

WE JUST LIVE HERE: HEALTH DECISION MAKING AND THE MYTH OF COMMUNITY

by

Jerome Crowder
Department of Anthropology
3H01 Forbes Quadrangle
University of Pittsburgh
Pittsburgh, PA 15260
crowder+@pitt.edu

Prepared for delivery at
The 1998 meeting of the Latin American Studies Association
The Palmer House Hilton Hotel
Chicago, IL
Sept. 24-26, 1998

DRAFT COPY : not for citation

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Abstract

Over the past fifty years the population of El Alto, Bolivia has dramatically increased. Expanding across the Altiplano, El Alto is home to nearly 500,000 people living in more than 200 barrios. Many are Aymara (Indian) migrants, some have moved in from the *campo* and sought employment in the city while others have moved up from La Paz because the capital is too expensive. Displaced and isolated, new residents must adapt to their urban environment in order to survive. They do this by creating their own “community,” which is not necessarily composed of fellow barrio residents.

The rapid population growth has left El Alto unable to cope with the steady influx of new residents. Due to the substandard living conditions, Alteños suffer from intermittent illnesses and chronic diseases which are often left untreated. When Aymara seek medical attention, they face a decentralized health care environment which offers a host of treatment options. Primary Health Care (PHC) was introduced into the periurban barrio of Huayna Potosí in the early 1970s, carrying with it general assumptions about the people and community it would serve. Indigenous conceptions of illness and healing as well as trust and politics influence Aymara choices about health care providers within the urban context of El Alto.

This paper investigates the various decisions made by urban Aymara residents and discusses how these reflect their perceptions of community, acknowledging historical changes, trust and politics to be equally influential in medical decisions and health care. Contradicting assumptions of community made by PHC and development literature, urban Aymara migrants act upon their individual notions of trust as developed through familial, political and social relationships. [health care decision making, community, urban *ayllu*, Aymara, Bolivia]

Introduction

Raised in the nearby Tiwanaku valley, Alvaro migrated to La Paz to attend the university. Now at 31, he has recently completed his studies in accounting and aspires to hold a secure position in the future. Like other Aymara residents of his barrio, Villa Huayna Potosí, Alvaro works hard to provide for his family, juggling multiple jobs while he and his wife Salome raise their four children. Even though he is a local barrio leader, Alvaro feels disconnected from those he represents and the community who elected him.

My father purchased this lot where we live in 1976 from one of the original property owners in the barrio. He didn't spend much time here, but built a small house on this lot, thinking that one day his children could move to El Alto. Now Salome and I have lived here for five years, along with my brother and two sisters. We moved up here when La Paz became too expensive for us to raise our children. We do the best we can with what we can afford. Our house here is supposed to be our home, but we just live here.

Although he has lived in El Alto for some time, Alvaro's dispiriting comment on living in the barrio reflects his sense of separation from his neighbors (*vecinos*) and community. Alvaro hopes that his fellow residents will learn to cooperate and help make the barrio a more comfortable place to live. But his idealism has met with skepticism, as neighbors slander him and maliciously gossip about his administration of barrio affairs and his tenure as president of the *junta de vecinos* (neighborhood council).

Further discussions with Alvaro and his neighbors revealed that although many residents of barrios like Huayna Potosí in El Alto carry on their daily activities, few feel a connection with the place or their neighbors. As Alvaro lives on his father's property, other residents comment that they moved to the barrio because it was the least expensive place they could find, or it was in the vicinity of other family members. Despite the countless reasons people had for living in Huayna Potosí, economy tends to be the common denominator.

Pascual's single comment influenced my perception of the barrio from that day forward. No longer were the residents of Huayna one large group of urban Aymara migrants, I learned to view them as individual households operating within the context of a larger, inhospitable barrio. My perspective of the situation filtered my understanding of how Aymara speakers from all corners of the Altiplano could live in El Alto and not find a sense of community within the boundaries of the barrio. I realized that if I could be so easily mistaken, so too were other outsiders. Originally interested in observing how urban Aymara migrants health decisions are influenced by the

urban environment, my study turned to better understand how their health decisions reflect their sense of community. In exploring how residents view themselves within the context of the barrio, I also found that their perceptions of their neighbors are equally clouded, as they maintain many provincial attitudes towards Aymara speaking strangers, as well as preconceived notions of Mestizos, Gringos and urbanization.

Practicality suggests that people who move into a new environment will maintain prejudices, fears and notions associated with their past. Migrants bring with them cultural mores, beliefs and opinions which not only influence, but are the basis for, their perceptions of their new home and neighbors. Cohen (1985) identifies this “sense” as normative structure. Migration and urbanization temper the *normative structure* as it is implemented into the daily lives of the residents. One place to observe residents’ moderation of normative structure is in their medical decisions. It is hypothesized that recent Aymara migrants maintain a working level of traditional medical knowledge which they employ during an illness episode. By observing those families who use the health clinic, and those who do not, I explore the multiple influences which guide migrants’ ideas about health care. Ultimately, such decisions would reflect residents’ sentiments regarding community. The focus of the work studied residents’ health care decisions to better understand how local *vecinos* of the barrio maintained and negotiated their sense of community.

Previous medical decision making studies have shown that economy plays a significant role in health care utilization (Stoner 1989, Young and Garro 1994, Morgan 1993). However, an economist who recently studied the 1989 multipurpose household survey for urban areas in Bolivia (Encuesta Integrada de Hogares) analyzed the determinants of demand for medical services and concluded that for El Alto, “price elasticities do not vary much by ethnic groups and gender, but estimation results show that Aymara speakers are more likely to care for themselves. Probably there are *cultural* barriers that prevent Aymara speakers from seeking formal care” (Ii 1993: iv; emphasis mine). Although for anthropologists this is not a novel realization, indeed it seems obvious; the above example underscores the fact that so much research does not consider **culture** a significant component of the health decision making process — including international health projects and personnel.

This paper argues that residents of Villa Huayna Potosí base their medical decisions on trust and confidence in practitioners as much as they considered the economic expenditure for health care. Understanding who residents trust and why they do so clarifies how they establish a sense of community. By observing the patterns associated with health care decisions such behavior reflects individual residents definitions of community. Residents who use the local clinic may do so as a last resort, and not maintain much confidence that their health will improve, but in so doing, show that their definition of community is malleable enough to encompass such a decision.

Methods

Research in the barrio of Villa Huayna Potosí was carried out over the course of 16 months between April 1995 to July 1996. Data were collected using basic components of the ethnographic method. Participant observation in the home of my sponsor and within the local health clinic allowed me to understand the everyday workings of a home, and of the clinic. Formal and informal interviews were conducted with randomly selected households in the barrio (93), patients in the clinic (402), as well as doctors, nurses, administrators, and bureaucrats. Also, I followed six families for 8 months, accounting for their recurring illnesses, health decisions, and remedies (and other life affecting variables). Market surveys conducted in nearby markets established a general sense of the medications locally available to residents in the barrio. Medical histories from the local PROSALUD health center (1,436) were reviewed to determine the most common illnesses suffered by clients. Archival records were employed to provide demographic statistics from census data as well as review other research conducted in El Alto.

El Alto

Located between 3,880 and 4,480 meters (12,729 ft and 14,698 ft.) above sea level¹, El Alto is the highest city of its size in the hemisphere (Montes de Oca 1989). The terrain of the city gently slopes downward from the base of the Cordillera Royal (northwest) towards the Choqueyapu valley (southeast). Characteristic of other locations on the Altiplano, El Alto has an average annual temperature of 7.78°C and receives nearly 584 mm of

¹ The official altitude at the International Airport is 4,050ms or 13,287 feet above sea level.

rain each year. Because of its relatively arid and cold environment El Alto is not hospitable, but the city continues to grow, expanding over 45 Km², and encompassing nearly 1,200 Km² of adjacent rural lands.

Alto La Paz began to grow rapidly during the 1960s and 1970s and accelerated through the 1980s as distant barrios of the capital city. The population and area of expansion increased dramatically as more people from the rural areas arrived in La Paz. The urbanization process was sustained and accelerated by successive mining booms, first in silver and then in tin, that greatly expanded the cities of La Paz and Oruro as commercial and supply entrepôts and created urbanized mining enclaves in the Altiplano.² In 1950 there were only 11,000 inhabitants in El Alto, making up 3.4% of the people in La Paz; ten years later the population tripled, doubling its contribution to La Paz (Sandoval 1989). By 1970, El Alto accounted for almost 11% of the urban population of La Paz with 88,000 inhabitants. Between 1976 and 1986 El Alto experienced its greatest growth, reaching an estimated 307,394 inhabitants, a dramatic increase, boosting it into the fourth position of largest polities in the country and contributing 12.4% to the country's population (INE 1989).

Over the past twenty years a large portion of the influx to El Alto have been local Aymara peasants from proximal locales. Citing greater economic opportunities, residents have migrated from nearby provinces and far away departments, as well as neighboring La Paz, to live in El Alto. The great influx of migrants results in El Alto being the youngest city in Bolivia, with 75% of the population being less than 40 years of age, and over half of the population being younger than 20 years old (Antezana 1993, INE 1992).

Not only has such rapid growth left in its wake unbridled urbanization, but it has also contributed to the increase in public health problems such as a lack of potable drinking water, proper waste disposal and generally poor sanitation. These effects compound the already precarious health situation for residents of El Alto who commonly suffer from respiratory infections, gastrointestinal illness and malnutrition. Insufficient electrical, water and sewage systems, as well as, inadequate public health facilities contribute to the high infant mortality rate (300/1000), and potential for infectious disease epidemics (Proyecto 1993, Sandoval 1989). Despite its prominence, its large and growing population and proximity to La Paz, El Alto cannot support its residents with adequate utilities nor is it taken seriously by those in the capital (Antezana 1993).

On the March 6, 1985, El Alto de La Paz became simply known as El Alto. This name change was due to the creation of the Fourth Section of the Murillo province, mandated by a law from the National Congress. After 30 years of being the migrant reservoir for La Paz, El Alto became an independent municipality via another law (651) on September 26, 1988, when El Alto was elevated to the status of City. The local leaders then became members of the city council whose size increased from 4 to 13 members. Lacking basic utility services and infrastructure, the National Law of the Republic on September 10, 1991 declared that the City of El Alto was in a state of national emergency and a committee was formed to propose solutions for the socio-urban problems facing the young city. By 1993 the city of El Alto was the third most densely populated urban area in the country following La Paz and Santa Cruz.

In 1992 the population of El Alto was projected to be approximately 406,000 people (Antezana 1993). This growth indicates a 9.02% annual rate for the previous ten years, and if this rate is maintained until the end of the century (as is projected), there will be over 1.05 million people in El Alto accounting for 19% of the entire country's population and a population density of 107 persons per hectare (Wolowyna 1992). However, more recent statistics suggest that the actual population size of El Alto in 1997 is less than what was projected in 1992. The Dirección de Políticas de Población (DPP) estimates that El Alto currently has 480,435 residents, 239,500 who are female; by 2000, El Alto will have 512,323 residents, 255,170 female.³ Although there is a discrepancy of the population statistics, the general growth reflects a national tendency of urbanization. In 1992, 58% of Bolivians lived in a city and by the year 2000 it is projected that 68% of the population will be urbanized (Wolowyna 1992). While migration is often thought to be the major factor in population increase, the culprit of urbanization is actually natural increase (Harpham et al. 1988).

² Bolivia's main 20th century export commodity tin peaked in 1929 at 42,082 metric tons, fell to 18,014 tons by 1958, gradually revived to another peak of 33,787 tons in 1977, only to fall precipitously to 17,875 tons in 1984, amid signs of the industry's collapse. (Gall 1985)

³ With more accurate accounting measures and reliable controls, the DPP developed a different algorithm for population projection in Bolivia (DPP 1996), which the national government and other health agencies use to forecast populations who will need health care in the future.

The La Paz International Airport divides the city of El Alto into three major sectors, Alto Norte, El Centro and Alto Sur, respectively the northern, center and southern regions of the city. Alto Centro or the central sector, includes the airport and the business district of La Ceja (the Eyebrow). The demographics of El Alto follow distinct class lines, where the northern and southern sections of the city are considerably less affluent than the center, which is primarily “middle class” by Bolivian standards. Generally speaking, Aymara peasant migrants tend to gravitate towards Alto Norte, while former mine workers and migrants from La Paz comprise the majority of the inhabitants of Alto Sur.

Outline and Strategy

In the following pages I will explore how the local health clinic PROSALUD in Huayna Potosí assumed a general definition of community when it moved into the barrio and illustrate how residents perceptions and health decisions were persuaded by elements clearly different than those supposed by the health clinic. I begin by posing the theoretical history and derivation of the concept of “community” and its implementation into Primary Health Care (PHC) by the World Health Organization and other health projects. In contrast, I take an anthropological perspective of community, using relative examples from the barrio of Huayna Potosí. A brief description and history of Villa Huayna Potosí sets the stage for understanding where the health clinic factors into the barrio’s community equation. Once established, I take excerpts from interviews and observations of the clinic administrators and personnel to illuminate the policy and personal philosophies of those running the clinic. Afterwards, I explore issues of health decisions and clinic patronage using quantitative and qualitative data gathered during household interviews, to illustrate how residents perceive of the clinic. Building upon interview and clinic data, I use the voices and stories from Alvaro and his fellow residents to highlight how they make decisions and illustrate the impetus for their use or disregard of the clinic. What we find are that trust and politics play pivotal roles in residents’ perceptions of the clinic, linkages which the administrators and medical personnel in the clinic were not aware influenced their reputation and position in the barrio.

Community: An Applied View

Over the past three decades the definition and recognition of *community* has been an ongoing debate between government officials, development experts, and social science researchers. Although many have sought and composed an accurate definition of community, a universal definition has not been mutually determined by both those who live in the community and those who study community residents (Jewkes & Murcott 1996). Of critical interest are the residents, defining their existence and position from the *emic* or cognitional perspective, incorporating their worldview and living situation into their interpretation of community. Outsiders and nonresidents define community *etically*, or more from an operational point of view — based on uninformed perceptions, without the intricate knowledge of personal relationships, political tension and economic disparity. With at least two different points of view of the same community, no definition will hold for either party because these perspective differences are linked with culture and may only be studied and understood within the cultural context. When discussing definitions of community, a complex set of relationships are intertwined, all of which depend upon the cultural perspectives taken when attempting to understand the subtleties of *community*.

Throughout the health development literature, including the 1978 World Health Organization’s Alma Ata Declaration, implicit definitions of community are derived in order to indicate the “beneficiaries” of health projects⁴. The WHO’s operationalization of *community* provided health workers in community participation programs to identify the target population and work within the boundaries of such a definition. Jewkes and Murcott (1996:558) review the WHO definition of community in the Declaration, “as a locality-bound aggregation of people who share economic, socio-cultural and political characteristics as well as problems and needs.” For all intents and purposes the WHO Declaration assumed two things about communities: 1) the community members operate together because of mutual interests, and 2) that these communities are levels within the hierarchical framework within a country or region, beginning with individuals, then families, communities and finally nation. All subsequent WHO projects from this time forward used this implied “definition” in the foundation of their prospective outlines on the subject of community involvement in health (Jewkes & Murcott 1996).

⁴ It should be noted that the WHO adopted their approach towards “community” from the Chinese “barefoot doctor” program initiated after the Chinese revolution in 1949 (Morgan 1993). An interesting framework to borrow from a communist movement and incorporate into a capitalist development project.

Definitions given by health workers interviewed for this study in Bolivia slightly differ from each other and the WHO's position. The following examples illustrate that geography and demography play important roles in the definitions of community as seen by two public health workers. The two respondents are employed by the same NGO health project in La Paz, not associated with the PROSALUD health clinic in Huayna Potosí.

Dr. V.:

A concentration of population within defined geographical limits which looks for the same interests and combines common cultural factors and language.

Dr. B.:

A concentration of people who live in a defined geographical territory, with similar socio-cultural and ethnic characteristics having fundamental common interests. This definition implies that the community and the individuals should be the object of attention and converse in subjects which they know, participate and make decisions about their problems, and assume specific responsibility.

For administrative reasons, the SNS (Secretaria Nacional de Salud) in El Alto defined communities as political and geographic entities. In the headquarters offices of *Distrito I* (for northern El Alto) large maps posted on the wall indicate the various sectors, clinics, hospitals and health offices which report statistics to the secretary. Color coded regions represent numerous barrios combined to form large, homogeneous sectors of the population. *Distrito I* reports that it represents more than 100,000 individuals from 20 different barrios. Health policy decisions within the Secretariat are derived from health statistics taken from these sectors. The basis of such figures comes from population statistics provided by the INE (Instituto Nacional de Estadística) which calculates such numbers with every census (the most recent in 1992). Annual population projections for El Alto, and its barrios, are based upon an algorithm calculated by the INE (and DPP) and distributed to offices such as the one in *Distrito I* for their use in population health matters.

Definitions of community are not objective as they serve to support the perspective of the author rather than the subject. As Jewkes and Murcott illustrate (1996), since the time community participation was conceptualized by the WHO at Alma Ata, the idea has served as a reference point for other health programs worldwide. No exact definition of community accompanied the idea of community health, leaving the term open for interpretation by all who embraced the idea of community participation. As such, multiple meanings were assigned and used, but none similar enough to warrant a quorum and adjudicate such a definition. Jewkes and Murcott (1996) argue that those involved in the ongoing debate were more interested in what “community” should mean rather than what it does mean to patients.

In the case of community participation, Ugalde argues that Latin American development projects' implementation of community health did little for the people it was designed to serve, instead they were used as political tools to support fledgling democracies (Ugalde 1985). NGO applied uses of the term are not thoughtful and reflective, illustrating the nature of the power of definition — it was eticly conceived with no intention of accuracy, serving the development agencies, not the members of the “community.” Regardless of the accuracy of the identification of a community, a health project may find that their “community” does generate enough numbers to illustrate to superiors the project's “success,” although the results may not be exactly what was originally conceived.

In short, based upon WHO writing and accounts taken from health workers in NGO related projects, development and health agendas tend to define the communities they work with along geographic and demographic lines. By doing so, projects may emphasize their agenda, instead of listening to the local voices, and evaluate their success based upon issues relevant to their cause, not necessarily those they are “assisting.” I emphasize that not all development health projects intentionally avoid the issue of community; to their credit recent attempts to visualize clients' needs have changed how primary health care is administered in countries around the world. Today health resources are available to people who have never had as many options for health care, but along with such facilitation, one caveat must be considered: with the focus on biomedically defined and treated illnesses, urban residents may slip-through the gaps left unfilled by primary health care facilities which directly market to the urban poor. In other words, despite the good intentions of PHC, it is still quite inflexible in its approach to urban health care, and in its rigidity has not only assumed a potential client base from the urban populace, but also assumed its role within that “community,” as being provider to all and without political watermarks. Such is not the case.

An Anthropological View of Community

For anthropologists and other social scientists, determining a viable definition of community has been a contested issue for years. Anthony Cohen (1985) and Benedict Anderson (1991) both contributed to the discussion of community and what it means to the members of such an organization. The symbolic composition of community is most important for Cohen, diverting from the structural functionalist approach towards community, he focuses on the symbols people use to define their communities and the meanings inferred within. Anderson (1991: 6) argues that all communities are imagined, in the sense that not all members will ever know or see the others, but their solidarity and communal spirit are shared between them. However salient Anderson's ideas are, he couches his interest in that of nationalism and projects the community onto the nation state, arguing that it is a concept which binds people together, defenders of a sovereign nation. Cohen diverts from traditional structuralist thought on community, as proposed by Durkheim (1964), Weber (1948), Barth (1969), and Redfield (1955) to journey beyond analysis of the community structure to find cultural significance in the symbols people attach to the idea and construction of community.

The discussion of community should begin with its structure and follow into an understanding of the multiple symbols and meanings woven into its design. From the etic perspective, a community may appear to be irrational or chaotic because it does not operate based on cultural codes familiar to the observer. Urban theorist Amos Rapoport suggests that “there is a cultural meaning to order, and all cities have an order which is intimately (and ultimately) related to culture via schemata” (1984:50). For Rapoport, *schemata* are similar to, but different from, Cohen's symbols because they maintain a specific meaning for the people involved (Cohen 1985), which others outside of the community will not fully understand. “The misunderstanding (or inappropriateness) of such orders is clearly due to the use of an imposed etic spatial organization,” states Rapoport (1984:53). Fundamentally, however, Rapoport bases meaning on structure rather than symbols, to which Cohen responds that without experience community is sterile. Community studies then become “obsessive attempts to formulate precise analytic definitions” writes Cohen, whose goal is to approach “community as a phenomenon of culture — constructed by people through their symbolic prowess and resources (1985:38).”

Beyond the basic structural meanings of community, a society masks the differentiation within itself by using or imposing a common set of elements (Cohen 1985; Eriksen 1993). The culture migrants bring to the city does not remain intact, but the group maintains a set of elements which make it clear that there has been detachment from the “normative structure” (Cohen 1985) or schemata. Community is therefore composed of elements, the meaning of which are shared among the community members as symbols. Interpretations of meanings change over time as occurrences take place within the environment. In this sense community is not absolute or timeless, but dynamic (Cohen 1985).

Rapoport's ideas (1984) about community correspond to that offered by Cohen. Arguing that people organize their communities similarly to their worldview, Rapoport suggests that the component elements may be divided along spatial, temporal, and social planes. Central to his hypothesis is the idea that urban landscapes (like cultural landscapes) take on distinct and recognizable characteristics over time. Therefore the evolution of the urban landscape is not the result of an individual, but of many individuals who act accordingly to create their environment— based on cultural schemata, not because of the organization of work groups, etc. Although architects or urban planners may have drawn on paper the outline of the physical neighborhood (*barrio*), the residents are those who place the discernible flesh on the *community* skeleton. Rapoport believes that “one can think of design as a choice process which produces environments (or other artifacts) by eliminating some alternatives and retaining others, thus approaching as closely as possible those ideal environments embodied in *schemata*” (Rapoport 1984:51). In other words, it is the people acting together in their individual ways which bring unique characteristics to the urban environment. If the independent decisions by many individuals and groups, over long periods of time, produce recognizable landscapes, that suggests that these decisions must have things in common. It follows that the people whose decisions create these landscapes share certain ideals or images, certain *symbols* or *schemata* which provide rules for making choices, for deciding what to include and what to eliminate (Rapoport 1984). Not only are those choices related to culture, but they reflect the culture of the group in question (via symbols or schemata). In this sense, all urban or built environments have order in the sense that none of them are a random assemblage of elements but a systematic arrangement of elements (Rapoport 1984:53). Migrants who move into a community conscientiously contribute their perception of what a community is and should be, through their

physical constructions, political affiliations and social networks. Such is the case for El Alto, as nonresidents frequently comment on the city's people, its discombobulation, filth and impoverished barrios without having ever visited or spent any length of time in the place.

However, it is important to realize that the spatial order of a community is only significant if related to the social order. In some cases, this social order may not be manifested spatially, i.e. in terms of spaces, buildings or other features; it may not be *visible* (Rapoport 1984). What is being organized are social relationships, networks and group membership, terms Cohen accepts as symbols. Experientially there is no order, but once the social order of the culture is understood, what appeared chaotic becomes comprehensible and hence orderly — the apparently disordered environment is highly organized in terms of social groups and relationships. The relation of the urban order to culture, and the difficulty of understanding these, suggests that urban orders are related to *meaning* (Rapoport 1984:59).

In terms of health care, Nichter (1996:388) has pointed out, the concept of “community” is often reified in public health literature. Communities, like households, are fluid and mobilized around sets of activities (Brownlee 1987; Schwartz 1981; Wilk and Netting 1984). What appears to outsiders as “community” demarcated by an administrative structure is often a collection of factions which compete as well as cooperate for resources (Nichter 1996). Primary Health Care (PHC) should then be approached and integrated with caution in relation to both existing patterns of social interaction and opportunities for new forms of interaction given historical changes.

How is the case for El Alto and its migrants? This paper combines Cohen's symbolism of culture and Rapoport's (1984) divisions of order (physical, social, temporal) with Nichter's straightforward take on the etic perspective of health care to explain how residents in the barrio of Huayna Potosí negotiate their sense of community amidst outside organizations who would just as well define it for them. I argue that beyond the physical order, the residents maintain familial, political and social orders, which are cumulative in their construction of community. While outsiders may focus on the physical nature of the “community” they miss the intricate construction of community as developed through family interactions, political connections and societal relationships.

For example, urban Aymara migrants hail from villages in provinces all over the Altiplano. Sharing similar linguistic characteristics (although there are many dialects, see Briggs 1985) the Aymara are subdivided and provincial in their attitude towards other members of the linguistic group. Highly critical of each other, urban residents speak poorly of those who come from provinces other than their own, propagating stereotypes and myths how particular people cannot be trusted or are notorious thieves, etc. Having interviewed residents from all parts of the Altiplano, no discernible patterns precipitated when individuals generally spoke about people who came from certain provinces. There seemed to be mutual conjecture and derogatory banter related to other residents from provinces such as Camacho, Los Andes, Omasuyos or Ingavi. I could not determine if their all speaking poorly of each other was simply a symptom of urbanization, or the consequence of general dislike. However, it did seem relevant that these stereotypes were fostered and maintained within the urban environment, affecting individuals' perceptions of each other, restricting interaction between people and discoloring relationships from the onset.

Cohen (1985), Barth (1969), Anderson (1991), and others have written extensively on the construction of identity and group affiliation while Abercrombie (1991), Bastien (1978), Crandon-Malamud (1991) and Nash (1979) have focused on Andean constructions of the same. Aymara social organization has revolved around the existence of the *ayllu*, a close-knit kin group whose solidarity is formed by affinal, work, territorial, religious and sanguinal ties which were then a part of larger rural villages. Interpreting Rapoport's position, it is the maintenance of the *ayllu* within the city which actually creates communities for residents. Unlike early accounts of community migration *en masse* from the campo to the city to construct similar community organization (Gilbert & Gugler 1993; Isbell 1978), in northern El Alto, where the Altiplano influence is greatest, it is logical that the *ayllu* has not disappeared from the social landscape. If anything, a metamorphosis has taken place, one which exceeds the relatively close geographical boundaries of Altiplano *ayllu* systems and become one in which distance does not factor considerably into the construction. Instead, members of barrios maintain *ayllu* ties, patrilineal and sanguinal affiliation. During the single family barrio interviews and long-term family observation and interviews conducted during this research, we found that residents construct their community along these lines of loyalty, identity and trust (see below table). Seventy-five percent of families interviewed indicated that during a crisis, health or

otherwise, they would turn to a family member (natal or extended) who lived in El Alto or La Paz, instead of a friend or neighbor.

TABLE 1: *Confidence among Residents*

| Relation | Percentage |
|----------------------|-------------------|
| Spouse | 32.3% |
| Parent(s) | 24.7% |
| Siblings | 9.7% |
| Parents and Siblings | 5.4% |
| Aunts and Uncles | 3.2% |
| Friends | 2.2% |
| Neighbors | 3.2% |
| No one | 9.7% |

These were the closest relationships, ones which are maintained throughout the year, requiring visits, reciprocity and regular communication. Appropriately, few residential neighbors are included in this group, they are not part of the *urban ayllu* because they do not have sanguineal relationships nor do they share a common sense of order.

Political

Between the social and spatial orders, there is the political order. Perhaps the most permeable order to individually control, this level of organization within the barrio maintains the physical community. Political alliances between neighbors creates a sense of community which is only as deep as political affiliations are permanent. Men and women who join political parties do not do so because of moral or philosophical views, instead they support politicians and their organizations because of promises made, and the myth of promises kept. It is believed that if you support a party then you will be repaid in the form of a job. The more work and contributions made to the political party, the better one's chances are of landing a job if the party wins (very reciprocal in this sense). Besides being one of the many carrots which hypnotize locals to join and support politicians and political parties, politics provides a social arena in which individuals work together for a cause and form small cohorts. Because the political system is based on geographic statistics and demographics, neighbors who are of the same party are often encouraged to work together on political matters within the sector of their particular barrio. Alliances are formed which lead to social interaction between political comrades; sometimes these relationships lead to more intense interactions, friendships may result, and if further realized, fictive kinship arrangements may be brokered. I argue that the social level is based on the traditional Andean *ayllu* system, whereas fictive kin relationships hinge on economic obligations and issues of political reciprocity.

The catalyst to political change in El Alto and the barrio of Huayna Potosí came in 1988, when the city gained autonomy from La Paz. According to residents I interviewed and medical staff who were working in the barrio, at this time barrios in El Alto became extremely political. The reason being was that in becoming independent of the municipality of La Paz, El Alto was then governed by its own city council and gained more of a legislative voice within the national congress. Accordingly, politicians poured into El Alto to enlist the support of “new” constituencies, since more representatives were required in local and national politics. Political parties scoured El Alto, carving up districts and gaining support in regions, which until that time had been virtually ignored by Paceño politicians — previously they had weak representation and therefore little power. Politicians campaigned on popular platforms which economically poor residents were more than willing to accept, offering jobs to those who supported the party and promising that they would improve living conditions if elected. Residents readily embraced such political rhetoric and the city, whose political spin had gone ignored for nearly its entire history, soon found itself reeling from a newly charge political valence.

Political autonomy brought empowerment to the local residents. One doctor I interviewed, who was working for the SNS during this period in Huayna Potosí, felt that this moment in El Alto history was critical in the degradation of social “community.” She explains,

. . . up until the time El Alto became a city of its own, the people who lived here really did have a sense of community. Life here was secure, people trusted each other and got along well. . . people were not polarized as they are now with all of the political fighting and debate.

Longtime resident, Don Juan Q. commented that because of the ravenous politicians eager to develop their parties' position in the barrios, normal, disinterested residents became caught up in the hoopla. "To this day," comments Don Juan, "politicians still use and abuse residents of the barrio and in turn do not do anything for us. Injustice prevails and continues." Don Juan cites several projects initiated by the residents, and proposed to politicians for backing and financial support, such as the installation of a sewage system.

Because this barrio is so politically subdivided, we residents cannot present a united front to the municipal government. It is too bad that this barrio is so large, unlike others around here, where they have nice streets and good utilities because they are no as polarized.

Politics has certainly forged a hostile arena in Huayna Potosí since El Alto gained autonomy from La Paz. Recently there has been talk, mostly by Paceño politicians, to rebuke its sovereignty on the grounds that the Alteños cannot properly govern themselves. This accusation has met with suspicion in El Alto, as residents feel that once more history may be repeating itself, as middle and upper class politicians look upon El Alto as an unguarded fruit, waiting to be used for their political gain.

Roberts (1974) argues that an important factor in whether migrants maintain a distinctive identity in the city is the extent to which urban life involves maintaining social and economic relationships with the provinces. When urban residents are actively involved in both the city and the provinces, their behavior is less likely to be influenced by the character of the political or economic organization of their city than in those cases where fields of activity are restricted to the city. In other words, when people maintain ties with the *campo*, urban influences are less strong than for those whose range is limited to the city (see Adams 1988). In Huayna Potosí such ties may be reflected in use of traditional medicines and curanderos.

The urban situation juxtaposes the migrant's rural background with that of modern, technology oriented capitalistic economies. Arguments have been made in medical anthropology that as people in developing countries participate in the capitalist system, their commitment to western biomedicine increases (Comaroff 1983; Frankenberg 1980; Minocha 1980). However, Adams (1988), and Nichter (1980) have found that the traditional uses of medicine persist, despite the involvement of the patients or healers within the capitalist economy. Options within a medically plural environment include those publicly available in the "professional realm" (Unschuld 1975), as well as those lay options, including home based health care (Finerman 1985). Principally, Aymara migrants are influenced by their family, and others they trust regarding their medical choices. However, they will not seek help until they perceive a problem, and this self-diagnosis is what sets the health-seeking process into motion (Stoner 1989). As the migrant's social, political and economic environment changes due to their urban existence, their perceptions of health disorder, what Kleinman (1980) considers "illness," also changes.

This paper follows Rapoport's argument, implying that there are three different levels on which community may be perceived: familial, social, and political. Although he is more concerned with a social order, it is within the same line of reasoning that community may be defined. Cohen's ideas about community are fundamental when exploring an issue as complex as community. Culture's innate ability to change and adapt to new situations arouses the senses of critical inquiry. We must ask how migrants' health care decisions reflect their definition of community within an apparently "uniform" urban barrio. This may most critically be contrasted with the etic interpretation of community as perceived by those who only work there.

Primary Health Care in Huayna Potosí

At the 1978 Alma Ata Conference of the WHO, Primary Health Care (PHC) was endorsed as a key strategy to achieve health for all by the year 2000 (WHO 1978). This novel policy provided the basis for the WHO and UNICEF to provide basic health care to underserved populations around the world by emphasizing the preventive aspects of medicine and stressing the importance of community participation. PHC became the cornerstone for a new global public health policy which decentralized health care and attempted to bring it to the people at the local level — incorporating appropriate and acceptable methods at affordable prices (Morgan 1993, Mull 1990, Tatar 1996). At the advent of the new millennium, PHC celebrates 20 years of service to the world

community, and in light of its tenure, it is necessary to reflect and understand what PHC has actually achieved. At one time PHC was enthusiastically proposed as the solution to the world's health problems, but with twenty years of hindsight we must now ask ourselves why it is still the foundation for world health policy. An excerpt of the policy outlines the framework of the PHC program (WHO 1978:3).

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact with individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of continuing health care process.

Community is an integral component of PHC. From the onset, PHC outlined that by improving socioeconomic status and environmental conditions within communities the overall results would be significant amelioration in health for all. With this in mind, health policy makers began to design and implement programs to provide basic health care information, address basic needs and create an improved environment for low income communities. The key to such projects was a decentralized community based clinic from which community health workers (CHWs), disease control, and family health programs would operate. PHC became the template for all development projects interested in implementing health care around the world — focusing on local communities became the urbane answer to previously maladroit interaction with bureaucratic national health systems and strategies.

Within the PHC framework a number of assumptions have been either neglected or forgotten by current implementation programs (Jewkes and Murcott 1998). Within the WHO document of 1978, and subsequent explanatory publications by the WHO on the PHC concept (WHO 1979, 1981), projects were encouraged to incorporate local health care providers into the PHC program. Traditional healers, local midwives, *curanderos* as well as western trained medical personnel were expected to participate. By casting such a wide net across the sea of medical knowledge, the authors of the WHO document perceived an ability to legitimate local perceptions of illness, efficacy and nosology; however, looking back today it appears that western based medical organizations understood such a statement as *carte blanche* to not only import, but coerce rural and urban people to “convert” their medical beliefs. The proselytization of western medical care to countries around the world was not necessarily intentional, but rather the consequence of development agents' myopia; based on scientific tests and methods, western based medical care was the logical choice because it provided answers for nations with only problems. Instituting PHC at the community level was instrumental in changing how bureaucracies perceived health care, and by highlighting the fact that implementation required focused attention on small, defined groups appealed to organizations and governments worldwide.

A plethora of PHC literature has been published over the past ten years, a fraction of which is based in anthropology — the majority being in medicine, development and public health. This section explores how one urban “community” in Bolivia copes with implementation of a community based Primary Health Care facility. In terms of Escobar (1995), Ugalde (1988) and Sachs (1992), the USAID funded NGO project PROSALUD is the quintessential example of western based assumptions in action. While trying to provide low cost care to deserving poor, the project assumes its role in the community without considering the consequences of such presumptions. I move the discussion to the role of a primary health care clinic operating and functioning within the geographically delineated *barrio* — Villa Huayna Potosí. I argue that although the clinic plays a role in the *barrio*, the ultimate goal of both patient and provider will never be met because the expectations each “side” feels for the other will never be realized due to assumptions made by the residents and the clinic.

Prosalud: Purpose and Administration

At the time of the research the only viable western style health clinic operating in the *barrio* of Huayna Potosí was the PROSALUD center (PSHP), an NGO with headquarters in Santa Cruz, Bolivia and sponsored by USAID. Although PROSALUD has been operating in Bolivia for over ten years, the seven (7) clinics in northern El Alto opened in mid/late 1991. These clinics continue to be the most well equipped and staffed health centers in

the city, providing service to all surrounding residents. PROSALUD's mission is "to support human development by contributing to the health and well-being of the population, especially those with few resources." Furthermore, the PROSALUD system is "able to provide integrated, comprehensive and continuous Health Care through decentralized, multipurpose and permanent delivery units. Primary Health Care and community participation are the basic concepts" (Fiedler 1995).

Because the organization must validate its existence to its financiers through numbers, each clinic has defined its catchment community along geographical and statistical lines. Determined by the regional office (Management Support Unit) in La Paz, this particular PROSALUD clinic serves the barrio of Huayna Potosí and five other surrounding barrios: Villa Anexo Huayna Potosí, Urbanización Ingavi, Urb. Mercurio, Villa Tupac Katari and Villa Esperanza. The MSU calculate the total population to be served and the clinic sends out Auxiliary nurses and promoters (CHWs) to these barrios instructing residents on using the clinic for health ailments, prenatal exams, births and family planning. It should be noted that PROSALUD's primary goal is to provide their defined communities with free preventative health care, vaccinations for children, family planning service and prenatal care consultations. On the other hand, each PROSALUD health center generates revenue, recuperating their costs, by providing curative care services. Revenue brought in by all clinics throughout the network help the system become self-sustaining, ultimately allowing the network to no longer require outside support provided by USAID.

As a PHC model PROSALUD is an effective way of helping economically strapped residents of Bolivia obtain free preventative health care and access to thorough, quality curative health service. However, developed in the lowland city of Santa Cruz, PROSALUD was designed to accommodate the health care needs and lifestyle of people in this part of the country. As scholars have noted in a variety of ethnography written on Bolivian cultures, the *colla* and *camba* maintain opposing worldviews which fuel their antagonistic relations (Stearman 1985). At the onset, I am puzzled as to why the PROSALUD model was implemented in El Alto without taking into consideration the drastic cultural differentiation. In essence, PROSALUD may have thought it was working with "immutable mobiles" (Kloppenbergh 1991:531) — information that is seen as transferable without transformation across any spatial or social location. In fact, taking the PROSALUD model to El Alto and La Paz directly confronted what are "mutable immobiles" — knowledge that is relatively malleable (mutable) and is finely tuned through the trail and error of local practitioners to the continually changing circumstances that define a particular locality. While scientific medicine may be considered an "immutable mobile," in that its theory may be implemented anywhere, when taken to the Altiplano, the model faced a system of "mutable immobiles" because indigenous systems of health were already in operation, catering to the specific needs of the people in El Alto.

I begin by presenting the director of medical personnel, Dr. Julio Rosas who maintains contacts with the clinics and believes to "understand" the clientele with a significant degree of insouciance. Rosas' explanations about migrants and health care in El Alto provide significant information reflecting one administrator's beliefs, but more so, the fact that despite his worldly medical experience, his top-down approach has not been tempered, but supported and reified by his co-workers and staff. Employees of the clinic then speak about their perceptions of the clients and the meanings residents attach to their use of the clinic.

Dr. Julio Rosas, Director of Medical Personnel, Prosalud La Paz

An adroit, charismatic leader, Dr. Julio Rosas served as the head of medical doctors and was responsible for health center operations for La Paz and El Alto. All doctors within the La Paz PROSALUD health system answered to him as the authority concerning clinical operations, community relations and development. Regarded within the establishment as being the most knowledgeable staff member in terms of "understanding" El Alto, what Julio Rosas said was as good as the "truth" within the administration of the La Paz office. Dr. Rosas took pride in his wisdom and often shared his philosophies with the clinic teams and office staff. Preaching his rubric to his employee audience, it was Julio's responsibility to make sure the clinics performed, meeting their quotas and generating enough revenue to maintain the NGO.

My numerous encounters with Dr. Rosas occurred both at his office in La Paz as well as at the clinic in Huayna Potosí. In each circumstance Julio emitted his political charm, a true salesman of policy, convincing me that my research was worthwhile and would be well suited for Huayna; and then he would turn to a room full of clinic employees and recount a well rehearsed citation for the successful work the staff accomplished within the past month. Over time, I realized that Julio's innate ability to tell people what they wanted to hear enabled him to navigate through difficult situations, and allowed him to lower the iron fist when necessary. However confusing

such behavior was to staff, he tried to maintain a level of consistency in his own mind, although this was lost upon those he managed. For the most part, Rosas maintained confidence amongst the medical doctors by allowing them to think that he was on their side, while placating their complaints and implementing policy which required more from them without significant salary increases. Other staff were subject to his clever attitude and questionable sincerity when he glossed over difficult issues with circular reasoning and pretentious logic.

In the following pages Dr. Julio Rosas discusses his philosophies about clients, community and health in El Alto. His “insight” into El Alto is influenced by his socioeconomic position and profession, which ultimately affect his perceptions of Alteños and their medical decisions. Afterwards I discuss the PSHP clinic team and offer three other PROSALUD employees’ voices. Each shares their impressions of how residents of Huayna Potosí may feel about the PROSALUD clinics and what affects their medical decisions.

Dr. Rosas: views of Migration and Health Care in El Alto

After graduating from medical school in La Paz in 1975, Dr. Rosas traveled to Europe for his residency, studying dermatology and public health in Belgium. Upon his return to Bolivia in 1983, Julio Rosas began his career in the Ministry of Health, where he worked until 1991, when he moved to PROSALUD. Despite his vast experience practicing health care both in western and developing countries, Dr. Rosas’ perspective of El Alto and its population reflects a certain degree of his mestizo social position (class) and ethnocentrism.

A grand part of the Alteño population is influenced by La Paz, and they try to live in their campo way of life in the city, but they are not able to, but they cannot change their minds. The health problems of the people in El Alto, of campo origin, it is not a need of modern medicine because this does not fit into their own logic regarding health and medicine. Their solution is in the curandero, or in the witch or in this type of person, no? And why this type of solution? Because few of them understand more than this. If you ask people of this community, what is this illness, the illness is related to in spiritual terms. It is witchcraft or some other malignant anomaly, always the explanation is spiritual, no? But talk with someone like myself and ask them what causes an illness and you get a different explanation. It is caused by a microbe, or you have eaten some bad food, it is a completely different explanation.

However, Dr. Rosas’ *astute* perceptions of culture change in the city reflects the fact that he has contemplated and dealt with the issue of migrants’ conceptions of health care and where the western based health clinic corresponds with their perspective. In the following quote Julio Rosas explains why peoples’ attitudes towards health care remain static, despite their origin of birth.

Whatever person, a recent migrant, you ask them, and they know the remedies to their spiritual ailments. Even after ten years in the city, these ideas do not change. They change when they die (chuckles). . . And there is a critical moment in life which between zero years old to seven years of life, this is a critical part of life when one’s personality is formed. Apart from this, you can say that the people from the campo after this stage, cannot change their manner of conduct or the way they think about the world, including health.

Rosas believes that people have an innate belief system which does not change over time because it has become such an integral part of who they are, and they are reluctant to change because this would require changing basal parameters of themselves. According to Dr. Rosas, the majority of Alteños who migrated to the city will not change their campo beliefs or conduct because doing so is more difficult than simply living with what they already understand.

Continuing his discussion about migrants in El Alto, Rosas addresses the issue of *community* and explains how such a central theme in Aymara cultural history plays itself out in the barrios of El Alto. Using the following as background, Rosas begins his theoretical construction of how health care promotion in El Alto is strained by community relations and why people hold strong grudges against PROSALUD and other health centers in general. Rosas states that the community whose culture is changing with the influx of strangers defends itself. The urban migrants’ feeling of family is not the same as that they share in the campo.

There is also a survival phenomena, when someone arrives that is not a part of their community they are ignored. And nearby campo communities are considered their enemies because they have to share territory and goods with each other. There is a series of things they have to share. But they do not want to share these things, they are for themselves, no one else. But what happens when people of this community migrate to El Alto, and they have to sit down in the middle of 500,000 people (inhabitants)? They go from a rural community of

possibly 150 people to all of these thousands of people, a literal sea of people. Their feelings about family and community are completely affected. Then their new community is not one which shares and is together, rather they are now dispersed throughout the city. In their minds they have to create a new territorial structure of community. Between them they still celebrate their fiestas and visit each other, between them they help each other. When they complete a house, they all come to help, but the local neighbors don't help, because they are not part of their "community." Through a series of issues it becomes a different mental imagination of community territory. But what happens with the neighbors? Are they friends? No, they are the new enemy, they are the neighboring community because they are also living in this way. They are each other's enemies. And they slander (hurt) the enemy, whatever bad practice will do. Lies, slander, it is all used to deface the enemy. There are no limits between the communities. This is how migrants think and act when they arrive in El Alto from the campo.

Rosas believes that migrants maintain their animosity for neighbors in the city as they do in the *campo*. Such behavior emulation, or rather preservation of attitude is similar to what Cohen (1969, 1974) believed to be migrants' normative structure. Components of this cultural framework include social organization, religion, and kinship.

Even though different groups may share similar components in their cultural repertoire, community is an emic category of ascription (Barth 1969) because the elements which make it up are defined by its members. Boundaries between groups are established by the differences in their interpretation of shared cultural components (Cohen 1969, 1974). Community is an aspect of a relationship, not a property of a group. However, such definitions are not absolute or timeless, rather they are dynamic and change as the situation in communities change (Cohen 1985). Through his explanation, Rosas argues that such change takes a very long time, and persons maintain community ties while living in newly defined group organizations. Rosas connects his discussion of community with people's decisions to use the health center and when they decide to do so. Rosas states that PROSALUD can only serve patients in the clinic because if they went to individual homes, the people would expect a gift (reciprocity). Since PROSALUD employees only talk to people about going to the clinic and do not give them goods, residents are disappointed and slander the clinic. Rosas feels that the clinic has to wait for people to come to it, and when they do, clients are treated well and have a positive experience — which offsets the negative publicity they receive from residents. However, Rosas admits this process takes time, between one to three years to have an impact on the population.

In the health center we have to maintain the attitude exactly like a priest. Each day we receive a lost sheep. And then they return, how great! The joke is that they are our clients, and we are not stupid enough to take out the devil and show it to them. The secret is quality of care and we simply wait for the moment for them to come to us, not convince them to come while in their home. The person who needs help will go to the open door. When you go to speak to people in their home, they speak so badly about the clinic, they accuse it of everything, but guess who ends up in the clinic? those people who speak badly about it! They come and continue to come [chuckling].

Dr. Rosas predicts that western medicine will outlive the traditional practices of the urban migrants. With confidence, Julio explains that migrants have to undergo a "cultural process of transformation" as residents "change their perceptions of the clinic through changed mental or cultural values." His reasoning is as follows.

One day, inexorably the people are going to realize that the clinic is their best and only viable choice for health care, and they will use it. One day the Kallawayas and the curanderos will die, and what have they written down, who will know their cures? No one. I will tell you now, in ten (10) years, of the one-hundred (100) or so Kallawayas who live in the Ceja and La Paz, only one or two will still be around, and they will not nearly have the same influence as they do today. Some things are simply inevitable, that all of the society will change. The funny thing is this, that we are going to live through this time, God granted, and success is secured. Not specifically for PROSALUD, who ever it will be, but the success for health care services is guaranteed to succeed. I don't have one doubt about this. Development never goes backwards, it always advances. There will be a moment when even religious beliefs do not impede people from going to the clinic, because that will be all that they know. Today, the success lies in the fact that they even come at all.

Inevitably the day will come, according to Rosas, that traditional healing via curanderos or shaman will not exist in El Alto because the need for them will evolve out of existence. As people grow to embrace the western medical

facilities, becoming more urbanized in the process, their epistemology of health will no longer include traditional ways of curing known to the ancestors who originally migrated to the city. However, Rosas does not explain that if it can “evolve out of existence,” what is keeping it from adapting itself to the urban scene? It seems that the biomedical care strategy is much more rigid than traditional forms of healing and health care. Rosas balked when I asked him to explain why doctors could not be educated to understand residents’ spiritual nosologies, stating that,

[d]octors and nurses are taught how to speak and think differently of illness in their schooling. This is what their certificate says, that you know how to speak differently than others. It is like passing from one world to another and the doors are closed. It is a communication and cultural problem. We would have to change the university in order to teach the doctors differently. There are things that doctors could do to understand the people's perceptions of illness better, but the moment that you change this you would be affecting other interests. Someone could change their ideas, but how to get many doctors to do this? It is not possible.

By inquiring of the medical hierarchy about why doctors could not learn more about locals’ ideas of health, when there are so fewer doctors than patients, physicians respond citing the power of their own epistemology. Rosas’ open disregard for indigenous medical beliefs directly counters the basic anthropological tenet of cultural relativism, but is typical of other health professionals in Bolivia and the west.

Placing a chronological tag on his forecast indicates how secure Rosas feels in terms of “knowing” western medicine will ultimately dominate El Alto. For him it is processual, logical, a fact that society evolves to become more sophisticated, resembling early anthropological theorists such as Tylor and Morgan. Such myopic, or culturally insensitive attitudes towards the residents of El Alto explains why the clinic, nor anyone in the administration, realized the significant role trust, politics and community actually play in medical decision making and health care utilization in El Alto’s barrios.

Typical of other doctors practicing at PROSALUD, Dr. Rosas believes that western medicine is the best antidote to the health problems plaguing Alteños. However, Rosas speculates that it is not the lack of health care facilities which debilitates the people from improving their health, rather he believes that the lack of money constricts the lives of the Alteños. Dr. Rosas is not blind to culture as it exists in El Alto, but maintains a biased view towards the residents. Some of his interesting observations about the people, though, remind me of remarks I have made to him about migrants which he has mixed with his other beliefs about urban Aymara. What makes this testimony important to this paper is that Rosas is in charge of the health clinics and his views influence how all of the clinics in El Alto and La Paz operate, treat their patients, and perceive of their position within the community.

The PSHP Team

An integral aspect of the PROSALUD (PS) system, and to PHC programs in general, is the idea of teamwork in the provision of health care. At PROSALUD, before potential employees are hired and placed onto a team, candidates provisionally work in a clinic to evaluate their compatibility with other team members. During daytime hours of operation, a medical director oversees the clinic and is assisted by a head nurse, receptionist, auxiliary nurse and cleaning person. Larger clinics maintain proportionally sized staffs, appropriating the use of two nurses, a dentist and health promoter.⁵

Over the course of the investigation eight (8) people regularly staffed PSHP: Dr. Claudia Zalles, the medical director, Maria, the head nurse, Ludres, the receptionist, two auxiliary nurses who rotated day and night shifts, Monica, the health/family planning promoter and Juana, the cleaning person. Of the crew, Juana had worked there the longest time, beginning when the clinic opened in 1991. Despite the low turnover rate of staff, Dr. Zalles was the third medical doctor to run the clinic since its inception. Minimal changes amongst the team is crucial for staff cohesion and validates its relationship with the clientele. Continuity of staff provides the team with a solid foundation on which to operate, and the patients a reliable, secure service. In the following discussion the goal is to explain how the “team” functioned as a unit and how individual team members performed their duties within the clinic and for its clients. As employees of the PROSALUD system and members of the PSHP team, this staff worked towards the common goal of the NGO — to bring low cost, high quality health care to residents of El Alto. I argue that although each team member honestly aspired to perform to the best of her ability, standards upon which they

⁵As of 1997, one PROSALUD clinic in El Alto and another in La Paz provided optometric services to their clients.

were judged by their superiors were asymmetrically biased and unclear, which ultimately led to team dissension and morale degradation, trickling down to affect the client base.

However, internal “team” conflicts resulted from their dissatisfaction with the management of the team and PROSALUD’S policies towards health care. This discussion regarding attitudes towards patients, the barrio and the clinic itself will illustrate the realistic position of the clinic within the barrio, not necessarily the one sponsored by the administration, or even the medical director, for that matter. Although the coordination between clinics was imperative for the proper functioning of the PROSALUD health system, PROSALUD clinics in El Alto were placed in direct competition with their sister PROSALUD clinics, placing the success of the team upon individual quotas instead of judging their team success independent of their sibling clinics at the systemic level. Quantitative results determined the clinics’ evaluation by the MSU regardless of particular variables or mitigating circumstances. From a macro perspective this may seem inconsequential to the overall relationship each clinic maintained within its “community;” however, the micro-management of the clinics served to dissolve the “team” spirit, dividing management from staff, a fissure which eventually affected the clients and their perspective of the health center. Citing observations and interviews to compose the characteristics of this team, the current section serves to briefly sketch three employee’s views of their job, their interaction with patients and their performance of assigned tasks.

Dr. Claudia Zalles: Medical Director of Prosalud Huayna Potosí

The third doctor to take the helm of the clinic since it opened in 1991, Claudia Zalles began her PROSALUD career at PSHP in 1993, following another female doctor, who transferred to another PS clinic in El Alto. A friend of Zalles, she confided to her the knowledge of what PSHP’s clients greatest needs were, so Zalles was aware of the responsibilities she would have to her staff and clients. Despite the advice of her colleague, Zalles operated on her own terms, disregarding the social status, economic position, and cultural history of her regular clients and potential patients.

Unlike the PROSALUD nurses’ uniform, Zalles simply wears a long white coat over her “regular” street clothes. She wears professional styled suits and dresses (usually tailored) indicating her rank within the clinic, but also highlighting her class consciousness between herself and her patients. Claudia accessorizes herself with modest amounts of make-up, gold jewelry, painted nails, red lip stick and high-heel shoes. Her style is not uncommon for professional dress in the central sector of La Paz city (Gill 1990), but in the peripheral barrio, Zalles is considered flamboyant. Such conspicuous behavior has earned her the nickname of “La Rubia” within the barrio because of her died red hair. Considering that in La Paz black hair predominates, Zalles’ colorizing her hair symbolizes to the residents her “westernization” or “gringo” sympathies.

For a woman who has dealt with numerous medical situations in El Alto and diligently applied herself to earn her position within the Bolivian medical profession, Dr. Zalles maintains a contentious attitude towards her work in El Alto. In reference to a comment I made to Dr. Zalles about the her reputation within the barrio she said, “if they hate me, I don’t care, because I have pride in what I do, and I know I do a good job.” While she does believe in herself, being a care giver requires one to also foster trust and empathy for one’s patients. Aymara residents of Huayna Potosí and the surrounding barrios maintain beliefs about a plethora of illnesses and causes not found in Bolivian medical books or classrooms. Claudia claims that is not possible to take the time to listen to each of her patients while trying to serve twenty to forty who are sometimes waiting outside her door. Dr. Zalles’ somewhat callous perspective about her reputation within the barrio reflects her frustration with the situation, but is indicative of the overall attitude of the clinic team. As it’s director, Claudia is responsible for making sure the health center maintains ties to the “community” while also delegating tasks to her staff. Being team captain requires that she set the example, and while everyone appreciates a doctor who is willing to work, insensitive medical practitioners are not well tolerated in the Aymara “community.”

While living in Huayna Potosí I tried to spend time each week working with the staff at the clinic, either participating in vaccination campaigns with the nurses, weighing babies or observing Dr. Zalles examine patients. While she tended to be very conscientious and open with her patients as they described their illness or problem, Dr. Zalles’ responses connoted indifference to their opinions. Instead, she took pride in diagnosing their disease and properly treating it, paying little attention to their etiology or nosology. Patients not complying with her medical regimens endured a lengthy explanation as to why they were not healing properly. Dr. Claudia Zalles conducted consultations rather fluidly, but on her own terms. When a patient did not speak Spanish, Claudia would have to call Maria, the head nurse, to translate for her. Curious as to her methods of cultivating rapport and trust with her

patients, she told me in no uncertain terms that the doctor must always state that he or she is in charge and they should listen to what you tell them.

If you don't yell at these people sometimes, they won't understand you! [sigh] Sometimes people really do not have a clue about what is wrong with them, and you talk with them about it until you are blue in the face, trying every possible way of explaining it to them, and they still don't understand. Finally you just have to tell them to do what you say and have faith in your knowledge and understanding of the situation.

Clearly Dr. Zalles' competency as a physician was not the issue, rather she felt frustrated working with people who had a difficult time expressing themselves and understanding her regimen. Her class consciousness, as expressed through her dress and manner, effectively served as a barrier between herself and her clients. Other members of the team held different attitudes towards the patients and their position in the community.

Maria, the head nurse, thinks of herself as the first-mate to the doctor, and holds her position as such with pretension and self-importance. During one of our interviews Maria admits that her uniform is as exciting to her as the work itself. Although she does not further explain the appeal her uniform plays in her nursing practice, she considers her specialized clothing to be illustrative of her rank and professional success. When interacting with Aymara speaking patients, Maria tends to use an abrupt and harsh tone of voice, which she defends by explaining that "people here are used to being yelled at, it is the only way they will understand that what you are saying is important. These people here are very hardheaded." Despite her language proficiency and local residence, Maria does not identify with her patients as being "one of them," but rather her sentiment towards clients reflects her education and class — she is not a peasant, but rather a miner, and Maria has earned a degree from the university. By acting stern and yelling at her patients Maria acknowledges her higher professional position gained through an education. In other words, Maria now exercises power she once felt beyond her. Maria exemplifies in her own mind, what one can achieve with education and tenacity, while judging her patients' ignorance to uphold her elevated status. Through reprimanding patients Maria chastises them for not pursuing a better education, resulting in maintaining poor health practices and not understanding medical knowledge.

Before any other clinic staff member listens to, diagnoses, or analyzes a client, Ludres the receptionist has talked with her, taken a brief history and assessed her medical needs. Particularly personable and gregarious, Ludres is the first line of patient care for the clientele in the clinic. Therefore her job is a key component to the success of the health center and its relationship with the "community." Ludres admits that the key to her success as the receptionist in the clinic is based on the trust she earned from the clients. "If they trusted me, they were more likely to trust the other clinic staff." In 1997 Ludres completed her nursing school training and began working in another clinic in El Alto, where she often meets former clients who ask her why she left PSHP. Commenting that "they say that they cannot return to PROSALUD because they do not know anyone who works there anymore, and do not feel comfortable with the new staff" Ludres reaffirms her belief that the continuity between patient and provider is important to the long term affects to maintain health care in the barrio. Emphasizing her stance she comments, "trust that develops between the staff and the patients significantly affects whether patients will return for follow-up visits and even comply with medication regimens."

Between the doctor, the head nurse and the receptionist there is a significant difference in how they visualize each relationship with the clientele. For Dr. Zalles, she is confined by her socioeconomic and professional views, preferring to do the job she was hired to do and help the residents with their problems. Maria indulges her past by living out her dream of becoming "successful," while holding it against those who do not act similarly. Ludres recognizes her position as liaison between patient and clinic, knowing that if she treats residents fairly and with respect, they too, may trust the clinic and its team to provide sensitive service. From the team we now turn to the utility of PSHP in the barrio. Drawing from data taken from interviews conducted throughout the barrio, the following discussion details who uses the clinic, why they use it, and when they do so.

Health, Illness and the Clinic

Of the 93 families interviewed in Huayna Potosí, more than one-third (34% or 32) responded that they had gone to the PSHP clinic at least once. This figure combined with 15 other families who mention that they visited a different health center, not necessarily PSHP, within the past year, accounts for 50% of the families in the survey having used a health center. One family replied that they had been at least 12 times within the past year, while 89% responded that they had visited fewer than five times. Twenty percent had never gone to a health clinic, while 31%

responded that they had gone twice within the year. Residents visit the for serious illnesses (17), prenatal exams (6), dental (4), vaccinations (3), pregnancy exams (1) and birth (1). Add to those the families who did not specify a particular clinic, but did mention the reasons they go, serious illness increases to 23 or 51%, prenatal exams increase to 9 or 20%, vaccinations grow to 7 or 15% and births double to 2 or 4%. The trend for people living in the barrio is to seek the help from the health center in times of dire need, when the health situation has deteriorated from what they feel they can handle in the home to understanding that the illness is not improving and they must consult with someone outside of the household.

TABLE 2: *Household Use of a Health Clinic.*

| # of Visits | Percentage of Households |
|---------------|--------------------------|
| Never Gone | 20.4% |
| Once | 8.6% |
| Twice | 31% |
| Three to Four | 25.8% |
| Five and more | 14% |

Thirteen families (14.2%) said that they never go to a clinic, no matter how dire the circumstances, while nine others admit that they specifically do not go to PSHP, but have frequented other area clinics. Four families commented that they prefer to use home remedies for all of the health problems, rarely seeking western medical attention in El Alto or La Paz. Of those families who used El Alto clinics, not PSHP, the most popular was Hospital Los Andes, in the barrio of the same name (7), followed by the Sec. National de Salud clinic in the Ceja (6), Clinica San Martin de Porres in villa *16 de Julio* (5), clinic Santa Maria (3), PROSALUD Alto Lima III (1), and PROSALUD Villa Ingenio (1). The catholic clinic *Juan 23*, in the La Paz barrio of Munaypata, was mentioned by three families as being their preferred location for health services. Most likely these families had each moved up to Huayna Potosí from Munaypata, and were previously familiar with the services and staff at this clinic.

The following table summarizes 78% of the responses of families when questioned about when would they seek a health clinic, and if so, where. The remaining 22% were too numerous and disassociated to compile into the table. Grave situations account for the majority of reasons people seek the services of a western medical clinic, if they decide to at all. Preventative care such as vaccinations and prenatal exams make up the difference, reflecting residents interest or use of these services.

TABLE 3: *When and Where households seek medical treatment.*

| Care Option and Reason | Frequency | %. Households |
|------------------------------------|-----------|---------------|
| PSHP — Grave Situation | 22 | 23.7% |
| Do not go to a clinic | 14 | 15.1% |
| Unspec. Clinic — Grave Situation | 6 | 6.5% |
| Unspec. Clinic — Vaccinations | 6 | 6.5% |
| Hosp. Los Andes — Grave Situation | 5 | 5.4% |
| Unspec. Clinic — can't cure @ home | 4 | 4.3% |
| Hosp. Munaypata — Grave Sit. | 4 | 4.3% |
| Clinica Sta. Maria — Grave Sit. | 3 | 3.2% |
| Hosp. 20 de Oct. — Grave Sit. | 3 | 3.2% |
| PSHP — Vaccinations | 3 | 3.2% |
| PSHP — Prenatal Exm. | 3 | 3.2% |

The wide variety of options provided to the Alteño customer does not serve to confuse residents, instead help them. As could be argued by capitalists, competition makes for better services. In El Alto, the numerous health centers do not necessarily identify other clinics as strictly competition, opting for the attitude that they simply want people to get help from whatever health service, wherever it may be, as long as they get some sort of help. Families told us that they go where they feel most comfortable, meaning places which provide good services, but also those who care about them as people. Those families who trek down to Villa Munaypata for help find the clinic responds

to more than their illnesses, they get a personal touch from the nurses and doctors. In fact, Father David's name was mentioned in light of being in the families' opinion, the most caring of all doctors they knew.

Although clinics such as PSHP spend time, energy and money promoting their free services, residents tend to associate clinics with expenses — such that they are reluctant to even consider the clinic an option until they are informed otherwise. Sixty-eight percent of the residents queried replied that they did not have much contact with the PSHP clinic, while 22% said that they did. Over 86% of those who claimed to have “much contact” with PSHP acknowledged that the consultation and treatment fees were too high, averaging B\$55 (median B\$40), with a maximum being B\$150.

What informants say they do when compared to what they actually do are often different. Residents' comments indicate that of the options available to people of the barrio, they utilize them in different ways, and for a variety of reasons. It appears that when families encounter illness, the first response is not to do anything. Waiting for the illness to “pass” provides the family a relief from spending money to cure the problem, but may also cause distress for those who are sick, as well as others in the household. While children are understood to often become ill, some parents refuse to immediately treat them, believing that the child may simply have a cold, and if so, could be readily treated with *remedios caseros* (home remedies) and ride out the illness. Some parents explained that it was not the illness, *per se*, which caused them to seek more formal health care, but rather the fact that the child's incessant crying kept them from sleeping at night. Restless nights prompted parents to take their child to a clinic for a remedy so the family could sleep. Since herbal remedies for common illnesses (colds, coughs, stomach aches) may be grown at home, families may be “waiting” for the illness to pass, while actually treating the symptoms with simple, local, known solutions. Therefore one cannot assume that because respondents replied that they tended to wait until the illness passed, that they did not take action to counter the illness episode.

From the parental perspective, infants are considered ill when their crying is intense and frequent enough to cause alarm. Usually infant illnesses are addressed without much ado, since young children are considered weak and prone to die if not taken care of in a timely fashion. Older children (4 years or more), who fall ill are not thought of to be at risk of death because they are seen as being stronger than infants, no longer breast feeding and not requiring the attention of an infant. As is common in most Aymara families (rural and urban), younger children are cared for by their older siblings, especially when the mother is nursing a neonate or infant.

Family members venture outside of its perimeter to solicit help once the illness episode has degenerated enough to require stronger medications (greater attention). Options commonly considered by the residents of the barrio of Huayna Potosí are the local corner store, the pharmacy, clinics, hospitals and *curanderos*. The severity of the illness usually dictates residents' decisions for health care. Families commented that they will try to treat a child at home, using over-the-counter (OTC) medications purchased at the local corner store until it is apparent that further help is necessary. If clinic remedies or advice fail, then the family may then seek the help of a *curandero* or *yatiri* for spiritual guidance or alleviation.

Worth mentioning are those respondents who cited that no one in their family ever falls ill. Certainly such claims cannot be determined or verified, and while assuming that such statements are false, it is important to consider why such responses were given. Of the 93 families interviewed, 11 (12%) stated that they do not fall ill. Two of these households replied that their good health was due to their diet which consisted of *campo* foods, not the “weak” foods of the city. By maintaining a *campo* diet these families felt that they were strong enough to fend off the illnesses prevalent in the city. One particular woman I approached was making adobe bricks and I noticed that her children were also covered in mud. She believes her diet affects her wellness; she commented:

[n]either myself nor my children are sick much and this is basically because we eat potatoes, chuño, fava beans, and kañawa; these are strong foods. In the campo we do not know any illnesses, except for birthing, which gives us great pain, and the colds which pass and do not need any attention.

Considering the living conditions and the statistics taken from the national census and others in this study, it is highly unlikely that one family does not experience an illness episode over the course of one year. Instead, families may not want to admit to becoming ill because it indicates some weakness within the family which they prefer to not discuss. In such cases the researcher continued to ask questions regarding the family's health history, knowledge of illnesses and herbal remedies. For the most part, those families who reported rarely being sick did indeed manage an working knowledge of *remedios caseros* and identified the majority of common illnesses.

A number of families turn to spiritual beliefs to cure illness. Although in this study only four families mentioned that they based their medical decisions on their religious beliefs; leaving the curing of illness to God is becoming more popular amongst the evangelical population of El Alto. In each case the family had experience with medical centers or hospitals, from which the sick person was not cured or saved. When the family turned to God, the patient did recover, and therefore their spiritual beliefs were reinforced and strengthened. One husband commented about his wife that:

[f]or three years she was covered with blisters from head to foot, her face was paralyzed and her tongue did not work properly due to *mal de aire*. We took her to the doctor and he did not cure her. For this reason we became evangelicals and she became well; neither the herbs or the drugs of doctors could save her, only the strength of God cured her.

Another couple, recently converted to evangelical beliefs, told our Aymara researcher that they both knew the cures for various Aymara spiritual illnesses, but since he was now a Christian he did not believe in such things. Instead, he claimed that God would cure him when he fell sick, so he did not need to practice his traditional Aymara herbal remedies. A single mother for five years, one other evangelical woman claimed that the Devil causes all illnesses and therefore God will protect her and her children and cure whatever ails them.

Equally important in the discussion of spirituality and healing is the aspect of traditional or indigenous beliefs. Families often simultaneously used both physicians and *yatiris* (curanderos, shaman) in their responses to illness episodes. Nine families (10%) reported to have used, or continue to use, traditional Aymara healers for illness treatment. Some have used *yatiris* as a last resource while others continue to embrace such practitioners for serious illnesses. Those employing spiritual healers do so because they trust them to understand their illness beliefs and know the proper way of curing such maladies. Others seek traditional Aymara medical practitioners in response to western medical technology, either because western medicine has failed them in the past, or they are reluctant to trust a practitioner who does not understand their Aymara worldview.

Olivia told the story that her husband, a teacher, died in the hospital with other instructors where he was waging a hunger strike against the government. She believes that the doctors were not able to save her husband and therefore she did not trust them or their medicine, subsequently preferring to call on the services of a *yatiri* whenever she or her children were sick. Another man, Alejandro, commented that when he went to PSHP they treated him poorly and claimed to not be able to help his son, instead referring them to the hospital in La Paz. On the way down to the city the child died in the minibus. From that moment forward Alejandro has not trusted any medical doctor, claiming that they are too expensive and ignorant of Aymara ways. Instead, Alejandro prefers to return to his village in the campo to seek the help of the local *yatiri*. Alejandro escorts the *yatiri* back with him to the city, so the spiritualist may treat the family member in the house, while Alejandro provides lodging, food and the herbs required to cure the patient. “In this way I save money and trust the man who treats my family without having to visit a clinic or deal with ignorant doctors and nurses,” Alejandro replied. “The fee for his services, as well as the food and herbs is less expensive than the visit to the clinic and all of the drugs they make me purchase, which do not work!”

Numerous families share similar experiences with *yatiris* and western medical care. The two previous incidents involved families who had mishaps with western medical care and sought more traditional options. Another man replied that since his children were older now, he could not readily recall all of the traditional herbal remedies for various illnesses, but knew when to use a *yatiri* as opposed to a doctor. If a child or adult had diarrhea from the cold and it did not pass, then he knew it was caused by *larpha*⁶ and would employ a *yatiri* to read the coca leaves to tell him how to cure it. “Today,” he commented, “with my grandchildren it is no longer like that, we simply take them to the pharmacy or doctor to cure them.” A woman washing clothes outside her house commented that her family rarely goes to the medical clinic because it costs them too much money and they prefer to cure themselves at home with natural remedies and medications from the store. She said that in cases of prolonged illness, she goes to the *campo* to retrieve her mother to assist them in curing the sick — they may also bring herbs from the *campo* as well, or purchase some from the *16 de Julio* market in El Alto. In times of serious or extreme

⁶ *Larpha* is a spiritual illness thought to be caused when a child or pregnant woman sees a dead animal. This causes the child to have diarrhea, or the newborn to be malnourished.

illness, she prefers to bring the *curandero* from her community because they trust him and his expenses are few compared with the health center.

What we find in these data are residents of Huayna Potosí acting upon their notions of trust and necessity to find the appropriate health care remedy. Most interesting is that only half of the families interviewed visited a health clinic within the past year, and those who had visited PSHP did so for serious circumstances. We cannot infer that if the clinic had been more understanding of their worldview, more would have gone, but it is stated that some residents preferred not to go to PSHP because of their past unsatisfactory experiences. Critical are the alternatives available to residents, displacing clinics from the “primary” role of care giver. Local stores provide OTC medications, markets sell herbs and traditional remedies, while residents’ villages are not too distant from the city that they cannot return for consultation or to invite a local *curandero* to return to treat the sick. Even religious beliefs factor into the equation of medical decision making. But the common denominator between all of the remedies is trust. Because of the social and political situation in the barrio, people depend upon alternatives that support their worldview. When these do not come through, residents manipulate the symbols within their sense of community in order to find an alternative which is viable.

Ethnographic Examples

At various times throughout the fieldwork particular incidences occurred which concisely illustrate intricate interactions between people and situations. The following ethnographic anecdotes serve to define circumstances relevant to the discussion of community and health which I was fortunate enough to witness. The following two stories each concern health as related to family, society, politics, religion and the local PROSALUD health clinic (PSHP). Although while I lived in Huayna Potosí numerous events took place which could define multiple levels, these narratives best relate the particular issue with health care, western medicine and community.

A Family Negotiation

The health of Alvaro’s father, Julio, was a family concern predating my arrival in El Alto. Suffering from intense coughing episodes and chronic fatigue, family members had been treating him with indigenous remedies for over a year. A nurse friend of mine accompanied us during one of our visits to the campo, and listened to his lungs, evaluating his condition, she recommended that he have a chest x-ray to check for Tuberculosis. Julio came to El Alto for medical consultation, the results were that he did not have TB, but a lung infection. He was given a prescription and Julio returned to the campo.

Three months later, Alvaro’s brother, Alberto, came to El Alto to talk with his brothers. In much haste Alberto explained that Julio had fallen ill once more, and he wanted to discuss with his brothers what they should do for their father. At that moment he left to find his uncle, Valvino, who lives in a nearby barrio. “Valvino knows a yatiri who will help us find out what is really the matter with our father,” he told me as he left. I went with Alberto to observe their consultation with the yatiri.

Don Luis is the yatiri with whom Valvino has *compadrazco* relations. He read the coca leaves and decided that Julio was not suffering from spiritual maladies. Instead, Don Luis suggested that Julio’s problems are medical, and he should be treated at a clinic.

Returning home to Huayna that afternoon, Alberto confronted his brothers Alvaro and Germán with the news of the yatiri. Germán recently became an evangelical pastor and was not interested in discussing his brother’s use of a yatiri to predict his father’s illness. Germán felt that prayer and the laying of hands upon his father would be best for him, and he advised Alberto and Alvaro that he would take their father to his church where the entire congregation would focus their prayer on him. Alvaro, annoyed with Germán’s blind faith, considered the local health clinic, PSHP, where he knows the doctor, Dr. Zalles and feels she is better to talk with than other doctors they do not know. Alberto remained adamant about keeping their father in the campo and consulting with another yatiri, who could possibly identify the specific ailment.

Each brother presented his own case to the others, who listened and critiqued their position. In the end Germán said that he would leave the next day for the campo to retrieve their father and take him to church. Alvaro said that he would also return to Tiwanaku to discuss this with their father and try to convince him to go with him to the health clinic. Alberto asked if they could not have medications sent from town to the campo, so their father would not have to travel and could stay at home and rest. In the end Julio did return to El Alto and went to the church with Germán after he and Alvaro visited the PSHP clinic and Dr. Zalles. Claudia requested a sputum sample be taken to the hospital for verification that he did not have TB; she began treating Julio for asthma. One month later Julio returned to El Alto for a checkup. Appearing in much better health, Julio was happy to be “well”

and his children all relieved that they knew what had been the problem. Dr. Zalles explained to Alvaro and Julio that he would continue to need the medication and suggested that he purchase pills each month. Alvaro commented that each of Julio's children would contribute some money each month towards the purchase of medications for their father.

Although many issues arise in this story about Julio and his children, the most revealing is that of group decision making and community. Since the father was ill, the children took the responsibility to help him, basing their actions on their beliefs, in what they trusted would provide a cure. The family used its urban *ayllu* to find trustworthy practitioners for their father. In the end, none of the brothers felt slighted by the outcome, as Alberto knew that without his visiting Don Luis, facilitated through Tío Valvino, they would not have sought another medical doctor. Germán knew that the strength of his prayer would influence his father's condition regardless of his brothers' intentions. Alvaro relied upon his relationship with Dr. Zalles, as formed from his political days as the president of the junta, to serve as a trustworthy medical practitioner. In this example we see that the negotiation of health care depends upon contacts and trust, as the brothers relied upon those facets of their lives which would be most beneficial to help their father. Alberto called upon his uncle to employ his *compadrazco* ties with a yatiri. I should note that Alberto was reluctant to use a local Huayna Potosí yatiri because neighbors may notice them visiting his house, jeopardizing privacy. As well, this anecdote illustrates residents' multiple use of health care options, as the family used traditional remedies, medical doctors, religion, and spiritualist healers in their healing quest.

Politics and Healing

A different incident involving Alvaro illustrates how political views affect one's health care decisions. During a construction project, Alvaro stepped on a nail. We cleaned the puncture wound, and I advised Alvaro to get a tetanus shot. Overnight his foot swelled and caused him great discomfort, so the next morning we went to PSHP. Unable to walk, Alvaro rode on my bicycle. I parked the bike and went inside the clinic. Alvaro waited until I had gone in, and then entered alone. Maria and Alvaro had little to say to each other as she cleaned his wound with alcohol and dug the dirt out with the tip of a needle. Alvaro winced, but endured the pain. Maria thoroughly cleaned the foot and flushed the puncture wound with water, placing some salve on it with a bandage.

Upon leaving the health center, Alvaro exclaimed, "man, I almost screamed in there when she was poking my foot!!" I asked him why he refrained, to which he replied, "I couldn't scream in front of her, if I did that she would know I was weak. I am not weak. Besides, she is in the MIR and was intentionally hurting me because she knows I am in CONDEPA, we are political enemies. She was doing it because she knows I am in the other party, and she doesn't like me." The groups Alvaro mentions are national political parties, and the relationship he infers between himself and the nurse caught me off guard, as up until that point in time, I had never considered politics in this fashion to factor into the health care equation.

Returning to his house, Alvaro limped along, not complaining about the shot (which is what usually worries most people about going to the clinic), but talking about how he will never go to the clinic again as long as Maria continues to work there. Since then Alvaro did not return to have the nurse look at it, even though she told him to come in every day that week to have the wound cleaned and re-banded. Alvaro believed that Maria wanted to continue torturing him in the name of health.

Suspicious about why Alvaro had intentionally delayed his entrance into the clinic, I asked him what he had been doing outside. Alvaro stopped walking down the street and turned to me, grabbing my arm and turning me around so I would see his face as he spoke.

Brother Jerónimo, because you are a Gringo, and even though you live with me, and most of the neighbors around here know this, I still have to be cautious about entering that clinic with you. For fear of what our neighbors might say. People around here see and know everything, if they were to see me enter that clinic with anyone they don't know, especially a Gringo, they would think that I am going to have a political meeting with the doctor and you.

Alvaro's confession illustrated that the health clinic was a political lightning rod. As the fieldwork progressed and I spoke with other residents about PSHP, they accounted similar feelings about the nurses, doctor and relationship of the clinic with the residents. One of the longtime residents of the barrio, Don Juan Q., made a simple correlation, placing the health clinic in the middle of the political turmoil. "There is a plaque on the front of the building which

tells us that the building was constructed by the government of Jaime Paz Zamora (MIR: Movimiento de la Izquierda Revolucionara) in 1991, and for that reason we feel that people who work for PROSALUD are associated with him and that party.” As well, Don Juan also claims that because the barrio gave PROSALUD the land on which to build the clinic, the residents have a right to give their input on its operation. Since PSHP denies the residents their “right” to meet or discuss with the staff those things it feels need to be tended to, vecinos disregard the clinic as a viable health option within the barrio.

PROSALUD denies any political affiliation whatsoever, precisely to disassociate themselves from that inferred stigma. However, what PSHP does not realize is that interaction between residents in the barrio usually takes place along the political plane. For example, Alvaro once inquired of Dr. Zalles to use the community room for a junta meeting and she denied the request, stating that no political meetings of any sort are to take place there. Alvaro’s comment to me was that “what she needs to understand is that the only people I know who want to meet there are politically motivated.” From the onset PSHP and PS have assumed that fractions do not exist within the barrio, and that residents will see the clinic as only a health center. Because residents are so politically divided, in order to understand the clinic, PSHP must take on a political valence in their minds.

Miscellaneous Anecdotes

Other examples taken from the ethnographic data concern residents consulting with each other regarding specific illnesses and treatment. Medical inquiry between neighbors illustrates that residents have developed a relationship, an expansion beyond their familial community. Ruben drives a taxi and suffers great pain in his back and feet, which he attributes to his kidneys not being able to properly filter his blood due to sitting in the car all day. To improve his circulation Ruben drinks a warm herbal tea made from a locally known plant: *cola de caballo*. I mention this incident because the wife of another local leader spoke with Ruben one day while I was present. Antonia confided to Ruben that her husband, Santos, also had pain in his legs and back, which they attributed to poor circulation from sitting all day, repairing televisions and radios. Antonia’s inquiry as to what Santos should do illustrates that residents do discuss illnesses and remedies between themselves; however, I believe that they do so because of their political alliances — as politics serve as one of the only means for getting together and meeting other residents. Ruben refuses to go to PSHP because he does not trust the doctor; instead Ruben and his family drive to the catholic clinic in *16 de julio*, where they receive “adequate” treatment.

During household interviews with residents, nine families said they did not go to PSHP because of their distrust for the head nurse. Such dissension regarding Maria, apart from that encountered with Alvaro, was based upon trust more than politics. Since Maria held a position of power within the clinic, and was privy to private information about clients, the fact that she lived within the boundaries of the barrio did not improve her standing. Although Maria states that she believed she had a good relationship with members of the community, residents commented that they had a hard time relating to her their private issues since she was also their neighbor. Clients preferred to speak with other nurses or the doctor who they knew would not have the opportunity to gossip about them within the community because they did not live there. While Maria maintained that she never spoke a word to others about her patients, nor was there proof that she had, residents felt uncomfortable dealing with her, despite her speaking Aymara.

Local residents Gregorio and Pablo are two men who have well paying jobs and were currently constructing new additions onto their preexisting homes at the time of the research. During the course of the fieldwork I asked each man to explain what made living in Huayna Potosí appealing and expound on the ties they had to the “community.” Gregorio lives with his wife and two children, his brother and younger nephew. The house they are building will allow them to expand from their two room existence and into a house three times as large. Two factors tether Gregorio to Huayna Potosí: the fact that his sisters lived nearby, and that he could not afford to live closer to La Paz, since his job is with the water utility, a longer commute would make his life that much more difficult. I asked Gregorio if he ever visits or talks with people from his home village of Laja, in Los Andes province. His reply was startling, he said, “it is not as though I don’t care to see other people from Laja here in Huayna, it is simply I have little time to talk, but I do acknowledge people I know. If we want to visit, we will in Laja at a festival. Huayna is not the place to talk with them, why should I be interested in seeing them here in the city?” Gregorio’s sense of community differentiates between people he knows from the campo and those in the city, choosing to keep the two separate. He does not confide in other residents of the barrio, nor members of his campo heritage, preferring to keep all issues within his family, including health decisions, private.

Pablo decided to augment the home he has lived in for 4 years, to make room for his children and grandchildren who will soon need the space. Pablo is 63 years old, and twice married, he lived in La Paz for 30 ys. and in El Alto (barrio Los Andes) for another 20 ys. Pablo does not sense a community spirit amongst his neighbors in Huayna.

Every person in Huayna fights to live here, but who really wants to live up here in the cold? I moved from La Paz because it was so expensive, and purchased this land 14 years ago while I was living in Los Andes. We have enough room here, which is what we need, and that's why I'll stay until I die. I only have two good friends here, both who regularly visit me, no one else.

When asked about who he trusts and if he ever speaks with his neighbors about health he replies. . .

Almost never, if ever! Why should I discuss family issues which don't concern other? When we have problems we take care of them here, within the house. Between my wife and me, we can cure illness with home remedies. If it doesn't go away, we purchase medications from the store, but rarely go to the clinic, I really don't like that nurse because she shouts at the women. No one in the family is sick much because we eat soup, which has meat and vegetables in it giving us strength.

These examples illustrate residents' health care decisions in accordance with political and/or trust based relationships. Social interaction between individual residents in the barrio are based upon knowing each other. In the political atmosphere of the barrio, residents do not speak to each other confidentially, if at all, if there is not some basis for the relationship. Since neighbors are reluctant to openly share with each other because of preconceived prejudices, political affiliation serves as a viable means for social interaction. Since the *club de madres* was dissolved in the late 1980s, and other social groups do not exist, politics serve as the primary means for people to become acquainted without the pressure of competition and distrust.

Conclusions

Throughout the paper the themes of family, politics and society support my argument that residents of El Alto, Bolivia view community differently than simply the geographical boundaries of the barrios and the demographic statistics of its population. While physical characteristics of a barrio enable outsiders to define a community, they do not illuminate the actual sense of community shared between residents of the barrio. Residents must share more than language, architecture and fashion to consider themselves a community. Although these are symbols of an overall Aymara nation, as may be imagined by Anderson (1991), such diacritical features shared amongst urban Aymara speaking migrants, do not serve to construct their "community."

In Huayna Potosí, residents place their trust in their family members and *compadrazco* relationships while they hold grudges against their neighbors. People find support within their extended family and share a commonly defined set of symbols, which in turn create their sense of community (Cohen 1985). Because of prejudices and beliefs about other members of the Aymara nation, once living together within the barrio, provincial biases serve as walls that divide residents, restricting them from interacting and inhibiting trust between them. Motivated by political views and the need for employment, some residents become politically active within the community. Political organizations encourage *vecinos* to work together. Such cooperation provides a level at which residents may relate to each other, and counterbalance their preconceived notions of one another. Once a political relationship is established, residents may then decide to interact at a social level.

Community is constructed by individuals within and between the three levels of interaction: familial, political, and social. Residents primarily trust their family members, extending beyond this realm to interact with neighbors who share similar political views. As the barrio has been divided by the political tension of local individuals vying for power, residents maintain a close group of political/social friends, many of whom they cannot trust as family members. In an urban context, Aymara migrants have created an *ayllu* within the city, crosscutting barrio boundaries. Their familial, political and social contacts form a web from which they derive their support and sustenance, reflecting symbols provided by their bucolic heritage.

Health care decisions made by urban migrants illustrate how residents perceive of their community. Migrants make their health care decisions based upon those they trust the most to help them with their ailment. Most frequently used are traditional home remedies, *remedios caseros*, which are formulas and curatives brought with them from the *campo* and maintained within the city as needed. When family remedies do not cure, residents turn to multiple care strategies, purchasing medications at local stores, seeking advice from their political/social

neighbors, visiting health centers, or even securing the knowledge of a traditional/spiritual healer. Residents' health care behavior reflects their sense of community as they turn to those most trusted. Although they may live within a large barrio and be considered no more than a resident by external organizations (NGOs, Political parties, etc.), individuals depart from these mythical definitions of community, preferring to designate their "community" as those people with whom they share particular symbols — as illustrated by those they trust.

In the case of PROSALUD in Huayna Potosí, residents most frequently use the clinic in dire situations. Upon arrival in the barrio, PROSALUD assumed three things about the residents. First, they assumed that they would serve a catchment area of five barrios, believing that residents of these barrios would visit the clinic simply because it was in the vicinity. As I have shown, residents easily move between regions of the city, while a significant majority of clients come from Huayna, but few from the other barrios served. Secondly, PROSALUD assumed that as a PHC provider, it could adequately handle the residents' medical needs. While the clinic does practice preventative and curative medicine, residents do not identify with the clinic as a place for indigenous ailments. Finally, the clinic assumed that it was politically neutral. Perhaps this was the worst oversight as the clinic ignored factionalism within the barrio. Each assumption was rebuked by the actions of the residents. Indeed, this paper has shown that *vecinos* often travel beyond the parameters of the barrio in search of medical help, as transportation nor cost are as important as trust between patient and healer. Also, within such a politically divided community, it was impossible that PROSALUD not be politically marked, as residents had to understand the clinic using symbols from their worldview.

The theme of trust is woven throughout the discussion of Aymara residents' health care decisions. Residents' stories indicate that they do not maintain confidence in people outside of their family, or *urban ayllu*, but as they need health advice, they move into political and social realms in order to find remedies for their ailments. Such are residents' communities within and between the barrios — not delineated by maps or population statistics, but across the city, dendritically organized with family members closest the trunk and political- social ties on the branches. Health care organizations continue to indulge in the myth of urban communities as defined on maps, serving catchment areas and not paying attention to how local people organize themselves within their specified regions. Such a perspective misinterprets the actual situation in the barrio and may cause friction between the residents and the health center. While governments and organizations need to define their populations, they need to also realize that residents will find health care where they feel they receive the best attention and are respected for their worldview.

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