018). Although the term was originally used in the context of collective agriculture, it has broadened over the years and gained applicability throughout Filipino society (Beza et al., 2018; Eadie & Su, 2018; Oracion et al., 2005). *Bayanihan* has been especially important during difficult or challenging times such as disasters and emergencies (Aruta et al., 2022; Bankoff, 2020; Boquet, 2017). Accordingly, studies have noted and explored the presence of *bayanihan* in typhoon contexts and during the COVID-19 pandemic (Aruta et al., 2022; Bankoff, 2020; Eadie & Su, 2018; Jovita et al., 2019; Siena, 2022). Importantly, the term has also been contentious as political authorities have employed the concept to promote compliance among residents, as was evidenced during Typhoon Haiyan and the COVID-19 pandemic (Bankoff, 2020; Eadie & Su, 2018; Siena, 2022).

1.2.3 Ethics of care: History, concepts, and applications

In 1982, moral psychologist Carol Gilligan advanced the idea that there were two distinct approaches to morality: morality based on justice and morality based on care (Edwards, 2009; Gilligan, 1982). Her theory stemmed from conversations about moral issues with women and girls and observations around how they described, understood, and navigated morality. Gilligan identified that they held an alternate view of morality that was not well represented and thus, presented what she termed an "ethic of care" (Gilligan, 1982, p.73). According to Gilligan, a

morality based on justice entailed analysis, impartiality, abstract principles, and drawing conclusions, and was formal, being underpinned by rights and rules (Branicki, 2020; Edwards, 2009; Gilligan, 1982). To the contrary, a morality based on care held interdependence, context, and emotion to be central and was underpinned by relationship and responsibility (Branicki, 2020; Edwards, 2009; Gilligan, 1982). Gilligan described care accordingly: "The ideal of care is thus an activity of relationship, of seeing and responding to need, taking care of the world by sustaining the web of connection so that no one is left alone" (Gilligan, 1982, p.62).

Following Gilligan's initial theorization around a care-based versus justice-based morality, other scholars contributed to the development of an ethic of care. Joan Tronto, in contrast to Gilligan, presented a care-based ethic which included a role for justice within the broader frame of care (Edwards, 2009; Tronto, 1993). To Tronto, justice was needed to discern and prioritize the urgency of care needs (Tronto, 1993). Similar to Gilligan, Fisher and Tronto presented a broad description of care as, "…*a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible*" (Fisher & Tronto, 1990, p.40; Tronto, 1993, p.103). Further, Fisher and Tronto (1990; Tronto, 1993) developed a four-phase model of care which outlined distinct components involved in the act of caring, each of which corresponded to a unique moral quality. The first phase and moral quality, 'caring about' and *attentiveness*, involved noticing and identifying the presence of an unmet need. Second, 'caring for' and *responsibility*, involved assuming the burden of meeting the identified need. Third, 'care giving' and *competence*, involved performing the care work with moral and technical competence. Fourth, 'care receiving' and *responsiveness*, involved observing the response of the care receiver to assess whether the care given was appropriate, complete, and whether new needs had emerged. Following this initial delineation, Tronto (2013) added a fifth

phase and moral quality, 'caring with' and *plurality, communication, trust, respect, and solidarity*, to emphasize that care work could be a collective endeavour which held solidarity, justice, equality, democracy, and freedom for all as central.

Since earlier theorizations by Gilligan, Tronto, and others (see Held, 2006; Noddings, 1984) which situated the theory in feminist thinking and literature, ethics of care has diversified with application in a broad range of disciplines and fields. These disciplines and fields include, but are not limited, to: social work (Collins, 2015), education (Langford et al., 2017), disability studies (Kittay, 2011), geography (Bastia, 2015; Hanrahan, 2020; Skovdal & Evans, 2017), economics and business (Hamington & Sander-Staudt, 2011), technology studies (Pols, 2015), sociology (Lynch et al., 2021), climate change studies (Bond & Barth, 2020), political theory (Engster & Hamington, 2015; Hankivsky, 2014), nursing and healthcare (Nortvedt et al., 2011), and migration studies (Locke, 2017). Due to the broad theorization of care ethics, no commonly held definition exists to date (Engster & Hamington, 2015). While some scholars have expressed concern about the theory's lack of organization and have argued for boundaries to establish care ethics as a distinct discipline (Klaver et al., 2014), others have asserted that it remain interdisciplinary, flexible, critical, and beyond such demarcation to stay authentic (Leget et al., 2019). Nevertheless, several core themes are commonly endorsed by theorists, which Engster and Hamington (2015) identify as: relationality and interdependence, responsiveness to others, the inseparability of context, crossing the private-public divide, and the inherence of emotion.

Several scholars have called for further expansion of care ethics theorization. Due to the theory's roots in the Global North, Raghuram (2016) has contended the need to "emplace" (p.512) care beyond the Global North to explore the multiplicity of care practices globally. In doing so, she argues to not only apply ethics of care to varying locations but to build up our understanding of

care ethics through studying care as grounded in various localities. Further, Raghuram (2016) has presented the need to "trouble" (p.515) care by exploring unfamiliar forms of care and the "uncomfortable relations" (p.526) in care to theorize care more comprehensively. Similarly, Hankivsky (2014) has contended for the integration of intersectional analysis and examination of power relations to avoid essentialism in care ethics. In addition, Bartos (2018, 2019) has demonstrated that care is not necessarily positive but can result in care-less, even harmful outcomes, and has called for more critical engagement with care to explore provocative and uncomfortable cases of care as well as contentious relations and contradictions within care in order to "stretch the boundaries of care" (Bartos, 2019, p.769). Similarly, other scholars have agreed for the need to explore diverse forms of care as situated in various geographical and cultural contexts and to embrace the complexity and contradiction inherent to care (Hanrahan & Smith, 2020; Kallio, 2020). Indeed, while some have criticized Fisher and Tronto's (1990; Tronto, 1993) definition of care for being overly broad, Tronto herself has agreed but has asserted that, "Care needs to be further specified in particular contexts…[and] that care not be left on this most general level, but that the context of care be explored" (Tronto, 2013, p.21).

Previous research and discussion have explored the ethics of care in contexts which intersect with the present project. Accordingly, care has been considered in relation to non-governmental organizations (NGOs) and civil society (Collins, 2015; Dodd, Brubacher, et al., 2022), crisis management (Branicki, 2020), food and livelihood security (Giraud, 2021; Hanrahan, 2015), community voluntary work (Tuyisenge et al., 2020), faith actors (Barnes, 2020), the COVID-19 pandemic (Gary & Berlinger, 2020), spiritual care (Leget, 2021), and social support in the Philippines (Ofreneo et al., 2022; Turgo, 2016). Despite the increase in research in these areas, there is an opportunity to further explore care in these various contexts and fields as well as at

their intersection to continue to expand our understanding of care beyond traditional concepts, contexts, and relations.

1.3 Study context

1.3.1 Impact of the COVID-19 pandemic on food insecurity

Measures meant to contain the spread of COVID-19 have resulted in a wide range of unintended consequences. One such negative outcome has been on food security (Dodd, Kipp, Bustos, et al., 2021). During the COVID-19 pandemic, public health procedures such as movement restrictions, quarantines, and workplace closures have disrupted food chains and resulted in income loss, which in some cases, has exacerbated food insecurity (Aborode et al., 2021; Dodd, Kipp, Bustos, et al., 2021; Food and Agriculture Organization, 2021a, 2021b; Food and Agriculture Organization et al., 2021; Ong et al., 2020; The World Bank, 2021; United Nations, 2020). Accordingly, food insecurity has risen globally during the pandemic, being considered a crisis within a crisis (Aborode et al., 2021; Food and Agriculture Organization, 2021a; Food and Agriculture Organization et al., 2021). For instance, in 2020, the percentage of the world's population experiencing moderate or severe food insecurity rose to over 30% and Asia held the majority of undernourished individuals worldwide at 418 million people (Food and Agriculture Organization et al., 2021). Further, those most vulnerable to the food crisis were individuals who already faced food insecurity prior to the pandemic (Food and Agriculture Organization, 2021a; United Nations, 2020).

In the Philippines, following the Philippine Department of Health's confirmation of local transmission on March 7, 2020, and the World Health Organization's declaration of COVID-19

as a global pandemic on March 11, President Rodrigo Duterte implemented several mandatory country-wide non-pharmaceutical interventions intended to reduce disease transmission (World Health Organization: Representative Office for the Philippines, 2020; World Health Organization, 2020b, 2021). Interventions included workplace closures, movement and gathering restrictions, and personal protective equipment protocols (World Health Organization: Representative Office for the Philippines, 2020). Further, on March 15, 2020, President Duterte implemented the first of ongoing strict community quarantines which were enforced on the entire nation by May 1 with varying levels of severity based on disease risk assessment (Republic of the Philippines Official Gazette, 2020a, 2020c; Santos, 2020). Notably, the Philippine lockdown was considered to be one of the longest and strictest worldwide (Hapal, 2021).

Such measures resulted in unintended consequences on the nation's residents, especially those already experiencing income-poverty (Lau et al., 2022; Lau, Hung, Go, et al., 2020). Particularly, income loss, restricted access to essentials, and reduced supply of goods exacerbated food insecurity for individuals experiencing extreme poverty (Asian Development Bank, 2020; Hossain, 2020; International Care Ministries, 2020, 2021; Ong et al., 2020; Philippine Department of Agriculture, 2020c; Philippines Humanitarian Country Team & UN Office for the Coordination of Humanitarian Affairs, 2020; The Philippines Star, 2020). Accordingly, the Philippine Department of Science and Technology's Food and Nutrition Research Institute found that 62.1% of households in their 2020 Rapid Nutrition Assessment Survey faced moderate or severe food insecurity, a 21.9% increase from their 2019 Expanded National Nutrition Survey. Further, they found that households in the lowest wealth quintile were 1.7 times more likely than middle-income households to become moderately or severely food insecure during this time (Angeles-Agdeppa et al., 2022; Philippine Department of Science and Technology, 2020). Thus,

the gravity of the crisis was emphasized by the Philippines Secretary of Agriculture who stated, "If no action is done, the threat of hunger is as real as the threat of the virus" (Philippine Department of Agriculture, 2020c, para 3).

Importantly, several efforts were enacted to address the emergent need. Particularly, actions were taken to strengthen the access, availability, and stability pillars of food security. The Philippine Department of Agriculture implemented a Food Resilience Action Plan in the National Capital Region (NCR) to counter panic buying by providing access to rice, vegetables, poultry and meat, eggs, and fish; a nationwide Plant, Plant, Plant Program which encompassed various initiatives meant to boost agri-fishery output such as provision of seeds, fertilizer, and technical assistance; and channelled funds to numerous projects to support the agri-fishery sector (Philippine Department of Agriculture, 2020a, 2020c, 2020b). In addition, the Philippine government encouraged use of food carts to increase food availability and reduce travel (Hossain, 2020), provided emergency subsidies to low-income households, and directed funding toward various departments and programs to augment provision of support to vulnerable individuals including but not limited to grants, food, non-food items, and feeding programs (Republic of the Philippines Official Gazette, 2020b). Further, the Asian Development Bank implemented its Rapid Emergency Supplies Provision (RESP) in the NCR to provide food to vulnerable households (Asian Development Bank, 2020), and local and international organizations responded by providing food and cash assistance (Bollido, 2020; FundLife International, 2020; Philippines Humanitarian Country Team & UN Office for the Coordination of Humanitarian Affairs, 2020). Despite these efforts, the need was great and persistent.

1.3.2 Research partnership

This study builds on an existing partnership between the University of Waterloo and International Care Ministries (ICM). ICM is a Philippines- and faith-based NGO which has been in operation since 1992 (International Care Ministries, 2017). ICM serves individuals and families experiencing extreme poverty across the Visayas and Mindanao islands of the Philippines through its poverty-alleviation programming (International Care Ministries, 2021). Their cornerstone program is Transform, a 15-week experiential learning program for individuals living under US $0.50 per day which covers training in health, values, and livelihoods (International Care Ministries, 2021; Luu et al., 2022). The health curriculum includes education and screening for maternal health, tuberculosis (Lau, Hung, Dodd, et al., 2020; Lee et al., 2019), and child malnutrition (i.e., undernutrition) (Lau, Dodd, et al., 2020).

To reach potential Transform participants, ICM partners with local faith leaders who volunteer to host Transform in their communities. These local faith leaders make up a vast network of over 15,000 members, known in ICM as the Thrive network (International Care Ministries, 2021). Most Thrive network faith leaders and their communities are located in urban slums, mountainous areas, or coastal regions (International Care Ministries, 2021). At the time of writing, ICM operates through 12 regional bases in the Philippines: Palawan, Kalibo, Iloilo, Bacolod, Dumaguete, Cebu, Bohol, Tacloban, Dipolog, Koronadal, General Santos, and Davao (International Care Ministries, 2021).

Following the destruction of Typhoon Haiyan in 2013, ICM responded by distributing millions of meals to affected families and communities (International Care Ministries, 2018). This event became the catalyst for the development of the Rapid Emergencies and Disasters Intervention (REDI) network, which would enable ICM to address community-level emergency needs more

effectively in future humanitarian crises (International Care Ministries, 2018). Faith leaders in the existing Thrive network were invited to join the REDI network and interested individuals were provided with program orientation. Subsequently, they became members of the REDI network which gave them access to request ICM's aid during national or community-level humanitarian crises. From REDI's inception until the COVID-19 pandemic, the REDI network had not been utilized to address a national-level emergency but had been primarily employed to respond during localized fires, floods, and armed conflict.

When President Duterte enacted community quarantines on March 15, 2020, ICM responded in several critical ways (Republic of the Philippines Official Gazette, 2020c; Santos, 2020). Importantly, it suspended its Transform program and pivoted to activate its REDI network (International Care Ministries, 2021). By enlisting support from existing REDI network members and interested Thrive network members, ICM was able to disseminate food packs, vegetable seeds, and other essential items to individuals and families facing emergency food insecurity in the areas it works (International Care Ministries, 2021). By doing so, ICM became a leading NGO in the Philippine pandemic response, reaching 5.3 million people with resources and delivering 14 million meals and 314 million seeds (International Care Ministries, 2021; The Philippines Star, 2020). Enabling ICM's noteworthy success was its REDI network faith leaders who were the vital link in the operation. Faith leaders identified local emergency needs and communicated with ICM to request, receive, and distribute the available aid. To do so, they determined aid eligibility of recipients and an amount of aid needed, submitted the request to ICM, waited for approval, obtained the aid from ICM, and distributed the aid to their constituencies. Faith leaders were encouraged by ICM to collaborate with their Local Government Unit (LGU) to implement REDI when possible; for example, to determine aid

recipients, arrange transportation of aid, and remain aware of up-to-date pandemic protocols. Faith leaders exemplified great dedication to their communities and to their partnership with ICM through their efforts during the pandemic as they voluntarily gave personal time, energy, and resources to implement REDI and meet emergency food insecurity around them.

1.3.3 Study rationale

As ICM had expanded their use of REDI during the pandemic, they identified a need to understand the functionality of the program in greater depth; particularly, the experiences of their partner community faith leaders. ICM hoped that increasing their knowledge in this way would enable them to enhance REDI's effectiveness, thereby aligning them with their goal to deliver evidence-based programming that is focused, effective, and efficient (International Care Ministries, 2021). Since study results will be shared with ICM, findings have the opportunity to inform REDI operations moving forward.

In addition, the study speaks to less developed areas of scholarly literature. Specifically, needs were identified for: an increased understanding of the roles and efforts of faith leaders at the community level, particularly during humanitarian crises; and empirical studies framed by ethics of care, especially care rooted in the Global South and as practiced by local faith leaders in a humanitarian setting. Thus, this research can expand ethics of care theorization and increase the visibility of community-based engagement of faith leaders.

Accordingly, the aim of the study was to explore the experiences of faith leaders who were addressing local emergency food insecurity during the COVID-19 pandemic through involvement in ICM's REDI program. Therefore, the following question framed the research:

What are the experiences of community volunteers implementing an NGO's program to monitor and mitigate emergency food insecurity during the COVID-19 pandemic in the Philippines? Additional study objectives included investigating how faith leaders understood their role as caregivers in their communities, practiced care for community members, practiced self-care and care for their families while acting as frontline workers, navigated pandemic guidelines, were impacted by demographic and contextual factors during implementation, and perceived REDI program effectiveness.

1.4 Consideration and statement of positionality

In recognizing that research is a dynamic process and that qualitative research in particular "sets the researcher as the data collection instrument" (Bourke, 2014, p.2), it becomes imperative to consider the identity of the researcher as personal subjectivities will necessarily impact the research and its outcomes (Bourke, 2014; England, 1994; Holmes, 2020; Manohar et al., 2017). Thus, I acknowledge that my own beliefs, socio-cultural context, past experiences, and demographic characteristics uniquely intersect with the research topic, participants, context, and process and thus, have shaped the project distinctively (Bourke, 2014; England, 1994; Holmes, 2020; Manohar et al., 2017). In addition, I understand and appreciate qualitative research to be a shared space between researcher(s), participants, and in cross-language research, interpreter(s), all of whom bring distinct and multiple co-existing identities from which they make meaning and to which they approach the research, all of which indelibly bear an impact on the research. (Blumenthal, 1999; Bourke, 2014; England, 1994; Holmes, 2020; Kezar, 2002; Manohar et al., 2017; Temple, 2002). While it is not feasible to identify the complete range of potential impacts, here I aim to critically examine and openly depict "where [I] stand" (Merriam et al., 2001, p.411)

in relation to the research and consider how such factors may have shaped the project and its outcomes (Bourke, 2014; Merriam et al., 2001).

At the time of writing, I identify as a young, female, white, anglophone, middle-class Canadian-American graduate student from a Canadian university. I came to this master's program at the University of Waterloo's School of Public Health Sciences with an educational background in International Development Studies through a Bachelor of Arts from the Canadian Mennonite University and a certificate of Teaching English as an Additional Language from the University of Winnipeg. In addition, I brought my professional experiences which included working and volunteering in various cross-cultural settings both in Canada and in several low- and middle-income countries (LMICs), entailing but not limited to working within a diverse range of faith-based NGOs. Further, I held my personal experiences which included visiting and residing in several countries including the Philippines in child- and adulthood as well as having a faith background. Thus, I had limited prior exposure to qualitative research, public health, global health, and humanitarian crises; no former acquaintance with ICM; and familiarity with development work, aid, volunteerism, cross-cultural relations, faith traditions, and NGOs. I spent the duration of my time with this project working and residing in Waterloo Region, Ontario, one of four places I call 'home', along with Winnipeg, Manitoba; Seattle, Washington; and Manila, Philippines.

To examine intersections between personal factors and project elements, I have considered how aspects of my identity may have positioned me as an 'insider' (i.e., member) or 'outsider' (i.e., non-member) and the potential impact of holding either status (Holmes, 2020; Merriam et al., 2001). Notably, I acknowledge that being considered an insider or outsider of a particular group or identity is not concrete, static, or consistent; nor is one status objectively better than the other,

but both hold advantages and disadvantages (Bourke, 2014; Holmes, 2020; Merriam et al., 2001).

First, previous experience with volunteerism broadly, voluntary work in the Philippines, and in connection to faith-based NGOs may have placed me as a relative insider. Accordingly, it is likely that I understood the research topic and faith leaders' experiences through the lens of my own voluntary work. Doing so may have provided deeper insight, a heightened ability to notice nuances, and an inclination to pursue specific features of their experiences. However, it may have also meant holding predetermined understandings and therefore making assumptions and not inquiring as deeply about certain aspects. On the other hand, lack of voluntary experience with ICM, in a humanitarian crisis, or addressing food insecurity may have placed me as a relative outsider. This status may have increased curiosity regarding those elements and thus, caused me to pose questions which may have been obvious to an insider.

Second, personal characteristics such as gender and age may have placed me as a relative insider or outsider. Since personal characteristics varied among study participants, my insider or outsider status likely fluctuated according to whom I was speaking. Thus, as a female, I may have felt more comfortable in conversations with female participants than male participants; and likewise, female participants may have felt more at ease conversing with me than male participants. Similarly, as a younger researcher, I may have felt more relaxed during interviews with younger participants than older participants; and likewise, younger participants may have felt more comfortable sharing with me than older participants. Thus, instances with an enhanced feeling of ease may have facilitated rapport building between the participant and myself, conversation may have flowed more fluidly, and content generated may have been richer. On the other hand, details may have been omitted unintentionally based on an assumed shared understanding.

Further, while connection or conversation may not have felt as natural when gender or age differed, there may have been increased curiosity, deeper inquiry, and more detailed explanation. Notably, the presence of the interpreter who was a younger male may have mitigated some of these effects. Additionally, interviewing by telephone may have lessened the impact since differences or similarities were not visually observable.

Third, personal characteristics such as ethnicity, nationality, occupation, and cultural elements may have placed me as a relative outsider. Since all participants were Filipino faith leaders from the province of Negros Occidental, characteristics with which I do not identify, it is likely that I approached the research and participants' experiences with genuine and enhanced interest as I desired to fully grasp their unique perspectives. Accordingly, I may have inquired about aspects which may have been apparent to an insider. However, it may have also meant that I did not notice or question particular elements that an insider may have considered important. On the other hand, having spent time in the Philippines, being acquainted with national culture, and sharing a similar faith background may have placed me as a relative insider. Thus, I likely perceived the research and participants' experiences through my own understandings of these familiar aspects. Doing so may have offered greater insight, a sensitivity to nuances, an ability to comprehend and appreciate particular perspectives, and a disposition towards certain features of the research and their experiences. However, it may have also meant holding preconceived notions and making related assumptions, refraining from questioning particular aspects that an outsider might. Importantly, the presence of the interpreter who was Filipino and from Negros Occidental may have moderated some of these effects. Additionally, as I disclosed being a Canadian university student from Waterloo but not my ethnicity, prior experience in the country, or faith background during interviews, participants likely interacted based on understandings

they held, which may have meant they shared more explanatory accounts or omitted details they thought I would not understand.

In addition to insider and outsider statuses, my personal interests, values, and perspectives certainly shaped the research. Thus, study design decisions, engagement with the work, and my positionality were fundamentally entwined. For instance, perspectives formed through my past experiences led me to be drawn to the project initially. I was intrigued by research grounded in community-based partnership, the Philippines, voluntary work, the COVID-19 pandemic, and faith-based community mobilization, which strengthened my resolve to take on and remain engaged in the project. Further, a desire to build qualitative research skills contributed to my choice to employ qualitative methodology in the study. In addition, a perception of REDI faith leaders as risking their lives to save the lives of others, which I understood to be moral in nature, led me to bodies of literature discussing morality and ethics. In doing so, I discovered ethics of care, which provided framing for their efforts and in turn became the theoretical underpinning of the project, impacting all stages of the research from design to reporting.

Beyond personal characteristics, broader contextual and structural factors have provided "conditions of possibility" (Bourdieu, 2003, p.282) for the research; that is, limitations and opportunities available for the study (Bourdieu, 2003). For instance, I worked within the School of Public Health Sciences in the Faculty of Health at the University of Waterloo, which meant the project had to meet departmental and university standards. In addition, I studied under the supervision of Dr. Warren Dodd, which meant research decisions were made collaboratively and were impacted by his positionality, values, and perspectives. Further, the study was conducted in partnership with ICM, which meant the research was determined by organizational need, values, procedures, and feasibility. Finally, the project was carried out during the COVID-19 pandemic,

which influenced the study topic and meant all aspects of the research had to meet public health safety standards, placing limitations to be managed throughout the study.

Chapter 2: Methods

2.1 Study design

2.1.1 Overall research approach

This study investigated the experiences of local faith leaders caring for their communities during the COVID-19 pandemic through involvement in International Care Ministry's (ICM) Rapid Emergencies and Disasters Intervention (REDI) network. Once a larger research team was formed (inclusive of members from ICM and the University of Waterloo), collaborative discussions surrounding study timelines, appropriateness, and feasibility began. Several key study design decisions were made at this initial stage. First, as pandemic-related public health restrictions prohibited in-person contact, it was determined that all collaboration and stages of research would occur remotely (between Canada and the Philippines). In addition, it was decided that the study would employ qualitative methodology and specifically, semi-structured interviews, to obtain relevant data. In line with the goal to understand REDI faith leaders' experiences, it was agreed that conversations with faith leaders would be the focus of data collection, analysis, and reporting. To provide context for the REDI program and its faith leader members, it was also determined that ICM would share program documents with team members and that several context-building conversations would take place with ICM staff members having experience with the program. Further, due to feasibility, pandemic constraints, and the remote nature of the study, ICM's Bacolod regional base in the province of Negros Occidental was chosen as the study site due to their experience facilitating remote research. Study design was

broadly informed by an ethics of care theoretical framing and data analysis followed an inductive thematic analysis approach while being shaped by sensitization to ethics of care concepts.

2.1.2 Study location

The province of Negros Occidental is located in the Western Visayas (Region VI) of central Philippines (Figure 1). Composed of 13 cities, 19 municipalities, 662 *barangays*[1], and over two and a half million residents, Negros Occidental is the most populous province in Western Visayas (Philippine Statistics Authority, 2021c, 2021a). Bacolod City, the province's capital and most populous city, is the site of ICM's regional base (Philippine Statistics Authority, 2016). Agriculture is prominent in the province, earning it the reputation as "Sugarbowl" of the nation by producing over half the country's sugar output (Luzaran et al., 2022; Philippine Statistics Authority, 2015). However, poverty incidence in the province remained at 19.4% of the population in 2018 (Philippine Statistics Authority, 2020b) and barriers to food availability and stability have meant that 70% of the population is mildly to severely chronically food insecure (Integrated Food Security Phase Classification, 2015). A major limiting factor in the province is food availability and stability; for example, production of pork, fish, and rice in the province is insufficient to meet the food needs of residents (Integrated Food Security Phase Classification, 2015). Other contributing factors include livelihood strategies, susceptibility to shocks, and vulnerability to natural calamities (Integrated Food Security Phase Classification, 2015). Along with the rest of the Philippines, food availability, access, and stability were worsened by community quarantines during the pandemic.

[1] A *barangay* is the smallest political unit in the Philippines, akin to a district or village (Matthies, 2017).

2.1.3 Study sample

All research participants were connected to ICM's Bacolod regional base and thus, located in Negros Occidental. Through collaboration, it was determined that faith leaders would be purposively sampled with the aim to select information-rich cases that would be useful for in-depth study (Green & Thorogood, 2014; Patton, 1990). Particularly, the objective was to include demographically diverse participants from a range of ages, genders, and geographical locations to obtain a comprehensive understanding of REDI program experiences. Sampling decisions were made both prior to and during data collection; thus, employing both an *a priori* and ongoing sampling technique (Gentles et al., 2015). Accordingly, sample size was determined iteratively and through collaboration based on feasibility, data saturation (Boddy, 2016; Hennink et al., 2017; Morse, 2015; Saunders et al., 2018), and Malterud, Siersma, and Guassora's (2016) concept of respondent "information power" (p.1754), which considers the study aim, sample specificity, established theory, quality of dialogue, and analysis strategy to ascertain a sufficient sample size. Therefore, a sample size of 10 participants was initially determined. Following the completion of these 10 interviews and a collaborative meeting, it was decided to increase the sample size by another 15 individuals to further pursue less understood aspects of REDI experiences. Thus, a total sample size of 25 was established.

This sampling approach aligned most with a combination of five of Patton's (1990) 15 purposive sampling typologies: homogeneous, criterion, maximum variation, convenience, and opportunistic. Specifically, we sampled for a particular subgroup (REDI faith leaders) who met predetermined eligibility criteria (connected to Bacolod base; involved with REDI during pandemic), while aiming for a range of perspectives within the group (demographic and

geographic diversity), having to prioritize feasibility (organizational; pandemic-related), and remaining open to continued sampling after data collection had begun to "follow where the data [led]" (p.179) (*a priori* and ongoing sampling). This blended sampling approach allowed us to be flexible, operate within constraints, focus on in-depth experiences, and obtain a variety of perspectives to learn whether or how shared patterns existed within the variation across participants (Patton, 1990).

2.1.4 Theoretical framing

Ethics of care provided theoretical grounding for the study. First, the broad depictions of care that Gilligan (1982) and Fisher and Tronto (1990; Tronto, 1993) offered shaped my understanding of faith leader efforts as a form of care work. Additionally, points of convergence between ethics of care elements and faith leaders' involvements in REDI confirmed the appropriateness of its application to the study. Thus, ethics of care was instrumental in each stage of the project: during study design, ethics of care contributed to overall research conceptualization and the development of study objectives and the semi-structured interview guide; during data collection, ethics of care shaped the direction of conversations; and during data analysis, ethics of care broadly informed thematic analysis. Accordingly, study objectives aimed to understand faith leaders' concepts and practices of care through REDI involvement. In addition, the interview guide explored faith leaders' concepts and practices of care, implicitly encompassed Tronto's five phases of care (Fisher & Tronto, 1990; Tronto, 1993, 2013), and interrogated contextual factors which may have impacted care work. Finally, coding and analysis decisions were shaped by care concepts such as responsibility, relationship, and emotion. That is, through an initial round of inductive coding and thematic organizing and mapping, the

prominence of these care concepts was identified. Subsequently and through discussion with Dr. Dodd, the decision was made to conduct a second round of inductive coding clustering around these three broad concepts, which in turn shaped how study results were analyzed and presented. Thus, the report of findings elucidated how faith leaders practiced care in this setting as connected to the concepts of responsibility, relationship, and emotion.

2.1.5 Interview guide development

The semi-structured interview guide was developed by me with input from the research team (Appendix A). The guide inquired about faith leaders' experiences with REDI as well as broader contextual factors such as demographic characteristics, COVID-19 context, and wider involvement in the local community. I designed the guide to allow time for participants to share about themselves before discussing REDI specifically. In doing so, I aimed to facilitate rapport building and establish a comfortable and safe environment for participants, which was especially important in the context of virtual interviews (Green & Thorogood, 2014; Rapley, 2004). Further, I included prominent open-ended questions and several possible follow-up probe options to follow depending on content shared and what seemed important to participants or interviewers (Green & Thorogood, 2014; Patton, 2015; Rapley, 2004). To account for potential language barriers, I included a fuller list of possible questions and probes to ensure a range of directions, angles, and approaches during conversations. In these ways, I aimed to provide space for flexibility during conversations. In addition, I took an iterative approach to the interview guide. Thus, following each round of interviews, I adapted the guide for improved clarity and to pursue particular features of content while maintaining consistency within the overall research question and objectives (Green & Thorogood, 2014; Rapley, 2004) (Appendices B, C). Further, by the

final several interviews, I had created a consolidated visual interview guide map to facilitate ease and fluidity of conversations (Appendix D).

2.1.6 Language considerations

The study was conducted primarily in English. A few factors shaped this decision, including its status as an official language in the Philippines which meant familiarity among ICM staff and faith leaders, and it being my only language of fluency. Accordingly, communication between research team members and conversations with ICM staff occurred in English, and REDI program documents were written in English. Recognizing that levels of English fluency may vary among faith leaders, it was decided that a multilingual member of the research team who was also an ICM staff member (Danilo Servano Jr.) would be virtually present during all interviews to explain and interpret concepts as necessary. It was intended that Mr. Servano Jr.'s presence would mitigate potential language barriers, ensure accessibility of interviews, facilitate relationship development, and contribute to creating a relaxed and supportive setting for participants. In effect, his presence would enable us to reach a greater range of potential participants and engage more deeply and meaningfully with those participants.

2.1.7 Research ethics and funding

Research ethics approval was sought and obtained from the Research Ethics Board at the University of Waterloo on October 27, 2020 (ORE #42565; Appendix E). In addition, funding for the project was provided through a Joseph-Armand Bombardier Canadian Graduate Scholarship (SSHRC), the University of Waterloo President's Graduate Scholarship, and the

University of Waterloo Global Health Policy and Innovation Research Centre's Global Health Scholarship.

2.2 Study participants

Recruitment of study participants occurred between October 2020 and January 2021. In alignment with our *a priori* and ongoing sampling approach (Gentles et al., 2015), recruitment of an initial group of faith leaders occurred in October and November (n=10), followed by recruitment of additional faith leaders in December and January (n=15). Recruitment took place through telephone by ICM staff members who were also members of the research team based on pre-existing relationships. REDI faith leaders who were available to participate, considered to be information-rich individuals, and represented a diversity of demographic factors were informed about the study and invited to participate (Green & Thorogood, 2014; Patton, 1990). I developed a recruitment script in collaboration with ICM research team members which was used when inviting individuals to participate. All participation was voluntary, and this was made clear to potential participants. In total, 25 faith leaders agreed to participate in the study and demographic distribution included both male and female participants, ages ranging from 34 to 70, and locations across Negros Occidental (Figure 1, Table 1).

2.3 Data collection

Semi-structured interviews took place in three rounds. This approach was taken to accommodate feasibility and our sampling method (Gentles et al., 2015). Thus, interviews occurred remotely from Waterloo, Canada and virtually via Skype and telephone in November 2020 (n=10),

December (n=6), and January 2021 (n=9). Danilo Servano Jr. was present from Negros Occidental on all calls, both initiating and concluding interviews. First, Mr. Servano Jr. called me via Skype. Once our connection was established, he called the participant via Skype at their provided telephone number. In this way, a three-way call was facilitated between the participant, myself, and Mr. Servano Jr. Further, this arrangement enabled video communication between researchers despite audio-only communication with participants. This format enhanced the quality of interaction between Mr. Servano Jr. and myself, thereby improving our ability to work in partnership during interviews, and in effect, enriching our dialogue with participants. This approach was especially important in the context of virtual and cross-language conversations. In addition, this arrangement allowed for pandemic protocols to be followed and contact to be made with individuals located in remote areas and regardless of Internet access. Furthermore, conducting interviews by telephone was a common method used by ICM and thus was recommended and considered appropriate in the context of this study. In these ways, safety, ease, accessibility, and comfortability were prioritized for participants.

Once the call commenced, Mr. Servano Jr. provided introductions, I presented an explanation of the study, obtained oral consent, and then we proceeded with interviews. We opened conversations with space for participants to share more broadly about themselves, their involvement in their community, and their local pandemic context. In doing so, we aimed to create a warm, personal atmosphere and establish trust with participants (Green & Thorogood, 2014; Rapley, 2004). We then inquired more specifically about participants' experiences with REDI. We used the interview guide to direct conversations while remaining flexible to follow what seemed important to the participant, Mr. Servano Jr., or myself (Green & Thorogood, 2014; Patton, 2015; Rapley, 2004). Each round followed a unique interview guide in accordance with

my iterative approach (Rapley, 2004) (Appendices A-D). Participants were welcome to communicate in English, Tagalog, Hiligaynon, or Cebuano during conversations, and Mr. Servano Jr. took a literal approach to interpretation when required.

Interviews lasted 50-120 minutes (average length 77 minutes), were video- and audio-recorded with permission, and notes were taken during and after conversations. Following interviews, Mr. Servano Jr. and I debriefed to discuss interview content, points of clarification, and strategies for improved communication with participants and co-facilitation of interviews by researchers. Further, dialogue among the larger research team occurred throughout data collection to discuss project progress and determine next steps.

Supplementary data, namely, REDI program documents and conversations with ICM staff (Appendix F) were also obtained during this time. These data aided with context building around the program. Thus, collecting these data provided valuable insights into REDI network operations and supported my understanding of faith leader experiences.

2.4 Data analysis

2.4.1 Analysis approach

Data from REDI faith leader interviews were analyzed thematically. To do so, I followed Braun and Clarke's (2006) six phases of thematic analysis as a guide. Accordingly, I aligned my analysis with what Braun and Clarke have termed 'reflexive thematic analysis' (Braun & Clarke, 2021a, 2021b). Further, I considered Braun and Clarke (2006) and Elliot's (2018) critical qualitative analysis decisions to inform my broader approach.

First, Braun and Clarke (2006) and Elliot (2018) present several critical choices the qualitative researcher must make when determining an approach to data coding and analysis. In considering the outlined decisions, my approach was as follows. Codes and themes: encompassed the entire data set rather than one specific aspect; were data-driven (i.e., inductive) rather than *a priori* (i.e., deductive); were explicit rather than interpretive; and were realist rather than constructionist in ontological and epistemological nature. Additionally, I coded interview data by monothematic chunk, consisting of a line, sentence, or group of sentences.

Second, Braun and Clarke (2006) delineate six phases of thematic analysis, which I utilized to direct my process. The first phase, "familiarizing yourself with your data" (p.87), involves activities such as transcribing interviews, reading and re-reading interviews, and noting preliminary ideas and impressions. The second phase, "generating initial codes" (p.88), involves coding the entire data set and collecting corresponding data extracts for each code. The third phase, "searching for themes" (p.89), involves generating a list of all initial codes, then using thematic maps to organize codes into possible themes and sub-themes, and collating all data extracts which correspond to each code, sub-theme, and theme. The fourth phase, "reviewing themes" (p.91), involves two levels of review: Level 1 to review all extracts and ensure themes appropriately represent data, re-naming and re-working until a final thematic map is established; and Level 2 to review the entire data set and ensure the thematic map appropriately represents the data set. The fifth phase, "defining and naming themes" (p.92), involves refining themes by defining and naming each to capture the "essence" (p.92) and characterize the "story" (p.92) being told by each. The sixth phase, "producing the report" (p.93) involves final analysis and writing up of results, selecting compelling extracts, telling a convincing "story" (p.93) of the

data, and articulating an argument which relates to the original research question and relevant literature.

2.4.2 Phase 1: Familiarizing yourself with your data

To familiarize myself with the data, I engaged in several tasks. Each task was completed discretely, systematically, and fully, but not necessarily consecutively. Performing the data familiarization activities described below aided in forming the "bedrock" (p.87) of my analysis, as identified by Braun and Clarke (2006).

First, following the initial round of data collection, I engaged in a series of consolidated note taking. This preliminary analysis was conducted in preparation for a collaborative research team meeting. The purpose was to analyze data collected to that point to inform steps forward with the study. Accordingly, I reviewed the data and recorded notes; reviewed the notes and created a consolidated list; then repeated to generate a further condensed list of notes. I organized content by various potential themes and concepts to explore how the data may fit together. Finally, I condensed the list once more to produce a set of preliminary findings. These findings were shared with the research team and became the foundation for our decision to continue recruitment to further build our understanding of content and context.

Second, I created content maps by hand on large paper poster boards. Following each round of data collection, I listened through the interviews and mapped content relating to five broad topics discussed. That is, personal demographic characteristics, contextual factors before and during the COVID-19 pandemic, experiences with REDI, and perceived effectiveness of the program. I produced one poster board per round of interviews, three boards in total. Doing so allowed me to

obtain a visual, topical, consolidated depiction of interview content, facilitating my familiarization with the data. In addition, I was able to observe similarities and differences between rounds of interviews as well as the evolution of content and my understanding of it. The creation of these three poster boards contributed immensely to a deep familiarity with the data.

Third, I transcribed interview audio recordings to written text. To do so, I recorded interview content verbatim and only included English text. Instances of conversation in Tagalog, Hiligaynon, or Cebuano were indicated, but not transcribed verbatim. I maintained participant confidentiality by anonymization of transcripts through pseudonym use and omission of identifying data such as precise location, workplace, and church affiliation (Green & Thorogood, 2014; Wiles et al., 2008). Transcription support was received from a University of Waterloo research assistant; however, I examined each transcript carefully for accuracy. Further, several meetings between Mr. Servano Jr. and myself were held to clarify interview content and review unclear segments to ensure accuracy. Once interviews were transcribed, I listened through all conversations and checked the transcripts, recording global observations of the data. Performing transcription manually enhanced my close acquaintance with the data.

Finally, I read and re-read interview transcripts and written memos. In doing so, I noted initial ideas on content, patterns, recurring concepts, and potential themes. This process facilitated my ability to begin making connections within the data, between concepts and participants, and informed my subsequent analysis decisions.

2.4.3 Phase 2: Generating initial codes

To generate initial codes, I undertook three main tasks. Each task was followed by its distinct counterpart described in Phase 3 (below).

First, I read through the data set and created a list of over 400 descriptive codes (i.e., nouns) (Elliott, 2018) in a Word document. Second, I reviewed the data set again and created another list of codes in a Word document; this time, process codes (i.e., gerunds) (Elliott, 2018), which generated a list of over 40 words and phrases. While these tasks were similar in nature, I desired to explore the data through both descriptive and process codes as each type of code provided a unique lens through which to understand the data. Doing so helped me begin analyzing the data more comprehensively. Third, I completed a round of inductive coding using *QSR NVivo 12©* software. Coding was organic and open, in line with a reflexive thematic analysis approach (Braun & Clarke, 2021b). I aimed to give each piece of data equal attention when assigning codes (Braun & Clarke, 2006). In addition, as NVivo automatically collates data extracts by assigned code, I did not complete this step manually as Braun and Clarke (2006) delineate.

2.4.4 Phase 3: Searching for themes

To search for themes within the codes and data, I carried out several tasks, each corresponding to its counterpart in Phase 2 (above).

First, I transferred the 400 plus descriptive codes to an Excel spreadsheet. In Excel, I examined, organized, collapsed, and categorized codes into a consolidated list of 340 words in nine categories. Similarly, I transferred the 40 plus process codes to an Excel spreadsheet and

examined, organized, collapsed, and categorized codes to form two consolidated lists, one of 41 codes in five categories and one of 41 codes in seven categories.

Finally, following the round of open coding, I collated codes into potential themes, analyzing codes rather than data (Braun & Clarke, 2006; Elliott, 2018). To do so, I examined, organized, collapsed, and categorized codes in NVivo. I also utilized thematic maps to explore various arrangements of codes, themes, and sub-themes in effort to "make sense" of the data (Braun & Clarke, 2006, p.94). Through collaboration and the creation of several digital and hand-drawn thematic maps, I identified the "candidate themes" (Braun & Clarke, 2006, p.90) of 'Emotion', 'Responsibility', and 'Relationship'. These three candidate themes broadly related to concepts within ethics of care, as I was sensitized to this theoretical orientation through study design and preparation. However, I did not refer to a particular definition or demarcation of these concepts during this process. Rather, I refrained from consulting literature to remain open to discovering whether or how the data spoke to these concepts. In this way, I aimed to maintain an inductive approach, while appreciating the inductive-deductive continuum and my movement towards deduction. Additionally, I did not collate data extracts corresponding to potential themes during this phase, as Braun and Clarke (2006) outline. Rather, I proceeded to conduct a second round of coding as described in Phase 4 (below).

2.4.5 Phase 4: Reviewing themes

To evaluate the candidate themes of 'Emotion', 'Responsibility', and 'Relationship', I performed two levels of review (Braun & Clarke, 2006).

First, to confirm the themes appropriately represented coded extracts (i.e., Level 1), I reviewed the data and conducted a second round of coding. I coded data inductively, but clustering around the broad concepts of emotion, responsibility, and relationship. Again, in line with a reflexive thematic analysis approach, coding was open, organic, and iterative (Braun & Clarke, 2021b). Thus, at times I coded by the broad themes then sub-coded for subthemes and codes, while other times I coded by subthemes and codes then collated them by theme. Further, I renamed, collapsed, organized, and re-arranged codes and subthemes as I progressed. Through this process, I also utilized and reworked the thematic map to create a final coherent thematic map (Appendix G). Notably, Braun and Clarke (2006) did not prescribe a second round of coding, but rather a reading of coded extracts by candidate theme. Therefore, doing so was an adapted completion of their Level 1 of theme review.

Second, to confirm the themes appropriately represented the entire data set (i.e., Level 2), I reviewed the entire data set and ensured the thematic map, themes, subthemes, and codes fit and represented the data.

2.4.6 Phase 5: Defining and naming themes

To define and name themes, I engaged in two tasks. First, I reviewed each theme individually and wrote a description which aimed to capture the "essence" (p.92) and characterize the "story" (p.92) being told by each theme (Braun & Clarke, 2006). Second, I reviewed each theme again and confirmed that the theme names I had developed appropriately fit the data.

2.4.7 Phase 6: Producing the report

Writing was an iterative, ongoing, and recursive process that occurred throughout the previous five phases. In this way, writing was an essential part of my analysis process and meaning making of the data. Thus, I did not produce the report as a discrete task per se; rather, I generated several drafts throughout my analysis journey. I developed a preliminary draft by scanning through each theme, compiling a list of vivid and compelling extracts, and crafting a descriptive summary of each theme with illustrative extracts. Subsequent drafts were developed by reading through themes, sub-themes, codes, and extracts, to create a report that represented a multiplicity of voices, viewpoints, and experiences while maintaining cohesiveness within a central story. I selected vivid and compelling extracts to illustrate and highlight the story being told through the data and ensured that my report articulated an argument which related to the original research question and relevant literature (Braun & Clarke, 2006).

2.4.8 Adaptations and iterations

Since I approached Braun and Clarke's six phases of thematic analysis as a guide, I made several adaptations and iterations as I moved through my own analysis process.

First, in alignment with Braun and Clarke (2006) who state, "analysis is not a *linear* process of simply moving from one phase to the next…[but a] more *recursive* process, where movement is back and forth as needed, throughout the phases" (p. 86), my process was also not linear. Rather, my movement through the phases was fluid and cyclical as I moved back and forth recursively between the phases until the final report was produced.

Second, as described above, to review and confirm the fit of the candidate themes, I re-coded the data set clustering around these concepts. I made this adaptation to ensure the identified framing represented the data well and thereby enhance coding rigour and credibility of findings.

Third, during Phases 1 to 3, I undertook a process of determining the data set from the data corpus and from this, an analysis method that fit the data set established. Specifically, since I had collected more data than could be included in one cohesive analysis and manuscript, I considered which data would be included in this report and an appropriate analysis plan moving forward. These decision processes occurred concurrently, recursively, and through collaboration. Accordingly, the three candidate themes provided parameters to the data set along with other limiting factors such as data directly related to REDI involvement in the pandemic (i.e., not including broader contextual data or data related to pre-pandemic REDI involvement). In addition, it was determined to proceed with an inductive thematic analysis of the identified data set, which is what followed in Phases 4 to 6 and is reported in Chapter 3.

2.5 Rigour and reflexivity

2.5.1 Establishing project rigour

In addition to having Braun and Clarke's (2006) six phases of thematic analysis and their and Elliot's (2018) critical analysis decisions guide my steps, I consulted several other sources of literature to ensure I conducted the research with rigour, coherence, and consistency.

First, I consulted Tobin and Begley's (2004) description of rigour in qualitative research for guidance. Tobin and Begley advocate a pluralistic rather than simplistic approach to legitimizing qualitative research. In doing so, they outline several concepts which establish trustworthiness

and uphold quality in qualitative research. Central concepts include goodness, credibility, transferability, dependability, confirmability, authenticity, triangulation, and crystallization. To consider the application of these concepts to my project, I created a table wherein I charted strategies and practices I aimed to employ in alignment with each concept. I returned to the table periodically to reflect on and refine my process.

Second, I referred to Giacomini's (2010) visual depiction of health research traditions by theoretical orientation. Consulting this diagram aided in conceptualizing and positioning my project amongst other health research and supported decision making to ensure consistency within my tradition and "ontological and epistemological neighbourhood" (p. 130). That is, I utilized this resource to confirm that my steps aligned with a realist ontology, an inductive epistemology, and a qualitative description tradition.

Third, when reporting findings, I consulted a number of literature sources and key concepts for direction. First, I aimed to provide "thick descriptions" (Geertz, 1973, p.10) of the study context and results to enable readers to assess "fittingness" (Guba, 1981, p.86) between this study and other contexts; in this way, enhancing the study's applicability to a larger audience and its ability to speak to other situations (Geertz, 1973; Green & Thorogood, 2014; Guba, 1981; Guba & Lincoln, 1982; Schofield, 2002). In doing so, however, I sought to avoid excessive description and summarization of results, ensuring I "made sense" (Sandelowski, 1998, p.379) of the data and balanced description with analysis and interpretation (Sandelowski, 1998). Second, I aimed to maintain "authenticity" (Tobin & Begley, 2004, p.392) in my presentation of data, which meant striving not to emphasize one participant or aspect over others but to highlight a multiplicity of realities, perspectives, values, and contradictions within the data when possible (Blumenthal, 1999; Tobin & Begley, 2004). At the same time, however, I prioritized presenting a

coherent “story line” (Sandelowski, 1998, p.376) with a “central point” (Sandelowski, 1998, p.376). Third, I aimed not to describe data and theme development as a passive process, or as “emerging” (Braun & Clarke, 2006, p.80), but rather maintained my active role as subjective researcher in the generation of themes and results (Braun & Clarke, 2006, 2021b).

2.5.2 Maintaining reflexivity

Finally, I employed several strategies in effort to maintain reflexive throughout the research process. In doing so, I hoped to enhance the trustworthiness, transparency, credibility, and overall goodness of the study (Berger, 2015; Dodgson, 2019; Tobin & Begley, 2004).

Reflexivity has been described as, “the process of a continual internal dialogue and critical self-evaluation of researcher’s positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome” (Berger, 2015, p.220). In effort to actualize this process, one practice I employed was to keep a research journal. This journal provided space to critically reflect on the research process including my positionality, actions, reactions, and impacts on the study, as well as to record my observations and internal and external dialogue throughout the project (Berger, 2015; Birks et al., 2008; Dodgson, 2019; Tobin & Begley, 2004).

Another strategy to practice reflexivity was to debrief with Mr. Servano Jr. following interviews and each round of interviews. These debriefs provided an opportunity to clarify interview content, discuss the interview process, assess how conversations flowed, consider strengths and weaknesses of the interview guide, and reflect on improvements moving forward. In addition,

these meetings helped ensure we critically considered the impact of our actions on the research as well as how to improve the research.

A third strategy to practice reflexivity was to have another research team member who was familiar with the interview transcripts review my written report of study findings. Doing so enhanced the confirmability of the results by verifying that observations, analyses, and conclusions were grounded in the data and not "figments of the inquirer's imagination" (Tobin & Begley, 2004, p. 392). Further, I had an additional research team member who was familiar with ethics of care literature review my manuscript (Chapter 3). Doing so ensured the appropriateness of my presentation of care ethics and integration of the theory with study findings, which enhanced the soundness of the research (Given, 2008).

Finally, I ensured to reflect upon, prepare, and include a detailed account of my positionality and consideration of how it may have influenced the research so that a reader may be informed (Berger, 2015; Dodgson, 2019).

Chapter 3 – Caring in crisis: The experiences of local faith leaders meeting community food needs in the Philippines during the COVID-19 pandemic

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3.1 Introduction

The COVID-19 pandemic has stimulated a wave of care. Unintended consequences resulting from essential public health measures have become a catalyst for people around the world to reach out to others – family members, friends, neighbours, strangers – to alleviate the negative impacts they observed. Thus, voluntary efforts have been abundant in activities such as grocery shopping, checking on others' well-being, medicine delivery, telephone helplines, packing and delivering food, supporting the public health system, and assisting non-governmental organizations (NGOs) deliver various services (Dodd, Kipp, Bustos, et al., 2021; Mak & Fancourt, 2021; Marston et al., 2020; Roy & Ayalon, 2021; Trautwein et al., 2020).

Among volunteers, faith leaders have been particularly active. Not only have faith leaders adapted their services to accommodate health restrictions, but they have been instrumental in disseminating information, encouraging disease prevention activities, and promoting public health and safety measures (del Castillo et al., 2020; Frei-Landau, 2020; Mbivnjo et al., 2021; Osei-Tutu et al., 2021; Wijesinghe et al., 2022; Yoosefi Lebni et al., 2021). Beyond disease prevention and health promotion, faith leaders have been active in addressing a range of needs which have arisen during the pandemic. In effort to address physical, mental, emotional, spiritual, and relational needs, faith leaders have mobilized food, hygiene items, clothes, and

financials; offered psychological support, counselling, prayer, and spiritual support; provided shelter; found creative ways to foster belonging and resilience despite isolation measures; and shared messages of hope and faith (Arruda, 2020; del Castillo et al., 2020; Frei-Landau, 2020; Osei-Tutu et al., 2021). Indeed, concern has been raised regarding the well-being of faith leaders as their roles and responsibilities have expanded during the pandemic (Greene et al., 2020).

In the Philippines, where over 90% of the population identifies as religious (predominantly Catholic, in addition to Protestant and Muslim), local faith leaders have played a crucial role in providing stability, hope, and meeting local needs during the pandemic (Corpuz, 2021; del Castillo et al., 2020; Guadalquiver, 2021; Hilario, 2020; Philippine Statistics Authority, 2019b). As President Rodrigo Duterte's pandemic response included implementing nationwide community quarantines which have been considered one of the longest and strictest worldwide, food insecurity became a critical problem, especially for individuals already experiencing extreme poverty (Asian Development Bank, 2020; Hapal, 2021; Ong et al., 2020; Philippine Department of Agriculture, 2020c; Republic of the Philippines Official Gazette, 2020a). Faith leaders responded to address the food crisis across the country by mobilizing food and other resources to provide for individuals in need (Calleja, 2020; del Castillo et al., 2020; Hilario, 2020; International Care Ministries, 2020, 2021). In doing so, faith leaders were recognized by the Philippine government for filling an essential gap since government aid alone had not been sufficient (Calleja, 2020).

In this study, we argue that the pandemic-related efforts of Filipino faith leaders can been understood as a type of care work. Accordingly, ethics of care (or care ethics) provides a theoretical underpinning for this research. Ethics of care has its beginnings in feminist moral psychology (see Gilligan, 1982) and has since expanded to a broad range of fields and disciplines

(Bond & Barth, 2020; Hamington & Sander-Staudt, 2011; Kittay, 2011; Langford et al., 2017; Lynch et al., 2021; Pols, 2015). While there is no commonly held definition of care ethics (Engster & Hamington, 2015), a widely known and used description of care is that which Fisher and Tronto (1990) have developed: "…a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible" (p.40; Tronto, 1993, p.103). Further, Fisher and Tronto (1990; Tronto, 1993) have theorized stages of caring, with each stage corresponding to a distinct moral quality. First, 'caring about' and attentiveness, involves identifying an unmet need. Second, 'caring for' and responsibility, entails assuming the burden of meeting the need. Third, 'care giving' and competence, includes performing the care work with moral and technical skill. Fourth, 'care receiving' and responsiveness, involves observing the care receiver's response to assess the care's appropriateness, completeness, and the emergence of new needs. Following this initial theorization, Tronto (2013) added a fifth stage and moral quality, 'caring with' and solidarity, plurality, communication, trust, and respect, which emphasizes that care work can be a collective endeavour which holds democracy, equality, justice, and freedom for all as central. Overall, several core themes of care ethics are commonly endorsed by theorists, which Engster and Hamington (2015) have identified as: relationality and interdependence, responsiveness to others, the inseparability of context, crossing the public-private divide, and the inherence of emotion.

More recently, scholars have called for further broadening of care ethics theorization to explore diverse forms of care as situated in various geographical and cultural contexts and to examine the complexity, contradiction, and conflict inherent to care (Bartos, 2018, 2019; Hankivsky, 2014; Hanrahan & Smith, 2020; Kallio, 2020; Raghuram, 2016). Importantly, Raghuram (2016) has

contended the need to “emplace” (p.512) care beyond the Global North and “trouble” (p.515) care by exploring unfamiliar forms of care and “uncomfortable relations” (p.526) in care. Further, Bartos (2018, 2019) has highlighted that care is not necessarily positive but can result in care-less, even harmful outcomes. Overall, there is a call for more critical engagement with care to explore uncomfortable cases and “stretch the boundaries of care” (Bartos, 2019, p.769).

Previously, ethics of care has been explored in relation to NGOs and civil society organizations (Collins, 2015; Dodd, Brubacher, et al., 2022), crisis management (Branicki, 2020), food and livelihood security (Giraud, 2021; Hanrahan, 2015), community voluntary work (Tuyisenge et al., 2020), faith actors (Barnes, 2020), the COVID-19 pandemic (Gary & Berlinger, 2020), and social support in the Philippines (Ofreneo et al., 2022; Turgo, 2016). While interest in the theory is growing, there is a need to better understand how care is practiced by local faith leaders in crisis settings in the Philippines particularly and the Global South broadly including instances that involve partnership with NGOs. In addition, there is a need to expand our understanding of care as practiced in diverse forms and contexts and to explore its inherent complexity. To address these gaps, the objective of the study was to investigate how local faith leaders in the Philippines practiced care for their communities by meeting food needs during the COVID-19 pandemic through partnership with a Philippines-based NGO, International Care Ministries (ICM). In doing so, we aim to respond to calls from care ethics scholars to stretch, complexify, and diversify our study of care as well as provide greater visibility and insight into the care practice of local faith leaders in humanitarian settings.

3.2 Methods

3.2.1 Study context and location

This study was grounded in partnership between researchers from International Care Ministries (ICM; Philippines) and Canada. ICM is a faith-based NGO that has served individuals experiencing extreme poverty in the Philippines since 1992. ICM offers poverty-alleviation programs through its 12 regional bases located across the Visayas and Mindanao islands. In response to the pandemic-aggravated food crisis resulting from nationwide quarantines, ICM activated its Rapid Emergencies and Disasters Intervention (REDI), a program intended to streamline mobilization of humanitarian aid. The REDI program operates through a broad network of approximately 15,000 volunteers, all of whom are faith leaders local to the areas ICM works. Volunteers play a critical intermediary role between ICM and the individuals they aim to reach; that is, ultra-poor community members who require support[2]. Faith leaders assess community needs to determine a required amount of aid, then connect with ICM to make their request. Following ICM's approval of the request, faith leaders determine a method for obtaining the aid from ICM and distributing it to community members. Aid available for request during the pandemic included fortified rice packs, seeds, and other essential items. Through use of REDI in the pandemic, ICM and faith leaders were able to reach 5.3 million people with resources, providing 14 million meals and 314 million vegetable seeds (International Care Ministries, 2021).

Notably, several transportation modes and networks were utilized to mobilize aid through REDI. Initially, resources were available or delivered to ICM's regional bases or associated sub-

[2] ICM defines 'ultra-poor' as households that live on less than US $0.50 per person per day (International Care Ministries, 2021).

branches, which is where faith leaders obtained their requested aid once approved. As faith leaders were located in geographically diverse areas (e.g., urban, rural, remote), travel distance and complexity varied accordingly. For instance, some faith leaders travelled several hours and required multiple modes of transportation to obtain the aid and reach communities inaccessible by car. Importantly, ICM recommended faith leaders collaborate with their Local Government Units (LGUs) to determine transportation methods including use of government vehicles if possible. In addition, ICM assisted faith leaders with transporting goods to their communities or an agreed upon meeting point when possible. Further, many faith leaders collaborated amongst each other to transport goods to a central location from which several individuals would obtain their requested aid.

Additionally, food aid requests were limited by the amount of aid available through ICM. ICM maintained a flexible approach toward faith leaders' determination of aid eligibility during the pandemic. Accordingly, faith leaders were encouraged to concentrate distribution to ultra-poor community members, whether within or beyond their faith community, and to collaborate with their LGU for an updated list of households most in need as recorded by *barangay* health workers. Faith leaders could also utilize accounts of individuals in need from participation in previous ICM programs, give to individuals who reached out to them for support, or raise awareness among community members and create a list of those who expressed need or desire for the aid. In cases where government officials assisted with REDI implementation, faith leaders were encouraged to provide an allotment of aid to the LGU which officials could distribute as they considered appropriate. Overall, ICM provided guidance but extended trust and autonomy to faith leaders to make decisions how they deemed suitable in their particular context and during a time of such crisis.

Furthermore, food aid offered by ICM during the pandemic was generally familiar to faith leaders. Accordingly, the fortified rice packs (i.e., manna packs) distributed were ICM's principal food aid utilized in other programs. Suspension of these programs due to pandemic measures meant that aid was available for re-direction through REDI. Thus, in some instances, rice packs were pre-positioned at ICM locations which facilitated ease of accessibility and mobilization of aid. Further, rice packs were familiar to faith leaders and to community members who had previous involvement with ICM programming, but novel to community members who did not have prior experience with ICM. In addition to rice pack distribution, ICM also provided seeds of commonly consumed vegetables (e.g., string beans, okra, bok choi, eggplant) along with fertilizer, which was familiar to some faith leaders and community members and novel to others.

In the context of the pandemic, ICM identified a need to better understand the experiences of faith leaders involved in REDI implementation. Since the pandemic was ongoing, safety measures and practicalities became defining parameters of study design, which included the decision to conduct the research entirely remotely. Accordingly, ICM's Bacolod regional base in the province of Negros Occidental was chosen as the study site as the base had previous experience facilitating remote research. In addition, focusing our scope of inquiry to one province allowed us to obtain a more in-depth understanding of how regional COVID-19-related public health measures shaped experiences of REDI implementation. Prior to conducting the study, and to facilitate context building for the research team, consultations were held with ICM staff members who were involved in administering REDI to discuss program operations.

3.2.2 Theoretical framing: Ethics of care

This research was framed by an ethics of care theoretical orientation. Ethics of care was chosen for its usefulness in understanding and characterizing faith leaders' community engagement through REDI implementation. Particularly, Fisher and Tronto's (1990; Tronto, 1993, 2013) comprehensive view of care and outlined stages of care provided an inclusive and practical lens through which to consider faith leaders' efforts to address emergency food insecurity in the context of the COVID-19 pandemic. In addition, more recent calls by care theorists (Bartos, 2018, 2019; Hankivsky, 2014; Hanrahan & Smith, 2020; Kallio, 2020; Raghuram, 2016) to explore diverse forms and locatedness of care including care's inherent complexities, contradictions, and conflicts provided a compelling foundation for engagement with ethics of care throughout the project. Accordingly, ethics of care broadly informed study design, semi-structured interview guides, data analysis, and research presentation.

3.2.3 Participant recruitment

Participants were recruited for this study based on their involvement with REDI during the COVID-19 pandemic. All participants were recruited through the Bacolod regional base in Negros Occidental. Purposive sampling was used to recruit individuals of diverse ages, genders, and geographical locations with the aim to explore a range of experiences. Individuals were contacted by an ICM staff member through a pre-existing relationship, informed of the study, and invited to participate voluntarily. A total of 25 faith leaders who resided in 17 distinct communities across Negros Occidental agreed to participate in the study (Figure 1, Table 1).

Figure 1. Map of the study region: Negros Occidental (Bacolod, Silay, E.B. Magalona, Cadiz, Sagay, Escalante, Don Salvador Benedicto, San Carlos, La Castellana, Isabela, Himamaylan, Kabankalan, Sipalay, Cauayan, Ilog, Hinigaran, Bago), Philippines

Participants included female and male individuals between the ages of 34 to 70 years and were all Christian faith leaders (i.e., pastors or pastoras) (Table 1). Additionally, most participants had attained a level of post-secondary education, and several held other occupations to supplement their ministerial roles. All participants provided informed oral consent for participation and audio recording of their interview. Research ethics approval for this study was obtained from the University of Waterloo (ORE #42565).

Table 1. Assigned pseudonyms and demographic characteristics of interviewees who were faith leaders engaged in the implementation of International Care Ministries' Rapid Emergencies and Disasters Intervention program (n=25)

Pseudonym	Gender	Age	Location	Occupation
Alejandro	Male	52	Bacolod	Pastor
Gloria	Female	65	Bacolod	Pastora
Jerome	Male	62	Bacolod	Pastor
Arnold	Male	55	Bago	Pastor
Simon	Male	66	Bago	Pastor
Charles	Male	46	Cadiz	Pastor
Evelyn	Female	51	Cadiz	Pastora
Nelson	Male	45	Cauayan	Pastor
Theo	Male	44	Don Salvador Benedicto	Pastor
Eduardo	Male	58	E. B. Magalona	Pastor
Dinah	Female	47	Escalante	Pastora
Vincent	Male	50	Escalante	Pastor
Marie	Female	62	Himamaylan	Pastora
Benilda	Female	51	Hinigaran	Pastora
Grace	Female	34	Ilog	Pastora
Dalisay	Female	42	Isabela	Pastora
Benjie	Male	59	Kabankalan	Pastor
Francisco	Male	54	Kabankalan	Pastor
Lucas	Male	58	Kabankalan	Pastor
Gerardo	Male	50	La Castellana	Pastor
Lester	Male	51	Sagay	Pastor
Faye	Female	52	San Carlos	Pastora
Manuel	Male	36	San Carlos	Pastor
Antonio	Male	54	Silay	Pastor
Ramon	Male	70	Sipalay	Pastor

3.2.4 Data collection

Between November 2020 and January 2021, semi-structured interviews were conducted with REDI faith leaders. Interviews took place in three rounds (November, n=10; December, n=6;

January, n=9). This staged approach was taken to accommodate organizational feasibility in the pandemic and to facilitate our ongoing sampling technique (Gentles et al., 2015). Interviews occurred virtually over Skype and telephone[3]. To facilitate a comfortable environment and alleviate communication challenges, a Filipino and a Canadian research team member were present in each interview. Participants were welcome to communicate in English, Tagalog, Hiligaynon, or Cebuano, and the Filipino team member was available to interpret as necessary. Space was given at the start of interviews for rapport building to establish comfort, trust, and bridge the relational gap due to the virtual setting. Thus, participants were invited to share more generally about themselves, their involvement in the community, and their experiences in the pandemic. Following this, interviews focused broadly on faith leaders' experiences with REDI during the pandemic. Conversations followed an interview guide while remaining flexible for participants and interviewers to engage with important content. Following each round of interviews, debrief meetings were held between research team members to discuss interview content and study development. Adaptations were made to the interview guide as necessary to enhance ease of discussion and focus on less understood aspects of faith leader experiences (Appendices A-D). The length of interviews ranged from 50-120 minutes (average length 77 minutes). All interviews were audio recorded and transcribed verbatim.

[3] Skype was used as the platform for interviews since it facilitated a multimodal connection. A three-way call was enabled whereby the Filipino and Canadian researchers communicated via videoconference while conversing with participants by telephone. This approach enhanced accessibility for participants (most of whom did not have Internet access), enriched quality of conversation, and supported adherence to pandemic safety measures.

3.2.5 Data analysis

Data were analyzed using an inductive reflexive thematic analysis approach (Braun & Clarke, 2006, 2021b) while being broadly informed by sensitization to ethics of care literature. Prior to coding, transcripts were checked closely by the interviewers for accuracy. A round of inductive open coding was first performed to identify initial concepts in the data. Thematic maps were utilized to categorize codes and concepts and determine dominant themes. A second round of inductive coding was then conducted which clustered around the broad themes identified, again using thematic maps to conceptualize data. *QSR NVivo 12*© software was used to code and organize data and retrieve participant quotations. Members of the research team met regularly to discuss observations and thematic development. Collaborative meetings and two rounds of coding enhanced analytical rigour and credibility of findings.

3.3 Results

3.3.1 Navigating care responsibilities

3.3.1.1 Motivation to care: "because they're so in need"

Faith leaders practiced care through holding and acting on a sense of responsibility for their community members. Many faith leaders described observing the negative impacts of pandemic restrictions in their communities, including exacerbation of food insecurity, and feeling concerned but unable to help due to lack of personal resources or structural pandemic-related constraints. A few participants described trying to meet emergent need by pooling and distributing collective food supplies through their faith community. Nevertheless, many faith leaders described feeling helpless in the situation. Thus, once faith leaders became aware of the

available aid through REDI, many participants described feeling relieved and motivated to become a conduit through which these crucial supplies could flow. Accordingly, a predominant motivator cited among faith leaders for engaging in the care work was seeing the need around them and feeling a desire to meet this need. Other motivating factors were also discussed, such as their faith, their connection to ICM, and relationships with their community. In addition, faith leaders often discussed multiple intersecting motivators, such as 54-year-old Antonio from Silay, who stated:

> …with the working relationship with REDI Help[4], we can really give assistance [to] people who are really needy in our place…So, as long as we have ICM, we are there, we are willing to support this organization. Because we pastors are located in places, you know, like ours, with a lot of people that are really needy.

Antonio's description highlighted that it was both the connection to ICM as well as the need of individuals in his local community that motivated his care work. From excerpts such as this, it was clear that faith leaders held a deep sense of responsibility toward community members and that this was reflected in their motivation to care. Further, the willingness and decision to participate in the REDI program demonstrated how faith leaders translated their sense of responsibility into action by taking the opportunity to meet the needs they identified.

3.3.1.2 Caring through commitment and creativity: "we are going to make a way"

Once faith leaders chose to become involved with REDI, a shift in how they practiced care took place. Importantly, faith leaders agreed to practice care by carrying out, and determining how to

[4] The term 'REDI Help' refers to ICM's REDI program as used during the COVID-19 pandemic.

carry out, necessary REDI program tasks; that is, they agreed to care through a predetermined process. Specifically, interviewees described engaging in several process-oriented REDI tasks including: assessing aid eligibility of community members, creating a recipient list, submitting a request to ICM, waiting for approval, obtaining aid, distributing aid, and following up with recipients (Figure 2). However, since REDI tasks were broad and individual and pandemic-related contexts were unique to each faith leader, we noticed that interviewees managed the tasks distinctively. Thus, across participants, tasks engaged in were largely uniform, but personal strategies, values, and approaches were employed to carry the tasks out.

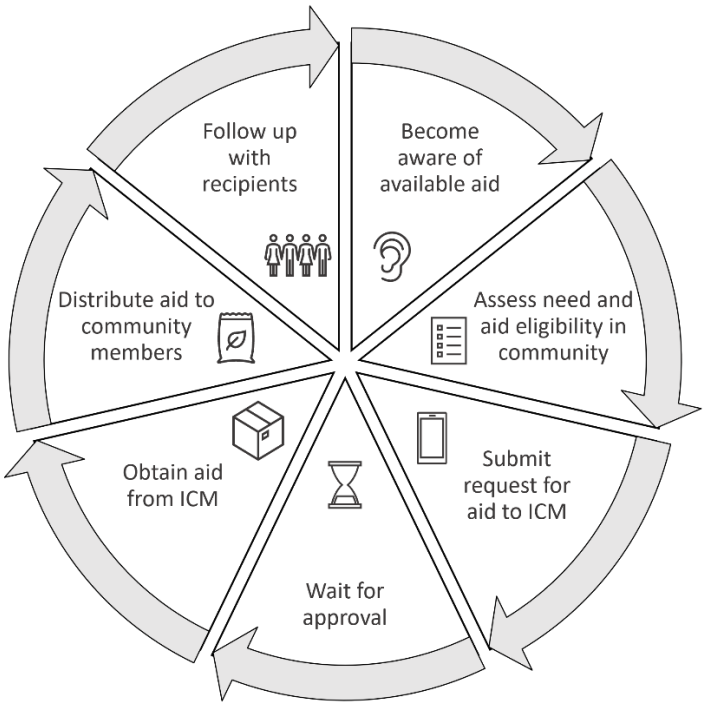

Figure 2. Process-oriented care tasks faith leaders described completing in International Care Ministries' Rapid Emergencies and Disasters Intervention program

For example, when determining aid eligibility, 34-year-old Grace from Ilog described that she was "the one deciding, with the coordination of the *barangay*[5] also," while 51-year-old Evelyn from Cadiz recounted going through the neighbourhoods to survey individuals about the aid:

> Okay, so, we go to *puroks*[6], it's the smaller part of a *barangay,* and we ask people if they want the manna packs[7] or not, 'cause it's a waste if they don't want the manna pack. And those that are okay with manna packs, they're the ones who receive the manna pack and [are] being listed[8].

Additionally, some interviewees described receiving and following guidance from ICM to target ultra-poor households, and several interviewees mentioned having pre-existent knowledge of individuals in need of support from involvement in previous ICM programs.

When it came to obtaining and distributing aid, 52-year-old Alejandro from Bacolod explained several methods he used:

> There are times that [ICM] deliver[s], but there are times that we pick it up. So, for me personally, I have my own car, so, I pick it up…I also use my car for distribution…and sometimes we use other people who have tricycles[9] to deliver the goods.

[5] A *barangay* is the smallest political unit in the Philippines, akin to a district or village (Matthies, 2017). The term is used both in reference to the administration and the geographical location.
[6] A *purok* is a subdivision of the *barangay*, akin to a sub-village (Matthies, 2017).
[7] The term 'manna pack' refers to the fortified rice pack ICM distributed through REDI during the pandemic.
[8] Community members had varying levels of familiarity and preference toward the aid which impacted interest in the aid.
[9] The tricycle is a common transportation mode in the Philippines which consists of a motorcycle and attached passenger cab (Guillen et al., 2013).

Similarly, 51-year-old Benilda from Hinigaran described several approaches to her aid distribution:

> So, I announce to the people nearby that ICM has manna packs as help. But I only scheduled them, like, five families, so I can get pictures[10]. So, I scheduled them by batch to avoid a big crowd and following protocols as well. And the rest of the boxes [were] given to my outreach church and the pastor in charge there has also his own list. So, he's in charge [of] distribution of those manna packs. And in my area, here, those who are far from my church, then we…loaded the boxes to the tricycle…and distributed house-to-house.

Further, 51-year-old Lester from Sagay clarified that, "it's not only giving them [the manna packs], but we have to explain how to use, or cook manna packs, 'cause [they have] ingredients that they have to understand how to use." Accordingly, interviewees recounted leveraging personal resources, navigating various guidelines, managing encounters with community members, and establishing methods for determining aid eligibility and aid dissemination.

In addition to describing their tasks and how they accomplished them, some interviewees shared a rationale for their approach. That is, they expressed their perspective on how a task 'should' or 'ought' to be carried out, which revealed a sense of morality they maintained toward their care work. For example, 65-year-old Gloria from Bacolod described how she thought aid 'should' be managed:

[10] REDI volunteers were requested by ICM to take and submit pictures during distribution while observing pandemic safety measures such as physical distancing and wearing personal protective equipment.

> Because…these people trusted me. I am a steward of this. So, I have to be handling [it] properly…So, though it is a dole out, we should be very careful to implement [it]. We will not just give this any way, this is for free…Though this is free, we should be handling this properly.

From excerpts such as this, it was clear that the *how* of accomplishing tasks was important for some participants. In other words, that practicing care went beyond merely performing tasks and involved discerning how to do them 'appropriately', whether according to personally held values and principles, instructions communicated by ICM, or regulations set by government administration. Notably, a few participants described instances of non-adherence to pandemic protocols, either due to forgetfulness, not maintaining prescribed physical distance, or in one case, delivering aid despite being disallowed to do so. Overall, however, participants shared striving to meet standards, whether internally or externally derived. This sentiment was echoed regarding various elements of REDI involvement, demonstrating the moral integrity connected to how these individuals practiced care. Thus, we observed that faith leaders drew on a depth of commitment, personal investment, creativity, and integrity when practicing their care work.

3.3.2 Leveraging relationships

3.3.2.1 Caring alongside others: "we distribute together to the community"

Another prominent way faith leaders practiced care through REDI was in connection to others. As interviewees recounted carrying out REDI tasks, all described doing so alongside their personal social connections. It was evident that faith leaders did not practice care in isolation but rather leveraged relationships to complete the care work. A wide range of relationships were

referenced by interviewees when recounting their experiences, including ICM staff, government officials, their faith community, and other community members. In doing so, all faith leaders drew support from personal relations to accomplish care tasks and many faith leaders offered support to other faith leaders through their care work.

Aid management was one context in which all interviewees discussed relational support. Predominantly, support with obtaining and distributing aid was discussed, but assistance with storing aid, listing recipients, and following up with recipients was also cited. For example, 47-year-old Dinah from Escalante, like many faith leaders, described the support she received from community members in transporting aid:

> So, the goods were just carried by motorcycle to the port and then to the pump boat and from the pump boat, our members, when we arrived to the community, they're the ones who got the boxes…So, that's when the manna packs were distributed…The rent of the pump boat is usually around 200 *pesos*[11], but [the] pump boat we used that day is from a member and he is also one of the recipients…So, we saved some rent on that.

Alternatively, several interviewees recounted providing, or both providing and receiving, support with transporting aid. 36-year-old Manuel from San Carlos, for instance, explained that he organized, facilitated, and funded transportation of aid for several other faith leaders and reached out to his Local Government Unit (LGU) to do so:

> So, we gather all [the requests] for just one big transport…Some pastors, since they don't do that, the huge task, I did it. I fund[ed] for the transportation and I didn't

[11] 200 Philippine pesos is equivalent to approximately US $4.00 as of May 2022.

> ask for help for that. So, it's an initiative that I did and I don't ask them to help with the transportation because transportation with big trucks will cost. So, I just do it, just to help them…So, [at] that time, during COVID, vehicles are actually not available because the government is busy, and it's hard for us to find a vehicle to help us. So, it's just God's grace that the government help[ed] us…I went to the office and thank God, they responded quickly!

Additionally, many interviewees mentioned the transportation support they received from ICM staff to obtain their requested aid. Further, some interviewees also described storing aid until other faith leaders could obtain their requested supplies, such as 54-year-old Francisco from Kabankalan, who shared, "This church [has] become the drop off of the material because pastors from rural area[s] [are] coming here and picking up the help, the [manna] packs that ICM is distributing." Notably, a few interviewees recounted the mutual support experienced between faith leaders. 46-year-old Charles from Cadiz put this well when he stated, "Regarding my fellow pastors…we help each other. Especially during the distribution of the manna pack[s], they help us, we help each other."

3.3.2.2 Value of pre-existing connections: "because we are already friends"

Other contexts in which relational support was discussed included connecting to the REDI program initially and navigating pandemic restrictions throughout involvement. Thus, many interviewees described instances of information sharing or support with the aid application process. For example, 51-year-old Evelyn from Cadiz explained that "[registration] was hard because it was online…but I called [an ICM staff member] and he guided me on how to

[register] and it went well." Many other interviewees also indicated receiving helpful assistance, instruction, or communication from ICM staff. Several interviewees also described reaching out to other faith leaders to share information or support them in applying for aid, such as 50-year-old Gerardo from La Castellana:

> So, first, what I did is I applied to REDI…And after, since they are far, I called them and shared with them that REDI Help will help their community…So, actually, during REDI, there's, like, 10 pastors that I've helped or facilitated.

With regards to navigating pandemic restrictions, several interviewees described how pre-existing relationships with government officials proved useful, such as 52-year-old Faye from San Carlos, who explained that having a church member in the LGU helped her gain permission to distribute the food aid:

> …before we distributed it, we should see to it that the LGU also know[s] us…So, we ask permission from them in order that we can go there in that area…We are so blessed because one of our [church] members is already in the LGU. So, we write a letter for the LGU to approve that we are already permitted.

Similarly, some interviewees shared how having established roles as frontliners or former engagement in the LGU aided their navigation of protocols. For example, 70-year-old Ramon from Sipalay discussed how prior involvement in the LGU facilitated his ability to cross checkpoints, "…most of them I have already met in the *barangay*, I have met in the City Hall. That's why sometimes it is easy for me to pass by [checkpoints] because we are already friends." Other interviewees described government officials handling aid distribution when local public

health protocols prevented faith leaders from doing so. Importantly, interviewees recounted the supportive role of government officials even when a pre-existing relationship was not mentioned.

Collective effort was observed across participants and throughout REDI tasks. Therefore, it was evident that faith leaders' sphere of care extended beyond their personal context to include other individuals. That is, as they reached out to elicit or extend support with care tasks, they opened their care work to invite and enable the participation of others. Accordingly, we observed that care was practiced within and through faith leaders' relationships as a collective and dynamic network of care.

3.3.3 Engaging holistically

3.3.3.1 Navigating care challenges: "sometimes it hurts my heart"

All interviewees described encountering challenging circumstances or emotions during their care work. Most of the challenges discussed related to navigating pandemic restrictions, transporting aid, lacking knowledge, physical conditions, aid limitations, and encounters with community members. For instance, several interviewees mentioned the difficulty of maneuvering heavy boxes of aid, feeling physically tired during or after involvement, or, in 59-year-old Benjie from Kabankalan's case, participating despite health concerns:

> …I and my wife, we were sickly. My wife has the high blood and [is] diabetic. And, also, I am a diabetic and [have] high blood pressure. My wife cannot walk long because she has a vertigo. So, she [is] always with me because I cannot leave her at home…So, in spite of those, what we feel, God [gave] us strength to finish the task…most especially during [the] pandemic to distribute manna pack[s].

Other interviewees discussed the challenge of crossing quarantine boundaries, such as 46-year-old Charles from Cadiz who recounted being sprayed "with a lot of chemicals from head to toe" at five different checkpoints, or of organizing transportation to obtain aid from ICM's base in Bacolod City which was several hours away. A few interviewees described observing that other faith leaders were unable to participate with REDI because the barriers they faced were too great to overcome (e.g., physical ability, application process, pandemic restrictions). Indeed, it was evident that social support with care tasks was essential as the challenges involved to complete the care work were not feasible to manage alone.

Several interviewees also described difficulties related to encounters with community members. 52-year-old Alejandro from Bacolod, for example, shared how he experienced and navigated the challenge of facing community members while having limited aid in a time of such great need:

> …sometimes it hurts my heart also to think of others thinking of us not extending help to all of them…because we are also limited…especially in one community where all of them, actually, are also in need during that time. So, how I wish all of them could receive, but we have no choice…there are people who are sitting and waiting and sometimes they are also asking me, "Pastor, are we included?"…Sometimes I, myself, will not go in that place because they will call me, "Pastor" and then I am not giving them…So, sometimes I just, I intentionally don't get involved in the distribution…I just stay in the car.

Similarly, other interviewees mentioned the challenge of providing an explanation to community members who were unable to receive aid, including 59-year-old Benjie from Kabankalan who described encountering angry individuals and 55-year-old Arnold from Bago who expressed nervousness about provoking a "riot" in the *barangay* and who was brought to tears when

explaining to individuals, “We cannot please you or give you anything.” In contrast, a few interviewees mentioned encountering community members who demonstrated a lack of desire for aid, which was an equally challenging experience, as 46-year-old Charles from Cadiz recounted:

> …sometimes they were ungrateful of the manna packs, telling us that they’re so tired of manna packs…So, sometimes it hurts our feelings as pastors distribut[ing] the manna pack[s], hearing [those] words.

Importantly, several interviewees also described instances where non-recipients of aid were understanding regarding the limited aid, and overall, interviewees recounted aid recipients responding positively to the support they shared. Nevertheless, from excerpts such as these, it was apparent that caring in this context was not always straightforward. Rather, the care work involved complicated and even uncomfortable situations and emotions which faith leaders had to navigate. That faith leaders continued with REDI tasks in the face of such difficulties demonstrated the perseverance with which they practiced care.

3.3.3.2 Positive framings of care: “I cannot describe my feelings; I was so very happy”

Despite encountering challenges, faith leaders practiced care with a degree of optimism. One way faith leaders revealed their positive outlook was by deemphasizing the difficulties they experienced. For example, some interviewees dismissed challenges, stating that they “don’t worry so much about the hardships and struggles” (Nelson, 45, Cauayan), “don’t see it as difficult” (Gloria, 65, Bacolod), or that they were “no problem” (Manuel, 36, San Carlos). Other interviewees highlighted positive elements over the difficulties or underscored their faith as a

source of strength to manage the challenges associated with REDI implementation. 54-year-old Francisco from Kabankalan, for instance, expressed both sentiments when he shared:

> …in the community, if that place is not reachable by vehicle, you have to climb the mountains, all while carrying the manna packs, requesting other families and workers to help carry the materials going to a certain place…the rains, the heat of the sun…but everybody's happy because we're doing [it] for the Lord.

Likewise, 59-year-old Benjie from Kabankalan spoke about how the positive response of aid recipients lessened his experience of adversity:

> …even though there are some hardship[s] because we are volunteers, but because of the joy of the people who received, those hardship[s] that we encountered [were] already gone.

Overall, faith leaders were expressly positive in their accounts of the care work, which further demonstrated their optimism. Describing the program and food aid as "a blessing", "a great help", and as bringing happiness to community members and faith leaders was echoed across participants. Similarly, all interviewees shared the gratitude they felt and saw during their care work, and nearly all interviewees identified positive outcomes from the care work and elements of care tasks managed with ease. For example, some participants shared how the food aid was an encouragement, such as 51-year-old Benilda from Hinigaran, who explained that "the people [were] revive[d] or had hope even in the midst of the pandemic." Similarly, several participants discussed the enjoyment the care work brought, as 70-year-old Ramon from Sipalay recounted, "When we received food packs from REDI, we were so very excited." In addition, many participants described the contentment derived from the care work. This was reflected well by

34-year-old Grace from Ilog when she shared, “My heart is very glad and touched because for them, the food packs, or manna packs, [are] very great or very delicious and nutritious.” Notably, all interviewees expressed willingness to continue participating in the REDI program, whether presently or in the future, a sentiment exemplified by 50-year-old Vincent from Escalante who expressed, “Yes, one hundred percent yes! I [will] continue partnering.” Therefore, faith leaders’ especially positive descriptions of the care work, even in light of challenges, demonstrated the deep value they held for the care work and the optimism with which they practiced care.

3.3.3.3 Caring through emotional connection: “[we] give them a word of encouragement”

Beyond managing a range of complex situations and responses, faith leaders practiced care multidimensionally by providing emotional support in addition to meeting physical needs through the delivery of food aid. Several interviewees described the negative emotional impact of the pandemic on their communities. With this knowledge and their position as local spiritual leaders, participants took the opportunity to care emotionally through their efforts with REDI. Thus, nearly all interviewees described providing some form of emotional care to community members.

A predominant type of emotional support provided was spiritual care. Accordingly, most interviewees recounted offering prayer or spiritual instruction during their care work. For example, 44-year-old Theo from Don Salvador Benedicto described of his experience distributing aid to community members, “They are smiling, and sometimes we pray for them…and encourag[e] them.” Indeed, it was clear that many faith leaders considered their care work with REDI to be part of their ministerial roles. Notably, several interviewees were explicit

in articulating the value of providing a "balance" of material and spiritual support. This was meant both to emphasize the importance of supplementing material aid with spiritual care, and to explain that REDI offered them a chance to complement their typically spiritual roles by meeting physical needs in the community through material aid.

Other forms of emotional support provided included encouragement and counselling. Several interviewees described encouraging either recipients of aid, other faith leaders, or community members who were unable to receive aid due to supply limitations. For example, 47-year-old Dinah from Escalante recounted assuring non-recipients that she would return if she received more aid and encouraging them "not [to] lose hope." Thus, we observed that some faith leaders aimed to address emotional needs even when they were unable to address physical needs. Further, a few interviewees discussed providing counselling. Gloria, for example, explained how her counsel to aid recipients extended beyond REDI tasks:

> So, my communication, my phone is 24 hours ready for all their calls. It's true. Sometimes they call me two o'clock in the morning if they have [a] problem, crying, asking for help, you know, advice, something like that. And I still answer them. Sometimes, five o'clock in the morning. I'm still sleeping.

Therefore, we observed that faith leaders practiced care by participating wholly in the work. That is, they involved their entire, multidimensional selves in the care work while also connecting with the entire, multidimensional selves of others. Thus, it was clear that faith leaders' sphere of care extended beyond physical needs to include emotional and spiritual aspects and that their holistic engagement with care included managing complicated circumstances and emotions with optimism.

3.4 Discussion

3.4.1 Caring in context

The findings of our study revealed that faith leaders practiced care by navigating care responsibilities, leveraging relationships, and engaging holistically with the care work. Our study contributes an empirical example that demonstrates how these care components have been realized when grounded in a particular caring context. In doing so, these findings offer new insights into our conceptualization of care practice. A central tenet in care ethics is that all care work is contextual (Branicki, 2020; Engster & Hamington, 2015; FitzGerald, 2020; Gilligan, 1982; Tronto, 1993). Accordingly, we identified several contextual factors to have shaped the care work in our research. Importantly, the care was performed by local faith leaders in the Philippines, carried out during the COVID-19 pandemic, and conducted in partnership with an NGO (i.e., ICM) through the REDI program. While geographic and demographic characteristics diverged between participants, the shared contextual factors "emplace[d]" (Raghuram, 2016, p.512) the care work in the Global South, within a humanitarian setting, in connection to an NGO and program, and as practiced by faith actors. In this way, the study builds on appeals by care scholars to broaden our examination of care situatedness (Bartos, 2019; Hanrahan & Smith, 2020; Kallio, 2020; Raghuram, 2012, 2016).

To provide a framework for exploring these emplacing features, findings can be situated within Tronto's five phase model of care and associated moral qualities (Fisher & Tronto, 1990; Tronto, 1993, 2013). First, to 'care about', faith leaders were *attentive* to the needs in their communities during the pandemic and identified food needs among community members. Second, to 'care

for', faith leaders assumed *responsibility* to meet the needs they had identified by deciding to participate with ICM's REDI program. Third, to enact 'care giving', faith leaders carried out the necessary REDI tasks with moral and technical *competence*. Fourth, to engage with 'care receiving', faith leaders were *responsive* to community members, observing and assessing the sufficiency of the care provided and the emergence of new needs. Fifth, to 'care with', faith leaders worked in *solidarity* with other faith leaders, community members, ICM, and local government officials to accomplish the REDI tasks.

The positionality of participants as faith leaders fundamentally impacted the care work. Notably, participant narratives indicated that the social and geographical (i.e., physical locality) embeddedness of faith leaders both provided grounds for the care work and enabled the care work. Thus, all five phases of care were made possible or strengthened by the social and geographical embeddedness of faith leaders. This finding is consistent with research in other humanitarian and health promotion contexts that has found faith leaders to be key stakeholders due to their connectedness (Lau, Dodd, et al., 2020; UNICEF, 2020; Wijesinghe et al., 2022). In addition, faith leaders exhibited a strong orientation to care. This orientation was evidenced through their deep motivation to engage with the work and commitment to carry out tasks despite the personal investment required and challenges encountered. It could be that their positionality as faith leaders enhanced their orientation to care as has been discussed elsewhere (Greene et al., 2020; Jackson-Jordan, 2013). Further, that participants offered holistic care – namely, emotional and spiritual support alongside material aid – reflects what has been previously discussed on the humanitarian efforts of faith leaders (Arruda, 2020; del Castillo et al., 2020; Osei-Tutu et al., 2021; UNICEF, 2020) and aligns with their pre-existing roles as spiritual leaders in the community.

The humanitarian setting and partnership with an NGO also profoundly influenced the care work. Importantly, it set parameters to the care in terms of the type of needs addressed, the type of care possible, the ways in which the care was to be completed, and the extent of the care. In other words, faith leaders addressed local food needs both since food needs became pressing in the pandemic context and because food support was the type of assistance available through ICM. Further, to meet the food needs they identified, faith leaders were required to follow the procedures laid out by ICM. Finally, the extent of food needs met by faith leaders was characterized by the amount of support available through ICM. Accordingly, all five phases of care were defined, to an extent, by the crisis environment and collaboration with ICM. We have termed this form of care as 'caring through a predetermined process' since partnership with an NGO meant that the care work followed a specific and delineated process. Given studies that examine ethics of care within a civil society organization are few (Barnes, 2020; Collins, 2015; Dodd, Brubacher, et al., 2022; Formentin & Bortree, 2019), our research provides a starting point for extended research into and conceptualization of care work that follows stipulated process-oriented care tasks.

Locatedness in the Global South broadly and in the Philippines specifically also necessarily shaped the care work. Despite the country's diversity, a widely held traditional concept is *bayanihan*, a sentiment which signifies communal effort for the common good (Ang, 1979; Aruta et al., 2022; Bankoff, 2020; Eadie & Su, 2018). Originally used in the context of collective agriculture, the term has since gained applicability throughout Filipino society, having particular importance during challenging times such as disasters and emergencies (Aruta et al., 2022; Bankoff, 2020; Beza et al., 2018; Boquet, 2017; Eadie & Su, 2018; Oracion et al., 2005). In the COVID-19 pandemic, use of the term has proliferated. *Bayanihan* has been used to refer to a

spirit of cooperation in navigating disease prevention, public health measures, and resulting impacts on livelihoods and food security (Bagayas, 2020). Further, the term has become especially prominent as President Duterte enacted the '*Bayanihan* to Heal as One Act' (Republic Act No. 11469) in March 2020 which enabled him greater authority over restriction implementation and enhanced provision of government support (Bankoff, 2020; Republic of the Philippines Official Gazette, 2020b; Siena, 2022). Importantly, the concept *bayanihan* has been contentious as political authorities have employed the term to promote compliance among residents, as evidenced during the pandemic and previous humanitarian crises (Bankoff, 2020; Eadie & Su, 2018; Siena, 2022). The sentiment has even been considered a myth since experiences of support during Typhoon Haiyan, for example, were found to be short-lived and largely uneven within and between communities (Eadie & Su, 2018; Su & Tanyag, 2020).

In this environment, a clear finding of our study was that participants did not complete the care work in isolation but alongside their social relations as a collective and dynamic network of care. It could be that the Filipino concept of *bayanihan* contributed to faith leaders' engagement with the care work in this communal manner and perhaps even their motivation to participate with REDI overall. Notably, *bayanihan* was not mentioned by faith leaders; however, during preliminary context-building consultations, one Filipino ICM staff member used the term in their description of observed faith leader efforts. The evident interconnectedness between participants and their personal relations is consistent with the literature on Filipino society and previous research showing the presence of strong bonding social capital (i.e., between family members, friends, neighbours) among Filipinos (Abad, 2005; Eadie & Su, 2018; Marshall, 2018; Morais, 1981; Pal, 1966; Turgo, 2016). Irrespective of whether *bayanihan* was an explicit motivating factor for faith leaders, their collective approach provides an empirical example of Tronto's

(2013) fifth phase, ‘caring with’. In addition, it furthers a non-dyadic view of care (i.e., as not occurring between two people) (Aslanian, 2020; Tronto, 1993) in that faith leaders provided care at the community rather than individual level and did so alongside others.

3.4.2 Caring complexities

As demonstrated by our study, caring required faith leaders to navigate complicated and at times uncomfortable circumstances and emotions. Some complexities faced included practical barriers and challenges, personal investment involved to perform care tasks, determining and prioritizing care needs, and navigating various emotional responses. The common experience among faith leaders to encounter challenges in their REDI implementation is consistent with our understanding of care as being inherently complex, conflictual, and resource-requiring (Tronto, 1993). Thus, their experiences build our visibility and understanding of the types of challenges caregivers face and the ways in which they manage them.

In the context of the pandemic, the complex and conflictual elements of care may have been particularly pronounced. In one sense, information was rapidly changing and there was uncertainty and unpredictability surrounding evolving public health measures and emergent needs. This environment may have heightened the complexity of care, especially since these factors placed parameters on how the care work was carried out. In addition, pandemic-related income and livelihood shifts experienced by community members and faith leaders may have intensified the challenge of acquiring resources to perform care tasks (e.g., arrangement of transportation and associated costs). Further, instances may have arisen in which individuals

considered between meeting their own food needs or that of others, a sentiment alluded to by a few participants.

More broadly, the complicated nature of triaging care needs when resources are limited and the need is great was evidenced by participant narratives, echoing what has been discussed in other humanitarian and emergency healthcare settings (Leider et al., 2017). This challenge also speaks to Bartos' (2018) statement that, "care for someone can result in carelessness for someone else" (p.68). In the case of faith leaders who are locally embedded, such as our study participants, triaging care needs may have been especially complex. On one hand, local faith leaders were well-connected in the community and had access to a broad range of individuals, which facilitated their ability to determine care needs effectively. On the other hand, as embedded members of the community, relationships between faith leaders and individuals often preceded and followed the instance(s) of care. This continuity of relationship may have impacted care triage decisions and likewise, care triage decisions may have impacted relationships, thereby enhancing the complexity of determining how to prioritize care needs.

Further, we question the impact on the caregiver when facing the challenge of triaging care needs in an emergency setting. As one participant in our study expressed, it "hurt [his] heart" to be unable to extend care to all who needed support. This finding speaks to concerns raised by others regarding the potential for moral stress, distress, or injury among faith leaders and disaster responders who must, at times, make conflictual moral decisions and actions (Greene et al., 2020; Gustavsson et al., 2022; Williamson et al., 2020). Moral stress has been identified as occurring when an individual is unable to act in alignment with their moral values due to external constraints (Gustavsson et al., 2020; Lutzen et al., 2003). Research and discussion around moral stress, distress, and injury has increased during the COVID-19 pandemic in recognition of the

complex decisions and circumstances frontliners and caregivers face (Greene et al., 2020; Hines et al., 2021; Williamson et al., 2020). Accordingly, we raise concern for the emotional and moral well-being of caregivers, and local faith leaders particularly, who make effort to meet emergency care needs during humanitarian settings as they navigate complicated and conflictual moral decisions which may negatively impact their health or relationships, especially as spiritual leaders providing non-tangible faith-based supports.

At the same time, the connection of faith leaders to others may have mitigated some of the emotional, moral, and physical challenges experienced by participants in the study. For example, guidance received by ICM and the LGU regarding aid eligibility requirements may have reduced the moral conflict and stress associated with care triage decisions. In addition, support received otherwise from ICM, the LGU, community members, and other faith leaders may have also reduced the emotional, moral, and physical impacts of care complexities. The connectedness and overall collective care approach of faith leaders also illuminates the core notion of interdependence in care ethics. That is, as faith leaders both offered and required support, they acted as both caregivers and care receivers through their REDI involvement, thereby demonstrating the interdependent nature of care (Engster & Hamington, 2015; Robinson, 2020; Tronto, 1993). In these ways, our research highlights the relationality of care, both as being relational in nature and as being practiced relationally. Thus, our research underscores the importance of understanding how relationships function in care work and can shape experiences with caregiving.

3.4.3 Limitations

This study was conducted through one of ICM's 12 regional bases. Accordingly, participant experiences may not be reflective of faith leaders connected to other regional bases due to regional public health measures and restrictions throughout the pandemic. In addition, as ICM is a single faith-based NGO located in the Philippines, participant experiences were influenced by their work with ICM and the REDI program. Further, the pandemic-induced remote nature of the study prevented in-person interviews which may have impacted rapport development. To mitigate these challenges, several context-building conversations were held with ICM staff members involved with REDI, efforts were made to enhance the use of active listening techniques (e.g., affirmative sounds) during interviews to encourage dialogue, and space was provided at the beginning of interviews for participants to share more openly about themselves to facilitate comfort and connection between interviewees and interviewers. Further research can explore care work conducted in partnership with NGOs, both faith-based and secular, to illuminate how individuals manage and contend with prescribed care tasks. Future studies can also examine the care motivations and efforts of local faith leaders from diverse faith traditions in crisis environments through an ethics of care lens to expand visibility of the role of faith leaders in providing care in these contexts.

3.5 Conclusion

Our study revealed how the care components of responsibility, relationality, and emotion unfolded in the context of Filipino faith leaders meeting local food needs through partnership with an NGO during the COVID-19 pandemic. In doing so, our study offers an in-depth

examination of empirical findings related to an under explored form of care work within ethics of care. Our research highlighted the integral role social and geographical embeddedness played for faith leaders in that it both enabled and enhanced their efforts. In addition, faith leaders practiced care holistically by offering material, emotional, and spiritual support. Further, faith leaders demonstrated a strong orientation to care as they expressed deep motivation to meet community needs and displayed commitment to complete care tasks by leveraging personal, material, and social resources, in addition to navigating a challenging and dynamic pandemic context with optimism. Overall, our study builds on an invitation within care ethics to explore care as situated and practiced in diverse settings and to examine the complexities inherent to care.

Chapter 4: Conclusion

This thesis explored the experiences of local Filipino faith leaders who cared for their communities by meeting critical food needs during the COVID-19 pandemic. To do so, faith leaders partnered with International Care Ministries (ICM) and volunteered in the Rapid Emergencies and Disasters Intervention (REDI) program. Through collaboration with ICM, this study employed qualitative methodology and particularly, utilized semi-structured interviews, to examine the experiences of volunteers with REDI. The study was framed by an ethics of care theoretical orientation. Thus, study design and presentation were shaped by an ethics of care lens. In addition, the efforts of REDI faith leaders were understood as a type of care work, and the research explored their caring efforts in this setting. Results of the study were presented as a manuscript (Chapter 3) which elucidated core elements of the care practice of faith leaders and drew out the complexity of caring in this context. In this chapter, I provide concluding thoughts on the study. First, I review key findings from the research. Second, I consider strengths and limitations of the study. Third, I reflect on the broader relevance and contributions of the research. Fourth, I consider implications of the study, recommendations for future research, and final comments on the research.

4.1 Summary of main findings

Conversations with faith leaders in the REDI program revealed that practicing care during the COVID-19 pandemic involved navigating care responsibilities, leveraging relationships, and engaging holistically with the care work. Navigating care responsibilities was demonstrated as

faith leaders were greatly motivated to engage with the care work and drew on a depth of commitment, creativity, integrity, and personal investment to carry it out. Leveraging relationships was exemplified as faith leaders completed the care work collectively. That is, faith leaders reached out to offer and elicit support with care tasks from their personal social connections, thereby caring through a collective and dynamic network of care. Engaging holistically with the care work was evident as faith leaders navigated a range of complex circumstances and emotions with optimism and offered emotional and spiritual support in addition to material aid.

Participant narratives also highlighted contextual elements of the care practice of faith leaders. Importantly, the COVID-19 pandemic humanitarian setting, partnership with a non-governmental organization (NGO), positionality as local Filipino faith leaders, and locatedness in the Philippines profoundly shaped the care work of volunteers. Thus, the humanitarian crisis and collaboration with ICM provided grounds and means for the care work on one hand, and set parameters and predetermined structure to the care work on the other hand. Positionality as faith leaders may have contributed to a strong orientation to care and the provision of multidimensional care. Local embeddedness was integral to their care practice as it enabled and enhanced the care work, and locatedness in the Philippines including the cultural concept of *bayanihan* may have played a role in their collective care approach.

The care practice of faith leaders was also situated and explored within Tronto's five phases of care and associated moral qualities: 'caring about' and attentiveness, 'caring for' and responsibility, 'care giving' and competence, 'care receiving' and responsiveness, and 'caring with' and solidarity (Fisher & Tronto, 1990; Tronto, 1993, 2013). Accordingly, faith leaders 'cared about' by being attentive to community food needs, 'cared for' by assuming responsibility

to meet those needs, enacted ‘care giving’ by completing care tasks with competence, engaged with ‘care receiving’ by being responsive to the reactions and needs of care recipients, and ‘cared with’ by working collectively with ICM, other faith leaders, local government officials, and community members to accomplish REDI care tasks.

The experiences of study participants also brought to light the inherently complicated nature of care. Thus, factors such as the COVID-19 pandemic environment, practical barriers faced, personal investment required, determining and prioritizing care needs, navigating emotional responses, and interconnectedness with others contributed to the complexity of care practice among faith leaders in this setting.

4.2 Study strengths and limitations

Several aspects of the study afforded strengths and limitations to the research. First, partnership with ICM had a defining impact on the research. Partnership offered a strength as the study was grounded in a particular context and could have an applied output in addition to a broader contribution to knowledge. Additionally, since research team members were from both ICM and the University of Waterloo and collaboration between members occurred throughout the project, the research remained relevant, feasible, and appropriate for ICM. Conversely, partnership posed a limitation since ICM is a single Philippines- and faith-based NGO, which may have meant that participant experiences were not reflective of broader volunteer experiences in the Philippines. Further, conducting the study through one of ICM’s 12 regional bases may have meant that participant experiences were not reflective of faith leaders connected to other bases, especially due to diverse regional public health orders as well as the decentralized nature of health and

social service provision across the country (Dodd, Kipp, et al., 2022; Dodd, Kipp, Nicholson, et al., 2021). At the same time, focusing the research on one NGO and one regional base offered an opportunity to explore in-depth experiences as situated in a specific setting. Moreover, to balance depth with breadth, the study encompassed individuals with diverse demographic and geographic characteristics. Doing so provided an opportunity to consider a range of experiences within this given context, which broadened the research.

Second, the ongoing pandemic placed constraints on the study. Importantly, it necessitated that the research be conducted remotely, which prevented in-person interviews and context building. Remote data collection brought potential challenges to study participation, conversation and data quality, and relationship development with participants. In recognition of possible negative impacts from these limitations, several strategies were employed to mitigate the effects, which in turn strengthened the research.

One strategy used was to choose a method of remote communication which would enhance accessibility of study participation and quality of dialogue. Accordingly, Skype was determined as the platform for interviews since it enabled a multi-modal and multi-person connection. Thus, a three-way conversation could be held between myself, an interpreter (Danilo Servano Jr.), and a participant whereby myself and Mr. Servano Jr. could communicate by videoconference while simultaneously conversing with faith leaders through telephone. This approach was significant since it ensured the safety of participants and interviewers, adherence to public health guidelines, and accessibility of study participation irrespective of Internet connection, which many faith leaders did not have. Further, the ability to videoconference strengthened communication between Mr. Servano Jr. and myself (e.g., through the use of visual cues during interviews), which enriched the quality of data collected.

Another strategy used was to ensure efforts were made to build rapport with participants and establish contextual orientation for their experiences. Thus, interviews were opened with a chance for participants to share more freely about themselves and active listening techniques (e.g., affirmative sounds) were utilized throughout interviews, both which encouraged richer dialogue and connection between researchers and participants. Additionally, prior conversations with ICM staff and a review of REDI program documents facilitated broader contextual awareness which in turn supported meaningful inquiry during interviews and may have inspired deeper relationship forming with participants. Further, having more comprehensive insight into participant experiences enhanced data interpretation and analysis, thereby enriching study results and outputs.

Third, English being my only fluent language had implications on the research. Namely, since English knowledge varied among REDI volunteers, conducting English interviews would limit study participation and pose a challenge to in-depth sharing. To mitigate this potential barrier, a multi-lingual ICM staff member, Mr. Servano Jr., was present for interviews. Mr. Servano Jr.'s involvement increased accessibility of participation, supported rapport development with participants, and facilitated in-depth discussion during interviews. Thus, the presence of an interpreter enhanced data quality and thereby strengthened the study.

However, the need for interpretation may have also brought limitations. Instances where concepts or content were not easily translatable may have resulted in misunderstanding or misinterpretation. Additionally, the interpreter's positionality as an ICM staff member meant that the interview environment was not entirely neutral, which may have had a twofold impact. On one hand, Mr. Servano Jr.'s association with ICM established a foundation of trust and familiarity for participants which enabled and enhanced interview quality. On the other hand, his

association with ICM may have impacted how honest participants felt they could be regarding their experiences with the program. Thus, participants may have emphasized positive elements over negative experiences. In effort to create a safe and open sharing space, Mr. Servano Jr. and I communicated that participant identity would remain confidential and that what was shared would not impact their ongoing relationship with ICM.

Further, the presence of two interviewers during conversations strengthened the quality of dialogue with participants. In one way, it meant that each interviewer could contribute to ensuring important content was discussed with participants. In another way, co-interviewers could debrief following meetings which supported content comprehension, reflexivity, and informed how subsequent interviews were conducted. Accordingly, the collaborative approach to interviews greatly enhanced study conduct, researcher accountability, and overall data quality.

4.3 Research contributions

This study offers several noteworthy contributions. Importantly, the research contributes an empirical example of caring efforts examined through an ethics of care lens. Since few empirical studies utilize ethics of care as a theoretical orientation, this research affords valuable and unique insights into the experiences of care practice. Additionally, study results present an empirical illustration of how Tronto's five phases of care (Fisher & Tronto, 1990; Tronto, 1993, 2013) and the care components of responsibility, relationality, and emotion played out when grounded in a particular caring context. Furthermore, the form of care work empirically examined is under explored within ethics of care. That is, caring efforts carried out by local Filipino faith leaders, during the COVID-19 pandemic, in the Philippines, and in partnership with an NGO, is a type of

care practice accomplished by distinct actors and within a unique context to ethics of care. Thus, the research builds on appeals by care scholars to broaden our examination of care situatedness (Bartos, 2019; Hanrahan & Smith, 2020; Kallio, 2020; Raghuram, 2012, 2016).

Based on key insights identified through the care practice of study participants, further contributions were made. First, as studies examining ethics of care within civil society organizations are few, this research provides a starting point for extended research into and conceptualization of care work that follows stipulated process-oriented care tasks. Second, this research builds visibility and understanding around the types of challenges caregivers face, especially in a humanitarian context, and the ways in which they manage them. Third, the study brings together ethics of care with the traditional Filipino concept of *bayanihan* when exploring the care work of study participants. Fourth, the study underscores the importance of understanding how relationships function in care work and can shape experiences with caregiving. Fifth, by examining contextual features which "emplace[d]" (Raghuram, 2016, p.512) the care work in a distinct setting, including locatedness in the Global South, in addition to highlighting the complexities present in this instance of caring, the study responds to calls by ethics of care theorists to diversify our exploration of care practice including care's inherent conflicts, complexities, and contradictions (Bartos, 2018, 2019; Hanrahan & Smith, 2020; Kallio, 2020; Raghuram, 2012, 2016). Thus, the research contributes to further complicating and expanding our understanding of care.

Beyond ethics of care, the study builds visibility around the roles and efforts of local faith leaders in community-based humanitarian response, and specifically when these efforts involve collaboration with an NGO. Particularly, the research offers insights into the actions, complexities, and emotions faced by faith leaders in ICM's REDI network. As partnership with

ICM underpinned this research, findings of the study will be shared with ICM and have the opportunity to inform REDI operations moving forward. In addition, findings can inform the actions of NGOs and civil society organizations who partner with local community volunteers for program implementation more broadly. Importantly, the research highlights the opportunity available in collaborating with local faith leaders in humanitarian response and health promotion generally and points to the advantages and challenges of doing so. Finally, the study provides an example of global health research conducted entirely remotely. Specifically, utilizing Skype as a means for multi-modal and multi-person communication was significant as it allowed for expanded reach and accessibility of study participation including the presence of a remote interpreter. This method of data collection affords a feasible and effective model which global health researchers can replicate in other contexts. In these ways, this study contributes to both research and practice.

4.4 Implications, future research, and concluding thoughts

Several recommendations can be made from this research. First, ICM could consider findings of the study to enhance REDI operations. Specifically, participant experiences revealed the depth of commitment, investment, and creativity involved as well as the collective effort entailed in accomplishing REDI tasks. Accordingly, ICM could consider additional means of equipping faith leaders to facilitate ease of implementation and accessibility of participation in the program. For example, further support with aid transportation and management could be provided.

Second, NGOs and civil society organizations more broadly could consider study findings to enhance their efforts. Namely, participant narratives highlighted the tasks and strategies involved

in REDI implementation as well as the opportunity present in collaborating with local faith leaders for effective implementation. Other NGOs and civil society organizations may consider ICM's REDI program components, including the role of local faith leaders, as a model to emulate in other contexts to facilitate a successful crisis response.

Finally, global health researchers could consider the methods utilized in this study to further develop their research practice. Particularly, that the approaches to remote data collection and context building employed in this study were successful, efficient, and garnered quality data could in turn inform how other global health studies are conducted. Additionally, researchers could consider the further value of remote global health research, including a significant reduction in financial expenditures, environmental impact, and the burden of time and effort on the community or partner organization. Further, remote data collection can offer study participants flexibility to participate in a location and manner they find most comfortable and convenient, thereby fostering an environment more conducive to rapport development and in-depth discussion. Accordingly, the remote nature of this study is notable and provides an alternative method to traditional approaches, which could be reproduced elsewhere.

Future research could expand on various elements of this study and its findings. More broadly, further research could be conducted with an ethics of care theoretical orientation to continue building the base of empirical research on caring efforts through an ethics of care lens. Doing so would contribute to further grounding, contextualizing, and broadening of our conceptualization of care practice. Further, research with a focus on diverse practices of care including exploring the complex, conflictual, and complicated aspects of care could be conducted to continue deepening our understanding of care. Moreover, studies could further explore specific elements of care practice which were highlighted in this study. For instance, studies could examine

possible connections and divergences between ethics of care and the Filipino concept of *bayanihan*, investigate cases of multidimensional or collective care, explore caring efforts conducted in partnership with NGOs to learn how caregivers manage and contend with prescribed care tasks, or examine the care motivations and efforts of local faith leaders in crisis environments to expand visibility of the role of faith leaders in providing care in these contexts.

In addition to studies relating to ethics of care, further research could explore the engagement of community volunteers, and faith-based actors specifically, in humanitarian crises more generally. With climate change and ongoing disasters, obtaining a more comprehensive understanding of the opportunity afforded by partnership with community volunteers and faith actors is pertinent. Within this premise, studies could examine various comparisons. For example, research could compare the experiences of community volunteers who are faith leaders to those who are not faith leaders to explore variations in motivation, methods employed, challenges faced, facilitative elements encountered, emotions experienced, strategies and approaches utilized, and overall effectiveness and achievement. Further, similar variations could be explored when comparing across other inherent distinctions: volunteers whose efforts are spontaneous versus organized, volunteers connected to distinct and diverse organizations (e.g., faith- versus non-faith-based, state- versus non-state-based, faith-based across various faith traditions), volunteers located in the Global South versus the Global North, or volunteers who are residents versus non-residents to the community being served. Moreover, any of the abovementioned variations or inherent distinctions could be examined through the lens of various positionalities, for instance, gender, age, ethnicity, occupation, or geographical location. By expanding our understanding of the experiences of volunteer engagement in humanitarian settings and teasing out similarities and differences between them, we can learn the forms, capacities, strengths, limitations, and

opportunities of voluntary efforts in these environments. Doing so can inform ongoing and future collaboration efforts and ensure volunteers are adequately equipped and cared for in their voluntary work.

In conclusion, this thesis research explored the experiences of local Filipino faith leaders who volunteered to mobilize food aid to community members in need during the COVID-19 pandemic through ICM's REDI program. The study utilized an ethics of care lens to explore how care was practiced by faith leaders in this context. Through conversations with participants, it was apparent that key features of their care practice included being greatly motivated to care, drawing on a depth of commitment and creativity to complete care tasks, facing complex circumstances and emotions with optimism, and caring collectively and holistically. These central aspects highlighted faith leaders' considerable orientation to care as well as their relational and multidimensional approach to care. Such insights into the care practice of faith leaders are significant as they point to the opportunity present in collaborating with local faith leaders in humanitarian response, the approaches that may be used by individuals when doing so, and the supports that may be needed by individuals in this process. Additionally, the experiences of faith leaders in the study contribute to further expanding and complicating our understanding of care, a necessary endeavour to ensure that diverse positionalities, practices, approaches, and experiences with care are recognized, valued, and cared for in research and practice. Finally, results sharing with ICM can provide a valuable glimpse into the experiences of their partner community volunteers in the REDI network, which has the opportunity to further the vital caring efforts of ICM and their volunteer faith leaders in future emergency and disaster response settings in the Philippines.

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Appendices

Appendix A: Semi-structured interview guide: REDI faith leaders (Round 1)

INTERVIEW GUIDE: REDI Pastors	
Date: Assigned pseudonym: Affiliated ICM regional base:	Translator: Y / N Translator sex: M / F Translator age: Relation to participant:
A. Demographic and contextual factors	
General	
***Could you tell me a bit about yourself to start? Where you are from, your occupation, etc.?**	
Community: Province: Ethnicity: Language(s): Education level completed: Marital status: Sing / Mar / Div / Wid / Child Household size:	Age: Sex: M / F Occupation: Hometown: Joined ICM: Joined REDI:
Before COVID-19	
***Could you tell me about how things were for you before COVID-19?**	
Questions	**Prompts**
1. Can you describe a typical day or week for you before COVID-19?	*Routine, religious activities, job, tasks, roles in the community, social networks, family*
2. Can you describe your interactions with community members before COVID-19?	*Relationships, religious activities, community-based activities, everyday socializing, cellphone / in-person*
3. Can you describe your role(s) and tasks in your community before COVID-19?	*Pastor, religious activities, educate, ICM, jobs, community involvement, political*
4. What motivates you to do what you do (for example, be a pastor, partner with ICM, other)?	*Why do you do what you do? Poverty, compassion, faith, values, personality, family, history*
5. Why do you think what you do (pastor, partner with ICM, other) is important?	*Poverty-alleviation, community well-being, religious*
6. How did you become involved with ICM?	*Reasons for joining, religious background, social connection*

During COVID-19		
***Could you tell me a bit about COVID-19 in your area?**		
1.	What is the current level of quarantine in your area?	*None / MGCQ / GCQ / ECQ / MECQ*
2.	Can you describe the COVID-19 measures in your area?	*Movement of people, stay-at-home policy, gatherings, checkpoints, curfews, transportation, quarantine passes, education, work, physical distancing, masks, safety procedures, PPE*
3.	Can you describe the effect of COVID-19 in your area?	*Virus transmission, job loss, income loss, food insecurity, mental health, access to health and social services, access to PPE*
4.	Can you describe a typical day or week for you during COVID-19?	*Roles in the community, tasks, safety procedures, quarantine protocols*
5.	Can you describe your interactions with community members during COVID-19?	*Relationships, social distancing, gatherings, everyday socializing, cellphone / in-person*
B. Involvement in REDI Network		
***Could you tell me about your involvement in the REDI Network?**		
General		
1.	How did you become involved in the REDI Network?	*Reasons for joining, religious background, social connection*
2.	What training did you receive when you joined the REDI Network?	*General, during COVID-19*
3.	Can you describe your tasks in the REDI Network during COVID-19?	*Monitor food needs, report to ICM through EngageSpark, receive food, deliver food, ensure adequacy, monitor new needs*
4.	How much time in a day / week do you spend doing tasks for REDI during COVID-19?	*Number of hours / days per week, too much / too little time spent*
5.	How does REDI fit with your other tasks and responsibilities outside ICM during COVID-19?	*Prioritize, busy, hard to find time, fits well*
Concepts and practices of care		
1.	Do you think your tasks in REDI are necessary? Why or why not?	*Poverty-alleviation, food security, religious*
2.	Can you describe your interactions with ICM staff in REDI?	*When, in-person / text message / call, available, responsive, helpful, positive / negative experience*
3.	Can you describe your interactions with other REDI Network members?	*When, reason, EngageSpark, in-person / text message / call, responsive, supportive, positive / negative experience*

4.	Can you describe your interactions with community members when you do tasks for ICM and REDI?		*When, in-person / text message / call, monitor, support (emotional, spiritual, physical), relationships*
5.	Can you describe how you determine food aid requirements in your community?		*Observe, record, monitor, prioritize, organize, visit, communicate (call, text, in-person)*
	a.	How do you decide which individuals and families need food aid?	
	b.	How do you know how much food aid is needed?	
	c.	How do you know if the food aid provided is enough?	
	d.	How do you know when individuals and families need more food?	
6.	Can you describe whether or how you follow pandemic guidelines?		*PPE, physical distance, sanitize, curfew, checkpoints, quarantine pass, self-isolation*
	a.	Where do the guidelines come from?	
	b.	When you receive food aid from ICM?	
	c.	When you deliver food aid to community members?	
	d.	In your personal life?	
7.	Can you describe how being in REDI during COVID-19 has impacted you personally?		*Physical / mental / spiritual well-being, emotions, anxiety, fatigue, isolated, movement, gathering, social support, time constraints, work, communication, food and essentials, PPE, pandemic protocols / precautions, self-isolation*
	a.	What personal challenges have you faced?	
	b.	How are you taking care of yourself?	
	c.	How are you taking care of your family?	
8.	Can you describe whether or how your identity (for example, gender, age, marital status, occupation, location) influences your ability to do tasks for REDI during COVID-19?		*Why / why not, age, gender, ethnicity, language, marital status, level of education, employment, geographical location (community, province, region)*
Perceived effectiveness			
***Could you share some of your opinions about how effective you think REDI is?**			
1.	Do you think REDI is an effective way for ICM to address emergencies?		*Why / why not* *Communication, logistics, EngageSpark, organization, training, resources, support, relationships, time commitment*
	a.	What do you think works well?	
	b.	What do you think does not work well?	
	c.	How could REDI improve?	
	d.	How could ICM support you better in REDI?	

2.	Do you plan to continue partnering with REDI in the future?		*Why / why not*
Conclusion			
Thank you for sharing everything you have today. That is all of the questions I have for you, but before we finish our interview…			
1.	Is there anything else you would like to say about:		
	a.	Your experiences with ICM and REDI during COVID-19?	
	b.	Your opinions about ICM and REDI?	

Appendix B: Semi-structured interview guide: REDI faith leaders (Round 2)

Interview Guide: REDI Pastors

(Updated December 13, 2020)

Date: Assigned pseudonym: Affiliated ICM regional base:	Translator: Y / N Translator sex: M / F Translator age: Relation to participant:

1) About self

- Can you tell me a bit about yourself? Where you are from, your family, your occupation, age, education, etc.
    - Demographics:

Community: Province: Ethnicity: Language(s): Education level completed: Marital status: Sing / Mar / Div / Wid / Child Household size:	Age: Sex: M / F Occupation: Hometown: Joined ICM: Joined REDI:

    - How did you hear / learn about ICM?
    - How did you hear / learn about REDI? Did you receive any training when you joined the REDI Network?

2) Before COVID

- Can you tell me a bit about how life was for you before COVID hit in March?

  A) Routine / Schedule

  - Can you tell me about your usual routine / schedule and activities before COVID?
    - A typical day / week
    - Your involvement in the community
    - Your interactions with community members

  B) Motivation

  - What motivates you to do what you do? (your work, the activities you described, etc.)

  C) Care

  - For you, what does it mean to care for your community?

3) During COVID

- I have heard that when COVID hit in March, there were a lot of protocols and life really changed for a lot of people.
  - Can you describe how life changed for you and your community with COVID?
  - How did this affect you and your community?
    - Physically, emotionally, mentally, spiritually

4) Involvement with REDI

- Can you tell me a bit more about your involvement with REDI during COVID?

  A) General

  - What motivated you to partner with REDI Help?
  - How many orders did you submit to REDI Help?
  - How many families and communities did you serve?
  - What supplies did you receive from REDI Help?
  - When did you receive supplies from REDI Help?

  B) REDI Tasks

  - Can you tell me a bit more about your REDI tasks?
    - So, I have heard pastors needed to:
      - Create a list of recipients
      - Submit the report to ICM
      - Wait for the supplies
      - Pick up the supplies
      - Distribute the supplies
    - Can you tell me about your experiences with these processes?
      - For example:
      - How did you make the decision who will receive food and who will not receive food? What were the requirements?

- How did you submit the report to ICM – text message, ICM staff, Facebook chat?
- How long did you wait for the supplies to be available for pick-up?
- Where did you go to pick up the supplies? How did you pick them up (own vehicle, collaborate with LGU, rent transportation)? How far of a drive? Checkpoints?
- How did you distribute the supplies (own vehicle, collaborate with LGU, rent transportation)? How far of a drive? Checkpoints? Door-to-door or one pick-up point for recipients?

- Can you describe your interactions during this process? (With ICM staff, other REDI pastors, community members)
- What was the response of recipients when receiving the supplies? (I have heard that many recipients were very grateful and also that some were not very grateful – what was your experience with how recipients responded?)
- Can you describe any personal difficulties you faced when doing these REDI tasks?
- Can you describe whether or how your identity impacted / influenced your REDI tasks?
    - So, for example, how do you think being a _____ gave you an advantage or disadvantage in your REDI tasks?

        - Pastor, other work/involvements, gender, age, location, ethnicity, language, education, marital status, household size
    - By partnering with ICM through REDI Help and doing these tasks, you have been a front-liner during COVID. Why did you put yourself at risk?
    - Can you describe whether or how you followed pandemic guidelines / protocols while doing REDI?
        - (Where do the guidelines come from? During pick-up and distribution of supplies? Personally?)
    - How did you take care of yourself and your family while being involved with REDI?

5) Perceived effectiveness

- I would like to ask about some of your opinions about REDI. ICM may not make any changes to REDI, but they would like to hear how you were doing with REDI.
- So, in your experience:
    - Was the training you received for REDI Help sufficient? Why / why not? (Did you know what to do and how to use REDI Help? Why/why not?)
    - How much time did you spend doing REDI tasks? How did you find the time commitment for REDI tasks? (Was this too much, too little, okay amount of time?)

- What worked well for you with REDI Help?
- What did not work very well for you with REDI Help? As in, what needs improvement with REDI Help, in your opinion?
- What was the impact of partnering with REDI Help during COVID?
    - Community, church, relationships, physical, mental, emotional, spiritual, you personally
- Do you plan to continue partnering with REDI Help in the future? Why / not?

6) Conclusion

- That is all the questions I have prepared for you!
- Is there anything else you would like to share about your experiences or opinions about REDI Help during COVID?

Appendix C: Semi-structured interview guide: REDI faith leaders (Round 3)

Interview Guide: REDI Pastors

(Updated January 16, 2021)

Date: Assigned pseudonym: Affiliated ICM regional base:	Translator: Y / N Translator sex: M / F Translator age: Relation to participant:

A. About self, before and during COVID

1. I would love to hear more about you – **where you are from, your family, your age, education, occupation, and your involvement in your community** (before COVID).
    - Demographics:

Community: Province: Ethnicity: Language(s): Education level completed: Marital status: Sing / Mar / Div / Wid / Child Household size:	Age: Sex: M / F Occupation: Hometown: Joined ICM: Joined REDI:

2. Thank you for sharing all of that! **What motivates you to do what you do?** (your work, the activities you described, etc.)

3. For you, Pastor(a), **what does it mean to care for your community?**

4. I have heard that when COVID hit in March, life really changed. **Can you share how COVID affected you and your community?** (physically, emotionally, mentally, spiritually)

B. Involvement with REDI

5. So, **what motivated you to get involved with REDI Help during COVID?**
    - How did you hear about REDI Help?
    - How did you know how to use REDI Help?
    - How did you know people were in need?
    - How did this involvement with REDI connect with your concept/idea of care (you shared before)?

6. *[If Pastor(a) is very positive about REDI]* It sounds like your involvement with REDI has been a very positive experience for you and your community. **Can you share a bit more about why it has been so positive/effective/impacting?**

7. I have heard that with REDI, pastors needed to: create a list of recipients, submit a request to ICM, wait for the supplies, and then pick up and distribute the supplies. **Can you share about your experience with these REDI tasks/processes?**

8. Many pastors have shared how they did not do REDI tasks alone but collaborated with other pastors, reached out to the LGU, asked for help from church members, or paid assistants. (You also mentioned ___.) **Can you share about your experience? Did you do REDI tasks alone or with others? If you did REDI tasks with others, who did you do it with and how did this look?**

9. We have heard from some pastors that REDI was challenging – to coordinate transportation, cover expenses, request supplies, use technology, carry heavy boxes, face weather and road conditions. (You also mentioned ___.) **Did you face any challenges with REDI? If so, can you share a bit about them?**

10. We understand there was a limited amount of aid you could request from REDI, and we have heard about different ways pastors decided who would receive aid and who would not receive aid (who would be on the list). **Can you share what your process was like? How did you decide who will receive aid and who will not receive aid? What were the requirements?**
    - Did you have (ICM) guidelines to follow? (If yes) Can you share about your experience with the guidelines?
    - Some pastors have shared that it was challenging because everyone was in need. Can you share what your experience was like?
    - How did it feel for you to not be able to give to some people in need?
    - How did non-recipients respond to not receiving aid? How did this feel for you?
    - How did recipients respond to receiving aid? How did this feel for you?

- How do you think ICM could support you better in this process of deciding who will/will not receive REDI Help?

11. Some pastors shared they received REDI supplies at the beginning of the pandemic, and others are still receiving supplies now. **How about you – when did you receive supplies from REDI Help? Are you still receiving supplies?**
    - How many requests have you submitted to REDI?
        - Were these requests for the same communities and families, or different communities and families?
            - How many communities and families did you reach?
            - How did it feel for you to only be able to supply to families in need once rather than repeatedly?
    - What supplies have you received from REDI?
        - (How was your experience switching from food packs to seeds?)
    - [If requested/received only at beginning]
        - Why haven't you requested more REDI Help supplies?
    - [If still requesting/receiving now]
        - Why have you continued requesting from REDI Help?
    - [If requested/received only recently]
        - What drew you in to participate with REDI Help only recently?

12. Some pastors have shared how their age, sex, location, role in the community (if they were a Barangay Chaplain, for example), health condition, marital status, personality, or

previous life experience impacted their ability to do REDI – so, maybe gave them an advantage or disadvantage in their REDI tasks. **Can you share about your experience? So, you are ___, ___, ___, how do you think this may have impacted, or given you an advantage or disadvantage, with REDI tasks?**

- **How accessible do you think REDI is for pastors?**

13. We have heard a lot about the COVID protocols during the lockdown and even until now. **How did the protocols impact your REDI tasks?** (list, report, pickup, distribution)

14. By participating in REDI, you have been a frontliner during the pandemic. **Why did you put yourself at risk?**

15. **How did you take care of yourself and your family while being a frontliner with REDI?**

C. Perceived effectiveness

16. Finally, **I would like to ask about some of your opinions about REDI**. ICM may not make any changes to REDI, but they would like to hear how you were doing with REDI. So, in your experience:
    - What worked well for you with REDI?
    - What did not work very well for you with REDI? (As in, what needs improvement with REDI, in your opinion?)

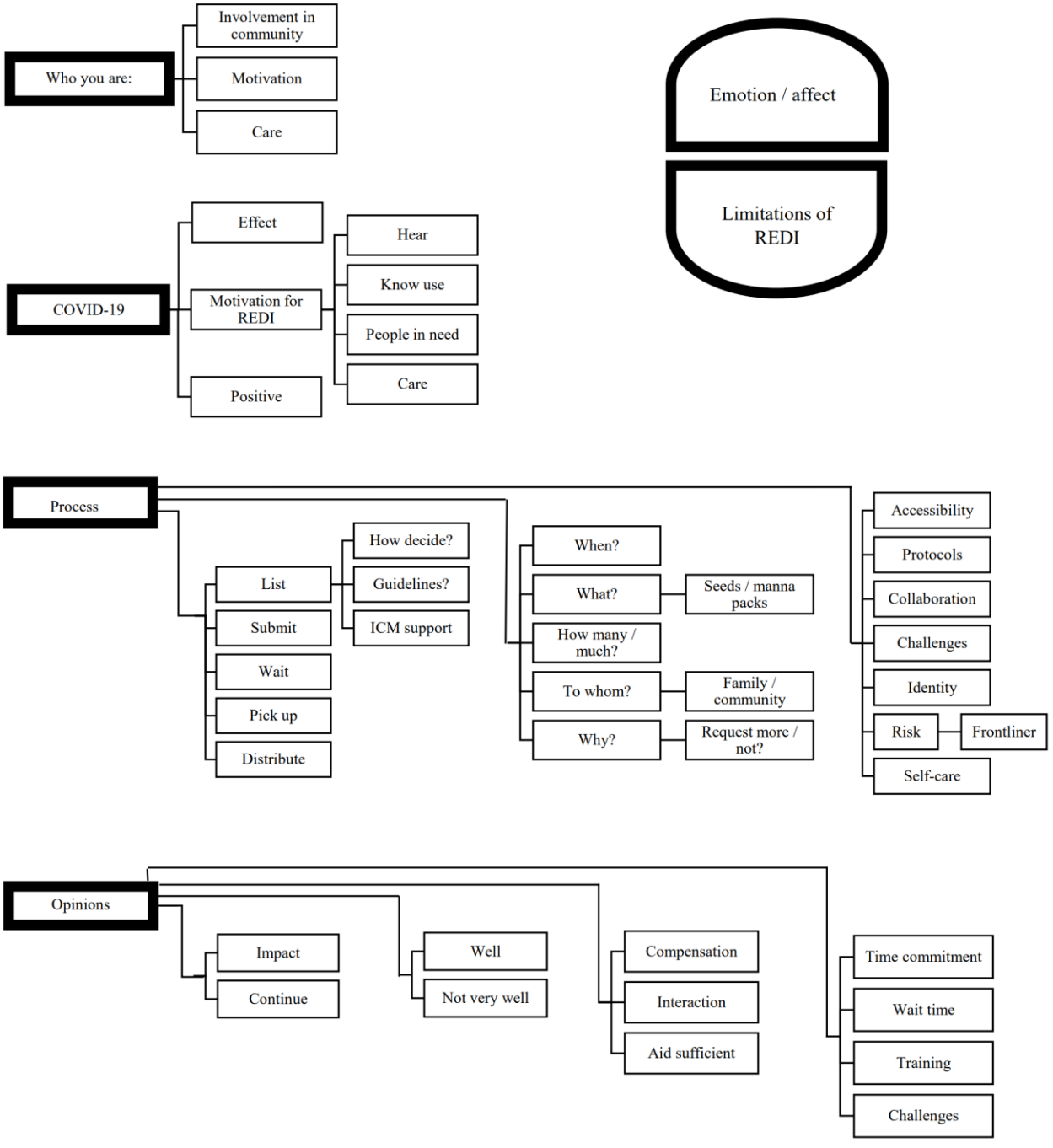
- Are there any other challenges you faced with REDI that you would like to share about?
- What is your opinion about: REDI training/orientation/preparation, wait time for supplies, and time commitment for REDI tasks?
- Did you receive any compensation from ICM for REDI involvement? If yes, what, and do you think it was sufficient? If not, do you think you should have? Why/why not?
- How was interaction with ICM (staff) throughout the process?
- Did you feel the aid provided by REDI Help was sufficient? Why/why not?
- What was the impact of partnering with REDI during COVID?
- Do you plan to continue partnering with REDI in the future? Why/why not?

D. Conclusion

That is all of the questions I have prepared for you! Thank you so much for everything you shared with me today, Pastor(a).

Is there anything else you would like to share about your experiences or opinions about REDI Help during COVID?

Appendix D: Visual semi-structured interview guide map: REDI faith leaders (Round 3)



Appendix E: Research ethics approval: Research Ethics Board, University of Waterloo

UNIVERSITY OF WATERLOO

Notification of Ethics Clearance to Conduct Research with Human Participants

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Principal Investigator: Warren Dodd (School of Public Health and Health Systems)

Student investigator: Shoshannah Speers (School of Public Health and Health Systems)

Administrative Support: Amy Kipp (School of Public Health and Health Systems)

Co-Investigator: Hannah Tait Neufeld (School of Public Health and Health Systems)

Co-Investigator: Lincoln Lau (International Care Ministries)

File #: 42565

Title: Experience of community volunteers monitoring and mitigating food insecurity during the COVID-19 pandemic in the Philippines: A qualitative study

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The Human Research Ethics Committee is pleased to inform you this study has been reviewed and given ethics clearance.

Initial Approval Date: 10/27/20 (m/d/y)

University of Waterloo Research Ethics Committees are composed in accordance with, and carry out their functions and operate in a manner consistent with, the institution's guidelines for research with human participants, the Tri-Council Policy Statement for the Ethical Conduct for Research Involving Humans (TCPS, 2nd edition), International Conference on Harmonization: Good Clinical Practice (ICH-GCP), the Ontario Personal Health Information Protection Act (PHIPA), the applicable laws and regulations of the province of Ontario. Both Committees are registered with the U.S. Department of Health and Human Services under the Federal Wide Assurance, FWA00021410, and IRB registration number IRB00002419 (HREC) and IRB00007409 (CREC).

This study is to be conducted in accordance with the submitted application and the most recently approved versions of all supporting materials.

Expiry Date: 10/28/21 (m/d/y)

Multi-year research must be renewed at least once every 12 months unless a more frequent review has otherwise been specified. Studies will only be renewed if the renewal report is received and approved before the expiry date. Failure to submit renewal reports will result in the investigators being notified ethics clearance has been suspended and Research Finance being notified the ethics clearance is no longer valid.

Level of review: Delegated Review

Signed on behalf of the Human Research Ethics Committee

Documents reviewed and received ethics clearance for use in the study and/or received for information:

file: Recruitment script_ICM regional base staff_V2_20201021.pdf

file: Recruitment script_REDI community volunteer_V2_20201021.pdf

file: Recruitment script_ICM staff_V2_20201021.pdf

file: Interview guide_REDI community volunteer_V2_20201021.pdf

file: Interview guide_ICM staff_V2_20201021.pdf

file: Letter of information_ICM regional base staff_V2_20201021.pdf

file: Letter of information_ICM staff_V2_20201021.pdf

file: Letter of information_REDI community volunteer_V2_20201021.pdf

file: Oral consent script_REDI community volunteers_V2_20201021.pdf

file: Oral consent script_ICM staff_V2_20201021.pdf

file: Oral consent log_REDI volunteers_V1_20200929.pdf

file: Oral consent log_ICM staff_V1_20200929.pdf

file: Confidentiality Agreement_V1_20200929.pdf

file: Letter of appreciation_ICM regional base staff_V2_20201021.pdf

file: Letter of appreciation_REDI community volunteer_V2_20201021.pdf

file: Letter of appreciation_ICM staff_V1_20200929.pdf

Approved Protocol Version 2 in Research Ethics System

This is an official document. Retain for your files.

You are responsible for obtaining any additional institutional approvals that might be required to complete this study.

Appendix F: Semi-structured interview guide: ICM staff members

INTERVIEW GUIDE: ICM Program Staff		
Date: Assigned pseudonym: Affiliated ICM base:		
A. Contextual factors		
General		
Could you tell me a bit about yourself to start? Where you are from, your position with ICM, etc.?		
COVID-19		
Could you tell me a bit about COVID-19 in your area?		
	Questions	**Prompts**
1.	What is the current level of quarantine in your area?	*None / MGCQ / GCQ / ECQ / MECQ*
2.	Can you describe the COVID-19 measures in your area?	*Movement of people, stay-at-home policy, gatherings, checkpoints, curfews, quarantine passes, education, transportation, physical distancing, masks, safety procedures, work*
3.	Can you describe the effect of COVID-19 in your area?	*Virus transmission, job loss, income loss, food insecurity, mental health, access to health and social services, access to PPE*
Involvement with ICM		
Could you tell me about your involvement with ICM?		
1.	Can you describe your work with ICM?	*Position, roles, responsibilities, tasks, time commitment*
2.	Can you describe your work with REDI?	*Position, roles, responsibilities, tasks, time commitment*
3.	Can you describe a typical day or week for you with ICM and REDI during COVID-19?	*Roles, tasks, safety procedures, quarantine protocols*

B. REDI Network volunteers		
General		
Could you tell me a bit about the REDI Network volunteers?		
1.	Can you describe the role(s) and tasks of REDI volunteers in their communities outside of ICM?	*Pastor, religious activities, educate, jobs, community involvement, political*
2.	Can you describe how volunteers came to join the REDI Network?	*Invited, reasons for joining, religious background, social connection*
3.	What training did volunteers receive when joining the REDI Network?	*General, during COVID-19, resources*
4.	Can you describe REDI volunteer tasks during COVID-19?	*Monitor food needs, report to ICM through EngageSpark, receive food, deliver food, ensure adequacy, monitor new needs*
5.	Can you describe your interactions with REDI volunteers?	*When, reason, EngageSpark, in-person / call / text message, positive / negative experience*
Observations of REDI volunteers		
Could you tell me about some of your observations of REDI volunteers?		
During COVID-19, can you describe your observations relating to:		
1.	Amount of time in a day/week volunteers spend working with REDI?	*Number of hours / days per week, too much / too little time spent*
2.	How volunteers' work with REDI fits with tasks and responsibilities outside of ICM?	*Prioritize, busy, fits well, hard to find time*
3.	How volunteers determine food aid requirements?	*Observe, record, monitor, prioritize, organize, visit, communicate (in-person / call / text message)*
	i.e. How do they decide / know:	
	a. Which individuals/families need food aid?	
	b. How much food aid is needed?	
	c. If the food aid provided is enough?	
	d. When individuals/families need more food?	
4.	Interactions between REDI volunteers?	*When, EngageSpark, in-person / call / text message, responsive, supportive, positive / negative communication*
5.	Interactions between volunteers and community members?	*When, in-person / call / text message, responsive, supportive (emotional, spiritual, physical), positive / negative communication*
6.	How volunteers follow pandemic guidelines?	*PPE, physical distance, sanitize, checkpoints, curfews, quarantine pass, self-isolation*
	a. When they receive food aid from ICM?	
	b. When they deliver food aid to community members?	
	c. In their personal lives?	

7.	How volunteers are being impacted personally by their work with REDI?		*Physical / mental / spiritual well-being, anxiety, fatigue, isolated, movement, gathering, social support, time constraints, work, communication, food and essentials, PPE, pandemic protocols / precautions, self-isolation*
	a.	What challenges they have faced?	
	b.	How they are taking care of themselves?	
	c.	How they are taking care of their families?	
8.	Whether or how volunteers' identity (for example, gender, age, marital status, occupation, location) influences their ability to work in REDI?		*Why / why not, age, gender, ethnicity, language, marital status, level of education, employment, geographical location (community, province, region)*
Perceived effectiveness			
Could you tell me about your opinions regarding how effective you think REDI is?			
1.	Do you think REDI is an effective way for ICM to address emergencies?		*Why / why not* *Communication, logistics, EngageSpark, organization, training, resources, support, relationships, time commitment*
	a.	What do you think works well?	
	b.	What do you think does not work well?	
	c.	How could REDI improve?	
	d.	How could ICM better support staff and volunteers in the REDI Network?	
Conclusion			
Thank you for sharing everything you have today. That is all of the questions I have for you, but before we finish our interview…			
1.	Is there anything else you want to say about:		
	a.	Your experience with REDI?	
	b.	Your experience with REDI volunteers?	
	c.	Your observations about REDI volunteers?	

Appendix G: Final thematic map