Can NGOs Make a Difference?

The Challenge of Development Alternatives

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Transforming or Conforming? NGOs Training Health Promoters and the Dominant Paradigm of the Development Industry in Bolivia

Katie S. Bristow

Since the end of World War II NGOs have played a central role in development assistance, with many taking a radical stance, challenging the dominant view (Eade, 2000; Hailey, 1999). In the 1980s and 1990s NGOs received substantial funding from national and international governmental organizations (IGOs). This, in part, was a consequence of reduced financial support from private sources during this period but also due to recognition by IGOs of the role that NGOs can play in achieving their agendas. It was argued that, through their ability to provide cost-effective welfare services and encourage citizenship, democracy and the creation of social capital, NGOs could play an important role in strengthening key components of what some term the New Policy Agenda (NPA) (Robinson, 1993; Edwards and Hulme, 1995). Midway through the present decade, the 'Golden Age' of international government funding for NGOs may be in decline as IGOs move to partnership agreements with a selected few (Agg, 2006). Whatever the case, IGOs continue to impose their agenda for international development, whether on NGOs with partnership agreements or on those striving for such agreements. Rather than challenge this agenda by implementing alternative approaches, most NGOs find themselves and their policies drawn in and subsumed to those of government funders (Edwards and Hulme, 1995; Edwards and Hulme, 2000; Pearce, 2000).

The reasons NGOs appear to have moved – consciously or unconsciously – towards a pro-market (neoliberal) and technology-orientated agenda of the IGOs are complex. This chapter argues that this move can be explained by four types of factor: ideological/philosophical, politico-economic, socio-cultural and pragmatic. These factors are, furthermore, interlocking, as illustrated in the following scenario. If an NGO's ideology leads it to refuse

to align itself with the NPA, this could lead to a reduction of financial support (a political economic factor). The organization may then need to make a pragmatic decision to reduce the number of its staff, which in turn will affect the services it can offer. For example, cutting back on learning support in training for women health promoters who already lack education may compound the socio-cultural factors that have already put these rural/indigenous women at a disadvantage.

The chapter will argue that the mesh of factors are part of the conscious and unconscious strategies used by social groups, in this case relating to different health systems, to maintain, promote and defend their specific world-view, knowledge and practice. A theoretical framework will be used to explore how power to influence is made relative using Gramsci's (Gramsci, 1971) conscious hegemonic strategies together with Bourdieu's (Bourdieu, 1989) unconscious mechanisms of habitus and field.

The framework will be applied to two NGOs in Bolivia, 'CÓDIGO' Bolivia and World Vision's PDA in Santivañez (Programa de Desarrollo del Area, Area Development Programme), and their training and management of community health promoters. The prevention and treatment of diarrhoeal diseases have been chosen as the foci or tracer issues for the study. Diarrhoeal diseases are one of the five main causes of death in children under 5 and as such they are included in WHO's and UNICEF's Integrated Management of Childhood Illnesses (IMCI) strategy. The reduction in the number of children who die from diarrhoeal disease is also an important intervention to address child mortality, MDG (Millennium Development Goal) four.

The NGOs CÓDIGO and PDA have been chosen because they take different stances in their approaches to health and development issues. CÓDIGO aims to challenge or transform the neoliberal development model that was dominant in Bolivia at the time of research, while PDA appeared to conform to this same model. To compare these two organizations, the chapter proceeds as follows. It opens with a brief description of the current development paradigm and analysis of different conceptual models of health and health care, in particular the biomedical, social and Andean models. This includes revealing how the biomedical model – using the IMCI strategy – has taken centre stage and supports broader global socio-economic goals and therefore the current development paradigm. The next section will discuss the ways in which the current development paradigm subsumes and weakens approaches that might hinder its pro-market, technical orientation. From this platform, I discuss examples of the ways in which both CÓDIGO and PDA are affected by the current approach to development, and the mesh of factors that influence this process. To elucidate the processes at work, the section also discusses the cases of two health promoters, Carolena and Felipe, who work with these organizations. The final section gives an

explanation of the relative power of CÓDIGO and PDA to influence the knowledge and practice of their health promoters.

The Current Development Paradigm

This chapter takes the position that the current socio-economic development model espoused by the International Development Community (IDC), in particular the World Bank and International Monetary Fund (IMF), is essentially neoliberal with an emphasis on science and technology. That is, despite acknowledgements of the value of other forms of development, in practice a pro-market Western scientific agenda dominates based on ideas of progress arising from the Enlightenment (Powell and Geoghegan, 2006; Bourdieu, 1998). A specific case in point is the relationship of biomedicine to other models of health.

Biomedical model of health

'Biomedicine' as a concept and in its practice has evolved along a similar path to other forms of Western knowledge (Burke, 2000). It is possible to use Hippocrates (460–360 BC), not as the start of medical practice, but certainly as a pivotal point in its history (Carr, 1997; Kiple, 1993). Biomedicine's evolutionary process has, then, taken it away from Ancient Greece, to the Middle Ages and the Middle East, before returning to Europe and the influence of the Renaissance and the Enlightenment periods in the eighteenth and nineteenth centuries.

The term 'medicine' means the 'art of healing' and is based on a wide range of natural sciences but especially biology (Wiseman, 2004). The prefixes 'bio', 'Western' or 'modern' are often added to 'medicine' to distinguish this form of medical practice from others. I prefer the term 'biomedicine' as it is no longer solely practised in Europe or the Western hemisphere, and Ayurvedic and Chinese medicine also have modern-day forms (Scrimshaw, 2006).

Indigenous medical models

Indigenous medicine refers to medical practice and concepts of health and illness relating to specific cultures and/or ethnic groups. Indigenous medicine is more commonly known as 'traditional medicine'; this is to contrast it with so called modern medicine (biomedicine). In fact all medical systems are indigenous, but some, such as biomedicine, Ayurvedic and Chinese medicine, are now practised beyond their original socio-cultural contexts (Scrimshaw, 2006).

Andean medicine is the indigenous medical system of the Aymara and Quechua people of the Andean Region in South America, of which high-

land Bolivia is a part. Like all aspects of Andean culture, health cannot be understood without understanding the cosmovision of which it is an integral part. Communal, symbolic, ritual and reciprocal practices link individuals and families to the wider social organization of the community, nature and the gods (Allen, 1988). Human and animal disease, or problems with the productive capacity of the land, signify a break somewhere within this cyclical relationship and a world no longer in harmony (Quiroga, 1997; Carrizo, 1993).

Social model

The social model of health proposes that various layers of socio-economic factors and conditions affect or determine health. These determinants include affordable food, education, employment, environment, health care, housing, income, sanitation and clean water, and transport. In order to improve health, all these factors need to be addressed both with the individual and across different socio-economic policies (Povall, 2005; Whitehead, 1995).

Indeed this understanding of health is at the heart of the World Health Organization's (WHO) definition of health: 'a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity' (PAHO, 2002; Povall, 2005). However, as in the way neoliberalism dominates the current development model, biomedicine overshadows this more holistic approach to health.

Biomedicine as central to the dominant development paradigm

It is possible to argue that there is a clear historical trajectory linking European culture, especially its knowledge and world-view, to current approaches to social and politico-economic development. Europe's colonial endeavours since at least the fifteenth century have been influential in defining the politico-economic and social structures of many nation-states worldwide. This influence includes a biomedical approach to the development of national health-care systems – systems that, it must be said, tended to be for the use of the colonializers rather than the indigenous population (Powell and Geoghegan, 2006; Cammack, 2002; Burke, 2000; Bergesen and Lunde, 1999; WHO, 2000). The next section explores this claim further by demonstrating how health-care initiatives, such as Integrated Management of Childhood Illnesses (IMCI), are also used to support a neoliberal approach to development.

To establish IMCI's link with neoliberalism it is necessary to go to the post-colonial era, the newly independent states' development of their health-care services and the Alma Ata Declaration in 1978 'Health for All by the Year 2000', through universal primary health care (PHC) (Morely et al., 1983).

The fledgling PHC systems initiated after the Alma Ata declaration in these new nation-states were allowed little opportunity to develop. This was because PHC implementation coincided with a period of oil crisis, which led to a subsequent downturn in the global economy and large national debts incurred by most of these countries. From the 1980s onwards many countries were required by the World Bank and IMF to follow the pro-market structural adjustment programmes (SAP) and more latterly the Comprehensive Development Framework (CDF) and Poverty Reduction Strategy Papers (PRSPs) to help address national debt. PRSPs were developed to provide at least some opportunity for national and international agencies to address the need for welfare services in the context of debt-reduction measures (Cornia et al., 1987; Marshall and Woodroffe, 2001).

An important consequence of these measures in the 1990s was the change in primary health care from the idea of 'health for all' as universal health coverage to what the WHO calls 'the "new universalism" – high quality delivery of essential care, defined mostly by the criterion of cost-effectiveness, for everyone, rather than all possible care for the whole population or only the simplest and most basic care for the poor' (WHO, 2000: 5). In other words, selective health care relating to the most cost-effective interventions for specific health issues or populations. IMCI is an example of this approach as it targets the five main causes of death in children under 5 – malaria, measles, respiratory infections, diarrhoea and malnutrition (WHO, 2001). Linked to these strategies was the endorsement by a UN Summit in September 2000 of the Millennium Development Goals (MDGs), a group of eight targets to be achieved by 2015 (World Bank, 2003; WHO, 2000). IMCI is seen as an important strategy for achieving MDG target four – reduction of child mortality by two-thirds by 2015 (World Bank, 2002).

The Health Nutrition and Population department of the World Bank directly links IMCI to PRSPs. As an example, Dr Hans Troedsson, Director of Child and Adolescent Health and Development at the WHO, addressed child mortality at a World Bank consultation, called 'Monitoring HNP (Health Nutrition Population) Goals using the PRSP Framework'. Dr Troedsson described the way the IMCI strategy can be employed to address MDGs relating to child mortality within the context of the PRSP framework. He noted that the PRSP provides an opportunity to improve child health because (i) determinants and indicators in the PRSP can have a major effect on country priorities; and (ii) focusing on the implementation of a limited set of effective interventions will lead to achievement of the MDG for child mortality (Troedsson, 2001: slide 38).

To address child mortality, he argues, PRSPs will need to include health

and other relevant policies to develop the capacity of the health system to respond appropriately. Such appropriate responses would include health interventions, such as good nutrition, clean water or oral rehydration solution, that reach the target population, children under 5. The IMCI strategy and its selected interventions are deemed the effective way forward for achieving a reduction in child mortality and therefore MDG target four.

To summarize the argument so far, the current paradigm of socio-economic development practised by the IDC is by and large based on neoliberal ideas, science and technology. It was also proposed that European cultures and scientific knowledge have had a significant influence on the evolution of this paradigm, especially in relation to Europe's colonial past. Biomedicine and interventions such as IMCI clearly have many of their roots in Europe and are principal components of the current development paradigm (Powell and Geoghegan, 2006; Cammack, 2002; Burke, 2000; Wiseman, 2004; McGrath, 2001). Using Gramsci and Bourdieu, this chapter will now address how actors within the international development community use conscious and unconscious strategies to maintain their dominance over others.

Conscious and Unconscious Strategies of Power and Influence

As discussed earlier, the model of development that the IDC seeks to promote is essentially neoliberal with an emphasis on science and technology. Gramsci argues that influence is not exerted through outright dominance but by the consent of the other groups to the dominant group's perspective.

> Indeed the attempt is always made to ensure that force will appear based on the consent of the majority, expressed by the so-called organs of public opinion – newspapers and associations – which, therefore, in certain situations, are artificially manipulated. (Gramsci, 1971: note 49)

The elite, in Gramsci's view, will also compromise and sacrifice if necessary and will attempt to maintain the equilibrium as long as it does not interfere with the overall direction of their cultural and economic project.

> [I]n other words, that the leading group should make sacrifices of an economic-corporate kind. But there is no doubt that such sacrifices and such a compromise cannot touch the essential. (Gramsci, 1971: 161)

The conscious use of consensus and compromise to gain support can be seen in the ways in which the Bank and IMF responded to strenuous criticism of the Structural Adjustment Programmes (SAPs) in the 1980s. These

responses, as embodied in the subsequent compromise approaches of the Comprehensive Development Framework (CDF) and the Poverty Reduction Strategy Papers (PRSPs), supposedly offer a more human face of development (Cornia et al. 1987). Attention to social and human development issues, including health strategies such as the IMCI, are now components of the neoliberal project to improve the economies of low- to middle-income countries and thereby the global market (Troedsson, 2004).

Consensus and compromise can also be detected in the way that NGOs are arguably losing their radical edge in order to gain financial support and recognition from the main development players such as the World Bank and other multilateral and bilateral agencies (Edwards and Hulme, 1995). This phenomenon of consensus and compromise in the face of power has been termed 'subsumation' by some (Cammack, 2002; Kothari and Minogue, 2002). It is a process in which ostensibly alternative approaches to development, such as participation, gender and ethnodevelopment, are taken over and domesticated to suit the neoliberal model. In biomedicine this can be seen in the way consideration of local health beliefs and practice is stressed in policy documents but is rarely followed through in practice (Bristow, 2005).

The notion of subsumation has particular importance for NGOs that train community health workers, especially in multi-ethnic and socio-economically diverse societies like Bolivia. Instead of indigenous medical knowledge and practice being actively combined with Western biomedical elements of health-care provision, these local knowledges are either subsumed or ignored. Ultimately this leads to missed opportunities to improve health-care practice. For example, in relation to diarrhoea – one of the health problems treated through IMCI – the main concern is to prevent dehydration by giving oral fluids. In Andean medicine mothers bathe their children in herbs, giving only small amounts of fluid orally. It is not hard to imagine that if the value of both medical systems were acknowledged in practice as well as in policy, biomedically trained health workers might be able communicate the importance of increasing oral fluids alongside bathing in herbs (Bristow, 2005; Nichter, 1988).

Domestication (subsumation) is an aspect of a process that combines both conscious Gramscian hegemonic notions of power and influence with concomitant unconscious processes. These unconscious processes can best be explained by using Bourdieu's notions of habitus and field (Bourdieu, 1989, 1999). Habitus relates to the way the norms, actions and representations associated with a particular social group are embodied, produced and reproduced within individuals. Past experiences inform actions in the present, and, in turn, present actions anticipate without conscious effort their future outcome. In this way the character of the group is maintained

and structures are reproduced. It is an 'embodied history, internalised as second nature and so forgotten' (Bourdieu, 1999: 111). It guides and directs individual behaviour while still giving choice, although limited to those decisions that might be consistent with the habitus of the social group.

> Agents shape their aspirations according to concrete indices of the accessible and the inaccessible, of what is and is not 'for us', a division as fundamental and as fundamentally recognized as that between the sacred and the profane. (Bourdieu, 1999: 117)

To explain how social groups, particularly dominant groups, reproduce themselves and maintain their influence, Bourdieu talks of primary and secondary habitus and of pedagogic action and authority. Primary habitus is the type into which a child is born, and learns though pedagogic action that has been authorized (pedagogic authority) by their family and class (or ethnic group) (May, 2001). Secondary habitus is developed, by pedagogic action, most notably, within schools but also through training in specialized areas such as health care.

Specialized training brings us to Bourdieu's other notion of 'field'. Field could be described as social space, a concept that is similar to physical space – divided up into regions, spaces within spaces, which are moulded by the taste and disposition of the dominant class or social group. Class itself is a field; so too are politics, education, art, health care, international development and ethnic groups, for example. These spaces, however, are 'constructed in such a way that the closer agents, groups or institutions which are situated within th[ese] space[s], the more common properties they have; and the more distant, the fewer' (Bourdieu, 1989: 16 col. 1).

Even within fields there will be those at the centre who will be more readily recognized by their pedagogic authority and identify more closely with each other. For instance, in the field of a UK national hospital, doctors and nurses will be near the centre and have much in common. Conversely, an acupuncturist may well be employed by the same hospital but have a lot less in common with both it and its doctors and nurses and therefore less influence.

Subsumation, therefore, can be described as the unconscious and conscious cultural processes that enable one social group to influence another, in particular where different social fields overlap.

Bolivia, Social Fields, Health Care and the NGO Sector

In order to understand how subsumation might be at work in training community health workers in Bolivia, a description of the various fields involved is necessary as they pertain to Bolivian society in general and

the two case-study NGOs in particular. Bolivia, like many other Latin American countries, is in reality at least two nations in one, Andean Indian and Creole Hispanic, with distinct cultures – two coarse categories, with variation within each. Subsequently, the two have very different habitus and fields, including their health beliefs and practices. Andean Bolivia is an integrated social, physical and metaphysical whole that grows out of its history and pre-Incan past. Creole Bolivia, by and large, conforms to the ideas and practices of the neoliberal Western scientific stance that characterizes most of the development community. However, there are those who have always fallen between the two, the Mestizos. Some of these, through marriage, education or wealth, have been able to move into the Creole Bolivia, while a few have returned to their Andean roots. Yet many, the Cholos, or urban and semi-urbanized poor, are left living on the edge of both cultures with minimal opportunity to make their views known or to effect change.

Health promoters who are associated with CÓDIGO and PDA tend to be spread along an Andean/Cholo continuum depending on their proximity to the city. Two such promoters are Felipe, who is nearer to the Cholo end, and Carolena, the Andean end.

Felipe and Carolena

Felipe is a voluntary health promoter with PDA but received his training from CÓDIGO. He is 18 and lives with his mother, grandmother and younger brother in Kuturipa, a rural community located a good ninety-minute steep walk from the road and then a forty-minute bus journey to either Cochabamba or the subdistrict capital Santivañez. Family members describe themselves as subsistence farmers and pastoralists. Though they have electricity, they have no running water; and their land is very arid. The nearest potable water is an arduous forty-minute walk away.

Felipe left school after six years of primary education, but CÓDIGO inspired him to return and he has subsequently started at a SEMA (secondary school for adults), which he attends once a week. As it takes him half a day to walk there, he usually stays overnight.

Carolena was sent by another organization, INDICEP (Instituto de Investigación para Educación Popular, Research Institute for Popular Education), to be trained by CÓDIGO. She is 20, unmarried and a goatherd on her parents' smallholding in Tapacari, in the high valleys of Cochabamba. Their home is a two-hour hilly walk to the nearest small town (the district subsection of Waca Playa). If a member of the family wants to get to Cochabamba he or she has to wait for a Saturday or Monday to make the three-hour lorry or bus journey. During the dry season they can go by a different route through another small town, from which lorries

leave every day. However, during the rainy seasons the paths to this town are treacherous.

Carolena is the eldest of nine children, with three sisters and five brothers. She and her sister Maria left school before completing the primary level, as will the two younger girls. The boys, on the other hand, are expected to complete and graduate from high school.

I have placed Carolena and Felipe at different positions on the Andean/Cholo continuum even though both live in rural areas. Felipe's primary habitus arises out of a greater mixture of fields than Carolena, because living nearer to urban areas he and his family are influenced by both rural and urban social fields. This does not necessarily give him an advantage when it comes to being able to work effectively as a health promoter. To understand this we need to look at the organizations providing the opportunities to become promoters, CÓDIGO and PDA.

CÓDIGO and PDA

CÓDIGO and PDA are both NGOs working in community health and involved in training health promoters; however, there are some clear differences, especially in their relationships to the current development paradigm. A brief description of each organization and in particular how each approaches community health will demonstrate how CÓDIGO aims to challenge or transform the current view of development while PDA appears to be conforming with it. The description also demonstrates that, despite CÓDIGO's radical edge, in practice it, like PDA, also conforms.

CÓDIGO Bolivia

CÓDIGO Bolivia is one of the country programmes of CÓDIGO International, a church-based and health-related NGO based in the United States. The work in Cochabamba Bolivia was begun in the late 1980s by a Colombian couple, Dr Juan Carlos De Pedro and Mgr Roxana Velasquez. Initially, they had expected to be developing a community-health programme that largely followed the standard biomedical model recommended by WHO after Alma Ata. Once acquainted with the specific Bolivian context of ethnic diversity, inequity coupled with paternalism, and poverty, they concluded that a new approach was needed. In 1992, inspired by the work of the Brazilian radical educationalist Paulo Freire, they moved to Chirimoyo, a semi-urban community on the outskirts of Cochabamba. Using Freire's theories of 'conscientization' and 'praxis', CÓDIGO Bolivia's approach is one that aims to transform people from passive objects of somebody else's world into active subjects contributing to their own individual and collective livelihoods (Gramsci, 1971).

In conjunction with their Freirean ethos they have also developed a very clear approach to health care that they call 'integrated health', based on the social model of health (Whitehead, 1995). Health is regarded as part of the wider socio-cultural, politico-economic context at all levels of society – local, national and international. CÓDIGO describes its approach as a 'systemic ecological healthgenic' model. This concept is intended to emphasize healthy people rather than disease, and to be participatory, democratic and sustainable. Within this, they attempt to address a range of interrelated issues: basic health care and prevention, including the use of traditional and local medicines as well as Western biomedicine; income generation; organic agriculture; protection of the environment; human rights and community law (De Pedro and Velasquez, 1992).

Implicit in this concept of health is the expectation that the health promoters will have an integrated knowledge where they are confident and conversant in both their own local health knowledge and practice and in biomedicine. Through this approach CÓDIGO also hopes to distance itself from Bolivia's national health service and other NGOs. At worst, according to CÓDIGO, the approaches of other NGOs and the public health system are reductionist, 'hospital-based pathogenic biomedical' models, focusing on the signs and symptoms of disease and not on people. Or, at best, they are 'community-based pathogenic biological' models that, while they address the social setting of health, are still biomedical and disease-focused (De Pedro and Velasquez, 1992).

CÓDIGO makes a clear distinction between its understanding of the term 'integrated' and the way it is used in IMCI programmes. It means health as an integrated part of individual and communal life, while in IMCI health is regarded precisely as what it says: 'integrated management of illnesses related to children' – for example, diarrhoea and pneumonia'. CÓDIGO's health-care and training programmes do cover some of the aspects found in IMCI, such as the management of diarrhoeal diseases, but as part of their overall work. The organization has resisted getting involved with IMCI initiatives with the SEDES (local health authority) in Cochabamba. They also wrote to CÓDIGO International stating their opposition to the organization's intention to obtain funding from IMCI programmes. This instance highlights another area of tension for CÓDIGO Bolivia. Funding, and therefore survival, is increasingly tied to the very initiatives or approaches, such as IMCI, to which CÓDIGO Bolivia is opposed.

PDA Santivañez

PDA Santivañez is involved in a range of community development projects in the subdistrict of Santivañez. It is one of six such organizations established in Cochabamba by the large international Christian NGO, World Vision. The

long-term aim is that eventually the PDAs will be financially independent from World Vision, but at the time of the field research they were all fully funded by it (pers. comm., director of World Vision in Cochabamba).

The main areas of PDA's work are maternal and child health, food security and nutrition, Christian pastoral support and child sponsorship on behalf of World Vision. At one time all the PDAs in Cochabamba sent their health promoters for training with CÓDIGO. In 2003 PDA Santivañez was the only one; the rest stopped after the initial training because they felt uncomfortable with CÓDIGO's ecumenical stance. They prefer to work with organizations that are more clearly evangelical (pers. comm., director of PDA's work in Viloma and CÓDIGO staff).

Normally, the Santivañez PDA will send people for training to CÓDIGO who have been selected by their local *sindicato* (community organization). Having completed their initial training they then have to work voluntarily for the PDA, running health promotion talks with either a group of children or women once every two weeks. They are also expected to complete their CÓDIGO training and attend monthly training meetings at the PDA office in Santivañez (pers. comm., PDA doctor).

My experience of the PDA in Santivañez and interviews with the director of World Vision in Cochabamba led me to believe that their approach to community development and health care followed the standard approach used within the development community more generally. For instance, they use the monthly training meetings to reinforce a very standard biomedical approach to diarrhoeal disease and nutrition. The PDA doctor is involved in the local health authority initiative to implement the IMCI programme at a community level. Finally, PDA's sponsor, World Vision, is a large, well-established, international NGO which receives funding from USAID and other bilateral and multilateral agencies (World Vision, 2005). The director in Cochabamba made a clear statement of the type of health care World Vision practises.

> Health, we say more, let's see ... clinical ... no? scientific, yes! And ... we are aware of how we might be able to talk about traditional medicine ... maybe to know *curanderos* [the Spanish name commonly used for traditional medical practitioners] also. I say maybe, because we have not yet taken, we have not fully reviewed, reflected on this. (interview with director of World Vision in Cochabamba)

To summarize, CÓDIGO aims to be a NGO that transforms. This can be seen through its commitment to a Freirean ethos, its integrated approach to health rather than disease, and the way it has distanced itself from strategies such as IMCI. Alternatively, PDA appears to be an NGO that conforms. Through its financial dependence on World Vision it is directly linked to

the wider international development community and a Western biomedical approach to health. It has adopted the IMCI strategy and subsumed notions of socio-culturally appropriate practices.

Theoretical Aims and Actual Practice

Having identified some of the differences between the two organizations, further distinctions need to be made between the theoretical aims of the organizations and what occurs in practice. This is particularly marked for CÓDIGO, because in practice it conforms to the current development paradigm despite its claims to the contrary. This can be demonstrated in how health promoters trained by CÓDIGO, instead of integrating their different forms of health knowledge, still keep them separated. Because PDA's approach is consistent with a biomedical approach, the differences between its theory and practice have distinct implications.

Separation of different forms of health knowledge by CÓDIGO-trained health promoters

Focus group work conducted early on in my field research proved to be significant. Focus groups were carried out with some of CÓDIGO's promoters taking their second-level course. The discussion involved the promoters answering the following question:

> Where or from whom have you heard information or learned about ARIs (Acute Respiratory Infections) or ADDs (Acute Diarrhoeal Diseases) before coming to CÓDIGO?

I made sure that I used words that CÓDIGO uses in their training manuals and that are therefore familiar to the promoters. Their reply, which I noted down in my diary, was that they had never heard of ARIs or ADDs before coming to CÓDIGO. After some discussion and clarifications in Quechua (the most widely spoken Andean language), the promoters did start to talk about the traditional illnesses such as *Sipi Chupasqa*. I was somewhat surprised by this response, as, in line with CÓDIGO's stated approach, I was expecting the promoters to talk with ease and respect about their local knowledge. In fact, what I seemed to be seeing was a separation or compartmentalizing of what they knew. This was confirmed later by observing training sessions, interviews, visits to health promoters and their families, as well as by responses to the questionnaire I designed. For instance, Carolena was involved in the group research but I found out later that she frequently diagnosed and treated family members using her local knowledge.

Her young brother had bad diarrhoea last year and they went to the *posta* [local state clinic]. He was given *suero* (ORS) but it didn't help. Instead they used local plants that everyone here knows about. Also *pepa de palta* (avocado stone). (research diary, 11 August 2003)

Felipe admitted to having very little local health knowledge but eventually acknowledged that his mother Angela had considerable knowledge, which she had learnt from her grandmother.

Katie Did she learn from someone in her community or from her grandmother?

Interpreter Yes, her grandmother. Her grandmother treated everything, including a baby or child with constipation. She put a little bit of matchstick in and they would start.

Katie Where did her grandmother learn this information, here or did she go and train somewhere else?

Interpreter Her grandmother has always known and she does not know from where. But she [Angela] learned from her grandmother. Her grandmother was always teaching her; she'd say, 'When I die you are going to do the treating!' (interview with Felipe's mother, Angela)

Four categories of interlocking factors

Health promoters on the Andean/Cholo continuum fall within a range that either, like Carolena, have both Andean and biomedical knowledge but do not use them together, or are more like Felipe, who has access to his mother's local knowledge but is reluctant to acknowledge its importance. In both cases the two forms of knowledge are not integrated despite the theoretical aims of the health workers' training institutions.

This is because the four types of interlocking factor – ideological/philosophical, politico-economic, socio-cultural and pragmatic – make the power of a field's pedagogic authority relative in relation to other fields that might be competing with it. Put a different way, CÓDIGO's power to influence its promoters is affected by both the interlocking factors and the strength of the other fields the promoters encounter – Andean, Creole/state and other NGOs like PDA.

Philosophical/ideological

In the initial CÓDIGO training course there are two modules that could be linked together to emphasize its ideological approach to integrated health: 'Process of Health and Illness' and 'Management of Common Illnesses'. The former involves the promoters' previous knowledge and the biological, socio-cultural determinants of health and illness, while the latter addresses the prevention and treatment of diseases, such as diarrhoea. Yet in practice

they are given as two very separate courses, with the 'Managing Common Illnesses' module run along clear biomedical lines. This, I believe, is because an integrated approach is not consistent with some of the staff's evangelical beliefs and their previous biomedical training. The clinic doctor, who ran the 'Managing Common Illnesses', was also an evangelical lay preacher. When he left, the module was not changed.

A further example is that while PDA sends its promoters for training with CÓDIGO, it has endorsed the IMCI strategy. This can only compound the unintentional biomedical emphasis of the training that the promoters, such as Felipe, receive.

Politico-economic

Many NGOs secure funding through aligning themselves with current international and national strategies, such as IMCI. CÓDIGO will not do this and therefore lacks the level of financial support enjoyed by other organizations, such as PDA. CÓDIGO also excludes itself from different arenas that reduce its opportunity to influence the dominant model. For instance, by not working with the Cochabamba SEDES (local health authority) on their IMCI implementation strategy it is unable to exercise any influence over this strategy.

Socio-cultural

Age and gender are important factors in determining whether people who have undergone training with CÓDIGO are recognized as health promoters by their communities. For example, Carolena, despite her training with CÓDIGO, was not chosen by her community to work as the health promoter to organize the three-monthly visits by the nurse from the local state clinic. Instead a male with no previous training was chosen and Carolena was asked to assist him. Neither was Felipe officially recognized by his community, even though he was selected by PDA for training. This was because there were two other older male promoters present in the community.

Educational approach and achievement also have socio-cultural relevance. CÓDIGO interprets gender-sensitive and inclusive learning to mean mixed-ability groups and the use of Spanish to improve competency in the lingua franca. The consequences appear to be that men, better-educated women and first-language Spanish speakers dominate group work and plenary sessions that put others, especially rural women such as Carolena, at a disadvantage. This observation leads us to our final category: CÓDIGO has made a pragmatic decision that it did not have the resources to give sufficient support to these women.

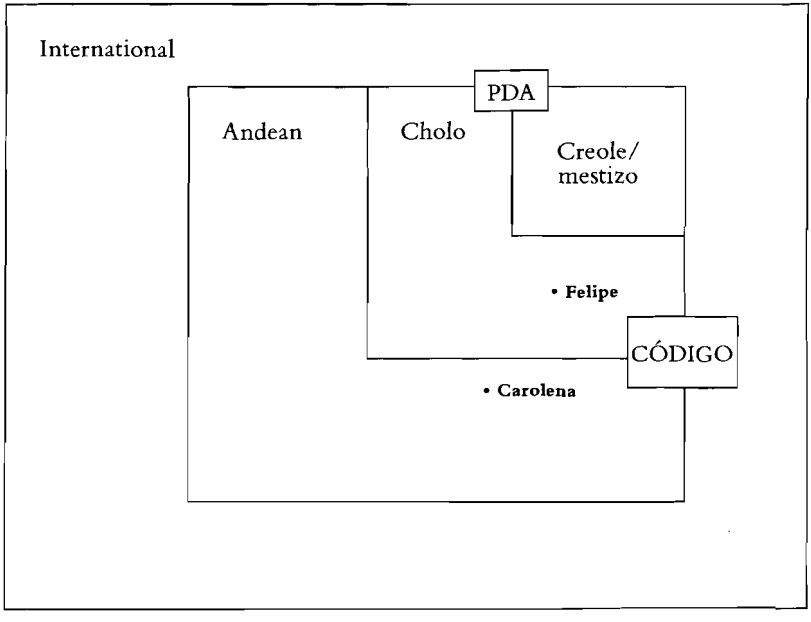
Pragmatic

Alongside insufficient resources to address the mixed educational and linguistic needs of the promoters, CÓDIGO also has very limited capacity to provide practical experiences, assess learning and make home visits for follow-up. The consequence of this is that they cannot reinforce learning or assess what knowledge their promoters actually use in their communities.

The promoters also have to make pragmatic decisions not to attend CÓDIGO training courses because of planting or harvest seasons or special occasions such as Todos Santos (All Saints' Day). They may also be prevented from attending because of the frequent strikes and road blocks associated with the ongoing political and social unrest in the country or simply because the rains have made the roads impassable. During my year in Chirimoyo, five courses were cancelled because there were insufficient promoters.

The four categories of factor affecting the promoters' use of health knowledge interlock with each other. For instance, CÓDIGO's ideological stance leads to the political economic consequence of reduced financial support. This in turn leads to CÓDIGO making pragmatic decisions that have led to lack of support to the minimally educated non-Spanish-speaking part of the population where they work. This then compounds the socio-cultural relationships that can put rural/indigenous women at a disadvantage.

Figure 12.1 Diagrammatic representation of relationships between fields



The four categories therefore work against CÓDIGO being able to produce in the health promoters it trains a secondary habitus that is stronger and more enduring than both their primary habitus and that of the Creole state system. Bourdieu talks in terms of positions within fields (Bourdieu, 1989); the closer an individual is identified with a particular group, the more their personal habitus will reflect the dominant habitus of that group. Unlike CÓDIGO's health promoters, Bourdieu's schooling was sufficiently long and effective that the primary habitus instilled in him by his poor rural parents was replaced by an enduring secondary habitus of the French intellectual elite (Webb et al., 2002).

Figure 12.1 is a diagrammatic representation of the relationships between the habitus and fields of the various social groups involved in the research as expressed through their different forms of health (medical) knowledge and practice. The outer box represents the international sphere from the perspective of the multinational and bilateral development agencies relating to Western biomedical knowledge and practice within the IDC. The next box represents the health (medical) knowledges and practices of Bolivia and within it separates the Andean and Creole representations (fields). The Cholos (urban poor) straddle both fields with their health knowledge and practice being a mixture of the two main forms. CÓDIGO and PDA are also represented. Figure 12.1 uses different shading to represent the various fields and the extent to which an individual's or an institution's habitus is influenced by their proximity to and or overlap with another field. Carolena is positioned clearly in the Andean field marking her health knowledge and practice from this field. The Creole state health system (Bolivia's national health system), despite being in the Bolivian box, is clearly continuous with the international biomedical field. Felipe is positioned in the indeterminate Cholo field that overlaps both the Andean and Creole. CÓDIGO and PDA as institutions are positioned overlapping the other fields to represent the idea that the four categories of factors make their fields weak in much the same way as the Cholo field.

In the context of their roles as health promoters, Carolena and Felipe encounter at least three or four fields: Andean, Creole, CÓDIGO and PDA. For example, Carolena's primary habitus is Andean, yet she comes into contact with both the Creole field through her assisting the male health promoter and nurse from the local clinic, and CÓDIGO's field through her participation in its training courses.

CÓDIGO's power to influence is relative while the promoters are doing its courses, but in the final instance it is not able to produce durable or consistent changes in the habitus of these promoters. It is affected not only by the constraints of the four interlocking types of factor but also by the conscious and unconscious cultural influences of the Andean and

Creole fields. When promoters like Carolena leave CÓDIGO and return home, the Andean field re-exerts its more powerful influence. In these circumstances CÓDIGO is not able to support its promoters to integrate Andean knowledge with biomedicine. Instead, the promoters' knowledge is separated into different realms, with different forms of knowledge being used at different times. Ultimately this leads to less efficient health care practices and demonstrates the limitations of CÓDIGO's ability to challenge the dominant system.

Separation of forms of health knowledge by PDA and Creole/state-trained health workers

The processes that affect the treatment of non-biomedical knowledge by fields that conform to the current development paradigm differ from those of CÓDIGO. Although the IDC, including PDA and the Creole/state health system, acknowledge that non-biomedical knowledge and practice are important, they are adapted and subsumed into a biomedical framework. The presence of the four categories of interlocking factors works to the advantage of the hegemonic processes of consensus and compromise because they help to keep both CÓDIGO's field and the general Andean field relatively weak – as such they do not have any influence outside of their own immediate contexts. This has the effect of ensuring that the cultural hegemony of the IDC is maintained.

Nevertheless the power of the dominant paradigm to reproduce its habitus is also made relative due to the presence of the interlocking factors, although to a lesser extent than for CÓDIGO. The Creole state-run clinic may exert a powerful influence on rural promoters like Carolena when they are in contact, such as during the three-monthly community visit. Yet the influence of the clinic is too infrequent and short for it to change her enduring Andean habitus. The field and habitus of Felipe are mixed, because he has had more contact with Mestizo Creole life through his proximity to urban areas and through PDA. Unless he moves into one or other of the main Andean or Creole fields via, for example, marriage or education he is likely to remain in an indeterminate Cholo field. Neither he nor others will then be able to benefit from his mother's considerable local knowledge.

In conclusion, this chapter has argued that the power of different fields to reproduce their particular habitus, is compromised by the existence of four categories of interlocking factors, which I have outlined. This is so both for NGOs that aim to challenge the dominant biomedical approaches as well as for those who conform to it. Yet, in the final instance, these interlocking factors have the effect of strengthening the hegemonic processes of consensus and compromise that has the ultimate effect of maintaining the

current dominance of neoliberal culture. This process comes at a price, as it seems to limit the effectiveness of programmes like IMCI that are central to the success of the MDGs and part of the overall approach to poverty reduction strategies (PRSPs). This is because other approaches, such as Andean beliefs and practices, are subsumed, with the result that although they may be acknowledged in theory they are not in practice. Opportunities for constructive engagement between the Andean and biomedical systems that might lead to improved health care are missed.

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