UNIVERSITY OF JYVÄSKYLÄ
DEPARTMENT OF SOCIAL SCIENCES AND PHILOSOPHY

ROLE OF COMMUNITY PARTICIPATION AND LOCAL CULTURE IN DEVELOPMENT CO-OPERATION.

A Case-Study of Bolivian Non-Governmental Organisations working in the Health Sector with the Aymara and Quechua people.

Elina Vammavaara
Pro-Gradu Thesis
Social Policy
May 2001
139 pages + 4 appendixes

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ABSTRACT

There are tens of Non-Governmental Organisations (NGOs) working in Bolivia for the improvement of the level of health and healthcare in the country. In their work they have to face several cultural obstacles such as old beliefs and healing traditions and the prevailing structures of the society.

In this paper, I study the experiences of the use of participatory methods in health work. For the research I interviewed the health project co-ordinators of ten health sector Non-Governmental Organisations (NGOs) working in Bolivia. The objectives of the study were to understand the role of the community participation in health work and to discuss the relation between the level of the community participation and the project personnel's attitude towards the local culture.

The paper is divided in three parts. The first part is the introduction to the paper, in which I present the main concepts of the study. The second part introduces the theoretical background of the study and discusses some previous investigation and experiences of the community participation in development co-operation. The theories deal with the empowerment of the people and intercultural communication in international development co-operation.

The third part I begin with introduction to the Bolivian political situation and current healthcare system. Further, I familiarise the lecturer with the Andean culture and advance the work by analysing this from the point of view of intercultural communication. Moreover, I measure the levels of the community participation in the projects included in this study and compare these results with the NGO's policy and attitude towards the local culture

The results of the investigation indicate that there is a relation between the level of community participation and the respect of local culture and traditions. Nevertheless, it cannot be taken as direct relationship, but rather, I understand it as a result of the nature of the project. Thus, I conclude that the objectives of the project determine the level of the people's participation. The role of the community participation depends on the objectives and policy of the NGO.

Keywords: Bolivia, community participation, culture, development co-operation, non-govrernmental organisation

CONTENTS

FOREWORDS

This paper has been a big project for me. It is the first academic work I have done, but it was also hard because of the topic and the conditions where it has been started. When I started the investigation in Bolivia many times I found myself in a situation when I did not know how to continue. There are many people who have helped me in their own way, and I would like to dedicate this space to thank all of them.

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1 INTRODUCTION

Two years ago, in 1998, a group of external evaluators visited a target area of a Non-Governmental Organisation. Arriving to the village, somewhere in Southern Bolivia they met a *campesino*, a farmer, walking uphill with his sheep. Surprised by the view, as it is a custom in Bolivia that women tend the animals, not men, they stopped the man to ask him where he was going. "To tend the sheep" the man answered. "And your woman?" "She's gone to the reunion".[1]

The reunion she had gone was a monthly women's group to discuss health related issues, talk about women's rights and learn to read. The reality is changing in some villages in Bolivia. What the evaluators saw, was, according to the interviewee who told me the story, a direct result of their work, men and women are becoming more equal, they share tasks, women are allowed more and more to take part in activities that used to be for men only. The change has not happened overnight, it took years of time and serious work with both men and women, but it is happening:

> *"Let me tell you, the problems with the roles, they share roles. What happened was a beautiful thing. But for this we have had to fight.... First with the men and then with the women themselves."* Organisation 9 (1)

1.1 Objectives of This Study

There are dozens of non-governmental organisations working in the health sector in Bolivia. They have done the work for a long time, as have the governmental organisations. Nevertheless, while millions of US dollars are spent every year to improve the situation, the level of health and healthcare remains bad in the country. (Gondrie 1995). There are many possible reasons for this, and this paper intends to study two of them, the level of community participation and the cultural aspect of the health work in the Andes. This I

[1] Original text from the interview?

consider important because I understand health as something more profound than a simple physical state. Health and illness can be seen as products of the prevailing social and cultural systems of the community. This in mind, the work with health should take into account the local culture.

In this paper I want to study the experiences of non-governmental organisation (NGO) of the use of the community participation method in health work in the Andean cultural environment. It is not the aim of this study to give a global picture of the participation in the development work, even though there is a chapter that introduces the reader with the general outlines of this, too. Participation is a widely used concept, it would make a whole study alone to find a common policy about its use or even about its definition. Neither is it recommendable to draw such conclusions within the developing agenda anyway (Atal et al 1996), the principle being local acting instead of global thinking.

My first intention was to analyse whether the popular participation method was efficient in relation to the results measured by the national (and international) indicators for development. A task I found out to be impossible within the frames of a Master's Thesis. Moreover, the deeper in I got to the "world of the NGOs" the less emphasis I gave to the numbers, instead I got more interested in the invisible results and the sole experiences, the difficulties and the victories that the method can offer.

As my objective, I had set the understanding of the role of community participation in the health sector within the work of the NGOs working with the Aymaras and Quechuas of Bolivia. Further, I want to reflect the relation between the level of the community participation and the project personnel's concept of the cultural aspect of the health work.

Using the experiences of the NGO's project co-ordinators interviewed and the literature, I have divided the objective in four parts. Firstly, in order to place the study in its political and cultural environment, I want to make a general overview of the political situation in

Bolivia, form an idea of the level of health and healthcare in the country and get more familiar with the Andean culture and society.

Secondly, I will discuss the cultural aspects of the health work as it has been reported by the interviewees. I will divide the organisations into three groups according to the way they see the local culture and analyse the cultural issues the interviewees bring up.

Thirdly, I will measure the levels of the community participation within the groups formed in the second part. I will compare the groups to see if there is any difference in the level of the local people's participation in the projects according to the different approaches to the local culture.

Finally, I will discuss problems related to the participation. Despite the good intention, the method that works well on paper, works well in some parts of the world, but it has not given too promising results in Bolivia. The official data from Bolivia and the interviews both reveal a sad truth; the same problems still exist. Are the roots of dependency deep in the Andean society?

Last, I will suggest some proposals based on the previous sections. The paper will be handed over to the NGOs included in the study and hopefully they find it useful in practise.

1.2 Main concepts of this study

The key concepts of this study are development co-operation, non-governmental organisations, community participation and culture. All these terms are wide and it is

necessary to define them for the purpose of this particular case. This work researches the development co-operation in the field of health thus excluding the conversation about other fields such as agriculture, education or others. Development for the organisations of this study means, in practise, the implementation of the modern medicine in the remote rural and peripheral sub-urban areas of Bolivia and the improvement of health of the people living there.

This study was made only with the non-governmental organisations (NGOs), thus not taking into account the official projects done simultaneously by the Bolivian State or within the bilateral or multilateral development co-operation projects. The role of the NGOs is growing in the field of development as more government projects are being managed through these. The NGOs are considered to have better possibilities for real grass-root level work than the governments that are usually less flexible and more bureaucratic due to their larger structure.

The last two concepts, participation and culture are the main pillars of the study. Participation has been a trend word in development co-operation for a few decades now and culture is the latest addition. In this study participation means the involvement of the local people in the projects. The term "popular participation" is most commonly used in Bolivia due to a law called "*La ley de la participación popular*" a law that aims to the decentralisation of the decision making (Ministerio de Desarrollo Humano de Bolivia 1997). According to this law, the power is to be transformed from the national level to the local municipal councils that know best what is needed in the area. The short history of this law faces back to the World Bank and IMF's Highly Indebted Poor Countries (HIPC) initiative. The initiative aims for forgiving some of the debts of the poorest countries (www.worldbank.org/HIPC) and imposes the decentralisation of the decision making as one of the conditions for entering the programme. I will use the term popular participation alongside with the other terms used in development co-operation: community participation and participation.

On the other hand, culture has its importance for the development work. For many reasons, it is seen vital that the local customs and values are taken into account in the projects. One of the reasons is the idea that by making culturally acceptable changes possible, it guarantees sustainable development. What is meant by culture and how is it seen in practice will be discussed in more detail later.

These definitions make some limits to the generalisations of the results, making the results and conclusions apply mainly in this study. On the other hand, the limits make it possible to discuss in more depth the wide issues that otherwise would be nearly impossible to deal with.

2 MAIN DEVELOPMENT THEORIES AND THE CHANGES IN THE DEVELOPMENT POLICIES AND CO-OPERATION

After decades of development co-operation and studies that tried to find a solution to the global problem of poverty and its consequences, there is an agreement of such a solution being impossible. The motto is "think globally, act locally", there is no global solution to the global problem. The way the problems of underdevelopment and poverty can be solved is a question to be asked in each place and case separately.

During the post World War II decades, the ideology of development assistance has remained the same, and even the methods and theories have changed. The justification or the obligation for development assistance to the poor countries has been the principle of guaranteeing human life conditions for everybody in the World. The United Nation's Human Rights Declaration writes down those conditions that development assistance is based on. Nevertheless, the economic growth was considered primary for the structural change needed for improving the living conditions. (Uurtimo 1994; 293.)

2.1 The 1950s and the 1960s, the beginning of the development assistance

In the 1950s and 1960s the development aid had the modernisation of the underdeveloped countries as its objective. The modern, Western technology was to be introduced there too, and the traditions and the following resistance would disappear as time goes by. It was then believed, that all that the Third World needed to develop was some money and experts borrowed from the Western countries and the rest would happen by itself. (Laitinen 1995; 13)

Development was considered to be a series of stages of economic growth. There was no emphasis on the social or human development, as this was thought to follow the economic growth. One of the most famous development theorists in the sixties was Rostow, who

developed a five-stage model of economic growth that all the nations would pass. These stages were:

1) Traditional society,
2) Pre-conditions for take-off into self-sustaining growth,
3) Take-off,
4) Drive to maturity, and
5) Age of high mass consumption (Todaro 1994; 68-70).

In the light of this model, it was understandable that the development co-operation also concentrated purely on material and economic aid. The local culture, if considered at all, was thought to be irrelevant to the development process. The poor people were supposed to adopt the superior Western knowledge and technology. Later this approach was recognised as ethnocentric and insufficient, and new models were introduced (Stone 1992).

2.2 The 1960s and the 1970s

In the end of 1960s and in the beginning1970s, the development work concentrated on providing the basic services to the poor. Meanwhile, the academics developed new theories of development. In the end of the sixties, the theory to gain most popularity was the structural transformation model, according to which the development was to happen when the non-productive rural population would move to the cities and become productive labour force. This model was developed by the Nobel laureate Lewis, as early as in the 1950s but did not get more popularity until ten years later. (Todaro 1994; 74-80.)

The criticism went against the simplicity of the model and underlined that it did not match with the reality of the Third World. Instead of following the Lewis model, the capital accumulated from the growing industry was invested in new labour saving technology, thus not creating new job opportunities as Lewis had planted. (Todaro 1994; 74-80.)

In the 1970s, the socialist movements in Third World countries, especially in Latin America, created new development models. The dependency models blamed the rich countries of creating relations of false dependency between the rich and the poor countries. The global capitalist system was seen unequal and forming the centre – periphery power relationship, that was obviously seen rather unjust for the poorest counterparts. (Todaro 1994; 80-84.)

In his research Uurtimo (1994; 268-278) states that the era, when the dependency theories were developed, were times of economic crisis that led to new arrangements in the global market. It was later realised that the problems in the North had influence in the South and vice versa, which took the reliability away from the previous centre-periphery models. Taking into consideration the new economic theories, it was also understood that development co-operation was for the benefit of all, not just the recipient poor countries.

2.3 The 1980s and the 1990s

The 1980s started the era of privatisation and free market economy. This new policy blamed the state ownership and central decision making of the poor management of the economy. The corruption of the governments of the poorer nations was seen as a cause of the poor allocation of the resources. As a result, it was thought that the private market would succeed in equal distribution of goods and benefits. The new idea of developed was that of the endogenous growth: the economic growth depends of the growth of the Gross National Product. This was seen as something natural that would happen along a long term economic planning. (Todaro 1994; 84-88.)

After the seventies, it had been understood that the basic needs supply did not give results and new approaches were taken in to use in development assistance. In the next decade the importance of the sustainability was brought into the stage of development politics. For the actors of development assistance this meant socially, economically and environmentally sustainable development. Not only the methods, but also the values and morals guiding the

development ideology transformed to answer to the demand of the time. Words such as solidarity, responsibility or humanity are being widely used in the development literature. (Uurtimo 1994; 279)

It was as early as in the end of the 1970s when the local cultures started to get more importance in the development. Suddenly, the voice of the locals was to be heard to create culturally acceptable programmes (Stone 1992). In the 1980s this approach led to rethinking of the role of the culture in development, also in health work. Nevertheless, the opinion was divided in two; one view considered culture as an obstacle to the introduction of the new health policies, and the other saw local culture as a context within the social scientists. (op.cit.)

In 1980s the word "participation" became a popular term. The academic movement of Frankfurt and social movements in Latin America and India had presented the idea in the 1950s and 1960s as a critic towards the developing aid, but it took decades to become a reality. (Vainio Mattila 1997; 6) It was finally understood that the state alone could not do much, and the civil society was called to join in to the development process. Furthermore, the state-to-state aid was seen insufficient, leading to a search of new channels. The end of the 1970s and the 1980s saw the rise of the non-governmental organisations in the field of development.

In the beginning the participation of the civil society meant that the local authorities took part in some stages of the co-operation. It was either the local government or at its lowest levels the village leaders who were involved with the work (Laitinen 1995; 14), but soon this was seen insufficient and the grass-root, or community level, was taken along (Growth through community participation : towards sustainable agriculture 1999; 13).

3 COMMUNITY PARTICIPATION IN DEVELOPMENT

It is not the aim of this paper to study the concept of popular participation in development in global level. Neither is it recommendable, nor does the empirical study give information for such a wide observation. The term itself changes; others speak of local participation, others of popular, some talk of grass-root participation and others simply about participation. And what they mean with participation vary, as do the results of the participation, according to the place, time, people and resources involved.

The aim of this study is to reflect the experiences the nine interviewees reveal, to discuss their projects, their problems and their success. This leads me to a wider discussion of the community participation in development co-operation. Thus, it is important to form a general picture of participation in development work, bearing in mind that one chapter is not enough tell the whole truth about participation.

3.1 Participation in development co-operation, definitions

Even though participation is not a new idea, the agencies have not got the policies straight. Reading through the literature and the project reports of several Finnish developing agencies one can see there really is no common idea of the participation, not even within a small country like Finland, a fact that Vainio Mattila (1997; 11) confirms in her study to be internationally applicable too.

Participation is a term used in many situations. The definition varies according to the purpose; there is no single definition or single policy of how to understand it. In a collection of essays about the participatory forestry projects financed by Finland Mlenge (1992; 5-7) defines participation as taking part in an activity in three ways: physically, mentally and emotionally. Physically by being present and using one's effort for the benefit of the action, mentally by taking part in the decision making and using one's mental skills for the benefit of the project and emotionally by getting emotionally involved with the project.

Participation can also been seen as follows:

- having an active role in an activity
- a process through which stakeholders influence and share control over development initiatives (World Bank)
- the organised efforts to increase control over resources and movements of those hitherto excluded from such control (UNRISD)
- participate in decision making, implementation, benefiting and evaluating
- cheap labour for the projects
- an outcome of an on-going encounter between development and those being developed (UNRISD) (op.cit)

As varied as its definition, is the use of participation. As a summary, at its best the local people participate on each and every step of the programme, of which the expected result is an increased level of conscience among the participants. At the worst it is abusing the local people as a cheap or free labour force to accomplish the physical work of the project under the excuse of community participation. (Laitinen 1995; 15) In every case, the idea is to give the poor a possibility to influence their own life, even the presence of the outsider cannot be totally eradicated.

There is a difference that has to be made between participation as a *means* to reach the set goals and participation as a *goal* of the project. It has different meaning to the local people if their participation is required to build the school building or if their participation has been risen by other project and as a result of this *they* have decided to build the building. According to Eklund who cites Oakley in her Doctorate thesis, in the former case the result of the participation is more important that the act itself. On the contrary, when participation is seen as an end or a goal, the process is dynamic and leads to long-term participation, which can be followed by a real change. (Eklund 1999; 34.)

It is possible to recognise different levels of participation Eklund continues. It can be *marginal*, meaning the people involved have only a little influence on the activity.

Participation is *substantial* when outsiders control the mechanism but the people are actively involved in the process. Finally, participation is *structural* when it is seen as an ideological basis for all project activities. (op.cit.)

Eklund identifies yet another way of considering participation. This approach examines the way the participation was initiated. At the bottom of the scale we find the *compulsory* participation, the local people are undertaking activities over which they have no control. Next would be the *induced* participation, a process that starts from external sources but requires support from the participants. Participation is *spontaneous* when it is based on local initiative. (op.cit.)

3.2 Reasons for the use of participatory methods in development assistance

Participation is defended as a means for empowering the poor. It gives them an opportunity to decide about their own life (Vainio Mattila 1997; 6), strengthens the rural society by building local capacities (Paths for change 1999; 13). Another justification is that participation supports the sustainable development by giving the project administration to the locals thus guaranteeing the continuity of it when the outsiders leave (Laitinen 1995; 9).

Many development projects have stopped when the organisation in charge left the area. There are many reasons found for this; first it was said to be because of the backwardness of the local people, they do not understand what would be best for them, lack of education: they do not know how to continue when the organisation is gone. Lately, also the inadequate knowledge of the project workers of the local issues that has led to a bad project planning has been considered as a major factor for failures, as suspicions of the outsider's possibilities to influence the others. (Laitinen 1995; 9.)

To avoid this, to aim for a truly sustainable development, the local's participation is included in the projects, more so, the project is aimed to start from the local's abilities and knowledge about themselves (Laitinen 1995; 9). The participatory development is thus a product of mutual learning: while the locals are supposed to learn new skills or gain more

knowledge, the project personnel is supposed to learn from the locals their values and knowledge (Laitinen 1995; 9).

The community participation is further defended by its ability to conserve the local culture (Simonen 1999), strengthen the local knowledge of traditions and create a feeling of community (Finnagro 1998). "Culture" is the another trend word risen alongside the "participation". Development aid has to respect and conserve the local culture and traditions (Simonen 1999), and participatory project is considered a better way to carry out culturally acceptable development work. The idea of the participation includes the belief that the poor, too, can think and process for themselves and the outsiders have to accept the local culture and traditions (Laitinen 1995; 17-18).

Besides conserving and strengthening the local tradition and culture, the participatory method offers a great learning environment, the learning is accumulative, it is understood that there is no single truth about the life and in the discussion groups everybody gets to say their opinion (Laitinen 1995; 33).

3.3 How does the participation work in practise?

The first step for a participatory project is to get the community, the target group, interested in the project and initiate their participation (Mlenge 1992; 9). Moreover, preparing oneself by learning beforehand as much as possible about the local culture through literature and other people is advisable (Mlenge & Chavangi 1992). There are handbooks for this[2], and it is not reasonable to examine the methods here in more detail.

The problems often faced in this phase are several. The most common seems to be the lack of interest from the part of the locals to start participating in the project. Laitinen (1995; 17) claims the deep dependency to be one of the possible problems. According to her, the people are used to someone else making the decisions for them. Moreover, the lack of self-

[2] See for exampleLaitinen 1995

esteem among the poor rural people is rather commonly reported difficulty. There are experiences of group discussions where the people do not want to say their opinion because they are afraid of being wrong (op.cit.).

The participatory project intends to abolish such problems. By acting in the project as equals to the project personnel, the people gain more self-respect thus increasing the level of the participation, Laitinen continues (op.cit.).

Some conditions need to be met for the project to work well. Arsalo (1997; 65) describes experiences gained in a Finnish project in Malawi. He suggests that the planning and inception phases should be long enough to give the locals the space and importance they deserve. Furthermore, it is important that objectives are to be drawn together with the locals and that both sides share the visions of development.

The local participation is seen elementary to all the projects. By the participation the NGOs want to make the target groups see their reality in a different light and give them the tools to change what they themselves see as a problem. The participation is created by organising meetings where the first step is education in participatory evaluation and planning, and from there on the rest of the project cycle. Usually, the first where the community participates is the election of the person to be educated to be the Communal Health Promoter.

As the process continues, the community takes over the whole project, including such achievements as taking over the communal shops, credit unions or making a proposal for a sewer system to the municipality.

3.4 Measuring participation

Rifkin, Muller and Bichmann (1988) designed a model for measuring the level of the participation in health care projects. According to them measuring participation needs clearly defined concepts of community and participation. In their article they define

community participation as a social process of a specific group of people who share their needs living in a defined geographic area. They explain participation as an active, not merely receiving process, that implies the right and responsibility of the people to make choices and that has the possibility of being effective.

On basis of these definitions, they build a five-part model of measuring participation. The model examines in a continuum in a scale from 1 to 5 the participation in need assessment, leadership, organisation, resource mobilisation and management. These factors were chosen using a former study of over 100 participatory projects. Rather than the impact of participation, this model studies the process itself. Thus, it can be used to compare differences in participation at different times or by different people, not to study the impacts or show better or worse levels of participation, a fact that the authors highlight. (Rifkin et al. 1988: 933)

The five factors each have a continuum of a scale of 1 to 5. In which the level of participation will be marked. The first level is 1, due to the assumption that there is always some action undertaken in the community concerning the people's health. To measure the level of participation Rifkin et al. introduce a guide of questions to be asked to determine the level. (op.cit.)

1) *Leadership.* It is necessary to examine who the existing leaders represent in the community. Special attention has to be drawn to the presentation of the poorest groups of the community. Within this indicator, while the level of participation increases, the Community Health Committee takes the position of the leadership.
2) *Organisation.* This factor indicates the way the community organisation used in the project has been build up, whether it has existed before the programme and has been created by the people of the community, or whether the project planners created it. Moreover, it takes into account the amount of activities and independence of the organisation.

3) *Resource mobilisation.* This indicator takes into account the commitment of the community in the resource allocation as well as the flexibility of the use of these resources. Low participation means that most of the resources are brought in by the external organisation, while high levels mean that the community is responsible for both raising and allocating the founds.

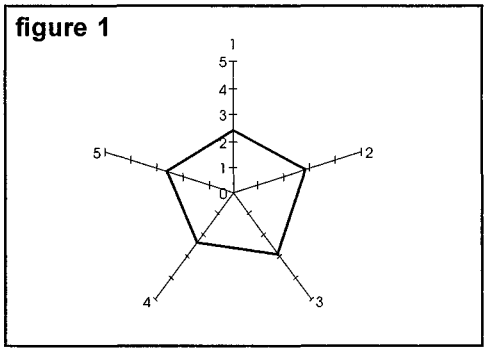
4) *Management.* The indicator shows who is managing the project. In the lower end of the scale, the external organisation takes the control, whereas in the higher end the community manages the project.

5) *Needs assessment.* To measure this factor it has to be questioned who makes the judgements about the health needs of the target community. Is it the professionals in charge of the project or do the local people participate in the evaluation of their situation? (Rifkin et al. 1988; 938-939)

Next, I will present an example of a participation measurement of a certain organisation. It has been constructed using the Rifkin's ranking scale for the indicators for community participation. The ranking scale can be found in the APPENDIX 1.

The example shown in the figure 1 demonstrates the levels of participation of some project at a certain moment. It can be seen that the level of *leadership* (1) is a little higher than 2 meaning that CHP works for the benefit of all the social interest groups, but is not a leader among his community.

figure 1



The level of *organisation* (2) is at the point 3 indicating that the community organisation was imposed by the planners but it later became active. Nevertheless, the community organisation is not independent, but is working under supervision. The indicator (3) for *resource mobilisation* at the point 2 shows that a part of the funds are raised from the community but the local people have no

influence on how the funds are used. Level 2 of the indicator for *management* (4) shows again low community participation in the management of the projects. On the Rifkin's ranking scale, this means that the CHP[3] works independently, but is supervised by the health committee. Finally, the indicator (5) for *needs assessment* at level 2 indicates that the needs are imposed mainly by the professionals, but the community's interests are considered.

What can be viewed from the figure 1 is that the levels of participation in general are rather low. The community is not involved in the project more than for view basic functions. According to Rifkin, this does not mean that the project would be worse than another with higher levels of participation, but the model can be used for the future planning of the project. Using this model the planners can easily see what aspects of participation could or should be increased and also how this could happen. (Rifkin et al. 1988; 937.)

According to Rifkin (1988), the starting levels of the indicators are usually at the grade 1 getting higher while the project matures. She suggested that if the levels of community participation stay low, it could be due to factors like economic or social situation in the area or the target group's previous negative experiences with other projects.

3.5 Deciding whose reality counts most

To ask whose reality is the right reality is the forever on-going debate about who knows best. Here, I would like to mention some of those realities present in development work. The critics of development work often say that we, as westerns or outsiders, do not know the reality of the people we pretend to "help", and thus are not capable of doing anything but harm. To a point this is true, the African farmers might know best how to cultivate their lands and the Indian women may suffer a great deal if their traditional society is changed according to what we see the better way. But the main question remains, are the human

[3] Rifkin uses the term CHL, community health leader.

rights, basic health care or education, such things that we should or should not provide to everyone.

At its best, the participation of the local people in a development project can offer one solution to this debate. It can contribute a valuable insight to the problems dealt with, open visions that the external experts would not see because their limited knowledge of the local environment, both cultural and material. Chambers (1996) goes through many examples of development projects that could have gone badly wrong without the good participation and activity of the local people. In the UNESCO World Summit for Social Development in 1995 the conclusion was drawn: it is necessary and advisable to involve the poor to the projects that consider their lives. (Atal et al.1996; 11)

In summary, the new way of development attempts to be more bottom-up than the previous top-down development work. It was based on the idea that the professionals knew better than the local people what was needed in order to improve the situation. Now, even anthropologists are included in the project planning to make sure the local traditions are being understood and respected. The projects are to be planned so that the local people get to do the project in a culturally acceptable manner. Nevertheless, what remains from the past is that usually the initiative for the project comes from the professionals.

More so, the idea of bottom-up development replacing the old top-down development does not offer any true improvements. Atal (1997; 23) suggested that instead of building up a new one way road, we should consider the option of two ways. In reality, the development work only at the grass-root level changes as little as the work with the government alone.

3.6 Participation and the official development politics

Whether the reasons were more economic or social, anyway the big international developing agencies like UNICEF, WHO, the International Red Cross or the World Bank

have changed their approach towards the developing methods and recommended everyone to follow their example. This has gone so far that the IMF's HIPC I programme of forgiving the debts of the poorest countries includes the condition of community participation in the governing of the forgiven amounts, forcing this way the governments to decentralise the decision making. (www.worldbank.org/hipc) In Bolivia's case, this has been in put in practise by the Law of Popular Participation which in practise means that the local decision making is gaining more weight in the internal politics (Ministerio de Desarrollo Humano de Bolivia 1997).

The term Popular Participation is a term used most in Bolivia, because of the law mentioned above, even when the participation does not have anything to do with the government politics. In the literature and in the development work, there are several terms for the same concept: participation, grass-root participation, local participation etc. In this paper, I have chosen to use the terms side by side.

Participation is not a new concept. Over decades development agencies both governmental and non-governmental, have been working with participatory methods in development interventions. Even so, there is still no consensus of what participation is nor how it should be understood. The term has gained a reputation of being "good" and "positive" for the local people, and it belongs to those criteria that should be included in all the development programmes. Like everything else, participation is a double-sided coin too and there is a great need for a critical study of the concept and its use. (Vainio-Mattila 1996; 31.)

4 EMPOWERMENT THEORIES AND PRACTICE

4.1 Theory of empowerment

The participatory projects are often considered as actions with empowering effects on the rural people. It is seen important that the poor take control over their lives and that they would became more aware citizens. Nevertheless, in a place where there is lack of everything, it is not the first priority of the people to become aware of the politics. Their main concern is to survive until tomorrow.

The reasons behind the empowerment ideology lie in our Western concepts of life and its meanings, similarly to the rest of the ideology of the development work. The development theorists define the empowerment of the people as something that will guarantee the sustainability of the development projects, an argument that many project leaders join. It is seen that the involvement of the locals creates emotional connections to the project at the same time increasing their conscience about the surrounding reality. (Stone 1992.)

Notwithstanding, the concept of participation can easily be manipulated to abuse the poorest, which in the end only promotes the existing unequal power relations. According to Stone (1992; 412) this tendency has been reported by several researches of the field.

Eklund (1999) discusses the different aspects of empowerment in her Doctorate Thesis about community participation in Finnish health work. There is a vast collection of research on empowerment (Eklund 1999; 39) but my interest is mainly on the couple of the first theories of this area, those of Paolo Freire and Julian Rappaport

Freire, who wrote his theory of pedagogy of liberation in the 1970s, declares a fight against the oppression of the poorest and develops a method for consciousness-raising of the oppressed (Freire 1972). Rappaport, in his turn understands empowerment as a part of community psychology, and views the person as a conscious citizen within his political and social environment (Rappaport 1987). These two theories, or at least the ideologies they represent, are often cited in the conversation in Bolivia. As a country that conserves the

memory of heroes like Che Quevara, they have a strong culture to resist the centralised power and the work among the poor is often seen as a way to fight against it.

Freire (1972) designed his theory of the education of the poorest and oppressed with the idea that the education would give them the tools to change the situation themselves, instead of depending on others to do it. The education is focused on creating a critical consciousness that on its turn would help the people to see the reality in which they live. In order to solve the existing problems, Freire suggests to search for the roots of the issues, to examine the consequences of these and finally, to develop a plan of action that aims for change.

The role of the educator, or in Freire's words, the facilitator, is that of waking up the consciousness of the people. The facilitator participating in the daily life of the people, speaking the same language and most importantly, guaranteeing the *dialogue* among the people are the means to get to the desired results, says Freire. (op.cit.)

Julian Rappaport (1987) defines the term community psychology as follows: Empowerment is a process by which people and communities gain mastery over their affairs. The situations and environments vary, thus the empowerment takes different meanings to different people. Therefore, a concern with empowerment leads us to look for local solutions. As a precondition for empowerment Rappaport sees an original power relation that has to be defined before the actual transform can happen. The main idea in Rappaport's texts is that of empowerment's double nature. Firstly, it helps the individual to determine one's own life. Secondly, in a wider perspective, it aims to the democratic participation through the structures of a community.

Eklund (1999; 40-41) further introduces some ideas of the Freire's methodology applied in health care. Instead of being a reforming action, the consciousness-rising in health work usually takes revolutionary characters. This is due to the process of looking for the real causes of the health problems. In the poor rural settings these tend to be structural, lack of cultivable lands, lack of clean water, unbalanced diet and other similar reasons. To be

solved these demand, rather than implementation of new ideas to the existing structure, deep structural changes.

In this light, the prevailing idea of empowerment in development work seems rather superficial. In theory it has the meaning of giving the people the tools they need for empowering themselves. Nevertheless, the reality is far from the theories that represent it. The real influence of, for example, a participatory health programme is, rather than offering the people power over their lives, offer just a few talks given. Judith Justice (1986) describes the situation in some villages in Nepal after a participatory health programme.

4.2 Case-study

The programme in question was a national Integrated Community Health Programme (ICHP) financed by several international donors. The community participation was a basic concept, and the aim of the project was to transform the old system for a decentralised primary health care system. The community was supposed to participate along the whole project cycle. (Justice 1986)

The first participatory action for the communities was to choose a person to take part on the course for Community Health Promoters (CHP). It resulted that the majority of the people chosen were members of the elite of the communities, children of the village leaders or similar (op.cit.). This is a rather common problem, the power-relations between the villagers and their leaders tend to be strong and it is culturally unacceptable to choose others to represent the community (Werner 1977).

Justice (1986) continues explaining that after the course, the new CHP were supposed, in voluntary basis, to help the paid personnel of the health posts and centres in their villages. Their tasks included keeping group discussions and talking about health related issues with the villagers. They were also supposed to attend some minor cases when the personnel were not present. As part of the ICHP, the communities were supposed to form health

committees to control and manage the work of the paid personnel of the health posts and centres.

What Justice (1986) found out when doing her research, was that in practise, many of the CHPs did not work anymore, if they had ever done so. Those who did, could be in charge of the whole health post, while the nurse or the doctor was occupied with his/her private issues, often being absent from the village. The same was noticed with the health committees, most of them had never gathered together. In many cases, the villagers did not know about the existence of the committees or did not know who the representatives were.

Justice finds several reasons for these failures. Firstly, she says, the rural people are poor, it is hard for them to take time from their daily duties to work as a volunteer CHP. Secondly, the CHPs were supposed to assist paid personnel, which is an obvious conflict situation. They also lacked the adequate skills to attend the patients, Justice continues (op.cit.).

The programme Justice studies was completed in the late sixties, and was one of the first ones in its class. The structure of this new, participatory, as it was told to be, programme, was as hierarchical as the previous programmes. The idea, the methodology and the management in reality came from the top, from the international development agencies, which had little, if at all, knowledge of the local conditions. The participation of the locals, in reality, was limited in taking part in the actions defined by the others. (op.cit.)

Similar results have been reported in Bolivia. In 1997, a group of Non-Governmental Organisations had an international conference on community mobilisation for health. There were participants from many Latin American countries, all representatives of NGOs working in the health sector. The organisers of the conference published a book about the talks given during the meetings. According to this book, the NGOs have recognised that the term "participation" is too easily used in development work (Alfaro et al. 1998).

The Bolivian experience of the popular participation is criticised to be a strategy that the authorities, including the NGOs, use to gain the people's co-operation for the projects. Mr

Torres-Goitia (1998; 35), one of the authors, admits that participation is a goal in the projects, but underlines that not in the sense of empowering the people. Quite the contrary, Torres-Goitia argues that participation has become a goal of the health services, a goal that has to be reached, without consideration of the community's real needs. The people who set the goals of the health programmes consider themselves the superiors of the hierarchy, or the professionals who know the ultimate truth, which requires no discussion.

Torres-Goitia (1998) goes even further in his critique. He sees participation reducing to a simple use of the health services, co-operation in the activities ordered by the authorities, and a means to reduce the costs of the projects. He thinks that the authorities use the excuse of participation to get the community to fight together in order to get better results on *their* programmes.

This is heave critique, and Torres-Goitia calls for rethinking of the meaning of the participation (op.cit.). He says that all the battle to improve the poorest people's living conditions, the search for justice and equality, also improves their health. Consequently, he argues, the poor should have the right to fight for their health as any other human right. Health should not be considered an item that one can buy, it can be gained only by organised social movement.

Rosa María Alfaro (1998) is another author criticising the Bolivian experience of participation. She is questioning the voluntariness of the participation. The principle of empowerment lie in the ideology of liberty, nonetheless, according to Alfaro, the participation is more an obligation than a right. The local people have to be active, they have to take part on the discussion, if they do not, they are blamed to be "backwards and ignorant" (Alfro 1998; 111).

4.3 Postscript on empowerment

Though it has to be mentioned that some projects have succeeded in the empowering of the local people in the Freirean sense, unfortunately many of the present programmes share the characters mentioned of Nepal ICHP (Stone 1992; 412) or criticised in the conference in Bolivia (Alfaro et al.1998) . The reality does not coincide with the theories. From this point of view, the whole idea of an outsider going into a village to "empower" the people sounds at least suspicious (Justice 1986).

To start with, it takes a great deal of knowledge of the local conditions to even start a participatory programme, a fact that is often ignored in development work. According to Eklund (1999), invited participation always requires penetration to the community. This in turn, requires that the project personnel has good knowledge of the local culture. In the next chapter I will discuss some aspects of culture that influence our behaviour and can be used to explain some of the problems faced in the development work, especially when concerning participation and empowerment.

5 CULTURE

Local culture, traditions, values and other similar terms are often used when talking about the factors that the development co-operation should take into account. What do these terms mean and why are they considered so important?

Many people might say culture is things like art, theatre, philosophy or formal education, and consider these somewhat "better" than other ways of behaviour. Some people talk about the ancient cultures of Rome or Greek, Aztecs or the Japanese culture.

All this is culture, but only a part of it. Taking a closer look to these mentioned above, we can see they all have something in common. They separate one group from another. Culture is, shortly said, all the rules and traditions, a set of guidelines, in a society, including the forms of solving technical, behaviour and psychological problems. It enables us to make sense of our surroundings. (Porter & Samovar 1997).

Culture can be divided roughly into two groups, the material culture and the values. The material culture includes those instruments used in, for example, cultivation, but also the techniques to use, maintain and produce them. (Almodio 1993; 12-13.)

In the other extreme of the definition of culture, there are the values of the society. These are those criteria indicating what is desirable and what is not. Alongside with the values there is the cultural knowledge of the natural and spiritual worlds. Each culture has its own way of understanding and organising the life. As a summary, one could say that the way of life of one society is a combination of its rules, behaviour and traditions that separate it from other societies, thus defining the cultural identity of the individuals. (op.cit.)

5.1 Characteristics of culture

Culture is *learned* in the process of growing up in a society. Talcott Parsons wrote about the importance of the surrounding society in the formation of the individual's personality (Parsons 1964; 15-33). Porter and Samovar continue explaining the six main characteristics of culture. Moreover, that it is a learned process, it is *transmissible, dynamic, selective, ethnocentric and has interrelated facets*. By saying that culture is *transmissible,* they mean that we can pass on our culture by using tools such as spoken or written words and non-verbal actions. Each person by each act represents and thus transmits his own culture. (Porter et al. 1997; 14)

The *dynamic* nature of culture guarantees that the culture is ongoing and subject to fluctuation. The changes can be caused by inventions inside the culture or by diffusion with another culture. Despite the possibility for the changes, most of these only affect the surface of the culture, leaving the deeper structure untouched. This deeper part, more resistant to the new ideas, tends to include the most important elements of the culture like values, ethics and attitudes. (op.cit.)

The *selectivity* of a culture includes the assumption that every culture forms within its values and morals, the correct behavioural patterns. Thus, if observing the behavioural patterns of a culture, we can see what is considered of most importance within it. This is also the character of culture that mainly draws the boundaries between two cultures, as the two might value totally opposite things as important. (op.cit.)

The *ethnocentrism* of the culture is the tendency for any person to give his own culture and society the priority. Ethnocentrism can be viewed as the window through which we look at the other cultures. (Porter 1997; 15.)

For the last, the *interrelated facets of culture* mean that the culture is like a net, you cannot touch one part without touching all of them. A change that occurs in a culture will sooner or later influence the other parts too. (op.cit.)

As a sum, it can be said that a culture is a complex system that influences all the aspects of our life. This influence can be seen on the way we behave, which will be discussed in the next chapter.

5.2 Culture and behaviour

Porter and Samovar continue explaining the way culture shapes our personality (Porter et al. 1997; 16). They list *belief/value/attitude systems, worldview* and *social organisation* as the most important aspects of culture in this sense. *Beliefs* are the personal ideas we have about a certain object and its characters. The fact that we consider the object to be, for example, a reliable source of knowledge, depends on our cultural background. Although the beliefs might vary a great deal - one believes in tealeaves while other on BBC news - nobody can say which is the right or wrong belief. One just has to accept the *difference.*

Values are those aspects of our beliefs that define what is good, desirable or necessary. *Cultural values* are the ones that target to reducing the conflicts within a society by providing us the tools of making choices, and by specifying the way one should behave in that society. On the other hand, there are the *normative values* that indicate what are we are expected to do. A failure to meet these can lead to a punishment, either formal or informal. (op.cit.)

Beliefs and values contribute to our *attitudes* towards the objects, Porter and Samovar continue (op.cit.). An attitude is a learned tendency to respond to a certain stimuli, avoid

others, while embracing others. Ultimately, the attitudes are the element that most guides the way we behave.

The *worldview,* given to us by our culture, helps us to organise the universe and place ourselves within it. A religion, or the atheism alike, might affect our behaviour in a great deal. Although on the surface the people can look the same, same clothes, same favourite music etc, a Catholic spends his Sunday in a different way than a Muslim. (Porter et al. 1997; 17).

Finally, Porter and Samovar (op.cit.) mention the role of the two major institution as the forces of the *social organisation* that control the cultural learning process of a child. These are the *family* and the *school.* They are both a link between the past and the future and are on their turn, shaped by the surrounding culture thus transmitting the beliefs and values, knowledge and attitudes of the society.

In summary, the culture that we live in shapes our behaviour. It also shapes the way we see and understand the objects. This process of giving a meaning to an object is called *perception. "If the men define situations as real, they are real in all of their consequences"* (Rogers et al. 1999; 145). In other words, the meaning given to an object influences the attitude of the person towards it, thus influencing the person's behaviour towards the object. (Rogers et al. 1999; 145.)

In determining the individual's behaviour, his perception of the object is considered more important than the objective reality. This comes out when comparing the perceptions of a same object in different cultures, Rogers and Steinfatt point out (op.cit.). They give an example of the definition of being overweight in different cultures; while the white American teenage girls thought a certain body to be overweight and undesirable, the same body was considered to be "normal" among the African-America adolescent girls.

Before moving on to the encounter of two different cultures, I would like to sum up what has been stated above. An individual's personality is constructed by the culture that surrounds him. Institutions like family and school are the main transmitters of the beliefs, values, and attitudes that define his perception of objects. Furthermore, these cultural rules shape his behaviour. Hence, the individual is a product of his culture and when judging his actions we should consider the cultural factors.

5.3 Cultural variability

The cultural variability is discussed by Gudykunst and Ting-Toomey (Gudykunst et al. 1988; 39-59). They list the most important variations in communications styles of different cultures using continuums of dimensions in which the cultures are located. The further away from each other the cultures lie on the continuum, the greater the difference. The most important variations are the following:

1) Individualistic versus collectivistic cultures,
2) Low- versus high-context cultures,
3) Low versus high uncertainty avoidance cultures,
4) Low versus high power distance cultures, and
5) Feminine versus masculine cultures.

In *individualistic cultures* the emphasis is on the individual goals and needs, and people are supposed to look after only themselves and their immediate family, while in *collectivistic culture* the emphasis is on the common good. Similarly, the individualistic culture values the individual's outcomes rather than co-operation like the collectivistic culture. Another important difference is the distinction between the groups. In the individualistic cultures, it is not that important to what group a person belongs, but the people of a collectivistic

culture tend to give priority to the people of the same group. (Gudykunst et al. 1988; 40-43.)

Citing Hall (1976) Gudykunst and Ting-Toomey (Gudykunst et al. 1988; 43-45) explain the next continuum, the difference between low- and high-context cultures. The people of a *low-context culture* tend to speak in a way that the interpretation of the message needs little observation of the hidden messages, but is rather direct. Whereas *the high-context culture* prefers a more indirect communication, in which the interpretation is mainly based on the indirect messages given. In low-context culture, it is not too important if the receiver of the message is from the same group, in turn this has a big meaning on the high context cultures. Thus, Gudykunst and Ting-Toomey state, the low-context cultures are individualistic cultures and the high-context cultures tend to be collectivistic.

Low uncertainty avoidance cultures are characterised by the acceptance of deviant, or different individuals, within the group, and individuals of this group tend to take more risks than the people from *high uncertainty avoidance cultures.* The people from the latter group have a greater need for formal rules and have less tolerance for deviant ideas and behaviour. There is also a higher tendency for consensus. (Gudykunst et al. 1988; 47)

In *low power distance cultures* people see power as something that should only be used when it is legitimate and used by a certain legitimated group, whereas the *high power distance culture* accepts the use of power as a part of everyday life. Thus, the ones with the power consider themselves to be different from the others, and vice versa. (op.cit.)

In *feminine cultures* things like people, quality of life, equality between the sexes and interdependence are highly appreciated, whereas the *masculine cultures* value power, assertiveness, performance and independence. (Gudykunst et al. 1988; 48.)

The schemas presented above present some of the variabilities in communication manners of cultures. Next, I will discuss the means of communicating, i.e. verbal and non-verbal communication.

The *verbal communication*, the spoken language, is not only the words we say, but it deals also with the way we use the word, and how we understand them, the meanings of the words are subject into a variety of interpretations. Learning a language in its real meaning is also a process of cultural learning. It is not enough to learn to translate one language to another, a truly fluent knowledge of a language requires at least a basic knowledge of the culture of the people who speak the language. (Porter et el. 1997; 18)

Knowing the patterns of thinking is equally important for verbal communication as the understanding of the words. People do not share a common "logic", but instead different cultures have their own rationality, the way they consider the things to happen. This influences their behaviour and communication style,too. (op.cit.)

Porter and Samovar (Porter et el. 1997; 18- 20) consider the non-verbal behaviour as the silent form of language. *Non-verbal communication* includes all those little details that we express while with other people, nodding your head, touching, clothes, gestures, etc. The concept of time, and the use and organisation of time are the most important non-verbal communication aspects.

Non-verbal behaviour, the signs that we give to send messages, is a learned process as learning the spoken language. This is a complex group of uncountable number of signs and gestures that might be interpreted differently in distinct cultures. *The concept of time* deals with the philosophy of the past, present and future of a culture and the importance it gives to time. Finally, *the use of space*, how close to the other person it is acceptable to go in a conversation, the orientation of the people involved in the conversation, and the way the objects are organised in the given space are all culturally defined positions. (op.cit.)

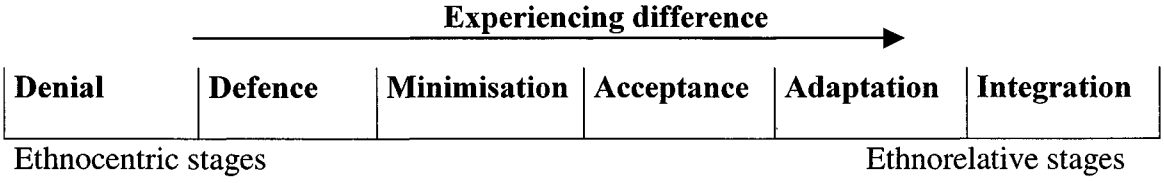
5.4 The encounter of two cultures – a problem?

The main interest of the intercultural communication studies lies at those differences in communication styles that are caused by the cultural variations. Because it is through the culture that a person learns to communicate, two people from different cultures do not necessarily share the way they communicate or perceive messages. To understand the others, we must learn to understand how their perceive the world. Thus, only when the two parties in intercultural communication have an honest interest to understand the other despite the differences, is the communication meaningful. (Porter et al. 1997; 24-25) This desire to understand the other's culture is called intercultural sensitivity.

Bennett (Bennett 1998) has studied the levels of the intercultural sensitivity. He created a Developmental Model of Intercultural Sensitivity (DMIS) that represents the six possible stages of experiencing the difference. Using the model, it is possible to, in theory, analyse the person's behaviour towards a strange culture and explain some of the problems that might occur. The model is widely used in intercultural communication studies, and I will discuss it in detail in the next chapter. The Bennett's model will be taken up again when discussing the importance of intercultural communication in development co-operation.

5.5 Developmental Model of Intercultural Sensitivity by Milton J. Bennett

Figure 1: Development of intercultural sensitivity (Bennett 1998; 26)



The three first stages belong to the ethnocentric group in which a person uses his own standards to judge the others. Moving towards the right, the ethnocentrism gives space to the ethnorelativism in which the person is able to change his behavioural patterns and to use different value systems in different contexts. (op.cit.)

People at the *denial* stage live in relative isolation from other cultures, either because of the circumstances or by choice. They either do not perceive the others at all, or see them as large groups like "foreigners". It is common for the people in this stage to make simplified stereotypes of the others. Due to their limited information, they tend to regard these as something less than the person's own culture. It is not unknown that people in this stage exploit the others or even use violence against them. (Bennett 1998; 26-27.)

People at the *defence* stage recognise the existence of the other cultures but label these with highly negative stereotypes. Members of this group consider themselves under siege, they feel themselves threatened by the others. The defence stage can occur also in reverse form: people consider their own culture worse than the others. (Bennett 1998; 27)

The last of the ethnocentric stages is *minimisation.* People in this group do not see the differences between the cultures, but instead, focus on the physical and philosophical similarities. They recognise some differences for example in eating habits, but consider that in the end "we are all just humans who need to eat". On the other hand the religious people can think that we are all "children of God", thus we are all the same. (op.cit.)

People at the stage of *acceptance* are at the first stage of ethnorelativism. They are interested in other cultures, but understand also their own role as a cultural creature. The acceptance of the other cultures does not mean giving up one's own to start to behave like in the other culture. Quite the opposite, one learns to deal with the differences and starts to understand that his values might not be the only good way to see the world. (Bennett 1998; 28)

People who are at the *adaptation* stage use the knowledge of their own culture and that of the others, the shift into a cultural frame of reference. They can take another person's perspective in order to understand, and to be understood across cultural boundaries. Advanced forms of adaptation are bicultural or multicultural, wherein people have "grown up" to one or more cultures in addition to their original one. The adaptation happens either by staying extended periods of time in a strange culture, or by growing up in a multicultural environment, for example, in a family of parents from another culture than the culture of the society where the family lives. (Bennett 1998; 28-29)

Integration is the last and the most difficult stage to meet. The people who have reached this stage identify themselves as "multicultural". Especially in the entering phace they might have problems in defining what are the patterns of one culture and what belong to the other. They are able to interpret behaviour from different points of view and recognise that there is no right or wrong answer. (Bennett 1998; 28-29)

Bennett (Bennett 1998, 29-30) continues explaining the importance of the ethics in intercultural communication. Ethnorelative ethics to him means that all the actions must be judged within the context they happen. There is no universal ethical behaviour. In order to be able to act smoothly in other cultural environments than one's own the consciousness of the differences between the cultures is the first step to take. Nonetheless, this is not enough, but should be followed by the acceptance of the differences

Through out the next chapter, I will discuss the concept of health as a product of culture. Similarly to other behavioural patterns, the behaviour involved with health/illness is defined through our culture.

6 HEALTH AND ILLNESS AS A PRODUCT OF CULTURE

6.1 Introduction to medical anthropology

Sociology of health and medical anthropology are sciences studying health and disease in their social context. Being healthy or ill is not simply a biomedical question, but a lot has to do with the patient's own culture. Also what happens when the person recognises himself as ill, depends on his cultural background. Sometimes even temporary life situation may affect on this, for example, a student who has an important exam the following day may "decide" that he is not ill despite the ill-feeling that any other day would have meant him staying in bed. (Honko 1994: 24.)

The individual and his immediate social group make these decisions under an influence of the standards of normal health concept of the individual's culture. These standards are formed and transmitted like other cultural aspects; they are defined in social contexts and influenced by such factors like socio-economic situation, belonging to ethnic or religious groups and others. These standards are not stable, but change over the time when the general living conditions improve or worsen. (Brearley et al. 1978: 8-15.)

Within these sciences and in intercultural studies, there is also research about the encounter of the cultures of the ill and the one curing. Sometimes they share the same ideas, language and the way of dealing with the illness, but often not. (Honko 1994: 24.) These situations belong to the intercultural encounters discussed above. Nevertheless, it is important to notice that it is not only the culture that guides ones behaviour in front of health matters. Sometimes, it can be that the person simply does not have the economic possibility to attend a doctor even if he would like to do so. Thus, it is important not to consider the poor health of a population solely a cultural matter, but also to notice the economic and social situation. (Helman 2000: 4.)

Before discussing the cultural aspect of health, it is important to define the concept of health. The next chapter presents some ideas of health and health care.

6.2 Concept of Health

The Oxford English Dictionary defines health as *"general condition of the body with respect to the efficient or inefficient discharge of functions: usually qualified as good, bad, weak, delicate, etc."* (Oxford English Dictionary) Thus, health can be simply understood as a state of one's body. In the following, I will present two definitions, that place health to a much wider context.

The reason why I choose these definitions is that the sources are both widely known within their circles. Parsons is one of the important Western sociologists, and often referred to in intercultural communication studies, whereas WHO is the leader of the health organisations, thus the organisation that guides the health policies in the modern world. Moreover, both Parsons and WHO, although very different, have strong Western connotations, both in their ideology and their formation. In my opinion, they present the two extremes of the continuum of the Western health concept. The WHO's highly human, personal and overstated definition on one end, and the Parsons functionalist definition on the other.

The WHO constitution defines health as *"a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living. It is a positive concept emphasising social and personal resources as well as physical capabilities"*. (http://www.who.int/terminology/ter/)

Another way of defining health is that of Parsons, according to which health is " *the state of optimum capacity for the effective performance of valued tasks*" (1964; 262). Parsons, (1964; 257-282) as a sociologist and functionalist, understands a person as a part of a larger group where each person has his place. Not only does he consider health to be necessary to fulfil one's obligations in a society, but furthermore, he understands illness, i.e. lack of health as a problem of social control. The different norms related to health, illness and getting better are forms of controlling the ill. This control aims to force the ill back to his normal position in the society, to guarantee his *state of optimum capacity for the effective performance of valued tasks.*

The Aymara/Quechua definition for health, on the other hand, can be viewed through the definitions of illnesses. The illnesses are divided into real and magic illnesses (Aguiló 1982 10-19). The real illnesses, like bone fractures or skin cuts, are considered with little importance, whereas the magic illnesses gain a major attention on the daily life of the Andean people. There is a great fear for these, up to a point that it controls the everyday life. The magic illnesses are avoided by the correct behaviour, rituals and avoidance of things considered taboos. The Aymaras and Quechuas try to maintain the good health by following the cultural rules of the society. Citing Federico Aguiló (1982; 20) the health is *"nothing but "fooling" the illness".*

The three definitions of health given above represent different points of view. Within the development co-operation in health sector, the different ideas meet and this has an unavoidable effect to the results of the project. Health is not a simple state of one's body, as the Oxford English Dictionary explains it, rather, it is a complex system of beliefs and values, just like any other cultural aspect.

The article 25 of the United Nations' declaration of Human Rights says the following:

"(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness,

disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection."

Similarly to the definitions of health, this article includes no definitions about what these terms health or well being include. Many of the development co-operation projects in health plead to the Human Rights Declaration and WHO health policies by stating that "everybody has the right for a better health care".

In my opinion, there are two ways of viewing this. Either we can say that the declarations above mean that every human being has the right to similar health care, ultimately meaning the modern Western medicine, or we can say that every human being has the right to a health care that corresponds to his own values and needs. Bennett (1998) said about the ethics in intercultural communication, that all the actions must be judged within the context they happen. For health care this means that the health care systems should be judged *only* within the context and by the people who know the local culture.

This is not, by any means, to say that Western medicine should not be taken to the places where it is still unknown. Rather, I would like to interpret the declarations above in the way that the local people should have influence in the decision-making that considers their health care. They are the ones that know the local conditions and needs better than anyone from outside. Moreover, they know the culturally correct way of implementing the new ideas to the society.

As pointed out by Helman (2000), anthropologists can help in the planning of different forms of health care. The importance of cultural sensitivity has also been noticed by organisations like WHO and UNESCO who declared the year 1996 the Year of Culture and Health (UNESCO 1996). Involving anthropology to health care has a purpose of searching long term solutions for the World's health problem. Experience has shown that the projects

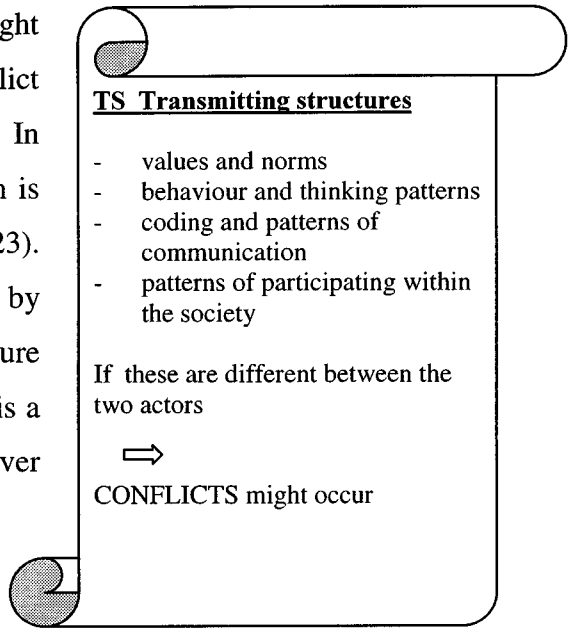
should include, not only the medical aspect, but also invite the community to participate and look for individual solutions that are acceptable culturally, socially and economically. (Helman 2000: 9)

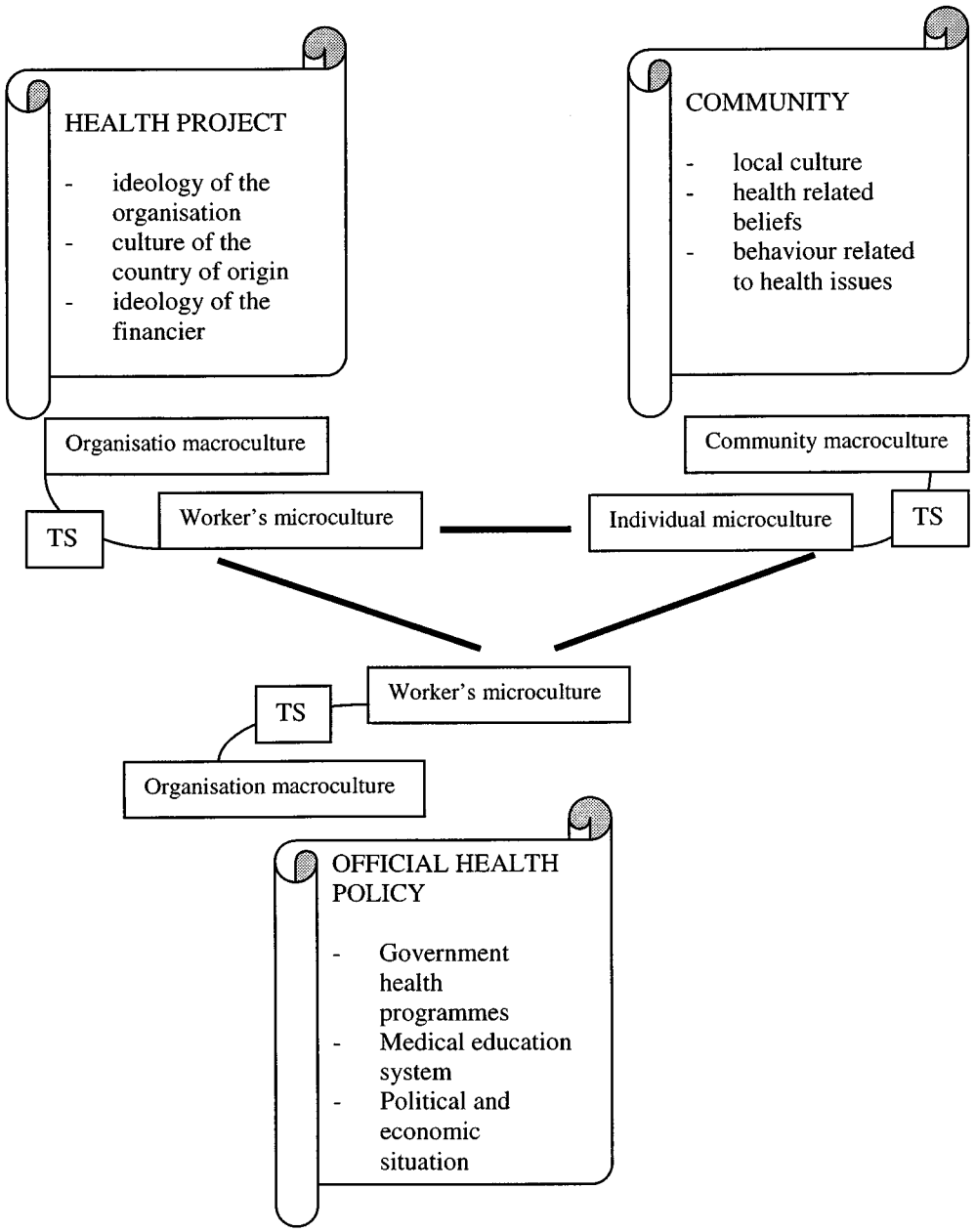
In his article *Kulttuuri ja sairaus,* Honko (1994) emphasises the compromise and interaction between the modern medicine and local traditions to create new forms of curing to answer the local demand. According to Honko, many successful health projects in Asia, Africa and South-America have been based on this ideology.

7 PARTICIPATION AND LOCAL CULTURE IN DEVELOPMENT WORK, ESPECIALLY IN HEALTH SECTOR - SUMMARY OF THE THEORIES –

The following figure is an adaptation of the figure used by Judén-Tupakka (2000; 22) in presenting the encounter of the cultures within the development work. The figure shows the three actors within the framework of development work in a local level. Each individual, through whom the encounters happen, represent two levels of culture, the larger macroculture and his own microculture. (op.cit.)

The box **TS** is the transmitting structures of the culture presented in the box below. If these structures are different there might occur a conflict. The depth of the conflict depends on how different the cultures are. In the figure we can observe how the situation is constructed (Judén-Tupakka 2000; 20-23). What Judén-Tupakka wants to emphasise by this model, is the inevitable presence of culture in the development work. Every individual is a product of culture and takes it along wherever he might go.





As can be seen, the person's culture is always present also in the development co-operation. The interaction between the counterparts is *intercultural communication*, but further, it is also *development communication*. Development communication is interaction between two people, the development agent and his client, an individual from the target group. The development agent seeks to assist the other person to achieve a higher level of well being by influencing his decision-making behaviour and attitudes towards innovations. For this

communication to be effective, it is necessary for the development agent to be familiar with the target group's attitudes and cultural values. (Rogers et al. 1999; 243-255.)

In the case that the cultures are significantly different, the conflict is too deep for co-operation to function, as it has been noticed many times when attempting to apply the Western values in a non-western culture (Stone 1992). To gain real familiarity of the local culture would take years (Bennett 1998), and this has risen the conversation of the local people's ability to participate in the projects. Not alone is it better to give the local's the tools for bettering their own situation, but also they know their culture and its way of functioning.

Thus the local people's participation is a part of the current development co-operation, also in health sector. There are projects that understand participation as the object of the project and put high emphasis on the real terms of participation. Through participatory programmes, the development agencies aim to gain the three levels of commitment. Physical, the presence and use of one's effort for the benefit of the action, mental, taking part on the decision making and using one's mental skills for the benefit of the project, and emotional involvement to the project. Through the commitment, the people are supposed to adopt the project ideology and start acting for their own benefit, the process called empowerment.

The empowered person is assumed to change his behaviour from passive acceptance of the events to active control over them (Rogers et al. 1999; 243-255). The aim for empowerment of the people through participation within health work is becoming the core element of the projects (Eklund 1999; 60).

Nevertheless, there is some critic towards the idealism of the "participation trend". Cleaver Frances (1999) criticises the lack of critic for the trend. According to him, the whole idea of participation has become a question of faith; everybody swears on its name, even when there is no real evidence of its long-term efficiency. Other critics blame the development

agents of superficial approach to the participation. Unfortunately, the participation is often limited to receiving the services, instead of real empowerment process. (Alfaro et al. 1998)

The object of this study is to seek the answer to what is the role of participation in health work in the Bolivian Andes. I will examine some health projects and the experienced role of participation in these. Furthermore, I will reflect the experiences of participation in relation to the attitude towards to local (health) culture. But before that, I will present a country profile of Bolivia and a cultural review of the Andes.

8 BOLIVIA

8.1 Political and Economic Past and Present

Bolivia has a colourful history of tribes, conquerors, wars, revolutions, and coup d'états. Fransisco Pizarro arrived to the territory in 1532, which begun the colonial era that would last for nearly 300 years. During these centuries, Bolivia became the economically most important part of the Spanish empire, the silver mines of Potosí made it a city bigger than Paris in those days. However, the silver was transported to Spain and there was not much of the richness left for independent Bolivia. (Country Profile 2000)

After the independence won from Spain with the leadership of Simón Bolivar in 1825, Bolivia started its long struggle among the nations of the world. As a consequence of the several wars against neighbouring countries, Bolivia lost over half of its original territory, last lost dating to the years 1932-35 in the Chaco war. (op.cit.)

Year 1952 meant yet another unstable era in the history filled with blood. The MNR (Movimiento Nacionalista Revolucionario) made their revolution and gave the country several positive reforms, including the land reform that took the land from the big landowners and divided it between the native people. The MNR did not stay in the power for too long, and revolutions followed each other for the next decades. (op.cit.)

Until the year 1982, military governments ruled Bolivia. They were many, shortest regimes lasting barely one day, while the longest, the regime of the current president General Hugo Banzer, lasted for eight years from 1971-78. (op.cit.)

Since the year 1982 Bolivia has had a democratically elected government and president. No single party has succeeded in winning the elections alone, but they have always made coalitions. The focus of each of these governments has been the stabilisation and growth of the economy. The era of democracy has been marked by several occasions of restlessness, last one occurring in April 2000, when the government announced the state of emergency and curfew for six weeks. (op.cit.)

Bolivia's most important international relationship is the one with United States. Most of the trade is done with the US, similarly most of the International aid comes from there. Bolivia is also a member of such international organisations as the World Bank, the IMF, the UN and other smaller ones. (op.cit.)

Despite the vast territory of more than 1 million square kilometres, Bolivia has very little cultivated land, only 2% of the territory, half of the area is forested and one quarter is given over to pasture. There are three geological zones, cold and arid Altiplano in the altitude between 3600 to 3800 metres above sea level, the temperate valleys to east from the mountain ranges, and tropical lowlands more towards the border with Brazil. There are several minerals and petroleum and natural gas deposits to be found in the national territory. (op.cit.)

Bolivian economy is characterised by uneven development and a large informal sector. The international economic crises affected Bolivia strongly in the 1980s, and the recovering is still under process. The old technology that is still being used slows down this process. Agriculture, manufacturing and transport are the main sources of income. (op.cit.)

Bolivia has been and still is heavily indebted country. In 1996, the foreign depth was 80% of its CDP, and Bolivia was accepted to the IMF/World Bank Highly Indebted Poor Countries (HIPC) initiative. (op.cit.)

8.2 Bolivian healthcare system

The Bolivian health care system relies on four elements, the public sector, social security, NGOs and private sector. The system is currently going through some major changes due to the new state policy that concentrates more and more on people's welfare. Until the year 1938, the Catholic Church was the main responsible for the health services, but that year

the new Ministry of Health took over the administration. (Ministerio de Salud y Prevención Social, Bolivia 1998)

The present system has taken form through many changes. This system faces back to the year 1984 when a three level model of local, regional and national administration and attention was created. Nowadays, the law of popular participation is giving more power on decision making to the municipalities.

The last reforms to the national health care system were made in 1998. These reforms were an attempt to decentralise the decision making by giving more autonomy to the health districts, and through this promoting direct citizen participation in the planning and development of the health services. (Ministerio de salud y Prevención Social, Bolivia at http://www.sns.gov.bo/reforma8.htm)

The national health policy, a basic health security programme *Seguro Básico de salud* identifies the following groups to be the main target of the health sector:

- Children under five years old
- Sexual and reproductive health
- Epidemic disease

(Ministerio de salud y desarollo humano de Bolivia at http://www.sns.gov.bo/segbasal.htm)

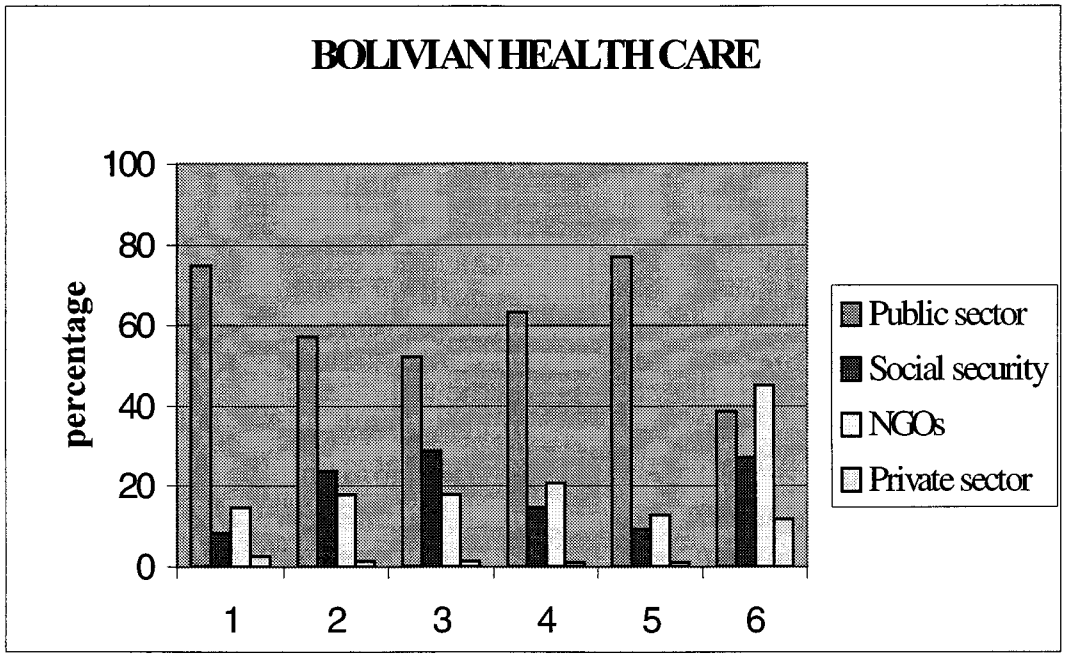
The indicators used in the national evaluation are those defined in the HIPC programme. These include, as the main indicators, the 69 % cover of attended childbirth; treatment for 70 % of the cases of Acute Respiratory Infections (ARI) of children under 5 years old; 56 % coverage on treatment on Control of Diarrhoea Diseases of children under 5 years old and 85 % vaccination coverage on children under 1 year. (Ministerio de salud y desarollo humano de Bolivia at http://www.sns.gov.bo/segbasal.htm)

Next, I will have a look at some statistics about the way the health services are dived between the four sub sectors of the Bolivian health care. (Ministerio de Salud y Prevención Social 1998)

1: % of the healthcare posts **2: % of the new consults**

3: % of all the consults **4: % of 1st time neo-natal control**

5: % of childbirth attention **6: % of education in FP**



The NGOs have traditionally covered approximately 20 % of the Bolivian health care. The geographical areas where the NGOs mostly work are those where the official health care does not reach, although the most isolated and remote areas are rarely covered by these either. (Gondrie 1995; 183-213)

The Bolivian health care is just starting its development, and the governments during the 1990s have made an attempt to improve the situation. If 20 years ago the Catholic Church and the NGOs had the major responsibility of the health care system, today the portions are

the opposite. Little by little with the international help and pressure the system advances. (Vammavaara 2000)

8.3 The Andean Culture

In order to understand the environment where this study has been done, I would like to start by talking about the Aymara-Quechua cultures. It was nearly 500 years ago when the Spaniards arrived to the territory of the Incas, a territory that also included the areas of Aymaras and Quechuas. Today, despite of several centuries of colonisation, first by the Incas and the by the Spaniards, they have not integrated in the "white" society. They keep their old traditions, their clothing is different to the European style, and their languages are still the main languages in the rural Altiplano. (E.g. Albó et al. 1990, Llanque Chana 1990)

Aymaras and Quechuas are in reality two separate cultures, with their own languages. But today the language is the only difference to be found between the two groups. So instead of speaking of two different cultures, it is better to speak about one common Andean culture, expressed in two languages. The apparent reason for this similarity is to be found back in the history. The Aymaras and Quechuas habited the same territory, and shared many aspects of the life. (Albó et al. 1990 p.21)

Today, the Aymaras are mostly found in the northern parts of Bolivian Altiplano, while the Quechuas mainly habit the south. The cities like La Paz, Oruro or Potosí follow the same division, although the Quechua population in La Paz is growing as they immigrate to the capital city in search of work. (E.g. Albó et al. 1990, Llanque Chana 1990)

The Aymaras and Quechuas of Bolivia habit mainly the Altiplano area, a highland of the Andes in the altitude between 3750 to 5200 metres above the sea level where the environment is hostile to human beings. In the northern parts, in the departments of La Paz and Oruro, the cold wind blows throughout the year, and the rainy season brings heavy rains every summer, usually starting in October - November. The rains cut the connections

to many communities, and they remain in that isolation until the rains reduce by the end of February. (Albó et al. 1990)

After the rainy season, the nature turns green, the harvest is ready and the landscape looks alive. But soon the beginning winter freezes the ground, and it is not unknown to snow during these months. Again in September, the temperature rises and the brown, dry landscape starts its preparation for the coming rainy season. In the southern parts, in the department of Potosí, there is a tremendous lack of rain, the same seasons follow as in the North, but the difference is that the summer is dry. The night temperatures during the winter may drop 20 - 25 degrees centrigrades below 0, in the summer it normally stays around +5 degrees while daytime temperatures fall between 10 to 15 degrees. (op.cit.)

After the Altiplano highlands, on the eastern slope of the mountain range, the valley offers a more pleasant environment to live in. The altitude varies between 1200 and 3600 metres, the temperature and the rains are stable and more suitable for production. And finally, we come to the "Yungas" area, laying in the altitude of 800 to 2000 metres, with close to subtropical climate. (op.cit.)

The arid land of Altiplano does not give a lot to humans nor to the animals. The production is concentrated on the traditional plants, potato, beans, and in the lower parts corn. The most common animal husbandry in the south is llamas and sheep, while in the North there are more sheep and thin cows. All the farm work is done manually, it is extremely rare to find a tractor or other machinery in the Altiplano, though bulls are often seen in the northern parts. (Albó et al. 1990)

The Valley and Yungas areas produce more in animal husbandry and some fruits. The difficulty in this area is the thin fertile layer of the ground.

8.4 Social organisation

Returning to the Gudykunst's and Ting-Toomey's (1988; 39-59) cultural variabilities some conclusions can be drawn about the Andean culture. If we look at the Andean culture using the theoretical terms provided in the chapter 5, we can take dawn the complex system of an entire culture to a few basic element. These elements will be helpful, firstly, to understand the new culture, and secondly, to analyse the cultural problems the NGO have faced in their work. Without this "labelling" and generalisation, discussing a foreign culture would be difficult, if not impossible. Thus, forgive me for the following simplifications and generalisation, I am not proud of them but it is something I must do in order to stay in the limits of this study.

Collectivistic culture

As can be seen from further below, the Andean culture is strongly *collectivistic* culture. Moemeka (1997) has studied some collectivistic African cultures. The same rules he presents for the African communication apply to other similar cultures. Moemeka underlines some important characters of these cultures, such as the supremacy of the community, the value of the individual and the sanctity of the authority. By the first he means the preference of the common good over the individual goals, which is also strong among the Andean culture. Further, this ideology includes the avoidance of critic against the community. While one can criticise another individual, the community as such should be respected. (op.cit.) In the following I will look at these characters in the Andean society.

Individual and family

The mother rises the child until the age of approximately five years. At this age he receives the baptism, which is usually a mixture of Christianity and old traditions. The baptism serves as a symbol that the child has survived the hard conditions of childhood and can start his life as a person, instead of a child. The girls will follow the mother helping her in the domestic labours while the boys start learning men's duties with the father. (Albó et al. 1990)

A full member of the society a person becomes only when he forms a family. The Andean culture considers a man or a woman as a half of a person that requires the other half to be complete. (Juaréz 1999) With the marriage he becomes *jaqi*, a man. The married couple gets a share of the land of the husband's family's land, and also a piece of the communal land. As an exchange for the communal lands, they now have to participate on the obligations for the benefit of all community. (Carter 1988)

Family, on the other hand is a unit with no clear definition. Some authors define a family as a couple, a man and a woman, and their children, some define it as the whole community, including the plants, animals and spirits living in the community, *ayullu* (Frédérique 1998 pp. 90-91).

The relationship between the children and their parent is strong. Aside the biological parents everyone has "godparents" who are considered equal to biological ones. This network of *compadrazco* forms a security system in a society where the State has not developed one. The families united in the *compadrazco* are supposed to help each other's in the moment of problems. (Vasquez 1989) In the Andean social system the communal farming and *compadrazco* system are good examples of the strong unity of the society.

The value of an *individual* in collectivistic culture, unlike in an individual culture where it is measured by his own achievements, is seen through the contributions for the community he has made. An individual finds himself connected to all the levels of the society, and these connections are highly valued. This kind of thought leads to strong social order and control when everybody is supposed to act for the common benefit. (Moemeka 1997)

Supremacy of the community

As I mentioned above, the union between the families is tight. And it is not only the human beings that are included in this union but also the animals, plants, and spirits, even the waters, rocks, hills, etc. In fact, everything visible and imaginable that habits the area of the *community*. This entity is called *ayllu* and it signifies community. The members of *ayllu* have rights and obligations they have to fulfil to avoid punishments. The group, or the

ayllu, is the most important and the common good passes the individual benefit. (Albó et al. 1990)

Insulting somebody or something within the society or breaking the unwritten rules can cause the individual's expulsion from the social group. Any deviant behaviour is considered bad, and the individuals should obey the rules of the society. (op.cit.)

While the right conduct of the members of the community is controlled by the assembly of the *jaqi*s, they intend to keep the *ayllu* united by other means than punishments of wrong behaviour. As mentioned above, the cultural value of the Aymaras is based on the community. This belonging to a group generates characteristics that guarantee the survival of the community. Solidarity, diligence, family, dignity, religion and land are factors that mark the Aymara and Quechua cultures. (Llanque Chana 1990.)

Sanctity of the authority

Moemeka (1997) continues by explaining how the sanctity of the authority, both formal and informal authors, is yet another way of social control. In the Andean culture an assembly of the *jaqi*s is the controlling organ of the *ayllu.* It is formed by all the heads of the families, usually the husband, but his wife or son can replace him in his absence. The assembly decides together about the communal issues, like farming or projects. (Carter 1988)

In an collectivistic culture, a person to be given the position of an authority has to meet certain requirements of good behaviour and serving his community. The role is highly respected thus many would like to be recognised as such. Many of the interviewees of this study commented that the Community Health Promoters could not work in their village because they could not reach the position of a leader. Some projects had looked for the "natural leaders" to work as CHPs, which tended to work out better. Considering health programmes that intend to work through CHPs this is an important notice, the leaders cannot be made, they have to be named by the community.

Many programmes for education of the CHPs give the community some guidelines on who would be a good health promoter. One of these advises recommends to choose a person of the age of 18 to 40 years (Werner 1977). This is the most convenient age for the organisation, the person is still young enough to work for a long period of time thus the organisation can avoid the problem of continuous changes of personnel. But in the light of what we know about the respect of the elderly in the Andean society, the older people are considered to be wiser and their advises are carefully listened, whereas the younger do not gain this respect easily. (Albó 1990)

Religion

Further, Moemeka (1997) presents the religion as the ultimate way of social control in a collectivistic culture. Where the religion and beliefs are strong they are used as protectors of the social norms and safeguards of the social order. For the Andean culture religion means living ones daily life in harmony with the surrounding spirits, the meaning of the belief is undeniable and when talking about health also has to be taken into account. If the beliefs are given the importance as means of social order it should be clear that they cannot be excluded of any work done in the Andean cultural environment.

The Spaniards, as all the conquerors of those days, used religion as an excuse for their conquest of new territories. During these 500 years the Aymara-Quechua religion has taken a Christian form, but maintains some prehispanic characters. In general, the Catholic religion is the strongest in Bolivia, although other Christian religious have got they share of the believers too (Country Profile Bolivia).

The Christianism is mixed with the prehispanic beliefs, and these old traditions are still easy to recognise in the daily life (Bouysse-Cassagne 1987 p.35). The most evident time to witness this is in February, during the Catholic Carnival, the fourth day of the celebrations is dedicated for *challa*, an offering given to the *Pachamama*. Even in La Paz, in most of the homes the people decorated their homes with paper flowers and serpentine and sprinkled pure alcohol in the corners of their house to ask *Pachamama*'s benediction for it, and get another good year at work and in life in general.

The complexity of the Aymara and Quechua world is visible on the way the good and evil, like the three worlds, equivalent to the Christian Hell, Earth and Heaven, cannot be separated. Even the most dangerous places can bring you fortunes, when treated well and approached properly. On the other hand, the kindest spirits, the guardians of homes, they can turn to evil if they are treated badly. (op.cit.)

In the Andean world, the equilibrium is achieved by combining opposite things. The good and bad are the same, the ancient belief still live together with the Christianism and the three worlds live in harmony, influencing one to another. Nevertheless, the delicate equilibrium in the universe can be easily unbalanced, if insulted, forgotten, or not respected the spirits, both the good and bad ones can send their revenge to the people. The punishments vary from illnesses to lightening, hails, floods, killing the animals and the target of the punishment can be an individual, a family or a whole *ayllu.* For forgiveness it is necessary to perform rituals conducted by the ceremonial master. (Rösing 1992

High uncertainty avoidance

Finally, the high uncertainty avoidance in the Andean culture culminates on what the outsiders interpret as "a resistance for change". The need for consensus causes, that everything new is placed under suspicion but this does not mean it would never be accepted. If the new way is proven to be efficient, it will be taken to use. (Fernández Juaréz 1999) The rules of the society are considered important in the high uncertainty avoidance culture, thus yet again proving the importance of the recognition of the local culture when working with the Andean people.

Outsiders

As part of the high uncertainty avoidance, the Andean people are precautious with strangers. The relationship to the outsiders is polite but distant. Meanwhile within the community the feeling of solidarity is strong, especially the "white" outsiders, those who are not peasants, become a subject of suspicion and distrust. The history has shown that an

outsider, *q'ara*[4] is somebody without dignity because he lives, not by working hard, but exploiting the others. On the other hand the outsiders are objects of envy and gratitude. The extreme politeness is due to the fact that the Andean people know they "need" the *q'ara*, for his money, for his government programmes, and other similar reasons. Thus the rather hippocratic behaviour towards the outsiders. (Albó et al. 1990.)

The other Aymaras and Quechuas are treated in different manner. They are not part of the *ayullu* but, they are treated according to their behaviour either like *j'aqi* or like *q'ara.* (Albó et al. 1990.)

Further, the nature of the Andean culture as a high-context culture creates some assumptions of its ways of communication, as described in the chapter 5.3. According to Gudykunst and Ting-Toomey (1988; 44) people of high-context cultures make a difference between people who belong to the same group with them and those who do not. When the priority is given to the people of the same community it is understandable that the outsiders, in the case of this study the people working for a non-governmental organisation, may get the feeling they are not welcomed to the community. As was mentioned before, the Andean societies have some expectations that the newly arrived will have to meet in order to gain the community's respect.

8.5 Health in the Andes

The people in the Andes divide the illnesses in two categories, real and magic. The magic illnesses are those caused by the spirits and can only be cured by the ritual healer, *yatiri*, who performs the ritual and offering for the spirits. The real illnesses, on the other hand, are those caused by something visible like car accident, being attacked by an animal, cut one's skin, break a bone when falling (or fighting). These health problems are understood as real and the cure does not involve magic rituals. (Aguiló 1982.)

[4] Means literally "pealed", uncivilised. (Albó et al. 1990; 74)

The people of the Andes do not consider the lack of hygiene, malnutrition or contagious illnesses as the cause of health problems. There are many illnesses that, because of their invisible cause are thought to be a message from the spirits, but would be a rather easily cured or prevented if these issues were taken into account. (Aguiló 1982 and Fernández Juaréz 1999) These illnesses include, among others, diarrhoea, rubella and long-term headaches.

Additionally, there are illnesses that do not coincide with any "western illnesses", the most severe probably being the *k'hari k'hari.* A person with this illness dies slowly and there is no cure. The *yatiri*s try to help the patient with the rituals and herbal medicine, usually with no success. The symptoms are headaches and loose of appetite in the beginning, leading to high temperature and drying of the patient in the end. The cause of death is said to be the mysterious disappearance of fat or blood in the body, the patient looses weight and is said to have no blood left when dying. (Aguiló 1982, Fernández Juaréz 1999 and Rösing 1992)

K'hari k'hari is result of being attacked by a spirit, usually during the night and near springs or brooks. The spirit sucks the blood (or fat) of the victim causing the symptoms described above. Curiously, the hospitals are often referred to be places of *k'hari k'hari* because there "the doctors take the patient's blood". (Fernández Juaréz 1999; 56)

Ina Rösing (1992, 1995) has conducted a profound investigation about the Callawaya healers. The Callawayas have traditionally been the healers of the Andes, they have travelled thousands of miles curing people all over Southern America during the past centuries. In her books she transcribes several curing rituals, including the prayers in both original language and Spanish. Further, she includes explanations about the rituals and the objects used in them given by the very healers. In the following I will present some of the main characters of the extremely complicated and multiple process of Andean healing.

The rituals for healing are usually conducted at the patient's home. The *yatiri* arrives late in the evening and the curing can take almost the whole night. The first hour is spent talking with the patient and his family to find out what and where might have caused the illness. During this conversation the people in the house chew coca leaves, smoke and might even have a drink. *Pachamama* is asked to bless the house by offering her coca leaves and alcohol that the *yatiri* sprinkles around the house. After this the *yatiri* can either consults coca leaves to ask what has caused the illness or if he already knows the possible reason he can start the ritual. (Rösing 1992, 1995).

Each *yatiri* has his own particular way of performing the ritual. There are some basic elements that are never missing though. The ritual table, the offering to the spirits is made with coca leaves, flower petals, llama foetus, egg, sugar, alcohol and decorations. All the ingredients have their own purpose and even one item missing can, not only foil the success of the ritual, but also prejudice the people involved by making the forgotten spirit angry. (op.cit.)

While preparing the table the *yatiri* says prayers. Again it is up to the *yatiri* to decide how much he prays, but there are certain elements that can not be missed. First he has to call for the spirit of the winds, *Ankari*, who will deliver the message to the other deities. Then, the most important Andean spirits will be remembered, and then, separately from these, the Christian God, Mary, and saints. All these are consulted to ask for forgiveness for the errors committed, to ask for cure for the illness and ask for protection in the future. (op.cit.)

After the prayers, the table is taken outside where it will be burned until everything has turned to ashes. The *yatiri* stays talking with the patient about the illness and about the life in general, again coca leaves are chewed and they can smoke cigarettes and have a drink. Still before leaving the *yatiri* makes sure the offering has been burned out totally. (op.cit.)

The *yatiri* does not give medicine, the *herbolares* are those people specialised on herbs and curing with these. They might sometimes consult the spirits too, but normally these occupations are separated. The common people know many herbs themselves and grandparents and neighbours are consulted regularly for advice. (op.cit.)

As can be seen, the ill person is treated in a complex way, all the aspects of his life are taken into consideration when looking for the solution. The curing process includes the family and often even the ancestors and their acts are revised in search of the cause of the illness. The concept of illness is connected to the balance of the universe, not merely to a certain part of the body of malfunction of a certain organ like in Western medicine.

Further, I would like to discuss the role and formation of the healers, especially the *yatiris*. They are people chosen by the deities, the people do not choose to become healers. The God of lightening, the equivalent to the Christian God, chooses the person and marks this by a lightening. The people who survive the strike of lightening are considered to possess the power to read from the leaves and communicate with the spirits. Nevertheless, these abilities do not come automatically, but need to be practised. A chosen person starts working as an assistant of an older *yatiri* and ultimately gains his knowledge from him. (Rösing 1992)

The young *yatiri* cannot perform the ritual on his own. The patients would not trust him before he, as an assistant of an experienced *yatiri,* has shown his skills. As the *yatiri* has the power to communicate with the spirits that can be used to cause harm too, the patient will only consult a *yatiri* already known with a good reputation. (Rösing 1992, 1995, Fernández Juaréz 1999.)

Finally, the death is considered as a natural part of the life. It is, although not desired, considered as the beginning of the new era in the circle of life. When everything has been done to cure the patient but there is no result, the patient is left to die. This attitude towards

death makes acceptance of the death possible. The patient will rest and start the journey to the unknown from home, surrounded by the loved ones. The body is then buried but, according to the Aymaras and Quechuas, the soul will stay at home to protect the bereaved. (Albó et al. 1990; 113.)

8.6 Attitudes towards the Western medicine

The negative attitude of the Aymaras and Quechuas towards the Western medicine is not merely a myth amongst the personnel of the health projects. There are several investigations that prove that this problem exists (e.g. Aguiló 1982, Albó et al. 1990, Fernández Juaréz 1999, Rösing 1995).

Xavier Albó (interview with Mr Albó) explained me some reasons to this attitude. Often the health personnel blame the Andean people to be "backward and closed, ignorant people who have no desire to change the existing structures of their society". The principle of this statement lies in the Western values of change and modernisation. Looking from the other point of view, like Albó, an anthropologist who has worked with the Aymaras and Quechuas for decades, the reality looks different.

Firstly, the Andean people do not resist change, when the change happens under their conditions. Too often the personnel of the health projects do not understand the Andean behavioural patterns and misinterpret what they experience. The distrust towards the strangers causes that an outsider is not taken seriously in the beginning, thus the promises made to them are often not kept.

The hospitals, Albó (interview with Mr Albó) continues, are sterile, cold places where the patient and his family are treated badly, according to the Andean way of thinking. The doctors perform acts that are culturally unacceptable, like a male doctor examining a female patient while strange people come and go in and out the room.

Later Albó (interview with Mr Albó) explains how the doctors in the countryside complain that their are ignored in the community. He agrees that this is true in many cases, but introduces an explanation that also gives the keys to the solution. According to him, as has been said before, the new *yatiri*s are not respected. They need to prove their skills, and only after years the patients start consulting him. What happens in the countryside in Bolivia, the doctors are usually the university graduate students who are about the start their first year of working. Moreover, most of them do not speak the local language and in many ways they behave like *q'aras* which means it is impossible for them to earn the trust of the society.

In addition to these justified reasons for not to have confidence to the Western medicine and the personnel, there are many more reason that are pure product of imagination and resemble the "modern horror stories". These include the stories about doctors in hospitals who take the patient's blood to sell it to somebody else (connection to *k'hari k'hari*) or vaccinations that sterilise the children. Everybody who has been working with the Aymaras and Quechuas knows these stories, but they should also recognise the positive experiences they have got, Albó (interview with Mr Albó) finishes. He believes the Andean people are interested on their health and has confident that if the healthcare would be organised in a culturally acceptable way, the indicators of health would look better they do today.

In the following chapter I will discuss the research methods used in the study. This chapter is followed by the chapters of data analysis, in which I introduce the work of the non-governmental organisation included in this study. Hopefully the description about the Bolivian political and healthcare systems above helps the lecturer to place the following in to its real, although physically far-away context. I would like the rest of this paper to be understood as a part of a wider concept than just a Master's Thesis written in Finland.

9 RESEARCH METHODS

9.1 Position of the researcher, the objectivity and the reliability of the study

I have chosen to make this research both because of my personal interest as a person who works in the development co-operation in the health sector, and because of the obvious need to conduct such a study in Bolivia. My objectivity, to the point it is possible to gain such a position in qualitative research, is a result of awareness of my former similar role to the people I have interviewed, I was working as a project co-ordinator for a healthcare project in Bolivia. Moreover I have done a conscious attempt to remove the influence of my personal opinion from this study. Ultimately, I am conducting this investigation to do my share in the attempt to improve the situation in Bolivia, thus it is in my interest too to search for the objective analysis of the situation.

Here I would like to review my own experience in Bolivia. I was the project co-ordinator for a community health promoter project in the rural municipality of Taraco, which is an Aymara community about 100 kilometres from La Paz. In my work, I struggled through the first three months trying to cope with the unexpected problems, which I did not understand. The first experience I had and the ignorance of my own boss towards the local culture had shocked me and gave an image of the Aymara culture as hippocratic and closed culture that strongly resist the change.

When I started to find out more about the Aymara culture I was able to reflect the past experience and realise what *I* had done wrong. I understood better the way the local people behaved and was able to admit that the problems we had had were totally our fault. Consequently, our project started to progress, and we were able to communicate with the local people. In November 2000 the project was slowly advancing, whether there will be any results is to be seen in the next two years.

The attempt to "impersonalise" this investigation I decided not to make any assumptions of the possible results beforehand, but instead, start with an open minded attitude and honest

curiosity towards the problem. I try not to judge the actions through my experience, but rather take the reality as the interviewees have expressed it.

I chose the open interviews because I wanted to make sure the people would have the possibility to express what they considered important. By not giving too tight instructions about what should be said I made it possible that my influence on what was said was the smallest possible. Perttula (1995; 65) underlines the meaning of the free speech of the interviewees when studying experiences.

Before starting, I had underlined to the interviewees that this study did not aim to judge their work, but solely to review their experiences. Moreover, the interviewees suggested me to send them a copy of the work, as they thought it might help them to reflect the everyday struggle in the Bolivian Andes. Thus, I can consider that they have told me the truth about their experiences, the way they understand the reality of their work.

The problem of perception that Porter and Samovar (1997) pointed out in intercultural encounters, dealt with in the chapter 5.2 of this study, is reduced by my background of working in the same position as the interviewees have. The common experience as health project co-ordinators makes the cultural gap smaller. On one hand, it can make me more subjective, that is for the lecturer to evaluate. On the other hand, it helps me, as an investigator to understand what my research subject are speaking about.

Further, through my experience, I know what the health work deals with, and I know what the problem I wanted to investigate exactly is. Thus, I consider that it also helped me to compose the interviews, and later to point out the relevant issues when constructing the categories for the analysis of the interviews.

9.2 Getting Started in Bolivia, November 1999

As Eskola and Suoranta (1999: 15, 34-36) describe, the qualitative research often develops during the process. The new information collected gives new ideas to the researcher and the research idea gets rewritten over and over again. In my case, this process took a few months, starting in Bolivia and finally taking shape in Jyväskylä. Returning to Finland caused me some problems because of the lack of material about Bolivia, but on the other hand, it guaranteed the distance (and peace) needed for the writing process.

I had started the work by collecting literature about the Aymara and Quechua cultures, an essential part of the participation method is to understand the culture of the others. Then I looked for similar investigations done in Bolivia and information about the NGOs in Bolivia in general, as well as some data about the health situation in Bolivia.

This information was collected from the libraries of the Museum of Ethnography of La Paz, CIPCA; a research and promotion centre for peasants, UNICEF Bolivia, and several departments of the Ministry of Health of Bolivia and the Royal Embassy of the Netherlands. The literature was collected during the Bolivian summer months November 1999 - February 2000, while I was still working myself. The interviews were done during the period of April-May 2000 when my work was over, and I had got some distance to my own experience.

Bolivia is an interesting, but a difficult country when studying the NGOs. As Nico van Niekerk points out (1995), Bolivia offers the NGOs an environment with characters unlikely to be found as profound as this elsewhere: the persistent poverty, weak state interference and the importance of the international aid, just to mention a few. What makes the investigation difficult, is the lack of information about the NGOs. Further, the reliability of the data available can be questioned for many reasons, one of them being the collecting method. (van Niekerk 1995 and Gondrie 1995.)

During my own stay at the villages working with the nurse I followed her way of keeping the statistics that the government uses to gather together the national health statistics, and I found out that she was not capable of handling the complicated statistical forms she had been given. Furthermore, the interviewees stated that not everything arrives to the eyes of the personnel of health workers to be included in the statistics. A good example is the mortality of those babies never registered in the rural and remote areas, making the official infant mortality rate too low. The evaluation reports I was given by the NGOs can be questioned because of the method used. A report made by a group of outsiders who did not even speak the local language, cannot express the whole truth. The interviewees and other people working on this field also admit this problem.

These are the reasons I will not rely too much on the statistical information I have gathered. Rather, I use it as a guideline of the real situation, the measuring of which would be close to impossible. To the debate of choosing between qualitative and quantitative research method, the fact that the local statistics should not be trusted too much, gave me a simple answer. The nature of this study is definitely not to form any universal truths about the use of the popular participation method. The experiences vary according to the people involved, place in question and the time when it happens. My intention is not form statistically reliable universal information, but to study the 10 cases I came across with.

9.3 Background of the interviews

In my interviews, I wanted to cover the whole Bolivian Altiplano, the main area of the Aymara and Quechua people. These two cultural groups were chosen out of the group of dozens of cultures, because of the similarity of the two cultures, and because of the geographical accessibility from La Paz where I was based. For example, some tribes in the tropical Amazon basin can only be reached by a month-long riverboat trip, and this would not have been meaningful given the time limits of my stay in Bolivia. Also, the available literature covers best the Aymara and Quechua cultures.

Thus, the NGOs chosen to the interviews were working in the Altiplano area, being the departments of La Paz, Oruro and Potosí. The sudden restlessness and the following state of emergency, roadblocks and lack of security in Bolivia in April 2000 foiled my plans to travel for over a month. Consequently, I had to choose two out of the three departments, and La Paz was the easiest one to cover, I made the interviews there during the state of emergency. When it was finally possible to travel again, Potosí won over Oruro, it being a poorer and culturally more homogenous area (mainly Quechuas).

My intention was also to visit the projects of the NGOs included in my investigation. However, it was not possible for two reasons. The distances to the target areas were often long, and the access was limited to the car of the NGO going and returning once a month. When I required about the possibility to visit the projects, the interviewees politely told it to be almost impossible for the reason mentioned, and invited me to visit them in some other occasion. The second reason is obviously the same lack of security that prevented me from travelling to the other cities, countryside would have been even worse.

Because of the lack of information about the contact addresses, I had to take my sample from the organised NGOs. This might influence on the results of this work, being that the non-organised NGOs might have different policies and experiences, but unfortunately it became impossible to find them. So I chose the two big networks of health sector NGOs PROCOSI and FENASONGS or its local representatives ASONGS La Paz and Potosí as the object of this study.

Other problem with the interviews was the lack of interest or time of the personnel of the NGOs. I wanted to interview the director of the health programmes of the NGO in question, and my first attempt to contact them by email failed. Out of nearly 20 emails sent to the NGOs based in La Paz, only one got an answer. I then called to the people directly, and the result was three more interviews.

I decided to exclude the members of ASONGS La Paz being that I was working together with their network and there was a pressure from their part which made me feel

uncomfortable and little objective. The interviews in Potosí were arranged by the representative of ASONGS Potosí, thus the organisations there were members of ASONGS Potosí. I did not see this as a problem, being that the network there was basically only a name without a real function and did not have a close contact to ASONGS La Paz. Also, it did not make sense to interview organisations of PROCOSI since those had been already interviewed in La Paz with another project.

The same problem of taking a well representative sample is mentioned by van Niekerk (1995) and Gondrie (1995). it is not easy to localise the NGOs and their interest to be investigated is not very great. Despite this, the 10 people who agreed to the interview seemed interested and were helpful. With many of them the conversation went on after the official and recorded interview, and they also asked more questions about my work, studies and life in Finland in general. Moreover, they asked me to contact them later to tell the results of this study thinking it might be useful for them in the future.

The position of all the interviewees was the director/co-ordinator of the health programme. Although their experience in this particular NGO or on this field in general varied from few to more than twenty years, they seemed to have a lot in common. All of them considered their work important and meaningful and were proud of the work they were doing. They recognised the failures and defects of the NGOs and themselves, but even so stood behind the ideology.

The political situation at the time of the interviews was difficult, which also shows on the speech of my interviewees who often refer to the current situation as a proof of the lack of democracy in the country, and to demonstrate what kind of government they are dealing with. In the recording of one of the interviews, one can hear the explosions very near, from time to time covering the speech.

Even in Potosí, when officially the worst was over, I found myself walking long distances in the town because of the roadblocks. Once the interviewee and me were running to escape the tear gas and explosions, and one interview was about to get cancelled because the police

would not let me go through suspecting me of participating in the demonstrations. In general, I could say that most of the interviews were done in tears because of the tear gas fired close to us.

This caused also other problems than the obvious ones already mentioned. I have to admit that the emotional stress and simple fear had an effect on my concentration from time to time. The constant threat of having to leave the country affected my motivation to start the whole project. Those days when there was no food left in the shops of La Paz and tear gas was all over the city, the army was on the streets and people were reported dead, the thesis did not feel as relevant and did not get the importance it probably should have had.

As ironic as it may sound, the Bolivians are used to this and the life went on normally where possible. A good example of this, a local newspaper had two main titles in the front page. One told how many people had already died during the fights, and the other cited an IMF committee visiting Bolivia those days saying: "The situation in Bolivia is better than in years" (La Precencia, La Paz, Bolivia 09.04.2000). I got used to this too, and tried to do as many interviews as possible despite the troubles.

9.4 Structure of the interviews

The interview was based on five themes, the organisation, the health project, the cultural aspect that affect the project, the problems that have occurred during the project and their solutions, and the role of the Non-Governmental Organisations in general in the Bolivian society. (In original language in APPENDIX 2)

1) Organisation
   - What is the political/religious ideology of the organisation?
   - Who are the people who work in the organisation, where are they from?
   - What projects the organisation has had and has going on at the moment?
   - Based on what information/ideas the new projects are planned?

- Who makes the evaluation of the project and how is it done?

2) Health project
   - Project profile; what interventions are included?
   - Where is the project conducted?
   - The target group?
   - Objectives of the project?
   - Duration, at which point of the project circle is the project now?
   - What was done to enter to the community?
   - What will happen/happened when the project is/will be over?
   - Who is on the field working with the local people?
   - How are the local people involved in the project?
   - What methodology is being used?
   - What have been the results of the project in your opinion?

3) Cultural aspects
   - What (local) health related cultural aspects can you mention?
   - What (local) cultural aspects that affect the project can you mention?
   - Do you know the yatiri/is there co-operation with the yatiris?
   - How does the project deal with the traditional medicine?
   - What does the local culture mean in practise to the project?
   - What is the local culture? Health, gender etc...?

4) Relationships and possible problems
   - What have been the biggest obstacles during the project?
   - Why these and how were they solved?
   - What do you do to avoid further problems?
   - How was the project received in the target area?
   - What is the relationship with the local people like?
   - Relationship with other organisations and institutions in the area?

5) The role of the NGOs in the Bolivian society in your own opinion
   - The political influence of the presence of the NGOs?
   - The role in the health policy?
   - The role in the health sector as a provider of services?
   - Who should do the health work in Bolivia, the state or the NGOs?

The interviews were recorded, none of the interviewees had a problem with this. One of the recordings had failed due to the quiet speaking of the interviewee and to the fact that she was moving around the room while she was speaking. The recording is of such a bad quality that I have abandoned it from my material.

The interviews were made in the premises of the NGOs in question, excluding one interview that was made in a cafeteria, because the offices of the organisation were away from the centre and there was no transportation due to the strikes in Potosí.

9.5 Other activities in the collection of information

To form a more practical idea of the framework of the NGOs, I got valuable help from the people of ASONGS La Paz. They invited me to participate in meetings and introduced me not only with important people, but also with the system of Bolivian health care and NGOs working within. I participated in several workshops, in some of them I was only a listener, but in some I was also invited to give my opinion about the topic.

In Potosí I had an opportunity to visit a kindergarten working with one of the organisations and speak to the teachers there about the living conditions and social and economic situation of the miners of Potosí. I also visited the co-operative mines of Potosí where I had a chance to meet some miners and talk with them. One night I took part to an event organised by one of the NGOs and got to talk with their CHPs (Community Health Promoters) and local people from the poor *barrios* of Potosí.

I had an interview with a famous and respected anthropologist Xavier Albó who speaks about his opinion about the possible co-operation of the modern and traditional medicine. Albó is known in Bolivia of his significant works among the Aymara and Quechua people.

A practical picture of the rural Bolivia, at least at the Altiplanic part I got during my work and several trips I made to the countryside. How deep my understanding of the Andean life is, I cannot say, but I have got a good basic but first hand knowledge.

9.6 Analysis of the interviews, Jyväskylä, autumn 2000

I have transcribed the interviews and then taken them to separate files by the themes, a method described by Eskola and Suoranta (1999: 154-155, 175-182). The themes are programme, target group, working methods, problems, cultural issues, popular participation, keywords and evaluation of the work. The themes are created in a way that it will ease the linking of the interview data with the theories used in this study.

I have used two methods to analyse the categorised data. The first one forms the cultural analysis of the projects as it has been described by the project co-ordinators. I will divide the organisations into groups according to the attitude towards the local health culture. This grouping is based on the Bennett's model of intercultural sensitivity adapted to serve this function. The groups are 1) ethnocentric organisations, 2) neutral attitude organisations and 3) ethnorelative organisations. The first group is characterised by negative attitude towards the local culture, and feeling of superiority of the NGO personnel. The organisations in the neutral attitude group admit the existence of the local culture, but give no importance to it. Finally, the ethnorelative organisations depart from the idea that the local culture is to be conserved and base their project to this ideology.

In the categorising of the organisations I have used the data given in the interviews. I asked the interviewees directly what is their relation to the traditional medicine. Furthermore,

what the interviewees speak about the cultural problems and especially how these have been taken into account, reveals what the attitude is.

Further, I will study if there is relation between the problems reported and the grouping. Comparing the reported culture related problems within the groups, I hope to find out whether the attitude towards the local culture makes a difference on the experience.

The second analysis measures the level of the local participation in the project, again, as the project co-ordinators have experienced it. For this, I will use the model designed by Rifkin (Rifkin et al. 1988). The model examines the level of the participation in need assessment, leadership, organisation, resource mobilisation and management. These indicators were chosen using a former study of over 100 participatory projects. Rather than the impact of participation, this model studies the process itself. Thus, it can be used to compare differences in participation at different times or by different people, not to study the impacts or results of a project. (Rifkin et al. 1988: 933)

The five factors each have a continuum of a scale of 1 to 5 in which the level of participation will be marked. The lowest level is 1, due to the assumption that there is always some action undertaken in the community concerning the people's health.

For the grading of the level of participation I use the questions designed by Rifkin et al. (1988) (See APPENDIX 3). To answer the questions, I have used the transcribed and categorised interviews. The categories helped me to follow the Rifkin's model.

I will explain the Rifkin's indicators and the grading system in more detail in the chapter 11, in which I measure the levels of participation.

Comparing this analysis with the cultural groups formed according to the Bennett's model, I want to examine the connection between the levels of community participation and the attitudes of the organisation personnel towards the local culture.

The direct citations from the interviews are written both in English. The original version can be found in the APPENDIX 4. The number in brackets () after the citation indicates the number of the original text in the appendix.

9.7 Presentation of the data of the empirical study and the problem of privacy protection in the presentation

Out of the ten interviews one was of such a bad quality that it has been disqualified from the data. The remaining nine interviews summed up to nearly 15 hours of recordings and more than 100 pages of transcribed text. In the following are the main characters of the projects included in the study. The interviews are numbered from 1 to 10 in a random order that has no relation to the order in which the interviews were made.

The people working in the organisations were mainly Bolivians, in both international and national NGOs. The financing of the projects came without exception from European or North-American donors and financing agencies.

In this table I present the main areas of intervention of the NGOs of this study. The numbers are the total numbers of organisation working with that particular issue.

PROJECT IN	**No.**	**WORKING WITH**	**No.**
Primary attention	8	**Community Participation in**	
Communal Health Promoter	7	Identify the problems	6
Child survival	4	Organise activities	5
Maternal health	4	Post project evaluation	5
Sexual and reproductive health	4	Chose the CHPs	4
No priority of area/integrated	4	**Culture aspect**	
Education in discussion groups	6	Gender issue	5
Education workshops	3	Co-op with local doctor	4
Education with families	2	Adequate material	3
Rural areas	6	Use the CHP as link	3
Semi urban or urban areas	3	Long-term personnel	3

I have tried to keep the individual organisations as anonymous as possible. However, the total anonymity is impossible because I analyse the organisation as a whole, and cannot separate the different categories in a way that it would make impossible to follow the individual stories. Thus, somebody familiar with the NGOs of this study might recognise what organisation is in question. The interviewees were conscious about this before the interviews and have agreed on the condition.

10 DATA ANALYSIS; THE CULTURAL ASPECTS OF THE HEALTH WORK

This chapter discusses the cultural issues of health work that the NGO personnel commented in the interviews. During the interviews, I was often told that the personnel of the NGO represents the same culture as the locals being that they are all Bolivians. Nevertheless, inside Bolivia there are dozens of cultural groups that do not share their values or traditions. Even those nurses who were originally from an Aymara or Quechua village but had gone to the town to study had been influenced by another culture.

Woelk (1992) explains how problems can occur when the people involved in the health work, say the NGO personnel and the local community, have different concepts of the issues dealt with. He goes even further and identifies different cultural groups within the community. The men, the women, the children, the elderly, they do not necessarily share their ideas or interests.

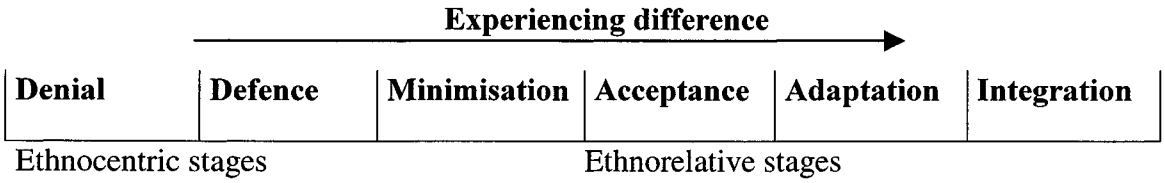
Thus, it is important to identify the target group well and plan the projects according to this. (op.cit.) Some interviewees mentioned that although the discussion group was meant for women, the participants were men. Later they learned that it was difficult for the women to walk long distances with small children or leave the house in the care of the oldest daughter. They changed the method, and instead of one discussion group in the central village, the groups were then organised in several villages where the women were able to arrive too.

This was a positive change but there were other comments that argued that instead of trying to organise the people in the villages, they rather take the future CHPs somewhere easier for the NGO. The courses are organised in a nearby town from where the CHPs return to their homes to organise the discussion groups on their own.

10.1 Division of the organisation according to Bennett's Developmental Model of Intercultural Sensitivity

Beforehand, I had formed three possible groups adapting the Bennett's (1998; 26) Developmental Model of Intercultural Sensitivity (DMIS) that is presented in the chapter 5.5 in more detail. Although Bennett developed the model to analyse individual persons, I see it as a useful guide to form the groups to analyse the organisations. Before going to the categorising of the organisations, I will present the three hypothetical groups.

Figure 1: Development of intercultural sensitivity (Bennett 1998; 26)



The hypothetical groups are defined as follows:

1) *Ethnocentric organisations*. The organisations that are in the two first stages of ethnocentrism. These organisations are characterised by either denial or ignorance of the local culture. They consider the local culture as negative, as an obstacle for development or have any other obviously negative connotation towards the target group, or their beliefs and traditions. The personnel consider themselves superior to the local people. Health work is done from the Western point of view.

2) *Neutral organisations*. The organisations from the centre of the scale. These organisations are characterised by admitting the existence of the local culture. Notwithstanding, they do not take it into consideration when planning the project. The traditional medicine does not gain importance. They either claim the Western medicine can be easily introduced because the local health culture is not different to the Western one, or they have the idea that as long as the traditions are kept aside there is no problem. The personnel consider themselves equal to the local

people. Health work is done from the educational point of view, with maybe some consideration to the local traditions.

3) *Ethnorelative organisations.* The organisations that are in the two last stages of ethnorelativism. In reality they are closer to the adaptation, as integration is extremely difficult to achieve (Bennett 1998; 29). The organisations see the local culture and traditions important and are able to deal with these. The personnel recognise themselves as "different" but not better in relation to the local people. Health work is done from the local perspective.

It resulted that there were no organisations that would belong to the group 1. Nevertheless, according to what the interviewees stated, I would place the doctors and the other personnel from the public health care system to this group. The lack of communication between the medical staff and the local people was seen as a big problem; the doctors were accused of seeing the traditions as something negative, as an obstacle for development.

> *"(...) you can notice that there is still resistance among the doctors, especially among the older ones. (...) There is still undermining towards the knowledge of the rural people. And even more towards the knowledge that the women have."*
> Organisation 7 (2)

The group 2 covered seven organisation, which I later divided into two sub-groups. The group 3 included the two remaining organisations. The next two chapters discuss the groups one by one.

10.2 The neutral attitude organisations

The interviewees of the organisations of the group "neutral attitude organisations" recognised the difference in the way of thinking, but treat it as something that does not need to be considered any further. One interviewee told me that those traditions that do not cause harm are acceptable and we should not worry too much about them.

> *"For example, a child with a cough, the only thing we say is that what they do traditionally, as long as it is not anything wild, keep doing it. Just that clean the nose every now and then, what is something many people do anyway, without taking a course."* Organisation 1 (3)

In total, there are seven organisations in this group. On one hand, the projects are based on the idea that the traditions are there, and they have no need to change them. On the other hand, these organisations do not include the traditional medicine in the programme.

Within this group, there were three organisations that take into account the traditions in order to make culturally acceptable Western medicine. I have taken these two into a separate observation, due to the slight difference on their approach towards the local traditions.

Subgroup 2.1: The neutral organisations that admit the "culture is out there"

The four organisations belonging to the subgroup 2.1 are the organisations 1, 3, 5 and 8. In the following there are some comments they have given about the local health culture.

> *"The question asked from the participants [of the course] and the reflection that is made with them is, what do they do, (...) what is their concept. And this is the reflection that is supposed to be done in the beginning of each education session, so that the educator could use this in the discussion. (...) The whole process they do, to respect what they do, but to show other methods they can do [of the Western medicine]"* Organisation 1 (4)

> *"The treatment in these institutions [public health centres] is not what we want. (...) thus we think we could solve this by capacitating and sensitization of the health centres... (...) the percentage of the mothers that prefer to consult a traditional healer because of the bad treatment in the health centres is high. So they seek the better, more familiar treatment with the healer."* Organisation 3 (5)

> *"What we try to make sure is that when they take modern medicine, this wouldn't interact negatively with the traditional medicine they take. But, for example, if somebody has to take, to say, a painkiller, and he wants to take it with a herbal drink, I have no problem with that."* Organisation 5 (6)

> *"They still use the traditional medicines, the herbs... and there are people who*

come for the Western medicine. And this is a qualitative change, that they are changing qualitatively." Organisation 8 (7)

These citations expose some of the important characters of the project of the group 2.1. There is a tendency to separate the Western and traditional medicine, it is an "either-or" situation. The NGO personnel do co-operate with the traditional medicine, even if the local people would use both ways of healing simultaneously.

The projects of the organisations in the subgroup 2.1 deal with education of the modern health concept. They accept that the local traditions exist, and see no reason to change this situation. A balance between the two cultures is the optimal situation. They recognise the differences between the Western and local way of thinking, nevertheless, the project does not allow the possibility for a more profound work with the traditions. The project is done with little consideration of the tradition and has a strong educational profile. The aim of the project is to implement the Western ideas to the target group.

The subgroup 2.2: The organisations that use the tradition to implement the Western medicine

The organisations 4, 7 and 10 belong to the subgroup 2.2. The organisations of this group try to search for culturally acceptable forms of the western medicine, instead of the plain implementation of this as such. These organisations have doctors who act in culturally acceptable manner and the educational part of the programmes departs from recognition of the traditions. Consequently, the local people are involved in the planning of the courses. The communal health promoters combine their knowledge of the Western medicine and traditions of the community. Although these organisations do not work directly with the traditional medicine, they take it into account much more than the organisations of the group 2.1.

The cultural aspect gains more importance for the project personnel too, they spoke a lot about the lack of respect towards the local traditions, beliefs and values. They also were

active advocates in the dialogue between the public healthcare system and the local people. Next some comments they said:

> *"Risking their health, the women prefer to be attended at home [for the childbirth]. So, (...) we have identified the traditional midwives. They are women from the same area, who can give advises to the woman, (...) advise her in the hygiene, which is important."* Organisation 4 (8)

> *" [the participatory method] is understood as respecting the traditions. (...) moreover, the methodology aims to reduce the gab between the community and the health services [through the sensitization]"* Organisation 7 (9)

> *"The educational process [of the modern medicine] is rather long, thus I believe that it is important to co-ordinate with the natural or traditional medicine."* Organisation 10 (10)

The organisations in this group work with the Western medicine while not ignoring the local traditions. In the discussion groups the local people learn about the modern methods, and adapt them in their own cultural context. The carrying idea remains in the implementation of the Western medicine to the community.

10.3 Group 3: Ethnorelative organisations

The last two organisations, numbers 6 and 9, belong to the ethnorelative group, group 3. They have adopted the traditional medicine as the main area of their work. The personnel of the organisation live among the target group, they learn the principles of the traditional medicine from the local people. The main idea of the project is to find a way the traditional healing can save human lives through developing the methods already used. The modern medicine is used only when it is necessary, culturally acceptable and physically possible.

Both organisations work in very faraway areas, where the distances are long and often a trip to hospital would be impossible. Both interviewees also admitted that this has been one of the facts why they have started to work with the traditional medicine.

> *"But I see it this way: when you live eight hours from the health post, you have*

> *to find a way to save. (...) So, I can not prohibit this* manteo[5] *because I do not have an alternative to give. And I know that women die in the hospital too, sometimes. Sometimes they die in Europe too. So, for me, it seems a bit unfair to say that they can not perform the* manteo*".* Organisation 6 (11)

> *So, they look at the coca leaves, and once he had looked at the leaves: "aa... Doñita" the healer says to the woman: "the coca tells me that I cannot cure you. Doña Rosalita [the nurse] will cure you." So we have succeeded in making the two work together."* Organisation 9 (12)

These organisations work with the traditional medicine, but at the same time recognising its limits. Nevertheless, they recognise the local culture, most of all, as a strength and a point of departure for the development.

10.4 Culturally related issues reported by the interviewees

It is not only the health concept that is different and causes difficulties. The interviewees reported many other cultural factors that influence their work. If we first look at the problems caused by the culture, the most commonly mentioned one was the machismo that affects in many ways. It causes problems in the participation of the women in the programmes.Besides, men's rejection of new ideas often leads to the women, who are interested in these, having to reject them too.

> *"Many of these problems of gender and equality are discussed in the groups (...) to give the women orientation in their rights and obligations and to increase their self respect. The same is being done with the men so that they could later change their behaviour and attitudes towards their wives" Organisation* 3 (13)

Working with only women has been noticed to be insufficient. Hence many organisations have adopted methods of working with both the wife and the husband. Nevertheless, there is some self-criticism involved with this aspect:

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[5] *Manteo is a method used to turn the foetus to the right position when it is to be born legs first. The mother is placed on a blanket which four men, one in each corner start to move throwing the mother up and down. In the medical circles this method is considered extremely harmful for both the mother and the baby but many have witnessed that it actually works. Often at least the mother is saved. As the interviewee said, if the mother is going to die anyway who are we to tell them not to try?*

> *"It is no novelty, [the work with the men] but often it does not reach the practise, but remains theoretical. We tend to write beautiful things, but it is a matter of making it happen"* Organisation 7. (14)

The project personnel do not always speak the local language, which is identified as a problem too. In most of the interviews, I was told that the nurses working with the organisation speak the local language, but the organisation staff, the managers of the programme, have problems in communicating directly with the people. It is not only the language that is not familiar, but often the contexts it represents are not clear either.

> *"(...) I will have to learn more Quechua, it is an obstacle in the communication not to be able to speak"* Organisation 6 (15)

A task for the education material is the high illiteracy rate in the rural areas of Bolivia. The material has to be in such a form that it can be understood with low or no reading skills. Furthermore, another part of the material construction is adapting it to the local context. The people and objects in the drawings or photos have to be similar to the local people:

> *"... the painter is from La Paz, who, in addition to be a young girl, never in her life has left La Paz. Well, she draw what ever she though to be a stove, and... [the reaction of the people was:] "ours is not like that!"* Organisation 1 (16)

Many of the project co-ordinators mentioned the problem of entering to the community, which was considered to be hard. The solutions for this had been many, the most effective being the direct communication with the local authorities.

> *"The first one is the priest, or the nun, the second one is the healer. Often the midwife is the authority. And the third one is the formal authority of the society. If you do not win these to your side, your project is in trouble"* Organisation 5. (17)

The other aspect of authorities, the role of the Community Health Promoters was also noted to be more complicated than expected. Some organisations had given up the training of the CHPs due to the difficulties such as high turnover of the CHPs who did not succeed to work for longer than a year or two. The other common problem with the promoters was that they did not gain the respect and trust of the local people needed in the task that included such delicate issues as family planning or childbirth.

> *"Within the project we make courses with the promoters, but we have also noted that the promoters are not often leaders in their community and they do not transmit [what they have learned], the idea was that they would transmit after the course, to have talks in their community. But as they are new, insecure, they do not transmit."* Organisation 6 (18)

Those organisations that had succeeded on the work with the CHPs had either looked for the natural, existing leaders like the traditional midwifes or worked together with the new promoters in workshops so that they would gain more experience before starting alone.

The strong feeling of community can cause difficulties when entering to the community but on the other hand it can be positive for the project. Although none of the interviewees mentioned this, those organisations that are working in high immigration areas have had difficulties because of the lack of sense of community:

> *"Thus it was to start working first with the idea of uniting these areas, to give them the feeling of community, the feeling of being a working team. It was a problem for us to form this participatory method (...) to start using it in a certain time. The time has doubled or tripled for us because we had to start from them getting to know each other."* Organisation 3. (19)

As they do not trust the strangers it seems that the method of discussion groups and workshops in the Andean cultural area requires that the participants can relate to each other. Thus the work in a group of people who do not feel this way is more complicated and requires longer time and flexible schedule.

The external factors have an influence on the possible achievements, as much as the internal ones. A health education project might be good, but there are not results if the local doctor does not treat the patients in a culturally acceptable manner. Thus, a lot depends on the medical staff of the area. Many organisations have tried working together with the doctors making these more sensitive for the local culture. Nevertheless, often this only offers a short time relief. The doctors working in the rural areas are usually graduated students doing the obligatory "year of province". When their time is done, the next doctor will start and the problem is there again.

Above has been a review of the cultural aspects the organisations brought out. It is notable that there are no directly positive statements of the local culture. Nobody said "*this works well, this is what helps us...*". In my opinion, this is not because of the lack of positive issues, nor because of the construction of the interview. Rather, it could be that as long as something is not a problem, it is not an issue. When I inquired the positive experiences in particular the interviewees could easily mention many.

Among the positive issues, the most important seemed to be the feeling when the person had noticed a change in the community during the programme. The general atmosphere had improved, and the simple fact of gaining the confidence of the local women was considered worth of all the work done. Moreover, one of the interviewees admires the unity of the Quechua couple. The example she gave is a fraction of her description of the childbirth practises in the rural areas.

> "*... the husband and wife are very united during the birth giving. This I consider to be of great importance. (...) this is were the husband really has his place, in assisting the woman to give birth. I also consider it valuable that the baby is born in a warm atmosphere, (...) they do it naturally*" Organisation 6 (20)

The problems related to the culture are many. Fortunately, the NGOs are aware of this, and do their best within the limits of the project to solve at least some of them. The nine organisations brought up the same cultural issues. I believe this is due to the fact that all the nine organisations belong to the more ethnorelative end of the scale, thus they react to similar cultural issues. Regardless, there was a difference in the way those had been experienced between the categories made according to Bennett's model. The organisations of the more ethnorelative end of the scale saw the cultural differences as a natural part of the encounter, whereas the other organisations understood these as difficulties.

The division made between the organisations is not saying whether one way is better than another. When the local traditions are recognised, even if not known perfectly, and they are respected, one has the keys for a meaningful co-operation.

The groups 2.1, 2.2 and 3 serve for the next part of the analysis. The categories are based on the attitude of how the organisation deals with the cultural differences and how do they organise their activities according to the culture. Next, I will study the levels of participation in the project of each organisation and see if there is any relation between the group division and the levels of participation.

11 DATA ANALYSIS; MEASURING THE LEVEL OF COMMUNITY PARTICIPATION

In this chapter, I will study the levels of community participation in each of the groups formed in the previous chapter. For the measurement, I will use the model designed by Rifkin (1988). The model is designed for a programme that works with community health promoters, but with a couple of minor changes in the ranking scale, I was able to adapt it for all the health programmes. Rifkin's guiding questions for detecting the level of community participation were useful as such. Rifkin (1988) points out herself that the model can be adapted to different kind of health programmes.

The model measures the levels of participation in five areas of programme, and the results indicate what the levels are at a certain moment of the project. The optimum would have been to be able to do the interview in two different moments of the project, or to get the opinion of the target groups to compare the results. Rifkin (1988) originally planned the model to compare the levels in different moments to measure if the levels grow while the project matures.

As I can not do the comparison, I will use the one-dimensional model to find any possible similarities within the groups formed in the previous chapter.

The analysis was done using the ranking scale and guide questions provided by Rifkin (1988) (See appendix 1 and 3). Obviously, these are my interpretations of the situation made according to what the interviewee has told me. Thus, the results can change if somebody else does the same evaluation, even with the same material. The guide questions Rifkin has made, as well as the ranking scale, are rather vague; when it depends of the evaluator to say whether something is "good" or "bad", it should be understood that it is a matter of opinion, to which somebody might disagree. Nevertheless, I have done my best to find the answers from what the interviewee has stated. In the case this has not been possible, I will mention that it is my opinion.

11.1 Ranking scale for community participation

In the following chapters, I will describe the projects of each organisation and give the grades for the community participation. The organisations are dealt with in the same groups as in the previous chapter.

The grading has been done using the ranking scale provided by Rifkin et al. (1988). To measure the level of participation, I have categorised the transcribed interviews using the method described by Eskola and Suoranta (1999; 154-155, 175- 182). The used categories were: programme, target group, working methods, problems, cultural issues, popular participation, evaluation of the work and key words. Under each tittle I collected the information of each organisation, and formed a profile of both each organisation and each tittle separetelly.

The categories helped me to follow the Rifkin's model (Rifkin et al. 1988) of measurement of levels of participation in the five areas, leadership, organisation, resource mobilisation, management and needs assessment.

The indicator *leadership* studies the Community Health Promoter's position within the community. In the grading I have taken into account the Community Health Promoter's possibilities and training for the leadership and his representation of the community,

whether he represents the whole community, or is obviously acting on behalf of only a part of this. Related to this, I also take into account the way the CHP has been chosen to his position: in the case the CHP has been chosen by the community, it gives a better grade than when the CHP has been chosen by the NGO or he has volunteered for the post on his own. In a community where the majority of the people take part in the choosing the promoter, it is more likely that the CHP functions as supposed. Considering these points, the grading follows these guidelines:

1. The CHP's role is limited to acting as a link between the community and the NGO and has no responsibilities on his own
2. The CHP has a bigger role, he is still a link between the community and the NGO, but has some small responsibilities on his own. Nevertheless, the supervision of his work is done by the NGO personnel only, there is no community based committee for this purpose
3. There is a community based committee that functions under the leadership of the CHP
4. There is an active community based committee that takes initiatives, but works under an independent CHP
5. The committee is independent, actively taking initiatives, and supervises the work of the CHP.

The indicator *organisation* studies the community health committees, and the way these work. Similarly to the previous indicator, it is studied whether the organisation was fund by the local people or by the NGO. In the first case, it is important to know if the community based organisation existed before the health programme, i.e. if the NGO was able to use existing community organisations in its work, or was it necessary to create new ones. In either case, I want to understand the way these organisations relate to other community based organisations like formal village leaders, labour unions or the church. This aspect is important in order to understand the real possibilities the organisation has to influence the local people. The independence of the organisation is measured by studying who has the

decision-making power in the organisation and how actively the organisation takes part to the activities within the health programme. The grading of the indicator *organisation* follows these guidelines:

1. The community based organisation is totally created and managed by the NGO. It has no influence on decision-making nor it has active role in other aspects of the health programme
2. The community health committee was created by the NGO, but later on it has gained some independence and has developed some activities on its own
3. The community health committee was created by the NGO, but later on become independent and takes an active role within the health programme
4. The community health committee was created by the NGO, but is now fully independent and is co-operating with other community based organisations
5. The community health committee was created using existing community organisations or it existed already before the programme started. It is active and taking the responsibility of the project.

Resource mobilisation measures the way the resources used in the health programme are contributed and managed. It is supposed that the more the local people contribute to the programme, whether it is direct financial help, labour or material contribution, the more committed they get with it. Thus, studying the depth of the community's role in *resource mobilisation* gives yet another idea of the interest of the local people towards the health programme. Nevertheless, it is not enough to study the contribution, but also the use of the resources needs to be studied. Who decides the use of the contributions, do the local people benefit directly from the contributions, and how are the benefits distributed between the local people? Answering to these questions the grading goes as follows:

1. The amount raised from the community is very small, the services of the health programme have no fee, and the community has no power over the use of the resources
2. The services within the health programme have small fees, but the community can not influence on how the money collected is being used.
3. The community contributes rather regularly to the programme in one way or another, nevertheless, it has no influence on the decision-making over the use of the resources

4. The community contributes to the health programme regularly and is involved in controlling the utilisation of these founds
5. A considerable part of the founds are raised by the community and it controls the money collected.

Management of the health programme can be arranged either by the NGO or by the community. When measuring the m*anagement* I study the role of both the NGO and the local people, and how are the tasks divided between these two partners. Especially I am interested on how much the beneficiaries can influence on the decision-making over the project in general. When the community's involvement with the project is low, practically the whole project is managed by the NGO personnel. Usually the Community Health Promoter is the first one of the local people to get involved with the management and later on the community health committee takes over the responsibility. Once again it is important to study how the management takes into account the different social groups within the community. The grading of the indicator *management* is the following:

1. The management of the project is done by the NGO personnel, the work of the CHP is supervised by the NGO personnel or the local health care staff
2. The CHP has some independence and influence on the management of the project. Moreover, the community has been involved to the decision-making. Nevertheless, the CHP still works under the supervision of the NGO personnel
3. The community health committee is active, but works under the CHP, who is still under the supervision of the NGO personnel.
4. The community health committee is active, working under an independent CHP
5. The community health committee is active and independent, also in the supervision of the work of the CHP

Finally, the local people's participation in *needs assessment* is measured. For this indicator I study how the needs of the community are detected, who is in charge of this, and how much the identification of the *local* needs influences on the health programme. The wider range of the community has been involved in the diagnosis of the local health need, the higher the grade is. Nevertheless, I consider it important to study also *how* the local people

were involved in the diagnosis, were they active doers in the project, or were they only interviewed by the NGO personnel. Similarly, the diagnosis should take into account other factors than simple health problems. For example, the social problems or the economic situation in the community should be monitored for accurate health programme. Taking into account these factors, the grading for *needs assessment* goes according to these guidelines:

1. The needs assessment has been imposed by the NGO or health care personnel, and follows the medical point of view, or the health programme follows some pre-planned programme
2. There is some consideration for the local interests, but the medical point of view dominates. The programme has strongly educational profile
3. The CHP acts as an active representative of his community, and takes part on needs assessment. The programme is designed taking this information into account
4. The community health committee assesses the needs of the community. The programme is designed taking this information into account
5. A majority of the community is directly involved on the needs assessment and the programme is designed based on this information.

The projects included in this study, although all health projects, had very different characters. Thus, the grading of each project follows the guidelines given above, but I will still explain the projects in more detail in the following chapters. The levels of participation are studied in each cultural group separately, including both internal analysis of the group and afterwards, a comparison between the groups.

11.2 Levels of participation; neutral attitude organisations 2.1

The organisations 1, 3, 5 and 8 belong to the first group of the neutral attitude organisation. The project of the organisation 1 was on the last part of the planning phase, thus, there was no work done in the field yet. Thus, there is no participation measurement for the organisation 1.

The organisations 3 and 8 work in semi-urban areas close to the bigger cities La Paz and Potosí. These areas are characterised by heavy immigration from the countryside, extreme poverty and social insecurity. The organisation 5 has this particular project included in this study mainly in the rural Altiplano, but also on the outskirts of Potosí. The projects include providing the healthcare services either at a small clinic, or as in the case of the organisation 5, using a mobile health unit, and giving health education. Within the projects, there have been some discussion and education meetings but the main focus remains on the medical attention. The duration of the projects varies from the 3-4 years of the organisations 3 and 5 to more than a decade in the case of the organisation 8.

The organisation 3 has no own clinics, but buys the services from either private clinics or the public health centres. The patient has to pay for the services himself, but the fees are very low. The NGO concentrates on giving health education and intends to rise the awareness of the local people, especially women, on topic related to health and social issues. The main focus of the programme is on Child Survival Programme.

In practise, the CHPs gather the local people for reunions with brochures and house calls. The "bush radio" is regarded as one of the most important manners of contacting new people. In the reunions the NGO personnel directs the discussion, with some occasional help from the CHPs. The idea of these reunions is to give the people information on health issues and to direct the patients to the clinics that co-operate with the NGO. The NGO policy is to react rather negatively towards the traditional healing methods, and as a part of the discussions the local people are being told about the possible dangers of the traditional medicine. Nevertheless, they are not told to abandon their traditions, just to take precautions when dealing with *curanderos.* Nowadays the NGO is working also with men, there are discussion groups that are meant for men only. According to the interviewee, there will be no progress, unless this kind of work is done with the male population too.

The personnel of the NGO is mainly from the city, but the CHPs are local people.

The organisation 5 works in a large geographical area, thus the NGO has developed a mobile health unit that circulates the villages. The personnel spends 20 days on the road, to return to the city for a 10 days break and then returns to the countryside. The main focus of the programme is on reproductive health.

Meanwhile the NGO personnel is not present in the village, the CHP is supposed to detect the pregnant women and those who are seriously ill. When the health unit arrives, they first treat the patients and then visit the houses of the pregnant women. They talk to the couple and ask whether they intend to attend to the hospital for the birth giving. If not, who is going to help the mother when the baby is born. The medical staff then give advises for the future mother, father and the person who is going to help with the birth giving, usually the girl's mother, mother-in-law or a mid-wife. After this session, the family is given a "clean birth" package, that includes everything necessary for a hygienic birth giving. The package is free for the family. The mother is asked to attend the health unit regularly for control.

Occasional discussion evenings are organised by the NGO, and the topics in these meetings cover mainly issues related to reproductive health. The local people have also participated on developing material for education.

The personnel of the NGO is from the same cultural background as the local people, i.e. they are Aymaras and Quechuas. Nevertheless, they are born in the cities, not in the same geographical areas where the project is done. The CHPs are local people.

The organisation 8 works mainly with primary attention. The NGO has own clinics in the area, but also uses the services of public institutions for more demanding medical care, i.e. in the need of hospitalisation. Some health education is given in discussion groups. The programme has no priority in any specific area of health care. Simultaneously with the health care programme they have other programmes that focus on rising the awareness of the local people in social issues. These programmes have developed for example women's groups that intend to create possibilities for women to earn some money.

The NGO personnel is originally from the same areas where they work.

In the following, I will present the evaluation of the level of the community participation by each indicator. In the end of this chapter, I will also provide a figure of these in a graphic form.

Leadership

In the programme of the organisation 3, the Community Health Promoters were chosen by the organisation. They are working under the supervision of the NGO personnel and have no influence on the decision-making, which is responsibility of the NGO field workers. The work of the promoters consists of house-to-house visits to inform the people about the project and helping the NGO personnel in the reunions and workshops. According to the interviewee, the CHPs represent the whole society independently from the social status of the people. The CHPs do not have a role of a leader, but rather, they act as a link between the organisation personnel and the community. Therefore, they have no role that would allow them to function for the benefit of the community on their own.

Similar situation can be observed in the organisations 5 and 8, the CHPs are meant to help the NGO personnel, rather than take an active position themselves. In the case of the organisation 8, the role of the CHPs is even smaller. Instead, the NGO personnel are in contact with the local people directly. The organisation 5 uses the CHPs to inform the local people about the schedule of the mobile health unit and to gain information of the community. For example, the CHPs are supposed to detect the pregnant women and present them to the NGO personnel.

The interviewees talk very little about the official leaders in the community. However, one of them mentions that after their project had started the official leaders have changed their attitudes towards the community for better, and that there has been an improvement in the

general conscious over the political issues in the community. Other mentions that there have been some problems because the official leaders of the community would like to include the politics into the health projects and manage the programme according to the political ideology. However, he continues, it is fortunately a problem with only a few people.

Based on the information above, I have given the organisation 3 the grade 2 in *leadership*. I see the current situation of leadership being improved little by little but the interviewee reveals some dissatisfaction of the official circumstances. The role of the CHPs is not aimed for leadership anyhow, although it is significant that the promoters are supposed to work equally with all the people living in their area. As can be observed from the evaluation of the *organisation* in the next chapter, the women's groups have developed further than the CHP in independence.

Similarly, the organisation 5 receives the grade 2, whereas the organisation 8 receives a 1. The latter has no significant role for the CHP but they have searched other means of connecting to the community. The organisation 5 is working with the CHPs and these have some role in the actual work done. Nevertheless, I do not see them having any independence from the NGO.

In summary, the role of the Community Health Promoter in the projects of the organisations 3, 5 and 8 is small and limited to acting as a link between the NGO personnel and the local people, with an additional small task of an informant. Nevertheless, I got an impression that it is important for the organisations that the CHPs represent the whole community despite the religious, political or economical backgrounds. Both the organisation 3 and 5 are still working on the development of the CHP, so in the future these are supposed to gain more independence. On the contrary, the organisation 8, after years of experience of working in the same area, has decided to use the CHPs only when necessary. According to Rifkin's hypothesis the role of the CHP should grow the longer the project goes on. Regardless, the case of the organisation 8 shows the opposite. The difference to

the other programmes is obviously that the NGO focuses the work within the health programme to the medical attention, instead of awareness rising and education.

Organisation

The organisation 3 had used some of the existing community organisations such as school boards, working place committees, and when possible, also the official community organisations such as neighbourhood committees. The majority of the women's discussion groups were formed by the external organisation, but they had become rather independent along the time. Some of these groups had reached the point when they were able to work without the supervision of the NGO and had been able to form contacts with other organisations.

The organisation 5 had created mothers' groups that gather when the NGO personnel arrive to the community. The women work together with the NGO organising some small activities like cooking or handcraft courses. Nevertheless, the main purpose of these groups is to ease the work of the NGO personnel and the groups do not have any decision-making possibilities within the health project.

Similarly, the organisation 8 uses the mothers' groups in order to gather the women for the education meetings. The organisation also works with men, and uses the labour organisations in order to get the men together. The idea of these meetings is educational, and the groups have no influence on the decision-making.

In the case of the organisation 3, the evolution of the groups had allowed the decision-making role of them to increase. The interviewee stated that the groups take part on the planning of the new phases of the projects, and most importantly, they can now make their own projects. Even the interviewee mentioned that there were groups that had not reached this far in the expected evolution, she did not talk more about those groups.

The attitude towards health and health project of these groups had changed along the time. The interviewee mentions that in the beginning the women wanted to do something more productive than "chat" about their body, but later they have understood the importance of health education. Nevertheless, the projects the groups have organised by themselves have been related to other issues than health.

I have given the grade 4 for the indicator *organisation* for the organisation 3, because I see that the community organisations are rather independent and they work to improve the situation of the community as whole. Even thought the activities are aimed mainly to improve the condition of the women, it can be seen as an indirect improvement of the whole community as the women are the ones who are in charge of the education of the children and the social well being of the family.

On the other hand, the organisations 5 and 8 are not using the community organisation for the same purposes as the organisation 3, but rather the role of the groups is to get people together for the education sessions. The organisation 5 has used the women's groups to develop some educational material and in general, the groups of the organisation 5 are more active than the ones of the organisation 8. Thus, I give the grades 2 and 1, respectively, for the indicator *organisation.*

Resource mobilisation

The indicator *resource mobilisation* describes the level of the community's participation in the material part of the projects. In practise this can be either paying for the services, looking for external financing, collecting the needed money from the community or providing material or physical help to the NGO. Furthermore, this indicator shows how much power the community has over the use of the resources of the project.

The organisations 3 and 8 collect small fees for the services they provide, but the organisation 5 donates the materials and services. The materials are donated under one

condition, though. The couples who are to be given the clean birth – package have to take part on the education and agree to go for maternity health check-ups.

As can be seen, the community's role in the resource acquisition is almost non-existing. Also, related to the previous indicator *organisation*, and the low level of community participation in the management of the projects, the community has no power over the use of the resources of the project. Thus, organisations 3 and 8 both get the grade 2 due to the fees collected and organisation 5 gets the grade 1 for *resource mobilisation*.

Management

Management of all the three organisations of this group is done by the external organisation. The organisations 3 and 5 have organised some community groups that take part in some activities, for example planning educational material, but the organisation 8 has not worked with this aspect at all. The role of the beneficiaries, is limited to receiving services or education. The management of these projects is thus vertical, although one of the interviewee said the opposite. He claimed that the needs of the community are taken into account in the project planning, which makes the management horizontal, from equal partners to other.

However, I do not share this point of view because I see an interest conflict there. In this case the community does not participate in the management of the project at all, but has a role of a receiver, while the others decide what is best for their needs. For this reason, I have given the three organisations low grades in *management*. The organisations 3 and 5 get a grade 2 because the groups have taken part to some activities, but the organisation 8 receives the grade 1 due to the lack of community's possibilities to influence on the management of the project.

Needs assessment

The last indicator represents the way the project takes into a consideration the community's own opinion about its needs. Although the community has no direct role in the decision-making, or in the planning of the project, the NGO personnel can still consider the

community's ideas when making the decisions. The interviewees of this group underlined that all their work is based on the community's needs. Nevertheless, the medical point of view dominates all the programmes. The project directors tend to consider their knowledge and experience higher to the villagers' ideas about health related issues. The three programmes concentrate on education and providing healthcare services, which in practise involves very little community participation.

The interest and needs of the community are verified by surveys and, especially in the case of the organisation 3, in the discussion groups. However, under the surface, the projects are all based on a readymade plan which is based on the previous experience and education of the project personnel, independently from the specific target area needs. The interviewees high-lighted the importance of their previous experience and education in the planning phase, leaving little space for the meaning of the local people's ideas about what they need.

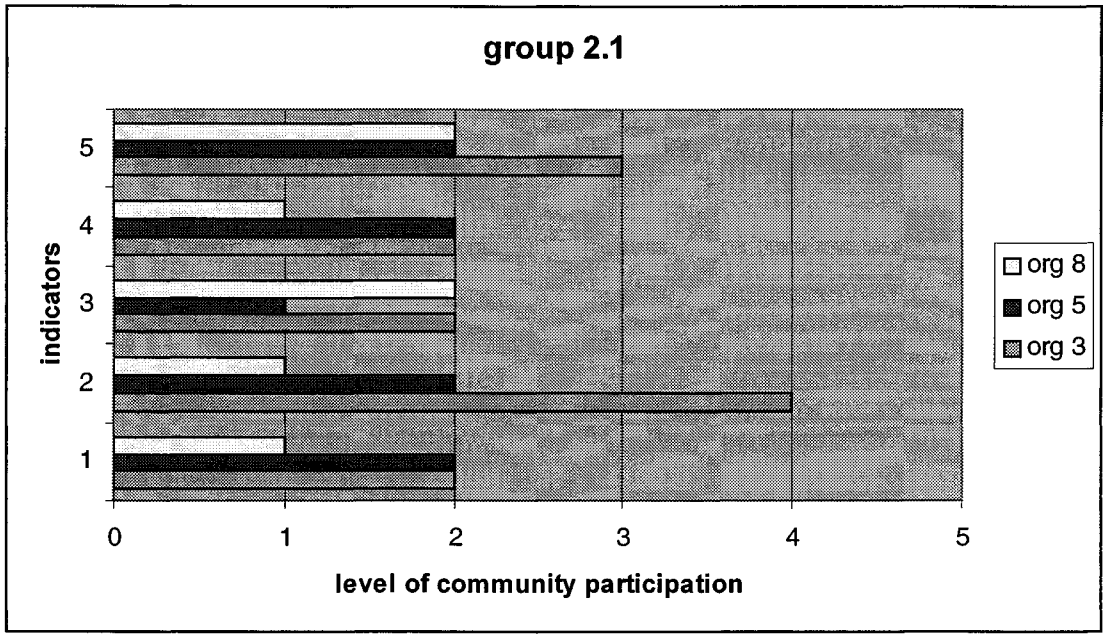
The organisation 3 gets the grade 3, and the two other organisations get the grade 2 for the indicator *needs assessment*. The project of the organisation 3 includes some community participation on the planning phase of the projects, thus offering better chances for the local people to be heard.

In addition, there was a remarkably low attempt to adjust the programmes to the local social and economical conditions. The lack of social security in general provokes that the people are more interested on other activities than their health and discussion groups. Like the interviewees mentioned, it seems to be difficult to work with health when all the more visible needs are still to be satisfied. I would like to bring this up here because I see this as one of the most important problems faced in the health work in the Bolivian Andes, to which I will return later.

The figure below represents the levels of community participation of the organisations 3, 5 and 8 as they have been introduced in the previous chapters

INDICATORS

1) Leadership
2) Organisation
3) Resource mobilisation
4) Management
5) Needs assessment



11.3 Levels of participation; neutral attitude organisations 2.2

The sub-group 2.2 differs from the sub-group 2.1 in that the projects are directly more involved with the community. The projects of the organisations 4, 7 and 10 are more community orientated; the idea of the participation of the local people is included in the programme plan.

The organisation 4 works in the urban areas of Potosí, where poverty and immigration cause several problems. The organisations 7 and 10 work in the rural areas of the departments of Potosí, La Paz, Oruro and Santa Cruz. The three organisations work with a long term plan: the organisations 4 and 10 have both over ten years plans and the organisation 7 bases the long-term planning on the independent work of the Health Promoters after the retirement of the NGO.

The organisation 7 has developed the whole project from the beginning with the community. In other words, the local women and mid-wives have designed the educational material and discussed which topics should be included and in which manner. Originally, the project and the material have been developed in one place. Nevertheless, nowadays the project has been published in two books that are used as handbooks for local people in similar projects elsewhere. According to the interviewee, the project gives different kind of results in different cultural surroundings, but has worked fine in many departments of Bolivia. Within the project the NGO personnel have organised women's groups, and aim to educate the local people in health related issues co-operating closely with the local mid-wives. The women's group start their work by identifying the problems in the area. Next they look for the possible solutions together with the NGO personnel, and finally, implement the new ideas. The last stage of the project cycle, the evaluation, is also done together with the local women.

The whole programme departs from the idea that the local culture should be respected. The NGO also works with the local medical staff in order to make them more aware of the value of the local culture.

The organisations 4 and 10 include in their projects the idea of community empowerment, thus the projects cover several areas. These are education for community participation, participatory planning and management, and reading and writing classes. The NGOs recognise these areas as vital instruments for better health.

In the project of the organisation 4, the local people have chosen the women to be trained as CHPs. These CHPs and the traditional mid-wives who have also received education, pass the learned to the other local women in discussion groups and work shops they organise. The NGO personnel and the discussion groups design the future projects together. Regardless, the NGO personnel have the ultimate decision-making power for the project planning and old projects and general health care statistics are used to guide the future plans. The traditional healing is considered important. Hence, the NGO works with the idea that the local people, and especially the women, have the right to be respected as they are, without changing their culture. Therefore, the NGO has worked with the local public health care staff and the municipality, trying to change the prevailing negative attitude towards the traditions. The NGO runs a small clinic with the equipment for primary attention, but when the mothers did not want to attend a hospital, they have also attended births with complications.

Together with the clinic works a small kindergarten and a bakery, both fruits of the women's programmes.

The organisation 10 has worked in the same area for several years. The planning of the programme has been done together with the local people. The NGO has formed women's discussion groups about health related issues and developing new programmes. These groups are independent and initiative in many areas, and they also play an important role in planning and implementing of the health programme. Notwithstanding, the NGO remains in the charge of the programme management.

The NGO 10 works together with the public health care system in the area, educating the nurses and providing extra doctors for the clinics. The two principles of the programme are to give health education to the local people and improve the quality of the work of the local health care staff. The Community Health Promoters are trained to cure simple health problems and advise the people to attend to the clinics when necessary. The role of the promoter is recognised very high, especially in the most remote communities, from where the access to the clinics is difficult.

Yet another aspect that the interviewee states as an important part of the programme, is that the personnel of the programme live in the village, thus they get closer to the local people and their culture.

Leadership

Compared to the previous sub-group, the organisations of this group have done more work with the Community Health Promoter. All three organisations have trained CHPs that have gained some levels of autonomy and have a bigger role in the projects. The idea of the organisations is that the CHPs can independently continue the work after the organisation retires, thus they are trained from the beginning to take more responsibility.

At the time of the interviews, the organisation 7 had closed the project, but unfortunately there was no follow-up on how the independent work had started after the NGO had left.

The CHPs of these organisations represent the poorest and most marginalised people in the community. They were well trained to treat everybody equal. The choosing and changing the promoters works mainly well and the community takes the responsibility on choosing the new promoters. Thus, the problem of a high drop-out rate of the promoters is diminished as far as possible.

The CHP- scheme seems to fail in the lack of charismatic persons who would seriously gain the respect and trust of the whole community. The other problem is the short duration of the promoters. According to the organisation 4, the drop-out rate of the promoters is close to 70% which complicates the long-term planning and the passing of the management of the project to the promoters.

To reply to this difficulty the organisations 7 and 10 have created committees that are prepared to take over the leadership of the projects. These committees are groups of local people who have been selected by the locals and been trained by the NGO in community participation and management. The NGOs believe that in the long run the committees will

function better than the individual CHPs. The project of the organisation 7 was left on the hands of these committees lead by the CHPs. Similarly, the organisation 10 is passing more responsibility to these committees in the planning, implementation and evaluation of the project.

The organisation 4 has created a network of promoters. They gather together regularly and the network seems to keep the promoters active. According to the interviewee they have not had very high drop out rate of the CHPs, which she believes is due to the good co-operation between all the promoters and the NGO personnel.

I have given the organisation 4 the grade 2 for the indicator "leadership", while the organisations 7 and 10 receive the grade 3. The lower grade of the first one owns to the lack of a community committee that might guarantee a better representation of the whole community and bond a wider group to the programme.

In summary, it can be said that the three organisations have worked with the aspect of leadership. In all these three cases the CHPs have got responsibilities and act as something more than a simple link between the NGO and the community. As was already mentioned, there are still problems to be solved before the CHPs can be recognised as leaders. The organisation 7 had already closed their project, but the two others continue working with also this issue.

Organisation

As was mentioned, the organisations 7 and 10 had created local committees that are used also for managerial purposes. In addition, all three organisations 4, 7 and 10 had worked with women's groups. The NGOs 4 and 7 organised these groups, but the organisation 10, used existing community organisations.

In the case of the organisation 4, the community organisations are organised for educational purposes and to provide information to the NGO personnel for the project planning. These women's discussion groups have only a little independence and they are managed by the

CHP, who works under the supervision of the NGO personnel. The CHP gathers the reunions, and occasionally, they might develop some events or activities without the NGO's supervision.

The organisation 7 has formed the women's groups, but these are active within all the project phases. The local women are consulted in order to make culturally acceptable projects that respond to the local needs. Nevertheless, the NGO personnel remains in the charge of the activities. Any new project starts by organising the local women together, they can then decide what they want or need to learn within the project framework. The NGO then provides the education. The evaluation of the projects happens both internally and externally. The local women evaluate the new situation from they point of view, but the only evaluation that counts for the financing agents is the one made by external evaluators.

The organisation 10 started working with existing community organisations. In the beginning these organisations were working under the NGO supervision, but nowadays they are gaining more independence and power. These community based groups have been trained in participatory planning and evaluation, and they are supposed to take over the project when the time is ready. Although the NGO remains in charge of the programme, all the phases are gone through with the community based organisations first. In fact, most of the new ideas nowadays arise from these groups.

Thus, all three NGOs of this group have managed to create active community based groups. The organisation 4 is not focusing on giving the women's group more independence or power regarding the decision-making. Rather, the NGO is supposed to remain in the area, which means that there is no need to move the responsibility for the community.

Due to the activities of the community based organisations the organisation 4 could receive a higher grade for *organisation*, but the lack of independence of these groups takes the grade down to a 2. On the other hand, the organisations 7 and 10 receive both the grade 3 on *organisation* for the active role of the community based organisations in the projects, although, up to a certain point, they are still working under the supervision of the NGO.

Resource mobilisation

The organisation 4 takes small fees for the services, and the medicine is sold on non-profit bases. The interviewee stated that although the fees for the services are small, the poorest people have difficulties on paying. Nevertheless, she considers these fees important, because the people are used to pay for the traditional healers too, "even if it is by potatoes", she says. Thus, to maintain the tradition of paying, which is a form of showing the respect in the Quechua culture, the fees are collected. The money that is collected with the fees is used to buy new medicine. In general, the financing of the project depends on external agents. The local people have contributed more on the physical resources, they have helped to build the health centre, both by providing some materials and by working on the construction.

The organisation 7 has placed small fees for the services of the CHP, and the medicine is sold on non-profit bases. The CHP uses the money he earns to buy new medicine and other equipment he might need. While the programme was still run by the NGO, it was responsible of all the financing. Now that the official programme is over, the CHPs are responsible of the budget they need. In the evaluation, I have taken into account the situation during the official programme, and the fact that nowadays the CHP, even responsible of the budget, still have not much influence on how the money is used. What is left of the budget is basically the maintenance of the equipment of the CHP.

The organisation 10 works a lot more with the community and the local people also have a bigger role in the financing of the programme. The people either provide the money, material or labour for the projects. When this is not enough, they have to find the external financing, obviously with the help of the NGO personnel. The community committees are also involved when the budget for the following year is been made.

The organisations 4 and 7 get the grade 2 for *resource mobilisation* due to the small involvement of the local people in both, collecting and managing the resources. The

organisation 10 receives the grade 4 for the people are well involved in all the phases of the resource mobilisation, while the NGO takes a small, guiding role.

Management

The management in the programme of the organisation 4 is a responsibility of the NGO personnel. This has been justified with the fact that the NGO is in the area permanently, instead of a temporary programme. The ideas and opinions of the local people are heard and taken into account, but there are no locals directly involved with the decision-making. The CHPs run some parts of the projects on they own, thus, the organisation 4 gets the grade 2 for the *management.*

In the case of the organisation 7, this indicator is complicated. If I consider the current situation, the NGO has left the area, and the CHPs have taken over the responsibility of the project and of the management of the Community Health Committee, that would give a higher grade. Nevertheless, there is no evidence whether the project is still going on. Thus, I have decided, as with the other indicators, to use the situation before closing the official project. Similarly to the previous, the organisation 7 had the responsibility of the management of the projects. The CHPs had some activities they run independently, and the community's voice was heard before the decision-making. The management was rather vertical, thus, the grade 2 for this indicator.

The management of the project of the organisation 10 is divided between the beneficiaries and the NGO personnel. The first has the role of an advisor, and the NGO makes the decisions accordingly. The NGO remains as the highest power, and also supervises the CHPs. In the future the NGO plans to give up the management for the local people, but that is in the future. At the moment the indicator *management* gets the grade 3.

Needs assessment

The organisation 4 uses questionnaires and discussion groups to detect the local health problems and the topics the people would like to deal with. Nevertheless, in the health programme, the medical point of view dominates and the health programme still has an

educational approach. The local people's participation in the needs assessment is limited to answering the questions made.

It is difficult to say, whether the grade should be higher, because there is a good amount of discussion with the local people about the needs. The interviewee mentioned that they (the NGO personnel) already know what the local people need, they know what is wrong in the area. Now, it is a question of interpretation how one understands this. Do the NGO personnel know the local situation because they have been with the local people or do they know it because of they education? I have come to the conclusion that the grade 2 is the accurate due to the facts said above.

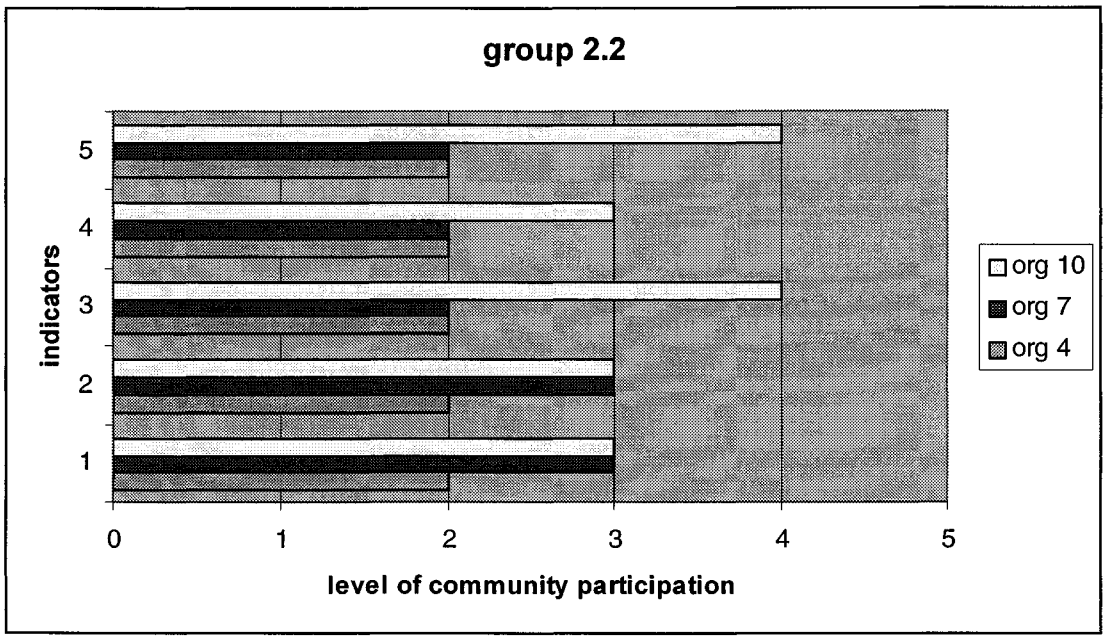
The same difficulty comes again with the organisation 7. The programme they had is a pre-planned programme for reproductive health care in the countryside. It has been planned with people from the countryside, midwifes, healers and mothers, and is adjustable to each village and its conditions. Thus, this indicator could receive a very high grade. Nevertheless, is the pre-planned programme really a product of the local people? On the whole, is it possible to make that *local* programmes? Once again, it is a question of interpretation, but in my opinion, I believe that for a higher grade the local people should have been more involved in the needs assessment, thus the grade 2.

With the organisation 10 there is no such problem, fortunately. The community health committee is actively involved in the needs assessment, just like in the other phases of the projects too. In fact, most of the ideas are given by the local people. But it has not always been this way, the two first years of the programme, the NGO trained the people in participatory planning and management, allowing now a larger participation. The grade for the indicator *needs assessment* is 4.

Figure of the levels of community participation of the group 2.2

INDICATORS

1) Leadership
2) Organisation
3) Resource mobilisation
4) Management
5) Needs assessment



In general, the organisations in this group are working with the community more than the NGOs in the group 2.1. The community is involved in all the phases of the project, at least to a certain extend. In practise, this difference means better adaptation of the projects to the local conditions by discussing these issues with the community and allocating some of the decision making to the local people. Furthermore, the community organisation and leadership issues have been dealt more efficiently than in the group 2.1. Notwithstanding, there are still many problems with the leadership.

11.4 Levels of participation; ethnorelative organisations, group 3

The organisations 6 and 9 base the health programme on the idea that the traditional ways of healing should be conserved and developed. The modern, Western medicine can be used when the traditional ways fail to cure. The interviewees highlighted the importance of recognition of the limits of the traditional healing, but stated that the old culture must be respected. Neither of the organisations has defined a priority, but work in all the areas of health care, giving the major emphasis on the most common decease, like diarrhoeas and respiratory illnesses.

The organisations work in a rural areas in the south of Bolivia. The access to the nearest hospital is difficult; from many communities the people need to walk hours to even reach the nearest road. This physical distance added to the cultural distance from the Western medicine means that people do not easily attend to a doctor.

The organisation 6 has started the programme in this area several years ago with education and agriculture projects, and finally, when other conditions allowed, the health project was included in the scheme. The Community Health Promoters have their own medicine-kit, of which one part consists of traditional medicine, i.e. herbs, and the other part of the western medicine. The CHPs are trained to cure simple cases and advice the patients to attend the clinics when necessary.

The workshops and discussion evenings that the CHPs organise together with the NGO personnel, deal with traditional and new ways of healing. The local people discuss the possibilities and limits of the old methods, and the possibilities and risks of the new medicine.

Together with the other projects, the health project has started the preparation of traditional medicines, that are also sold to other areas in Bolivia.

As an important part of the project, the local health care staff is given additional training. They are trained in medical issues, but also in managerial and cultural topics. The NGO personnel is hoping that after they retire from the area, the medical staff will assist on the management and continuity of the project.

The organisation 9 has a somewhat different approach to the programme. It all started in the end of the 1980s, when a long dry season left the poor farmers even worse. They gathered together and asked help from a group of people they knew from other occasions. This group, the founders of the NGO, started the work in the area. First it was emergency aid financed from foreign countries, but the emphasis slowly moved towards prevention of future emergencies. The main areas covered by the NGO have been education, agriculture and health.

From the very beginning the local people have been involved in the project, and meanwhile their experience in management grew, they took over the whole project. At the time of the interview, the local people had taken over the projects, but the NGO personnel remained in the area as a kind of moral back-up.

The health programme includes primary attention in two clinics where the NGO has provided two nurses. Nowadays the salary of the nurses is paid by the municipality. Community Health Promoters are an important part of the programme ,because of the long distances and difficult access to many communities. The CHPs have their medical-kit, that consists of both traditional and Western medicine. The CHPs are trained to cure the simple cases and direct the patients to the clinics when necessary. Both, the NGO personnel and the CHPs co-operate with the local *curanderos.*

The CHPs organise discussion groups and workshops where health related issues are dealt with. Some of the workshops have worked with cultivating herbs and preparing traditional medicine.

The core idea of the programme lies on the ideology of empowerment of the rural people, thus the focus of the activities has for a long been on this aspect.

Leadership

Despite the many attempts, the Community Health Promoter project has not worked as supposed for the organisation 6. The interviewee stated that the CHPs suffer lack of confidence and respect, and the drop-out of the promoters is too frequent for a successful project. She admits that the promoters are often too young and unknown in their communities, they are usually volunteers that are not chosen by the community. She also mentions that a small salary might help to keep the CHPs for longer, but as they do not earn anything, they loose the interest too easily.

The CHPs work as assistants in the reunions and workshops, and those who have the sufficient training can manage the medicine-kit and attend patients. Out of the 36 communities the NGO works in, in only 8 there are fully independent CHPs. In the rest of the communities the training of the promoters is still under work. Due to these 28 communities where the work is still to be done, I have given the organisation 6 the grade 2 for the indicator *leadership.* The fact is, that the majority of the CHPs have a small role and not much independence from the NGO.

The organisation 9 has trained the CHPs to work independently, and they are leaders of the community health committees. The responsibilities of the CHPs include the management of the medicine-kit and treatment of patients with minor health problems. They also gather the people for the reunions and have the role of an educator in the discussion groups.

I have given the grade 4 for the indicator *leadership* for the organisation 9. The CHP represents the whole community regardless the social interests, and he is leading the Community Health Committee. The CHP holds an independent position of the NGO, due to the retirement of the organisation. Unlike in the case of the organisation 7, in which it was not possible to say whether the project has continued after the retirement of the NGO, in

this case the NGO personnel still remains in the area, thus providing the information needed for the evaluation of the current situation.

Organisation

The organisation 6 begun the work in the area with other projects than health. Within these projects they helped to form community based organisations, that were later used for the purposes of the health programme. The organisations have become more independent from the NGO and are actively taking part in the different phases of the project. Nevertheless, the committees are not fully independent, but require help from the NGO, thus, the grade 3 for the indicator *organisation.*

The organisation 10 used community based organisations created by the local people. It did not come clear in the interview whether these organisations existed before the programme started, but during the years they have become fully independent from the NGO. The Community Health Committees have taken over the responsibilities of the project. Thus, I have given the grade 5 for the indicator *organisation.*

Resource mobilisation

The organisation 6 receives the financing of the programme from an external financier. Nevertheless, the local people contribute to the programme what they can: there are small fees for the services, some projects are financed by selling part of the products produced within the project, and all the physical and material resources are from the local people. Moreover, the community is involved on the planning of the budget, and there is an emphasis to move all the responsibility of the budget to the local people. At this moment, the grade for *resource mobilisation* is 4 due to the strong presence of the NGO personnel in the decision-making.

The organisation 9 has moved all the responsibility of the budget to the local Health Committees some years ago. The local people are supposed to contribute to the programme when necessary, but at this point of the project, the financing of the projects is intended to be maintained with the idea that everything earned within the project is used for the future

of the project. This means the payments for the CHPs and the selling of the herbal medicine produced in the community. The grade for the indicator *resource mobilisation* is thus 5.

Management

Although the community is involved in the decision-making with the organisation 6, and the community health committee is actively taking part in all the phases of the projects, the management of the programme remains responsibility of the NGO personnel. The local people are involved in the process, but their role is more of an advisor of the local situation. The community health committee has organised some events without the NGO. I have given the organisation the grade 3 for the indicator m*anagement.*

The organisation 9 has given the management of the programme to the community health committees. Nevertheless, these are working under the CHP, which means that there is a bigger risk that the management favours one social group over the others. If the CHP was under the supervision of the committee, the risk would be smaller and the grade would be higher. In this case, the grade for m*anagement* is 4.

Needs assessment

Both of the organisations have involved the community health committees in the process of needs assessment. Self-evaluation of the situation and prioritising the problems is done with the committees. Both organisations fail in bringing the whole community to this process, which might be close to impossible. The future projects are done according to the evaluations and priorities of the local people.

In the case of the organisation 6 this indicator was not that clear, because there are some aspects that would take the grade down. For example, the decision to teach about *chacas*, which is a very common illness in the area, but the local people do no recognise it as a problem. Is this a sign of not taking into account the local values, and having a medical point of view? I have decided that as the majority of the programme has been designed according to the opinion of the local people, we can put aside one or two exceptions.

Both organisations receive a grade 4 for the indicator *needs assessment.*

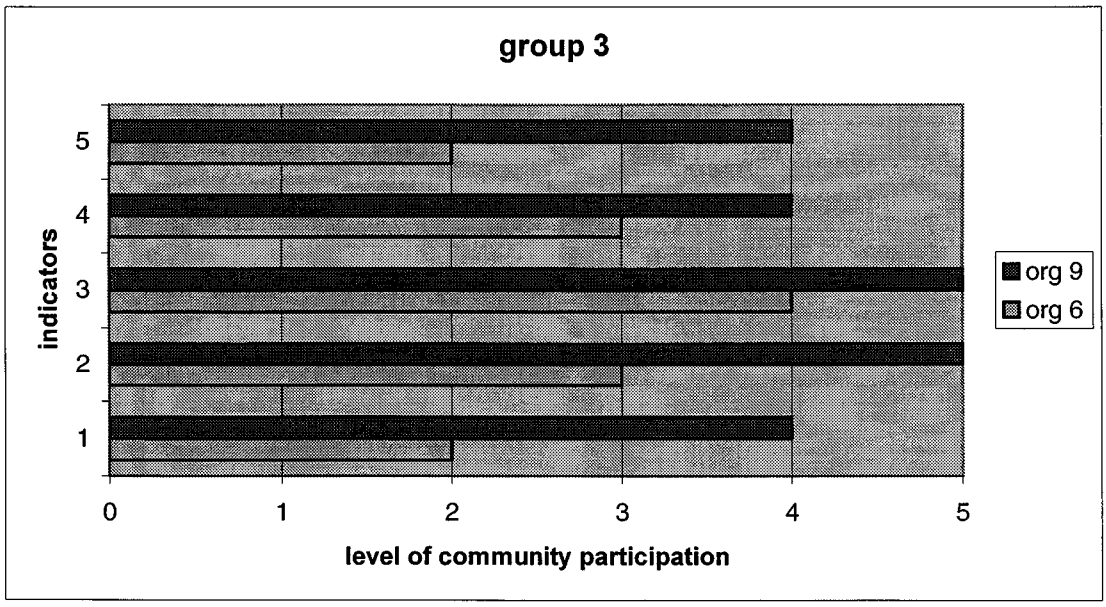
Figure of the levels of community participation of the group 3

In summary, these two organisations have taken a different approach to the health programmes than the others in this study. They depart from the idea that one's culture is one's identity, which should be conserved. Both organisations aim for the empowerment of the rural people, the local participation is seen as end of the project, not just a tool to achieve other goals. Although the organisation 6 is having troubles with the leadership of the CHP, both organisations have managed to create working community health committees, and activate the local people to join the projects.

This figure presents the grades of the organisations 6 and 9.

INDICATORS

4) Leadership
5) Organisation
6) Resource mobilisation
4) Management
5) Needs assessment



If we compare this figure to the previous two, we can see that in average, the group 3 has received higher grades that the other two. There are many possible reasons for this, beginning from the many years these projects have lasted, of the maturity of the programmes. Maybe even the local people were more open to a project like this. I will discuss these and other reasons in detail later, but first I would like to take a look on the role of the Community Health Promoter in these projects.

11.5 The role of the Community Health Promoters in the projects

The Community Health Promoter is chosen usually by the community. In other cases, the organisation has noticed that there is a problem of lack of confidence towards the promoters. The people chosen are often the traditional midwives. The organisation educates the volunteers in health related issues and some of them receive also education in project management.

> *"The internal committees are represented by the CHPs. They are women who are educated in health and other social issues, capable to organise and to be leaders; everything that they could become the leaders of their areas, their sectors, that they would be identified as leaders and could get involved within the field of health too.* Organisation 4. (21)

The tasks in the community vary from simple attention of basic health problems to organisation of workshops and leading discussion groups. The CHPs are also seen as an important link between the community and the external organisation, especially in the first phases of the project.

> *"The promoter is very important, both for us and for the community, fundamentally in the first phase of the project. Because it works as a link between the organisation and the community. Thus, they help with the organisation, with the health issues; they are educated in the basics to be able to help if there is an emergency in the community."* Organisation 10 (22)

Those organisations that work more with the traditional medicine considered the promoters a useful source of knowledge of the local culture, whereas the others mentioned that the CHPs know how to implement the modern medicine in a culturally acceptable manner.

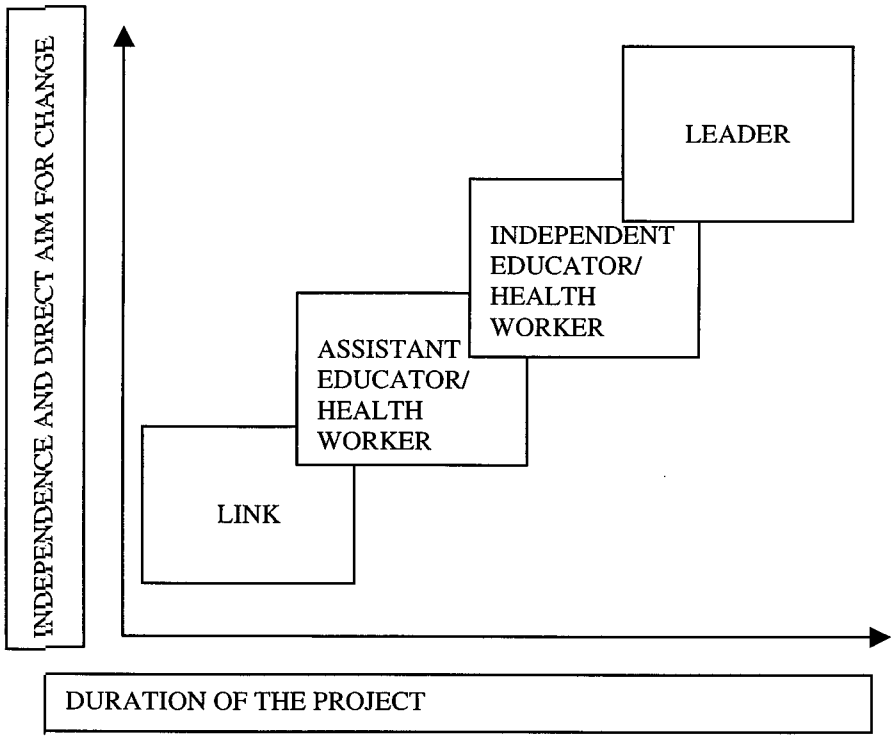
> *"We always depart from what they practise in their community to cure the*

> *diarrhoea, to cure the cold. And then we put together, make a scheme, and so...The good things of their culture are seen too, considering their traditional medicine as a resource."* Organisation 6. (23)

The role of the promoters thus is more educational and assistential than leading the community for a social change. Nevertheless, the CHPs were supposed to continue their work after the NGO would leave the area, thus they role is also to manage the project after the official period is over.

> *"This way the sustainability of our project is based on these promoters, these midwives who, after the project departs, will continue the attention in their communities."* Organisation 5. (24)

The following figure proposes my view of the evolution of the role of the promoter according to the project objectives and the phase of the project. It seems that the role of the CHP moves from the bottom left corner towards the top right corner in the following way.



The difference between the role of the Community Health Promoters in the projects thus varied according to the project objectives and duration of the projects. The interviewees commented that the promoters eased the entrance of the NGO to the community and acted

as a *link* between the local people and the NGO personnel in the beginning of the project. The community chooses the promoter, thus he can count with the people's confidence, at least to a certain point. Moreover, he has a better access to the community than the outsiders, in this case the NGO personnel. He can also provide important information of the community structure, the local culture and tradition.

Later, when the promoter has assisted to the course, he is able to perform some simple tasks on his own, he becomes a kind of an *assistant educator and nurse*. Out of the seven projects that have been discussed in this study, three (organisation 3, 5 and 8) had promoters in this stage. Organisations 3 and 8 work in the urban areas where the promoters are not needed to perform any medical action, as there are health posts close by. The organisation 5, on the other hand, provides a mobile health unit that moves from village to another, while the project lasts. When the organisation retires from the area, the promoters are supposed to take over the management of the project.

The promoters are supposed to organise the discussion groups, they can participate on the leading of the meetings, and help the people with minor health problems. When there is a bigger problem he is supposed to refer the case to the health post.

One step up in the role of the Community Health Promoter, is the role as an *independent educator and health worker*. The organisations 4 and 6 have their promoters in this position. The difference to the previous stage is that the promoters work rather independently from the organisation. They have the skills and the tools to perform simple curative practises and they organise community meetings on their own. They also make housecalls to discuss with the parents issues like family planning and maternity and childcare.

The CHPs also have an important role as transmitters of the local tradition, for they apply what they have learned of the Western medicine in a culturally acceptable manner. Furthermore, the interviewees stated that the promoters have thought them many aspects of the local culture and society.

Finally, the optimum stage of the promoter's role would be that of a *leader*. With leader I do not mean only running the project independently of the organisation, but also that he has gained the position of an opinion leader. Consequently, the people in his community respect his ideas and work.

The organisations 7 and 9 have come closest to this stage. I cannot say for sure that the promoters would have the position of opinion leader in their communities, for this I would need to visit the communities. Nevertheless, according to the interviewees the CHPs now work independently of the organisation and run the project, either alone or together with the community committee. The project of the organisation 7 has finished two years ago and when the NGO departed, the promoters were left with the idea of continuing their work. Unfortunately there has been no follow-up to see if this has worked. Similarly, the organisation 9 is about to depart from the area, thus leaving the future of the project with the promoters. Both interviewees described how their promoters had gone past the three first steps of the evolution of the role of the CHP scheme before becoming leaders.

12 DISCUSSIONS

12.1 Participation and local culture

On basis of the previous chapter, it can be said that there is a relation between the NGO personnel's attitudes towards the local culture and the level of community participation. I do not see this as a direct connection though, that culturally more sensitive NGO personnel would gain more participation or that more participation would create more culturally sensitive organisation personnel. This might work in a long run; the more time the personnel work with the same people, the more they learn to know them, and the cultural patterns start to make more sense and vice versa.

Nevertheless, I do not see the process this simple. The organisations that have gained higher levels of community participation have some similarities on the characters of their projects. These do not come out using the Rifkin's model in the way it has been used in this study. The original idea of the model was to compare the levels of one programme either in two different moments of time or from two different points of view. Rifkin's hypothesis was that the longer the project lasts, the higher the levels of participation (Rifkin 1988). She did not that prove due to the difficulty of collecting the material for the second measurement.

Neither could I do this kind of comparison, but it seems that there is more participation in those projects that have been running a longer period of time. Moreover, the interviewees affirmed that the projects had gone through the stages of lower level of community participation. The participation had increased when the project matured. In this chapter, I will do a summary of the possible reasons for the levels of participation of the organisations, including the characteristics of the projects and the attitude towards the culture.

The personnel of the organisations 6, 9 and 10 has a positive attitude towards the local culture. They consider themselves to be different, but equal to the local people, and they give the traditions high value believing these to be the basis of the identity of the local

people. Moreover, they regard the same culture to be part of their own past, hence being the source of their identity, too. Due to this ideology, they believe that the traditions should be conserved and developed, which can be seen also in the manner the projects have been designed.

The organisations have worked in the same area for a long time, the longest for 14, the shortest ten years. The objective of these project has been, from the beginning, a concrete change in the social structure of the target area. The work has been done together with the people from the step one, including the first situation evaluation, in which the local people participated identifying the most urgent problems in the area. All these three organisations work in other areas than health too. Education, agriculture and others, are all co-ordinated together, instead of making many separate programmes. The organisation 9 had reached the point when all the management of the project had been handed over to the community. In other words, the programme had become a part of the daily life of the local people and was not considered as "a development project" anymore. The other two organisations, 6 and 10, were both aiming to such a situation, their time schedules were flexible, the programme would continue until this point would be reached.

The interviewee of the organisation 7 believed on the importance of the local culture and the project aims to conserve some of the old traditions. Although the project works with modern medicine, it is done respecting the local culture. The low level of participation is more due to other matters than lack of knowledge of the local culture. In the evaluation report of the project they mention problems like distance to some communities, machismo, false expectations from behalf of the local people and "*negative attitude of some community leaders who did not understand and who did not agree with the philosophy of the institution, and who created false rumours and comments*" (Evaluation report of the project) The people referred had wanted the NGO to give donations for their communities, and when the organisation refused, this was the result.

Organisation 7, which also gained rather high grades had a programme that had been closed two years prior to the interview. The reason for my interest towards this programme owns

to the big fame this particular programme has gained in Bolivia. It is one of the first big attempts to create a culturally acceptable participatory method for health work. It has been developed together with traditional midwifes and rural women. The interview dealt with its two first implementations in practise. The interviewee was not too happy about the real outcome of the project, she considered it had not worked the way the organisation had expected. I asked her what the situation in the area was now, two years later, and this is what she answered:

> *"See, I have not been able to follow the situation in the 500 and so communities we left two years ago"* Organisation 7 (25)

Similarly to the organisation 7, the interviewee of the organisation 3 considers that the people have the right for their own culture. Therefore the Western medicine is brought to the area respecting the old traditions as far as possible. The NGO started to work in an immigration area, where the difficulties were caused by actors independent of the NGO: lack of sense of community and high social insecurity, just to mention the two biggest ones. I would like to believe that when these problems are overcome, the project will have more success, as it has done already in some areas.

The organisation 3 had big problems in the beginning because there was no feeling of community in the area where they work. This is a semi-urban area where the majority of the families are migrants from all the parts of the country. The mix of cultures and languages in the area caused confusion in the beginning of the programme. Nevertheless, owing to the flexible project time schedule and financing, the organisation was able to take the time to create the sense of community among the target group. Many changes were included in the project, including dividing the original geographical area to smaller zones which all progress their own speed. Some of these zones have reached good levels of self-management, while others remain at low levels.

The following three organisations 4, 5, and 8 have somewhat different orientation in their programmes. This group of organisations does not pay too much attention to the local culture. It is there, accepted, but does not require any special attention. The idea of the work

is to provide Western medicine to the communities, if the people still use the traditional ways of healing, that is no concern of the NGO personnel.

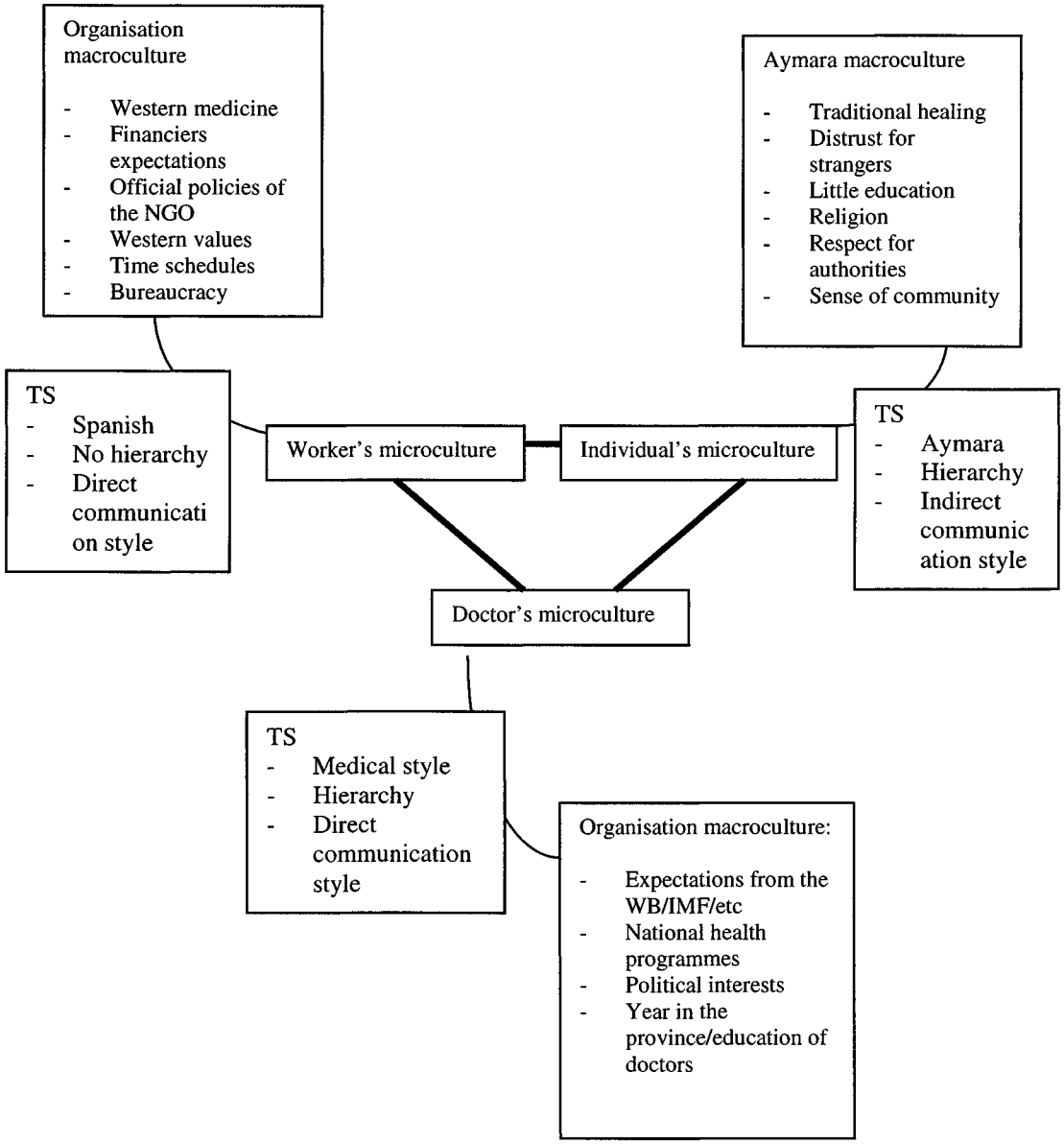
The organisations base their work on the medical and educational point of view, there is no interest for a deeper social change. The focus is more in the simple act of providing of the health care attention and education. Nevertheless, it is not solely patriarchal manner of pointing out that "that's what you are doing wrong", or bringing the solution readymade to the local people. Rather, the NGOs respect the local culture, even if that is shown only by not trying to affect it.

Some reasons for the low level of community participation were found in the society, as I explained in the chapter 10, in which I dealt with the cultural issues affecting the health work. The interviewees mentioned some socio-economic, as well as cultural factors that made the work more difficult.

The successful participation, if it does not have the roots in the community, requires penetration to the community. The outsiders need to know the means of getting to the community, they need to know the way the local people behave and communicate. If the NGO personnel does not know how the Aymara culture functions, the first clash will be in the communication between those two cultures.

If we return to the figure presented in the chapter 7 about the encounter of the cultures in development work, we can see how this works in practise. The transmitting structures include the values and norms that define our behaviour, the patterns of thinking, coding and patterns of communication and also, the patterns of participating within the society. In the figure, I have named only a few of these transmitting structures, the entire list would, of course, be endless. The interviews reveal that the NGOs are conscious about the differences, but are not always able to use their knowledge. Moreover, in development work it is not only an encounter between the cultures. The development agent is introducing a whole new way of thinking to the local people.

From the figure below, we can see an example of the interaction of the three cultures involved in the health work in the Bolivian Andes. The immediate interaction between the counterparts takes part in the triangle in the middle. This is where the conflicts happen, unless the differences are considered in a correct manner.



Even the most culturally sensitive NGOs have other obstacles to win. These obstacles can be economic or social factors that are not related to the local culture. The representatives of two organisations (7 and 9) said that they had cancelled projects in some communities

because the local people were not interested. They stated that health, or the lack of it, is not the most important problem for the poor rural people. Their priories are work, food, infrastructure or education. Health would come after these more urgent necessities are met first.

> *"We wanted to implement the methodology (...) but, to say something, out of 10 groups, only three have finished with the cycle. Why? Because they were dedicated to the commercial activities, it is a commercial town. Thus, they are not interested in talking about what is "a woman" or what is the problem of having 3, 6, or 10 children..."* Organisation 7. (26)

Sometimes the external factors, like the attitude of the NGO personnel or the local medical personnel keep the local people away from the project. The former experiences with other NGOs can make the new relation difficult, or can influence on the expectations towards the NGO. It can be difficult to convince the locals of the value of a discussion evening if there has been an NGO in the area which donated something for the community, or had a concrete programme, e.g. building a road or a school building.

> *"The communities lack of many things, so, they expect more and I think that when they have many expectations and the institution only gives education, which has qualitative impact. So it seems that there is no work, there is roads, no hospital, there is none of this..."* Organisation 3 (27)

The attitude of the local medical personnel is another task that is mentioned several times in each interview. The doctors are said to be arrogant, distant, they are blamed to have no interest on the local culture. There are even accusations of them treating the patients badly. However, the prejudices of the NGO personnel were not mentioned during the interviews. Although one could suppose that the people who want to work in this field have no strong negative feelings towards the different culture, it is not rare to find these between the lines.

> *"These people [the Aymaras] are known as "altiplanic" (i.e. they are closed, they do not trust the strangers, they habits are deep-bedded and they have no desire for the change or "progress") (Save the Children Bolivia. Final evaluation of the project Warmi. 1993 p 22) (28)*

The above is a fragment from an evaluation report of a well-known international NGO. These adjectives, that they use to describe the people they pretend to work with, are commonly used. I am not going to start an argument about whether the Aymaras are like

this or not, I am just asking if it is possible to relate with the locals if this is your way to see them.

Thus, it seems that the relation between the attitude towards the culture and the level of participation is positive. There is a tendency that the more culturally sensitive the organisations have gained more community participation. Nevertheless, it is important, I would even say vital, to recognise that the principles and the objectives of the project influence upon the results, too. Next I will have a look at this aspect, the objective of the programmes.

12.2 Participation and empowerment as objectives of the projects of this study

According to the empowerment theories the project can have a real impact only when there is profound community participation involved in the projects (Woelk 1992) . This means that the community is not only receiving the services provided by the projects, i.e. taking part to the discussion groups but instead, actively take part to all the steps of the project. This, in turn, means that the community or its representatives are involved with the planning, implementation and evaluation of the projects.

Next, I would like to discuss the nature of the community participation. I discussed the different stages of participation in the chapter 3, and I would like to return to those now in the light of the material collected and presented on the previous chapters.

Firstly, is participation seen as *means* or *goal* of the projects? Organisations 5 and 8 concentrate on other aspects than participation within their projects. The main goal of the two NGO is the provide primary attention and give health education. Thus, the local participation is rather the *means* of the project, a tool to gain the set goals, better the knowledge of health issues and increase the cover of medical attention. The participation of the local people in the projects can be described as *marginal* and *induced*: the people have little or no influence on what is being done. They are more like observers, the outside

organisation controls the activities and participation is nothing but a necessary activity to respond to the project needs.

On the other hand, the organisations 3, 4 and 7 lie somewhere between the *means* and the *goal* regarding the participation. I would say the participation is still more of a tool to achieve other goals, it is *induced.* The local people participate for the discussion evenings, they respond to the questions made for the needs assessment, and so on. Nevertheless, the nature of the participation is not so marginal, the local people are active, take initiative, and have some influence on the decision-making. However, the NGO controls the activities, thus marking the participation *substantial.*

The three last organisations, 6, 9 and 10 depart from a different point of view. Local participation is seen as a *goal* of the projects. They intend to create more participation with the projects, they have even included education for participatory methods in their projects. How they have succeeded in this work is seen in the chapter 11. The nature of the participation is more *structural*, it is the ideology behind the programme. Thus, the participation becomes *spontaneous*, it is born from the local people themselves. Naturally, this is rather idealistic way of seeing the reality, much of the activities are controlled by the NGO personnel, and many of the new ideas are brought in by these very same people. Nevertheless, there is an obvious difference compared to the other organisations.

If I compare these qualitative measurements to those made using the Rifkin's scale, there is a tendency that follows these new groups. Organisations 5 and 8 have got the lowest levels of participation, 3, 4 and 7 have a bit higher, and the highest grades have gone to the organisations 6, 9 and 10. Once again, these differences can be explained by concrete reasons, duration of the project, supporting idea of the project and the size of the project. I the last chapter, I gave some explanations for the relationship between the cultural aspect and the level of participation, and the same explanations apply here too. It is notable, although not surprising, that the organisations fall into the same groups regardless are we studying the cultural aspect or the objects of the projects.

12.3 The role of participation in the work of the NGOs included in this study

I will now return to the object of this study, to understand the role of community participation in the health sector within the work of the Non-Governmental Organisations with the Aymaras and Quechuas of Bolivia. This chapter seeks to answer the question written up in the beginning of this paper.

The question I made in the beginning has an answer, the role of participation depends on the object of the project. Those projects that concentrate on education and providing services saw the local people's participation as simple act of attending to the discussion groups and receive the other services.

On the other hand those organisations that aimed for culturally acceptable form of Western medicine used the local's participation as a means to make the culturally acceptable project. The community was consulted on the issues considering the local way of healing and adapting the educational material to the local culture.

Further, those organisations that aim for a deeper social change use other methods to create community participation. The idea of the projects is to work in many social areas simultaneously and the ultimate idea is that the whole social structure of the target area will change by the end of the project. The project will become part of the life of the local people and the Community Health Promoters, alongside with other social leaders, take over the project management when the time is ready for this.

These projects are characterised by respecting the local culture and they do not aim to change this. Rather, the organisations focus on increase the conscience of the people on matters like improving the production, but also work with the general infrastructure that eases the transportation of the products to the markets. Also the idea is to work with those products that really help the community, for example the production of medicinal herbs and vegetables for the consumption of the local people. Health is seen as only one aspect of the

general situation. The role of the community participation in these projects is seen as a tool for empowerment of the poor people.

12.4 Will there ever be a change in Bolivia?

The empowerment ideology supposes that to change the existing social structures the people have to achieve the change themselves. The external professionals should only act as advisors, to nurture the process. (Eklund 1999; 36) From this point of view, it is obvious that in order to reach the change, the local people's participation is essential. Nevertheless, it has been demonstrated that the levels of participation remain low in many programmes. Does this mean that we will never see social change in the Bolivian Andes?

I am tempted to give an affirmative answer. Years of work and millions of dollars spent for a better health in the Andes do not show much of a result. As many of the interviewees admitted, the results of their work can not be measured by improved numbers in the official statistics. Yes, there has been an improvement according to SNIS, the state health statistics, but those are cosmetic changes, statistics that can easily be manipulated. But what all the people working in the remote rural areas can see, is another reality.

What is common to those three organisations that have succeeded on giving the first steps on the long path of change? They are small organisations with a political ideology that supports the idea of social change. Due to the limited capacity, they are forced to work in small areas, less than 50 communities, whereas the bigger international NGO work in hundreds of communities simultaneously. The three NGOs have integrated programmes, they can cover and manage together several areas, not only health, and finally, they can be flexible with the schedules and project profiles, which is not always possible for big organisations.

I am not saying that the big NGOs could not be flexible, that they could not manage simultaneously several projects, or that the work in larger geographical would be an

obstacle for a change. But, the big NGOs are rarely willing to accept the challenge of changing the prevailing structures of an society. It is an political act, and the NGOs try to stay out from the politics. They work with the change in a smaller scale, trying to solve the lack of health education in the country, and providing health care services, both equally needed and important in Bolivia.

Without doubt, empowerment is a political act. It is a process through which the people are enabled to take control over their own lives. The interviewees of the organisations 6, 9 and 10 stress the political ideology behind their work.. Freire talks about the unjust social order that was to be changed through the empowerment, or conscientization of the oppressed classes (Freire 1972). Changing the social order is an act that necessarily involves politics.

Freire (1972) comments on Che Guevara's attempt to change the political order through the revolution. "*...revolutionary activity is really human, empathetic, loving, communicative and humble, in order to be liberating*", he states (op.cit. 139). The hero of the three politically orientated NGOs believed on the revolution. One of the interviewees had been in his troops as a guerrilla and considered his work nothing but to continua of what Che had started. Ironically, it was in Bolivia, where Che had to face the biggest problems. In his diaries he refers several times to the lack of peasant participation: "*the peasant participation does not exist. (...) It is a slow and patient task.*" (Guevara)

To ask if there is ever going to be a change in the Bolivian Andes, is not a simple "yes or no" question. To change the existing social structures it will take a lot more than health projects, time and patience being two of the most important issues. The community participation in health work allows the people to become more aware of those aspects of their environment that influence their health. Consequently, it improves the probabilities of sustainability of the project..

Guaranteeing the sustainability of the project is often used justify participatory methods in development work. The interviewees agreed that the projects do not give the expected results, there is no notable improvements in the level of health in the Bolivian Andes.

Nevertheless, the interviewees trust that little by little the education will change the attitudes of the people. Hence, the education is the aspect that carries on the project ideology. This questions the importance of the community participation in all the sectors of the projects. Discussions about empowerment and measurements of the level of participation are left without base, if the same results can be gained by health education. Health education alone might be a slower way to the change, but there can be hidden the seeds for the structural social change – people are given the tools for better health, they can use them, if they so desire.

12.5 Searching for better results in the health work in the Andes

At this point, I would like to underline again, that this study is based on the experiences of the project managers. What the interviewees mention as their greatest achievement is the creation of the self-esteem in the target. On the other hand they feel the shadow hanging over them. One interviewee pointed the common feeling out by saying:

> *"It is a bitter pill to swallow that, despite all this work, we still have high maternal mortality. It is a shadow hanging over us. (...) And this makes us working in a health project feel frustration. It seems like we were doing nothing" Organisation 3 (29)*

What she made me understand is that there is still no results, not where they work, nor in Bolivia in general. The other interviews and the official data of the Bolivian Ministry of Health confirms this to be true. Although there is a slight progress going on, the change has not been very great yet.

In order to say whether the organisations that take the local traditions into account get better results in their work, a more detailed investigation should be done. It would be necessary to compare the official results of the different organisation. I have not got this data, and I consider this rather difficult task for anyone. The results of a health project are difficult to measure. Should we use the method of the Bolivian government according to

which more pneumonia patients in the hospital means better healthcare? Or should we rely on the evaluations of the projects that claim nearly 80% people in the rural areas consult a doctor when ill or that as many couples use some form of modern method for family planning?

I have seen many evaluation reports like this. I have spoken about the reliability of these with many people who have experience in the Bolivian healthcare system, and they all agree on that one should not give too much importance to these reports. One of the organisations included in this study had remarkable results of their health project, so remarkable indeed, that I could not avoid asking the interviewee how they had succeeded on this when everybody else was struggling. He answered:

> *"They [the company which made the evaluation], what they did was to hire university students (...) for our favour or against us, maybe something can escape from the interviewers (...) I think they did not have the knowledge to perform this task, maybe they had a course of four hours or something... (...) and the truth is, do you want me to be sincere? We do not really care about the evaluation, because we are conscious about our work... "* Organisation 5 (30)

Now, if this is the reaction to overly positive evaluation... I think this is enough to show that the evaluations are not to be trusted. Thus the question remains, how are we supposed to identify the best way of making health work in the Andes?

My suggestion for those who work to improve the health of the Andean people, according to what has been noted above, is to take into account the cultural characteristics of the people. Understanding the way they think and view the world it is much easier to enter to the communication with the people of the target group. The project should be planned on a long term basis and according to the possibilities it should include other areas in addition to health.

The project should be planned with care, to identify the target group and the objective of the project are key issues for the success. If the object is to change the existing social structures, the target area should not be very large and the time limit should be flexible.

Most importantly, the project personnel should be prepared to prove they are worth of the trust of the local people, to demonstrate the are as good as *j'aqis*.

12.6 Ideas for further investigation

The conclusions of this study and the suggestions for those who work with health have not been surprising. Nothing much new has been said. There is a vast collection of investigations that come to the same conclusion I have reached. Thus, what has been the meaning of this study, why is it still important? I have tried to discuss the problem of development work, especially in the health sector from the Bolivian Non-Governmental Organisation's point of view. It is an area that is not investigated a lot. If the conclusion was the same as in the literature of community participation in general, this only proves the Bolivian organisations are not alone with their problems.

The importance of this study raises from the fact that it attempts to help the people working in Bolivia to reflect their work within a wider context. In order to gain more information about the issue, it would be important to research how the local people view the development work. If I had the chance to continue with this study, I would like to spend time in the rural areas of Bolivia, to hear the target groups of the projects for better understanding from their point of view.

It would be interesting to conduct an investigation in one of the areas where the project has been completed, to make an review about how the project evolved and how did it change the society and its structure. It is difficult to measure the quantitative results of a project, nevertheless it would be meaningful to study the experiences of the local people and their opinion about the changes.

13 EPILOGUE

The year I have spent with this work has shown me many aspects of development co-operation, especially in the health sector. I have understood that not only a good project plan or culturally sensitive project personnel are enough to make a change. While I have been in Finland writing this work, people in Bolivia, like in many other South-American countries are living times of restlessness and economic and political insecurity. This makes me look at my work in different light. It is not only the health that needs to be improved in countries like Bolivia, but there is a need for more profound social changes. During this year in Bolivia there have been two severe outbreaks of violence due to the dissatisfaction of the people. In this situation the importance of culturally acceptable healthcare seems less important. The people of Bolivia need a lot more. I hope the political and economic situation there finds a solution and the real work for development can start soon.

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Mr Andrés Bartos, director, Cotalma 09.04.2000

Mr Bernardido Fuertes, director of the health programme, CASEPO 11.05.2000

Mrs Lurdes Careaga Zhaparria, director of the health programme, CEMPOCEP 10.05.2000

Mrs Irma Carasana, director of the health programme, Care Bolivia 02.05.2000

Mr Hugo Medrada, director, PRODIS Yanapacuna 09.05.2000

Mr Fernando Robles, director of the health programmes, Caritas Bolivia 27.04.2000

Sister Maria Teresa and Mrs Evelyn Poreda, Consultorio Jampina Wasi 10.05.2000

Mrs Ana De Wulf de Bejarano, director of the health programme, ISALP 11.05.2000

Mrs Yolanda Vargas, director, Causananshispa 12.05.2000

APPENDIX 1
Rifkin's ranking scale

Indicator	Narrow, nothing 1	Restricted, small 2	Mean, fair 3	Open, much, good 4	Wide, very much, excellent 5
1 Leadership (wealthy minority - variety of interests)	One sided	WCH not fuctioning, but CHL works independent of social interes groups	WHC functioning under the leadership of an independent CHL	Active WHC, taking initiative	WHC fully represents variety of interests in community and controls CHL activities
2 Organisation (created by planners – community organisation	WHC imposed by health services and iniciative	WHC imposed by health services but developed some activities	WHC imposed by health services, but became fully active	WCH actively co-operating with other community organisations	Existing community organisations have been involved in creating WHC
3 Resource mobilisation (small commitment + limited control – good commitement + commited control)	Small amount of resources raised by community. No fees for services. WCH doesn't decide on any resource allocation	Fees for services. WHC has no control over utilisation of money collected	Community found raising periodically, but no but no involvement in control of expenditure	Community foundraising periodically and WHC controls the utilisation of founds	Considerable amount of resources raised by fees or otherwise. WHC allocates the money collected
4 Management (professional induced – community interest)	Induced by health services. CHL only supervised by health staff	CHL manages independently with some involvement of WHC. Supervision only by health stuff	WHC self-managed without control of CHL's activities	WHC self-managed and involved in supervision of CHL	CHL responsible to WHC and actively supervised by WHC
5 Needs Assessment (professional view – community involved)	Imposed from outside with medical, professional point of view or latrine building programme imposed on community	Medical point of view dominates an "educational" approach. Community interests are also considered	CHL is active reprecentative of community views and assesses the needs	WHC is actively representing community views and assesses the needs	Community members in general are involves in needs assessment.

APPENDIX 2
The structure of the interview in Spanish

1 Datos técnicos

1.1 Nombre y cargo de la persona entrevistada
1.2 ¿Cuál es la ideología política o religiosa de la ONG?
1.3 ¿De dónde son las personas que trabajan en la ONG?
1.4 ¿Qué proyectos tiene la organización en el momento?
1.5 ¿Cómo y por quienes está hecha la planificación de los proyectos?
1.6 ¿Cómo y por quienes está hecha la evaluación de los proyectos?

2 Proyecto de salud

2.1 Perfile del proyecto, ¿qué intervenciones incluye?
2.2 ¿En qué área trabajan?
2.3 ¿La gente con quién trabajan?
2.4 ¿Objetivos del proyecto?
2.5 ¿Duración del proyecto? ¿En qué momento están ahora?
2.6 ¿Planes para cuando termine el proyecto? ¿Qué pasó cuando terminó?
2.7 ¿Qué metodología usaron para entrar a la comunidad?
2.8 ¿Quiénes trabajan en las comunidades?
2.9 ¿Cómo se involucra la comunidad a los proyectos?
2.10 ¿Qué metodología se usa en el pryecto?
2.11 En su opinión, ¿cuales han sido los resultados del proyecto?

3 Aspectos culturales

3.1 ¿Que aspectos culturales puede mencionar que afectan al trabajo con salud?
3.2 ¿Que aspectos culturales puede mencionar que afectan al proyecto?
3.3 ¿El personal del proyecto conoce el yatiri/ hay cooperación?
3.4 ¿En que forma trabaja el proyecto al respeto a la medicina tradicional?
3.5 ¿Qué significa la cultura local para el proyecto?
3.6 ¿Qué es la cultura local? Salud, género etc.

4 Relaciones y posibles problemas

4.1 ¿Cuáles han sido los problemas mas graves durante el proyecto?
4.2 ¿Por qué estos y cómo los han solucionado?
4.3 ¿Qué hacen para evitar los problemas?
4.4 ¿En el área de trabajo, ¿cómo recibieron el proyecto?
4.5 ¿Cómo es la relación entre la ONG y la comunidad?
4.6 ¿Cómo es la relación entre la ONG y otras instituciones en el área?

5 El papel de las ONGs en la sociedad Boliviana (su opinion)?

5.1 ¿La influencia política?
5.2 ¿El papel en la política de la salud?
5.3 ¿El papel cómo proveedor de servicios en el sector salud?
5.4 ¿De quién es (¡no: de quien debería ser!) la responsabilidad del trabajo para la salud en Bolivia, el Estado o las ONGs?

APPENDIX 3

Guide questions to measure the level of community participation (Rifkin 1988; 938-939)

Needs assessment

- How were health needs identified?
- Did the identification include only health service need or other health needs?
- What role, if any, was forseen for community people in conducting needs assessment, in analysing health needs?
- Were surveys used? Who designed the surveys and who conducted them?
- Were the surveys used merely to get information or also to initiate discussion with various possible beneficiaries?
- Were possible beneficiaries involved in analysing the results?
- Was the assessment used for further to involve the possible beneficiaries in future plans and programmes?
- Was only one assessment made or is it an exercise for change, review and further involve the community people in the programme?
- How were the results of the assessment used in the planning of the programme?
- If community people were involved in the assessment, did they continue to be involved in the implementation?
- Was the assessment used to strengthen beneficiaries role in decision-making about the programme?
- Was it able to include various representatives from the wide range of possible beneficiaries for which the health programme was designed?

Leadership

- Which groups does the leadership represent and how does it represent these groups?
- How was the leadership chosen and how has it changed?
- Is the leadership paternalistic and or /dictatorial limiting the prospects for wider participation by various groups in the community?
- Does a charismatic leader exist who might not allow mechanisms for continuity to be developed?
- How does the leadership respond to the poor and marginalised people, i.e. peasants, women, unemployed, labourers?
- How does the leadership respond to demands of outside organisation in terms of gaining resources for the poor as well as the better off?
- Have the most of the decisions by the leadership resulted in improvements in the majority of the people, for only elites, for only poor?
- What was the attitude if the leadership toward the introduction of a health programme and what was the attitude of the leadership to health before the programme was introduced?

Organisation

- How were organisation focusing on health needs development?
- What is the relationship of the health professionals to these organisations – do they have a decision-making role and if so, how important is that role?
- If new organisations were created, how do they relate to existing organisations?
- How does the organisation get resources?
- What kind of input do the resource holders have in the organisation, is it a large decision-making role?

- Has the representation and the focus of the organisation changed since it was created, if so, how and to whose benefit?
- Who staffs the organisation- professionals, beneficiaries and which beneficiaries (elites-poor)?
- Can the organisation meet needs other than providing health services if other needs have been identified?
- Is the organisation flexible and able to respond to change or is it rigid fearing a change in control?

Resource management

- What have beneficiaries contributed?
- What percentage of total requirements come from these groups?
- What are the resources being used to support?
- Have these resources been allocated for support of part of the programme, which in other circumstances would be covered by government allocation?
- Who has decided how indigenous resources should be used?
- Do all groups that contribute have a decision-making role?
- How do the poor benefit from allocations to which, because of poverty, they can make little contribution?
- Can recourse raised to support a health programme be used to support more than than health services?
- How are resources mobilised from the community?
- Which groups influence mobilisation and how do they do it?
- Whose interests are being served in both the mobilisation and allocation of these resources?

Management

- What is the line of responsibility for management and what are the roles of beneficiaries, particularly community health workers (CHW) if present in the programme ?
- For instance, are CHWs responsible to community organisations or programme managers?
- Has the decision-making structures changed both from the beginning and from the baseline to favour certain groups and which groups are favoured?
- Have the management structures expanded to broaden the decision-making groups, have they been able to integrate needs which are not health needs?

1 "Entonces ya te cuento, problemas de roles, comparten roles. Eso fue una cosa bonita que sucedió. Pero para eso ha tenido que pelear... primero con los hombres y después con las mujeres mismas."

2 "(...) tu siempre notas que en los médicos hay una cierta resistencia todavía, y principalmente los médicos que son poco mayores. (...) Todavía hay un menosprecio al saber que tiene la población rural. Y al saber más todavía que tiene la mujer."

3 "Por ejemplo, un niño con tos lo único que se está diciendo es que todo lo que se hace tradicionalmente, que no es muy salvaje, que se siga haciendo. Lo único es que le limpien la nariz de vez en cuando, y mucha gente lo hacen sin hacer un curso."

4 "La pregunta que se hace a los participantes [del curso] y la refección que se hace con ellos es que hacen ellos (...), cual es el concepto. Y eso es una refección que en cada sesión de capacitación se haría de manera que luego el que capacita utiliza un poco de esos conceptos en la discusión. (...) todo el proceso que es lo que hace la gente, respeta lo que hace la gente, pero además de lo que hacen puede hacer estas cosas [de la medicina occidental]"

5 "El trato de estas instituciones [centros de salud públicos] no es lo que deseamos. (...) Entonces pensamos que tal vez esto podemos solucionar arrancando la capacitación de los centros de salud, sensibilizando ellos... (...) es fuerte el porcentaje de las madres que ponen esto precisamente la respuesta al no trato con calidez de los centros de referencia. Entonces ellas ven un mejor trato, mas familiaridad en la médica natural."

6 "Lo que sí procuramos es que cuando utilizan los medicamentos de la medicina moderna no vayan a interactuar en forma negativa con sus tratamientos de medicina natural. Pero, por ejemplo, si tiene que tomar, por decirle, un analgésico, y quieren tomarlo con un maté, no tiene ningún problema para mí."

7 "Todavía se sigue utilizando los medicamentos tradicionales, hierbas... y viene la gente para la medicina occidental. Y esto es un cambio cualitativo, que ellos están cambiando cualitativamente."

8 "A riesgo de su salud ellas prefieren ser atendidas en su casa [para el parto]. Entonces (...) hemos identificado las parteras empíricas. Son señoras del mismo barrio, que pueden en alguna forma orientarle a la señora, (...) orientarle en la limpieza, que es importante."

9 " Ha sido entendido por el método [que usamos] respetar las tradiciones. (...) incluso en la metodología [que usamos] lo que quería era acercar a la comunidad a los servicios de salud y los servicios a la comunidad [con la sencibilización] "

10 "Entonces en esto [en la medicina moderna] el proseso educativo es bastante largo, entonces yo creo que es muy importante de coordinar con la medicina natural o tradicional, para lograr resultados."

11 "Pero yo veo, que cuando vives ocho horas de una puesta sanitaria, tienes que buscar modos de salvar. (...) Entonces, yo no puedo prohibir ese manteo porque no tengo otra alternativa que darles. Y yo veo que en el hospital también mueren mujeres... A veces. Y hasta en europa a veces mueren. Entonces es un poco, para mí, injusto decir que no se puede hacer el manteo"

12 "Entonces ven coca, y una vez había visto coca, "aa... Doñita" le dice a una señora, le dice "la coca dice que yo no te puedo curar esto, la Doña Rosalita [la enfermera] te va a curar esto" Entonces, se ha logdaro confuncionar las dos cosas."

13 "Muchos de estos problemas de género y de equidad se están dicutiendo en los grupos (...) orientarlas a identificar cuales son sus derechos y sus oblicaciones y a levantar el autoestima de las mujeres. Lo mismo se

está haciendo es los grupos de los varones, sencibilisando, para que ellos puedan luego modificar su conducta y actidtud frente a sus esposas."

14 "No es una cosa novedosa, [el trabajo con los hombres] pero muchas veces se queda en el papel. O sea, mucho teorizamos nosotros, escribimos muy lindas cosas en los papeles pero la cosa es operativizar esta cosa."

15 "(...) voy a tener que profundizar un poco mi saber de quechua, porque es un freno en la communicación no poder hablar..."

16 "...la dibujante es de La Paz, nunca en su vida, ademas es una chica muy joven, nunca ha salido de La Paz, bueno, dibujó lo que a ella se le ocurrio que era un fogón, y...[la reacción de la gente:] ! nuestro no es así!".

17 "El primero es la cura, o la monja, de segundo es el curandero o la curandera. Muchas veces la partera es la autoridad. Y el tercero es el corregidor, la autoridad mismo social de la población. Si tu no lo ganas, no consigues entrar con estas personas, está perdido tu proyecto"

18 "En proyecto hacemos cursos con los promotores, pero también hemos visto que los promotores muchas veces no son líderes de su comunidad y no transmiten [lo que han aprendido], la idea era que transmitan después del curso, hagan charlas en su comunidad. Pero como son nuevos, inseguros, no transmiten."

19 "Entonces a comenzar trabajar primero con entorno a unir estas zonas en sentido de comunidad, en sentido de ser equipo de trabajo. Ha sido un problema que nos ha costado mucho al equipo a formar una metodología participativa (...) aplicarla en un determinado tiempo. Para nosotros se ha duplicado, triplicado porque hemos tenido que comenzar en que se conozcan."

20 "... el marido y la mujer son bien unidos para el parto, eso, yo pienso, que es un valor importante. (...) allí es donde tiene realmente su lugar el marido a ayudar a la mujer a dar a luz. Yo veo que es otro valor que la wawa nace en un ambiente caluroso (...) ellos lo hacen en una forma natural"

21 "El comité interno está representado por los RPSs, son señoras que son capacitadas en salud y en diferentes temas sociales, y preparadas en organización, liderazgo, todo para que esas señoras sean líderes en su zona, en su sector, se identifique las como líderes y puedan desenvolverse también en campo de la salud."

22 "El promotor, para nosotros y para la comunidad, es muy importante, fundamentalmente en una primera fase de trabajo. Porque es una enlace entre la organización y la comunidad. Entonces apoyan lo que es la organización, en lo que es salud; están capacitados en lo básico para poder ayudar en un momento de emergencia en la comunidad."

23 "Siempre partimos de lo que ellos practican en su comunidad para curar la diarrea, para curar el resfriado. Y después, ponemos en común, hacemos una plenaria y así... Se ve las cosas buenas de su cultura también, a nivel de recurso de medicina tradicional que ellos tienen."

24 "De esa manera la sostenibilidad de nuestro proyecto está a base a estos promotores, en base a estas parteras que después que se retire el proyecto ellos van a continuar manejando en su comunidad."

25 "Mira, no he podido hacer el seguimiento de las 500 y tantas comunidades que se han quedado hace dos años"

26 "Hemos querido implementar la metodología (...) pero por decirte, de 10 grupos solamente 3 grupos han salido terminando todo el siglo. ¿Por qué? Porque estaban en la parte comercios, es una ciudad que se preocupa por eso. Entonces, no les interesa de estar hablando de qué es la mujer, o qué es el problema de lo 3 ó 6 ó 10 hijos..."

27 "Las comunidades tienen un montón de carencias, entonces, esperan mas y creo que cuando tienen muchas expectativas y la institución da mas lo que es educativo, que es una cosa que impacta lo cualitativo también. Entonces, parece que no hay obra, parece que no hay caminos, no hay hospital, no hay eso..."

28 "A esta gente [los Aymaras] se les cataloga como "altiplánicos" (i.e. son cerrados, descofiados de los extraños, de costumbres muy arraigados y sin muchos deseos de cambiar o "progresar") (Save the Children Bolivia. Evaluación final del projecto Warmi. 1993 p 22)

29 "Con mucho amargo que a pesar de estos trabajos aún tenemos muertes maternas. Entonces la muerte materna es una sombra para nosotros. (...) Y, esa nos desespera en un proyecto de salud. Parece que no estuvieramos haciendo nada..."

30 "Ellos [la empresa que hizo la evaluación], lo que han hecho, es contratar gente universitario (...) A favor o a contra, a lo mejor se le van a escapar a la encuestador muchas cosas también. (...) yo creo que no era gente capacitada, o los han capacitado por cuatro horas o algo... (...) y la verdad, quiere que se lo diga sinceramente? Ni nos va ni nos viene la evaluación, porque somos consientes de nuestro trabajo..."