Exploring the challenges of implementing socio-culturally appropriate Primary Health - looking at community health worker training in Bolivia

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ABSTRACT

The need to increase access to health care, particularly in poor marginalised communities, means that training people to provide socio-culturally appropriate care at the local level remains a challenge, thirty years on since the 1978 Alma Ata declaration. This paper explores why training community health workers remains problematic, by revisiting ethnographic data of CODIGO, a community health organisation working in Bolivia. CODIGO clearly frames its health worker training in what it calls ‘integrated health’. Implicit in this notion is the need for health care to be socio-culturally relevant. A diverse body of literature is used to reveal the hidden macro-level power dynamics at play in current primary health care practice and also the interrelating factors at the micro-level that affect community health worker training in low and middle income countries (Bastien 1990; Fals Borda 1985; Freire 1996). While the data explored in this paper was gathered in 2003 it remains pertinent and adds a new perspective to the existing literature. May’s (1994) work looking at ethnic minority education is drawn on to apply the notion of mutual cultural competency to CODIGO’s training programme. Given May’s work is influenced by Bourdieu, the notions of habitus, misrecognition and symbolic violence are then employed for the analytic frame (Bourdieu, and Passeron 1990). The paper concludes that the complex and dynamic circumstances of community health care training, especially in socio-culturally diverse and resource poor settings, requires planners to be mindful of the macro- to micro-related factors and then make pragmatic decisions of what can and cannot be done.

KEY WORDS

Cultural competency, primary health care, community health worker training, politico-economic inequalities

Introduction

In 1978 the World Health Organisation (WHO) and United Nations (UNICEF) held a conference in Alma Ata (in the then USSR), which resulted in the Alma Ata declaration of ‘Health for All by the Year 2000’ principally through the provision of primary health care (PHC) that:

... reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities. (WHO 1978: 2)

Alma Ata was part of a broader movement which lead to the 1980 Brandt report (Green 2007). It encompassed activists of differing political persuasions and aimed to inspire ‘bottom up’
development strategies encouraging local communities and groups to participate in, and (hopefully) ‘own’, the work being done (Chambers 1983; Fals Borda 1985; Freire 1996; Warren, Slikkerveer, and Brokensha 1995). This included training people as community health workers (CHW) to provide basic health care services within their own communities and address the severe lack of trained medical personnel, especially in rural areas. The idea of CHWs was based on the bare foot doctors in China and similar programmes elsewhere such as Guatemala (Bastien 1990; Saunders, and Carver 1986; Zhang, and Unschuld 2008).

Even following the downturn in the global economy in the 1980s (Bergesen, and Lunde 1999; Cammack 2002) and the change to ‘selective’ primary health care (Cueto 2004; WHO 2000) the need to provide socio-cultural appropriate health care and train community workers to counter lack of other trained health personnel has remained (See - Davis-Floyd 2000; Goodman et al. 2006; Janovsky, and Peter 2006; Lewin et al. 2009; Replogle 2007; Sheikh et al. 2006; UNAIDS 2006; Warsame et al. 2007). However such initiatives tend to be framed by pro-market notions of social contracts, decentralisation and the transfer of technology and expertise from the ‘haves’ to the ‘have nots’ (Navarro 1984; Tarimo, and Webster 1997; Thérien 2002). Navarro (1984) critiques the suggestion that global development in this form is achievable, as it hides the ideological underpinnings of capitalism that maintain entrenched power relations. Similarly, Kelly and Charlton (1995) see the Alma Ata inspired ‘Health for All’ strategy in polemic terms. The subjective and holistic notions of health seem to eschew the biomedical model while being constrained by a technocratic and scientific rationale that in fact supports biomedicine. The inherent contradiction inevitably works against the idea that socio-culturally appropriate health care is possible.

How health workers are trained is central to the implementation of a health care service. Along with the many voices calling for changes at the heart of Alma Ata and community development in the 1970s were adult educationalists. Some like Friere (1996) and Fals Borda (1985) fuse a socio-political concern for community development and the need to increase adult literacy and education generally. Others have influenced health worker training as one field related to adult learning in particular David Kolb’s experiential learning based on Kurt Lewin’s work of the 1940s (Kolb 1984; Rogers 1986). At the heart of all adult learning theory, irrespective of whether it is the more socio-politically inspired forms of Friere and Fals Borda or that of Kolb and Lewin, is the belief that adult learning is based on their previous learning and experience and therefore needs to be socio-culturally contextualised in the learner’s own world. Joseph Bastien a medical anthropologist who has looked at the socio-cultural complexity of introducing Western medicine into the Andean regions of Bolivia, draws together the threads of this discussion. In particular he studied a community health worker programme in Oruro, Bolivia, during the 1980s (Bastien 1990). He concluded that community health workers ideally need to come from the community they will serve, and have the same socio-cultural background. They need to be supported and trained to continue embracing their community’s local health knowledge and beliefs, while using the relevant aspects of Western medicine innovatively. The incorporation with equal respect given to these different constructs of health knowledge and practice reflects May’s (1994) use of the term ‘cultural competency’. May argues for the need for learners to be culturally competent in both their own culture and in that of the prevailing dominant form. The road to achieving this level of mutual cultural competency and therefore socio-culturally appropriate health care is highly complex. It necessitates changes across a range of inter-connected factors, such as a shift in power relations away from biomedicine and neoliberalised healthcare provision. This would enable not only an acceptance of different health constructs, but practical infrastructural changes that decrease socio-economic inequity, by improving a nation’s infrastructure in terms of roads, water and energy supplies and importantly social welfare and education services (Bristow 2007). Until then, community health worker programmes are more than likely to continue to fail, especially when attempting to scale them up.
This paper seeks to understand why mutual cultural competency is easier said than done, by exploring the work of CODIGO, a community health Non-Governmental Organisation (NGO), training health promoters in the department of Cochabamba, Bolivia. In this paper ethnographical data is revisited to explore how CODIGO’s health promoters were trained and the ways this might affect their ability to be mindful of the socio-cultural context of the population they care for.

Bolivia

Bolivia is a politically unstable and tense country (López Levy 2001). In 2006, however, it elected its first indigenous president Evo Morales since independence from Spanish rule in 1825. The political tension remains and is indicative of the high socio-economic inequity in Bolivia with the indigenous populations being substantially poorer and marginalised than the rest of the population (Thorp, Caumartin, and Gray-Molina 2006). In terms of health related statistics Bolivia has an under-five mortality rate (U5MR) of 57/1000 live births and is ranked as having the 61st highest rate globally (UNICEF 2009).

The Bolivian Health Service was decentralised under the Ley de Participación Popular (Popular Participation Law) in 1994. While, the management for all public services is now at municipal level, a large proportion of health service delivery is managed by national and international NGOs such as CODIGO or Catholic and other religious bodies. The majority of these agencies are funded by bilateral and multilateral organisations including both international governmental organisations (GOs) and NGOs (Bristow 2005).

Culturally, Bolivia, like other Latin American countries, is at least two ‘nations’ in one, consisting of Andean Indian and Creole Hispanic populations, with distinct cultures and very different health beliefs and practices. Andean Bolivia is an integrated social, physical and metaphysical whole that grows out of its history and pre-Incan past (Allen 1988). Creole Bolivia, generally, conforms to the norms of a neo-liberal Western scientific stance. However, there are some who fall between the two, the Mestizos, some of whom through marriage, education or wealth, have been able to move into the Creole Bolivia, while a few have returned to their Andean roots. The Cholos/as, the semi-urbanised poor men and women, live on the edge of both cultures with restricted opportunities to make their views known or to effect change (Arnold, and Yapita 1996).

Researching the CODIGO project

The opportunity to do the original ethnography, which was conducted in 2003, developed out of a prior working relationship between the author and CODIGO director, Mgr. Roxana Valesquez. The ethnography explored how the hegemony of the dominant development paradigm informs and affects the transmission, integration and use of health ‘knowledges’ (diarrhoeal diseases being the focus) by local community based health promoters.

Ethnography was selected as the research methodology of choice as it allows the researcher to explore social groups and their ways of behaving in their everyday settings, in this case community health workers and their trainers (Lambert, and McKevitt 2002; Savage 2000; Walsh 2004) A reflexive research approach was taken building on the researcher’s previous experience as a health practitioner in resource poor settings in Latin America and Africa. Accordingly the research was framed by an expectation that the social phenomenon observed and experienced would be interrelated and complex (Lambert, and McKevitt 2002; Savage 2000). The research was carried out in three phases. The first and third phases, based in Bolivia, lasted just over five months each. The second phase of one month was based in the UK. The research extended from
CODIGO and its trainee health promoters at the micro-level and wove in and out of both the meso- and macro- levels of Bolivian and international socio-cultural contexts and health systems. Ethical approval for the research was granted via the Faculty of Education at the University of Manchester but formal ethical approval was not needed by the Bolivian authorities. Nevertheless, the researcher worked closely with the CODIGO directors to ensure all participants understood the nature of the research and that they were happy to take part. Verbal consent was also obtained prior to each interview.

Theoretical framing

As an ethnography this study lies within a critical sociological frame (Burawoy 2005) with the research enquiry centring on the issues and problems affecting society, especially in the ways these issues are formed by the politico-economic relationships between social groups.

In keeping with the grounded approach inherent in ethnography, no a-priori theoretical assumptions were made other than the desire to maintain a critical focus. However an ethnographic approach assumes that the researcher is a key actor in the research process seeking to interpret the social phenomena they have witnessed through the lens of their knowledge and experience (Lambert, and McKevitt 2002; Savage 2000). Thus while an open mind was kept, it became apparent that the use of May’s (1994) notion of ‘cultural competency’ as ‘mutual cultural competency’ was increasingly useful as an explanatory term. It enabled exploration of the different factors affecting CODIGO’s ability to train the health workers in the ways it had intended. May’s work is in part drawn from the work of Pierre Bourdieu, in particular the role education plays in developing a ‘secondary habitus’ (Bourdieu, and Passeron 1990). While Bourdieu can be criticised for being overly deterministic (Williams 2003; Williams 1995), he does enable a way to think about how agency and structure are involved in complex social contexts, such as training health workers in culturally diverse and socially inequitable contexts.

Habitus, the location of agency, 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. People of all social groups within a society are likely to assume the view of the dominant group is ‘correct’. According to Bourdieu, this can be to the extent that they ‘misrecognise’ their own ‘cultural capital’ (values, knowledge and practices etc) and thus devalue them. Bourdieu calls this process ‘symbolic violence’ in that the dominant group is able to suppress other cultural perspectives.

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 authorised (pedagogic authority) by their family and class (or ethnic group) (May 2001). Secondary habitus is developed, by pedagogic action of sufficient length for it to become an ‘enduring’ habitus, most notably, within schools but also through training in specialised areas such as health care. The formation of an individual’s habitus is structured by what Bourdieu calls a ‘field’. The most obvious field is social class but so are politics, education, art, ethnicity and medicine whether this is biomedicine, Ayurvedic or Andean. Fields intersect and overlay each other; they are moulded by the taste and disposition of the dominant class or social group and through this relatively more powerful social group’s influence over others.
Thus from a Bourdieuan perspective the field of biomedicine can be viewed as being relatively more powerful in many contexts than other forms of medical practice. At the heart of May’s cultural competency is not simply a concern for those whose habitus is formed by a relatively powerful field, e.g. a biomedical doctor or nurse educator, but a desire to understand those whose primary habitus is relatively less powerful, e.g. a trainee health promoter, in order for both groups to gain a mutual understanding and respect. At the heart is the desire for the less powerful trainee health promoters to competently affirm their own primary habitus while simultaneously benefiting from all that the biomedical field may have to offer. Thus this form of cultural competency is one of mutuality.

**Research methods**

A detailed research diary and participant observation were used throughout all the research phases (Ellen 1984; Walsh 2004). 300hrs of health promoter training were observed directly, with a further 32 hrs with other healthcare training institutes, to act as a comparison (CARE 1994; Foster 1996). Participants for interview were recruited purposively using a modified ‘snowballing’ or ‘networking’ approach (Bloch 2004). The aim being to reflect where possible CODIGO’s social networks and relationships with governmental and non-governmental agencies within Bolivia. This process was supplemented by indentifying other potential participants via an internet search. The final number of participants was determined by theoretical saturation (Ritchie, Lewis, and Elam 2003). At the meso departmental level 12 in-depth semi structured interviews were held with staff from the ministry of health (MOH), multilateral governmental organisations (GOS) and NGOs. At the macro national level 11 in-depth semi structured interviews were conducted with staff from the MOH, Multi-lateral and bi-lateral GOs and NGOs (Byrne 2004). The final phase also included a questionnaire developed from the funnelled data of the earlier phases. The questionnaire added breadth of data to the study and complemented the richness of information arising out of the other methods. It was completed by 119 respondents: 61 of CODIGO’s health promoters and 58 state-trained nursing auxiliaries (Bristow 2005; Silverman 2001; Walsh 2004). The qualitative analysis was an ongoing, iterative process of refining themes arising from the data (Seale 2004). SPSS was used to provide a descriptive analysis of the data obtained from the questionnaires (De Vaus 2002). Informed consent was obtained verbally in Quechua or Spanish as appropriate, either via an interpreter, or directly with the researcher. Given the trilingual nature of the research, the quality of the data collected was ensured via back translation, participant checking and triangulation of different research methods and participant groups (Kuper, Lingard, and Levinson 2008).

**Research Setting**

The ethnography specifically aimed to explore how the health promoters trained by the NGO use their new health related knowledge when they return to their home communities in the rural and semi-urban areas of Cochabamba.

**CODIGO Bolivia**

CODIGO Bolivia, is a country programme of CODIGO International, a church-based NGO from the United States, based in a semi-urban community on the outskirts of Cochabamba, Bolivia. CODIGO³ was started in the late 1980s by a Colombian couple, Dr Juan Carlos De Pedro and Mgr Roxana Velasquez. They rejected the adoption of the biomedical model that had evolved since Alma Ata as inappropriate in the specific Bolivian context of ethnic diversity, inequity and poverty. Instead they were inspired by, Freire’s theories of ‘conscientisation’ and ‘praxis’ (Freire 1996)⁴.
CODIGO’s stated aims are to transform people from passive objects of somebody else’s world into active subjects contributing to their own individual and collective livelihoods (CODÍGO 1992). In conjunction with their Frierean ethos they also developed an approach to health care called ‘integrated health’. This approach is based on the social model of health (Whitehead 1995), where health is regarded as part of the wider socio-cultural, politico-economic context at all levels of society - local, national and international. CODIGO describes its approach as a ‘systemic ecological healthgenic’ model, intended to emphasise healthy people rather than disease, and be participatory, democratic and sustainable. Within this, they attempt to address a range of interrelated issues: basic health care and ill-health prevention; 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 is the need for the health promoters to develop mutual cultural competency in both their own local health knowledge and practice and biomedicine. Through this approach CODIGO has distanced itself from Bolivia’s state service, including the SEDES (local health services), characterising them as ‘community-based pathogenic biological’ models that, while they address the social setting of health, are still biomedical and disease-focussed (De Pedro, and Velasquez, 1992).

CODIGO draws on an eclectic mix of learning theories for its health promoter training programme - Vygotsky’s activity theory, Montessori’s self-directed and contextualised learning, Freire’s popular education and ‘Problem-Based Learning’ based on US medical training. It is also mindful of the Andean forms of learning and knowledge that emphasise practice, incremental learning and reflective discussion or ‘nurturing dialogue’ (De Pedro, and Velasquez 1999, 2001; Stobart, and Howard 2002). These approaches together:

open possibilities of varied mental processes (gender based, cultural, multigenerational artistic, religious) encouraging the development of minds open to the search for the truth, using more natural, critical language, validating the values and visions of ordinary people. (De Pedro, and Velasquez [translation] 1999: 61)

The training programme consists of three phases, each divided into two parts. First is an Introductory Course lasting five weeks, followed three to six months later by a four-week Complementary Course. In total there are three Introductory Courses and three Complementary Courses. The aim of the Complementary Course is to consolidate learning from the Introductory Course in the light of the promoters’ experiences in the field. The introductory courses present the themes relevant to its phase, using a variety of training methods: talks, group work, role plays, codes, games, discussions and practical demonstrations. The complementary courses, on the other hand, are largely self-directed in that they concentrate on problem based learning approaches using the themes covered in the introduction.

Key Informants

The types of people CODIGO trains are selected to reflect its ethos – the ‘Cholos/as’ the rural and semi-urban poor of mixed or Andean origin such as, Felipe and Carolena. Felipe and Carolena became key informants with the author making frequent visits to their home as well as spending time with them while they were on training courses at CODIGO.

Felipe

Felipe was sponsored by OSL (Organizaciones del Salud Latina) to do his training with CODIGO. At the time of the research he was eighteen and lived with his mother, grand-mother and younger brother in Kuturipa, a rural community located a good 90 minute steep walk from the road and then a forty-minute bus journey to either Cochabamba or the sub district 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 CODIGO inspired him to return and he subsequently started at a SEMA (secondary school for adults), which he attended once a week. As this took him half a day to walk there, he would generally stay overnight.

**Carolena**

Carolena was sponsored by RIPE (Research Institute for Popular Education) to be trained by CODIGO. At the time of the research she was 20, unmarried and a goat herder on her parents’ small holding in Tapacari, the high valleys of Cochabamba.

Her home was a two-hour, hilly walk to the nearest small town (the district sub-section of Waca Playa). If a member of her family wanted to get to Cochabamba he or she had to wait for a Saturday or Monday to make the three hour lorry or bus journey. During the dry season they could 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.

Carolena and Felipe exemplify the people trained by CODIGO to be health promoters – young, Quechua (Andean language) speakers, with minimal or at least interrupted education, belonging to poor rural subsistence communities that are to varying degrees isolated from urban Cochabamba. In the following sections I will draw on examples from theirs and their fellow trainee’s experiences of health promoter training and practice.

**Research Findings – Exploring mutual cultural competency in CODIGO’s Integrated Health Training Programme**

Over the years CODIGO has justifiably gained respect for its work. However it is also possible to say that the rhetoric of its goals is not matched by its success in their implementation. Despite CODIGO’s achievements it has not been able to put its theory of integrated health fully into practice and therefore enable mutual cultural competency and socio-culturally appropriate health care.

**Separated knowledge**

The lack of evidence of integrated health knowledge can be seen in how CODIGO’s health promoters keep their local Andean and biomedical health knowledge separate, rather than drawing on both forms together. Group work conducted early on in the field research proved to be significant. This was carried out with some of CODIGO’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 Diarrohal Diseases) before coming to CODIGO? [Translation]

The words used to frame the group work were deliberately taken from CODIGO’s training manuals and therefore familiar to the promoters. Their reply, noted down in the research diary, was that they had never heard of ARIs or ADDs before coming to CODIGO. After some discussion and clarifications in Quechua (Andean language), the promoters did start to talk about the traditional illnesses such as ‘Sipi Chupasqa’. Their response was a surprise to the author,
rather it had been expected that they would talk with ease and respect about their local knowledge. Instead they seemed to compartmentalise what they knew. This was confirmed later by observing training sessions, interviews, visits to health promoters and their families as well and the questionnaire.

Keeping Andean health knowledge a secret

Very few if any of the health promoters appeared confident in engaging and negotiating with both their own cultural medical beliefs and those of biomedicine. In fact the promoters seemed reluctant to discuss their own local knowledge despite many of them or their relatives having considerable experience and competency in health care. For instance, it transpired later that Carolena 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 (ORS⁹) but it didn't help. Instead they used local plants that everyone here knows about. Also pepa de palta (avocado stone). (Research diary 11th August 2003.)

Felipe had difficulty in talking about Quechua names for causes of diarrhoea.

Interpreter What names in Quechua do you know for the causes of diarrhoea?
Felipe K’echelera... K’echelera, that’s all
Interpreter K’echelera, because they say the child is with orejasqa⁹, not so?
Felipe Orejasqa, that’s all... k’echelera, orejasqa.
Author When children fall, is there a name? Hurt their coccyx?
Felipe Sipi Chupasqa.⁷
(With Felipe. [translation] 10)

This was despite his mother being well informed having learnt from her grandmother:

Author 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.
Author 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, Felipe’s mother) learned from her grandmother. Her grandmother was always teaching her, she’d say, ‘When I die you are going to do the treating!’
(With Angela. [translation] 11)

CODIGO trainers

The possibility that CODIGO’s health promoters were using different forms of health knowledge separately despite CODIGO’s aim of integrated health focussed attention on how the trainers approached learning and what content they included. For instance there was a lack of synthesis between the training modules ‘Process of Health and Illness and ‘Managing Common Illnesses’. The former links the trainees’ previous knowledge with the biological and socio-cultural determinants of health. The latter addresses the prevention and treatment of disease. Given the aim of an integrated health approach it would seem appropriate for these modules to refer to
each other. However for some of the staff integrating the modules would not be consistent with their religious beliefs and previous biomedical training. The ‘Managing Common Illnesses’ module leader was the clinic doctor, an Evangelical preacher who refuted the metaphysical basis of Andean Knowledge. Thus this module took a biomedical approach inconsistent with the facilitation of mutual cultural competency.

**Pervasion of Biomedicine**

The integrity of CODIGO’s strategy of integrated health is also affected by the different approaches to health that the promoters may have experienced in other contexts. Visits to OSL the NGO who had sponsored Felipe to do his training and with the auxiliary nurse at the health clinic where Carolena sometimes worked, evidenced a standard biomedical approach. This reinforced a separated approach to health care and dismissal of local health knowledge. For example, the research diary records observations at OSL:

> Classes of diarrhoea - cholera, dysentery, salmonella. Repeat, repeat and reinforce, but is this the best way?... The emphasis on dehydration is very important but I think it could be better linked to beliefs and practices? (Research diary 16th November 2003, OSL monthly training meeting.)

The auxiliary nurse at Carolena’s local clinic suggested that practitioners have limited time to do anything other than that stipulated by the Ministry of Health.

Author | Do you offer any service for disability or only respiratory infections, diarrhoea, vaccinations and IMCI?
Nurse | More the Ministry programmes, 100%, very few other issues….almost nothing.

(Interview with auxiliary nurse at Carolena’s local clinic [translation] 12)

**Access to learning opportunities**

The examples above will have a direct affect on what a trainee learns in the first place and whether they are able to put such learning into practice. Other issues observed may have an indirect effect by affecting the ability of the trainees to learn. Approaches to gender equity are an example. CODIGO interprets gender sensitive and inclusive learning to mean groups of trainees with mixed-gender and education levels 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.

The guys are still taking the lead but there is more participation from the women (I wonder if this is to do with the subject - Nutrition?) In one group the girl in modern dress was writing and contributing a lot, although the 2 guys were dictating a fair bit. The other girls look disengaged or have disengaged themselves. (Research diary 11th March 2003)

Another example is of the extent to which CODIGO is able to develop its trainees’ practical skills. Observations of sessions suggested limited opportunity to practice. For example, how to make oral rehydration solutions (ORS).
She goes through the process and then gets people into 4 groups of 3 or 4 to prepare the solutions. What I don't think she did well was saying how to level off the spoons. She used her finger and the inside of the plastic bag, and in so doing, pressed the salt down. We always used to skim off with a knife as you don't pack down, that way and don't add extra in. It is very important to get the salt balance correct. The practice took ages and people had to watch the other groups and no one was able to do the whole procedure themselves. (Research diary 3rd September 2003)

Economic and material barriers

CODIGO’s training programme has not been popular with donors. This is because of differences between CODIGO’s philosophical stance to health and training and the biomedical market orientated perspectives of the donor agencies. Money for items such as textbooks, equipment and extra staff is restricted with the outcome that the trainers are often not able to carry through on their intended objectives.

Also talked to Roxana and Juan Carolos about funding… They can’t get funds for salaries- training team especially hit. XXX charity wants to fund its own suggestions. (Research Diary Friday 14th February 2003)

On a national level Bolivia’s infrastructure is weak. Roads for example are often impassable because of flooding. Stark socio-economic inequalities have lead to high levels of political unrest resulting in strikes and road blocks. During my year with CODIGO five courses out of a possible fifteen were cancelled, as were many follow-up visits to the promoters’ homes.

I had to begin the first complementary level of the course. However, because of the demonstrations, strikes and roadblocks in the Morachata area, 12 health promoters failed to arrive. (Training team coordinator’s November 2003 report [translation] 13)

The promoters may have to interrupt their training to attend to the planting or harvesting of crops.

At the end of the GM (genetic modification of crops) workshop there was a discussion about the problem of why not many promoters had turned up - practical reasons are that the date was changed at short notice, it is potato planting time and the weather has been good over the last few days. (Research diary 20th Sept to 2nd October 03 Cocapata workshop)

The findings presented here reveal that to work and live in the context in which CODIGO and its health promoters find themselves involves negotiation of a range of complex, interlocking factors. These factors constrain what is possible to achieve, especially objectives that go against the norm, such as actively wanting to enable mutual cultural competency and through this, health care practice that integrates Andean and biomedical health knowledge. These constraints can be at the philosophical level of a health worker’s habitus as a biomedical practitioner, relate to socio-cultural differences across gender, or materially, in terms of lack of resources or seasonal farming calendars. From a Bourdieuean perspective these constraints reduce the possibility of developing an ‘enduring secondary habitus’. They also encourage ‘symbolic violence’ by working to maintain ‘misrecognition’ of the importance of biomedicine at the cost of Andean health knowledge (Bourdieu 1989; Bourdieu, and Passeron 1990).
Discussion

This paper has sought to understand why CODIGO, despite its excellent qualities, was unable to facilitate a mutual cultural competency (May 1994) in its trainee health promoters and through this enable them to practice socio-culturally appropriate health care. Why mutual cultural competency might be difficult to develop can be explored through looking at the complex range of interlocking factors from a Bourdieuean perspective.

Partially different secondary and primary habitus may be behind the differences in the ideology that has led to a clash in understanding between the various actors, in particular with CODIGO’s staff. For example, the lack of continuity between the two modules ‘Process of Health and Illness’ and ‘Managing Common Illness’ has in part arisen out of the differing religious and medical beliefs of the CODIGO directors and the doctor involved in the training programme. A further example is the tension between CODIGO’s approach and that of other actors and agencies that might influence the health promoters, e.g. OSL’s clear biomedical stance on Felipe. It would seem that not only are CODIGO staff misrecognising the cultural dynamics at play but are furthering the capacity of the trainees to misrecognise their own local health knowledge.

Many NGOs secure funding by aligning themselves with current international and national strategies and therefore the field of the health-related international development agencies. CODIGO has not wanted to be aligned to such work, for instance by not collaborating with the Cochabamba SEDES (local health authority). CODIGO may well be being true to its political and ideological beliefs, but through this has weakened itself economically, losing the opportunity to influence the dominant biomedical habitus and prevent symbolic violence.

Misrecognition may also exist with regard to the secondary habitus of competing fields, such as the biomedical form of the state-trained staff of the local health clinic. The clinic staff, the promoters and the members of the community may all view the biomedical field as more legitimate than local/traditional healthcare. For Carolena and Felipe this is compounded by socio-cultural factors of education level, gender and age. Both Carolena and Felipe might agree tacitly with their communities that they are too young, or the wrong gender to be a health promoter. Neither Carolena nor Felipe completed their state school education. This probably relates as much to economic survival as to traditional roles within Andean communities. However, women are more likely to have left school with far less education than men. Carolena’s brothers have been able to continue at school to secondary level while she and her sister left after only five years’ primary education (See Arnold, and Yapita 2000).

At another level the primary habitus of the health promoters is stronger than the secondary form emerging through their training with CODIGO. In order to achieve an enduring secondary habitus CODIGO would need to strengthen its support of promoters on return to their communities, through more frequent follow-up. The organisation also needs to think through how it can meet the various educational needs of its promoters, especially the less well-educated women from rural areas.

Lack of time and resources can restrict what may realistically be achieved, e.g. promoters may make the pragmatic decision to finish planting potatoes rather than attend a CODIGO course. CODIGO’s follow-up programme has been limited by lack of finances to employ more staff. It does not have the human and financial resources to address the mixed educational and linguistic needs of the promoters. These pragmatic decisions directly affect CODIGO’s ability to encourage an enduring secondary habitus in their trainees and while also strengthening possibilities of gender and age related socio-cultural misrecognition.

The different factors produce the environment in which the hidden power dynamics can be maintained and affect the development of an enduring habitus in the promoters. For instance, CODIGO’s ideological stance relates to the political economic consequence of reduced financial
support, which in turn is linked to CODIGO’s pragmatic decision to reduce learning support to the minimally educated non-Spanish speaking trainees. The result is that CODIGO’s power to influence is relative and limited, for example by the short space of time that the health promoters actually spend doing its courses, and therefore come into contact with CODIGO’s particular ethos. In the final instance CODIGO is not able to produce durable or consistent changes in the habitus of the health promoters it trains. When health promoters leave CODIGO and return home, the Andean field re-exerts its more powerful influence. In these circumstances CODIGO is not able to support its promoters to use both Andean and biomedical knowledge. Instead, the health promoters’ knowledge is used separately in their different fields. This would indicate that CODIGO has not enabled its health promoters to develop socio-culturally appropriate practice and consequently valuable opportunities may have been lost to improve access to primary health care. The socio-cultural relationships that encourage misrecognition and hinder mutual cultural competency are compounded and maintain the disadvantage of rural/indigenous women especially.

As an ethnography of a particular context, the specific findings are not intended to be generalisable (Kuper et al. 2008). Nevertheless the paper does offer insights for settings with diverse socio-cultural populations and politico-economic inequalities similar to Bolivia. The trilingual nature of the research (English, Spanish and Quecha), along with its cross-cultural nature, clearly places limitations on the research findings. The use of a snowballing technique to recruit participants also has its limitations as the networks may dry up (Bloch 2004). This was countered by finding other contacts using the internet. Every attempt was made to ensure the quality of the findings through the use of multiple methods, participant checking and back translation of transcripts.

The paper attempted to unravel the complex dynamic of different factors that interrelate to hinder the development of mutual cultural competency in health care workers and thus the provision of socio-cultural sensitive health provision, especially within diverse inequitable settings, such as Bolivia. To achieve this, a diverse body of literature has been used to draw attention not only to the hidden macro-level power dynamics at play in current primary health care practice (Kelly, and Charlton 1995; Navarro 1984), but also, interrelating factors at the micro-level that affect community health worker training in low and middle income countries (Bastien 1990; Fals Borda 1985; Freire 1996). While the data explored in this paper was gathered in 2003, it remains pertinent and adds a new perspective to existing literature. The need to increase access to health care, particularly in poor, marginalised communities, has meant that training people to provide relevant care at the local level still remains a pertinent issue - not only in low and middle income countries, but increasingly in countries with high levels of resources (Davis-Floyd 2000; Goodman et al. 2006; Janovsya, and Peter 2006; Lewin et al. 2009; Replogle 2007; Sheikh et al. 2006; UNAIDS 2006; Warsame et al. 2007).

Finally these findings would suggest that those wishing to develop training programmes in such complex circumstances need to be mindful of the possible macro- to micro- related factors and attempt to make pragmatic decisions of what can and cannot be done in the circumstances. That is, training programmes should be implemented with as clear as possible understanding of the socio-cultural and politico-economic aspects of their own context and more importantly that of the trainees’. This is important not only to ensure the training is relevant and accessible but also to give the programme implementer a realistic understanding of the programmes strengths and weaknesses.
References


**Notes**

1. CODIGO is a pseudonym as are all names and places directly associated with it.
2. These are coarse categories, and there exists variation within each. However, the variations seem less than that between them and so the categories are useful for the analysis here. The various lowland indigenous peoples in Bolivia are not considered.
3. From this point CODIGO refers to CODIGO Bolivia
4. It could be asked why I have not used Friere’s work to analyse my data. I did not rule Friere out it was merely that the way the data emerged seemed to lend itself more to Bourdieu.
5. OSL and RIPE are pseudonyms.
6. ¿De dónde o de quien han escuchado o aprendido algunas informaciones/conocimientos sobre IRAs y EDAs antes de venir a CODIGO?
7. Sipi chupasqa is a form of diarrhoea said to occur when a child falls over when learning to walk and bangs the base of their spine.
8. ORS = Oral rehydration solution.
9. Orejasqa is the same as orejado – diarrhoea cause by the smell of a dead animal.
10. Interpreter: ¿Con qué otros nombres conozes en quechua cuando hace las causas diarrea? Felipe: k’echelera, k’echelera, no más.
   Interpreter: k’echelera pero la wawita está con orejasqa ¿dice no ve? Felipe: orejasqa no más, k’echelera orejasqa.
   Author: Cuando los niños se caen de trasero ¿hay un nombre? ¿Se daña su cóccix? Felipe: sipi chupasca.
Author   Es… de la comunidad or por su abuela?
Interpreter  Sí mi abuela, mi abuela curaba de de todo. Dice cuando inclusivo un bebe o niño
venía con estreñimiento, le pone un palito de fósforo, se va a empezar.
Author   Solamente aprendió esta información aquí o fue para capacitarse?
Interpreter  Su abuelita sabía siempre, no se sabe de dónde. Pero ella (Angela) ha sabido de su abuelita. Su
abuelita siempre le enseñaba a ella. ‘Cuando me voy a morir, volvás a curar’.
Author   ¿tu llevas en una manera un sistema de discapacidad o solamente IRAs, EDAs, PAI, AJEPI?
Nurse    Más programas de ministerio, cien por cien muy pocos otras temas caci nada.’
12  Author ¿Tu empezar el primer nivel complementario, sin embargo debajo a las movilizaciones, paros y
bloqueos de los pobladores de Morochata no pudieron llegar 12 promotores, ya estaban nueve
promotores del norte Ayopaya.
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Acknowledgements

I would like to thank Dr Caroline Dyer, Dr Jude Robinson and the anonymous peer-reviewers
for their comments and support during the process of writing this paper and the staff and health
promoters of CODÍGO for allowing me to do this research with them in the first place.

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