THE INTERCULTURAL HEALTHCARE APPROACH REVISITED: UNDERSTANDING INDIGENOUS WOMEN'S COMMUNITY PARTICIPATION IN HEALTHCARE.[1]

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ABSTRACT

This article examines how indigenous women who receive intercultural healthcare programs manage to develop cooperation networks, get involved in community affairs and improve their reproductive healthcare. It concentrates on the case of the Bolivian intercultural program "EXTENSA" and analyzes how this program is successful at activating greater community participation in health prevention and thus, improving the reproductive healthcare of the indigenous women who live in the Department of Beni, Bolivia. Through a qualitative analysis, it argues that increasing community participation and healthy behaviors are not associated with overcoming the cultural barrier with the modern medicine, as the intercultural healthcare approach would have expected. Indigenous women's community participation and healthy behaviors should be reinterpreted as the result of tapping into bonding social capital. The analysis shows that the program gives access to community leaders and networks members (who predate EXTENSA) to economic, educational and political resources, providing them with new opportunities. In this process, it does not transform cultural values or behaviors but instead transform women's community assets into sources of community empowerment.

Key words: intercultural healthcare, community participation, social capital, gender, Bolivia

INTRODUCTION

Historically, the model of "modern Western" healthcare has been characterized by its excessive emphasis on the psycho-physical aspects of the healthcare process (Menéndez, 2005). However, since the end of the 1980s, this model began to move away from an

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interpretation of healthcare based on merely physical elements to provide more room for social aspects, based on the belief that social determinants have a major impact on people's health and on healthcare inequalities (Marmot, 1986; Marmot and Wilkinson, 1999). Since then, "community participation" began to be seen as a critical element for understanding the health of poor populations. When (low) community participation in healthcare services began to be associated with poor healthcare, its increase became a necessary requirement for improving people's behaviors. From this new perspective, healthcare no longer depended exclusively on the actions of healthcare agents or program providers, but on the beneficiaries as well (World Health Organization, 1986).

This concern regarding active community participation in health programming was embraced by the intercultural healthcare approach when it emerged in the 1990s as a response to the specific challenge of reaching poor populations like the indigenous. The indigenous peoples have historically been identified as one of the most vulnerable groups health-wise, and the one with the strongest claims to ensure their interests are duly recognized. It is, however, just over fifteen years ago that governments started to attach priority to these groups, acknowledging their traditional culture (practices, knowledge and values) in national health policies. This recognition has become a turning point in how policies operate: instead of including indigenous populations in universal health programs, governments have started to design policies specifically focused on this population segment. To this effect, they have started implementing health policies from an intercultural perspective, which is deemed to include health practices that build bridges between indigenous and modern medicine. The intercultural perspective has been considered a key strategy to improve the health of the indigenous peoples. But this has especially been recognized as a unique opportunity for women, who are believed to be the most vulnerable group within this sector of the population because of poor sexual and reproductive health indicators and gender inequality.

Interest in indigenous health is related to a global demand of international organizations. Since the mid-nineties, international agencies started to develop the "Identity-based Development Strategy", with a view to applying it in developing countries. From the middle of the 1990s, international agencies faced the great challenge of fighting against social inequalities that were in place as a result of the Health Sector Reforms of the 1980s. Evaluations of the impact of reforms showed a large gap in indicators between the indigenous and non-indigenous population, and especially a very big difference in sexual and

reproductive health indicators. The conclusion of the agencies that analyzed the impact of the Reform showed that the poor health indices of indigenous women were due to cultural barriers which hindered access to modern health services. The cultural barrier is due to cultural differences that exist between the various notions and approaches to healthcare and illness, as viewed by the population and health providers. In practice, the lack of understanding between users and providers is expressed in a strong resistance by women to use health services, and a great distrust towards the professionals of modern medicine (Gonzáles Salguero et al., 2005).Therefore, within the framework of the Identity based Strategies of Development, the intercultural perspective was considered a unique opportunity to overcome cultural barriers that lead women to drift away from the modern health services (Camacho et al., 2006). Based on this belief, international organizations sought to incorporate the Strategy into the national health programs they supported in developing countries.

Different research has taken place to verify the impact of the intercultural outlook on health outcomes. In this regard, the idea was to analyze to what extent the incorporation of a cultural appraisal into the programs indeed has a positive effect on the population's health. They showed that the programs that include intercultural strategies help to overcome the cultural barriers that move the indigenous away from modern health services. Consequently, they allow communities to considerably improve their health conditions. Along the same line, they showed that this outlook also has a great impact on women's trust towards health practitioners in the modern services. In this case, it is interesting to see that the results not only identified improvements in health, for instance, in preventive behaviors, but also progress in gender equality, that is to say, a greater participation of women in community activities and in public decision-making (Gonzáles Salguero et al., 2005; FCI, 2005; Mignone et al., 2007; UNFPA, 2008, among others).

Here, it is worth observing the underlying logic of the intercultural healthcare approach. For the intercultural healthcare advocates, promoting active community participation was a broader means whereby modern medical health professionals could bridge the cultural divide (Gonzáles Salguero et al., 2005; Camacho et al., 2006; Ministerio de Salud y Deportes, 2005; Campos and Citarella, 2004, among others). In other words, it was a means of inculcating and transforming cultural values regarding health that were more in line with modern medicine. In a matter of fact, since the emergence of the intercultural healthcare approach, many intercultural health initiatives aimed at fostering community participation in

health affairs by training health promoters and local leaders in order for them to later transmit these values to the community.[3]

This article examines why indigenous women who receive intercultural healthcare programs manage to develop cooperation networks, get involved in community affairs and improve their sexual and reproductive healthcare. The article analyzes the communities that are beneficiaries of the EXTENSA intercultural program (National Program on "Expanding Health Coverage in Rural Areas)[4] in the Department of Beni, Bolivian Amazon and analyzes how this program is successful at activating greater community participation in health prevention and thus, improving the reproductive healthcare of the indigenous women. It argues that community participation and healthy behaviors—which are understood to result from the capacity that programs have to "promote healthy behavior, respecting the culture of indigenous peoples or implementing adequate processes at the socio cultural level,"[5]—should

[3] Ramírez Hita (2006) for example has pointed out that "training is one of the main activities of international organisms that work in Bolivia. These institutions work on the supposition that by training representatives from the traditional medical system (traditional healers, midwives), these representatives can then serve as mediators within the community and help to transform it. The point of reflection is placed on transforming traditional therapists and midwives by incorporating medical knowledge through education on detecting risks and taking preventative actions, especially with regard to pregnancy, birth and maternity. Training is based on the fact that certain behaviors of these social actors must be modified to optimize their practices in order to obtain improvements in the population's health" (Ramírez Hita, 2006: 405).

[4] The intercultural health program called EXTENSA is an example of the Global Development Strategy under the World Bank (OP-410),implemented by the Bolivian government to improve the health of the indigenous communities. EXTENSA has established in 2003. The program arose in Bolivia as a demand of international organizations to start up the "Bolivian Poverty Reduction Strategy" (EBRP, by its Spanish acronym), which includes among its objectives the Identity-based Development Strategy and the Millennium Development Goals (MDGs).

[5]Operational Policy on Indigenous Peoples and Strategy for Indigenous Development, Inter-American Development Bank (2006).

be reinterpreted as the result of tapping into bonding social capital. The analysis shows that the program gives access to community leaders and networks members (who predate EXTENSA), providing them with new opportunities and allowing them to transform their community assets into sources of collective empowerment. The article reveals that this process allows them to make their role within the community more legitimate and increases their impact in terms of getting the population involved in their own healthcare. When the community considers that their community assets are vehicles for improving their living conditions, they get collectively involved and acquire preventative behaviors. Thus, the article reinterprets the mechanisms that allow programs to increase the community's involvement in health: from what programs offer in terms of "transforming" indigenous women's culture towards another view on how programs help women understand their community assets, construct social networks and utilize their assets to increase the community's wellbeing in a positive way.

THE STRATEGY OF BONDING SOCIAL CAPITAL AS A SOURCE OF COMMUNITY PARTICIPATION

This article seeks to reinterpret the explanations provided by the intercultural approach when analyzing how programs that incorporate this perspective can increase participation and improve community health. Unlike the intercultural approach, the article does not share the notion that this achievement is related to the way these programs promote values or a greater awareness of healthcare among community members. Instead, it proposed a new perspective in which social capital is the key to explaining how intercultural program manage to increase community participation and improve health in a context like that of Beni.

Why is social capital useful in explaining how intercultural healthcare programs manage to increase participation and improve health in a poor context like that of the Beni Department in the Bolivian Amazon? The answer to this question is based on the potential that the social capital theory has to explain the process through which the programs get women to strengthen their existing community assets and use them to improve their living conditions.

The social capital theory is very useful for understanding this process in the case of the Department of Beni. Above all, it is useful when questioning the arguments provided by the intercultural healthcare approach. The notion of social capital contrasts with the idea of the cultural marginality (and its effects on people's behaviors)[6]. Social capital disputes this idea because it emphasizes the potential that the poor have to escape poverty and improve their behaviors through their own community assets in conjunction with the support provided by programs such as EXTENSA. For that reason, the social capital literature has pointed out that bonding social capital found at the level of community assets—such as informal networks and community leaders—can thus promote collective actions in resolving common problems (Putnam et al., 1993; Kawachi and Sapag, 2007; Durston, 1999; Durston and Duhart, 2003; Saegert, et al., 2001, among others).

Authors interested in analyzing the formation of bonding social capital have developed different approaches to understand how development programs can contribute to its formation. Community bond is not seen as a new one formed where there had been no bond in the past. Instead, it is seen as an existing bond, albeit a weak one which predates the arrival of external programs but needs them to grow stronger. Bonding social capital has been a particular focus of the literature on promoting health in indigenous communities. Durston (2000) notes how communities possess important informal networks that provide mutual support and designate community roles which are constructed as community assets. However, when communities suffer from poverty, they lack connections at a higher level and thus have few opportunities to use their assets as channels for improving the quality of their lives. However, as the author proposes, external programs can serve as intermediaries for strengthening these assets, thus increasing the opportunities of community members. As a result, they can help the assets become true vehicles for collective action or bonding social

[6] We mainly refer to the meaning attributed by the Theory of the Culture of Poverty. The notion of "culture" has been a part of a broad field of study in the theory of the "culture of poverty" (Lewis, 1968; 1965). The hypothesis suggested by this theory is that poverty and the behavior of the poor stem from their culture; in other words, from the ideas, beliefs or values they develop when living in these contexts. The notion of a culture of poverty reveals a situation in which people are trapped in a social environment characterized by irrationality, apathy, a lack of aspirations and fatalism. Once these behaviors are established, the poor are locked into a vicious circle of poverty that is difficult to end, even when structural conditions change.

capital which can then be used by the people who possess them to improve community wellbeing.

Authors interested in promoting bonding social capital have emphasized the notion of empowerment. The empowerment strategy is a critical element that programs can implement to transform community assets into bonding social capital or sources of collective empowerment. Empowerment, in fact, is opposed to the explanation provided by the intercultural approach in that it underlines the importance of existing community assets as elements that people can use to achieve positive results in their lives (Wallerstein, 1992). In other words, the change with respect to participative behaviors is not seen as the result of incorporating new values or standards of behavior. On the contrary, the change is conceived of as the result of a process of fomenting collective mobilization rooted in the collective organization and leadership assets that communities already possess.

The social capital literature was incorporated into gender studies to show how women can construct bonding social capital based on the community assets they already possess. This literature has shown that women play a critical role in their communities and that they develop networks for exchange and mutual support to improve their living conditions. In addition, it points out that women generally take positions of leadership—for example, as healthcare promoters—due to the knowledge they have acquired in caring for their family. However, the literature acknowledges that due to gender inequalities, women miss out on the opportunity to use these spaces to improve the quality of their life. For this reason, the literature argues, programs can develop different strategies to empower women and to transform their assets into bonding social capital. On the one hand, programs can make the roles of women and the networks they form more visible while strengthening the spaces for participation in order for women to take part in decision making and have the chance to get involved when their interests are at stake. On the other hand, programs can redistribute resources (educational and financial), giving men and women similar opportunities to increase their ability to mobilize resources (Montaño, 2003).

The notion of bonding social capital is highly useful for understanding how EXTENSA is successful at increasing community participation and improving health. I argue that EXTENSA raises community participation and increases the health of the women in Beni by drawing on existing community assets (community leaders and informal networks) that

women possess in their own communities to foster boding social capital. In addition, this result is part of a process of collective empowerment, which is enabled because the program provides those who possess these assets with new tools (financial, educational and political tools) that allow them to strengthen their assets and be legitimized by the population. When the community sees its community assets as a source of opportunity for improving their living conditions, they can take advantage of them, get involved in community affairs and work to improve the quality of their lives.

This article is divided in three parts. In the first one, it presents the methodological aspect of this study. In the second one, it shows the main result of the analysis to explain how the intercultural healthcare program, EXTENSA, is successful at increasing indigenous women participation in healthcare issue when tapping on pre-existing community assets. This section is divided in two sub-sections. First, it will analyze the case of some communities that possess community leaders in order to note how the program operates as the leaders gain legitimacy in the population and obtain positive community results. Second, it will examine the case of some communities that have informal community networks in order to see how the program works while noting how women can use these networks to improve their health. Last, in the conclusion, it offers a summary of the outcomes of the field work and it challenges the intercultural health approach. Based on the social capital theory, it suggests a new interpretation about how intercultural healthcare programs are successful at activating greater community participation in health prevention and thus, improving the reproductive healthcare of the indigenous women.

1. METHODOLOGICAL ASPECTS

This research has used several sources of information to challenge intercultural healthcare approach and explain the reasons that explain the low level of indigenous community involvement in healthcare prevention, in the Beni Department, Bolivia. It has used a combination of primary and secondary sources. On the one hand, the source of information is based on in-depth interviews with women and focus groups, including members of the indigenous communities. Main sources are the stories told by women. On the other hand, the sources of information also include statistical data of the latest Population and Housing Censuses (2001), and the National Health Information Service (SNIS), Departmental

Health Service, Beni Department, as well as the national surveys of the Bolivian National Statistics Institute (INE). Statistical data were used to complement qualitative information.

Field work was carried out at between 2006 and 2007. The final selection of the municipalities took into account health and poverty criteria, and also the rural and indigenous nature of the population. The selected municipalities in this case were San Javier and San Andrés. The selection of communities that were receiving the EXTENSA program within these municipalities was not predetermined but instead was done through the "snowball sampling" technique.[7] In total, 5 communities that were receiving the program were selected. Five focus groups were developed (one in each community) and 38 interviews were carried on (23 interviews in the Municipality of San Andrés and 15 interviews in the Municipality of San Javier).

Case studies do not confirm theories through the analyzed material. On the contrary, the methodological strategy uses empirical material to refine theories (Burawoy, 1998). In this regard, my case study has been selected to revise approaches that have been applied so far to studying indigenous health. The article aims at ensuring that the outcomes of the case analysis in Bolivia have the potential to enlighten and enrich those approaches to indigenous health that aim at understanding the mechanisms that explain how intercultural healthcare programs increase indigenous women participation in health prevention.

2. ANALYSIS

2.1 THE POPULATION'S INVOLVEMENT IN COMMUNITY HEALTHCARE AFFAIRS

When I arrived to the Nueva Flor community in the municipality of San Andrés on my trip to assess EXTENSA's impact on the population, the community sent me to Ángela, the healthcare promoter. In her account, Ángela acknowledged her leading role in the work done

[7] All of the names of the communities and certain features have been changed to ensure the anonymity of both the communities and the interviewees. However, none of the changes affected the analysis or its results. In all cases, the name of the municipalities is accurate.

by the program and explained that for the community, the fact that she was involved was a plus. *"The community is happy because they receive better care, since I explain the problems people have to the doctors beforehand, the doctors already know which houses they have to visit to see community members who are ill,"* she said.

Ángela was a legitimized representative of the population and she was successful at encouraging the population to care for its health. This became even clearer when a woman from Nueva Flor told me that the women met with the healthcare promoter so that she could share what she had learned in the program's training sessions with them. She added that as a result, the women were "slowly learning how to care for the community's health":

"When she (the healthcare promoter) comes back from the training sessions, she calls all of the women together and tells us about what she's learned. We get together and listen to her, so we are slowly learning how to care for the community's health […] We are taking better care of one another…"

The same results noted in Nueva Flor applied to other communities with healthcare promoters such as Salsipuedes and Universal in the municipality of San Andrés. In these two communities, the promoters also recounted that they were successful at encouraging preventative behaviors and at getting the community to participate in their initiatives. In Salsipuedes, for example, the promoter explained that she had gotten the population to participate in the healthcare talks that the program provided: *"I told people to come… The people come to me and ask me when the program will be visiting because they (the program) let me know when they are coming."* In addition, the promoter told me that she utilized the information that she had received in the EXTENSA training sessions to bring women together and teach them about treating water and using condoms: "*I always call a meeting with the women when I return from EXTENSA training. The first time, we talked about how to treat water to make it potable. All of the women attended. We also spoke about how to avoid getting pregnant, how to use a condom… I felt that they listened to me because I arrived with information, I had the knowledge,"* she explained.

The Valientes community in the municipality of San Javier further revealed the important role that the healthcare promoter played in terms of increasing community involvement in health-

related issues. In fact, in this community I also observed that through the promoter, the community was able to strengthen the community healthcare network that had formed some years before EXTENSA's arrival. That was not all: it was also clear that women were making use of this network in order to improve the health of their community and their own health as well. In the Valientes community, the community had set up a Health Committee before EXTENSA's arrival. The committee was comprised of different community members, who took on internal roles such as treasurer, manager, etc. One of the committee members was the health promoter. As in the other communities, EXTENSA provided the healthcare promoter with training on prevention and on fostering health. However, in this case, the promoter utilized this information and shared it at meetings organized by the Health Committee. According to the promoter, her role allowed the other members of the committee to acquire knowledge about health, which generated important benefits for the health of the entire population. In fact, this became even more evident when a committee member said that *"things have gotten better"* since the promoter had helped to foster preventative behaviors in relation to the environment, the upkeep of homes and personal hygiene:

"We all share the work: maintaining our homes and animals, disposing of trash, treating the water. Things have gotten better. It wasn't like this in the past but now people are trying to protect the environment so that it's healthier. Now we pay more attention to washing our hands and washing diapers as well. Things are changing because people have grown accustomed to taking care of themselves thanks to the fact that they (the program) have encouraged these habits"

Another talk with a member of the Valientes Health Committee revealed how women were using the committee to exchange information on community health and reproductive health as well, leading them "to pay more attention to childcare and to their own healthcare":

"People get together and learn and then we talk amongst ourselves about what we have learned […] Some people are already doing this and it works well. We share this information and we start to pay more attention to childcare and to our own healthcare"

The analysis of the communities that receive EXTENSA showed that healthcare promoters were well-respected by the population and that their role involved fostering community health. At the same time, the analysis showed that the population was making use of their community networks to improve community health. This leads to several questions: *what*

marks the difference? How does an intercultural program like EXTENSA get healthcare promoters to foster a community's participation in health-related affairs? How does the program help women to effectively use their informal networks to improve their health?

2.1.1 COMMUNITY PARTICIPATION BASED ON FOSTERING BONDING SOCIAL CAPITAL

In this section, I analyze how EXTENSA facilitated greater bonding social capital and thereby succeeded in getting women to increase their community participation and improve their health. The section shows that EXTENSA achieves these results because it strengthens existing community assets and transforms them into vehicles for collective mobilization or bonding social capital. It thus allows women to use these assets to improve their living conditions. The analysis reveals that EXTENSA strengthens two types of assets that are already in place when the program arrives: female community leaders and the members of community networks. Chart 1 shows both communities with existing community leaders, community networks or both (leaders and networks) that receive EXTENSA have high levels of healthcare participation.

Chart 1

EXTENSA communities by prior presence of community leaders, intra community networks and community participation in health

Municipality	Selected communities covered by EXTENSA	Existing community leaders	Existing community health networks	Participation in community health
San Javier	Valientes	YES	YES (Health Committee, Ana)	YES
San Andrés	Nueva Flor	YES (Ángela)	NO	YES
	Salsipuedes	YES	YES	YES
	Universal	YES	YES	YES
	Palermo	NO	YES (Mothers' Club)	YES

Source: Drafted by author based on five focus groups (one in each community) and five in-depth interviews

As we will see below, the analysis of the communities covered by EXTENSA reveal the limitations of the intercultural healthcare approach in explaining the causes that lead these

programs to have a positive impact on community healthcare participation. As we have mentioned, the intercultural healthcare approach argues that improving the health of the population and increasing its participation is related to how intercultural programs can foster the right values in the communities in question (such as the importance of getting involved in the community or adopting preventative behaviors) in order to then transmit these values to the rest of the population. However, this reasoning does not explain what occurs with EXTENSA in Beni. Culture "matters" in the analysis of the positive impact that EXTENSA has on community participation and health in Beni, but not as the result of a change to people's values or behaviors. On the contrary, my analysis demonstrates that women increase their participation and their health because the program affirms their community assets as true sources for improving their living conditions. As a result, the program gets them involved, helping them to use these assets to improve their health. In other words, the program increases the participation of these women because it acts on the community assets (community leaders and informal networks) that the women already have before the program arrives and allows the women to strengthen them. In this process, it does not *transform* values or behaviors but instead *constructs* bonding social capital by turning these assets into sources of community empowerment.

The two sub-sections below will show the mechanisms that allow the program to transform existing community assets into sources of collective mobilization. In the first place, it will analyze the case of some communities that possess community leaders in order to note how the program operates as the leaders gain legitimacy in the population and obtain positive community results. In the second place, it will examine the case of some communities that have informal community networks in order to see how the program works while noting how women can use these networks to improve their health.

2.2 TAPPING INTO BONDING-BASED SOCIAL CAPITAL WITH PRE-EXISTING LEADERS.

When I arrived to the Nueva Flor community, in the municipality of San Andrés, one of the first people I interviewed was the healthcare promoter. As in the case of nearly all the communities of the municipality of San Andrés, I reached Nueva Flor with the World Food Programme (WFP), which was taking non-perishable foods to the municipality. One of the

WFP members suggested that I interview Ángela, the healthcare promoter, because of the assistance that she was providing to the program. Ángela clearly had a position of leadership; she was in charge of receiving the food boxes and then distributing them to the population. She was not only a point of reference in terms of health, but also of other community affairs. Besides serving as the healthcare promoter, she was also the literacy promoter. She had studied at the university for a few years, and though she had not yet finished her degree, she had knowledge about literacy. Ángela was constantly working to encourage the population to improve the quality of their lives. For example, she told me that during the spaces for information that EXTENSA offered the community, she took advantage to motivate mothers to get involved in the education of their children:

"I take advantage of the meetings that the program holds here because I am both the (healthcare) promoter and the literacy promoter, so I go from house to house talking with mothers and I also let them know what they can do to help their children do better at school, for them to have the right mindset at school, for them not to go in from zero, like we say here […]"

Ángela invited me to her house for the interview. When I arrived, there were three mothers standing at the door waiting for Ángela to give them the food boxes that the WFP had brought for them. There was also a man with a recipe. In addition, a woman appeared with a sick son to see Ángela. One of the first things I noted in Ángela's house was how it looked like a *Caritas* center. Caritas is one of the social wings of the Catholic Church. In Bolivia—like in other countries of Latin America—Caritas has centers that provide shelter for the poor along with used clothing, medicine and food. A few days before I left for the municipality of San Andrés, I happened to pass by a Caritas center in the city of La Paz, the capital city of Bolivia. There were several people at the doorway, waiting to get into the soup kitchen; a few had a recipe in hand and others were simply waiting to get in. What impacted me was the similar dynamic i.e. at the Caritas office and Ángela's house: in both cases, people were waiting to receive food, medicine and healthcare.

During the interview, however, I came to see that Ángela's role was very different from that of Caritas. In the case of Caritas, the population visited the center only to receive resources. At Ángela's house, the resources allowed the promoter to get the population involved in collective care. Ángela was a community leader and was thus respected by the community. She was the healthcare promoter and had become a critical point of reference for solving the

community's problems. Ángela's legitimacy was based on the fact that she was a channel for assistance for the locals. EXTENSA had provided her with a health kit, as it did for the healthcare promoters of other communities. In addition, the program had trained her in preventing illnesses. Ángela had also been contacted by the organization Family Care International (FCI) to receive courses on reproductive rights and health. Thanks to the health kit and the training, Ángela had become an intermediary between external programs (such as EXTENSA, the FCI and the WFP) and the community. Above all, however, she had become a key source in people's daily survival: people went to see her to receive medicine from the health kit that EXTENSA provided, food from the WFP and care, which Ángela channeled using the knowledge she had incorporated in the training from EXTENSA and the FCI. The resources and knowledge that Ángela had obtained from the programs allowed her to take full advantage of her leading position and gave her a high level of legitimacy in the population, who went to her to obtain these benefits.

The stories of Nueva Flor show how EXTENSA allows the healthcare promoter to increase her power in the community as a healthcare agent and have a positive effect on the community's healthcare. In this case, the program achieved these results by incorporating existing leaders like the healthcare promoter as a critical agent in healthcare and also strengthened her role. As I suggested above, one key aspect of this has to do with promoting mechanisms of empowerment. Thanks to her role as a community leader and as a healthcare promoter, Ángela was able to take advantage of the spaces created by EXTENSA, transforming her role into an effective channel for improving the health of the population. As a result, the community organized itself around her, as they saw her as a way to improve their living conditions.

The case of María, the healthcare promoter in the Salsipuedes community in the municipality of San Andrés, provides further evidence of how important it is to focus on empowering existing leaders when attempting to understand how EXTENSA transforms them into vehicles for collective mobilization. From a young age, María has been active in supporting the demands of indigenous women. María is an excellent example of what is known in Bolivia as the "matriarchy." She is clearly a woman who has gone through difficult times, bringing up her three children on her own. Her husband had been a miner. During the 1980s, he died in Potosí Department, where he worked in a silver mine. Since then, María worked to bring up their three young children on her own. Today, all three have university degree and live outside

Beni Department; they are professionals and hold different posts in the Bolivian government. The death of her husband was a point of transformation in María's life. Since his death, María has taken on different jobs to support her family. In the last thirty years, she has worked as a seamstress and maid; she has worked at a ranch and as an employee at a green grocer's, and also as a babysitter, taking care of the children of the wealthy women from the Beni oligarchy.

María was born in the municipality of Santa Ana, some 50 kilometers from the municipality of Exaltación, which is where she lived with her children and husband until his death. Some time after her husband's death, she moved to Trinidad, the capital of Beni, looking for work. Suring the 1980s, Santa Ana was "no man's land," and much of the cocaine that was shipped from Bolivia to Colombia came out of this municipality to later be chemically processed in the country of destination. When the CIDOB (Confederation of Indigenous Peoples of Bolivia) was founded in 1982, María was working at a green grocer's in Trinidad. She decided to go to some of the confederation's first meetings "out of curiosity." This curiosity led María to become part of a process that led to the founding of the Confederation of Indigenous Peoples of Beni (CPIB) in the mid-1990s. In the public sphere, María also exhibited the strength with which she had lived her own life. At the end of the 1990s, she became of the leaders of the Center of Indigenous Women of Beni (CMIB/CIDOB).[8]At that time, María lived in the municipality of San Andrés, in the community of Sudamericana, where she had moved after her children left Beni to work on a ranch. Since then, María travels occasionally to Trinidad to participate in the meetings of the CMIB, where she works to ensure that the interests of indigenous women are taken into account by the CPIB. Two years ago, María was chosen by the community to be the healthcare promoter.

Thanks to her leading role in the CPIB, María is quite familiar with the situation of indigenous women in terms of accessing public healthcare services and aware of the fact that they are often mistreated by professionals. María was in charge of getting the community together so that I could organize the focus group. During the focus group, María interrupted the accounts of the women who were talking about how hard it was for them to get decent

[8]The Confederation of Indigenous Peoples of Bolivia (CPIB) has eight member groups, including the Indigenous Confederation of the Bolivian Amazon Region (CIDOB).

treatment from the healthcare center doctor and access SUMI. The women fell silent and María said:

"My comrades, you pay taxes. When you buy a kilo of noodles you are paying for SUMI. SUMI comes from your taxes, from what the national government charges, that's what funds SUMI. SUMI is all of your tax money. That is why they say that SUMI is a right, because by paying taxes, you become citizens, with the right to access the healthcare system. You know that simply a degree doesn't give you the right to boss someone around. As indigenous women, we all help one another, and we are aware that if someone doesn't know this, we are willing to explain it to them and talk to them. And that's what has to happen to them (healthcare professionals). They have to have even more patience, because our people know very little about health. The professional should also learn, at least learn to have a little consideration with our people. Our people do not have the training and they need the support of the professionals. It's a support they aren't providing. You need their support, you need them to come to you and explain things to you, for them to treat you as a patient but decently. In the same way that as a people, we treat other humbly and work to cooperate with them, that's the same way they should treat us"

María was an excellent speaker. She gathered the community women together and they listened to her as if she were their "savior".

When EXTENSA reaches a community, it offers a type of care based on the patience and dedication that, as María noted, are lacking in the public healthcare services. The program offers resources and spaces for information while assisting women in improving their health. María was aware of this. For that reason, when EXTENSA got to her community, María strengthened her role of leadership through her role as a healthcare promoter. For her, the possibility of being a promoter was yet another chance to defend the healthcare rights of indigenous women and help them improve their living conditions.

The case of María again shows how the success of healthcare promoters does not depend on the program's ability to foster values or healthy attitudes among the promoters in order for them to later transmit these values to the community. Instead, it is about the program's possibility to empower its community leaders. Through her role as a healthcare promoter and a representative of the Confederation of Indigenous Women of Beni, María takes full advantage of the tools provided by EXTENSA and utilizes them to motivate her peers in

defending healthcare rights. She thus encourages women to participate and the women, in turn, see María as a way to exercise their rights.

2.3 TAPPING INTO BONDING BASED-SOCIAL CAPITAL WITH PRE-EXISTING NETWORKS

As we pointed out earlier, some Bolivian communities have significant informal community networks (that predate the arrival of EXTENSA), which have been formed with the objective of providing mutual support and channeling community programs. This was the case of the Palermo community in the municipality of San Andrés. Although this community did not have a healthcare promoter, the women had formed a "Mothers' Club" several years earlier. The Mothers' Club worked to assist expecting mothers in taking care of themselves during their pregnancy and ensure their delivery was as safe as possible. A talk with one of the leaders of the Mothers' Club showed that before EXTENSA's arrival, the organization already played an active role in terms of staking claims for quality attention. Even so, the lack of access to healthcare services represented an obstacle in terms of obtaining information or reproductive healthcare resources, thus annulling the Mothers' Club's capacity to respond to other problems women were facing, such as their own healthcare.

The case of the Mothers' Club in the Palermo community also revealed how the program's success was based on community empowerment, which resulted from strengthening the existing community assets that the women possessed. In this case, the Mothers' Club shows how the program manages to strengthen this network and transform it into a vehicle for collective mobilization for healthcare. EXTENSA acknowledged the role of the Mothers' Club and opened up new channels for participation so that these women could attend informational workshops on the use of contraception methods and on doing Pap smears.[9] In addition, these workshops provided information on SUMI and on the benefits the universal coverage provided for women.

The focus group carried out among members of the Women's Club revealed that the educational spaces that EXTENSA offered allowed women to take advantage of the network and use it to benefit their health. In particular, the case of the Mothers' Club showed how the

[9] The Pap smear (Papanicolaou) is a study that is done to prevent uterine cancer.

educational spaces offered by the program became an opportunity for members to use the community network to defend women's healthcare rights. In this regard, it was clear how the network became a vehicle for collective mobilization. At the same time, mechanisms of empowerment were visible in this process. This became clear to me when I saw how the information that the program provided about SUMI led the members of the Mothers' Club to recognize the paternalistic focus of the system, which centered its attention on children. At the same time, this realization transformed the Mothers' Club into a vehicle for collective mobilization because women took advantage of this network to demand that the healthcare system guarantee care for women. One woman put it like this:

"He (the doctor) informed us about SUMI, (telling us) that we could go to the healthcare center. He told us that as women, we had the right to a delivery covered by SUMI so we are going to all demand this when the doctor from the post comes… We are aware that we need to make this demand of the healthcare center, because SUMI provides care for children but does not provide care for the women"

On the other hand, the opportunity of learning more about their healthcare rights led women to become active in searching for solutions for reproductive healthcare. For example, one woman mentioned that all of the club's members had participated in the talks the program gave on preventing pregnancy and that later, they had asked the program to return to do Pap smears and deliver contraception. This is how she explained it:

"Once EXTENSA came and called the members of the Mothers' Club together. They gave us talks on (contraception) methods to avoid getting pregnant. They also explained the Pap smear […] So we all participated in these talks and then asked them to come back to do the Pap smears and bring us the contraception"

One of the obstacles that women faced in terms of using their community networks for reproductive healthcare was associated with the perception of gender barriers. Women lost the chance to use their networks because their husbands pressured them to stay at home and because they were overloaded with other tasks (reproductive, productive and community tasks). The analysis of the stories of the Palermo community reveals how women use their own community network—the Mothers' Club—to defend their rights as citizens, to obtain healthcare resources and information, and to help other women care for their reproductive health. Unlike what proponents of the intercultural approach would have interpreted, this analysis shows that the results are not only based on the program's ability to establish a

"culture of participation or preventative health." The program gets women to start using this community asset to their own benefit because it constructs mechanisms for collective empowerment. In the specific case of the Mothers' Club, EXTENSA transforms this social network into an effective channel because it acknowledges the role that the Mothers' Club has had for women, opening up new spaces for participation and giving the members the chance to access educational tools on healthcare and rights. In other words, EXTENSA gives women the chance to overcome the gender barrier, strengthening the existing community networks.

The case of Ana in the Valientes community of the municipality of San Javier further demonstrates the effect of strengthening existing community networks on women's active role in their own health. Ana was 32 years old. She had finished elementary school in Trinidad, about three hours from the Valientes community, and had a few classes left to finish high school. Her family had lived in the Valientes community for her whole life. She had a happy childhood and she was one of a group of young people at the school that organized dances and raffles. At one of these dances, she met her husband and they are still together. In spite of the "enchantments" that the city of Trinidad had to offer, after her fourth year of high school[10] she decided to return to her community, where her whole family was living.

Although Ana's house had wooden walls, a dirt floor and an outhouse, it was a luxury for Ana. Her house was neat and pictures were hung on the wall, many of which showed her with members of the Valientes community. Ana was proud to live in this community: *"We are very united here. We help one another; someone is always there to see if you need something*." For several years, the community had participated in a community Health Committee. Since Ana was well-known in the community and was familiar with the people's needs, she was appointed president of the committee.

As president, Ana represented the community at the meetings of the DILOS (Local Healthcare Directory). When she could, she travelled to Trinidad, paying for the trip herself. She was not totally sure of the potential that the DILOS had in terms of channeling the population's demands because *"It's run by the mayor […] At the mayor's office, they get money from the municipality to purchase medicine but in the end, they keep the money and don't buy anything."* However, Ana's experience on the healthcare committee had made her

[10] High school lasts five years in Bolivia.

aware of the needs of local women and of the health problems that the families in the community faced. *"Of course we have problems, but we are united. We get together and divvy up the tasks so that we all participate."* Ana was optimistic and this could be seen in her perception of the community, her family and her own life. Ana was in charge of gathering the population together when EXTENSA visited the community. She also collaborated with the healthcare promoter, helping her with the community health kit and accompanying her in visits and talks she gave to the community.

Ana's case is a good example of how important it is to pay attention to strengthening existing informal networks in order to understand how women start to care for their own health. Ana is a key member of the informal networks of the Valientes community. She has lived her whole life in Valientes and is thus familiar with the people's needs. In addition, Ana loves her community and seeks to improve people's living conditions. When EXTENSA visits the community, Ana takes advantage of the opportunities provided by the program and strengthens the network she is already part of. Since Ana considers EXTENSA as a way to improve the quality of life of the community that she loves so much, she takes advantage of community networks and uses them to improve people's health. For example, Ana helps the healthcare promoter and uses her position as the president of the healthcare committee to bring together her peers in order for them to make the community a better place to live.

In conclusion, this subsection showed how the women who are EXTENSA beneficiaries see their informal networks as effective channels for improving their health, that of other women, and/or for getting the population involved in caring for the community's wellbeing. Unlike what proponents of the intercultural healthcare approach would have argued, this section again shows that this result is not related to the change that the program can make in terms of the values or orientations of the population. This section demonstrated that networks become an effective way to improve health because the women feel that the program allows them to turn these networks into effective vehicles for improving their living conditions. In addition, this section showed how this process results from empowerment, which takes shape when the existing community networks are strengthened. The case of the Mothers' Club in the Palermo community clearly showed how the educational and participative spaces that the program opens up allows the women who are part of this network to adopt a critical view in terms of the lack of care, acknowledge their rights as citizens and encourage other women to take an active role in the collective demands. The case of Ana in Valientes also revealed how she is

able to take advantage of the community networks that she is a member of and get them in gear and improve the living conditions of the community.

3. CONCLUSION

This article analyzes how the EXTENSA program succeeded at encouraging community participation and improving health. To respond to this question, the analysis focuses on the explanations provided by the social capital theory and uses this theory to analyze how EXTENSA promotes participation and healthcare. The analysis showed how the women who are EXTENSA beneficiaries see their informal networks as effective channels for improving their health, that of other women, and/or for getting the population involved in caring for the community's wellbeing. Unlike what proponents of the intercultural healthcare approach would have argued, the analysis shows that this result is not related to the change that the program can make in terms of the values or orientations of the population. This analysis demonstrated that networks become an effective way to improve health because the women feel that the program allows them to turn these networks into effective vehicles for improving their living conditions. In addition, the analysis showed how this process results from empowerment, which takes shape when the existing community networks are strengthened.

In spite of the fact that the women are isolated from the sphere of modern medicine, they are part of a broad network of social relations that operate within their communities. Nevertheless, the women come up against different obstacles when they attempt to mobilize. Just as the weakness of these assets can be explained by a lack of opportunities—and not a question of "values"—, they can also be strengthened if the local context changes. And this depends to a great extent on how programs can construct mechanisms of empowerment, enabling access to material and educational resources and political power, and opening up new spaces of collective participation. The point here is to understand that the ways of being in communities before the arrival of programs are not an "obstacle" to participation or to community health. Instead, there are the existing assets among the women that can be a source of empowerment in and of themselves. The article shows how the community's past, the knowledge of the community's needs and the interest in improving the quality of life of

community members are key elements that allow community leaders to take advantage of the opportunities which the program provides and transform their assets into vehicles for collective mobilization. For this reason, the mechanisms of empowerment are fundamental to understanding how the program manages to transform community assets into bonding social capital. When those who possess these assets can obtain tools to improve the quality of life of the population, they increase their ability to impact the community and to get people interested in improving their living conditions. In addition, in a context such as Beni that is characterized by significant gender barriers, these tools becomes sources of collective mobilization because women use these assets in the hope of overcoming this barrier. For this reason, the mechanisms that allow the intercultural health programs to increase community participation should be reinterpreted such that we move away from focusing on what programs offer in terms of transforming people's values or behaviors towards another one focusing on how they help women to strengthen intra-community networks and use these networks to impact the community's wellbeing.

BIBLIOGRAPHY

- Burawoy, M. 1998. "The Extended Case Method." *Sociological Theory* 12, pp. 4-33.
- Camacho, A.V., Castro M.D. and Kaufman, R. 2006. Cultural aspects related to the health of Andean women in Latin America: A key issue for progress toward the attainment of the Millennium Development Goals. *International Journal of Gynecology and Obstetrics* 94, pp. 357-363.
- Campos, R. and Citarella, L. 2004. "Willaqkuna. Un programa de formación en salud intercultural en Bolivia." In *Salud e Interculturalidad en América Latina. Perspectivas Antropológicas,* ed. Fernández Juárez, G. Quito: ABYA YALA, BOLIHISPANA, UCLM.
- Durston J. 1999. Construyendo capital social comunitario. *Rev CEPAL* 69, pp.103-18.
- Durston, J. 2000. ¿Qué es capital social comunitario?, "Serie Políticas sociales, Nº 38 (LC/L.1400-P), Santiago de Chile, Comisión Económica para América Latina y el Caribe (CEPAL). Publicación de las Naciones Unidas.
- Durston J. and Duhart D. 2003. Formación y pérdida de capital social comunitario mapuche. Cultura, clientelismo y empoderamiento en dos comunidades, 1999-2002.

Santiago de Chile, CEPAL, División de Desarrollo Social (Serie de Políticas sociales, 63).

- Family Care International (FCI)/Bolivia. 2007. *Evaluación Participativa del SUMI en cuatro municipios del departamento del Beni.* La Paz: FCI/Bolivia.
- Fondo de Población de Naciones Unidas. 2008. *Estado de la Población Mundial 2008. Ámbitos de convergencia: cultura, género y derechos humanos.* New York: UNFPA.
- Gonzales Salguero F., Martin A., Pérez Mendoza R. and Vernon R. 2005. Cross cultural adaptation of reproductive health services in Bolivia. FRONTIERS Final Report. Washington, DC: Population Council.
- Kawachi, I. and Sapag, J. 2007. Capital social y promoción de la salud en América Latina. *Rev Saúde Pública* 41 (1), pp.139-49.
- Lewis, O. 1965. *La Vida: A Puerto Rican Family in the Culture of Poverty. San Juan and New York.* New York: Random House.
- _____. 1968. "The Culture of Poverty". In *On Understanding Poverty: Perspectives from the Social Sciences,* ed. Moynihan. New York: Basic Books, pp. 187-220.
- Marmot, M. 1999. "Improvement of social environment to improve health." *Lancet* 351, pp. 57-60.
- Marmot, M. and Wilkinson RG. 1999. *Social Determinants on Health*, Oxford: Oxford University Press.
- Menéndez E. 2005. Intencionalidad, Experiencia y Función. *Revista de Antropología Social* 14, pp.33-69.
- Mignone, J.;Bartlett, J.;O´Neil, J. and Orchard, T. 2007. "Best practices in intercultural health: five case studies in Latin America." *Journal of Ethnobiology and Ethnomedicine*, No.3, September.
- Ministerio de Salud y Deportes. 2005. *Guía para la atención intercultural de la salud materna.* La Paz: Ministerio de Salud y Deportes.
- Montaño, S. 2003. Políticas para el Empoderamiento de las Mujeres como Estrategia de Lucha Contra la Pobreza. In *Capital social y Reducción de la Pobreza en América Latina y el Caribe: en busca de un nuevo paradigma,* ed. Atría, R.; Siles, M.; Arriagada, I.; Robison, L.; Whiteford, S., Santiago de Chile, Comisión Económica para América Latina y el Caribe (CEPAL), Naciones Unidas, pp.361-378.
- Putnam RD., Leonardi R. and Nanetti R. 1993. *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton NJ: Princeton University Press.

- Ramirez Hita, S. 2006. “La Interculturalidad sin todos sus Agentes Sociales. El Problema de la Salud Intercultural en Bolivia.” In *Salud e Interculturalidad en América Latina, Antropología de la Salud y Salud Intercultural*, ed. Fernández Juárez, G.QUITO: ABYA YALA, UCLM, AECI.
- Saegert, S.; Thompson, JP. and Warren, MR. 2001. *Social Capital and Poor Communities,* New York: Russell Sage Foundation.
- The World Bank. 2004. “Reforma del Sector Salud en Bolivia. Análisis en el Contexto de la Descentralización.” Washington: Banco Mundial.
- Wallerstein, N. 1992. “Powerlessness, Empowerment, and Health: Implications for Health Promotion Programs.” *American Journal of Health Promotion*, Vol 6. No. 3, pp. 197-205.
- World Health Organisation. 1986. Ottawa Charter for Health Promotion in First International Conference on Health Promotion; 1986 Nov 21; Ottawa, Canada, Geneva.