The Intercultural Healthcare Approach Revisited: Understanding Indigenous Women's Community Participation in Healthcare
Lila Aizenberg

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 has been successful in 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 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 community leaders and network members (who predate EXTENSA) access to economic, educational and political resources, providing them with new opportunities. In this process, it does not transforms 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 interpretation of healthcare based on merely physical elements to provide more room for social aspects. This was 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 peoples (Torri, 2012). 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 (Montenegro and Stephens, 2006). 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 (O'Neil et al, 2006). 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 (Camacho et al, 2006).
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 (OPS, 2008; Gonzáles Salguero et al., 2005; The World Bank, 2004; Mignone et al. 2007; BID, 2006). 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. 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.

In Latin America -one of the regions with the largest indigenous population worldwide- the Identity-based Development Strategy was quickly reflected at the local level. At the beginning of 2000, a great number of countries in the region had already included the Strategy in their national agendas, and had started implementing health policies from an intercultural point of view. This entailed a radical change of focus compared to those years of Health Sector Reform: instead of focusing on enhancing service coverage by extending the offer, actions were aimed at strengthening services by bringing in local culture (The World Bank, 2004).

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 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, 2007; O'Neil et al. 2006; 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; 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. As 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, have begun.  

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1 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).
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”) 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,” (IADB, 2006) 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), 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.

This article is divided into 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’s participation in healthcare issues when tapping on pre-existing community assets. This section is divided into 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. Finally, 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 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 was established in 2003. The program arose in Bolivia due to the 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). Within this framework, the World Bank -together with the Bolivian Ministry of Health and Sports- decided to implement a health program to improve the deficient levels of health among indigenous women. The program has two specific objectives. On the one hand, it aims at increasing health coverage for children and rural and indigenous women of reproductive age; on the other hand, it aims at bringing together traditional medicine and local culture, and places them into an intercultural perspective. In practice, the program is implemented through mobile health brigades that reinforce public primary healthcare (at health centers and posts) for poor rural and indigenous communities.

2 Within Bolivia, Beni Department is one of the most vulnerable ones. When noting maternal mortality rates, one of the most sensitive sexual and reproductive health indicators, we realize that the rate among rural and indigenous women is three, and up to four, times higher than among non indigenous inhabitants. The same happens with fertility. Rural indigenous women have an average number of two children more than women in the urban areas. The high level of geographical isolation of the communities and the lack of road infrastructure lead the people living in rural areas to face great barriers in accessing primary healthcare services. Statistically speaking, only 6 out of 10 childbirths take place at health institutions and are attended by skilled staff. One of the reasons for these low levels of using health institutions is that Beni is one of the departments with fewer resources and health infrastructure (UDAPE-UNICEF, 2006).


4 The notion of social capital contrasts with the idea of the cultural marginality (and its effects on people’s behaviors). Social capital disputes this idea because it emphasizes the potential that the poor have to escape poverty and improve their behaviors through their 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, among others).
1. Methodological Aspects

This research has used several sources of information to challenge the intercultural healthcare approach and explain the reasons for 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. Information provided here is mainly based on in-depth interviews with women and focus groups, including members of the indigenous communities. Main sources are the voices of indigenous women. In addition, statistical data has been gathered from 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).

Field work was carried out 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 Exaltación, San Pedro and San Javier. 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. In total, five communities that were receiving the program were selected.

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 of how intercultural healthcare programs increase indigenous women’s participation in health prevention.

2. Analysis

When I arrived at 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 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 that 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 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 been able to

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1 This research is part of a broader analysis that aimed at evaluating intercultural health programs in the context of the public health care system in the Beni Department. Interest in the EXTENSA program arose as a consequence of the differences found between communities not covered by EXTENSA and those that covered the program (Aizenberg, 2011).

2 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.
get 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 been 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”

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.

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 it has been argued, the underlying logic of the intercultural healthcare is based on the fact that improving the health of the population and increasing their 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 8

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8 As it has been mentioned before, it is our intention to challenge the underlying logic of the intercultural health approach that in our understanding is in line with the culture of poverty argument (Lewis, 1968; 1965). For several years different authors have challenged the culture of poverty argument, “blaming the victims for their own fate” (Swidler, 1986; Small et al., 2010). According to critics, the above theory has a severe limit in its reasoning, resulting from its conception of culture as that of values/beliefs or ideas. And they continue to hold that such a conceptualization of culture has led the theory to mistakenly analyze the link between culture and poverty, by transforming not only social notions into psychological reasons, but also implying that people can exit poverty if they “change their culture”. Critics contend that culture is not necessarily determined by the social structure or the socioeconomic conditions of people. Culture can be shaped differently according to how people respond to their environment and according to the different community networks they are involved in. Consequently, it would be a mistake to simply add “culture” or the “cultural variable” when explaining the low performance in poor people’s conduct or in the policies aimed at improving such behavior (Small et al., 2010).
contrary, the analysis demonstrates that women increase their participation and improves 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 these. 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.

2.1. Tapping into bonding-based social capital with pre-existing leaders.

When I arrived at the Nueva Flor community, in the municipality of San Andrés, one of the first people I interviewed was the healthcare promoter. 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 for 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 space for information that EXTENSA offered the community, she took advantage of motivating 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. 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 providing 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 other non-governmental organizations to receive courses on reproductive rights and health. Thanks to the health kit and the training, Ángela had become an intermediary between external programs 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 other non-governmental organizations. 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 was clearly a woman who has gone through difficult times, bringing up her three children on her own. During the 1980s, María's husband died in Potosí Department where he worked in a silver mine. The death of her husband was a point of transformation in María's life. Since his death, María had 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. Some time after her husband's death, she moved to Trinidad, the capital of Beni, looking for work. 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 one of the leaders of the Center of Indigenous Women of Beni (CMIB/CIDOB). 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 is 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 treatment from the healthcare center doctor and to 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. 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 others humbly and work to cooperate with them, that’s the same way they should treat us”.

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1 The Confederation of Indigenous Peoples of Bolivia (CPIB) has eight member groups, including the Indigenous Confederation of the Bolivian Amazon Region (CIDOB).
2 Universal Maternal and Child Health Insurance.
María was an excellent speaker. She gathered the community women together and they listened to her as if she was their "savior".

When EXTENSA reaches a community, it offers a type of care based on the patience and dedication that, as María noted, is 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 arrived at 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 to help them improve their living conditions.

2.2 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. 11

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. 12 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 Mothers' 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 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".

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11 The literature has shown the low performance of healthcare for indigenous women in Bolivia is due to gender discrimination within the healthcare system. According to this literature, the public healthcare system in Bolivia has been characterized by a paternalistic, charity-providing role since its beginnings. This role of the healthcare system is revealed in the limited capacity that women have to make decisions related to healthcare practices on their own bodies (including their reproductive health) (Dibitts and Terrazas, 2003).

12 The Pap smear (Papanicolaou) is a study that is done to prevent uterine cancer.
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 conduct Pap smears and to 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”.

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 for 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\textsuperscript{13}, 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 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 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

\textsuperscript{13} Research has shown that Bolivian indigenous women do not participate much in community affairs and do not employ preventive behaviors in the field of health, due to gender inequality. Indigenous women suffer great gender discrimination, which appears within their own communities, and also within the health system. In their communities, Bolivian women fill a leading position because of their three-fold productive, reproductive and community role. Nonetheless, this is not reflected in the public sphere. The very few possibilities for participating in the public sphere limit their education, and have a negative impact on their healthcare (Meentzen, 2001). See also Finkler (1997; 1994) for a discussion of gender inequality, culture and sickness in Mexico.
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.

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, the health 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 is not an “obstacle” to participation or to community health. Instead, there are 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


