IMPRESSIONS OF INTERCULTURALITY AND HEALTH CARE IN BOLIVIA: THREE CASES FROM COCHABAMBA

by

Alana DeLoge

BA, University of Miami, 2004

MA, University of Pittsburgh, 2007

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This thesis was presented

by

Alana DeLoge

It was defended on

August 7, 2012

and approved by

Thesis Chair:
Martha Ann Terry, MA, PhD
Assistant Professor
Department of Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

Committee Member:
Robin Grubs, MS, PhD
Assistant Professor
Department of Human Genetics
Graduate School of Public Health
University of Pittsburgh

Committee Member:
Christopher R. Keane, ScD, MPH
Assistant Professor
Department of Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

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Alana DeLoge, MPH

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Considerable health disparities exist that result in both poorer health outcomes and relatively low accessibility of health care for the world's indigenous populations. States and global/international health organizations have prioritized indigenous health. Intercultural health care plays a pivotal role in this prioritization. Recent governmental changes in Bolivia, a country in which two thirds of the population self-identify as indigenous, have resulted in state discourse centered on decolonization and interculturality that advocates indigenous rights as well as economic and popular democracy. Research that focuses on how intercultural policies are practiced on the ground or on how individuals are experiencing these policies is lacking. Using qualitative data gathered from semi-structured interviews of three individuals living in and around Cochabamba, Bolivia, this thesis explores participants' thoughts and experiences of interculturality, health, and the Bolivian healthcare system. Results are contextualized 1) through a discussion of the intercultural health care literature based on Latin American examples and 2) according to two health behavior theories: Social Cognitive Theory and the Structural-Ecological Model. The results presented here raise concerns about the implementation and effectiveness of intercultural healthcare policies. Participants have noticed very little change as a result of new polices and are skeptical of the motivations driving interculturality. Additional factors, such as substantial financial barriers, impede intercultural health care. Research that investigates how intercultural health care functions on the ground and in practice in Bolivia has repercussions for

health policy on a global scale. The research presented here is of public health importance because, if the goal is to improve the health of indigenous peoples worldwide, a more critical consideration of the implementation of intercultural healthcare efforts, of which this thesis is part, is necessary.

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1.0 INTRODUCTION

Considerable health disparities exist that result in both poorer health outcomes and relatively low accessibility of health care for Bolivia's indigenous populations. This is particularly significant because, with an estimated population of 10 million, two thirds of Bolivians self-identify as indigenous. Bolivia's indigenous populations are more vulnerable to communicable diseases, have a higher prevalence of vaccine preventable diseases, have more limited access to reproductive health care, have higher rates of both child and maternal mortality and suffer disproportionately from chronic diseases (Country Health Profile: Bolivia 2001 and McNamee 2009).

Recent changes to the Bolivian government have resulted in state discourse centered on decolonization and interculturality that advocates indigenous rights as well as economic and popular democracy. As a result of this discourse, the implementation of new policies and programs within the healthcare system should, in theory, help to improve both health outcomes and access to quality care for Bolivia's indigenous populations. While research has considered these policies within the Bolivian government and the healthcare sector (Johnson 2010), a focus on how policies are practiced on the ground and on how individuals of indigenous communities are experiencing these changes is necessary.

It is only through a holistic approach investigating the situation at multiple levels of the social ecological framework that a more critical and nuanced understanding of changes within

the Bolivian healthcare system can ensue, which is requisite for improved health and increased access to quality health care for the country's indigenous populations. Contributing to this understanding by investigating another level, that of individual level perspectives, the thesis presented here considers the experiences with and opinions of interculturality within the healthcare system for Quechua men and women living in and around the city of Cochabamba, Bolivia. Using qualitative data gathered from semi-structured interviews of three individuals, this thesis explores participants' thoughts and experiences of interculturality, health, and the Bolivian healthcare system.

Before proceeding, it is useful to define and explain a few concepts and terms that are used throughout this thesis. Broadly defined, interculturality is the bridging of indigenous medicine and biomedicine in a manner that is complementary (Johnson 2010). Interculturality is distinct from multiculturalism, a situation in which groups share a common space and emphases are generally placed on assimilation rather than on integration, often resulting in a masking of inequality and maintenance of current power structures. Instead, interculturality, in theory, moves beyond a discourse of respect and tolerance and advocates a sharing of power among different groups. In Bolivia, interculturality is not a new concept; however, it is only in recent years that it has emerged on a national level. Within the Bolivian context, interculturality is defined as an active process of transformation that integrates diverse social groups, including each group's cultural norms, practices and worldviews surrounding health (Johnson 2010). This should ideally occur in a context of respect, honest exchange, mutual growth, and, ultimately, transformation (Albó 2004).

Ethnomedicine is a term intricately connected with interculturality. Ethnomedicine refers to any culturally constructed medical system (Brown 1998). Based on this definition, both local

medical systems and biomedicine classify as ethnomedicine as they are cultural products and constructions based on a set of assumptions about the body, health, and healing. Additionally, the author has chosen to use the term *traditional medicine* to refer to the local ethnomedicines of indigenous peoples in Bolivia because this is the term used within the Bolivian healthcare system and by the Bolivian state.

In what follows, the author first presents background information pertaining to intercultural health care in order to situate the current research as well as a description of the methods and theories used to collect, analyze, and understand the data. The results are presented according to thematic categories. These themes are then discussed in two ways: 1) contextualized according to the broader political situation, history, and implications of intercultural health care and 2) viewed through a theoretical lens. Finally, the conclusion discusses the relevance and limitations of the current study. The main argument of this thesis, as the data demonstrate, is that the implementation of intercultural healthcare policies, thus far, has been insufficient and ineffective, at least according to how such policies have been perceived by the three participants in this study; therefore, unless substantial change occurs, it is unlikely that such policies will lead to improved health or increased access to quality health care for Bolivia's indigenous populations.

2.0 BACKGROUND

The burden of disease, disability, and death is much greater for the world's 370 million indigenous peoples when compared with non-indigenous peoples (Gracey and King 2009). This disparity is evident in almost all areas of health: infectious disease, chronic disease, mental and emotional illness, injuries, disability, and earlier and greater mortality. The poor health status of indigenous peoples is connected to issues of poverty, malnutrition, and environmental factors, such as overcrowding in urban areas and pollution (Gracey and King 2009).

A recent review (Gracey and King 2009) of the health situation of indigenous peoples worldwide makes several recommendations for health improvement. Although the authors mention what they consider to be inexpensive, simple, and effective strategies for improved health, such as hygiene education, clean water provision, and reduced labor demands on women and children, the social determinants of health play a critical role. According to Gracey and King (2009), several requirements must be met in order to focus on health improvement. These include the acknowledgement by governments of indigenous peoples' rights and needs, allotment of sufficient resources to close the gap in health between indigenous and non-indigenous peoples, and a focus on addressing the socioeconomic inequalities between indigenous and non-indigenous peoples. These kinds of recommendations require significant structural change within states' sociopolitical and economic realms and are not easily accomplished. The situation of indigenous peoples' health in Latin America is not dissimilar to the global context.

2.1 HEALTH OF INDIGENOUS POPULATIONS IN LATIN AMERICA

Comprising approximately 10% of the population of the Americas, there are between 45 and 50 million indigenous people, belonging to 400 ethnic groups, living in the region. Rates of poverty and extreme poverty are higher for indigenous populations in the Americas. Additionally, illiteracy, unemployment, lack of access to social services, human rights violations, and displacement are worse when compared to non-indigenous groups. In terms of health, indigenous populations of the Americas suffer from disproportionately higher rates of maternal mortality, infant mortality, malnutrition, infectious disease, and chronic lifestyle disease (PAHO 2006). This poorer health status is compounded by discrimination and inequality within state healthcare systems. Although indigenous populations make up the majority, or at least substantial sectors, of many of the region's countries, approximately 40% of the indigenous population lacks access to biomedical health care.

Although low quality healthcare services exist in many developing countries of Latin America, quality of care is worse in regions populated by indigenous peoples. Some factors that contribute to problems of quality of care for indigenous peoples include limited staff competency, medication shortages, poor staff retention, and geographic barriers (e.g. distance and transportation). Even if health care is officially provided without charge, out-of-pocket costs, such as family care, loss of workdays, and transportation, provide substantial barriers to healthcare access. Cultural and linguistic barriers present the most complex challenges, which include problems of discrimination, distrust, and fear.

The Pan American Health Organization (PAHO) has supported a number of initiatives aimed at improving indigenous health in the Americas. In the early 1990s, through the establishment of multiple resolutions, PAHO launched the Health of the Indigenous Peoples

Initiative, which, in collaboration with indigenous peoples, aimed to find realistic and sustainable solutions to the poor health of indigenous peoples throughout the region (PAHO 2006). Following an evaluation of the initiative in 2004, in which 19 Latin American countries participated and which revealed a range of successes and challenges, PAHO proposed four strategic lines of action: 1) to ensure the incorporation of indigenous perspectives into national health policies; 2) to improve information management in order to strengthen evidence-based capacities for decision-making and monitoring; 3) to integrate intercultural approaches into state healthcare systems within primary healthcare strategies; and 4) to develop alliances with indigenous peoples and other stakeholders to further improve the health of indigenous peoples.

In addition to the Health of the Indigenous Peoples Initiative promoted by PAHO, countries throughout Latin America committed to the Millennium Development Goals (MDGs) in 2000 in an attempt to reduce existing health disparities (PAHO 2006). By 2006, although there was some improvement in health, it was clear that the MDGs were not going to be accomplished, neither as outlined nor by 2015, especially among indigenous populations. A restructuring and reorienting of strategies was deemed necessary for a variety of reasons (PAHO 2006). The poverty reduction and economic development strategies of the MDGs did not consider or incorporate indigenous identities, cultures, rights to self-determination, or perspectives on health. Additionally, data used in evaluation of the MDGs are averages, and do not consider disaggregated data; therefore, health disparities that negatively affect indigenous populations are masked.

An important component of PAHO's strategic lines of action and the restructuring of states' plans to reach the MDGs, as outlined above, is the integration of an intercultural

healthcare model in healthcare systems. It is this concept of intercultural health care that is explored in this thesis.

2.2 INTERCULTURALITY AND HEALTH IN LATIN AMERICA

The integration of biomedical and traditional medical systems, referred to as interculturality by policy makers and within state healthcare systems, has increased over the past several years throughout the Andean region of South America as a strategy to improve the health for all populations, but particularly for the region's indigenous peoples (Aizenberg 2011). Neoliberal health reforms, common in low- and middle-income countries worldwide beginning in the 1980s, included such strategies as selective (as opposed to comprehensive) primary health care, targeting, and privatization, as well as deregulation of health, equity, and development. These reforms led to poor health outcomes in a majority of cases (Tejerina Silva et al. 2009). Beginning at the turn of the 21st century, Latin American countries have continued to distance themselves from neoliberal health models; intercultural medicine is one of the strategies used to move away from neoliberal health care.

Clearly, intercultural health practices have occurred throughout history and across the world as groups of people come in contact with one another. Individuals, healthcare providers, and health centers continuously make choices and adapt their health practices based upon this contact. For example, Crandon (1983) argues that the *mestizo* (who identify as non-indigenous) and Aymara (who identify as indigenous) residents of Kachitu, a town located in the Bolivian *altiplano*, strategically diagnosis illness according to either a biomedical model or indigenous ethnomedical models in order to gain access to political and economic resources. In Kachitu,

diagnosis is a social process that depends on and affects social, economic, political, and ethnic relations.

Yet the processes of clearly defining and operationalizing interculturality within state healthcare systems are relatively new, do not happen intuitively, and are not without problems. In most cases, interculturalism occurs in, and almost by definition implies, a context in which a struggle ensues of ethnic or cultural minorities against an oppressive state (Torri 2011). The inclusion of traditional medicine in a biomedical model as intercultural medicine can also be used as a strategy to circumvent the problem of providing costly biomedical resources to indigenous communities (Torri 2011) or as a means to increase compliance with biomedical practices (Crandon 1983). Both of these points oppose the idea of intercultural medicine as the bringing together of medical systems in a complementary manner.

2.2.1 Interculturality and Health in Latin America - Case Examples

This section presents a brief description and analysis of intercultural healthcare efforts in various countries in order to exemplify the approaches to and issues of interculturality across the region.

In Chile, governmental initiatives concerning intercultural health first appeared in the 1980s through raising the question of cultural diversity of health within the healthcare sector (Torri 2011). During the 1990s, the discourse of intercultural health expanded, and the Chilean government promoted joint interventions among Chile's indigenous groups and the state healthcare system. Interventions included 1) development of multidisciplinary teams comprised of physicians, anthropologists, and 'intercultural facilitators,' such as representatives of various indigenous groups, 2) creation of intercultural offices in healthcare facilities, and 3) encouragement of active involvement of indigenous representatives within healthcare facilities.

Torri (2011) uses the Makewe Hospital, which is run by a local Mapuche organization and delivers intercultural medicine, as a case to exemplify the sometimes conflicting interests of the indigenous community and the Chilean state. Although generally a successful case, Mapuche patients and healers who were interviewed often expressed negative views about the conception and implementation of intercultural health by the Chilean state. For example, the implementation of intercultural health can mirror existing power relationships. The author quotes a Mapuche healer: "The Mapuche don't have enough power to decide how the issue of interculturalism should be implemented. Interculturalism interests the government as it is an instrument to control indigenous people and make them behave in the way the government wants" (Torri 2011: 44).

Mignone et al. (2007) present five case studies (Chile, Colombia, Ecuador, Guatemala, and Suriname) to look at intercultural efforts in healthcare systems across Latin America. In each case, the intercultural approach takes a different form. For example, in Suriname, shamans and other traditional health practitioners lead workshops for primary care providers about traditional health practices. In turn, workshops for traditional healers relay information about primary care issues. Both sets of healthcare providers work closely with one another, altering their practices and participating in an intercultural referral system.

As a second example, a case in Guatemala connects *comadronas*, women who provide midwifery care in Maya communities, with the state healthcare system through a training program for the women. This training program is intended to increase the quality of care that the *comadronas* provide and create an effective referral structure between *comadronas* and the healthcare system. The goal of this program, ultimately, is to extend biomedical health care to poor Maya communities. Due to the nature of this program, very little exchange of knowledge or

integration of biomedical and local ethnomedical systems occurs; therefore, this case does not, in fact, seem to reflect the discourse surrounding interculturality.

Because several trends emerged across the cases presented in Mignone et al. (2007), the authors discuss interesting themes. On the positive side, intercultural efforts seem to increase trust toward the healthcare system among indigenous communities. An overall increased sense of pride and revaluing of traditional knowledge and practices, as well as an increased sense of ownership develop from intercultural efforts. Referrals between systems are timelier, which has the potential to improve health. On the whole, there is an apparent increase in access to both traditional medicine and biomedicine.

On the negative side, biomedical healthcare practitioners often have negative attitudes toward and do not support traditional medicine. Clarity regarding the legal terms of the practice of ethnomedicine is lacking in many cases, which also hinders efforts. Finally, a lack of data collection surrounding intercultural efforts makes programs and health outcomes difficult to evaluate.

Focusing now on the intercultural healthcare efforts that are most relevant for the current research, the following sections explore the sociopolitical and healthcare contexts of Bolivia.

2.3 THE BOLIVIAN CASE

Substantial health disparities exist that result in both poorer health outcomes and poor access to health care for Bolivia's indigenous populations. Of the entire population, about one third of Bolivians self-identify as Quechua, the largest cultural group in and around the city of Cochabamba, Bolivia, where the current research was conducted.

Although Bolivia has been formally independent for more than 185 years, a pseudo-colonial system has endured in which a *mestizo* minority has maintained cultural, economic, and political dominance over an indigenous majority. For example, it was not until the reforms that accompanied the 1952 Revolution that indigenous individuals or communities, at least according to policy, gained the right to vote and were permitted to own land. Nonetheless, the indigenous population remained largely subordinate and excluded from formal political participation (Kohl and Bresnahan 2010). Bolivia also has a long history of indigenous revitalization and attempted revolutions. The Katarista Movement of the 1970s, which took place during a period of continued dictatorships, called for an end to the colonial state and influenced recent indigenous social movements that helped bring to power Evo Morales, the current president, and his political party, the *Movimiento al Socialismo* (Movement Towards Socialism - MAS) party.

2.3.1 Political Context

Large parts of Bolivia's population, indigenous and non-indigenous alike, as well as observers around the world, have considerable expectations for substantial change in Bolivia. Evo Morales was inaugurated as president in 2006 and is currently serving his second term in office. Morales came to power promising to recreate Bolivia as an intercultural, plurinational, and socialist state through processes of decolonization. In his first term, he partially nationalized the hydrocarbons and telecommunications industries and made reforms in several sectors, including health, education, and social security. In early 2009 a new constitution was approved with 62% of the national vote (Kohl and Bresnahan 2010). Schilling-Vacaflor (2011) notes several obstacles to implementing the new constitution. These barriers include increased strength of the executive branch of the government, the government's attempts to exclude dissident views, resistance to

the conservative opposition in Bolivia, historically rooted inequality, and the extreme polarization of Bolivia's population. Although the effects of centuries of exclusionary colonial rule as well as fifteen years of neoliberalism are unlikely to be undone rapidly, Morales has promised change.

2.3.2 The Healthcare System

Prior to the national elections that brought Evo Morales and MAS to power, MAS conducted a study of Bolivia's health and healthcare situations (Johnson 2010). The results formed part of the National Development Plan of 2006, in which the health sector is discussed as a product of colonialism. This plan identifies multiple structural problems, including epidemiological differentials across the Bolivian population, which is a result of socioeconomic determinants such as poverty and unequal access to health services, inefficient health services that fail to consider cultural and ethnic differences, poor management of the health sector, and a lack of satisfaction on the part of an alienated population. To improve this situation, the plan proposes that the state guarantee equitable access to health care and active participation of the population in the health sector. Specifically, the plan calls for dismantling of colonial structures and eliminating the neoliberal economic system.

The Bolivian government has attempted to decolonize the healthcare system and promote intercultural medicine. Bolivia's *Viceministerio de Medicina Tradicional e Interculturalidad* (Vice-Ministry of Traditional Medicine and Interculturality), created in 2006 and housed within the *Ministerio de Salud y Deportes* (Ministry of Health and Sports - MSD), seeks to integrate culture, language and the practices of biomedicine and traditional medicine. Through this vice-ministry, strategies have been implemented that aim to decolonize medicine. These fall within

the *Salud Familiar Comunitaria Intercultural* (Community Intercultural Family Health - SAFCI) model, established by law in 2008. SAFCI demands the recognition of the strengths and limitations of both biomedicine and traditional medicine, as well as the exchange of knowledge and practice between ethnomedical systems, with the goals of complementarity and equal sharing of the provision of quality health care.

The primary foci of the SAFCI model are the social determinants of health; emphasized within the model are social participation, intersectoral cooperation, interculturality, and the idea of health as integral to family and community life (Johnson 2010). Two central programs enacted by SAFCI, which are supposed to change historically rooted attitudes within the medical community, have been the expansion of a mobile units program and the development of a specialized medical residency program. The mobile units regularly travel to rural health posts and, in addition to biomedical specialists, include sociologists or social workers whose role is to function as intercultural mediators. The new residency program involves training in ethnographic techniques, history and culture of indigenous populations and traditional medicine, as well as community participatory approaches.

In 2009, two important conferences were held in La Paz: the First National Forum for the Health of the Peoples and Nations of Bolivia and the National Conference on Municipal Health Management. Attendees numbered approximately 200 individuals at each event and included indigenous leaders as well as representatives from the MSD, the World Health Organization (WHO), human rights groups, and other social organizations. The conclusions from these two events were similar (Johnson 2010), calling for national health policy based on social determinants and on health promotion, universal free health care for all Bolivians, popular participation in the health system, and intercultural health care.

Although in theory the current political context supports improved health for the indigenous populations of Bolivia, serious health disparities continue to exist for numerous reasons. Johnson (2010) describes a juxtaposition of factors that have led to conflicts throughout the process of creating an intercultural healthcare system in Bolivia. These include newly formulated state policy objectives, abstract principles of intercultural theory, and the difficulties inherent in the Bolivian reality, such as the lack of financial resources available to the healthcare system. Neither a clear theoretical and operational definition of interculturality nor a clear articulation of how the process is supposed to work within the health sector and on the ground exist. Additionally, politically motivated position shifts and turnovers have led to a weakened healthcare system overall. Although traditional medicine and biomedicine approaches are supposed to exist on an equal level, the vertical structure with biomedicine situated at the top has been perpetuated: traditional medicine is, in practice, not as well respected as biomedicine (Johnson 2010).

Because the SAFCI model calls for a decentralized system in which responsibility falls on local and municipal levels and because smaller communities have limited resources, implementation has been incomplete and erratic. Consequently, a government focused on decolonization has placed more responsibility on international institutions for support in terms of financial, human, and material resources. Based on research in the Beni region of Bolivia, Aizenberg (2011) questions the sustainability of intercultural healthcare programs that are financed by international institutions in the context of a weak state and weak systems of public health care. Her research demonstrates that when social capital is fostered as part of intercultural health programs, it can counter the weakness of the Bolivian government in terms of ensuring

quality health care; however, it cannot compensate entirely for the limitations of the state, nor be sustained for the long term.

2.3.3 Access to Health Care

Multiple insurance systems operate in Bolivia, including free health care for pregnant women and children, members of the military, and teachers; however, the country is still far from providing universal health care as promised in the new constitution. This section briefly describes one of the insurance systems to provide an example. Bolivia has developed a national social health insurance program directed toward improving maternal and infant health. *Seguro Universal Materno Infantil* (Universal Maternal and Infant Insurance - SUMI) was passed in 2002 as an initiative in poverty reduction. This program initially provided care for only pregnant women and children (Quesada et al. 2006); however, by 2005, pressure from international agencies and the National Committee on Contraceptive Security as well as consideration for the MDGs encouraged the Bolivian Congress to incorporate family planning as a benefit for all women of reproductive age (Saunders and Sharma 2008). This includes universal, comprehensive, and free health care at all levels of the national health system. More recent policy research (Silva and Batista 2010), however, suggests that this expansion of SUMI never occurred.

3.0 METHOD AND THEORY

Prior to conducting the research that forms the basis of this thesis, the author spent much time living in and around the city of Cochabamba, one of Bolivia's many Quechua regions, beginning in 2002. The data presented here come from interviews that the author conducted during June 2011 in neighborhoods within and on the outskirts of the city. The project proceeded only after it received Exempt Approved status from the Institutional Review Board at the University of Pittsburgh. (See Appendix A for the IRB Approval letter.) Previous experiences in Bolivia, language skills in Quechua and Spanish, a background in anthropology and public health, and firmly established connections helped to facilitate making contacts and requesting participation in the project. Three interviews were conducted with Quechua men and women living in and around Cochabamba. Based on the proximity to a major city and the fact that many residents, both in rural and urban areas of this region, are bilingual, the author conducted the interviews in Spanish. This section addresses three main methodological topics: recruiting and sampling, data collection and theory, and analysis.

3.1 RECRUITING AND SAMPLING STRATEGIES

Sampling was purposive. Although there are up to 37 indigenous groups within Bolivia (Silva and Batista 2010), the Quechua population is the largest, accounting for approximately 34% of

the entire population (Country Health Profile: Bolivia 2001) and is the focus of this study. The sample included both younger and older adults, over age 18, to investigate if age is a factor in experiences with and opinions of the healthcare system. Initially, the intention was to incorporate both rural and urban perspectives because there might be differences in access to, social structures regarding, experiences with, and opinions of health care in Bolivia as well as differences in potential barriers, such as those relating to language and culture, between rural and urban regions. However, given time and resource constraints, the author was able to conduct interviews with individuals living in urban or peri-urban neighborhoods.

3.2 THEORY

Because this research focuses on how Quechua men and women experience health and navigate the healthcare system, a combined theoretical approach is needed to look at personal, interpersonal, and societal forces. Interviews included questions and discussion points that addressed the current situation of health care from a larger social ecological framework in order to understand the greater context in which participants' behaviors and attitudes are situated. This is important because, in most cases, health and access to health care are affected by much more than an individual's personal beliefs and decisions. Therefore, the questions that were used to guide the interviews are derived from two health behavior theories: Social Cognitive Theory (SCT), an interpersonal-level theory, and the Structural-Ecological Model, an ecological-level theory. This allows for an investigation of sociopolitical factors, interpersonal relationships, and personal agency. Although these theories are often used to guide health behavior interventions, they are useful for the purposes of this research because their inclusion ensured that multiple

levels of the social ecological framework were considered at all stages of the research, from development of the interview guide to interpretation of the data.

3.2.1 Social Cognitive Theory

SCT posits that behavior is the result of a dynamic interaction among personal, behavioral, and environmental influences (Bandura 1986; McAlister et al. 2008). According to SCT, although the environment certainly shapes behavior, the focus is on an individual's potential abilities to alter his or her environment as well as on the capacity for collective action. This is an appropriate theory for the current study because it helps to elucidate both environmental changes (i.e. new health discourse and policy) and their effects on individuals' health as well as how individuals respond to these changes.

Important concepts of SCT that guided the formulation of questions for the interview guide include self-efficacy, collective efficacy, and facilitation. Self-efficacy refers to an individual's confidence in his or her ability to behave in ways to reach a desired outcome. Similarly, collective efficacy refers to a group's confidence in its ability to act in ways to reach a desired outcome. These two concepts allow for a consideration of how individuals or communities are engaging with or perceive that they could engage with the Bolivian healthcare system. Finally, facilitation refers to the provision of tools and resources or environmental changes that make behaviors easier to perform, which could reflect the implementation and efficiency of intercultural policies. Examples of interview questions that target these concepts include: "Are you comfortable talking with and asking questions of your healthcare provider? Why or why not?" (self-efficacy); "Do members of the Quechua community come together to improve their health as a community? If yes, how? If no, what might be done to allow this to

happen?" (collective efficacy); and "Do you think there could be improvements made in the healthcare system that would make it more accessible to the Quechua population? If yes, what might these be?" (facilitation).

3.2.2 Structural Ecology

Ecological models of health behavior emphasize the environmental and policy-related contexts of behavior and concurrently incorporate social and psychological influences (Sallis et al. 2008). Because this research attempts to understand how people are interpreting, engaging with, and being influenced by new policies, the Structural-Ecological Model (Cohen et al. 2000) is appropriate. The model posits four categories of structural influences, two of which are 1) social structures and policies and 2) media and cultural messages. Examples of interview questions that target these categories include: "Have you noticed any changes within the healthcare system in the recent years? If yes, what kinds of changes?" (social structures and policies) and "Does the MSD use media messages to communicate about health issues or healthcare services? What kinds of media messages? TV, radio, posters, or fliers? How do you perceive these? Do you have a sense of popular opinions regarding these media messages? If yes, what are these? About how many have you seen in the past month?" (media and cultural messages).

3.3 DATA COLLECTION

Semi-structured interviews are an appropriate choice as a research methodology to investigate interculturality within Bolivia's healthcare system. Because very little is known about how

Quechua men and women experience any of the recent policy changes and because this is an understudied topic, qualitative and exploratory information gathered from interviews is necessary to learn the range of experiences, ideas, and opinions surrounding the current context of the healthcare system in Bolivia. The qualitative methodology utilized here resulted in a more sophisticated understanding of attitudes and experiences, as participants were allowed to tell their own stories. Guided by the theories discussed in the previous section, the interviews addressed 1) opinions regarding health, interculturality, and changes within the healthcare system, 2) the social, cultural, and political contexts of health care in Bolivia, and 3) access to health care. (See Appendix B for the English translation of the interview guide.) These questions formed the foundation of the interviews; in most cases, participants elaborated in ways that required follow-up questions not included in the guide.

Interviews lasted for approximately one hour and occurred in a place and at a time convenient for each participant. Prior to each interview, the author read a consent script to the participants, which was approved by the Institutional Review Board at the University of Pittsburgh. (See Appendix C for an English translation of the consent script.) Upon completion of the interview, as a token of appreciation for participating in the study, each participant received a box of tea, an appropriate gift in Bolivia.

3.4 ANALYSIS

Data analysis occurred after the author transcribed the interviews. After several readings of each transcript, the author created a codebook, which includes codes reflective of themes that emerged throughout the interviews as well as a description of each code. (See Appendix D for the

codebook.) Upon completion of the codebook, the author coded each transcript. This kind of analysis is an iterative process, so the codebook was modified repeatedly as transcripts were read and reread. After coding, text assigned to each code was grouped using scissors and paper. In other words, the author created physical groups of thematic items rather than utilizing a computer program. Initially, text was grouped according to individual codes; eventually, codes that referred to similar or related topics were grouped into broader themes. For example, those items coded as Treatment, Opinion of Doctors, Trust, Understanding Needs, and Encourage present a much clearer, cohesive, and holistic understanding of the participants' thoughts when grouped together. As a second example, Program Governmental Health and Program Non-governmental Health are connected, albeit contrastively, because they were often discussed in conjunction with or in comparison to one another. The process described above occurred primarily in Spanish. After analysis, the author translated the transcripts into English in order to present the data found in this thesis.

4.0 RESULTS

This section presents the results of the analysis described above. The background of each participant is described, replacing real names with pseudonyms, in order to situate their responses and opinions. Following this, the results of the analysis are presented, grouped into major themes or concepts. The author translated the quotes included below from Spanish into English.

4.1 DESCRIPTION OF PARTICIPANTS

As mentioned previously, the author conducted three interviews with participants of varied ages and from different backgrounds.

José is a 63-year-old man who currently lives in a neighborhood on the outskirts of Cochabamba. His first language is Quechua, which he spoke in his home as a child; however, he began to learn Spanish at an early age. José does not identify as Quechua but instead as a Bolivian and as part of larger global culture, that of a human being; he does not believe in purity of cultural groups. José was born and grew up in a mining community in the Department of Potosí, moving to Cochabamba as an adult. José attended university in Bolivia. Politically active as a young adult, he was exiled to Switzerland during a period of dictatorship in the 1960s. Working for several years in Switzerland, he met his wife, a woman from that country, and the

two of them returned to Bolivia to raise a family. For the past 20 years they have run a language program in Cochabamba, teaching Aymara, Quechua, and Spanish, mostly to non-Bolivians. At home, José currently speaks a mix of Spanish, Quechua, German, and some English.

Maruja is a 50-year-old woman, also living in a neighborhood on the outskirts of Cochabamba. She lives in a neighboring community to José. Maruja was born and grew up in Independencia, a small rural province in the Department of Cochabamba. Her first language was Spanish, but because she lived in a Quechua-speaking rural community, she learned Quechua at an early age in order to communicate with her peers and to function within her community. Maruja moved to Cochabamba to pursue university education. She currently works as a Quechua instructor at many language institutions in Cochabamba, including José's school, a local high school, and the city's major public university. Maruja identifies as Quechua and is very proud of her Quechua background. Although she currently speaks only Spanish at home with her two daughters, she wishes that they spoke to one another in Quechua.

Luis is a 27-year-old man who lives in an urban neighborhood to the north of Cochabamba. He was born in Argentina, to Bolivian parents, and moved to Cochabamba when he was five years old. He is a monolingual Spanish speaker and is in the process of learning English. Stating that his family is Quechua, Luis identifies as Quechua. Luis does not have a university degree. He currently works in the tourism agency, coordinating tours primarily in and around Cochabamba, and also throughout Bolivia.

4.2 EMERGENT THEMES

Several broad themes emerged from the three interviews. They fall into the following categories: 1) conceptualizations of interculturality and intercultural medicine, 2) changes to the healthcare system, 3) financial constraints as a barrier to health care, 4) access to health information and health services, 5) perceptions of physicians and biomedical healthcare providers, 6) Quechua communities' efforts to improve health, 7) governmental vs. non-governmental health programs, and 8) health campaigns and the role of the media.

4.2.1 Conceptualizations of Interculturality and Intercultural Medicine

Throughout each of the interviews, participants explored and discussed in detail their understandings of and ideas about interculturality as well as intercultural health and medicine. They also provided many examples of their own usage of various ethnomedical systems. No definition or description of interculturality, as stated by the MSD or other source, was provided to the participants. The following presents their ideas on the topic of interculturality; this is compared to national discourses of the Bolivian state in the Discussion chapter.

In terms of fundamental tenets or definitions of interculturality, Luis feels that interculturality entitles all Bolivians, from every ethnic group, to the right to health and health care: "With interculturality, we all have that right [to health]. Not like before. Before, not everyone had that right." For him, interculturality implies a bringing together of biomedical and traditional ethnomedical systems. In a similar sentiment, Maruja described interculturality as the creation of a common community incorporating all of Bolivia's indigenous groups and the inclusion and participation of these groups within the realms of politics and health: "Before, the

indigenous populations were excluded. Now, with interculturality, there are efforts to create a community with them too… In other words, they have participation in politics and health." Elaborating further, she stated that interculturality should imply choice: "I think that in all health centers there should be both traditional medicine and other medicine. Then people, if they go there, would have an option. The choice… I think that would improve health for all. And perhaps there would be less mortality." She believes this already occurs in many healthcare facilities in La Paz but not yet in Cochabamba. Finally, José expressed the concept of interculturality as the process of rescuing, combining, and applying knowledge from biomedicine and traditional medicine in a way that "the two medical systems, harmonically joined, work together to the benefit of all humans." To him, humility and openness on the part of healthcare providers and healers, whether biomedical or traditional, when confronted by various medical systems, are requisite.

Unique to José's description of interculturality, a focus on healing the environment is necessary. José invokes the Quechua concept of *ayninaku*, or mutual aid and support shared between beings, as a useful term to express interculturality: "I am not alone. There are others that surround me, including the plants and animals… I have to also be capable of doing *ayni* with what surrounds me." This concept, José believes, is still missing in the national expression and implementation of interculturality.

All three participants also mentioned examples of intercultural medicine as it occurs on a local level, either within communities or households, and not as part of the national healthcare system. Maruja stated that it is very common for indigenous people in Bolivia to "first treat themselves using plant-based home remedies for whatever illnesses they have. But if that doesn't work and they continue to be sick, they go to a health center." Both Maruja and Luis commented

that traditional medicine is more common in rural areas, and that many people who live in urban settings utilize primarily biomedicine; however, in the words of Maruja, "People in the city use biomedicine more than anything else. But it seems to me that now many people are turning to traditional medicine. We have many stores in the city with natural medicine, without chemicals." Maruja also commented that, although with urbanization knowledge and use of indigenous medicinal plants was lost, there is a current revival; more and more individuals are growing and using medicinal plants: "With urbanization and building their houses, they had stopped planting. Now they are recovering [the practice] and planting again."

4.2.2 Changes to the Healthcare System

In terms of intercultural medicine in Bolivia, José believes that until several years ago, a terrible divide existed between biomedicine and traditional medicine, in which all biomedicine and traditional medicine systems devalued and degraded other ethnomedicines. In his words, "There was a terrible differentiation in what we call academic medicine, or biomedicine, and traditional medicine. They were two completely separate worlds that had no contact. There was no contact between them. They were so divided that they underestimated, undervalued, and scorned one another." In recent years, which began prior to the new constitution and regime, however, "the two medicines began to flirt a little and they could see that each one has knowledge."

The three participants stated that very few changes, if any, in the delivery of care within Bolivia's healthcare system over the past several years have occurred. José feels that "there are not many changes. Unfortunately, the changes are occurring very slowly and only in some places, but are not taking place across the board. There are no changes that truly reach the

Bolivia population." He also feels that many of the programs, such as the mobile units programs, touted as new, have, in fact, been strategies utilized by previous regimes.

The changes that have been noted have to do with financial issues. (See Subsection 4.2.3 for greater detail on the impact of financial issues.) Maruja commented both that insurance is provided to more sectors of the population than in previous years and that the program Juana Azurduy Bonus, a program that provides financial compensation to women during pregnancy if they access prenatal care, has helped to reduce maternal mortality.

4.2.3 Financial Constraints as a Barrier to Health Care

One theme that emerged repeatedly about hindrances to improved health in Bolivia is that of financial constraints. Financial problems were discussed in two main ways: those that related to individual or family ability to afford health services and those that related to governmental resources and investment into health and health services.

All informants regretted that insurance, and consequently health care, is not provided to all Bolivians, as mandated by the new constitution and according to government discourse of universal health and health care. In the words of Luis, for example, "There is insurance, but not for everyone. It's for very few." Only certain sectors, such as pregnant women, children under five, teachers, and the military, receive free health care. According to Maruja, "You always have to pay. And if people don't have money to eat, they are not going to have money for health."

José understands universal health care as "a right of all people to equal access to both biomedical and traditional health care." In Maruja's discussion of universal health care, "It's health for all, without exclusion. But I don't know from where they will get the money. We don't know how the project will unfold, but we're skeptical about that and other benefits, because

perhaps the capacity of the health centers isn't entirely about helping the people." This issue is of utmost importance to Luis: "It's easy to access information; what doesn't allow us health, more than anything, is the economics… This theme is difficult and very complicated."

When electing between biomedicine and traditional medicine, this issue of financial cost plays a considerable role. Informants agreed that, because traditional medicine services are much less expensive, people elect traditional medicine when they cannot afford biomedicine, even if they might otherwise choose a biomedical option. Luis stated, "It's difficult to access [health services] because of the cost. People don't have many resources and they prefer not to go at all or turn to traditional medicine, which is less expensive."

José feels that government investment in the health sector is critical, a topic which neither Maruja nor Luis mentioned. When asked what could be done to improve health for all of Bolivia's populations and to make health care more accessible, he said, "For me, what is very important, I believe, is investment. I believe that the Bolivian state would have to invest more into health and education." He believes that this investment is necessary, yet lacking, and that only when more resources are invested will the health of all Bolivians improve. This investment includes both financial and human resources. When talking about health care in rural regions of Bolivia in terms of investment, he stated, "To have a building does not serve any purpose if you do not have people to work in it."

4.2.4 Access to Health Information and Health Services

All informants expressed concern about the disparity between rural and urban regions in terms of access to information. Each of the three stated multiple times how much easier it is to access health information if one lives in a city. According to José, "In the city it's much easier. It's

much easier. Radio, television, newspapers, and neighbors all exist [in the city]. Because we live in a society with many connections, and in the city those connections are much closer." Additionally, although it is possible to find all kinds of information through the Internet, including information about traditional medicine and healers, Internet access is limited, even in urban regions, and a luxury. Urban regions do facilitate the possibility for the creation of networks, commented José, and it is easy to pass on health information to neighbors. Another way to access information in urban areas is through pharmacies. Maruja commented that "many people, when they're sick, elect to go to a pharmacy and ask a pharmacist what is best for them… rather going to a doctor" because pharmacy staff will more quickly attend to them and because they trust pharmacists more than biomedical doctors. Finally, radio campaigns, according to all participants, are an effective method to disseminate health information, whether about specific health problems, health promotion of free services, or where and how to access health services. These campaigns, again, are more successful in and target urban regions. (See Subsection 4.2.9 for more information on campaigns and media messages.)

In terms of access to services, all participants commented, as noted above, that access to biomedical healthcare services is hindered because of financial costs, whether the cost of a consultation or the cost of medication. Although neither José nor Luis mentioned access to health care in this context, Maruja commented that another impediment to accessing services is that there is often a shortage of medications or other therapeutic items. This renders visiting a health center fruitless: "For any given illness, they [biomedical healthcare providers] only have enough medicine to reduce the pain a little bit, but not to cure the illness."

4.2.5 Perceptions of Physicians and Biomedical Healthcare Providers

All three participants expressed negative opinions about the biomedical community in Bolivia. They expressed concerns about the ability to trust, talk with, and understand doctors, as well as doctors' abilities or efforts in understanding patients, regardless of ethnic affiliation, class, or economic situation. This point demonstrates that interpersonal relationships are critical in intercultural efforts. For example, Maruja commented that biomedical doctors tend to be rude and to not ask any questions of their patients: "They don't ask us anything, they don't look at us well, and then the appointment is over…We don't have the chance to tell them about our pains or anything." The three participants agree that few doctors attempt to connect with or understand Bolivian society. José was the only participant to specifically mention language and cultural barriers, which to him are substantial: "It's not only about [translating] single words, right? It's not only about 'learning to wash with soap' and all that, right? But is much more, right? And that is the first hurdle, the first problem of academic medicine." José did comment, however, that an increasing number of doctors attempt to learn about the various indigenous language and culture groups in Bolivia and that this concern is considered seriously within the MSD: "There are projects with young doctors, very few, but still, right? They go to the countryside not only with their native language, but with having learned the [indigenous] language of where they will work" When asked if he believed healthcare providers understand the needs of patients, Luis responded, "It should be that way. But it isn't… Doctors don't understand well the reality of the people, how they live, what they think… This is part of health. They should know."

José returned several times to the theme that doctors hold an elite position: "They have always been different worlds. Unfortunately, when one begins to study medicine, he or she begins, at the same time, creating an elite world." This elite world is reflected in the fact that

José feels that many Bolivians consider doctors to have an elite status and therefore cannot connect to, question, or easily communicate with them. Although, for José, a slightly more open and respectful perspective exists within the medical community, both about patients and about other ethnomedical systems, the majority of doctors are still closed-minded and there are still many "chains to be broken." In his words, "They need to understand that not only their medicine, what they have studied for six, seven years, is what works and has value. That there is also another humble medicine that has years of history. That has value. And that is very important for doctors to also understand." José does know, however, doctors who work together with traditional healers or who attempt to learn from traditional healers. For both José and Maruja, a major difference between biomedical and traditional healers is that traditional healers spend time with patients and attempt to understand the larger picture of a patient's wellness and health. Biomedical doctors, on the other hand, do not. According to José, "Unfortunately academic medicine listens only to what hurts you and tries to calm the pain, period."

Luis commented that the situation is different if a patient attends his or her local health center. He said that a patient will feel more comfortable because he or she knows the staff and the staff knows the patient, along with his or her medical, life, and family histories: "If in your neighborhood, there is a health post or health center, you already know them, who they are, and you always go. But if you go to a different unfamiliar one, it's not the same at all."

All three participants passionately mentioned the problem of treatment of patients in rural areas. According to Luis, when doctors provide service in rural areas, which occurs usually as part of required period of rural service, they often do not understand well the reality of their patients and have no interest in doing so: "It's very few that are interested in this part when they go to rural areas." After the required service period, according to all three participants, healthcare

providers choose to live in more urban settings. Therefore, there is a serious shortage of healthcare providers in rural regions of Bolivia. In the words of Maruja: "In the countryside, there are hospitals which have been built, but they are white elephants because no one [i.e. the healthcare providers] wants to go there. They want to be only in the cities."

4.2.6 Quechua Communities' Efforts to Improve Health

When asked if Quechua communities come together to improve their own health, both Maruja and José responded in the affirmative. Maruja commented that women are the ones who unite and discuss health and health issues, such as available family planning options. When asked if people in Quechua communities come together to improve their own health, she responded, "Yes. Women do this more than anyone. Indigenous women organize and have workshops, workshops about health." She believes women exchange health information in order to help one another in situations when information is more difficult to access. While José was not specific about gender, he also commented on the informal ways in which Quechua communities come together to improve their own health. José stated, "The support of one neighbor helping another, and also in communities. Yes, happily that still exists. Relationships among people, support among people, trying to resolve problems as a group. They talk a lot about health problems." José provided a specific example from a rural community outside of Cochabamba, in which he had lived for many years and in which his daughter still lives. During a *mink'a*[1], community members talk about what they have seen during the past week in terms of health and illness

[1] A *mink'a* is a group labor party in which members of a community work on a project for the benefit of the entire community, such as a road or communal house.

within their community. If they notice that someone has been sick, they talk about which healing remedies have worked in the past for similar situations or about how to help that person and his or her family. José described this scenario as "… the best method. It's the exchange of knowledge and a bit of common, community medicine." When this topic was presented to Luis, our discussion changed topics and transitioned to a more general discussion of health improvement campaigns in Bolivia.

4.2.7 Governmental vs. Non-governmental Health Programs

Maruja commented that patients, including many who live in cities and have better access to the healthcare system, prefer to be seen by doctors who come from Venezuela or Cuba because they provide services, including medication, consultations, and operations, free of charge. According to Maruja, these foreign doctors also come to work in the rural areas: "I believe that in Bolivia Cuban doctors have arrived to work in rural areas because Bolivian doctors only want to be in the city, city, city." All three participants believe that many of the programs that provide care for free or at a reduced cost come from non-governmental and foreign organizations. In the words of Luis, "It's from outside, from outside of Bolivia, what helps us."

4.2.8 Health Campaigns and the Influence of the Media

All participants talked with ease about various recent public health campaigns sponsored by the MSD that covered topics such as the flu, tuberculosis, and HIV and AIDS. These campaigns are broadcast through various channels, whether through the radio or through workshops in primary and secondary schools. Luis and Maruja both stated that these are relevant and that people take

them seriously, applying what they learn. According to Maruja, “To me, they seem very good. They communicate well the information and after people know what are their rights and all that.” Luis also stated that campaigns are most successful when they advertise services that are free or are provided at a reduced cost. José, on the other hand, was skeptical of and upset by the fact that, in his opinion, these campaigns projected more political propaganda than health information and that the politics hindered attempts to improve health: “To take advantage of all that space [e.g. radio time and posters] that they utilize for health messages mixed with political intentions to simply educate people about health. I believe that would be much more effective.” He commented that this is a popular opinion among Bolivians, Quechua and non-Quechua.

5.0 DISCUSSION

This chapter connects and contextualizes the results noted above with the larger picture of intercultural healthcare efforts in Bolivia as well as with the theoretical approach that guided the research as presented in the Background and Method and Theory chapters.

5.1 INTERCULTURAL HEALTHCARE EFFORTS IN BOLIVIA

Although there are some differences in expression, all informants understand intercultural health care as a concept similar to what is advocated by the MSD and through national discourse. For example, informants brought up themes of universal health care, integration of medical systems for the benefit of all Bolivians, and participatory approaches to health care and Bolivia's healthcare system.

The participants reiterated some of the challenges that have been documented both within Bolivia's healthcare system and in other Latin American countries as governments attempt to implement intercultural health care. The most important of these seem to be financial constraints and the persisting attitudes within the biomedical community.

In terms of financial constraints, it is not merely a question of being able to afford medical care (as a patient) or providing medical care to all citizens (as a state). The financial problems hinder or even potentially negate the intended goals and processes of intercultural

medicine. As discussed in the results above, people elect to use traditional medicine at times out of necessity because they cannot afford services or treatments of biomedicine. This means that equal access to all forms of medicine does not exist and in a sense traditional medicine is demoted and devalued (i.e. traditional medicine is the fallback). In order for the various ethnomedical systems to be brought together in a way that incorporates the positive healing potential of all systems, financial constraints cannot be a deciding factor. Additionally, participants' responses suggest that Bolivians are more likely to access health care that is delivered by foreign or non-governmental organizations or providers because of financial constraints, which demonstrates the severity of the financial barrier to state health care.

In terms of the attitudes within the biomedical system, participants confirmed and shared many examples demonstrating that a vertical structure between biomedicine and traditional medicine within the healthcare sector exists and causes problems for healthcare delivery. Such examples include unwillingness to work in rural regions, unwillingness to listen to patients, discourteous treatment of patients, and unwillingness to be open to the diversity of language and cultures within Bolivia.

Participants noted very little change within recent years, and the incremental change that has occurred does not seem to be attributable to the current political regime's focus on interculturality. Participants are generally skeptical that change is possible and do not have confidence in the government's commitment to health or intercultural medicine; they question the motives behind the promotion of intercultural health care. Both Maruja and José felt that the discourse of intercultural health was more about government propaganda than about improving health for Bolivia's populations. While the discourse is certainly prevalent and clear, it does not seem that there is any indication of how it has been put into practice.

Although none of the participants explicitly articulated how intercultural healthcare efforts might work better, they all shed light onto this subject. For example, Maruja and José emphasized the informal structure involved when Quechua communities come together to improve their own health. Due to this informal nature, these strategies might have been missed in health planning efforts and would have not, therefore, been effectively brought into a participatory intercultural healthcare system.

5.2 THEORETICAL APPROACH

Considering first SCT, based on the comments of all three participants, self-efficacy and collective efficacy are present both within Quechua populations and the general Bolivian population, and there exists the potential for individuals and communities to act on their environment. Participants easily talked about ways that they as individuals or others they know navigate the healthcare system, and are confident in making decisions as well as want to make decisions about their health care. Additionally, Maruja and José talked about communities coming together to improve health and for collective solutions to health problems. In fact, this sense of efficacy could be harnessed by the healthcare system to improve health.

According to the experiences of the three participants, intercultural policies are not successfully enacted on the ground. Therefore, what is lacking, at least in terms of these three concepts, is facilitation. As defined above, facilitation refers to resources (e.g. tools, environmental changes, financial resources) that facilitate certain behaviors; in this case, the behaviors under consideration are those pertaining to health and seeking health care. Facilitation could include financial resources, access to health services and information, and the creation of a

healthcare system that welcomes and includes the various populations in Bolivia. All of these are lacking, according to the participants. The discourse of interculturality within the Bolivian healthcare system as described in the constitution and through policies should lead to the provision of such facilitation; however, this does not appear to be the case.

A second theory used in this research, the Structural-Ecological Model allows for consideration of the environmental and policy-related contexts of health and health care seeking behaviors. The two categories of the model used in this research are 1) social structures and policies and 2) media and cultural messages. The Bolivian government and the MSD have developed intercultural healthcare policies that aim to increase the availability and quality of health care for all Bolivians, but especially for the indigenous populations. Based on the opinions of the three informants, however, because these policies are not clearly implemented, they have not led to or allowed for changes in behavior. Finally, it does appear that, although it is difficult for certain segments of the population to access media outlets, media messages are a potentially positive and successful method for behavior change; however, because health care remains difficult to access, these messages have yet to make an impact.

6.0 CONCLUSION

Intercultural healthcare efforts have increased worldwide as a strategy to improve both the quality and reach of health care. Intercultural health care is often developed to target indigenous populations, which have typically been excluded from state healthcare systems. This thesis contributes to the literature on interculturality and health through exploratory and qualitative research in Cochabamba, Bolivia, and provides a new lens through which to consider intercultural health care. The research presented here raises concerns about the implementation and effectiveness of intercultural policies. Participants in this study have noticed very little change, if any, as a result of intercultural policies and are skeptical about the motivations driving intercultural healthcare efforts. Additionally, financial constraints are perceived as significant and impede potential gains that might result from interculturality. Nonetheless, participants were able to identify behaviors that could be utilized by policy makers and staff within the MSD as part of intercultural health care; however, these would require a more highly nuanced understanding of community participation within health care.

The research presented and discussed in this thesis has limitations; however, especially because no research yet exists that investigates the topic of intercultural health care efforts in Bolivia from the perspective of potential patients, it offers a foundation upon which to build additional research endeavors. Due to time and resource restrictions, the sample size is small. The goal has not been to present a representative or generalizable argument; instead, the goal is

to provide particular examples and allow for a thicker description (Geertz 1973). In the future, however, further exploration with a larger sample size would likely elicit new and different information.

Related to the issue of sample size, the sample was more restricted than the author had originally intended in terms of the informants' backgrounds. As mentioned briefly in the Method and Theory chapter, it was not possible to interview either residents living in rural areas or monolingual Quechua speakers. These interviews potentially would have yielded new and differing perspectives. For example, it is likely that monolingual Quechua speakers would have increased barriers to information access, whether in verbal or written form. In future related research, it would be interesting and informative to broaden the diversity of informants. Even so, for the same reasons discussed in relation to sample size above, the goal for the data presented here was not to represent all of the varied perspectives of Bolivia's population.

A final concern for the research presented in this thesis is the possibility that not enough time has passed since the introduction of interculturality into and the implementation of intercultural policies within the state healthcare system in order for actual change to have occurred on the ground. Although it cannot be expected that Morales and the new government could have transformed Bolivia, after centuries of colonial and exclusionary rule, in just a few years, it is nonetheless fruitful to pay close attention to what is happening on the ground in order to consider the prospects for future change. Similar research should continue as Morales moves further into his second term in office.

Because the health of indigenous populations has been prioritized worldwide and because intercultural healthcare efforts play a pivotal role in actualizing this prioritization, research that investigates how intercultural health care functions on the ground and in practice is necessary not

only for the Bolivian case, but has the potential to contribute to improved health policy on a global scale. This thesis has presented one look at interculturality in health care on the ground: from the perspective of three potential patients who identify either as part of or as connected to Bolivia's Quechua population.

The role of interculturality in health is advocated not only by states such as Bolivia, demonstrated through government discourse, recent policies, and the new constitution, but is also promoted by global health organizations, including PAHO. If the goal truly is to improve the health of indigenous peoples worldwide, a more critical consideration of the implementation of intercultural healthcare efforts is indispensable. For example, how different are intercultural healthcare policies and programs compared to previous attempts at health improvement? Participants commented that much of what is touted as intercultural health care, such as the mobile units program and decentralization, actually has a much older history in Bolivia. Also, intercultural medicine has occurred throughout history, whenever groups are in contact with one another; people continuously make decisions, navigating multiple systems of belief about health and healing. Does interculturality, therefore, belong within state healthcare systems? Or should biomedical healthcare systems continue to work alongside other ethnomedical systems? What are the concrete benefits of bridging the two systems? Only with such consideration can intercultural health care be developed in a manner that serves to improve quality of and access to health care for the world's 370 million indigenous peoples.

APPENDIX A

IRB APPROVAL LETTER

University of Pittsburgh
Institutional Review Board

3500 Fifth Avenue
Pittsburgh, PA 15213
(412) 383-1480
(412) 383-1508 (fax)
http://www.irb.pitt.edu

Memorandum

To: Alana DeLoge

From: Christopher Ryan PhD, Vice Chair

Date: 6/22/2011

IRB#: PRO11060182

Subject: Personal Experiences with Interculturality and Bolivia's Health Care System

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The above-referenced project has been reviewed by the Institutional Review Board. Based on the information provided, this project meets all the necessary criteria for an exemption, and is hereby designated as "exempt" under section
45 CFR 46.101(b)(2)

Please note the following information:

- If any modifications are made to this project, use the " **Send Comments to IRB Staff**" process from the project workspace to request a review to ensure it continues to meet the exempt category.
- Upon completion of your project, be sure to finalize the project by submitting a "**Study Completed**" report from the project workspace.

Please be advised that your research study may be audited periodically by the University of Pittsburgh Research Conduct and Compliance Office.

APPENDIX B

INTERVIEW GUIDE

The Spanish translations of the following questions guided the semi-structured interviews used to gather data for this study.

1) How old are you? Where do you currently live? Where did you grow up? What language(s) did you speak growing up? What language(s) do you speak currently at home? Do you identify as a member of the Quechua community?

2) Have you heard the term interculturality used in reference to health and the healthcare system? If yes, what does this mean to you? What about the terms biomedicine and traditional medicine? If not within the context of health, have you heard the term used at all?

3) Have you noticed any changes within the healthcare system in the recent years? If yes, what kinds of changes?

4) Do you know of any popular opinions or beliefs among the Quechua community about Bolivia's healthcare system? If yes, what are these? Have these changed recently?

5) How easy is it to access health care or information about health? What makes it easy? What are some of the barriers? Have you noticed a change in terms of access in the recent years?

6) How well do you feel healthcare providers understand the needs of your family or of the Quechua community?

7) How do local healthcare facilities encourage the Quechua community to seek care?

8) Do you feel you have the information that would be needed in order to access healthcare services?

9) Do members of the Quechua community come together to improve their health as a community? If yes, how? If no, what might be done to allow this to happen?

10) Are you comfortable talking with and asking question to your healthcare provider? Why or why not?

11) Does the MSD use media messages to communicate about health issues or healthcare services? What kinds of media messages? TV, radio, posters, or fliers? How do you perceive these? Do you have a sense of popular opinions regarding these media messages? If yes, what are these? About how many have you seen in the past month?

12) Do you think there could be improvements made in the healthcare system that would make it more accessible to the Quechua population? If yes, what might these be?

APPENDIX C

CONSENT SCRIPT

"I am a public health graduate student at the University of Pittsburgh and I would like to welcome you here today. I am grateful for your willingness to talk with me. The purpose of this research study is to learn about the experiences with and opinions of recent changes to Bolivia's healthcare system, especially those changes related to interculturality. In order to accomplish this, I will interview adults over the age of 18 in and around Cochabamba during the next few weeks. If you are under 18, please let me know so that we do not move forward with the interview. Our interview today will last approximately thirty minutes. I will be asking questions about your background (such as age, ethnic background, and place of residence) as well as about your thoughts of interculturality and the healthcare system in Bolivia; I will not be asking any questions about your health or the health of your family. Because I'm looking to gather information, I encourage you to be open and to share as many of your ideas as you would like. You are an expert on your own attitudes, beliefs, experiences, and knowledge. By sharing these with me, you can help to illuminate important issues that might be unknown to many healthcare providers and policy makers in Bolivia. There are no anticipated risks associated with this project. There are also no direct benefits to you; however, you will receive a box of *mate* at the

end of this interview as an expression of my gratitude. In order to ensure accuracy of the information for analysis, our discussion will be recorded, but this recording will be destroyed after the material is transcribed. I can also assure you that the notes will be locked away and your responses will be kept confidential. Although I will work to maintain a warm and open environment, if you feel uncomfortable, you may choose to end the interview at any point. Your participation is entirely voluntary. If you have any questions about this research, you are welcome to ask me during the interview or to contact me at a later date. My email is and86@pitt.edu and my telephone number in Bolivia is 4440842. Please let me know if you have any questions."

APPENDIX D

CODEBOOK

PERBACK	Personal Background: Personal background or information about the participant or his/her family
DEFNINTER	Definition Interculturality: Definition of interculturality, in terms of health or health care
DEFNBIOM	Definition Biomedicine: Definition of biomedicine
DEFNTRAD	Definition Traditional Medicine: Definition of traditional medicine
EDUCATION	Education: Role of education, as related to health and health care
TRMEDDES	Traditional Medicine Description: Description of traditional medicine
KALWAY	Kallawayas: Mention or discussion of kallawayas
CHANGES	Changes: Mention or discussion of changes within Bolivia's healthcare system within recent years
EXINTER	Example Interculturality: Example of interculturality, either of intercultural medicine or intercultural policy
DESCINTER	Description Interculturality: Description of interculturality, in terms of health or health care
URBANIZ	Urbanization: Mention or discussion of urbanization
PROBTRUST	Problem Trust: Problem related to trust between patient and provider
PROBFIN	Problem Financial: Problem related to financial issues
PROBACC	Problem Access: Problem related to access
PROBLANG	Problem Language: Problem related to language
PGVTHLTH	Program Government Health: Discussion about an MSD program

PNGVHLTH	Program Non-Governmental Health: Discussion about an NGO program
BHLTHPROB	Bolivia Health Problem: Mention of a health problem in Bolivia
TREATMENT	Treatment: Mention of treatment received by patients
ACCMED	Access Medicine: Access to medicine
ACCINFO	Access Information: Access to information
ACCSER	Access Services: Access to healthcare services
SELFORG	Self Organizing: Mention of people or communities coming together to improve their own health
MEDIAMESS	Media Message: Role of media in terms of health and health care
INSURANCE	Insurance: Health insurance plans and issues in Bolivia

BIBLIOGRAPHY

Aizenberg L. Towards a Critical Approach to Intercultural Healthcare Programs: A Case Study of Indigenous Women in the Bolivian Amazon. Binghamton: Binghamton University State University of New York; 2011.

Albó X. Interculturalidad y salud. In: Fernández Juárez G, editor. Salud e interculturalidad en América Latina: Perspectivas antropológicas. Quito: Ediciones Abya-Yala; 2004. p. 65-74.

Bandura A. Social Foundations of Thought and Action: A Social Cognitive Theory. Englewood Cliffs: Prentice Hall; 1986.

Brown PJ. Understanding Medical Anthropology: Biocultural and Cultural Approaches. In: Brown PJ, editor. Understanding and Applying Medical Anthropology. Mountain View, California: Mayfield Publishing Company; 1998. p. 1-9.

Cohen DA, Scribner RA, Farley TA. A Structural Model of Health Behavior: A Pragmatic Approach to Explain and Influence Health Behaviors at the Population Level. Preventative Medicine 2000;30:146-154.

Country Health Profile: Bolivia. In: Pan American Health Organization; 2001.

Crandon L. Grass Roots, Herbs, Promotors and Preventions: A Re-evaluation of Contemporary International Health Care Planning. The Bolivian Case. Social Science & Medicine 1983;17(17):1281-1289.

Crandon L. Why Susto. Ethnology 1983;22(2):153-167.

Geertz C. Thick Description: Toward an Interpretive Theory of Culture. In: The Interpretation of Cultures: Selected Essays. New York: Basic Books; 1973. p. 3-30.

Gracey M, King M. Indigenous health part 1: determinants and disease patterns. The Lancet 2009;374:65-75.

Johnson BB. Decolonization and Its Paradoxes: The (Re)envisioning of Health Policy in Bolivia. Latin American Perspectives 2010;37(172):139-159.

Kohl B, Bresnahan R. Bolivia under Morales: Consolidating Power, Initiating Decolonization. Latin American Perspectives 2010;37(172):5-17.

Kohl B, Bresnahan R. Introduction Bolivia under Morales: National Agenda, Regional Challenges, and the Struggle for Hegemony. Latin American Perspectives 2010;37(173):5-20.

McAlister A, L., Perry CL, Parcel GS. How Individuals, Environments, and Health Behaviors Interact: Social Cognitive Theory. In: Glanz K, Rimer BK, Viswanath K, editors. Health Behavior and Health Education: Theory, Research, and Practice. 4th ed. San Francisco: Jossey-Bass; 2008. p. 169-188.

McNamee C. Wanted and Unwanted Fertility in Bolivia: Does Ethnicity Matter? International Perspectives on Sexual and Reproductive Health 2009;35(4):166-175.

Mignone J, Bartlett J, O'Neil J, Orchard T. Best practices in intercultural health: five case studies in Latin America. Journal of Ethnobiology and Ethnomedicine 2007;3(31).

Pan American Health Organization. Health of the Indigenous Population in the Americas. Washington, D.C.; 2006.

Quesada N, Abramson W, Betancourt V, Dayaratna V, Gribble J, Sarley D. Contraceptive Procurement Policies, Practices, and Options: Bolivia. Washington D.C.: USAID Health Policies Initiative; 2006.

Sallis JF, Owen N, Fisher EB. Ecological Models of Health Behavior. In: Glanz K, Rimer BK, Viswanath K, editors. Health Behavior and Health Education: Theory, Research, and Practice. 4th ed. 2008: Jossey-Bass; 2008. p. 465-485.

Saunders M, Sharma S. Mobilizing Political Support and Resources for Family Planning in a Decentralized Setting: Guidelines for Latin American and Caribbean Countries. Washington D.C.: USAID Health Policy Initiative; 2008.

Schilling-Vacaflor A. Bolivia's New Constitution: Towards Participatory Democracy and Political Pluralism? European Review of Latin American and Caribbean Studies 2011;90:3-22.

Silva E, Batista R. Bolivian Maternal and Child Health Policies: Successes and Failures. Ottawa: FOCAL: Canadian Foundation for the Americas; 2010.

Tejerina Silva H. Socialist government health policy reforms in Bolivia and Ecuador: The underrated potential of comprehensive primary health care to tackle the social determinants of health. Social Medicine in Practice 2009;4(4):226-234.

Torri MC. Intercultural Health Practices: Towards an Equal Recognition Between Indigenous Medicine and Biomedicine? A Case Study from Chile. Health Care Analysis 2011;20(1):31-49.