Community Health Workers among indigenous people in Amazonas, Venezuela: their role in a shifting context

Gregorio Leopoldo Sánchez Salamé

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Health Policy Unit

Department of Public Health and Policy

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Abstract

Background:

Auxiliares de Medicina Simplificada (AMS) is a community health worker programme of the Venezuelan Ministry of Health launched in the 1960's. AMS remains the most permanent and direct presence of the Amazonas Health System in rural indigenous communities. Recent political and legal changes have occurred in the country in relation to health and indigenous people's rights thus affecting the role of the AMS.

Aim:

To examine the role of Auxiliaries in Primary Health Care among indigenous populations in Amazonas, their relationship with the regional health system and their potential contribution to the health of indigenous people in the light of the current legislation.

Methods:

A descriptive study was carried out using a qualitative approach and ethnographic methods including in depth interviews, participant observation in selected health posts in Amazonas state, and documentary analysis. Thematic analysis explored self-identification of Auxiliaries as health workers and as indigenous, the ideal and actual roles they play, and their relationship with the regional health system.

Findings:

Auxiliaries developed a strong biomedical professional identity mainly shaped by their curative tasks. Values attached to "The Manual" of the programme were highly illustrative of this identity and the influence of the health system. AMS also identified themselves as Indigenous of Amazonas, and their professional and ethnic identities were not mutually exclusive or conflicting. Promotion and

prevention appeared in their normative discourse as very important but what they most valued were their curative tasks and access to and use of drugs. The study showed that AMS play an important intermediary role between traditional and biomedical medicine systems, and between the indigenous communities and the health system. This intermediary role has been neglected in the training process and in the guidelines. Support from the regional health system has decreased during the last decade and the political decentralisation process was identified as crucial to the weakening of the program and perhaps of the entire primary care level in Amazonas. Current reforms implemented nation-wide have altered the role of the indigenous AMS.

Conclusion:

In the current Venezuelan legal framework of health, health care and indigenous rights, the role and space that the AMS have as intermediaries between traditional medicine and biomedicine, and between the indigenous communities and the health system provide the greatest opportunities for improving the health of indigenous people in Amazonas.

Recommendations:

To integrate the AMS programme into the current PHC policies being implemented by up-dating the programme, extending the training course and redefining their role as health promoters in line with the constitutional rights to health for indigenous people.

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Doctorate in Public Health Summary Statement

The Doctorate in Public Health (DrPH) programme of the London School of Hygiene and Tropical Medicine (LSHTM) is designed to provide the candidate access to a wide range of skills and insights from a variety of disciplines in order to face the challenges of understanding and adapting scientific knowledge to achieve health gain. There are three components in the programme. Theoretical knowledge is provided in the first or taught component, where compulsory study units about research methods and paradigms, leadership skills and management, are complemented with units selected according to the candidate's own interest. The second component is the Professional Attachment, which has the educational purpose of closely observing a public health organisation in order to develop a better understanding of the broader context within which effective public health leadership can be provided. The third component, the Research Project, aims to help the candidate learn about the role of research in public health practice (LSHTM, 2002).

I have a medical background and an MSc in Tropical Medicine and for the last nine years I have worked at CAICET, a centre for research and control of tropical diseases, in Amazonas state, Venezuela. The centre's mission is to contribute to the production and dissemination of information and knowledge relevant to health, and to contribute to the design of health policies to prevent and control tropical diseases. A particular focus is on the needs of the indigenous peoples that inhabit the region (CAICET, 2001). As a medical doctor and public health practitioner I have used clinical and epidemiological methods in my work, but these methods are of limited assistance in understanding the relationship between health systems and health services with the indigenous peoples and communities.

I decided to continue my professional career through a DrPH programme, and to broaden my approach to public health practice in indigenous settings.

I began the doctorate in April 2002. During the taught component I complemented the compulsory study units with social science courses: Principles of Social Research, Qualitative Methodologies, Sociological Approaches to Health, Medical Anthropology and Ethics, Public Health and Human Rights. The units were chosen to help me to gain knowledge and skills in order to conduct and analyse research and public health practice from a social science perspective.

Between May and August 2003, I did my Professional Attachment at a small Non Governmental Organisation (NGO) called *Ethnic Minority Partnership Agency* (EMPA) in the London Borough of Barking and Dagenham. EMPA has the goal of articulating and prioritising the needs of ethnic minorities and joins in efforts to help to eliminate discrimination in the provision of public services on the grounds of ethnic origins. I observed and participated in the internal processes of the organisation applying management and organisational theory learned in the taught courses to understand EMPA's structure, objectives and culture, management and leadership style, and its relationship with the local authorities of the governmental sector. This was an opportunity to put into practice and to gain new skills in qualitative data collection and analysis. It was also an opportunity to better understand the role of the voluntary sector in a high income country with a modern democracy and pluralistic political system, and how the state deals with ethnic minorities and racial issues in a very diverse society such as Britain.

I decided to carry out my research project to explore the relationship between the health system, health care and indigenous communities at a particular moment of my country's history when there are ongoing fast changes of political and social values.

For this purpose I chose to study the role of "*Auxiliares de Medicina Simplificada*" (AMS) community health workers among the indigenous population in Amazonas state. I hope that this thesis will contribute to the development of interventions that strengthen the contributions of the AMS to the well-being of their communities.

I have been very fortunate in having the opportunity to study at the LSHTM gaining knowledge, skills and experience that I expect will contribute in improving strategies that lead to equity in the state provision of services in Amazonas and Venezuela.

Table of Contents

List of Tables, Figures and Boxes

Statement of Own Work

I have read and understood the London School of Hygiene and Tropical Medicine definition of plagiarism and cheating given in the Research Degrees Handbook.
I declare that this thesis is my own work. It was designed, carried out, analysed and written up by myself. During the data collection I was assisted by another researcher with my support and under my supervision as outlined in Chapter 4.
I have acknowledged all results and quotations from the published or unpublished work of other people. The entire thesis was undertaken by me as my own work, with support provided by my Supervisor, Dr. John Porter, and Advisory Committee members, Karina Kielmann and Carolyn Stephens

Signed:..... Date: November 4th, 2005

Gregorio Leopoldo Sánchez Salamé

List of abbreviations

AMS: Auxiliares de Medicina Simplificada (Simplified Medicine Auxiliaries)

CAICET: Centro Amazónico para la Investigación y Control de Enfermedades Tropicales "Simón Biolívar"

CHW: Community Health Workers

CPHC: Comprehensive Primary Health Care

DrPH: Doctorate in Public Health

FG: Focus Groups interviews

GOBI: Growth monitoring, Oral rehydration, Breast feeding, and Immunisations

HSR: Health Sector Reform

ILO: International Labour Organisation

LSHTM: London School of Hygiene and Tropical Medicine

MoH: Ministry of Health

MoHSD: Ministry of Health and Social Development

MoHSW: Ministry of Health and Social Welfare

NGO: Non Governmental Organisation

NCIPH: National Coordination of Indigenous People's Health

PAHO: Pan-American Health Organisation

PHC: Primary Health Care

RHP-I: Rural Health Post Type I

RHP-II: Rural Health Post Type II

SPHC: Selective Primary Health Care

TM: Traditional Medicine

UHP-I: Urban Health Post Type I

UN: United Nations

UNICEF: United Nations Children's Fund

USSR: Union of Soviet Socialist Republics

WHO: World Health Organisation

CHAPTER 1: Introduction, Aim and Objectives

Auxiliares de Medicina Simplificada or Simplified Medicine Auxiliaries (AMS) is a programme of the Venezuelan Ministry of Health (MoH). It was launched in the early 1960's with the specific goal of delivering basic health services in hard-to-reach rural areas through a cadre of employees selected by their own communities and trained, supervised and supported by regional health systems (González, 1975; MSDS, 1999).

In the 1970's, the Venezuelan AMS programme was hailed internationally as a successful experiment in community-based delivery of health services that contributed to the formulation of Primary Health Care (PHC) embodied in the Alma Ata Declaration of 1978 (Newell, 1975b; Benyoussef and Christian, 1977; Walt, 2001; Hall and Taylor, 2003).

Since the launch of PHC, in developing countries Community Health Workers have been considered as its cornerstone, but rural health projects involving workers such as the AMS have always been under criticism and suspicion due to their potentially political nature (Ugalde, 1985). Doubts raised include whether programmes increase dependency, oppress or, on the contrary, support and empower local communities. In a seminal article David Werner translated these doubts into a contentious disjunctive: Are the community health workers such as AMS "*lackeys or liberators*"? (Werner, 1978). This was a departure point of enquiry for this thesis.

After 40 years the national and international context has changed, but the AMS programme remains the most permanent and direct presence of the health system in suburban and rural indigenous areas of Venezuela (MSDS, 1999).

Since 1999, new constitutional rights and legal texts state that health programmes and services should be culturally appropriate based on the principle of vertical equity, recognising identity, world view, values and spirituality (See Annex 1).

Participative democracy is an emerging concept prevailing in the current political discourse in Venezuela (Venezuela, 1999; 2002).

The new Constitutional and legal framework has opened the political space and increased expectations have arisen regarding the design, planning and provision of sensitive and appropriate health services, particularly for the indigenous population (Rivero *et al.*, 2002). Those who have been at the interface of the health services and indigenous communities need to have a say in the process to come.

1.1 The problem

After 40 years of development of the AMS programme, relationships between the State, local health actors such as the Auxiliaries and the communities they serve, have been exposed to political, social, economic and epidemiological change. These have been particularly relevant in Amazonas state and for indigenous peoples. In this shifting context the study addresses the following question: What is the actual role of indigenous Simplified Medicine Auxiliaries (AMS) within the health system and what interventions could strengthen their contribution in light of the current health reform and constitutional recognition of indigenous rights?

1.2 Aim of the thesis

The overall aim of this DrPH thesis is to better understand the practices and concepts prevailing in the PHC for indigenous people in Amazonas, Venezuela, the relationship between the Auxiliares and the Regional Health System and their response to change.

From a programmatic perspective the findings of this research will be used to develop interventions to strength the contribution, if any, of the *Auxiliares de Medicina Simplificada* in current legislation and rights concerning Venezuela's indigenous peoples.

1.3 The immediate background and context of the thesis

Venezuela is experiencing a deep and amazingly fast process of political reform with a mobilising rhetoric promoting the transformation of social institutions (Adelman, 2002). Massive social programmes are being implemented directed toward the less well-off, who are the majority of the population. This group includes indigenous peoples. Attention has been given to their right to ancestral land, education, recognition of cultural identity, political participation and their right to health (Mansutti-Rodríguez 2000).

Within the content of the reforms implemented nation-wide in the health sector, the role of indigenous community health workers is uncertain. While the programme has been unofficially "phased-out" since 2002, AMS in Amazonas retain their functional duties. Still today, 75 out of the 102 existent health care services in the State are *Rural Health Post Type I* attended by *Auxiliaries de Medicina Simplificada*. Any decision affecting them, impacts not only on the programme but on a whole level of primary care.

With the rapid changes, official initiatives have been taken to address the health needs and demands of indigenous peoples country-wide, an experience with no precedent. Between 28th and 29th of February 2004 the Minister of Health and his appointed Head of the recently structured National Intercultural Coordination of Indigenous People's Health visited Amazonas and had a meeting entitled "Encounter of Knowledges" *("Encuentro de Saberes")* promoted by the Ministry of Health and held in the very interior of the Amazonas, where AMS and Shamans from several ethnic groups were gathered together. The Minister himself placed emphasis on a previously designed agenda to obtain support for policy initiatives that were to be implemented regarding indigenous people's health: a) the structure of a regional council of indigenous health where shamans and representatives were to be appointed by the communities; b) the establishment of a School of shamans "*where the oral transmission of traditional knowledge would prevent the expropriation of the collective property*" of this knowledge and; c) and he

reported on his decision to recognize the work of shamans and traditional healers work by the payment of salaries. A Yanomami shaman present at this meeting, far from agreeing with the Minister's initiative, emphasized the need for more medical doctors and medicines in his area because "*just with shamans was not enough*". Other assistants, Indigenous as well from various ethnic groups, agreed with these claims, emphasising that sometimes the shamans were "*not enough*" or not effective for certain types of diseases, and asked for more AMS and people trained in the diagnosis and treatment of malaria, the most important endemic disease in the state. The Minister offered to increase training opportunities for indigenous AMS.

Reviewing the recorded material from this event a particular perception is that there is little "encounter" in the dialogue with the result that need, demands and current services go in different directions.

My work duties in Amazonas over the last nine years have put me in contact with *Auxiliares de Medicina Simplificada.* They have come with patients from their communities to the Tuberculosis (TB) clinic I run, and have assisted me in my visits to indigenous communities when conducting epidemiological surveys. As the TB control programme coordinator I have worked with them to follow active TB cases and have been one of the trainers on their courses and a supervisor of their activities in health posts. As a public health practitioner, I have observed the attention given to the massive extension of medical services and the integration of multidisciplinary professional teams for primary health care strategies. I have also seen that little attention has been paid to the role and experience these Auxiliaries have had in cross-cultural settings as health care service providers in Amazonas. For me, the AMS represented a window through which to explore the evolution and development of PHC among indigenous people, to look for ways to transcend beyond the rhetoric of guidelines and to help to facilitate processes to put into public health practice the principles and values contained within the indigenous and health rights of the Venezuelan Constitution (See Annex 1).

1.4 Objectives

1. To examine the professional profile and current roles of AMS in Amazonas, Venezuela within the context of the health sector reforms and the new constitutional Indigenous Peoples Rights.

    1.1. To understand the role of the AMS in Amazonas (Chapter 2, 3, 5 and 6).

    1.2. To explore how the AMS identify themselves both as health workers and as indigenous in the light of current health reforms and Indigenous People's Rights (Chapter 2, 5, 6, and 7).

2. To examine the relationship of the AMS within the Regional Health system in Amazonas

    2.1. To explore how the AMS in Amazonas approach and work within the Regional Health System (Chapter 2, 3, 6 and 7).

    2.2. To explore how regional officers and medical doctors approach and work with the Simplified Medicine Auxiliaries Programme (Chapters 3, 6 and 7).

1.5 Structure of the thesis

This thesis is divided into nine Chapters. The first chapter contains the aims and objectives of the study. Chapter 2 is a literature review of the principal themes of the study: Primary Health Care, Community Health Workers, and the Health of Indigenous People. Chapter 3 provides an overview of the history and organisation of the Venezuelan and Amazonas' health care system, describes the development and evolution of the AMS programme and emphasises the current events in health policy implementation in the state. Chapter 4 contains methodologies, methods and the principles underpinning the research process and

what was actually done to accomplish the objectives. The main findings of the study are presented in Chapters 5, 6 and 7. Chapter 5 contains a description of the occupational profile of the AMS, who they say they are as health workers and how they self-identify as Indigenous. In Chapter 6 the "ideal role" of the AMS, as established in the normative guidelines, is contrasted with what the AMS say they actually do in work areas such as health promotion, prevention and cure of diseases. Their role as *intermediaries* is emphasised. Chapter 7 describes the relationship between the AMS and the regional health system in the evolution of the programme in Amazonas and provides their responses to the current changes. Chapter 8 is a discussion of the most relevant findings that emerged in the study and how these links with the objectives of the thesis. Chapter 9 contains an overall conclusion and recommendations for future interventions and research.

CHAPTER 2: Primary Health Care, Community Health Workers and Health of Indigenous People: an overview of international policy

This chapter gives an overview of the literature from the international policy perspective of Primary Health Care, Community Health Workers and the Health of Indigenous People. It starts with a brief review of the origins and evolution of Primary Health Care as a concept and as strategy, then the profile and expectations that Community Health Workers have had in developing countries is summarised. It continues with a description of how the health of Indigenous People gained importance in the international forum, and finally refers to some experiences of CHW among indigenous people in Latin America and other regions.

2.1 The emergence and fading of Primary Health Care: a shifting policy context

Health policy changes occur as a result of a complex sequence of ideas and events not easily distinguishable over time (Walt, 2001). The origins of Primary Health Care as international policy can be traced back to the 1960´s as a response to the then prevailing model of health care.

During the 1950´s most of the low and middle income countries had emulated and imported health systems models of industrialised and wealthier countries, based on large hospitals built in urban areas, dependent on skilled health professionals and on high cost technology (Justice, 1986). At the time, many of those countries still had a large percentage of people living in rural areas, poorly or not covered at all by the hospital-based approach. Deficiencies in coverage were palliated with disease-focused vertical programmes, structured and implemented from top to bottom, with centralised administration and in many cases planned and financed

by international agencies. (Justice, 1986; Unger and Killingsworth, 1986; Mull, 1990; Walt, 2001).

The 1960's was a decade of disillusionment with the hospital based-model and with the western medical model in general. Critics arose firstly in wealthier nations, which were later echoed in low income countries of the so called developing world. Critics of the model came from different ideological perspectives: those concerned with the excessive control of the state in health care, others criticizing the unbearably high cost of health care with standards of productivity prevailing over quality, and others with an anti-scientific discourse, reacting towards the technological dependency and asking for the revival of traditional practices. All critics coincided in their belief of a necessity for increasing preventive practices and community participation within local health services and in new conceptualisations and approaches to human development (Menéndez, 1990). These were contributing factors to the gestation of Primary Health Care (PHC).

In the international forum, industrialisation as a recipe for development was being rejected and progressively surpassed by the concept of basic needs satisfaction with health care included (ILO, 1976; WHO/UNICEF, 1978). For many international health policy makers and planners, it was evident that the hospital-based approach and the vertical programmes were failing (see: Newell, 1975a). It is in this context that in the late 1970's PHC emerged as an ideological shift in health systems development.

Primary Health Care was a concept introduced in 1978 by the World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) in an international health conference held in Alma Ata, capital of Kazakhstan, former Union of Soviet Socialist Republics (USSR) (WHO/UNICEF, 1978). In the historical declaration issued by the 134 governments and 67 international organisations, PHC was endorsed as the approach that countries of the world should adopt in order to reach a stated goal of achieving "Health for All by the

Year 2000". PHC was to be truly comprehensive consisting of essential care made universally accessible to individuals and families by means acceptable to them, with their full participation, and at a cost that each given country as a whole could afford. It was conceived as a strategy to provide preventive, curative and rehabilitative services consisting of at least the following components:

- Health education enabling people to prevent and deal with problems
- Basic sanitation and adequate sources of water
- Immunisations
- Promotion of food security and proper nutrition
- Maternal and Child Care including family planning
- Prevention of endemic diseases
- Appropriate treatment of common ailments
- Provision of essential drugs

It has been stated that behind the rhetoric of PHC there was an ideological shift, with equity and community participation as underlying principles (Walt, 2001). Low and middle income countries focused PHC implementation on local health services and people's participation in them. Most of the countries started with formation, reinforcement or recognition of local community organisations with relevant objectives: 1) to organise communities to solve problems that could not be solved individually; 2) to exercise control over local health services; 3) to assist in financial services; 4) to link health actions with wider goals, and 5) to select, appoint and legitimise local health workers (Newell, 1975b).

But moral and political principles underpinning PHC were difficult to translate into practice. Comprehensive Primary Health Care (CPHC) represented a drastic

change from the doctor-centred urban-hospital approach, going beyond the health sector in its perspectives, and challenging the *status quo* of political order.

The width of its principles made the implementation of CPHC difficult. It was considered as too comprehensive and its implementation required structural social changes as was evident in countries where the most successful results were being obtained (Mull, 1990). China, USSR, Cuba, Sri Lanka, Nicaragua, were countries undergoing deep political and social transformations and where the allocation of resources was directed toward the poor majorities in their population (Mull, 1990).

During the 1980's, difficulties for and resistance to CPHC implementation contributed to its progressive fading. Low and middle income countries went through a severe economic recession and increasing proportions of their national budget were devoted to the payment of growing debts to international financing agencies (Hall and Taylor, 2003). In Latin America, the impact in the social and economic spheres was such that the 1980's has been recognised as "the lost decade" (Dos-Santos, 2002).

International health agencies shifted their attention and focus to the costs of service delivery. The increasing influence of conservative right wing leadership within international health for a challenged and undermined CPHC that was labelled as too idealistic and expensive (Mull, 1990). The alternative was to narrow it down, to select health priorities according to cost-effective control measures available and with outcomes that were easy to evaluate by international donors (Unger and Killingsworth, 1986; Mull, 1990). Growth monitoring, Oral rehydration, Breast feeding, and Immunisations (GOBI) were the health interventions selected for general application all over the developing world as components of Selective Primary Health Care (SPHC) (Warren, 1988).

In the late 1980's, the fading of PHC was accelerated by the emergence of a new international health policy product of the prevailing liberal economic trends. Even the few selected PHC measures, the pillars of GOBI, were shown to be failing:

Growth monitoring was thought as an end in itself and detecting those in vulnerable situations did not provide the means for CHW to intervene; rehydration salts were known about but not used; breast feeding was under pressure from multinational food industries, and immunisations were being more efficiently applied on a vertical basis at national scale (Walt, 2001).

Within a context of economic recession in the developing world, international health agencies prioritised issues of financing and organisation of health systems: Health Sector Reform (HSR) arose as a new international policy. This was related to the set of structural adjustment policies that were conditions of the international financing agencies on developing countries if they were to reschedule their external debt payment (Zwi and Mills, 1995; Walt, 2001; Hall and Taylor, 2003).

Structural adjustment pursued the reduction and decentralisation of the state, the reduction of civil servants in the ministries, and a reduction in social expenditure by introducing charges in educational and health services that were previously provided for free (Zwi and Mills, 1995). These adjustments were determined by the ideological shift to neo-liberal policies "*emphasising individual over collective choices and private sector, market provision over public sector state provision. And all this was heightened by the break up of the USSR and disillusion expressed with communist regimes and centrally planned economies*" (Walt, 2001, p. 281).

However, PHC was not completely ignored within HSR. It was repackaged under decentralisation and within the very basic services countries should provide for the very poor, based on expectations that market forces will solve the resource problems for the rest of the population (Zwi and Mills, 1995; Walt, 2001). In many countries Community Health Workers (CHW) remained as local health providers for the very poor and their survival depended on the economic and policy support they received from the health system (Walt, 1988; 2001; Hall and Taylor, 2003).

2.2 Community Health Workers in PHC: profile and expectations

Low and middle income countries focused their implementation of the PHC approach on the structure and organisation of local health services following the trend set by international agencies (Navarro, 1984; Walt, 2001; McElmurry *et al.*, 2002).

Engaging communities in the control over local health services by selecting local health workers emerged as a strategy to guarantee accessibility, acceptability and appropriateness of those services. Some countries extended programmes initiated before Alma Ata in a deliberate effort to increase basic health care services. Others rapidly started to introduce a new cadre of CHW. These later initiatives were, in many cases, motivated by the interest of governments to show their commitment to the PHC approach, adopting a rhetoric and jargon in their policies. Depending largely on foreign funding sources, the interest was to attract donors, following their recommendations and requirements. In some cases workers were imposed on communities (Justice, 1986; Walt, 2001). In either way, Community Health Workers appeared as links between the formal health systems and the community and became a distinguishing feature of many PHC schemes (Newell, 1975b; Werner, 1978; Walt, 1988; 1990).

Community participation was mentioned by international agencies as a key-strategy in health projects, underpinning the Primary Health Care approach (Morgan, 1993). The political dimension of community participation in health programmes has been a contentious issue and a matter of debate. It was promoted in the historical declaration of Alma Ata as a "new strategy" and principal element to ensure acceptability and viability of PHC, a way to ensure equity. But on the other hand it has been pointed out that the real political objective of promoting community participation was to legitimise low quality care for the poor and to generate needed support for liberal democracies or authoritative regimes. In the case of Latin America, health planners were late comers in promoting community participation that in the 1950's had become a common feature already in

agricultural development projects but with meagre results in terms of improving the quality of life for the majority of the population (Ugalde, 1985).

CHW programmes expanded during the 1970's and 1980's as long term evidence grew from the effectiveness of small-scale programmes. The initial enthusiasm and optimism saw CHW in many roles: pillars of "health for all", the cornerstone of PHC, liberators of communities and extenders of services (Benyoussef and Christian, 1977; Walt, 1988; 1990; Bhattacharyya *et al.*, 2001; Hall and Taylor, 2003).

Given the heterogeneity of characteristics of CHW programmes within and between countries, it is difficult to give a unique and universal definition. Experiences diverge in many senses such as: 1) the relation of the programme to the health sector and to social development; 2) the expectations upon the workers and goals of the programmes; 3) the source of funding; 4) the profile of tasks and skills of the CHW; 5) the extension or scale of the programmes; and 6) remuneration of the workers.

1. *CHW programmes' relation to the health sector and to broader social development policies*: These were described as overlapping types of programme: a) those related to structural and national changes such as the Cuban, Chinese and Nicaraguan experiences, b) those programmes conceived as an extension of the official health system as demonstrated in the experience of Iran and Venezuela and c) those experiences that focused on local rural development local projects in Guatemala and India (see Newell, 1975a).

2. *Expectations and goals*: In a few situations the role of the CHW was seen as political with less emphasis on service delivery and more on determinants of health, expecting them to be health advocates to rally their communities to tackle the determinants, even in developed countries (Baker *et al.*, 1997; Rodney *et al.*, 1998). In this sense there were expectations of CHW to be agents of change. In other programmes the health sector limited its

expectations of CHW to them simply being care service extenders (Newell, 1975b; Walt, 1990).

3. *Profile of tasks and skills*: CHW have a number of tasks within the health sector ranging from preventive and promotion and health education to curing common ailments. According to educational level and skills, among the range of experiences they can be distinguished from Auxiliary Nurses or Technicians who frequently have primary education and two years of training, and Health Promoters or Village Workers who are literates with incomplete primary school (Werner, 1978; Walt, 1988; 1990; Bhattacharyya *et al.*, 2001).

4. *Sources of Funding*: Programmes of CHW were financed by public funds from regional and national governments or by Non Governmental Organisations (NGO). Governmental or non-governmental programmes could also receive support from national, bi-nationals or multinational agencies (Newell, 1975b; Walt, 1990; Frankel, 1992a).

5. *Extension or scale of the Programme*: Programmes were designed and planned for local, regional or national scale. Frequently local programmes were run by NGOs and programmes on a national scale were dependent on public and centralised funding (Newell, 1975b; Werner, 1978; Walt, 1990).

6. *Remuneration of Workers and relation to the communities*: A range of modalities is found in different experiences. Some CHW were from outside the community and were full time employees, others were selected by their own communities to work on a volunteer basis or to become part or full time employees of the Ministry of Health and for all purposes considered civil servants (Bhattacharyya *et al.*, 2001).

From the diversity, profiles and characteristics of CHW and reported outcomes of many different experiences, the following general features and observations can be drawn:

a) When effectively conceived as agents of change, CHW were part of a larger development ideology, expected to be catalysts to engage communities to understand and modify determinants of ill health (Ugalde, 1985; Mull, 1990). This could have been true in a reduced number of national programmes, in countries undergoing more profound political change, or in many small scale non governmental experiences. In many other national-basis programmes the developmental goal or the agents- of- change role of CHW, did not go further than a rhetorical statement.

b) In the cases of national programmes where CHW are civil servants it is logical to understand their strong identification with the MoH, tending to be more committed to their jobs than to communities. In this case instead of agents of change, CHW act largely as extenders of health services and many have argued that they are captured by health service professionals and used as "*another pair of hands*" (Walt, 1990, p. viii; Walt, 2001, p. 270).

c) The basic characteristics or foundations of CHW programmes, all had in common the aim to extend health care to underserved populations and to involve members of the community in such programmes. In this sense, CHW were largely successful in assisting an unprecedented expansion of health services to previously neglected areas (Newell, 1975b; Frankel, 1992b). And even being simply service extenders, without accomplishing the developmental or agent-of-change role, CHW were perceived as a threat to the status quo, with critics from the conservative medical establishment (Werner, 1978; Walt, 1990; Wood, 1990).

d) It has also been documented that if CHW do not have curative tasks and access to drugs they are not greatly valued by communities and their preventive role is undermined (Bhattacharyya *et al.*, 2001). But when they can

give treatment their attention could be totally diverted and their goals confined to the health sector as extenders of curative services (Walt, 1990).

2.3 Health of indigenous people in international policy

In the last decades indigenous people's rights organisations have made substantial progress in institutionalising their demands and rights in the international forum. They have been persistent and successfully transformed the status of indigenous peoples from peripheral minority groups with little political recognition to transnational activists with international lobbies (Hodgson, 2002), and a particular focus has been given to their health.

In international health policy, precedents of the recognition and relevance currently given to indigenous people's health can be located in the recognition of Traditional Medicine (TM). In this regard the inclusion of China in the United Nations (UN) system was important (Lobo-Guerrero, 1991). It was in the 1970's, after China's inclusion into the WHO, that the term TM appeared in the international arena. In 1978, the same year as the Alma Ata conference, WHO launched a Programme of Promotion and Development of Traditional Medicine (PPDTM) grounded in expectations to extend health care to all, in concordance with the strategy of PHC (Velimirovic, 1990; Lobo-Guerrero, 1991). This initiative was not without controversy, and some have argued that such recognition of TM is no more than "wishful thinking" and that incorporation of TM in the international agenda was simply for political reasons and lacked a scientific basis (Velimirovic, 1990).

Traditional Medicine was being identified with community participation. The PPDTM encouraged the incorporation of traditional practitioners into community development projects and recommended them to be trained in PHC techniques (Velimirovic, 1990). The WHO's PHC and TM agendas were echoed in many low and middle income countries who saw in them the mechanisms to reinforce and

strengthen self-reliance, identity and independence (Lobo-Guerrero, 1991). In India and other Asian countries, in the African continent and in many parts of Latin America indigenous and traditional medicine programmes started to be implemented aimed at articulation with official health systems (Velimirovic, 1990; Lobo-Guerrero, 1991).

Before continuing, the term *Indigenous People* needs to be clarified. Categories that presently classify groups of human beings and differentiate one group from another, such as race, gender, or culture, are all social constructs determined by multiple factors. Debate on the identification of indigenous people has raged for over half a century and there is no internationally agreed definition. The term "indigenous" has an historical dimension. Indigenous activists and organisations have a long history in North, Central and South America in which their status of "first peoples" is generally uncontested. In Africa by contrast, the term indigenous has been adopted much more recently as a tool for social and political mobilisation (Hodgson, 2002). Indigenous derives from the Latin "*indigena*" meaning "born in country"[1] . However its current social and political definitions are more ambiguous. We assume the only definition that is legally binding to ratifying governments-states, the one included in the *Indigenous and Tribal Peoples Convention 169* adopted in the ILO in 1989:

> "*...peoples in independent countries .... are regarded as* ***indigenous*** *on account of their descent from the population which inhabited the country or geographical region to which the country belongs, at the time of conquest or colonisation or the establishment of present State boundaries and who, irrespective of their legal*

[1] **indigenous** *adjective*
1 originating or occurring naturally (in a country, region, etc.); native
2 innate (to); inherent (in)
Etymology: 17th Century: from Latin *indigenus,* from *indigena* indigene, from *indi-* in + *gignere* to beget. (Collin's English Dictionary, 2000)

> *status, retain all of their own social, economic, cultural and political institutions*" (ILO, 1989, Article 1.1).

In 1982, the UN established a "Working Group on Indigenous Populations" that had two main aims: to produce a "United Nations Draft Declaration on the Rights of Indigenous Peoples" - which is still going through the tiered UN approval system- and to successfully lobby for the approval in 2000 of a *Permanent Forum on Indigenous Issues*. One of the matters brought to the attention of this *Forum* was whether to determine the access of direct health care of indigenous people and how health services become sensitised to traditional health care practices (GHW, 2005; UN, 2005). The Draft Declaration includes articles to establish rights to determine, develop and administer health programmes, and to use and develop traditional medicine and health practices (GHW, 2005).

Other achievements of the lobby of indigenous organisations in international agencies should be mentioned. In 1992, on the occasion of the Fifth Centenary of the arrival of Europeans to America, the UN declared 1993 as "*The International Year of Indigenous People of the World*" and this decade 1995-2004, as "*The Decade of the World's Indigenous Peoples*". In correspondence in 1993 the Pan-American Health Organisation (PAHO) launched a "*Health Initiative for Indigenous People in America*". According to PAHO the Initiative responds to inequalities that exist in health status and access to basic services and emphasises the clear interdependence of health and development and helps to strengthen social participation, health promotion, decentralisation in the solution of prioritised problems departing from the principle of equity and the ideal of "Health for All" (Macêdo, 1993). More recently the Initiative has emphasised the need to integrate indigenous perspectives and practices in Primary Health Care promoting as a strategy the incorporation of indigenous health systems with conventional or official health systems through juridical, conceptual and practical harmonisation:

> *"The term incorporation is used as synonymous of association, entrance, access and the term harmonization is used as conciliation, agreement, intercession.....*
>
> *Juridical harmonisation is a process orientated towards the adaptation of juridical framework-policies, laws, regulations and norms, to the social cultural characteristics of indigenous populations.*
>
> *Conceptual harmonisation..... (is) orientated to the generation of new paradigms and alternatives that allow the understanding of the complexity of theoretical-practical and material-symbolic responses of indigenous health systems....*
>
> *Practical harmonisation is orientated to the design and implementation of new health care models...for indigenous populations"* (PAHO-OPS, 2003, pp. 3-4).

This concept of incorporation is opposed to that of integration or assimilation, features that have characterised most of the States policies regarding indigenous people in an attempt to consolidate one national identity, intrinsically homogeneous. Incorporation is then referred to as a way to acknowledge and respect cultural differences to be taken into account in the design and implementation of policies and in the structure of health systems.

Despite the important institutional developments that have taken place in the framework of these initiatives, as the UN itself has acknowledged, indigenous people in many countries continue to be among the poorest and most marginalised. With regard to one of the main objectives of the *Decade*, namely the adoption of a Declaration on the Rights of Indigenous Peoples, this has not been achieved (UN, 2004).

2.4 The CHW in PHC among indigenous populations: some experiences

Essential for the ideal of "Health for all" was to provide preventive and curative services that were universally accessible and socially acceptable. International agencies, such as the WHO in 1978 and, even before, the International Labour Organisation in 1976, insisted on the accessibility and appropriateness of health delivery services (ILO, 1976). Accessibility was conceived in geographical, economic and cultural dimensions.

Community Health Workers were thought of as tools to bridge the gap, to overcome geographical, social, and cultural distance between the official health services and their target population, achieving this aim within acceptable costs. During the 1980's a wide range of experiences took place in Africa, Latin-America, Asia and Indonesia (see Frankel, 1992a). CHW were seen as encompassing all the Alma Ata principles to an extent that in some countries they were equated with PHC rather than comprising a part of it. These roles of health service extenders and cultural brokers have also been predominant in the experiences with CHW in indigenous populations (Wood, 1990; Lobo-Guerrero, 1991; Sagers and Gray, 1991; Torzillo and Kerr, 1991). If accessibility and appropriateness is a principal feature common to all CHW programmes, the presence of the cultural element is remarkable in those related to indigenous or aboriginal people. Several strategies have been designed seeking comprehensiveness and *cultural appropriateness*, some have focused on non indigenous official personnel, some on the indigenous CHW and others in linking traditional practitioners to the official health systems (Leslie, 1983; Herrera, 1991; Lobo-Guerrero, 1991; Sagers and Gray, 1991; Last, 1996; PAHO-OPS, 2003).

Ideas of services with *cultural-sensitiveness* and *cultural appropriateness* are high in the debate of CHW's working for indigenous people. Terms such as *cultural safety* have appeared in the literature referring to the set of principles or specific

ideal requirements for personnel working and health programmes implemented for indigenous populations (Williams, 1999; McPherson *et al.*, 2003).

During the 1970´s, countries like Australia made efforts to mainstream services more acceptable for their indigenous population, and aboriginal health workers were increasingly incorporated into local services. They were considered as a key strategy to improving aboriginal health, serving as a point of entry for community into the western health system while acting as mediators between western and traditional medical systems (Hecker, 1997). Their role varied according to the training programme provided. In urban areas, the role was of promotion and liaison between the population and the health system while in rural areas the provision of curative services was prioritised (Sagers and Gray, 1991).

In the early 1980´s, New Zealand implemented a cultural-sensitive health programme with health workers drawn from the aboriginal Maori population. It coincided with a period of heightened Maori political and social awareness and indigenous health was given the status of national priority by the national government (Wood, 1990). The experiences with the indigenous CHW is reported as largely welcomed by the communities but not without opposition by members of the medical establishment. The diagnosis and allopathic treatment of ordinary ailments, such as ear infections, by the CHW were considered as a threat posed to the medical bodies. Despite the opposition, Maori CHWs satisfied a felt need by partially bridging the gap separating their people from the utilisation of existing medical service (Wood, 1990).

From the perspective of the health planners in massive programmes such as that initiated in India in 1977, CHW would be to serve as cultural brokers between villagers and the state system of professionalized health care (Maru, 1983; Leslie, 1985).

Well before Alma Ata, Latin American countries such as Colombia, Ecuador and Venezuela were developing experiences with Rural Health Workers as liaison between the official system and communities. In Venezuela and Colombia these

programmes were designed to serve peasant populations but were progressively extended to indigenous populations aiming to decrease the socio-cultural barriers between services and indigenous communities (Baldó, 1961; González, 1975; Herrera, 1991; Lobo-Guerrero, 1991). In Ecuador, the CHW were considered as the main strategy of the official health system to face indigenous health problems (Lacaze, 2002).

In these countries, PHC in indigenous communities has been limited to the training and supervision of different profiles of CHW that remain until the present as an aim of culturally-sensitive preventive and curative care for indigenous people that otherwise would not have access to biomedical health services (Lobo-Guerrero, 1991; Rivero *et al.*, 2002). In indigenous areas of Venezuela, such as Amazonas state, the extension of services through this CHW has been documented as determinant on the structure of the regional health system (Lobo-Castellanos, 2002) and on the health status of the population, but has not been without cultural impact as well (Zent, 1993).

CHAPTER 3: The Venezuela and Amazonas health care system and evolution of the AMS programme

In this Chapter the health care system in Venezuela and Amazonas state will be briefly presented. Using a chronological approach it will describe how the AMS programme contributed to the initiation and unprecedented expansion of the structure and organisation of the health care system in this State. Details are given of the health sector reforms launched in the last six years and the way they been implemented in Amazonas.

3.1 The Health System in Venezuela and Amazonas

3.1.1 Overview of the Venezuelan Health Sector

For descriptive purposes, the current Venezuelan health sector can be distinguished by two sub-sectors: the private and public. The private sub-sector includes insurers, pre-paid care, direct care, profit and not for profit private sector among many other institutions or initiatives funded by private sources. The public sub-sector is made up of many centralized or decentralized institutions, whose budgets primarily come from fiscal or contributory funds that operate in a non-integrated manner. The public sector bears the greatest responsibility for providing health services for the general population (PAHO, 2002) and its weight as a direct supplier is so significant that some authors have called the structure *monopolistic* since the government is mainly responsible for funding, being the main health care provider (Cartaya, 1997).

Important institutions of the public sector are the Venezuelan Institute of Social Security, the Institute of Social Welfare of the Armed Forces and the Institute of Social Welfare of the Ministry of Education. These are decentralised institutions funded by contributory funds financing and providing health services to their affiliates. But the main and most important institution of the public sub-sector is

the Ministry of Health and Social Development (MoHSD), which is an organisation of central administration currently responsible for planning, implementation and evaluation of national health policies as well as financing and providing health services (Venezuela, 1999; 2000).

The origins of the MoHSD can be traced back to 1936, when governmental activities in agriculture, animal health and hygiene sectors were separated and the Ministry of Health and Social Welfare (MoHSW) was founded (López-Ramírez, 2002). The exploitation of oil had started in the country a few years before. In 1926 for the first time the revenues for oil exportation exceeded those of coffee (Briceño-León *et al.*, 2003), but still the economy of the country mainly depended on agriculture. The population was highly rural, estimated at more than 70% of the total.

The MoHSW had been founded for purely preventive and promotion functions leaving health care responsibilities to regional governments. During the 1950's, the MoHSW initiated a process of nationalization of the hitherto federal hospitals becoming the most important health care provider institution in terms of services and resources. The country was then divided in Health Regions and, in each region Health District structures were organised with levels of health care represented by Regional Hospitals, District Health Centres and scarce Rural Health Posts.

The current MoHSD was created in 1999 when the former MoHSW and Ministry of the Family were merged in the context of the political, legal, economic and social transition that was initiated that year (PAHO, 2002). Besides the functions of prevention, promotion and care provision, the new MoHSD assumed the planning, implementation and evaluation of prioritised social programmes (González, 2001).

The MoHSD is now divided in two Vice-Ministries, Health and Social development. The Vice-Ministry of health has two main general directions,

Environmental Health and Population Health[2]. At the sub-national level the MoHSD has Regional Directorates of Health. Most of these Regional Directorates are decentralised organisations dependent on the Regional Governments, as a consequence of the political decentralisation process started two decades ago.

In 1988, Venezuela started a process of state reform characterised by the decentralization of the political-administrative structure with direct participation of the citizens in the election of representatives at every level of government (Mascareño, 2000). In 1990, a process was initiated to transfer the health services of the then MoHSW to the states (PAHO, 2002). The political-administrative decentralization process has clashed with the public health sector unification's initiatives (González, 2001). Since 1986, there have been attempts to achieve a national integration of the main institutions in the public health sector in order to provide a desirable coherence to the heterogeneity and complexity of the current inter-institutional and intergovernmental health system.

Within the health sector, the decentralisation process has been characterized by heterogeneity depending on the structure, organization and financing capacities of each federal entity. There are still a few federal entities whose health sectors have not yet been decentralised; Amazonas state is one of them.

3.1.2 Evolution of the Health system in Amazonas

Amazonas state is located in the southern region of Venezuela with an extension of 180,475 Km^2. It has the highest proportion of indigenous population in the country, with about 49% of its 119,564 inhabitants indigenous, the lowest population density, and the lowest income as well (INE, 2001).

[2] On July 2005 the Venezuelan Government decided to again split the responsibilities of Health and Social Development into two different Ministries. The Ministry of Social Development and Popular Participation was created, and the Vice Ministry of Social Development will eventually disappear.

Amazonas was the last Venezuelan federal entity to achieve the condition of State, in 1992. Until then it had been a Federal Territory with political authority appointed directly by the President of the Republic.

Since the creation of the MoHSW in 1936, prevention and promotion duties in Amazonas were assumed by the central administration through the Sanitary Unit located in the capital of the former Federal Territory. As in others territories with indigenous populations, the organisation, funding and provision of curative services historically had relied upon philanthropic and religious organisations. In 1937, a covenant was signed between the Federal Territory and the Salesian Society of the Catholic Church assigning to the latter duties in missionary actions as well as education and health care in places that lacked an official presence. Later, in 1947, a National constitution handed over to the Federal government the responsibility of technical and normative coordination of public health (Armada, 1997).

By 1947, besides the Sanitary Unit, there were in Amazonas other dependencies of centralised administration such as the Yellow Fever Special Campaign Local Office, established in 1937, and an administrative Zone of the Malaria National Control Programme established in 1954. The state had in its capital, Puerto Ayacucho, a small regional hospital that, a little later, in 1956, was merged with the national Sanitary Unit creating a Health Centre, financed and organised entirely by the MoHSW to deliver curative and preventive services but limited in its coverage to urban areas of the capital. In the rest of the former Federal Territory, the rural indigenous areas were served mainly by the religious organisations. In the following years the Health Centre broadened its competencies and started to co-ordinate the preventive activities of the recently created Rural Health Posts. These posts were dependencies of the regional government, and partially funded by the MoHSW which kept a directive and co-ordination role (Armada, 1997).

By 1961, the year when the Simplified Medicine Auxiliaries Programme was piloted, there were three Rural Health Posts irregularly staffed by foreign medical doctors in the face of a scarcity of Venezuelans physicians willing to work in that region (González, 1975; Armada, 1997). In this decade the increasing demand of a growing population and the implementation of the Programme led to the establishment of a network of outpatient clinics necessary in the capital and rural areas. A Primary Health Care level was progressively structured with Urban and Rural Health Posts in the capital and in the main villages of the interior districts. Since then Health Posts and the Hospital have been the basic structure of the Regional Health Care System. (Rodríguez-Ochoa, 1992; Armada, 1997; DSRS-Amazonas, 2002).

Nowadays, the presence of other institutions of the public sector in Amazonas, like the Venezuelan Institute of Social Security, the Institute of Social Assistance of Military Forces, the Institute of Social Assistance of Ministry of Education, are much less important when compared to the presence of the current MoHSD. The contribution of the private sector in the Amazonas health system is marginal. There are very few private health centres in the capital of the state, with limited specialities and medical technology and staffed by personnel, doctors, nurses, and other health professionals, who work for the public sector as well.

As a result of the decentralisation process Amazonas gained political and partial administrative autonomy, but in the meantime the evolution of the health system has been characterised by the increasing influence of, and dependence on, the national level through the Ministry of Health. This ambiguity reflects the fact that centralism was the main feature of the political and economical structure of the country from the beginning of the last century. Governor and Municipal authorities have been elected by popular direct vote since 1993. But in terms of the public health functions the decentralisation process in the state is poorly developed: health authorities are still appointed by the Minister of Health and the budget and programmatic guidelines come mainly from the central level (Armada 1997). The regional and municipal governments have not developed health

policies. There are managerial, financing and organisational constraints to be overcome in order to decentralise the health functions.

Currently, the administrative authority is represented by the Regional Directorate of Health, headed by a Director appointed by the Minister of Health in agreement with the Governor of the State. The regional headquarters combines the professional and technical staff who coordinate the health programmes and the administrative duties.

3.2 Auxiliares de Medicina Simplificada: Beginnings of the Community Health Workers Programme in Venezuela and Amazonas State

During the thirty years following the foundation of the MoHSW, the demographic situation of Venezuela progressively reversed. At the beginning of the 1960's the rural population was estimated at 30% of seven and a half million people. The country then had an oil-based economy and the health care in rural areas was still very precarious. Most of the territory did not have medical assistance and even those areas covered by Rural Health Posts were classified as "*zones of insecurity*" to emphasise the difference with areas with Districtal Hospitals or Health Centres labelled as "security zones"(González-Herrera., 2002). The majority of rural posts were staffed by untrained nurse auxiliaries whose functions were to help and assist medical doctors on their infrequent visit to rural areas (Pico-Méndez, 1998). Gastroenteritis, heart diseases, pneumonia, cancer and tuberculosis, were the major causes of mortality in the country, and in rural areas diseases were predominantly tropical and infectious (Arreaza-Guzmán, 1961).

Dr José Ignacio Baldó, one of the architects of the national health care organisation in the 1930's, was the pioneer of the idea of "simplifying " the level of complexity of health care to increase coverage of health care among the rural population (see Mondolfi-Dugat, 2002). For conceptualisation of the AMS

programme he was much influenced by experiences of medical education and health care in the USSR which he visited in the late 1950's. He was particularly interested in the *Feldshers*, non-professional medically trained personnel, working in rural health posts under the district health system supervision (Baldó, 1961).

These were the early 1960's and Venezuela was in the process of an Agrarian Reform that pervaded the political discourse and public policies and is repeatedly mentioned as a context for the AMS programme (see Baldó, 1961). But these were also years of social and political upheaval in Latin-American, markedly influenced by the Cuban revolution of 1959 (Ugalde 1985). This governmental policy has been understood as the contribution of the health sector to assisting in suppressing the emergence and spread of guerrilla movements in the country (Briceño-León *et al.*, 2003).

Baldó worked alongside Dr Arnoldo Gabaldón, another outstanding figure in the Ministry since the 1930's. Gabaldón had an international reputation in the organisation of the malaria control programme (Litsios, 1998) and also helped to shape the structure of the health care system in Venezuela. He was appointed to the Ministry of Health in 1959 and remained in office until 1964, the period that covered the launching of the AMS programme. Both, Gabaldón and Baldó were committed to the social-democratic political project prevailing in the country, both were charismatic leaders who created a vision, mobilised commitments and institutionalised values in the Ministry.

AMS was conceived as a programme of the Venezuelan Ministry of Health (MoH) with the specific goal of delivering basic health services in hard-to-reach rural areas through a cadre of employees selected by their own communities and trained, supervised and backed up by regional health systems (González, 1975; MSDS, 1999).

In the beginning of the programme the medical establishment strongly opposed the idea (López-Ramírez, 2002) worried about excessive delegation of curative tasks on lay personnel (MSDS, 1999). To overcome the resistance, the determined

high level unit of health officers led by Baldó decided to pilot the Programme in Amazonas state, deemed to be, "*free from the prejudice and criticism where it was inconceivable that doctors could ever practice ... and [where] populations suffered from extreme poverty and the cultural and anthropological characteristics of nomadic and semi nomadic populations were still in the tribal phase*" (González, 1975, p.171).

The programme was piloted in remote indigenous areas in Amazonas State, the opposition of the professional bodies was progressively diminished and the AMS was officially launched. Finally in 1963 the Medical Federation manifested its decision toward the AMS Programme in the following terms: *"The XVIII Assembly of the Venezuelan Medical Federation ...supports the Simplified Medicine Auxiliaries Programme.... Its development must be preceded by the creation of Rural Health Posts and other local health services hierarchically linked, necessary to guarantee the operation of the system"* (MSDS, 1999, p.7; González-Herrera., 2002, p. 142).

The AMS programme received strong governmental support and was scaled up to the whole country contributing to an increase in the official presence of the state in rural areas through the health services aimed at improving living conditions particularly of the peasants. The community health workers received support from regional health systems, some of them were incipient systems such as in Amazonas, which grew under the impulse given by the AMS programme.

The following years were marked by the success of the AMS, success measured in operational terms by the number of personnel trained, and curative, preventive and promotion activities carried out as well as the extent that AMS increased access to health care to people previously underserved or not-served at all (Lobo-Castellanos, 2002).

At the international level, AMS gained the attention of health agencies and governments of other countries. In the early 1970's Venezuela was visited by health ministers, officers and planners, included Halfdan Mahler, General Director

of the World Health Organization, who was interested in the success of this experiment as an alternative to improving the health of communities (Lobo-Castellanos, 2002). The Venezuelan AMS experience contributed to the shifting in international health policy expressed as *Primary Health Care* embodied in the historical Alma Ata Declaration of 1978 (Newell, 1975b; Benyoussef and Christian, 1977; Walt, 2001; Hall and Taylor, 2003).

The direct effect of the AMS programme on regional health care systems in the country has been widely recognized. Given that a basis for the programme implementation was its insertion into an organized work structure, federal entities like Amazonas received assistance and resources from the national level to structure a system to satisfy a doctrinaire principle and a requirement of the medical professional body.

It was considered that regional governments by themselves would not give guarantees for the development of the programme on the terms established by the Ministry and required by the Medical Federation. This demanded inter-governmental cooperation that was the beginning of "*Cooperative Services*", linking efforts from the regional and national government to create a health care organisation with its structural alignment of people and processes.

In the next decades, from the 1960's to the 1990's, the presence of the Ministry of Health and Social Welfare increased in Amazonas state, financing and organising the health care system, growing with Rural Posts, staffed by Medical Doctors and AMS. This has been emphatically hailed as one of the most important benefits yielded by the Programme: "....., *[It] brought, as a consequence, a betterment in the infrastructure at the district and regional level, [and] a higher degree of assistance by the national level in all the aspects [such as] an undeniable impulse for agreements and covenants between the Ministry and Regional Governments... New rural health posts were built and health units and hospitals were improved. Demonstrative [examples] of the above mentioned were Apure and Amazonas [States]*..." (Lobo-Castellanos, 2002, p. 154).

Successive cohorts of nurses, missionaries and indigenous AMS were trained in Amazonas and sent to remote areas backed up by the incipient health organization. To have an idea of the expansion of the national primary care level, in 1950, Venezuela had 482 Rural Health Post Type I (formerly "*dispensarios*") staffed by very badly trained workers (González, 1975); in 1986 the number of these health posts was 1,913, staffed by trained AMS; and in 1997 the number of Posts had increased to 2,084 (Pico-Méndez, 1998). In Amazonas, the numbers of Rural Health Posts Type I increased from very few in 1961, to 50 staffed by AMS in 1986, 67 in 1997 (Pico-Méndez, 1998) and to 80 in 2004[3].

After four decades AMS remains a programme of the Venezuelan Ministry of Health covering approximately 1,700,000 persons (7% of the national population) (MSDS, 1999). Within this are included the great majority of the indigenous population of the country representing 2-3% of the general population and located mostly in frontier states (OCEI, 1992; INE, 2001).

3.3 Today's shifting context in Venezuela and Amazonas

3.3.1 Primary Health Care in the Reforms agenda

Since 1998 Venezuela has been going through the most dramatic political upheaval in its contemporary history (Wilpert, 2003; Feo and Siqueira, 2004) characterized by deep political change, health sector reform, social mobilization and the recognition of indigenous rights. The election of Hugo Chávez to the Presidency of Venezuela has been the point of departure of a movement which is known as the "*Bolivarian Project*" (after Simón Bolivar, Latin American hero, who in the early 19th Century won independence from Spain for five Andean countries: Perú, Ecuador, Bolivia, Colombia and Venezuela). The political project

[3] Source: Nurse Department Regional Directorate of Health, Amazonas, 2004

lead by President Chávez has been the subject of national and international controversy. Some scholars and politicians would agree when it is characterized as "*A strong progressive, redistributive and participatory democratic impulse*" (Wilpert, 2005) embodied in a new Constitution written, for the first time, with indigenous minority representation and voted for democratically in 1999. The legal framework has shaped conditions "*for the development of a new health system confronting the neoliberal platform that has characterized most health sector reform in Latin America* " (Feo and Siqueira, 2004), and for "*a new paradigm in the relationship between the State and Indigenous People, based on the coexistence of different cultures"* (Clarac, 2001). The preamble of the Constitution states the pluriethnic and multicultural nature of the Venezuelan Society and includes a specific Chapter on Indigenous Peoples Rights (Annex 1).

There were also significant changes in the health framework. The Constitution explicitly endorses Health as a Social Right and the role of the state as guarantor. It incorporates notions of health promotion and prevention as priorities of the national public health system governed by the principles of universality, comprehensiveness and is free of charge. It also includes community and individual participation as a right and duty in the decision making process concerning policy planning, implementation and control over public health institutions (Articles 83 and 84, Chapter V, Social and Family Rights; see Annex 1).

Several reforms in the sector have been implemented during the tenure of the new government. Each reform has had Primary Health Care as a cornerstone concept, with equity, and universal free health care as fundamental principles, thus following the Constitution.

The first reform launched in 1999 focused on the organisation of health care delivery, fostering the integration of programmes with the launching of a "*Comprehensive Services Delivery Model*" ("*Modelo de Atención Integral"*) (MSDS, 2001b). During 1999 to 2001 efforts were made to integrate activities of

vertical control programmes into the primary level of care nation-wide. Regionally, in Amazonas, it was during this period that the premises of the Directorate of Regional Health and the regional headquarters of the Malaria Control Programme were fused. They have been separated geographically and administratively and this is the first time that regional unity of command has been established. In the mean time, the AMS were officially integrated into the activities of the active and passive case detection of the Malaria control programme. This represented a significant moment for a much centralised programme, being integrated into Rural Health Posts in the hands of the AMS. Several cohorts of active AMS were trained in basic microscopy to diagnose the main endemic disease in the State.

In 2001 a new policy was launched, linked to the integration of health care activities but focusing on planning as a strategic tool. The policy aimed at the effective articulation of social development policies that cross the boundaries of health, education and productive sectors. Within the "*Strategic Social Plan*", planning was conceived as a strategy to ensure inter-sector cohesion and coordination, and the reform intended to place health as the axis with which to articulate comprehensive social development policies (MSDS, 2001a).

Within this reform there were official announcements of reorganisation of the levels of health care in *Networks*, and within the *Primary Care network* the role of the AMS was blurred. Even in the rural areas the *Primary Care Nucleus*, the name given to the most distal Health Posts, were to be staffed by medical doctors, nurses and Health Promoters, with no mention of the AMS (MSDS, 2001b).

At the end of 2002, a representative from the national level of the Ministry of Health, an experienced Nurse civil servant who had for many years been the national coordinator of the AMS programme, visited Amazonas to promote the new organisation of health care in networks. During this visit she made a verbal public announcement that the AMS were to be transformed into Health Promoters, and that the Program was eventually to be eliminated.

There was never an official formal document regarding the elimination of the programme, but given that the source of the information was a former national officer linked to it, the regional coordination reacted in consequence. Since then, no more training courses have been opened in Amazonas.

In the mean time the political climate in Venezuela has been one of increasing unrest. The legitimacy of Mr Chávez government has been vigorously questioned. This lead to a failed coup in April 2002, and to a general strike from December 2002 until February 2003. The impact was not enough to force the president's resignation, and the government managed to control the uprising. The political struggle was set into the constitutional framework and efforts of the opposition were then funnelled to call for a *national referendum*, a legal resource included in the Constitution of 1999[4]. The political wrestling between the government and the opposition lasted for 18 months, until August the 15th, 2004, when the electoral consultation took place. This date corresponded with the end of the field work of the thesis.

During the period from the failed coup of 2002 and the referendum of 2004, the implementation of new social programmes targeted at the less well-off sector of the population were begun. These provide literacy teaching and adult education, and increase access to community health care. They also promote local cooperatives, employment training and the distribution and delivery of food through a chain of subsidized supermarkets. These programmes crossed sector boundaries and were rapidly refined to constitute the main basis of massive social policies named by the government as *"The Missions"*.

[4] "Article 72: All magistrates .. filled by popular vote are subject to revocation. Once half of the terms of office ... a number of voters constituting at least 20% of the voters registered .. may extend a petition for the calling of a referendum to revoke such official mandate". Chapter IV Political Rights and Public Referenda Venezuela (1999) *Constitución de la República Bolivariana de Venezuela.*

Since September 2003, the MoH assumed a new health sector reform, one of the massive social programmes named "*Barrio Adentro Mission*[5]" with the basic objective to increase free access to medical attention through community based heath care services.

Barrio Adentro had started as a campaign restricted to the slums or shantytowns of Caracas and rapidly extended nation-wide, mainly focused in overcrowded areas of bigger cities. The campaign was implemented through a cadre of medical doctors coming from Cuba. Initially the cadre arrived in Venezuela during a humanitarian crisis due to the country's worst disaster in a century, massive landslides and fast-floods that in December 1999 affected the mountainous coastline with more than a million people affected and up to 30,000 died (IFRCRCS, 2001). The Cuban medical doctors remained in the country and progressively increased in number, now within the framework of a binational agreement of services-by-oil exchange.

For the fast implementation of *Barrio Adentro* it was considered necessary to avoid the rigidity of the bureaucratic structure of the Ministry of Health. The extension of services provided by the Cuban Doctors was then conducted as a parallel system to the Ministry of Health, through the regional and local governments identified with the "*Bolivarian project*". The Minister of Health publicly explained the reason "*...the structural response to the health situation (in Venezuela) is Barrio Adentro . [It] was launched as a parallel system, because of the backwardness of the Venezuelan state structure. And we couldn't wait until its transformation to guarantee health (to the population)..*" (Davies, 2004a).

National medical bodies activated judicial actions against the *Barrio Adentro Mission* arguing that illegal medical practice by unauthorized foreigners and the use of unregistered medicines was happening. The legal claims went to the Supreme Court that decided the Cuban doctors ought to be replaced by

[5] Barrio refers here to the overcrowded neighborhoods of poor people, slums or shantytowns, living in the main cities of Venezuela and *Barrio Adentro* can be translated as "*The Barrio inside*".

Venezuelans (Yánez, 2003; Tabuas, 2003). This did not happen and the implementation went forward. Progressively *Barrio Adentro* got extended to other federal entities and it was officially hailed as "*the most important health policy of the new Venezuelan state, [and] the basis of the National Public Health System, the way to make Primary Health Care concrete"* (MSDS, 2004). The policy explicitly reaches "*zones and areas where indigenous peoples live*" (MSDS, 2004).

The PAHO-WHO representative in Venezuela gave public acknowledgement to *Barrio Adentro* declaring that "... *WHO support the Barrio Adentro programme [which has had] a positive impact on 17 million people covered in very short time. We have spent years talking about this, and all of a sudden, with a political decision, we achieved the goal...the challenge is to nationalize the programme with a cadre of Venezuelan professionals able to assume the duty...Barrio Adentro can hardly coexist with the conventional medical system, that has to be transformed and adapted to Barrio Adentro, giving priority to the poor, peasants and indigenous people*" (Davies, 2004b).

In States like Amazonas, with a Governor identified with Chávez's political project and with a health sector not decentralized, it was politically feasible to implement the *Barrio Adentro Mission* in a hybrid way. On the one hand, the regional government managed to find houses in urban crowded neighborhoods of the capital, Puerto Ayacucho, where Cuban doctors attended patients and live, and on the other hand the *Mission* was also implemented within the official health structure, utilizing Health Posts infrastructure and health personnel already working in them.

In the framework of *Barrio Adentro,* some urban and rural health posts in the capital and the main towns of the interior already staffed with Venezuelan Doctors, were reinforced with Cuban professionals. In the periurban areas of the capital District, Atures, some Health Posts, until then occupied by single-handed AMS, were staffed with Cuban doctors.

3.3.2 Indigenous People's Health in the agenda

The constitution for Indigenous People's Rights opened a political space for indigenous organisations and increased expectations have arisen regarding the designing, planning and provision of sensitive and appropriate health services (Rivero *et al.*, 2002).

Until recently there had not been specific health policies or health programs designed and/or adapted to indigenous population. In 2003, the Ministry of Health created a Working Group of Health and Social Development for Indigenous Peoples and Communities that was upgraded in 2004 to a National Coordination of Indigenous People's Health (NCIPH) (Reverand *et al.*, 2004). Its aim is to design policies and strategies for developing the principles established in the Constitution regarding indigenous people's right to health, such as culturally appropriated services and recognition of traditional practices. Since the creation of the Working Group some initiatives have been announced including professionalisation of indigenous healers through their integration into PHC, promotion of schools of shamans to guarantee the promotion of intercultural principles in the training courses of health personnel, and the review and adaptation of the *Barrio Adentro* programme to indigenous areas.

In all these proposed initiatives the figure of AMS remains ambiguous. Official documents concerning Primary Care in the country have not explicitly mentioned the AMS and the training and recruitment of new AMS have stopped in Amazonas and other states. While the AMS programme is "unofficially" being phased out country-wide, the AMS retain their functional duties in Amazonas. In some periurban areas around the capital city, medical doctors have come to work in health posts where traditionally AMS work by themselves. In other areas, the majority, continue to work single handedly. It was therefore timely to revisit the role of AMS in Amazonas and to assess their eventual contribution in the light of current debates about health sector reform and indigenous rights in the country.

CHAPTER 4: Methodology and Methods

In this Chapter the methodology and methods used for the thesis are described.

4.1 Methodological approaches

For the purpose of this study it was assumed that several ontological perspectives relate and connect to help to understand the role of the Auxiliaries. Attitudes, beliefs, views, ideas, perceptions, representations and constructions shape and are expressed in this role. The *reality* where this takes place is a result of historical, social and political processes and therefore socially constructed (Patton, 2002, p. 96; Green and Thorogood, 2004d, p.13). A constructivist approach was adopted and qualitative methods used to study this reality on an empirical basis. *Empiricism* and *value-free inquiry* are elements of a *positivist* approach to knowledge (Green and Thorogood, 2004d, pp.11-12). For this study it is considered that human and social processes, such as research and health care, are not value-free, but on the contrary, are value driven (Bowling, 2002, pp.103-111; Green and Thorogood, 2004d, p. 13).

Qualitative approaches are best suited to study these social processes as they are able to explore the meanings that the AMS attach to their role and practices and to their interaction with their communities and the health system. The usefulness and role of qualitative approaches lies in their ability to answer these types of questions that cannot be answered from a quantitative perspective. Qualitative approaches aid in the understanding of different perspectives on how reality is constructed and provide evidence for the development of appropriate policy (Mason, 1996; Silverman, 2000; Green and Thorogood, 2004d, p. 24).

The research design allowed a circular process using an iterative and inductive approach [6] flexible enough to incorporate new questions arising during the research process (Mason, 1996; Silverman, 2000; Green and Thorogood, 2004b) . For this study no hypothesis was previously stated. An initially inductive approach was appropriate for a setting such as primary care services in Amazonas in which little or no research has been done, and allowed at the start of the research an exploration of the relevant themes and the most useful avenues for deep enquiry. I also took elements of a holistic approach for health programmes evaluation, a *"story telling approach"*, that requires the researcher-evaluator to undergo a process of socialisation where s/he not only observes but participates in the processes being evaluated, and from this experience and other pieces of evidence builds a multisided picture of a complex situation (Jan, 1998). This approach was intended to incorporate the perspectives of social actors[7], emphasizing the subjectivity emerging from the evaluation-research process of health programs such as the Auxiliaries, and health services such as the primary care posts (Uchimura and Bosi, 2002).

Ethnographic methods were used including in-depth and group interviews and participant observation. Data generation started with preliminary visits to health posts in periurban areas of Puerto Ayacucho and informal interviews with Auxiliaries and Medical Doctors.

From the designing of the project I was concerned about the hierarchical relations between me and the Auxiliaries (see *Reflexivity* in this Chapter). A strategy to reduce the potential effect of this relationship was to engage a Research Assistant (RA), a young female anthropologist with no previous experience in Amazonas, to

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[6] Inductive and deductive reasoning constitute an important component of scientific reasoning and knowledge. Inductive reasoning begins with the observation and builds up ideas and more general statements. With deductive reasoning the researcher starts with general ideas and a testable hypothesis that is then tested by gathering and analysing data. Bowling A (2002) *Research methods in health: investigating health and health services.* Buckingham: Open University Press., p. 120-121

[7] Approaches alternative to positivism, emphasise that social reality cannot be understood by facts but by the meaning that different members of the social world attribute to these facts. These members are termed as "actors". Ibid. p.111-112

conduct interviews, do observation and participate in the preliminary analysis of the data gathered.

Issues and questions identified during preliminary observations and informal interviews were extensively discussed with the RA and were further explored in formal interviews and participant observation aided by general guides and techniques previously tested and refined.

As far as possible interviews and observation were conducted in communities and health posts, "natural" environments of the Auxiliaries, focusing on the understanding of the world from their perspective and on capturing the importance of real-life context (Bowling, 2002; Green and Thorogood, 2004d).

Interviewing has a long history in research and is probably the most used method for gathering qualitative data (Fontana and Frey, 1994; Green and Thorogood, 2004c). Interviews were conducted within this project to gather information about the accounts, reported experiences and judgments of the participants in order to understand the world from their point of view (Green and Thorogood, 2004c), to help to construct evidence in relation to perceptions, opinions and understanding of the actors, being specially concerned with how interviewees actively create meaning (Silverman, 2000, p. 95).

Information gathered by interviews was also complemented with that obtained through observation. From the moment when this project was being designed in London it was clear that it was not possible for me as PI to conduct non-participant observation given my known previous role and status of medical doctor and regional health officer. It was not feasible to make my self invisible in the settings where the observation was to be conducted, therefore participant observation was adopted.

Participant observation in selected posts was carried out to approach the daily routine and social interactions of the AMS, their relations with medical doctors (when present), their communities and other members of the regional health

system. The observation period was also useful to informally talk to a wide range of actors and particularly with the Auxiliaries.

Participant observation entails the researcher participating in the every day lives of a group in a particular setting as communities or health posts (Patton, 2002, p. 265). While "participant" means becoming an "insider", being an "observer" has to do not only with watching and recording systematically but of being an "outsider" with a theoretical and ideological understanding of society through which the detail in the field are constantly compared. The role of "participant" and "observer" are always in tension (Wright, 1994, p.11). During the whole research and particularly during the observation I was aware and conscious of this tension that was an object of constant reflexivity (see p. 62 this Chapter).

Verbatim transcriptions of interviews were conducted almost immediately. Their content and those of our field notes were subject to constant reflection and discussion with the RA. Besides this, seminars were held to share insights with professionals of several disciplines working in the area and on two occasions feedback was given to groups of Auxiliaries who were consulted about the preliminary results and to prepare a closing workshop attended by Auxiliaries and health officers as well as actors from local, regional and national levels. This workshop was conducted with several purposes in mind: validating and gathering data, the dissemination of preliminary results and as the first intervention consequence of this study.

4.2 Study Site

Amazonas state is located in the southern region of Venezuela. It has an area of 180,475 Km^2 that represents 20% of the national territory, with 1,650 Km of international border, 960 Km with Brazil and 690 Km with Colombia (Figure 1).

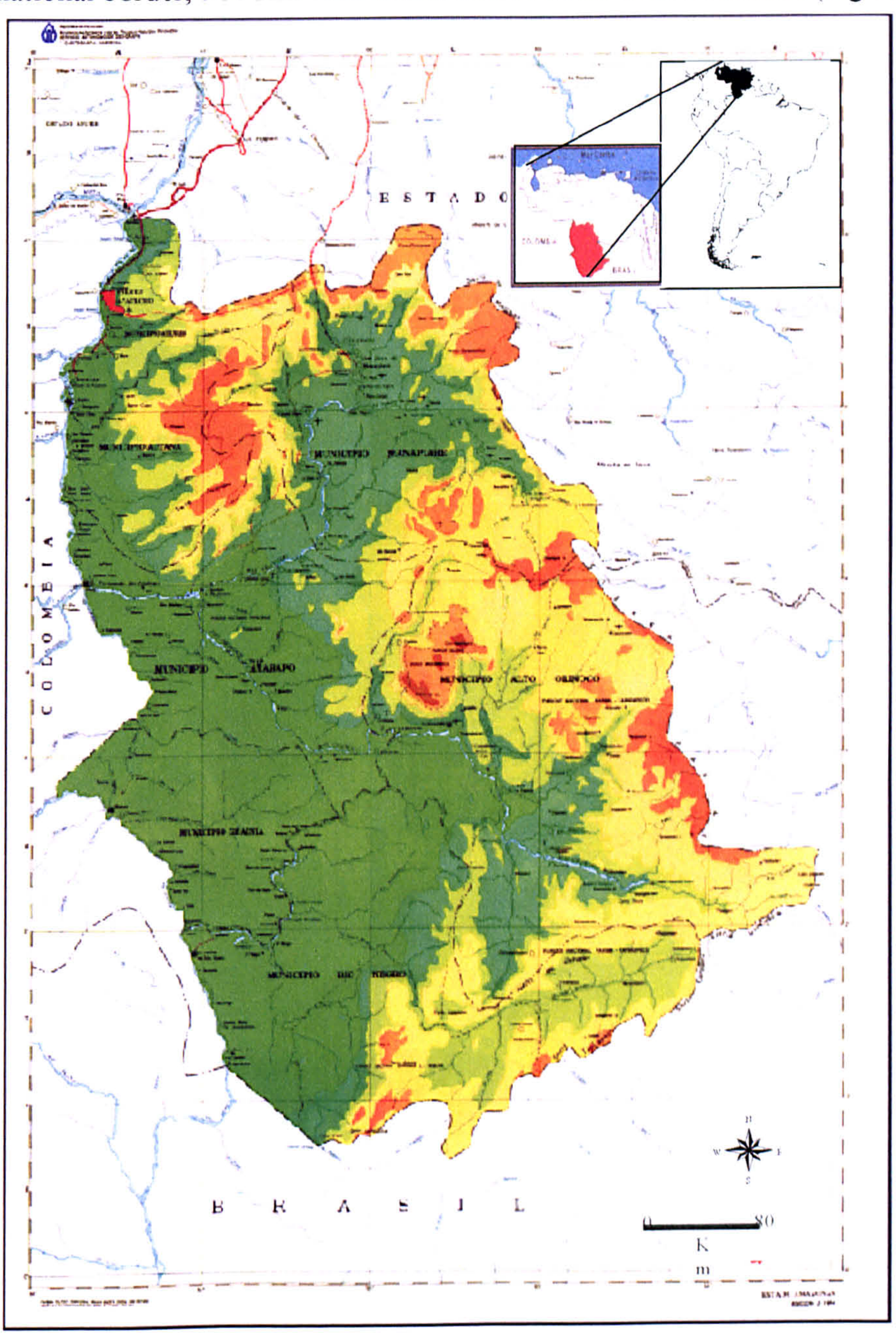

Figure 1. Amazonas state, Venezuela

The public health system is nominally divided into seven Health Districts connected to the political-administrative division of the State and its Municipalities (Figure 2). It is only nominal because none of the Health Districts have technical or administrative independence from the capital.

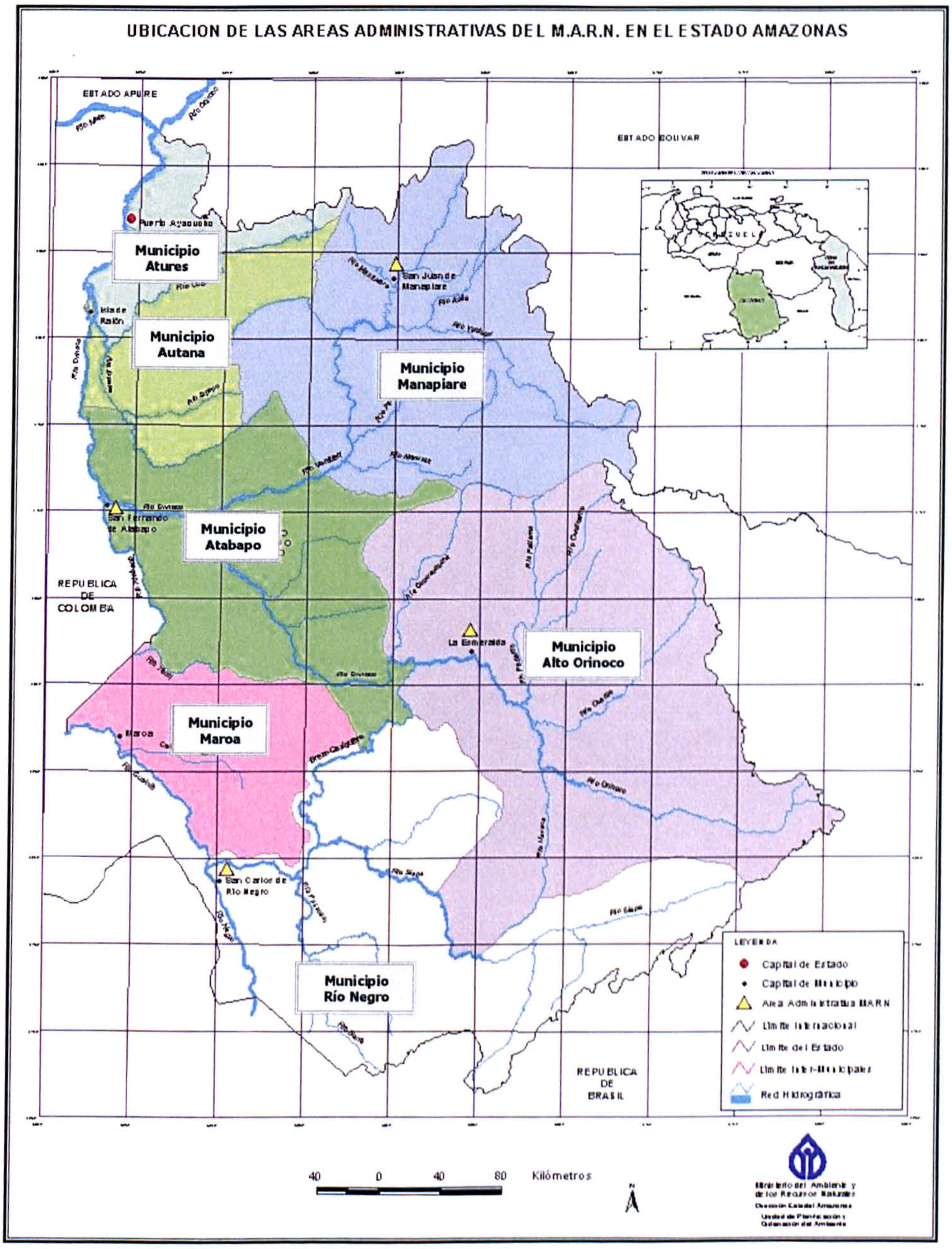

Figure 2. Political-administrative division and Health Districts of Amazonas

The current structure of the regional health services is as follows:

- A 65 bed Hospital with basic specialities and amenities located in the capital of the state, Puerto Ayacucho.

- 21 Urban and Rural Health Posts, staffed by Medical Doctors and, occasionally by Dentists, all in their first years of professional activities. They are backed up by Auxiliary Nurses, and, in some posts, by AMS. The official nomenclature classifies these Posts as Urban Health Post Type I (UHP-I) and Rural Health Posts Type II (RHP-II). These health posts cover limited areas of Puerto Ayacucho (UHP-I), and the main villages of periurban areas of the capital and of the Municipalities in the interior (RHP-II).

- 80 Rural Health Posts I (RHP-I), located in villages at some distance from the RHP-II. RHP-I are staffed by the AMS.

AMS are located in RHP-II, working with rural medical doctors, and mainly in RHP-I facilities, they work by themselves, single-handedly, and, theoretically, regularly supervised by radio and through periodic visits by medical doctors of RHP-II and officers from the regional and national level.

In this basic structure, shown in table 1 and figure 3, there is no intermediary level between the Health Posts and the Hospital.

Table 1. Health Care Services in Amazonas state, Venezuela

Health District	Hospital	Health Posts				Total of Services
		Urban Health Post I	Rural Health Post II	Rural Health Post I	Total of Health Posts	
Atures	1	8	3	24	35	36
Atabapo			1	9	10	10
Río Negro			1	1	2	2
Alto Orinoco			5	12	17	17
Manapiare			1	14	15	15
Maroa			1	4	5	5
Autana			1	16	17	17
Total	**1**	**8**	**13**	**80**	**101**	**102**

Source: Nurse Department Regional Directorate of Health, Amazonas, 2004.

Atures Municipality has approximately 70% of the state's population, the only Hospital, and it is the only district that has a road axis that links the city with the periurban communities. The rest of the districts, where most of the scattered indigenous communities are located, are accessible by plane or boat, through many rivers.

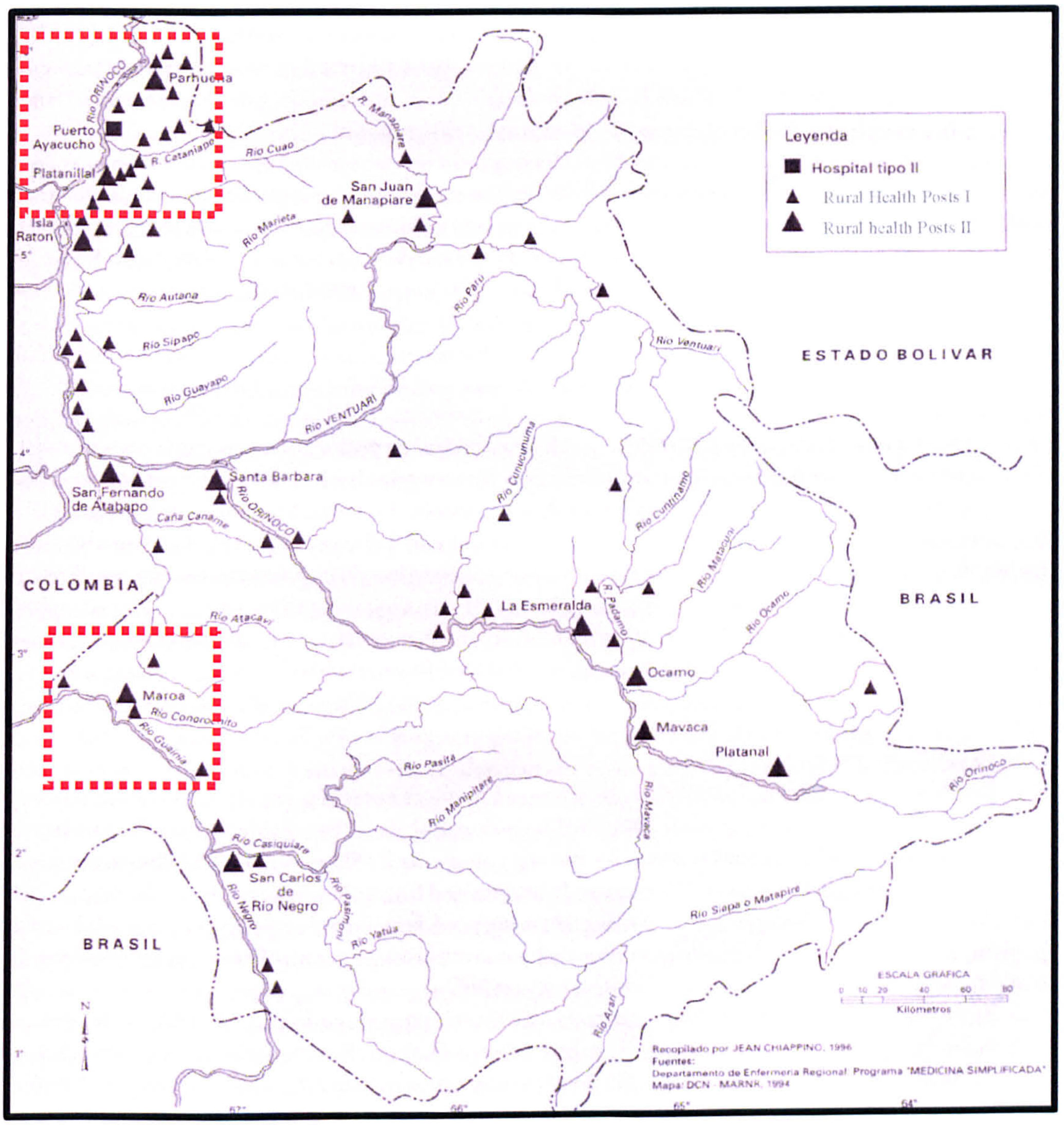

Figure 3. Health Care Services in Amazonas state with study area inside red squares.

4.3 Study Population

Amazonas has the lowest density and the highest diversity and proportion of indigenous population in the country. About 50 % of its 119,564 inhabitants are indigenous belonging to 14 different ethnic groups (OCEI, 1992; INE, 2001; MARN, 2004) (Figure 4).

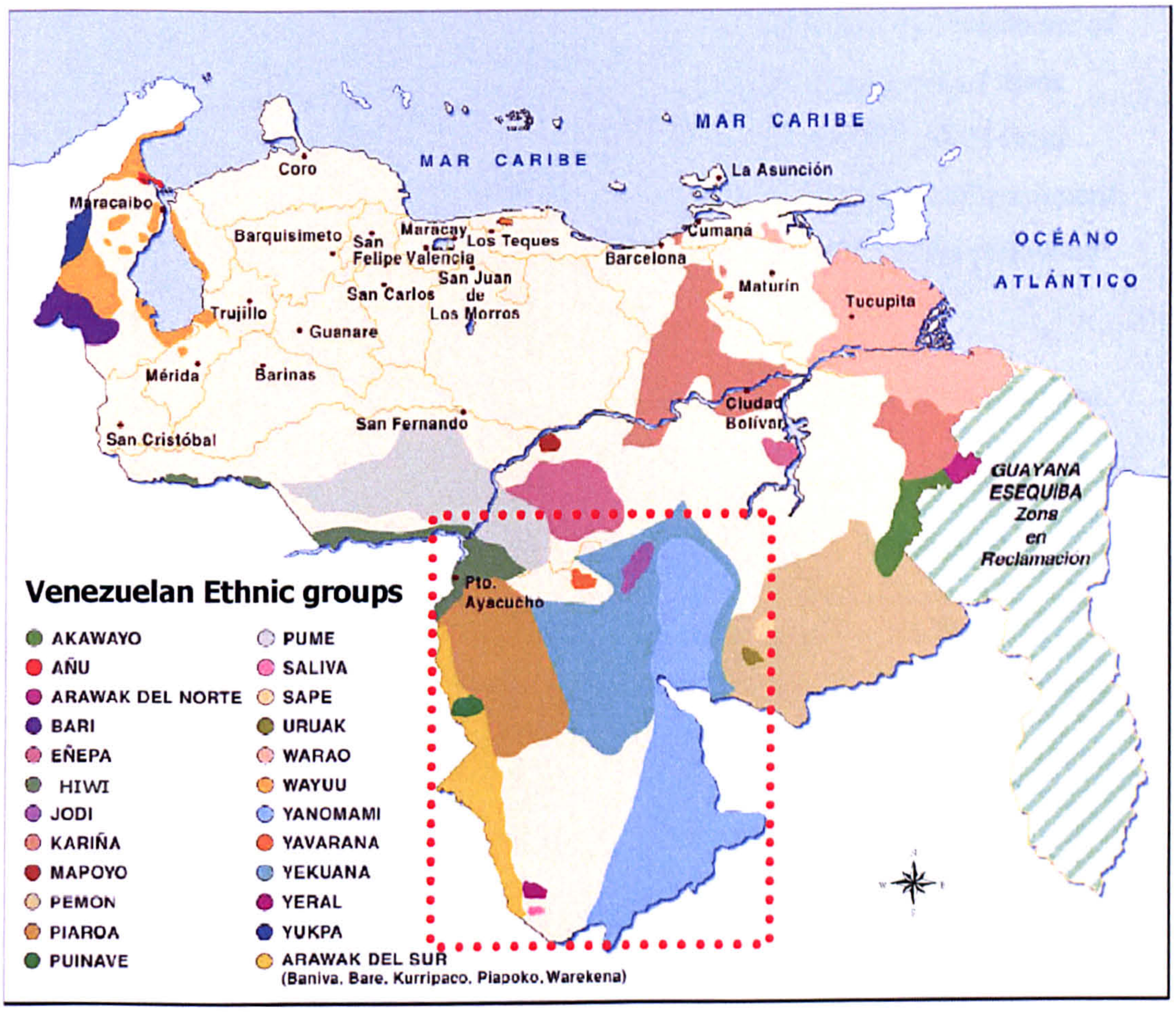

Figure 4. Venezuelan ethnic groups: There are 28 indigenous groups in the country with an estimated indigenous population of 534,818 that represents 2.1% of the general population. Fourteen of the 28 groups inhabit in Amazonas (dotted red square in this figure).

Most of the indigenous population of the State live in 649 scattered communities in the periurban areas of the capital and in the interior (INE, 2001; MARN, 2004). Atures Municipality has the highest proportion of indigenous population in the State; however most of the population in this Municipality that includes Puerto Ayacucho the capital, are *criollos*[8]. In municipalities of the interior, like Maroa, 90% of the population is indigenous.

According to the records of the Nurse Department of the Regional Directorate of Health there are 104 AMS currently working in Amazonas state. All of them indigenous. There are only four females currently active as AMS, all of them working in RHP-II. The distribution of AMS by Ethnic group, time of enrolment in the programme, District and type of Health Post is presented in the following tables:

Table 2. Distribution of AMS by Health District and Type of Health Post in Amazonas state, 2004

Health District	No. of AMS by type of Health Post		Total of AMS
	RHP II	RHP I	
Atures	4	24	28
Atabapo	2	11	13
Rio Negro	4	1	5
Alto Orinoco	5	11	16
Manapiare	2	13	15
Maroa	4	4	8
Autana	2	17	19
Total	23	81	104

Source: Nurse Department Regional Directorate of Health, Amazonas, 2004.

[8] "*Criollo*" is a term used in Venezuela to refer to non-indigenous people.

Table 3. Distribution of AMS by Ethnic Group in Amazonas state, 2004

Ethnic Group	No. of active AMS
Piaroa	38
Hiwi	20
Yekuana	18
Yanomami	5
Kurripaco	11
Baré	5
Baniva	2
Puinabe	2
Piapoco	1
Yabarana	1
Warekena	1
Total	**104**

Source: Nurse Department Regional Directorate of Health, Amazonas, 2004.

Table 4. Distribution of the AMS by type of health post and time of enrolment in Amazonas state, 2004

Enrolment decade	Type of Health Post		Total
	RHP-II (with MD)	RPI-H (no MD)	
1965 – 1979	2	5	7
1980 – 1989	8	25	33
1990 – 2002	13	51	64
Total	**23**	**81**	**104**

Source: Nurse Department Regional Directorate of Health, Amazonas, 2004.

The Department for Human Resources of the Directorate of Health in Amazonas includes on its payroll 120 Venezuelan doctors as currently working in the State. The majority of them are concentrated in the Hospital and the Directorate offices, and around 25 of them in Primary Care Services such as UHP-I, and RHP-II (see table 1).

4.4 Pilot Work

The study started with preliminary visits to health posts in periurban areas of Puerto Ayacucho and informal and in-depth interviews with several actors. These interviews carried out during the pilot work were transcribed and analysed in order to identify the salient themes to be incorporated into those themes already foreseen at the time of the design of the study. From a list of questions we progressively refined a guide for the definitive interview schedule (Annex 2a and 2b).

Visits, conversations and discussions were also carried out with several purposes: a) to look at feasibility and predict problems, b) to promote participation in the subsequent stages of the research design, c) to determine the expectations of the research and to discuss and define how to fulfil them, d) to share insights and ideas between the research team for the subsequent phases of the study, and finally e) to look at alternatives to explore responses to the implementation of *Barrio Adentro* that has not been considered when this study was initially designed.

4.5 Sampling of Districts, Actors and Health Posts

Sampling in qualitative research is intended to allow in-depth understanding rather than empirical generalisation. In this thesis a purposeful sampling was used. Purposeful or *purposive* sampling involves the selection of *information-rich* cases from which one can learn about the issues of central importance (Patton, 2002, p.230). Variations among the AMS in terms of health district, years of experience, experience working single handed or with medical doctors, and ethnic group were approached using an *heterogeneity sampling strategy* that aims at describing central themes that cut across the variations, applying the logic that any common patterns that emerge from those variations are of particular interest and value in capturing the core experiences and shared dimensions of a setting (Patton, 2002, pp. 234-235).

4.5.1 Health Districts studied

Two health districts were selected mainly under the criteria the of feasibility: 1) **Atures District** with the largest number of health facilities, personnel, services accessible by road axis, and 2) **Maroa District** the least populated of the interior (INE, 2001; CNE, 2005) with scattered communities served by five health posts accessible by boat, all but one exclusively attended by *Auxiliares de Medicina Simplificada* (table 4 and figure 3). In my professional experience in Amazonas, Maroa was the only district where I had not been before and this was considered an advantage as I had had no previous or scarce interaction with the AMS of this District.

Table 5. Summary of Study Site and Population of two Districts selected

	District	
	Atures	**Maroa**
Extension (Km^2)	7,550	14,250
Estimated Population	78,044	1,654
Estimated Indigenous Population	22,152*	1,524
Ethnic Groups	Piaroa, Hiwi, Kurripaco	Kurripaco, Baniva-Baré, Warekena and Yeral

*The estimated population living in periurbans and rural communities of Atures is around 11,804.
(Figures from the Department of Epidemiology, Regional Directorate of Health, Amazonas, 2004

4.5.2 Auxiliares de Medicina Simplificada

Twenty eight AMS working in Atures and eight working in Maroa Municipalities constituted the basic sampling frame for this study. A sampling grid was created categorizing AMS of these two districts by decade of enrollment in the programme and by the type of Rural Health Post they worked in.

Most of the periurban communities of Atures district were served in a direct and permanent basis exclusively by Auxiliaries until the launching of "*Barrio Adentro*". From October 2003 (coincidentally when this thesis proposal was

discussed and approved at the LSHTM), seven periurban RHP-I in Atures were newly staffed with Cuban medical doctors. It was therefore important to sample across the presence or not of Cuban medical doctors to explore changing roles and responses of AMS in this new circumstance.

Table 6. Sampling grid of Auxiliaries according to time of enrolment and type of health posts in Maroa and Atures Districts.

Sampling grid	Type of Health Post				Total	
	RHP-II		RHP-I			
Enrolment decade	**Maroa**	**Atures**	**Maroa**	**Atures**	**Maroa**	**Atures**
1965 – 1979	1	-	2	1	3	1
1980 – 1989	-	3	1	12	1	15
1990 – 2002	3	1	1	11	4	12
Total	4	4	4	24	8	28

Table 7. Sampling grid of Auxiliaries according to time of enrolment and type of health posts in Maroa and Atures Districts

Sampling grid	Type of Health Post		Total
Enrolment decade	**RHPII (with MD)**	**RHPI (no MD)**	
1965 – 1979	1	3	4
1980 – 1989	3	13	16
1990 – 2002	4	12	16
Total	8	28	36

Seven out of the eight AMS working in Maroa, and 12 of 28 Auxiliaries in Atures were interviewed. Five of the AMS working in RHP-I in Atures were actually working with medical doctors in the frame of *Barrio Adentro* (See Annex 4.2).

Interviews were also held with: a) a very experienced AMS, who worked single-handedly in Atures for nearly 30 years, and who is already retired from his position b) a young Yanomami from Alto Orinoco District, trained as a

microscopist (Chapter 6 p. 96) and as AMS in 2001, and c) An AMS from the Yukpa ethnic group, from Zulia State, north east of Venezuela, with more than thirty years of experience.

Table 8. AMS interviewed in Atures

Enrolment decade	Type of Health Post		Total
	RHPII (with MD)	RHPI (no MD)	
1965 – 1979		1	1
1980 – 1989	1	6*	7
1990 – 2002		4**	4
Total	**1**	**11**	**12**

* Three of these six AMS started working with Cuban doctors since October 2003.
**Also two of these four AMS started working with Cuban doctors since October 2003.

Table 9. AMS interviewed in Maroa

Enrolment decade	Type of Health Post		Total
	RHPII (with MD)	RHPI (no MD)	
1965 – 1979	1	2	3
1980 – 1989			
1990 – 2002	3	1	4
Total	**4**	**3**	**7**

Table 10. AMS interviewed in Maroa and Atures Districts

Enrolment decade	Type of Health Post		Total
	RHPII (with MD)	RHPI (no MD)	
1965 – 1979	1	3	4
1980 – 1989	1	6	7
1990 – 2002	3	5	8
Total	**5**	**14**	**19**

4.5.3 Medical doctors

Four Venezuelan Medical Doctors were interviewed, one currently working in a Rural Health Post II in Atures District, and three with previous work experience of two to four years in Rural Health Post of the interior who continued working in Amazonas in different levels of care and with cumulated experience with the Auxiliaries. Contact and informal interviews and conversation with many Venezuelan and Cuban doctors were held during the study period and particularly during the participant observation in both of the health districts. Attempts were made to interview Cuban medical doctors but consent was not obtained.

4.5.4 Trainers and Supervisor Nurses

Nationally and regionally professional nurses have had the supervision and coordination role of AMS training and activities. Four experienced nurses were interviewed, one from the national level who was in charge of the programme between 1985 and 2003, and three from the regional level. One nurse from the regional level coordinated the training courses for more than two decades until 1998, and the second was a former supervisor of the AMS. The third nurse was the head of the Nurse Department also with experience as a training coordinator. As with the medical doctors, we had many opportunities for informal conversations with these three health professionals during the study period.

4.5.5 Health Officers and politician

Two Health Officers were interviewed, the National General Director of Environmental Health, who is the former Regional Health Director and Medical Doctor in Amazonas state, and the current National Director of Primary Health Care. Both officers reside in the main headquarters of the Ministry of Health in Caracas.

Interviews were also held with one of the initiators of the AMS programme in the country, the former Minister of Health and Governor of Amazonas state who was involved in the launching of the AMS programme in the 1960`s. A further interview was also conducted with a politician who is a current member of the Amazonas state parliament.

4.5.6 Health Posts

To conduct participant observation in Atures and Maroa districts entailed methodological and logistical challenges. The selection of health posts related to feasibility. In Atures, where most of the AMS of the State are located, some issues were considered relevant for the sampling: Two main ethnic groups inhabit this capital district in overlapping geographical areas. The Piaroa and Hiwi populations are served in Rural Health Posts staffed with Auxiliaries that also belong to one of these ethnic groups. In total three health post were observed, one served by a Piaroa Auxiliary, and two others served by a Hiwi AMS, one working with Cuban doctors and the other single-handedly.

In the interior District of Maroa all but one of the communities with RHP-I and attended by AMS were visited but participant observation was conducted mainly in two of these health posts, one of the Kurripaco ethnic group and the other from the Baré-Baniwa ethnic group, both located in the riverside of Maroa River.

Table 11. RHP-I where PO was conducted.

	Atures District			**Maroa District**	
	El Progreso*	**Rayao**	**Los Paujies**	**Pueblo**	**Severiano**
Population	668	405	365	119	212
Ethnic Group	Hiwi	Hiwi	Piaroa	Baré-Baniva	Kurripaco

* *Barrio Adentro* was implemented since October 2003.

4.6 Data Generation

Data generation began in December 2003 and progressed uninterruptedly until completion in September 2004. A range of methods were used and these are described in detail below. All data was collected by the author assisted by the research assistant trained and supervised by the PI. In the middle of the data collection period (June- 2004) a visit of a member of the Advisory Committee at the LSHTM took place. This visit was for the purpose of supervising the data collection process, to extensively discuss about the methods used in the field and to prepare further in-depth analysis of the data.

4.6.1 Documentary Analysis

Available versions of the AMS programme since 1961 until today were reviewed. Planning documents, policy statements, reports, pamphlets, health- post diaries and news from journals were examined to provide descriptions, narratives and a chronology of events relating to the launching, implementation and evolution of the programme as well as primary health care policies in Amazonas.

4.6.2 Interviews

Four main types of interview were conducted. ***First. Twenty-two interviews of AMS,*** 19 active from Atures or Maroa, one retired AMS, one Yanomami and one Yupka AMS (See p. 54, this Chapter). All these interviews explored perceptions regarding their identity as Auxiliaries and as Indigenous, their feelings and opinions about the training course, their relations with their communities and the regional health system and the perceptions of the reforms in the health sector and the constitutional changes. Each interview lasted between 60 and 80 minutes and most were conducted at their work place or residence.

These interviews were guided by pre-prepared or semi structured questions that were progressively designed and tested to facilitate elicitation of themes of interest and to probe specific issues arising from observation or earlier interviews. The pre-prepared set of questions was developed during the process giving attention to expected types of answers by specific questions: a) Descriptive answers: seeking accounts and narratives; b) Structural answers: seeking to identify the grouping or domains constructed by the Auxiliaries; and c) Analytical or reflexive answers: ideological positions, judgments and opinions.

Second. Four in-depth interviews were conducted with Venezuelan Medical Doctors. These were in addition to the informal and spontaneous conversations with other Venezuelan and Cuban medical doctors that formed part of the participant observation. The formal in-depth interviews lasted about 60 minutes and covered the opinions and perceptions of the work in indigenous areas and the observed and expected roles of medical doctors assigned to the Auxiliaries.

Third. Four formal in-depth interviews were conducted with Nurses, one at the national and three at the regional level. The formal in-depth interviews lasted around 60 minutes and covered the observed and expected roles they assigned to the Auxiliaries as well as aspects of the evolution and development of the programme.

Fourth. Formal in-depth interviews were held with ***National Health Officers***; ***a former Minister of Health*** and ***a regional politician***. All these interviews lasted around 60 minutes, with the exception of the former Governor and Minister that run for two and a half hours in repeated sessions. In these interviews narratives of the policy development and implementation of the AMS programe as well as issues related to the AMS current roles were explored.

4.6.3 Participant observation

As with the interviews, observation was formally and informally carried out during seven months of the field-work. Initially informal observation was done in conjunction with the RA in order to introduce her to the area and to share insights. This proved to be effective diverting the exclusive attention of the Auxiliaries from my presence and enhancing a range of diverse interactions with the new-comer RA. In our visits I would initially approach the Auxiliaries and progressively and subtly try to find a way of observing the interaction between the Auxiliaries and doctors (when present), the patients who came to the post, ordinary routines, the layout of the posts, the content of boards, maps, charters, pharmacy, bins, etc.

When asked about the reasons for my presence I explained that we were looking at how the AMS worked in the conditions of their posts and their relations with the regional health system. In this way we tried to differentiate ourselves from the Regional Health System, and from the responsibility of the implementation of "*Barrio Adentro*". I made it clear that I was not in a position of a decision-maker, a resource provider or a manager.

The same themes covered through the interviews were covered during the participant observation. These were explored in more depth and also the values given to things and objects related to the routine work of the AMS such as medicines, radios, and medical instruments.

4.6.4 Discussions, feedback groups and workshop

As the data collection proceeded, preliminary thematic analysis was conducted with the available transcripts of interviews and notes taken during the continuous observation.

Drafts of preliminary findings were shared in a range of informal discussions and meetings with the RA and other professionals with experience in the area. Two

seminars were given during the data collection attended by a multidisciplinary audience of anthropologists, medical doctors, teachers and technicians to further define themes.

Feedback sessions were conducted with the AMS interviewed to ensure validity of results and to shape the ideas as the data collection progressed. During and after these feedback sessions detailed notes were taken.

Data collection was concluded by a workshop inviting national and regional stakeholders from the Ministry of Health and Auxiliaries under the slogan of "*Auxiliares de Medicina Simplificada* and Primary Health Care in Amazonas". During the workshop formal presentations to national authorities of the preliminary results of this project was followed by small groups discussions where the AMS interacted with representatives from the national and regional levels of the Ministry of Health and regional health institutions. Issues discussed included a) The current role of the AMS, b) Legal and constitutional change and the AMS Programme, and c) the Training Course and career plan for the AMS in Amazonas. The final session in the workshop consisted of the presentation to the audience of the conclusion and recommendations produced in each of the tables. This transcription and written products of the event were included in the analysis.

4.6.5 Field Notes

Notepads were used to write down keywords and significant issues noted during the routine of observation of the social interactions as well as thoughts and feelings of what was being observed. After the observation sessions, field notes were written in detail. The content of the field notes were constantly reviewed and compared, and descriptive and analytical features discussed in order to improve the quality of information retrieved.

4.7 Data analysis strategy

All in-depth interviews were transcribed verbatim initially by me, the RA, and after a few of them, by a third party. Some interviews transcribed were reviewed and "cleaned" by listening to the audiotape and these and the field notes were then discussed with the RA.

The basic analysis of interviews and notes was conducted through a Thematic Analysis[9] (Green and Thorogood, 2004a). Elements of Framework Analysis (Ritchie and Spencer, 1994) and grounded theory (Strauss and Corbin, 1990; Green and Thorogood, 2004a) were incorporated.

Field notes and interviews were examined as one body of data and indexed into broad thematic areas: Who the AMS say they are, What they say they do and about their relationship with the health system. Within these areas categories or themes were identified and explored. Examples of these categories are: "Roles", "Professional Identity", "Ethnic Identity", "Traditional Medicine", "Changes in the Health System", "Relations with Communities" "Relations with the Health System", and "Responses to change".

This set of original themes was opened in the first pilot interviews and other themes were identified during the process. Examples of these emergent themes are "The Manual", "Supervision and Supply", "Decentralisation" and "Responses to *Barrio Adentro*". They were integrated into the analysis.

Thematic areas and original and emergent themes shaped the descriptive layers upon which the findings are organised and presented. The graphic representation of the descriptive layers is shown in Annex 3.

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[9] Thematic Analysis is the most basic type of qualitative analysis, identifying common themes across the data set (interviews, field notes, documents). Green J and Thorogood N (2004a) Analysing Qualitative Data. In: *Qualitative Methods for Health Research.* London: Sage. pp. 173-201.

Storage, filing, coding and retrieval of the textual data was aided by computer assisted software N6 (Nud*ist 2003-2005, *Qualitative Research Software Solutions, QRS International Pty. Ltd, Victoria*). This was envisaged as an aid to gain rigour and order to the analysis process. The process of analysis was conducted in Spanish and then translated.

Translations of all the quotations or data extracts included in this document were reviewed by a Spanish-English speaker with experience in public health and qualitative research. Some original quotations in Spanish and their translations are presented for comparison in Annex 4 which includes a description of the AMS interviewed and the codes used to identify the interviewees.

Document analysis of laws and official documents, reports, pamphlets and journal news were integrated with oral histories obtained in interviews and interpreted in chronological order of events to describe assumptions, activities, consequences, official responses in relation to the Simplified Medicine Auxiliaries programme in the last 40 years in Amazonas (Bowling, 2002, p.419).

4.8 Reflexivity

Reflexivity is defined as "*a concern with how the selves and identities of researchers and researched affect the research process*" (Brewer, 2000, p.126), a recognition that the researcher is part of the process of producing the data and their meaning, and a conscious reflection of that process (Green and Thorogood, 2004a, p.194). Facing reflexivity in qualitative studies is not about removing the interviewer and context effect on the data but about accounting for and explaining them. In practice this involves representing as conscientiously as possible the world as experienced by the research subjects while being aware of the values and beliefs brought to the research by the researcher and the manner that these, the methods of data collection and the theories used to interpret the data, may interact with and influence the research findings (Lewin, 2004).

From the time of the designing of the project I was aware and concerned about my professional background and status in the regional health system and the consequent hierarchical relations between myself and the Auxiliaries and how this might affect the research process. Initially my presence was a disruptive influence during observation of AMS in their Health Posts. This was progressively changed as issues not directly related to their work or they performance were discussed. The presence of the young woman anthropologist also counterbalanced the potential effect of my presence. She elicited confidence in the Auxiliaries who happily presented their tasks and skills allowing me to observe their interaction with her and with others in the post.

I was also concerned that my training as a biomedical health professional might inhibit my ability to use an anthropological eye to view these settings. The RA helped by noticing and calling attention to changes in attitudes when these corresponded to my roles as evaluator or clinician.

On the other hand however, it was my previous experience in the regional health system that facilitated and allowed us to have relatively easy access to the AMS and sources of information for this study.

4.9 Ethical issues

The proposal was submitted to and approved by the ethics committees of the London School of Hygiene and Tropical Medicine and the Amazonic Centre of Research and Control of Tropical Diseases (CAICET), in Venezuela (Annex 5 and 6).

All the documents and texts analysed are in the public sphere. The objectives, aims and intentions of the research were clearly outlined in an informed consent sheet (Annex 7, English and Spanish versions) that was submitted to those willing to participate in the interviews. The voluntary nature of their participation was

emphasised. Confidentiality was maintained with regard to the contents of all responses and interventions during the interviews. Health Posts were given pseudonyms in the present document and participants' interventions are identified by codes (see Annex 4.1). Availability of the transcripts was restricted to the researchers, and participants were informed that they were entitled to see the transcripts if they wished to. The informed consent procedure also asked for approval of the data being archived and used in eventual future studies related to this thesis.

4.10 Limitations of the Study

This research undertakes a study of a forty years old programme. By definition the AMS are the least accessible health workers and therefore difficult to study.

The AMS with the longest experience in the more distant communities of the seven Health District of Amazonas, would have been ideal as i*nformation-rich cases*, but sampling was limited by time and resources available for the research. Observation may be the best way to ascertain what the AMS are actually doing but in depth-interviews were used as the principal method in order to cover more CHWs and to draw general conclusions from their points of view. Interviews were complemented with observation in the selected health post of two districts.

The thesis did not attempt to evaluate or analyse the impact of the programme on morbidity and mortality in Amazonas. Separating the influence of the Auxiliares work from the health system and social development conditions is impossible. Previous experience within the regional health system indicated that the reliability of the secondary data regarding operational performance and epidemiological impact would have represented an important source of bias, compromising the validity of any quantitative analysis. Operational and epidemiological information produced by the AMS is not systematically collected, processed and integrated into the records of the regional health system. Cost- effectiveness was well out of my scope and interest.

Ideally, the study should have incorporated values, perceptions, and expectations of the communities served by the Auxiliaries (Walt, 1988; Oliveira-Nunes *et al.*, 2002). The thesis deliberately focuses on the frontline health care providers and did not attempt to explore in depth views and perceptions of the communities. These were not ignored however, during the observation period and when analysing statements of the AMS which included community perspective and perceptions. The time and financial resources available, and, the diversity of languages that I do not speak, were also barriers and limitations for a study of this nature.

Language is problematic in general in qualitative research but it was a particular problem in this study. Most of the AMS interviewed were fluent in Spanish but came from different cultural and educational background. To some extent every interview implied translation. Besides this, the data collection and analysis were done in Spanish, and thereafter, communication of the finding in this thesis, was done in English which is not my mother tongue. Translations of the selected quotations were reviewed by a third party. This process of successive translation is to be taken into account when the purpose is to understand and describe how the respondents see the world. In this document we provide as much description as possible of the context and of the interviewees. Original quotations and their translations are presented for the reader's comparison in Annex 4).

Amazonas has the greatest diversity of indigenous population in the country and current AMS belong to at least eleven different ethnic groups (See table 3 and Figure 4 this Chapter). Each of these groups has a different conception of health and disease and different political dynamic and social organisational links between AMS and communities, and between communities and the health system. The ethnic specificities of these relationships were far beyond the possibilities and purposes of this study which aimed simply to identifying commonalities among the heterogeneity.

The initial research plan included Focus Groups interviews (FG) with AMS. These were to be conducted according to their experience and type of Rural Post and were intended to obtain complementary data about professional and ethnic identity as well as sources of knowledge. During the fieldwork five groups were conducted, three of them attended by three Auxiliaries, one by four and one by seven. During every single FG there were difficulties in getting participants to engage in active discussion. This method turned into multiple individual interviews. The possible reasons for this outcome related to the expertise of the researchers and to the educational background of the Auxiliaries. This issue was extensively discussed with other professionals who work with indigenous populations. The transcriptions of FG were done partially. These data were then used to inform the analysis of themes including identity, sources of knowledge for the AMS, and their responses to the current political changes and health reforms.

The complexity of the research process was significantly affected by the ongoing changes of *Barrio Adentro* that is occurring in Venezuela and within the regional health system during the period of field work. The social character of this study touched on issues where different institutions and people had different and even polarised positions, particularly regarding policies implemented by the government. This made the environment a little restrictive to openly talk about *Barrio Adentro*. This was an aspect not foreseen during the design of the study that became apparent at the beginning of the field work, during the preliminary planning stages and pilot work.

As a research team, we were very careful not to disclose information gained from research through interviews and observations, in any other setting. For the purpose of this thesis document, it is intended to give the readers sufficient information about the context while protecting the identity and confidentiality of the interviewees using pseudonyms and codes for sites and individuals respectively.

CHAPTER 5: Professional and Ethnic Identity of the AMS

This Chapter describes who the AMS are as health workers. Attention is focused on their professional-identity-building process, reflecting upon their motivations for becoming Auxiliaries, accounts about the training process and their perceptions of the Programme Manual. This professional identity building process is complemented by perceptions from medical doctors and health officers about the role of the Auxiliaries. Ethnic identity will be described through the Auxiliaries references to their relationships with peers, to medical doctors and to traditional medicine and healers.

5.1 The profile of an AMS in Amazonas

Current national official guidelines establish the following requirements for enrolment on the AMS course:

- Age between 18 and 35 years
- Live in the community where the AMS will work
- Be selected by the community for the training course
- Male or female "*according the conditions of the geographic area and cultural patterns of the population*"
- Have 9th grade approved education, with the exemption of states with indigenous populations, where "*candidates will be accepted with 6th grade approved due the ethnic and geographic situation*" (MSAS, 1998; MSDS, 1999). Until the 1980's the level of education required nationally was 6th grade. For the states with indigenous people "*to know how to write and read and basic numeric skill*" was all that was required. (MSAS, 1965; 1968; 1982).

From 1962 until 2002 there have been 25 training courses of *Auxiliares de Medicina Simplificada* in Amazonas. In the Nurse Department of the Regional Directorate of Health basic information about characteristics of the candidates that enrolled on the training courses from 1985 to 2002 was found. Ten courses were given during this period, enrolling a total of 125 people from communities. A general profile of the current candidates can be drawn: All 125 in the period were Indigenous, 10 were women, and the average age was 23 years with a minimum age of 17 and a maximum of 37. The average level of instruction during the whole period was 8th grade approved, and the minimum educational level was 5th grade approved. Up to 10% had completed high school and 91% concluded the course. Not all those who completed the course got a job as an AMS.

It was evident that the level of instruction of the candidates has progressively increased during the last two decades. In 1985, 58% of the candidates registered for the course had reached sixth grade of education, a percentage that dropped to 7% in 2001 and 0% in the last course of 2002; while the percentage of candidates with 9th grade approved education rose from 17% in 1985 to 57% in 2002. In the last two courses of 2001 and 2002, 30% of the candidates had high school approved education.

According to the records of the Directorate of Health, all the current active AMS are indigenous from most of the different ethnic groups that inhabit Amazonas state (see table 3, Chapter 4, p 50).

During this study we interviewed 22 AMS (See Chapter 4, p. 54), all of them indigenous, with and average age of 40 years, ranging from 26 to 61 years. They have from two to 34 years of work experience. Two of them were women. The average educational level was 8th grade, from 5th grade to 11th grade of education approved. Five of the 22 AMS have worked in RHP-II staffed with medical doctors, 17 have worked single-handedly in RHP-I. Out of these 17, five recently, (in October 2003), started working with Cuban medical doctors in the framework

of *Barrio Adentro.* The description of the AMS interviewed is included in Annex 4.2.

Most of the AMS interviewed received basic education from religious missionaries, mainly from the Catholic Church. Since 1915, through a *Missions Bill (Ley de Misiones)* and successive covenants with the Venezuelan state, the Catholic Church has had responsibility for education and health service provision in places with a scarce official presence (Armada, 1997). Most of the education in rural areas of Amazonas continues to be provided in catholic boarding schools in the capital of the municipalities. This follows an educational model officially approved by the Venezuelan state in the late 1970's known as Bilingual Inter-cultural Educational Regime *("Régimen de Educación Intercultural Bilingue")* (DAI-MECD, 2002).

According to the testimony of one of the health officers that participated in the first explorative expedition to Amazonas to decide a place and requirements for the first AMS course to be given, the Catholic Church was first asked for its cooperation with this pilot experience. However there was not much receptivity:

"*may be they did not understand well our purpose... We then turned to the "New Tribes" [missionaries] where we found quite good acceptance for our initiative*" **[Ho Na M-1]**.

The first ever AMS training course was given in 1962 to evangelist missionaries of "New Tribes Mission" living in hard to reach communities in the tropical rain forest of the Amazonas state. After the success of the pilot course, progressively, catholic missionaries, army personnel, professional nurses and members of indigenous communities were enrolled in the courses.

5.2 Forming professional identity

The identity building process of community-based workers has been studied through three perspectives: that included in their official training, that produced by the workers themselves, and that transmitted by the community (Oliveira-Nunes *et al.*, 2002). We asked the AMS and explored through the data their reasons or motivations for becoming AMS, their descriptions about the training course and other sources of knowledge such as the national guidelines, and explored the perception about their role from the community and from other personnel of the regional health system.

5.2.1 Motivation for becoming an AMS

When exploring motivations for becoming an AMS, individual and collective reasons were elicited. The idea of "becoming someone", to improve on through effort and education was a frequent reason for deciding to enter the training course. This idea of individual and social betterment through education was present in accounts of AMS of all ages.

A retired AMS recalled his decision to become an Auxiliary more than thirty years ago:

"*I had the idea of bettering myself and I thought that [the AMS course] was a great opportunity*" **[AT Ba 68]**.

At that time to enter the course he was just required to be literate in Spanish, and proudly mentioned being one of "*the first candidates with 6th grade (primary school) approved*".

Thirty years later, the context has changed but becoming an AMS remains an opportunity for personal betterment in Amazonas. A younger Auxiliary who

trained in 1999, with 9th grade approved at the time, pointed at the same motivation as his predecessor:

"[In my first attempt] I wanted to do the course, but there were difficulties, as usual, due to [party] politics, [and I was not chosen by the community] but [after some time] I don't even know how [the community] looked for me, and I was able to enter [the AMS training course] I wanted to learn more, to keep studying..." **[MA Ku 99]**.

To have a salaried post appeared as another reason to aspire for the course, as well as elements of medical vocation and community expectations, as expressed in these utterances of an AMS from the 1985 and 1999 courses respectively:

"...I concluded primary school and the "captain"[10] and other members of the community were looking for volunteers to do the Simplified Medicine course, but many didn't want Simplified Medicine, what they wanted was to be teachers, better paid, and with just a half-day work schedule. But I put myself forward, I wanted to go...I had seen many wounds...., that's how the vocation got to me, I'd rather be an Auxiliary, to at least offer my services to those in need" **[AT Hi 85]**.

"...during those years I used to work with my father in agriculture, fishing, handicraft, [because] there were no jobs (salary posts) for my community. In the mean time I took every health course that was offered in town. I was always present when the courses were related to health. I ha[d] always liked the health career, to become an Auxiliary" **[MA Wa 01]**.

The legal support provided by the AMS course to have access to basic medicines included in The Manual[11] and to perform curative tasks was also mentioned for an AMS who had previously been trained as a nurse:

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[10] "*Captain*" refers to a political authority selected and appointed by the community to interact with official statutory institutions.

[11] "*The Manual*" is the name given to national instruction guidelines also used as reference book of the AMS programme that include tasks, activities, and procedures.

"[in the early 70's I was already an auxiliary nurse] not an Auxiliary...but I was obliged to do the Auxiliary Course because [as an auxiliary nurse] I was not authorised to receive a Manual, or to prescribe medicines included in that Manual..." **[MA Ba 73]**.

Personal and community motivation to become an AMS contrasted and also merged with the influence of the health system through the training process, shaping the professional identity of these CHW.

5.2.2 The training course and sources of knowledge

The expectations and motivations of the candidates for becoming Auxiliaries are formally shaped in the training course. The objective of the training programme, established in national guidelines, is to "*train personnel elected by the community as Simplified Medicine Auxiliaries to guarantee comprehensive health care to scattered rural population"* (MSAS, 1998).

The course is designed on a "boarding school" scheme, requiring a full time presence during the six months period. The candidates are provided with a temporal collective residence in a premise that in Amazonas is popularly and historically known as *"La Escuelita"* (*"The Little School"*). This is a small and modest complex that includes classroom, residence, kitchen and refectory and two administrative offices, built specially for the programme in 1981. It is attached to the only Hospital of the State, in its Capital, Puerto Ayacucho.

This is a six month training course given by non-indigenous trainers, most of them professional nurses, medical doctors and officers without any pedagogical or inter- cultural educational skills. According to national guidelines, the course is currently divided in Modules (Health Promotion, Health Protection, Child and Maternal Health Care, Health Restitution, First Aid, Rehabilitation, Surveillance and Information Systems) with theoretical and practical components. The taught component given at "*La Escuelita*" is followed by a stage in a Rural Health Post Type I. Most of the interviewees pointed to difficulties in the theoretical

components and many of them referred to languages barriers. One experienced training coordinator of the region commented that the theoretical contents of the course that were basically transmitted by repetition and the practical contents by learning-by-doing. The AMS expressed more interest and profit out of the practices and the stage at the RHP-I. When asked about what they learnt the AMS recalled: how to give injections, how to vaccinate, how to attend deliveries and to give stitches, the use of medicines, and the experience of the placement at the health post.

In the words of a very experienced retired Auxiliary:

"The Course was worth it. We were really well trained, in many senses. We had classes with the [nurse] instructors during the day and [talks] with medical doctors from the hospital during the night. We came out of the course as excellent [health] workers" **[AT Ba 68]**.

The accounts of the Auxiliaries about the training course *discipline* appeared as a relevant term to be explored. Many referred to how the instructors assumed a strict and rigid disciplinary role. Most of the interviewees from all ages manifested having coped with norms and rules in order to achieve the goal of "*graduating as an AMS*". Discipline was assumed as a value or characteristic necessary for their professional profile:

"Well, we first had to respect the rules, no alcohol, no smoking at the school, and we respected all the rules because we really wanted to be well trained. And we achieved (our) goal...." **[MA Wa 01]**.

"I learned many things at "Little School", besides discipline. There they were really strict, almost like in the Army. We were not allowed to smoke, something that we could do in the Army and here we were not allowed ...And for me it was better like that, because many of us had not been in the Army, so they arrived with no discipline to "Little School", so the Teacher (la profesora) put discipline. It

was hard for [my classmates], as they were not used to it.... I told them that every institution has its rules to follow" **[AT Pi 92]**.

But others commented on their resistance to the discipline, arguing that it was unnecessary given their level of commitment and personal maturity. However they accepted discipline as being an obliged prize to pay in order to achieve their goal:

"In 1984 I was already married, and my wife used to come to visit me and [the instructor] said that the School was not for visits.... They treated me as a teenager, I had to diminish myself (rebajarme) if I did not want to get fired. I had to diminish myself to approve the Course" **[AT Hi 85]**.

For most of the interviewees *discipline* represented a value linked to their desired outcome and necessary to become "excellent" workers.

Gathering information about the sources of knowledge "The Manual" of the programme appeared as a strong symbol of their personal and collective identity as Health Workers. This was a constant finding among the AMS of all ages.

Since the launching of the Programme in 1962, "The Manual" has had ten editions. The first five editions were mimeographed versions considered "experimental work" (MSAS, 1968) and the subsequent editions were published and distributed by the Ministry of Health. Principles, objectives and the main body of content, has been maintained since the beginning of the programme and even in the last version words from the founder leaders back in the 1960's can be recognised (López-Vidal, 1962; MSAS, 1968; 1982; 1991; 1998; MSDS, 1999).

The initial versions were very simple in structure but progressively "The Manual" was filled with many contents to become a huge book. In the voice of one experienced training coordinator:

"[They] wrote the first Manual in very simple language, for everyone to understand, but as time went by the Manual was reviewed and every single

(health / disease control) programme wanted to have a content in it. Now it (looks like) an encyclopaedia" **[HO Re N-2]**.

This has resulted in basic procedures being unnecessarily repeated across the several modules. This is seen, for example, with the treatment of fever, a common ailment, that in the current Manual appears under "*Varicella or Chicken pox treatment"* Module II p. 37, under *"Dengue fever treatment* ", in p. 41 of the same Module, and again under treatment of "*Tonsillitis*" in Module III p. 46 (MSDS, 1999).

The way the Auxiliaries refer to this Manual, the values attached to it, are highly illustrative of their professional identity and the strength of the influence of the health system on the health workers. Special reverence and solemnity, is given to this book as reflected in their statements.

An old AMS was asked directly "*Did you receive the Manual when you started working?*" he answered: *"Yes, (and) under oath, that it should never be out of our minds"* **[ZU Yu 73]**, as a professional moral code for the AMS, resembling the Hippocratic Oath. "The Manual" embodies the programme as an institution.

The Manual deserves more than animation, it becomes a person, who justifies their duties, legitimises their actions, and gives support:

"The Manual I have here doesn't talk scientific words but simple words, I guess that's why it is called "Simplified Medicine Manual" ...This is a doctor, [and] a lawyer at the same time. With this book we make consultations and figure out what we can do for our patients" **[AT Hi 85-3]**.

When recalling his duties while in service one AMS said:

"I was the doctor, I was the midwife...But I had a companion for my work. That companion was the Manual of the Programme, where every sick-person has his/her recommendation... " **[AT Hi 79]**.

Since 2003, there has been an environment of uncertainty regarding the functions of the AMS in Amazonas (see Chapter 3, pp. 32-37). In this context the AMS have been told that they could be transformed into "*Health Promoters*" and to this eventual transformation several responses and reactions have been elicited (see Chapter 7, pp. 119-126). When asked about differences perceived between the eventual roles of these health promoters when compared to the AMS, this answer shows the significance of the Manual in the professional identity:

"*....There is a big difference [between an AMS and a Health Promoter], we have a responsibility; we have a Manual, ... A Health Promoter just [has] recommendations from the doctor...*" **[MA Ba 73]**.

Most of the interviewees did not give any precise answer when asked about what to change or what to leave in the current content of "The Manual". Few of them coincided in an aspect that they thought would be worth changing, other than updating the contents related to medical treatments, doses and usages of new drugs "*..medicine names change, and [the Manual] should be updated...*" . Regarding this point, one AMS mentioned that he would like "The Manual":

"*...to include other medicines that are [currently] not included, those that I know more or less that can be good, that I have knowledge about, like some medicinal plants...*" **[MA Wa 01]**.

There have been recent initiatives to introduce indigenous perspectives in the AMS training programme and in "The Manual" that have mainly come from the Ministry of Education (DAI-MECD, 2002).

The professional identity shaped by the training course and embodied in "The Manual" is reinforced by the status the AMS have gained in the communities and by the actual role being ascribed to them by the health system.

5.2.3 "Little doctors" for the Health Systems and their communities

AMS have built an identity as professionals, based on their expectations, shaped during the training course, but also around the role ascribed to them by the health system and their relationship with the communities where they live and work.

In their statements AMS referred to their occupational choice as a career, as a profession, a full time occupation with specialised skills:

"...I did the course and I gained my degree. I graduated as an Auxiliary...well, there was a time in which I had to quit...and then I realized how much love I have for my profession..." **[AT Hi 79]**.

They referred to being identified as medical doctors by the communities and they have assumed this identity which renders them status. As one of the experienced AMS pointed out:

"[We] are very special, [we are] the only personnel besides the medical doctor that work with human lives...any mistake that an Auxiliary could make when giving medicines either oral or intravenous, and kills someone, then regrettable [the AMS] will be punished. It is not like other institutions, like a teacher or a policeman...it is a big responsibility that of the AMS" **[AT Ba 68]**.

Another AMS stressed how he perceives his importance for the health system and how he is perceived by members of the community:

"If there were no Auxiliaries the hospital would have collapsed, right? I often laugh because the kids in town call me doctor....." **[AT Hi 85-2]**.

Another more explicitly said: *"I had been working by myself for 18 years, I felt like a little doctor, a little epidemiologist..."* **[AT Hi 85]**.

The professional identity was also manifested in several symbolic representations such as the frequently observed use of white robes in non-working areas with a stethoscope proudly worn hanging around the neck.

AMS were conceived to work single handed, in hard to reach small communities that would be visited periodically by medical doctors from bigger communities who provided supervision and medical attention. A medical doctor who worked for a few years in the interior of Amazonas was asked about the main tasks he expected from the AMS, and said "*..actually they cover the doctor's tasks*" **[RMD- 1]**, describing them as *"little doctors" ("pequeños doctores")* who solve and respond to health problems in their communities. This term was also used by a Nurse who has coordinated the AMS training courses and who is currently in charge of the Programme:

"*they do the job through the Manual, they are like.. umm, a little doctor, like the doctor there, of that community"***[HO Re N]**.

In front of their community the status of the AMS changes when medical doctors are present. As one experienced AMS from Atures mentioned:

"when the doctor is here I change my circle, to put myself in his, and he is the one who leads, and I have to follow the orders" **[AT Pi 89]**.

Another, from Maroa gave some insights into the incentives for being an AMS:

"*....and I enjoyed it more when people trust you, when I receive acknowledgments, and it is perhaps even better when you are an Auxiliary that works single-handedly. I liked this work because I work by myself"* **[MA Ba 73]**.

An AMS, that had worked single-handed in RHP-I and was relocated to a RHP-II where he has since been working with medical doctors expressed the changes in his status and role shaping a different perception of his professional identity:

" *I was trained in 1987 and worked for a few years by myself in a health post. At the beginning I was the AMS and I was the doctor. According to symptoms and signs and following the Manual we treated the patients. Then I was transferred to [other health Posts] where I have worked with doctors. It is a great advantage, we*

keep on acquiring more knowledge, I just follow medical orders. I am not the doctor anymore but an Auxilliary to the doctor..." **[AT Hi 86]**.

Those AMS that have worked single handed have developed a strong professional identity clearly identified with the role model of the medical doctor, identity linked to their curative tasks. Those who have worked in RHP-II, staffed with medical professionals, seem to cope with their role as "*Auxiliary to the doctor*", assuming tasks and functions of nurses rather than those of AMS established in the national guidelines.

The changes of status and roles they play when working single handed are important elements to understand responses that active AMS have given when facing the implementation of the *Barrio Adentro* programme in Amazonas, as will be depicted in detailed in Chapter 7.

It was also important to explore if this professional identity conflicts with or contradicts the links they have with families and communities on the basis of ethnicity.

5.3 National Guidelines and AMS practice in indigenous areas

The training process and "The Manual" are fundamental in shaping how the AMS perceive themselves as health workers. The relationship between professional identity and their self-identification as indigenous of Amazonas was explored. Firstly, the official guidelines were examined to establish the provision of services in cross-cultural settings such as indigenous areas, and this was then compared and contrasted with the opinions and experiences of the AMS referred to in their statements.

In a programme that was piloted in remote indigenous areas, there is little direct mention of indigenous related issues in official statements and documents. But these few mentions were relevant in describing a constructed idea of the

Indigenous[12] and areas inhabited by Indigenous by the designers of the programme in the MoH at that time.

During the 1960's, after a decade of military dictatorship, Venezuela was re-building a democratic political system with a national-democratic ideology, relying economically on the exploration of oil and constructing a national identity which was internally homogenous, racially and culturally standardized and embodied in "*el mestizo*" (Clarac, 2001). The only mention of the indigenous population in the National Constitution that ruled the country from 1961 to 1999 is in Article 77: " *The State shall strive to improve the living conditions of the rural population. The law shall establish the special system required for the protection of Indigenous communities and their progressive incorporation into the life of the Nation"*. In the Constitutional text, indigenous people were marginally treated, and the trend was to contribute to their progress through assimilation into the national society. Many Indigenous interiorized the stereotype and consciously avoided being identified as "Indians"[13]. They preferred to be identified as "non Indians".

As previously mentioned piloting the programme in Amazonas was officially justified by the presence of a population " *suffering from extreme poverty and [with] cultural and anthropological characteristics of nomadic and semi nomadic ... still in the tribal phase*"(González, 1975). A sense of poverty and backwardness associated with the Indigenous' conditions of living was exploited as a moral argument to begin to extend the health services using lay personnel.

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[12] To explain what we mean by "*constructed idea of the Indigenous*" we follow the concept of *Indigenism* provided by Ramos (1998) : "*Indigenism is a set of ideas (and ideals) concerning the incorporation of Indian people into the nation-states...* and *the popular and learned imagery among the national population onto which is carved the many faces of the Indian... imagery that varies according to the fluctuations of the moment's social consciousness*" Ramos AR (1998) *Indigenism.* Wisconsin: The University of Wisconsin Press. pp. 6-13 (emphasis added).

[13] In English language the term "*Indian*" is understood as synonymous of "*aboriginal*" "*first nation*", as the concept of *Indigenous* we have assumed in this text (see Chapter 2, p.17). So can be understood in the Spanish language. But in Venezuela, the term "*Indian*" has been ascribed pejorative connotations. In the quotations translated we have used the term "*Indian*" when the word "*indio*" has been used by the interviewees and in the text we have preferred the term "*Indigenous*" over "*Indian*".

In the first version of "The Manual" in 1962, a heading links public health practice in local settings with particular cultural characteristics that had to do with the expected relationship of Auxiliaries with traditional healers and shamans. In nine of the ten editions of the manual the issue was headed as *"The problem of the Witch"*. Under this title the designers called attention to the social importance of traditional healers and shamans (Box 1).

Box 1: "The problem of the Witch"

"The best way to fight against the witch is not by attacking him, but by demonstrating that our systems are more effective and beneficial. Among uncivilised peoples the witch has many advantages over the medical doctor. The witch belongs to the same social stratum as the native community and expresses himself in the same language as the conglomerate where he belongs, therefore being better understood than the doctor himself. The witch is tightly linked by sentimental nexus with the population, since all share beliefs and superstitions, worries and distress....the witch delivers psychosomatic treatment, a system that is not taken into account by professionals. Therefore, we have to proceed very carefully with patience and understanding of the rural environment, when we attempt to eliminate the prestige of those taking advantage of "herbs" many of which have evident effects that the community has had the chance to prove, and we want to replace these traditional practices by scientific medicine of "first aid"

(López-Vidal, 1962; MSAS, 1991).

This statement remained unchanged in editions of the programme over thirty years (López-Vidal, 1962; MSAS, 1991). It was in the version of 1999, in times where Indigenous Rights for a New Constitution were being discussed, that the heading changed to "*El Curandero*" *("The Healer")* (Box 2).

Box 2: "The Healer"

"The healer, witch, herbalist, shaman is defined as a recognised person by his own community as a skilful character who provides health services through the use of vegetables, animals and minerals and the application of some methods of social, cultural or religious origin based on knowledge attitudes and beliefs of the community. The health worker should have the support of the healer, witch, herbalist or shaman, given that he belongs to the village or town, expresses himself in the same language and is tightly linked by sentimental nexus with the population and understands worries and distress. The vision that the healer, witch, herbalist or shaman has about the health-disease process is comprehensive and deals with elements of nature, culture and biology that are important for prevention and health rehabilitation. Because of these and other similar reasons the healer, witch, herbalist or shaman is a relevant social actor to be taken into account to in the negotiation process in order to achieve the proposed goals with health promotion strategy. In the same trend it is convenient that the therapeutic health workers assimilate knowledge and skills used by the healers to better understand the behaviour of the population and take the most out of these elements for their own work" (MSDS, 1999); Module I, p. 11).

5.4 Ethnic identity

The content of the official guidelines regarding AMS practice in indigenous areas, was then compared and contrasted with the opinions and experiences of the AMS referred to in their statements. Aspects of their ethnic identity[14] will now be described. These aspects were identified when the Auxiliaries referred to themselves on an ethnic basis during the interviews, when talking about their peers in the training course and about their relationship with traditional medicine, healers and medical doctors.

According to the records of the Amazonas Directorate of Health, from the 1980´s, almost all the participants in the courses and currently all the active AMS are indigenous from most of the different ethnic groups that inhabit Amazonas state.

It was assumed that the basic source of this information about ethnic affiliation was the self-identification of the Auxiliaries. Thus this issue was explored across the data collected. Spontaneous personal identification as Indigenous was frequently registered when AMS introduced themselves during the interviews. For example, in this particular case, at the very beginning of an interview, after explaining its aims and purposes, the AMS was asked, rather precisely, about the place where he was born. He directly answered:

"*My name is SAP, AMS of Cataniapo clinic. I am a Piaroa indigenous from Atabapo Municipality....*" **[AT Pi 92]**.

Another went straightaway to vindicate his identity and educational achievements:

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[14] Here *ethnicity* is referred to as a construction of a collective identity, changing in time but based on a common origin, memories of a common past, to share important segments of common culture. Ethnicity is taken as an indicator of a process in which people create and maintain a sense of group. Torres C (2001) *Ethnicity and Health: Another perspective towards equity*. Washington DC: Pan American Health Organization.
Ethnic. Etymology: Middle English, from late Latin *ethnicus*, from Greek *ethnikos*: national, gentile, from *ethnos*, nation, people, akin to Greek *Ethos:* custom (Murrain-Webster Dictionary 2005)

"I am GC, from Rio Negro, I belong to the Baré ethnic group...., I have never tried to hide what I am... I think no AMS should deny his identity and his ethnic origin...., I'm proud of being called an Indian because I got education with much sacrifice but with a great hope, of bettering myself, to become someone, and I have succeeded... " **[AT Ba 68]**.

When exploring the reasons for training to become an AMS, personal motivations of self-betterment, and medical vocation were often mixed with manifestations of identification with their ethnic communities. Two AMS, from Zulia and Amazonas state, said:

" [*In those days, 1973,*] *there were no Indigenous Auxiliaries anywhere...I did sacrifices to do the course....we need[ed] an Auxiliary here, because there [were] wounds, accidents, epidemics attacking, viruses, [and I said to myself] "how can we change peoples' lives?: Doing the [AMS] Course"* **[ZU Yu 73]**.

"In 1970's I saw the humanitarian need [in these communities], there were few doctors, there were too few health workers. ...And I also want to make something clear (palpable), that our indigenous people were dying as if they were animals, like any chicken that gets ill and passes away, when it actually existed the curative part, when actually medicine existed. I got inspired in this and told myself: I have to be someone [and became an Auxiliary]" **[AT Hi 85-2]**.

In this statement the AMS consciously expressed his ethnic identity as critical in his relationship with mainstream national society or *criollos* and his awareness of inequity and social injustice.

To assume a professional identity did not contradict the fact that the AMS also retain an identity as indigenous and this was expressed in several ways. When talking about the presence of Medical Doctors, during visits or on permanent basis, one said:

"For me...there should always be a person from this community in the health post, because the community has other culture, and doctors come from the University with their experience ..to change the culture" **[AT Pi 92]**.

Clearly professionally identified with the doctors this AMS assumed a cultural or ethnic-bound standpoint that he represented as a "*person of this community*".

But ethnic differentiation was not only toward relationship with the *criollos* but also toward other ethnic groups too.

"I studied, made an effort. It was my vocation, to help my people, my ethnic group" **[AT Hi 85]**.

"We arrived [in this community] when I was a kid, I grew up here, [and]I saw the Auxiliaries were not Hiwi [from my ethnic group], they were criollos or from other ethnic groups, who lasted two, three months [in the post] and went away..." **[AT Hi 85-3]**.

According to the AMS interviewed, the fact that groups in the training courses at "*La Escuelita*" were candidates with different ethnic backgrounds was not a problem in itself. It was referred to as an opportunity to learn from each other. Communication between companions was not a problem and language was not referred to as a barrier, partly because one of the course's local eligibility criteria was to be fluent in Spanish. Spanish is the "*lingua franca*" among the indigenous people from different ethnic groups in Amazonas. Those who had the chance of having non-indigenous people (*criollos*) as classmates referred to competition to stand out within the course. When referring to the group of classmates, there was a clear distinction between those who were indigenous and those who were not. There was also evidence of deliberate differentiation between ethnic groups, but, in general, toward those non-indigenous (*criollos)* there was a sense of common identity.

The way they referred to how they relate to and approach their colleagues and companions at "*La Escuelita*" gave an impression of collective identity, not as Auxiliaries but as Indigenous:

"*..there were [people from] different ethnic groups, Yekuana, Hiwi, Piaroa, Kurripaco...I communicated very well with them. I helped, I felt like a brother there*" **[AT Hi 85-2]**.

"*At the beginning we didn't know each other well. There were Yanomami, Kurripaco, Hiwi, and as time went by we were just like brothers*" **[MA Ba 99]**.

"*There were just Indigenous, there wasn't even a Colombian or a Brazilian, just Indigenous, no whites (criollos). We were Hiwi, Warekenas, Piaroa, Yabarana...little by little we became to know each other very well, we became brothers*" **[MA Wa 01]**.

There were many cases in which Auxiliaries gave value to traditional medicine *vis à vis* scientific or bio-medicine. Some of the interviewees placed their indigenous status, jointly with the scarcity of industrialised medicine in the health posts side by side with that of Auxiliary to justify the use of medicinal plants which, so far, are not included in the Manuals. An Auxiliary from the Warekena group states

"*...we have to look for solutions when we do not have medicine from "the whites", we search for medicinal plants that we know, we get to cure with them many times*" **[MA Wa 01]**.

Heavily trained in biomedical practice, the AMS still refer to explanations and solutions for health situations that come from a particular knowledge, a particular way of seeing and understanding things:

"*...that is why I say that both medicines have to move forward, because a traditional healer (curandero) can cure, for instance, a bewitchment (daño) but with scientific medicine you cannot, a doctor does not cure a bewitchment. Doctors cure what they diagnose, what they believe it is, what they consider...but*

a bewitchment, that is something for a traditional healer to cure, the western doctor cannot..." **[AT Pi 92]**.

More than a formula of convenience, as recommended in "The Manual" in their relation to traditional healers, this statement reflects a particular "common sense", a local knowledge to explain how the medical sphere is divided up.

Despite the AMS having developed a strong biomedical identity they stand as indigenous of Amazonas, and their identities as indigenous and health workers appear not to be mutually exclusive or conflicting. Both identities are reflected upon the roles they have assumed within the health system and within their communities as will be presented in the next Chapter.

CHAPTER 6: The roles of the AMS in Amazonas

This Chapter examines and contrasts the occupational profile of the AMS within the health system with the expectations of health officers have about the tasks of the Auxiliaries. This profile is further interrogated through the role the AMS themselves say they play within their communities.

6.1 The Tasks of the AMS

In the national guidelines the occupational profile of the AMS is defined as:

> *"...a full-time Ministry of Health and Social Development worker trained to perform actions of health promotion, protection, restitution, and rehabilitation directed to the scattered rural population according to established norms...engaged in the following activities:*
>
> a) *Comprehensive health services to individuals, families and community including health promotion, individual and community development, planning, organisation and coordination of curative services and specific prevention, epidemiological surveillance, antenatal care, monitoring child growth and development, control of empiric midwives, rehabilitation and to provide First Aid in case of easily recognised diseases, not dangerous, and in case of accidents following guidelines.,*
>
> b) *Administrative such as needs assessment and actions planning for environmental health and surveillance system.*

c) Educational such as literacy teaching, hygiene, and farming and cooperatives.

d) Research, action-research activities..."

(MSDS, 1999, p. 23, Module I).

This profile stated by the Programme is normative, it is about what the AMS "should do". But actually the short subcomponent encapsulated in "*to provide First Aid in case of easily recognised diseases, not dangerous, and in case of accidents*" becomes the task that conspicuously shapes their professional identity.

The content of the Manual is mainly disease-orientated, with curative tasks occupying most of the time in the training course and most of the AMS' daily work. These curative tasks are most valuable for the AMS themselves and their communities. Upon this curative role they have built their identity and role as "little doctors". The Manual does not indicate what are "*easily recognised diseases, not dangerous*". The latest version of the Manual provides instructions as to how to manage the diagnosis, treatment and eventual referral of endemic or frequent conditions such as Acute Respiratory Infections and Acute Diarrhoeal Diseases in children, and even Mastitis and post-partum genital tract infections (Module III (MSDS, 1999), Cardiovascular diseases, Asthma, Tuberculosis, Tobacco use , Diabetes, Cancer, Mental Disease, Module IV (MSDS, 1999)).

To examine the relevance the AMS assign to their tasks and the discrepancies between what is written in the guidelines and what the AMS actually do, the AMS were asked about their main tasks. Prevention and promotion and curative tasks were included as themes with specific questions. Other roles referred to by the AMS that are not established in the guidelines were also explored. These included translation, mediation and advocacy that were grouped together as the "*Intermediary Role*".

6.2 Promotion and Prevention

When asked about their main or most important tasks AMS usually referred to prevention and promotion. An experienced AMS, who retired after 34 years of work, says:

"...my goals as an AMS were, firstly the preventive work. That's the work that every AMS must do..." **[AT Ba 68]**.

Another AMS recently trained, recalled his satisfaction when he obtained his salary-post:

"...when I gained the post I was so happy and I put more work in it, and meetings and talks about how to prevent malaria, to get rid of puddles, tires, all that, to prevent diarrhoea, ..., to boil the water, to give sandals to the kids, to sweep the houses, to give advice to all of them..." **[AT Pi 99]**.

Health Promotion is directly associated with "*charlas*" (*talks* to groups of community people) and "*carteleras*" (boards) hung in the walls of the Rural Health Post. Promotion is made synonymous with gathering people together to talk about sanitation and control of infectious diseases. Boards are set up in the health posts containing messages from "The Manual" or leaflets of national campaigns that are delivered to all the country. On the boards are written messages rarely translated into indigenous languages.

An AMS with thirty years of experience, who works in a remote community, was asked about how he carries on health promotion activities. He said:

"...I take [contents] out of the Manual and I translate them into our language.....We give the talks, we must keep carving, giving them their talks...how to prepare the food, how to keep the cutlery...how to store water. Whenever we have a meeting I have to take the chance [to give a talk].."
[MA Ku 73].

Prevention and promotion are not clearly differentiated one from the other, jointly appearing in the AMS accounts as important, as prioritised tasks. But delving a little deeper it is clear that these are not the activities that they most value. A young AMS, from the last cohort who has worked mainly with medical doctors in a RHP-II, talked about what he considered health promotion to be:

"*...promot[ion] is [to deliver] Oral Rehydration Salts, to teach people how to store the water; little things like that, that you do not see the sense of it.....*" **[MA Ku 99]**.

There is scepticism about this idea of health promotion through community talks. For example an AMS with twenty years of experience said:

"..that is the Auxiliary's work ...to give educative talks ("charlas educativas") ...that's work of the Auxiliary, to prevent, prevention...(But) myself, for example, I do not run meetings with the community. If you set up a meeting, just a few attend, and do not pay me attention, and some get bored. I have to take the opportunity when people come to the clinic, when they sit down to talk with (me)" **[AT Hi 79]**.

In this statement from this AMS, the clinic is revealed as an important, if not the most important, work environment for his preventive practice carried out on an individual basis.

There are mixed feelings among the AMS about the importance of their role in promotion and prevention. In "The Manual" it is highlighted as a very important task, incorporated into the AMS normative discourse but openly contested in relation to the relative value they give to promotion in their actual activities. These ambiguities are reflected in the answers of an AMS, who has worked single-handedly for almost 20 years, when asked about his most important activities:

"...Auxiliaries' most important activities?.... First and mainly preventive ... we work with prevention, talks in the households, at the schools, to the pregnant women and teenagers, not to self-medicate..." **[AT Hi 85]**.

But in the same interview, when asked his opinion about the possibility of AMS being transformed into Health Promoters, as has been unofficially announced as part of the latest health care reforms, he said:

"...well, I think that the AMS would be much downgraded (muy rebajadito), too much with all the effort done, having administered medicines, [if transformed into Promoters] I will feel very annoyed.." **[AT Hi 85]**.

To be transformed into "promoters" seems to interfere with what appears to be most valuable for them, their curative role, and such a transformation would be perceived as a downgrading:

"... and I have patients, ...[Educative] talks will not help, because I won't help to eliminate fever with talks, or a cold or a patient's headache..." **[AT Hi 85-3]**.

A common statement in this regard in several interviews and conversations with AMS was that *"You do not get to cure just with words"* (*"Con palabras no se cura"*).

The prevalent idea around promotion, associated with talks and boards referring to sanitation and control of infectious diseases, contrasts with the relevance given to health promotion in the constitutional text and with what has been observed outside the health sector in the rapidly changing context of massive policies' implementation within the *Bolivarian Revolution* (see Chapter 3, pp. 32-37). Social Promotion is being interpreted as social organisation and mobilisation, and terms such as "*social accountability*", "*social control over services*" and "*health committees*", are prevalent in the discourse. Thousands of youngsters of all Venezuelan states are being sent to courses of "*social promotion*" in Cuba and on their return to their communities and neighbourhoods they integrate local

committees for social development called "Social Fighters Front Francisco de Miranda" *("Frente de Luchadores Sociales Francisco de Miranda")* after a forerunner of Latin American independence. Testimonies of these youngsters were registered in our visit to communities in the Capital district and in far distant communities of Maroa.

Within the health sector Local Health Committees with community participation are also being structured in the frame of *Barrio Adentro* (CNAP-MSDS, 2004) with a rhetoric that encourages community governance at all levels of health care services. The mixed feelings of the AMS with regard to health promotion and the discrepancies in its conceptualisation with the use of the term outside the health sector, points to a necessity to redefine these tasks.

6.3 Curative tasks and the power of medicines

Balance between prevention and promotion with the curative tasks was identified as a contradictory issue among the AMS and among the health officers as well.

While some of the AMS initially mentioned prevention and promotion as their main responsibilities others, more explicitly, were straightforward in defining their role:

"Mine, as an Auxiliary, is to cure the patient, that's my job..." **[AT Pi 92]**.

Analysing the main tasks expected from an Auxiliary even health officers showed ambiguity in expectations:

"AMS should not be that much curative, [they should be] more toward educative, to transform the environment, to educate the population about environmental health and prevention..... Their promotion activities have to be strengthened because I know their curative tasks are good..." **[HO Re M]**.

Later in the interview when asked about the possibilities of the AMS being transformed into health Promoters in the framework of *Barrio Adentro* the same officer said:

"Because the Auxiliary is not just to promote health but to provide primary care. In my criteria this cannot be done by Health Promoters...[Regarding an eventual transformation] it's serious, we are taking out equity from the communities. Then, where is that curative assistance going to be available? In this case they will go to the shaman but neither can he do everything..." **[Ho Re M]**.

To have curative tasks and access and use of medicines mainly defines the professional identity of AMS and dealing with medicines has always been a contentious and contested issue.

Since the times of the launching of the programme in the sixties, one of the main worries of medical bodies opposing the programme was the fact of lay personnel, with no professional level, prescribing medicines (Baldó, 1971; González, 1975). This issue about the opposition of medical bodies to the drugs prescription by non-professionals was even included in the historical synopsis of the programme within the operating Manual (MSDS, 1999, Introduction, p. 7).

One of the most outstanding repercussions of the official recognition of the AMS programme is that Auxiliaries are legally authorised to prescribe medicines that are included in "The Manual" and perform curative procedures. These permissions are not given to professional nurses, who have to take the six months course of the Simplified Medicine Auxiliary programme both to become qualified as trainers, as well as to be legally supported when they have to prescribe medicines or do curative procedures in hard to reach areas. This is mentioned by a professional nurse, who coordinated the AMS programme for many years in Amazonas, who had to do the AMS course:

"W*hen I was in Marieta* (a 400 people community in the tropical rain forest, reachable by plane or by boat) .. *I gave them all assistance. I had to do everything*

myself...thank God I didn't have any problem, I mean legal problems, because I had done the AMS course and I consulted everything in the Manual", because as nurses we are not authorized to give medicines, just to assist the Medical Doctors, but as an Auxiliary I was authorised [to give medicines].." **[HO Re N -1]**.

At different levels of the health system and in discussion with community members or local authorities, the first complaint regarding the health situation was the unavailability of medicines in the health posts. As a regional Health Officer pointed out:

"What are the communities' complaints [regarding health]? The first thing they refer to is the lack of medicines, that's what they complain about, that they do not have medicine for a headache. But, they never say that the AMS do not instruct about removing garbage. Medicines, that's what you just hear about."
[HO Re M].

During the observation period we collected testimonies of the interest of the communities in getting one of its members trained as an AMS to gain access to industrialised drugs, and about the efforts some communities go to to pay expenses for the active AMS to fly to the capital to get the medicines. This is because of the progressive inefficiency of the health system in delivering supplies to the health posts particularly in the interior.

Even today, after 40 years of experience with AMS in hard to reach communities, one of the arguments held in Amazonas to promote the policy of extension of direct medical attention to places already served by Auxiliaries, is the concern about lay people prescribing medical drugs. In the cases where *Barrio Adentro* medical doctors have been assigned to RHP-I, the AMS have been relieved from the responsibilities of managing and prescribing drugs. This has had an impact on the main attribute that renders them power and credibility in their communities: the access to industrialised drugs and their curative role. Being relieved of the use of drugs has been perceived generally as a disincentive and on occasions has constituted a source of conflict:

"They [the doctors] took away our authority to be Simplified Medicine [Auxiliaries]. We can not consult the Manual any more, we don't have the option to give any drug..." **[AT Hi 85]**.

Incidents of disagreements between AMS with the newly arrived Cuban doctors, have had the medicinal drugs as an apparent cause, its qualities when compared with "Venezuelan medicines", Cuban doctors prescription patterns, etc.. Behind these apparent causes lie conflicts of power and hierarchic relations but "drugs issues" give more importance and relevance in the minds of those who are not involved in the basic causes of the disagreements. *Barrio Adentro* has received a high level of acceptance, nationally (Datanálisis, 2005), and in communities of Amazonas where it has been implemented (CAICET, 2004). *"A blessing"* was an expression heard to characterise its implementation. One of the reasons for this acceptance is the better availability of drugs where Cuban medical doctors work in comparison with the lack and scarcity that has progressively characterised the primary care level and particularly the health posts attended by the AMS.

6.4 Microscopist: a boosting in the Auxiliaries role and status.

To traditional tasks assigned to AMS in Amazonas by the national guidelines as comprehensive service providers, basic microscopy of malaria and tuberculosis were recently added. The AMS already trained in microscopy gave information about the relevance attributed to this task and how it could eventually contribute to their role and status.

Malaria is the most important endemic disease in Amazonas state[15]. The role of the AMS within the malaria control programme was clearly established in the 1999 version of "The Manual": *"to take blood smears from symptomatic patients; to send these slides to the Malaria Services in the capital of the District, while the*

[15] Between 1996 and 2002 Malaria is among the ten first causes of general morbidity and general, infant and childhood mortality. Source: Department of Epidemiology and Strategic Analysis, Regional Directorate of Health, Amazonas, 2004

patients has to be referred for medical evaluation" (MSDS, 1999, Module II, p. 63). But the AMS in Amazonas actually do more than that. They have assumed a role in passive case detection[16] and have been giving treatment to clinically suspected cases of malaria, called "*presumptive"* treatment when symptoms are suggestive (fever and shivering). But the parasitological diagnosis cannot be confirmed because of a lack of local resources (microscopy and trained personnel).

When slides are referred to the district or regional laboratories of the Malaria control programme they are read by *Microscopists*, personnel specifically trained in a six-month course just to do the parasitological confirmation and classification of malaria infection. *Microscopists* have worked within a very structured vertical Malaria Control Programme, one of the oldest and most traditional in the Venezuelan public health system. Since the year 2000 the integration of malaria and tuberculosis control activities into rural Health Posts had the AMS trained as *microscopists* for both diseases in a four weeks course held at the regional level. AMS integrated in the malaria and tuberculosis microscopy are theoretically under quality monitoring and supervisory systems established in the national guidelines for both control programmes. They should refer all positive slides to the regional laboratories and 10% of those diagnosed as negatives.

Integration of diagnosis and treatment of malaria at the primary care level was a breaking point in the history of the vertical structure of the malaria programme and for the AMS programme too. The initiative had to overcome the resistance in both sectors. Regarding the changes in the AMS daily activities, a Regional Coordinator of the Malaria Control Programme recalls:

"*There was great opposition at the beginning, from some colleagues, as well as from medical officers, from the Nurse Department, because they said that we were*

[16] *Active and Passive Case Detection* are operational terms that refer to the identification of individual suspects of having malaria when visiting communities explicitly asking for cases of fever (*active case finding*) or by screening everyone coming with fever to the Health Post (passive case finding).

taking [AMS] away from their basic tasks, or because we were giving them a task that corresponded to the Malaria Programme. That looking at malaria slides [through] the microscope was very time-consuming and that [AMS] were going to leave patients unattended" **[HO Re M]**.

But for most of the AMS, even for those that have not yet been trained as *microscopist*s, this new capability has been perceived as improvement in their work conditions and as a benefit for their communities. One of them said:

"[Before being trained as microscopist] I had the medicine to treat the patient but I could not treat him/her without a [parasitological] result. Now I can do the diagnosis [of malaria], and give the treatment. Now is very necessary, it is beneficial for the community, to have a microscope..." **[AT Pi 92],** while others referred to seek for training from AMS-peers already trained (see Chapter 7, p.122).

To be engaged in the diagnosis of malaria has brought a sense of "a step up" in their skills, which has not yet been related or recognised in their status within the health system: *"We have been trained in microscopy, [now] we can give an accurate diagnose of malaria and tuberculosis. Nevertheless we have the name of Simplified Medicine (Auxiliaries). This should be reviewed..."* **[AT Hi 85]**.

The training courses in Microscopy of malaria and tuberculosis have represented an upgrading in their skills. The expertise in dealing with a technologic device, such as the microscope, and being prepared for a better response to the main endemic disease in the state have yielded the AMS new incentives and elements of power.

6.5 Intermediaries: The political role

As emphasised, the AMS are extenders of comprehensive services which, normatively (according to the guidelines) include health promotion, disease prevention and curative tasks. The AMS in Amazonas also conduct roles that are not included in normative guidelines. The AMS among indigenous populations have assumed a non established intermediary role between biomedicine and traditional medicine and between communities and the health system. This role was explored through themes related to their relationship with traditional medicine and healers, and themes related to translation-interpretation and advocacy.

6.5.1 Biomedicine and Traditional medicine

The AMS act as important curative service extenders; biomedically trained, they have built a professional identity and biomedical discourse. Even though, to perform their curative role they say they use the available types of health care resources in the context and dynamics of their communities.

Role and identity are contested and negotiated when they place themselves as indigenous in their local scenarios. Many referred to their indigenous ethnicity to illustrate their orientations to both "science" and "tradition", demonstrating awareness and consciousness of their double field of interest and performance. As a Hiwi AMS, with almost 20 years in service, said:

"... I believe that for a person it is important, for example, if I am indigenous, I ought to practice my traditional medicine, that doesn't mean that I, as an Auxiliary, have to practice just the scientific medicine, not at all. I must practice both of them. That makes me important, the fact that I am accepting them two. First the scientific because I render a service for science, don't I?, and the

traditional [medicine] because I am an indigenous descendant, I must take into account that both of them are important" **[AT Hi 85-2].**

They showed a pragmatic approach to therapeutic decisions encompassing alternatives available, established or not in "The Manual":

"[If] a patient comes to the clinic and I ask him what he has... He says, ' I have fever, I have headache', and I talk tenderly to my patients – 'Look, there is this plant, you drink this and that will eliminate the fever', - if he says 'no, no, that doesn't work [for fever]' well, it's ok, I have to respect his decision. If a child comes with his parents and they don't like [plants] well I give him a little glass with acetaminophen and explain them how is to be given ...This is how I am with my patients" **[AT Hi 85-3]**.

The pragmatic approach to their curative role seems to come from a "common sense", to use and let use the available types of health care resources, as found in the words of two young AMS from different ethnic groups when speaking about their practice:

"*...I know a few plants for diarrhoea, flu, things like that...I do not have to recommend them... because everyone knows them..."* **[AT Pi 02]**.

"*When people ask to see first the shaman, we respect that...I do not have to recommend them to go to the shaman, because they know themselves ..."* **[YA 1]**.

Regarding the relations Auxiliaries have with shamans and traditional healers most of the Auxiliaries show attitudes of complementarity. For most, shamans and traditional healers are regarded as authorities, as a helping hand, especially when there are no other resources for cure available. We knew about a long-lasting relationship between an Auxiliary and a highly recognised shaman in a community of the Maroa River, far from the capital. For more than twenty years they co-inhabited and interacted professionally in this 200 people community.

Each recognised the field of expertise of the other and the need of mutual cooperation and respect. The AMS says about their relationship:

"*...he's saved many lives...many people came to see him, directly, without stopping by the health post. And sometimes, when he noticed that he could not cure the disease, he said 'Hey look, this is not for me, this has to be treated by the Auxiliary'. The shaman truly knew*" **[MA Ba 73]**.

The pragmatism showed in the use of health care resources available not only responds to the fulfillment of their curative role. As health workers AMS represent an extension of the official structure within their communities where they have to relate with traditional authorities. In this dual condition they must fit into local power structures[17]. An experienced AMS, a former leader of one a regional indigenous organization, points out how the strategic relations with shamans are maintained by telling an account about his approach to patient referrals from his community health post to the hospital:

"*....I have never had problems with [shamans]. I also even suggest to my patients, before referring them to the hospital, the recommendation I give them is 'If you want, go to the shaman..', for me not to enter in conflict with the family. If something happens [in the hospital] I could be called guilty* for *all my life....*" **[AT Hi 79]**.

This pragmatic approach to patient's referral is not just a conventional formula but shows an essential political will.

[17] *Local power structures* refers to the network of hierarchical relationships in indigenous communities that includes traditional political and religious authorities, such as elders and shamans, who operate within a social structure of kinship relations, alongside the newly arisen figures of leadership such as community representatives to the statutory authorities, to indigenous organizations, political parties, religious leaders as evangelist ministers, and official employees such as teachers and the AMS.

6.5.2 The community and the health system

While the AMS are service providers working for the regional health system they are also effectively part of their communities, as expressed quite assertively by some of them in relation to their motivations to become AMS (see Chapter 5, p. 70). Indigenous ethnicity was also referred to in interviews when AMS explained their career choices, and it was crucial in what they saw as their role as intermediaries between the community and the health system:

"*In those times there were other opportunities for me, like becoming a [soldier] ..but it didn't attract me, I am of indigenous family, right?. My parents did not study, and many times when they went to the Health Post, they needed a translator. Well, many problems because of not being [literate] (estudiados), ..., I feel attracted by this job [as an Auxiliary], because to me it was not only a matter of finding a job, but to help my family. That was what [really] attracted me...*" **[AT Pi 92]**.

To be translators and interpreters between the non-indigenous health practitioners and communities were often mentioned as outstanding features of their role. A young Yanomami AMS also trained as a *microscopist* when asked about his most important activities as an AMS, answers:

"...me?, what I do is to talk to the people, to make them feel safe, to be more confident when the doctor comes, what I do is to talk with the people, explaining what the doctor says, to make the doctor feel well, comfortable too...I explain to the people, what the medicine are for, how to take it..." **[YA 01]**.

Another, more experienced working single-handed, when describing his duties during the doctors visits, recalls:

" ...when doctors come they send a message 'this day we will be there at this time' ....then I inform the community, house by house, ...I follow them [the doctors] I have to be present with the patient during the consultation...to

translate...how they have to take the medicines...they feel safe with me" **[AT Hi 85-3]**.

Both AMS, of different ages, from different districts and ethnic background referred to their common capability to create a space within the health care system where the people can feel safe.

This translator-interpreter role entails much more than simply finding equivalent words between two languages or jargons. It also bridges knowledge, adapts and gives sense and meaning to different representations, like the *body*:

"...many times one of my ethnic group Hiwi goes for consultation either to the hospital or health post and doesn't know how to express her/himself, s/he doesn't know where it hurts. In Spanish it is difficult to manage [the situation]. It is easy to say "sell me bread". Yes, but to see inside you, and explain to the doctor, that is very hard. And we as Auxiliaries in the field, in the reality, [we] expect that each patient who comes to me or to the doctor is satisfied. And I understand the pain and understand where it is located" **[AT Hi 85]**.

It became clear that simple translation moves into more complex mediation between the community and the health system where tensions and conflicts often emerge, as made explicit in the interviews. For example, a very experienced AMS from Zulia State explained:

"Guaitias [white or non-indigenous] do not feel the pain as we Yupkas do. Look here in the Hospital, we [AMS] refer patients seriously ill, seriously, and they do not receive immediate attention. 'Wait here at the door' they say. And that has happened many times, because many of us do not understand. That's why we want to train more of us. I wish some day we could have Yupkas as doctors, to speak our language here in the hospital. They'll feel the same pain as we do. But they [the government-the health care system] keep hiring non-indigenous doctors, ..., if there were other Yupkas working, they will feel the same pain as we do, but whites don't feel the same pain" **[ZU Yu 73]**.

In similar terms a Piaroa from rural area of Amazonas, with twenty years of experience, reflects:

"...when I referred patients to the hospital, doctors could say 'there are no medicines, I will attend to you soon, I'm busy', and I think they don't work with love because they are not really from this territory. I have worked and I keep myself here, and working with love, because they are my family, from my same ethnic group ..." **[AT Pi 89]**.

The mediation and the tensions it entails was not referred to just in terms of passive complaints but also in an active advocacy role, monitoring the clinical practice of medical doctors:

".. *If I had doubts with the medicines the doctor was indicating, I had to fight for my patients, ...(because) if a drug was not appropriately indicated (by the doctor), then I am responsible, ...the patient would argue that I am the one who is supposed to understand (what the doctor is doing), then I have to fight for my patients..."* **[AT Hi 85]**.

Auxiliaries presented themselves as uniquely able to represent their communities because of a common experience, a common identity and a strong affective link.

For indigenous communities in Amazonas having a health post and an AMS are positive achievements. Their members lobby in the district and regional government or political parties to have a Health Post built, and in many cases community initiatives support the application of one of its members to become AMS, organizing to cover the living expenses of those selected or elected to enter the training course.

However, for the AMS relations with the community are not always straightforward. During the observation period we witnessed frequent complaints from the communities regarding time availability of the AMS and the scarcity of medicines in their Health Posts. From the AMS perspective there were two

problems evident in this relationship: one related to expectations and demands of the community that could not be satisfied because of a lack of supplies; and the second that had to do with the community not being politically homogenous as a result of the increasing influence of party-politics.

A lack of supplies, supervision and updating activities were constant complaints of the AMS, who, besides their professional dissatisfactions, have to deal with the communities' demands:

"...[regarding the community], *it's neither easy to deliver health service, nor to say 'No, I do not have medicines, they have not supplied me'..., then the one to be blamed [by the community] is the AMS, for not doing our job, and it's not the case..."* **[AT Hi 85-2]**.

Other AMS referred: *"Often the community does not appreciate that you are rendering services for them and they don't thank you. The job is like that. Some people thank you, but other people, instead, make destructive critiques against me"* **[AT Hi 85]**.

The AMS also referred to tensions in their relations with their communities, produced in an increasingly and highly politicized environment where AMS may be identified with particular political parties:

" When I got back from the training course, arrived at the community and told them that I was trained, ... that I was going to work with their support, ... from the community. But, the people, they never got to cooperate with me, they never got to make that link, that team work, and I told them 'let's do a clean up in the community, let's pick up the garbage' [but] they never collaborated with me .....This was a united community but we are now in this situation because of [party] politics...if some people do not like my party then they won't cooperate with me....most of the community do not know how to manage this issue of politics..." **[MA Wa 01]**.

Beyond the service provider role the AMS assume a crucial intermediary service between biomedicine and traditional medicine, the communities and the health system. This role as interpreters, cultural brokers and advocates is something that has been taken for granted and never addressed in the manuals or in the training courses.

The AMS role and status depend on the level of support received from the health system and the priority given to them within the health reforms.

CHAPTER 7: The relationship of the AMS with the Health System in Amazonas

This Chapter is a description of the changes in the relationship of the AMS programme with the regional health system structured from the lived experience of actors involved[18]. Using a chronological approach the rise and fall of the relevance given by the Ministry of Health to the AMS in Amazonas is recounted. Exploring across the data the themes "Supervision and Supply", the decentralisation process emerges as a turning point in the relationship between the regional health system and the AMS programme, and highlighted through a rapid decay in support. Particular emphasis is given to recent political events and health care reforms implemented and on the way Auxiliaries in Amazonas are responding to them. Their role and status have been challenged leading to a range of responses that relate to their years of experience, to their developed professional identity, and to the way the current health reforms have been implemented.

7.1 The launching of the Programme, its Golden Age

Accounts of the health officers[19] involved in the origins of the AMS programme coincide with how the design of the AMS Programme was embedded in a "public health doctrine" ("*doctrina sanitaria*") based on "*unity of command, comprehensiveness of health care delivery, continuity, operative decentralization, normative centralization, supervision and evaluation"* (González, 1975; Pico-Méndez, 1998; González-Herrera., 2002; Lobo-Castellanos, 2002). In their accounts these officers concluded that the AMS programme made a significant

[18] Social reality cannot be understood by facts but by the meaning that different members of the social world attribute to these facts. These members are termed as "actors". Bowling A (2002) *Research methods in health: investigating health and health services.* Buckingham: Open University Press. p.111-112 (See Chapter 4, p. 39-40)

[19] Here *health officers* refer to civil servants, employees of the MoH who have managerial or technical responsibilities at different levels of the organisational structure.

contribution to the national public health organization in terms of establishing structure and processes in those states or federal entities with rural population, such as Amazonas.

Words such as "doctrine" and "principles" pervaded the organisation from top to bottom and even today, officers, nurses and old AMS use them in their accounts when making reference to the origins and first years of the programme. Such is the case of a professional nurse from Amazonas who did one of the first courses herself, being in charge for more than 20 years of the coordination of the training courses in the state:

"*Well, it was a doctrine to train all the Auxiliaries that were working in remote health services where there were no medical doctors, because they could not reach or scarcely reached those areas. To train personnel, to deliver better service, following guidelines, to offer preventive and curative medicine to better serve indigenous population*" **[HO Re N 1]**.

A national health officer that worked alongside Baldó, pioneer of the conceptualisation of the programme, during the launching period of the 1960's, recalls him in the following terms:

"*His politics was Venezuela, to make possible the implementation of several programmes related to the health of the Venezuelan people.....I gave support to all his initiatives because I knew he was assisted by reason and the truth...*" **[HO Na M 1]**.

These values of the founders, passed from generation to generation, from the central to the local levels, as observed in the health officers reference to Baldó and how AMS from any age group referred to "The Manual" and the founder.

An AMS from Amazonas, trained during the 1980's, when asked for his opinion about the eventual transformation or elimination of the programme said:

"I believe that the Venezuelan national commemoration dates are important, that the national symbols are important, they deserve respect. They same with the Public Health Practitioner ("sanitarista") Baldó, who made [the AMS] programme. If the programme is eliminated then the name of the Ministry should be eliminated too..." **[AT Hi 85-2]**.

Auxiliaries of the older generations remember the support they had from the health system in Amazonas in terms of supplies and supervision. An already retired AMS that did the course in 1968 recalls:

"In those times we had good supervision and received enough supplies, a good relationship with the Head of the Cooperative Services [and], rural doctors that visited the communities... Those were the best years....." **[AT Ba 68]**.

After those "*best years*" two relevant moments were identified as crucial for the AMS programme in terms of the priority and support received from the regional health system in Amazonas: one is the period following the political decentralisation process of 1992, and the other is the period of ongoing health reforms that started in 1999.

7.2 Decentralisation

"... The Municipalities appeared in the scene, and they [the Municipality and the Ministry of Health in the region] play ping-pong with their supervision and supply responsibilities" **[MA Ba 73]**.

Exploring across the data two themes, "*Supervision*" and "*Supply*", the period after the political decentralisation emerged as critical in the evolution of the AMS programme. In the set of interviews of the AMS and health officers, and in conversations with indigenous leaders, a prevalent association between decentralisation with the changes in the dynamic of indigenous communities, and with the decline of the programme in Amazonas was clear.

Supervision visits can be taken as a proxy for the level of support the AMS has had from the health system. The decrease in visits is a sign of a weakening of the links between the system and the health workers in hard to reach areas. According to the guidelines all level of the MoH structure, district, regional and national, should be involved in supervision.

In the organisational chart of the Ministry of Health the AMS programme was, from its origin, dependent on the National Nurse Department. In 1995, the programme was relocated under the Medical Attention Department, a decision that was taken based on the important curative tasks of the AMS that should be closely supervised by medical professionals (Pico-Méndez, 1998). Regionally, for a nurse-officer in charge of the Programme for many years, this decision was due to other reasons -a progressive decline observed in the attention given to the programme:

"We were ignored, no supervisions, no resource to supervise, [I think it was] because [the programme] was part of the Nurse Department...then it was decided in 1995 to ascribe it to the Medical Department, [nationally and regionally], that had more power to find resources, to find everything, and for doctors [getting] more involved in supervisions.." **[HO Re N]**.

Currently out of the 104 active AMS, 23 are employed by the MoH, 67 by the Regional Government and 14 by the Municipal governments. All AMS are normatively ascribed to the Directorate of Health in Amazonas[20]. Historically, the strongest link of the AMS with the Health System has remained the Nurse Department. Training, supply and supervision has been and continues to be their direct responsibility. According to the normative guidelines, the AMS should be supervised by National and Regional officers (nurses and/or doctors), and by rural medical doctors of their geographic area.

[20] Source: Department of Personnel, Regional Directorate of Health, Amazonas, 2004.

All the AMS interviewed independently from the District, concluded that supervision has progressively decreased mainly in the last decade. This is more accentuated and perceived by AMS that have been working for a long time in remote areas of districts of the interior such as Maroa, with few health posts in small communities, one to two hours from the capital town, reachable only by outboard motor boat. An Auxiliary, still active and working since the early 1970's in one of these communities, pointed out how he perceived the decreasing support and its association with specific events: "...*In the past we used to receive [from the Ministry] enough resources to work according to the Manual, ... a boat, outboard motor, fuel, medicines..... [Nowadays] you have to go outside of the rule, to go beyond the Manual...Now the supervision has decreased, the drug supply has decreased, doctors rarely come. The Ministry was supposed to take care of that ... The Municipalities appeared on the scene, and they [the Municipality and the Ministry through the Directorate of Health in the region] play ping-pong with their supervision and supply responsibilities*" **[MA Ba 73]**.

All the Rural Health Posts staffed by AMS have a "*Supervision and Visits Notebooks*". The AMS are particularly zealous about their notebooks and insist on every visitor signing up. It is also an obligation for the supervisors to make comments and sign the respective notebook. During our participant observation in Atures and Maroa Districts we were asked to sign both notebooks giving us a chance to review them. The notebooks provided a rough chronicle of each Health Post and trends in supervision over time.

In a community an hour by boat from the Maroa's capital-town, staffed by one of the oldest AMS still on duty, we carefully looked at the Supervision notebook. The registers went back to 1973, to the very day of inauguration of his Health Post. It was striking to see the amount of visitors signing the book during the 1970's, with regular visits from Nurses from the central headquarters of the Ministry of Health in Caracas and from the regional headquarters in Puerto Ayacucho. Progressively, during the 1980's, supervision visits were mainly from regional supervisors and less from the national level. In the 1990's the number of

visits, even from the local level, the Maroa Medical Post (RHP-II), became progressively less abundant. The current situation is referred to by the AMS of this post:

"*...supervision, only during vaccination campaigns, symbolically, when there is an immunisation campaign...*" **[MA Ku 73]**.

Drug availability and the direct presence of the AMS in their health posts are crucial for a positive perception of their work by the communities The scarcity or lack of medicines highly compromises the perception of AMS performance in their communities (Chapter 6, pp. 104-5). Administrative procedures for the requisition of material and medicines have been referred to as intricate, and recently as pointless. It was frequently mentioned by the AMS and observed that the health posts are now being supplied with medicines and work-material thanks to the voluntary efforts of the AMS, the communities and/or the medical doctors of the area of influence.

The lack or absence of medicines was a constant complaint of all the AMS interviewed in Maroa and Atures, and those with years of experience were nostalgic for the "*best years of the Programme* ":

"*...in 1985 when I started working, I think that the country was still rich, I think it had too much money for the [health] budget and medicines. Every medicine I asked for [at Regional Pharmacy Store] they gave me a full box of each, they [even] brought it directly to the health post. Nowadays they don't, nowadays they give me small amounts of medicines, ten bottles for three communities...What do I do with a flask of Acetaminophen?. Now it has to be picked up from the Regional store and pay for the trip....We [the villagers] collect the money [among us] for me to go [to pick up the medicines] because we are a community.*" **[AT Hi 85-3]**.

And this latter account comes from an AMS working in periurban areas of the capital of the State, accessible by public transport, making it easy to understand

the difficulties that AMS in remote areas have for their regular access to medicines and general supplies.

Many of the AMS referred to the decentralization as a turning point in the history of the programme:

"...we used to receive our supplies directly from Ayacucho, it got here fine, [but] after we have this Municipality it changed it all. That was the mistake .....the Municipality is the problem, it doesn't work. Now everything seems dispersed and they don't send more [supplies]...." **[MA Ku 73].**

" Well, now we are Municipality [and], I think that it was even better before, ... We [used to] receive everything [fuel, work material and medicines] directly from the [Ministry of Health from Puerto Ayacucho,], it came in a tank-boat, every three months, to supply us. Now you go to the Municipality and you don't receive.." **[MA Ba 73-2].**

The regional health system is not decentralised but the general perception is that it has been negatively impacted upon from the moment that local and regional legislative and executive authorities started to be directly elected in the Municipalities and the State.

Decentralisation has also had a wider impact on indigenous communities. It is associated with, and directly linked to, the pervasive influence of party politics. For a young leader of a regional indigenous organisation " *Party politics has been as an atomic bomb for [indigenous] communities",* a situation better explained in the account of a young AMS of the Maroa municipality when talking about his village:

"This was a united community , but we are now in this situation, in this division, because of [party] politics...[if] people belong to different parties they refuse to cooperate, to offer friendship, ...most of the community doesn't know how to

manage this issue of politics that started with the [municipalisation]" **[MA Wa 01]**.

Some communities of the Maroa Municipality communities have experienced demographic shrinking during the last decades. The same young AMS quoted above gives his opinion about why his community, that used to have 100 people a few years ago, now has 60 people:

"Well... there is many people who flee [to the capital town of the Municipality] not [just] looking for education for their kids, they are looking for the party-politics, they want to make a living out of politics, to live from it...they think they are going to live better where the political mass (masa política) is" **[MA Wa 01]**.

He kept reflecting on the impact of party-politics to justify himself in his decision to become a representative of the national and local ruling party in his small community. This community is one of the last, if not the last, of an ethnic group (Warekena) that has been progressively absorbed and diluted into other bigger multi-ethnical communities:

"I am the coordinator of the [a national party] in this community.. I am giving a little life to the few people remaining [here]. I tell them not to leave pursuing the political mass, ... if I wasn't here there wouldn't be a Municipal teacher, a Municipal Generator Operator, Municipal Janitor, Municipal Worker. If I don't get into politics there wouldn't be [these] jobs for them, I am giving chances for them to work ..." **[MA Wa 01]**.

These accounts illustrate the impact of decentralization on indigenous communities, on their demography and political structure. It also shows the influence that AMS have as intermediaries in this relationship and their level of integration into the power structure of the state and their communities.

The political decentralization process has produced confusion in the competences and responsibilities of the different levels of government in areas of public interest

such as health. There has not been transference of health competences to regional even less to municipal level. The advent of the political decentralization has had a negative impact on the work conditions of the AMS and, perhaps, on the entire primary care level in Amazonas. Changes in the regional and municipal political context have had a direct impact on the relationship between the health system and the AMS, in their status and role. These changes have been even more significant in the last six years.

7.3 The Bolivarian Project and the health care reforms

"*...that law that is written in the Constitution is our highest pride, it comes from Amazonas, Delta, Zulia [States with indigenous people]...*" **[AT Hi 79]**.

The reactions stimulated in the AMS by the new Constitution, and particularly to the chapter of Indigenous Peoples Right, were identified as a theme in the design phase of the study. Reactions were not spontaneously and easily evident and when elicited through direct questions, the AMS frequently associated the new "Rights" with the recognition of traditional medicine (Article 122 of the Constitution).

When asked about the impact that the "Rights" have on their work, there was evidence of awareness about the institutional duties to satisfy those rights:

"...well, I think it [the constitution] has an influence on my work. Health is our right, but not only health, as I told you, also education. And as we move forward we keep learning that indigenous people have also their rights. Whatever problem I have, we have rights and we should take the most out of the institutions..."
[AT Pi 99].

But there was also a sense that the awareness is rhetorical and at times skeptical. An already retired AMS expressed this:

"... Despite many people advocating for the Indigenous [people], institutions, organizations, parties, I think that there is still discrimination against the indigenous" **[AT Ba 68]**, while a young Yanomami gave his opinion *"...rights, well, that's in the paper...but in reality it is not evident"* **[YA 01]**.

An AMS, a former leader of a local indigenous organisation, was very explicit about the ambiguities perceived:

"...that law that is written in the Constitution is our highest pride, it comes from Amazonas, Delta, Zulia [States with indigenous people]),....without the law we are nothing, without the Constitution we are valueless,... (But) in my work there is no change at all...they (the regional health system) do not pay attention to the law, the law is not put into practice, you can't see it. I say so because I know we have the right to health and to participate (but) if I go now to the Regional Directorate of Health [saying] 'according to this Article X, and the Right Y', what would they say?: 'there are no (medicines)'...." **[AT Hi 79]**.

Impacts of the changes are more evident when looking at the health sector reforms in the last five years. The initial reform labelled "Comprehensive Care Model" (See Chapter 3, p. 33) when implemented in Amazonas, administratively and programmatically integrated the Malaria control to other health programmes. This had a direct impact on the AMS given that the skills acquired in the diagnosis as malaria, and the use of the microscope gave new elements to their role and status within the system and their communities (See Chapter 6, pp. 96-99).

Within the reorganisation of the levels of health care proposed in the framework of the "Strategic Social Plan", the second reform in this last period, the role of the AMS was blurred. Following the public announcement made in Amazonas by a National Officer regarding the transformation or eventual elimination of the programme at the end of 2002 (Chapter 3, pp. 34-35), a regional Nurse, still with responsibilities for the coordination of AMS, expressed the limitations they have had locally and acknowledged the eventual decision of transformation of the program as a logical and expected decision:

"We have taken the most out of the [AMS], as much as we could. I think they have been really helpful, the problem is that they don't have the resources to carry out all they would like. That is why we now [focus] on the boys doing mostly education..., prevention and promotion, given the limitations in resources. We have trained them for [curative activities] but they cannot obtain the resources to do so, therefore that's why we focused on prevention and promotion...."
[HO Re N].

In general the AMS are anxious about their current status and their future as health workers expressing outspokenly their opinion about eventually being "*much downgraded*" as Health Promoters, because "*promotion is something that you do not see the sense of it*", condition that affects their status and their professional expectations (see Chapter 6, pp. 90-93).

The announced elimination or transformation of the AMS programme was neither fully conceived nor planned. But in Amazonas uncertainty still surrounds the Auxiliaries programme. They are still working within the health care system but their role has being progressively questioned, receiving less supervision and supplies. They continue to work in a framework of successive health policies produced in a very unstable socio-political context.

7.4 Barrio Adentro in Amazonas

By June 2004 the official figures of the National Coordination of Primary Health Care of the MoH estimated that 12.884 Cuban medical doctors ascribed to *Barrio Adentro* were working in the Venezuela, 79 allocated in Amazonas state[21]. Here, the regional Directorate of Health had on its payroll 120 Venezuelan medical doctors registered to be working in the public sector and distributed: three in a tropical diseases research centre (CAICET), 60 of at the Hospital, and 57 in

[21] Figures provided by the National Coordination of Primary Health Care of the MoH on September 2004

administrative duties and at the primary care level[22]. From October 2003, when *Barrio Adentro* implementation started, to June 2004, the presence of medical doctors working in Primary Care in Amazonas has more than doubled in number.

The implementation of *Barrio Adentro* in Amazonas has elicited several responses from the personnel working in the health sector due to changed routines and a new situation. A Venezuelan medical doctor, with five years of experience in several districts of the interior and currently working in a Urban Health Post where *Barrio Adentro* has been implemented, expressed his opinion about the process:

"Cubans doctors are now all over the state, working in the premises of the Ministry in the region ...[in rural areas] they are living in the houses that traditionally were the Venezuelan doctors' houses, sharing the house but not the work. In terms of statistics, and the clinical practice, we do not share, we keep it separated... the decision is on the patient, about which doctor s/he wants to be attended by.." **[RMD-1]**.

Even in the health posts and medical residence there is a sense of two systems running in parallel *"sharing the house but not the work"*. Several asymmetries of the treatment given by the health system and regional government to the Cuban professionals in comparison to their Venezuelan colleagues have been a cause of unrest. Medical residences in the Health Posts have been rapidly equipped with computers, TV and video, and these have being pointed at as "privileges".

In Amazonas, while this has been happening with professionals, the status and role of AMS within the system has been challenged. We were particularly interested in the reactions of the AMS to the implementation of the policy either in Health Posts that were previously staffed by Venezuelan Doctors or, and more importantly, in those where AMS used to work single- handedly, and whose health post were recently reinforced with Cuban Doctors.

[22] Figures provided by the Direction of Human Resources of the Regional Directorate of Health, Amazonas, September 2004.

Attitudes and responses to changes were better observed in Atures District as it concentrates the majority of Health Posts in the State (see table 1, Chapter 4, p. 46). It was in Atures where *Barrio Adentro* was more intensively implemented in terms of numbers of doctors allocated, and because it was in its periurban areas where Rural Health Post I (RHP-I), traditionally staffed by AMS, were reinforced with medical doctors. Seven out of twenty-eight existing RHPI were recently staffed with Cuban medical doctors.

7.5 AMS responses to Barrio Adentro

"They talk about Barrio Adentro, but we are not slums, we are indigenous communities" **[AT PI 97]**.

Information collected from Auxiliaries and observation done in Health Posts located in the eastern road axis of Atures shed light about the range of responses toward the program implementation: from a willing-to-learn and accepting attitude, to resisted-displacement and rejection.

El Progreso is a multiethnic community of around 625 people located 10 kms from downtown Puerto Ayacucho, accessible by car. Hiwi is the main ethnic group of this community that has a Rural Health Post I staffed since 1985 by a Hiwi AMS, currently 40 years old with a high school degree recently obtained, who was also trained for the miscroscopic diagnosis of Malaria in 2000. Two Cubans Medical Doctors arrived in October 2003. In the first months of 2004 there was open conflict involving doctors and the Auxiliary. The latter unilaterally decided to quit working at the Health Post alleging that he had been mistreated by the doctors and announcing his will to start procedures for his retirement, yet he had one more year to go to complete the required twenty years in service. In his account of the problem the AMS referred to having been treated roughly, in a way that is not justifiable *"here in Venezuela"*, and explaining himself he said: *"its up to them, there [in Cuba], with their dictatorship, but not here"*; and continued:

"I had been working by myself during 18 years, I felt like a little doctor, a little epidemiologist.... But it happens that this year with the implementation of "Barrio Adentro" I feel a bit downhearted because the Medical Doctor, let's say a foreigner, not a Venezuelan, comes with a very central mentality and they thought they were going to find it similar to where they were working before, but I was already here, psychologically more prepared, and there have been some conflicts because of my experience....few days ago the doctor told me to apply a dipyrone to a patient with Varicella , and in my Manual, the one I have worked with, doesn't say that, so I said no (that I wouldn't apply the dipyrone). Then he said that my Manual was dead, that for us it was now valueless, and I replied that for personnel already trained the Manual was still alive..." **[AT Hi 85]**.

The Cuban´s regional coordinators of *Barrio Adentro* decided to relocate one of the doctors involved in the incident to another health post of the District, and the AMS went back to his duties in the health post.

The above mentioned incident sheds light to one of the determinants in one of several responses of the AMS in Amazonas to the implementation of the programme.

A resistance to the sense of displacement was elicited in this experienced Auxiliary who saw his medical identity challenged. In his account his expertise is reaffirmed by his knowledge of the content of "The Manual", the equivalent of evidence-based practice, whose symbolic content was attacked. "*The Manual is dead"* is the death of the AMS professional identity.

Colorao is a periurban community located at the end of Atures eastern road axis, 30 Km from El Progreso, and 40 Km from downtown Puerto Ayacucho. It was founded in the 1970's around the basin of the Cataniapo River, inhabited mainly by the Piaroa ethnic group. It has a population of 300 people served by a Rural Health Post that had been staffed until the late 1990's by an AMS who was not

Piaroa, but from the Baré ethnic group, born and bred in the interior of Amazonas. This AMS had 6th grade approved education, and had stayed in this periurban community for more than 20 years. Since 1999 a new AMS, a young Piaroa from the community, with 9th grade approved, was trained and assumed the post. Also trained for diagnosis on malaria he worked single-handedly until October 2003 when the Health Post was included in the *Barrio Adentro* programme and staffed with two medical doctors. He seemed to be at ease in the new situation. Our conversations with the Cubans doctors located in this post said they were satisfied in their work relations with the AMS, "*who has shown responsibility*". They highlighted how useful he had been translating and mediating with the community and patients, "*working with the microscope*", and about how well he "*subordinates*" to them. They also reported being surprised at how the AMS had such a level of responsibility for providing first aid and health care without basic knowledge, like human anatomy for example.

Since their arrival in Colorao, the Cuban medical doctors have offered the AMS "informal training" that they said included prevention of endemic diseases and anatomy, topography of the human body and technical denominations of its parts. They also provided formation medicines in stock, brought from Cuba for the *Barrio Adentro* programme. The AMS of Colorao indicated that he has been relieved from any responsibility regarding the managing and prescribing of medicine and showed enthusiasm toward the training courses and the benefits of his experience with the doctors. He summarised the changes in his professional identity and roles as well as his concerns when he said:

"After the doctors arrived, well I told the people that they are more superior than I am, but that I still keep working, relating well with [the doctors] and that I will be always in the health post...but I do not want to forget how to use medicines, to be [a] Simplified Medicine [Auxiliary]" **[AT Pi 99]**.

This young and recently trained AMS showed his willingness to cooperate with the full implementation of *Barrio Adentro*, acknowledging its benefits for his

community but referring to the changes in his role and his identity as a health worker.

Colorao is also a quay, on the way to two Piaroa communities, San Isidro and San Genaro, accessible by the Cataniapo River, one and two hours by outboard-motor boat respectively. These Piaroa communities have kinship links but a recent history of social and political fission. Before this event they were both served by the same AMS, but today they each have a Rural Health Post, San Isidro's founded by the Ministry of Health in the 1980's and staffed by an experienced Auxiliary and the other, San Genaro's built in 2001 with resources from the regional government. The San Genaro community has 125 inhabitants and the health post is staffed by a young AMS with high school level, trained in the last course offered in Amazonas in 2002. This young Auxiliary of San Genaro was also invited and enthusiastically joined the informal training provided by medical doctors in Colorao, spending many days of the week out of his own community thus giving tacit approval to his training sessions with the neighbouring doctors. He also referred to being trained by his more experienced AMS colleague from Colorao in the use of the microscope in diagnosis of malaria transmitting his enthusiasm with the whole pedagogical experience.

The young and recently trained AMS showed an interest in *Barrio Adentro* and this attitude of interested-pupils, to self-improve by learning, was reported as a driving force in their decision to become an AMS. Older AMS, who have worked single-handedly, reacted differently.

San Isidro is the farthest community reachable in this road-river axis. It has a population of 150 people served by a 37 years old AMS trained in 1989, with 6th grade approved. No doctors have been assigned to the health post. The AMS has been an outstanding leader in his community, once disputing the traditional political leadership position as "captain", and more recently as the Minister of the Evangelist church which he joined seven years ago.

He shows himself to be demoralised in his relationship with the Health System and sceptical about the arrival of doctors in neighbouring communities. He assumes that their permanence depends on the stability of the national government, which was considered uncertain in the months before the referendum. He gave his opinion about his work:

"I have abandoned it a bit, I blame it on the government, I do not ask for medicines, I do not bother the Municipality, I do not bother the regional Government ...[When I began as an AMS] I was really interested but I started to realize how everything was run [in the health sector], ... they took advantage of me ...I still have five years before retirement, and I have been observing how the Cubans work. They have called me [for the training] and I have not gone. But if the President wins [the referendum] I will make a meeting with the community to call for the Cubans ... in case they come I do not want to continue as an Auxiliary.." **[AT Pi 89]**.

This experienced AMS, with many years working single-handedly even without having worked with *Barrio Adentro*, expressed reluctance in the implementation of the *Mission.* Referring to the weakening of his relationship with the health system, political and ethnic arguments arose leading to an attitude of rejection.

Barrio Adentro was blamed by some experienced AMS for the eventual elimination or transformation of their positions: "*I have worked 17 years by myself (solito) and I know the program works when there are medicines. Since October I have been told to work with the Cubans. Here they are, and we have had few little problems...We [AMS] are sad because the programme will be eliminated, because of them [the Cubans Doctors], we are going to be transformed into Health Promoters... when we began we had support and supervision but all of the supervisors are now retired ...we should make a general meeting of AMS those more experienced, with skills, to appoint a Supervisor among us....*" **[AT Ku 85]**.

The first signs given by the national authorities to an eventual transformation and/or elimination of the programme had started before the implementation of *Barrio Adentro* in Venezuela. The highly politicised environment of these years could explain the association that experienced AMS in Amazonas made between the arrival of Cuban Doctors with the changes, highlighting the ethnic and cultural differences with these doctors.

A Hiwi AMS, with primary school approved education, who has been working for almost twenty years in a periurban community of Atures was cautious in his diplomatically expressed opinions regarding the presence of Cuban Doctors. He highlighted the importance of the AMS for the community and the Health System with a nationalistic perspective:

"[They are] always welcome, I do not feel uncomfortable, I do not feel quiet either, ...the doctor is the right person for the job, s/he studied the medical career, but we offer cooperation, integration between the doctor and the Auxilliary ....., we are Hiwi here, and as Auxiliaries we are mostly to translate, mainly to the elder, to help the doctors in their visit to the houses...and to explain to our people, because they are foreigners, to explain to our people that they are humans too, that they have to be confident, the same as with the Venezuelan doctors, that they [Cubans] also suffer, and cry, they feel hunger, it is important to promote that rapprochement using the oral-word..." **[AT Hi 85-2]**.

Another AMS, thirty two years old with high school level education, and with seven years duty as a single- handed worker, referred differently to *Barrio Adentro* but also recognised and highlighted their specific input as AMS in community health care:

"I was trained as AMS in 1997 and have worked a few years by myself, I also work with the microscope (doing diagnosis of Malaria) ...When the Cuban doctors came I told them that the fundamental thing is that I was here, that I am a Piaroa, and [that they] ought to understand us, how we are, how our life is, our culture, our customs, because their cultures, as criollos, [is] different. They talk

about Barrio Adentro, but we are not slums, we are indigenous communities, not slums[23]*. I gave them the key of the Health Post but asked them to leave medicines for the weekend (when they are not here) ...I told them they have to get used to it, because they are not in Cuba, and little by little they are adapting. What I have as an AMS is quite a lot, and they need me...* **[AT Pi 97]**.

The implementation of *Barrio Adentro* has produced a range of responses among the AMS, responses that were found to be related to their years of experience; a willingness to cooperate or to be engaged in the *Mission* was found among young and recently trained AMS, willingness that is complemented with this attitude of interested-pupils (p. 122). Younger AMS with a few years of single-handed experience seem to cope better with their new situation of permanent subordination to medical doctors. They referred to advantages with the permanent presence of medical doctors in their health posts for the benefit of the communities, and their own, by having more opportunities to learn while emphasising their value as health workers, with their intimate knowledge of their own culture and acquired professional skills. The older AMS who have worked for many years single-handedly reacted differently in face of the challenge to their identity as health workers and consequent changes of status (p. 123). They resisted the sense of displacement by Cuban Doctors, and some rejected *Barrio Adentro*, despite the level of community acceptance of this latest and more significant change in the regional health system.

When recalling his 15 years of experience, a 36 years old and 8th grade of school approved AMS, made a summary of the principal changes in the regional health system mentioned in this Chapter, and the way these changes reflected in his role and status. He showed a positive attitude and an optimistic view of the current situation:

"I have been working since 1989. At the beginning everything was normal, I worked with medicine, I saw patients...I visited communities on my bike, I went

[23] "Slum" is the word to translate *Barrio* in this particular context.

there because I had medicines. But since around 8 years ago that was over, because we now receive just very few medicines, I just do not feel like going, and losing the communities. The [communities] say that we do not work and it's because we don't receive medicines. The other issue was Malaria, since I did the training we have been helping to reduce malaria...well Barrio Adentro was a blessing. It was very good ... thanks to those people (Cuban Doctors) .. We have medicines again, and I am working well with them" **[AT Pia 89]**.

CHAPTER 8: Discussion

In rural areas of Amazonas most of the health care provided by the state is delivered through the AMS programme. Despite the speed of the extension of medical facilities, still today 75 of 102 health care services in Amazonas are RHP-I attended by AMS who remain the most permanent presence of the health system in scattered indigenous communities. They function and have the responsibility of taking forward policy initiatives for Primary Health Care. This thesis was designed to give them a voice, to listen to what they have to say about the programme in order to help to inform the changes to come in the context of the current rhetoric of Right to Health and Indigenous People's Rights. The study explored the political nature of the programme by describing the self identification of the AMS as health workers and as indigenous and by comparing the role assigned to them by national guidelines with what they say actually happens in their local scenarios. Through their views this study provides insight into the impact of changes such as decentralisation on the primary care level in Amazonas, and insights into the ongoing health policy implementation such as *Barrio Adentro*.

8.1 AMS among indigenous people in Amazonas: Lackey or Liberators?

The political nature of the CHW such as the AMS has always been criticized raising questions about their role in community oppression or community support. This tension has led to the disjunctive question of Werner (1978): *"Are they Lackeys or Liberators?"*.

Werner's question is a useful way of engaging the Venezuelan experience, especially among the indigenous population of Amazonas where the AMS was

from the beginning an official national programme. Werner saw this type of programme as the most dependency-encouraging and initiative-destructive programme when compared with small local initiatives created and conducted by NGO's which he saw as community supportive. The AMS started in indigenous areas and is now the most permanent presence of the health system in hard to reach areas in states such as Amazonas.

In all its years of functioning the AMS national program could have made the indigenous AMS *lackeys* if:

1. Seen as a peripheral extension of a paternalistic state-supported system, good enough for marginalised and hard to reach populations but limited in capacity and restricted in their tasks and contributing to the extension of an hegemonic biomedical model that suppresses traditional alternatives of health care (Menéndez, 1990; Herrera, 1991; Zent, 1993; Lacaze, 2002).
2. Seen as reproducing the official discourse that has characterised the governmental development projects including health programs for indigenous population in Amazonas, where indigenous people are seen as an obstacle to national development (Vidal, 2002; CAICET, 2004).

On the other hand the programme could be conceived as making the AMS liberators if:

3. Seen as genuine community representatives providing curative, preventive and promotion services and being responsive to indigenous health needs particularly in the current times when Venezuela is experiencing political and social reforms.

In this discussion I will give answers to the first two assumptions. In further work I expect to give answers to the third, keeping an eye on the evolution of events in Venezuela and Amazonas around *Barrio Adentro*, primary care related policies and other social development programmes.

In general, the expectations of the CHW roles in a broader context of social development have been presented as another dichotomy. As *Service Extenders vs. Agents of Change* (see Chapter 2, 12-16).

The AMS in Venezuela were initially not conceived for the purpose of becoming agents of change. The AMS represented, and particularly for Amazonas, an unprecedented expansion of the health system into rural areas with the specific purpose of providing basic comprehensive health services. This study provides answers to the kind of services they extended, the roles assigned to them and those they, the AMS, have assumed in their own turn.

8.1.1 Services extenders

This study showed that the AMS developed a strong individual professional identity directly linked to their biomedical training and to the emphasis given to their curative tasks. Despite the discourse of comprehensiveness of the services to be provided by Auxiliaries, rhetorically highlighting promotion and prevention, they developed a professional identity which clearly reflects the curative focus of the health care system in Venezuela. By the time the programme was launched and during the last forty years, the real emphasis has been given to their "*first aid*" services, reproducing a highly curative model prevalent in the country since the early 1960's (Briceño-León *et al.*, 2003; Feo and Siqueira, 2004). This identity has been echoed and maintained with the feedback of the expectations of their communities and the health system about their role as "Little doctors". The study found an identification with the professional role model of the medical doctor and with the programme embodied in "The Manual". More recently the skill acquired in the diagnosis of malaria through basic microscopy has contributed to the broadening of their tasks, increased their usefulness for their communities and strengthened their biomedical identity.

The excessive emphasis on the curative tasks of personnel such as the AMS in indigenous areas has been seen as a caricature of the biomedical health system suppressing other alternative systems of health care (Lacaze, 2002). Other authors have stated that unless the training places more emphasis on the social and cultural factors influencing health status among indigenous population, their integration as CHW into health services *"is disguised assimilation"* (Sagers and Gray, 1991). We argue that, in their biomedical practice the AMS showed more than expertise, they help to solve health problems that they can legitimately treat while fitting into the local power structures. The results of this study enable us to conceptualise the role of the AMS not as marginal curative service extenders but as relevant contributors to the social and political life of their communities.

Based on their accounts and our observations this study found an inventory of roles that are not addressed in the occupational profile of the current national guidelines for the AMS programme. Beyond the curative-provider role the study showed a crucial *intermediary service* that ranges from translation and interpretation, to complex transcultural mediation between biomedical and traditional medical systems and between families and the health system.

8.1.2 From service extenders to agents of change

As documented in other studies of persons from ethnic minorities working in mainstream health services, to assume an apparent simple task of translation entails a more complex role (Kaufert and Koolage, 1984; Green *et al.*, 2005). As translators they become interpreters, cultural brokers, explaining to non-indigenous health workers about the environment and the culture of communities. They adapt biomedical knowledge into local systems of knowledge, giving sense and meaning to different representations of the body and to disease and health, and also act as advocates in making common cause with their patients and communities. This position as intermediaries is not free of conflict with the health system and/or with the communities and relates to occasional clashes of roles and

loyalties, and to the differentiation or separation of CHW's from the rest of the community as salary paid workers (Kaufert and Koolage, 1984; Oliveira-Nunes *et al.*, 2002). But in general, the AMS in this study presented themselves as uniquely able to represent their communities through a common experience, a common identity and through affective links. The study also showed that their position as public servants is also a convenience and motivation for their families and communities who receive direct and indirect benefits by having someone with a salary post. This provides not only monetary income but also ways of access to official institutions through their intermediary role.

It is this function, as intermediaries, that suggests that the AMS, even in the context of an extension of direct medical attention, will continue to be a critical element of the Venezuelan health care system for indigenous populations. Their intermediary role is something that has been taken for granted but not addressed in the guidelines and training courses.

The argument here is that as health service providers they can better serve their communities if Health Promotion is re-conceptualised and adapted to indigenous areas and officially included in their training, guidelines and expected tasks. The health system as a whole may learn from what they have been doing, translating, interpreting, mediating and advocating. They provide "*cultural safety*", to use the term coined by Maori's health personnel to define and create an environment within the health system where people's identity is prioritised " *to promote more effective and meaningful pathways to self determination for Indigenous people*" (Williams, 1999).

The newly recognized Indigenous Right to Health and the current trend in Venezuela to train and enroll social promoters to work in the massive social development programmes pushes the health sector toward a change in the concept and practice of Health Promotion among Indigenous People. This is a shift from paternalistic advice dispensed to individuals for life-style changes delivered through talks and boards and found to be boring and pointless by the AMS (see

Chapter 6, p. 90-93) to a more political conceptualization of community organization and mobilization. They play an active role, firstly in community participation on governance over the health services and secondly in assessments of health needs by the communities themselves. In essence, they move from a medical approach of promotion (which is prevention) to a health promotion approach of empowerment (Webster, 2001, pp. 197-252; Tones and Green, 2004, pp. 2, 89-97) that supports the recognition of identity, spirituality and community cohesion as essential to indigenous peoples health (Herrera, 1991; McLennan and Khavarpour, 2004).

The study showed that in the context of the political and legal reforms the AMS are aware of the new proclaimed rights regarding health and Indigenous Peoples but there is also a sense of skepticism of the impact of these changes on their work conditions and lives. Located as intermediaries between indigenous communities and the health system their cumulated experience informs health programmes and transcends from rhetoric to practice the recognition of rights contained in the Constitution. For example the "*right to maintain and develop their ethnic and cultural identity, world view, values, spirituality*"(Venezuela, 1999), and principles of the National Health Service such as "*cultural and linguistic pertinence*" (Venezuela 2002).

In this study *Ethnic Identity* was seen in the self-identification of the AMS through the way they introduced themselves as Indigenous during the interviews and through the way they referred to their companions during the training course where links of an ethnic basis were expressed as brotherhood. This did not hinder expressions of deliberate differentiation between ethnic groups, but in general toward the *criollos* there was an evident sense of common identity as Indigenous from Amazonas (Chapter 5, 83-87). We explored ethnicity as a construction of individual and collective identity (Torres, 2001). In this sense ethnicity was used as a proxy of process by which people create and maintain a sense of group identity and solidarity, giving an "us" statement emphasising individual self-identification over outsiders' designations (Kelleher, 1996).

Identity as a hallmark of ethnicity is a sense of property. This can emerge in particular historic circumstances when ethnic status can determine gains of political benefits (Kelleher, 1996). The current favorable legal framework could have determined that members of ethnic minority groups, such as the AMS in this study, are more likely than in the past to claim rather than to disavow their indigenous ancestry.

Assimilation of indigenous people into mainstream national society has characterised developmental policies for indigenous people in most Latin-American countries including Venezuela during the last decades (Stavenhagen, 1998; Mansutti-Rodríguez, 2000; Clarac, 2001; PAHO-OPS, 2003). Even progressive sectors of society have fed this approach. From the 1930's left-wing political movements have discussed whether the Indians should be considered part of a subordinated social class as peasants, in a very orthodox Marxist approach, or on the other hand considered as oppressed people culturally differentiated in nations (Stavenhagen, 1998). These were two ideologically different approaches discussed by indigenous organisations to achieve social and political rights. If the class approach prevailed, struggles or resistance or political effort should have come from the unions, peasants' organisations, and through the agrarian reform process. But if the conceptualisation of *People*[24] prevailed, the emphasis on *identity* was fundamental, and that related to social class became secondary.

The latter was the strategy recently taken up by indigenous organisations and leaders in Venezuela: to place an emphasis on *identity* and the recognition as *Indigenous as Peoples*, moving toward the goal of giving indigenous not only equal rights before the law but special rights based on cultural difference. This was introduced and put forward during the discussions leading to the Constitution of 1999 (Clarac, 2001). With the approved legal framework, the official ideology of the Venezuelan State turned from the promotion of a homogenous national

[24] See Chapter 2, p. 17, ILO's definition of *Indigenous*.

identity embodied in "*el mestizo*"[25] that characterised the Venezuela of the 1960's and onward, to the promotion and defence of a multiethnic and multicultural society. This represented a turning point for a country that was considered to have a very anti-indigenous hard-line (Gray, 1997).

Any evidence of ethnic identity, the conscious self-attribution registered in this study when the AMS referred to their relationship with traditional medicine, healers and shamans, has been produced despite the Programme, despite the absence of any acknowledgement of cultural or ethnic differences in the content of the guidelines and training material and "The Manual". It has also occurred despite the prevalent view of indigenous people as an obstacle to national development; a view that has pervaded projects in Amazonas for the last forty years (Vidal, 2002; CAICET, 2004). This is reflected in the content of scarce references related to cross-cultural public health practice found in the official documents of the programme (see Chapter 5, pp. 79-82).

Health systems are complex sociopolitical institutions and not merely delivery points for biomedical interventions. They are part of the social fabric, and their contribution to broader social values are expressed and produced directly from the interaction between citizens and the health system (Gilson, 2003). In indigenous areas the experience of the AMS can add to the societal values promoted by the new Constitution, as a "*multiethnic and multicultural society*" with a health system based on the principles of "*equity, solidarity, and cultural pertinence*"(Venezuela, 1999). In the current Venezuelan context, the AMS being comprehensive service extenders can act as agents of change.

[25] *Mestizo* or "*mixed race*", is a construct used to promote an homogenous national racial and cultural identity.

8.1.3 AMS promoting the extension of Biomedical hegemonic model, or embodying medical pluralism?

Ethnic Identity was also evident in this study when the AMS positioned themselves as members of their community in cultural and ethnic opposition to medical doctors and their understanding of traditional medicine in contrast with the medicine of "*the whites*" or scientific medicine. Despite the AMS having developed a strong biomedical identity, they stand as indigenous, and these identities, as indigenous and health workers, are not mutually exclusive or conflicting.

In general, the AMS seem at ease in their relations with traditional healers and in most circumstances respect and combine the use of traditional medicine with scientific medicine. They show a pragmatic approach to therapeutic decisions encompassing alternatives available in their local scenarios which may or may not be included in "The Manual". The combination and acceptance of drugs and medicinal plants could be supported by the idea that for some indigenous groups of the Amazonas the use of industrialized medicines could be paralleled with the preexistent use of medicinal plants (Albert, 1985 quoted in (CAICET, 2004). Studies done among the Baniwa population in Rio Negro Brazil suggest that the appropriation of curative models is not a simple reproduction of practices enforced by biomedical institutions "*people take the most out of this appropriation when they are congruent with their pre-existent knowledge*" (Garnello, 2003: 218).

It has been argued that programmes such as the AMS limit or inhibit the use and development of traditional medicine and shamanism (Kroeger and Freedmann, 1984; Jackson, 1995; Alexiades and Lacaze, 1996), and that, in other scenarios within the Amazonas region, they can promote "collision of authorities" between the CHW and shamans. Correa (1993), quoted in (Jackson, 1995) studied the Colombian Vaupés health promoter program very similar to AMS and stated:

"Ultimately the Medical service of the Vaupés has [attempted] to integrate the two kinds of medical knowledge. The experience began with the training of Indian "health promoters" and "nursing aides" located in the communities, who would contribute to supplying primary care and community education. Despite their good intentions this generated competition with shamanic practices".

This has not been the case in this study. We are not questioning that biomedicine exerts an influence on traditional practices but it appears that it is not biomedicine the driving force in the reduction of traditional medicine and shamanism. These medical systems do not compete, they rather complement each other. Ethnographic work supports this observation which seems to be the same throughout the Amazonas region (Buchillet, 1991; Kelly, 2003). Personnel such as the indigenous AMS in similar scenarios of Colombia have provided us with examples of being able to analyse the differences between the two medical systems and to search for paths to optimise care services of the official health systems (Herrera, 1991). Other forces such as commoditization of traditional medicine, turning it into a for-profit good of exchange, and Evangelism, whose missionaries consider shamans literally to be agents of the devil (Jackson, 1995), are factors more associated with the decline in acceptance and use of traditional medicine and shamanic practices than biomedicine services themselves.

Biomedical knowledge and acquired skills do not seem to contradict their communities' interests and identity. In the case of the Auxiliaries in Amazonas, as documented in other Amazonic scenarios regarding national-official policies such as the case of intercultural schools, there is a will of the communities to accept the programme as part of a life project. If cultural transformation is included, this is a choice (Rival, 2002), a choice to find ways of improvement, by combining and occasionally mixing alternatives of health care available, ways to modernization through *hybridisation*, a term understood as "*socio-cultural processes in which discrete structures or practices, that existed separately* (such Traditional Medicine and Biomedicine) *are combined engendering new structures, objects and practices"* (García-Canclini, 1989, pp. I-X).

As seen in this study, to have access to health services and education is seen as a source of social mobility, as key instruments for the improvement of indigenous life. The AMS training programme has been and still is one of the few chances to progress through formal education. This was an important motivation for becoming Auxiliaries. They are workers that are generally required and supported in their training period by their communities for which having a Rural Health Post and an AMS are collective assets. To assume that biomedicine goes against the cultural integrity and wellbeing of indigenous communities is an assumption that lacks indigenous perspective.

It is important to frame the discussion of access and use to diverse resources of health care in the current legal environment, in what Last (1996) calls the *"Medical Culture of the State"*: the lesser or greater degrees of state regulation of coexistent medical systems. Amazonas in Venezuela, as in many rural areas in other countries of the developing world, has had a "*de facto*" plural medical system (Last, 1996). There is no way that the state can regulate the practice and use of other alternatives to health care than those delivered through the limited official health care system. However, the Venezuelan State *"Medical Culture of the State"* seems to be changing, as expressed through the Constitutional recognition of traditional medicines and traditional practices of health care.

Initiatives from the national government to institutionalize shamanism, to integrate their practices into the official health system, have been put forward by high health authorities including a Minister of Health (see Chapter 1, p 3-4). However they have been resisted even within indigenous organizations and health professionals working with indigenous people health in Amazonas, who argue that shamanism cannot be learnt and taught under institutionalized conditions. It is a tutorial lived experience, not demonstrative or academic. This initiative ignores the importance of secrecy in the shamanic knowledge and the potential dangerous

rivalry among shamans[26]. Similar experiences of integration of shamanic and traditional healers into official health services have proved to be ineffective in other Amazonic settings (Lobo-Guerrero, 1991). In this unedited process of adapting or designing health policies for PHC in indigenous areas of Venezuela other alternatives deserve to be studied and discussed. Instead of institutionalizing the shaman it would be better to train, update, upgrade and back up the community health workers such as the AMS. It is important to encourage a process of reflection within the health system, communities, and traditional authorities such as the shamans, and other traditional healers. With their cumulated knowledge, AMS embody much of the *de facto* medical pluralism that has been prevalent in Amazonas and their experience could inform and facilitate health policy implementation in this regard.

Several authors have pointed out that traditional medicine has retained a firm foothold in the face of modernisation and the spread of biomedicine, and that the politics of nationalism in many instances gives the indigenous medical traditions a powerful boost, assuring continued legitimisation and expansion. (Lock and Nichter, 2002). In the experience of countries undergoing radical social and political changes such as China during the 1970´s, the so called "Bare-foot doctors" *were one solution to the problem of integration [of medical systems], trained partly in traditional but mainly in western medicine they serve as medical auxiliaries*" (Last, 1996, p. 386). During the 1970's and 80´s the government of Indonesia used the commitment to development as an ideology and at the same time traditional values such as aboriginal medical practices, were lauded as essential to the state's vision of reflexive and unique modernisation (Ferzacca, 2002).

This resonates with the current Venezuelan government's ideology that prompts modernising movements that seem to be in search of lost authentic traditions,

[26] José Antonio Kelly, PhD Political Anthropology, current coordinator of *Health Plan for the Yanomami People* of the MoH, Germán Freire PhD in Anthropology and Antonio Camico, Baniva, Teacher and indigenous leader. Personal communications.

including indigenous traditions, as part of a process of constructing multi-cultural nationalism. For the indigenous population this national project represents an opportunity to exercise rights and to negotiate interests, among them, medical pluralism, cultural pertinence of health services and increasing governance over them.

8.2 The AMS role in a shifting context.

After 44 years the question is whether the programme of extension of services such as the AMS should be maintained. It could be argued that the AMS programme has remained in rural indigenous areas because they have been neglected in terms of the priorities of the state. In organisational cultural theory the AMS programme of Venezuela can be taken as an example of how values, beliefs and assumptions promoted by charismatic leaders are accepted and endure to become traditional or historically rooted, lending stability to a programme (Cook and Hunsaker, 2001). This was reflected in the statements made from personnel from all levels of the health system involved in the Programme, from young AMS to old health officers.

The best possible evaluation of CHW programmes is to show an impact in epidemiological and demographic outcomes. Such evaluations, demonstrate cause-effect relationships between community health workers input and decrease in indicators such as morbidity and mortality, are notoriously difficult to design (Walt, 1990; Wood, 1990). In a very circumscribed area of Amazonas in Venezuela, Zent (1993), analyzed the relationship between the health care services and cultural change among the Piaroa ethnic group. He showed that the expansion of the biomedical system through the AMS has had a positive impact in reducing morbidity, mortality and possibly increasing fertility.

We argue that even by increasing the access of medical services provided by doctors, the geographical and demographic conditions in Amazonas make it

impossible to have permanent direct medical attention all over the area. The presence of AMS is still necessary for the expansion of the health system in geographical and cultural terms. The health system and indigenous communities in hard to reach areas benefit from these comprehensive service extenders. Their role as health promoters should be strengthened and their curative tasks maintained. AMS are fundamental in a culturally-sensitised and community-based health care system and are one of many necessary factors for sustainable rural development projects in Amazonas.

AMS should maintain their multipurpose role, including the recently integrated tasks in the diagnosis of endemic diseases such as malaria. They will need to function in RHP-I and to maintain their curative tasks.

It has been documented that the credibility of CHW as the AMS is highly dependent on the worker's curative role (Parlato & Favin, 1982 in Bhattacharyya *et al.*, 2001), and that the lack of access or poor medicine supply undermines their preventive and promotion role (Walt, 1990; Wood, 1990). Therefore, if their promotion role is to be strengthened their curative tasks have to be maintained.

The management and delivery of essential drugs yields material and symbolic power for the Auxiliaries. Symbolic capital is understood "*as the legitimate recognition in a social environment of the accumulation by individual or groups of material and cultural goods that render them of social conditions for success in concrete interventions*". It is a source of power socially recognised (Bordieu (1989, 1996) quoted in (Garnello, 2003, p. 223). The AMS could be capable of developing health education and promotion, and prevention activities, but nothing renders more prestige to them than the use of industrialised drugs. This has also been documented in other Amazonic areas, with similar indigenous CHW within a context of local pluralistic medical systems (Garnello, 2003).

It is not that they have to keep the curative role and access to medicines just for symbolic purposes, but because curative tasks and dealing with drugs are necessary to respond to the villagers most frequent diseases. In the last five years,

according to the records of the Epidemiology Department of the Amazonas Directorate of Health, diarrhoea, helminthiasis, skin infections, tonsillitis, malaria, anemia and wounds are the most frequent diseases registered in the general population, and gastroenteritis, pneumonia, accidents, sepsis and malaria are among the ten main causes of mortality in the general population[27]. For most of these diseases, particularly for malaria and helminthiasis, the benefits of biomedicine are widely recognized and appreciated by indigenous communities. To have access to medicines is a constant demand from community representatives, even from traditional healers and shamans (see Chapter 1, pp.3-4).

One of the main worries regarding the massive extension of medical coverage through *Barrio Adentro* is how to make it culturally sensitive, economically sustainable and coherent within a frame of rural development in indigenous areas.

The barriers to rural medical practice have been structural. The model of medical education in Venezuela, as many other countries in Latin America, is oriented toward individual curative practice, hospital based, and located in urban areas relying on sophisticated technology, and with ethical, political and social values oriented to the liberal exercise of the profession, within the private sector (Braveman and Mora, 1987; UCV, 1988; UCV-OPS-UDUAL, 1989). Consequently, despite the progress of the extension of the health care system in Venezuela and Amazonas in the last forty years, the professional assistance in primary level is characterised by being geographically limited and permanently rotary. There have been recent initiatives to massively train medical doctors within a new model oriented by values of equity and solidarity and towards community medicine and PHC. But it will take decades, in the best circumstances, to have professional human resources to replace the support currently received from Cuban professionals in Amazonas.

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[27] Source: Department of Epidemiology and Strategic Analysis, Regional Directorate of Health, Amazonas, 2004

Besides this, the immediate sustainability of these massive social programmes depends on the political stability of the country. Currently there is still strong opposition both inside and outside Venezuela to the current changes. Particularly in the health scenario, today as yesterday, programmes to expand public health services to traditionally marginalized areas have been resisted by professional bodies. This is the same theme seen in the launching period of the AMS programme and in the current medical professional bodies' resistance to *Barrio Adentro.*

To foster the progressive training and education of local human resources is a priority for Amazonas development. Within the regional health sector, despite the increasing level of formal education of the candidates and perhaps of the Amazonas' general population, to become an AMS still represents an opportunity for personal betterment and social mobilisation.

There is a lack of professional medically-qualified personnel of Indigenous ancestry in Amazonas. This is a serious deficiency reflecting structural inequities. Recent initiatives have been taken from the newly created National Coordination of Indigenous People's Health (NCIPH) in the MoH pursuing the induction of health professionals already working in indigenous areas with elements of anthropology, human rights, ethics, and indigenous peoples rights. An immediately attainable goal is that of enhancing cultural sensitivity among health professionals currently in practice at all levels of care and particularly those linked to *Barrio Adentro.* The experience of the AMS as intermediaries between indigenous communities and doctors and between traditional medicine and biomedicine, can help to inform the design of this induction. But the fast track vertical implementation of *Barrio Adentro* has meant that those AMS with more experience, those who could be more useful in informing and implementing the policy, are feeling displaced. They resist being captured by health professionals as "*another pair of hands*", a tendency reported in other CHW programmes (Walt, 1990; 2001).

The massive social development programmes including *Barrio Adentro* are a deliberate effort to expand public services to traditionally marginalized areas reflecting commitment to social justice and redistribution of welfare. Equity in the provision of health services in areas of very low population density and cultural diversity, must include, on the one hand, the periodical mobilization of professional personnel such as doctors based in areas of demographic concentration, and on the other hand the presence of Community Health Workers such as the AMS providing basic health services, with curative, preventive and promotion roles. AMS are indispensable in strategies of extension of health services in the context of a wider developmental effort. They can help adapt the service extension strategies within the current *Barrio Adentro* intervention.

8.3 Amazonas health system and the AMS programme. What next?

Decentralization policies are concerned with changing power relationships between levels of government. They are necessary reforms for putting resources closer to the population to be served and for increasing accountability over the management of those resources (Mills, 1990). In the case of CHW programmes, decentralization should allow local authorities to decide on how and whether a particular district can support them (Walt, 1990).

As a result of the state reform process in Venezuela, Amazonas gained political autonomy in 1992, but in the mean time the regional health system has been increasingly dependent on the national level because it has not been decentralized. Amazonas is still far from having its health sector decentralised to the District level due to an extremely weak organisational structure (see Chapter 3, p.27, Chapter 4, p. 44).

Significant policy changes can be monitored not simply on health effects but on perceptions, attitudes, systems and institutions (Zwi and Mills, 1995). This study found that political decentralisation brought a progressive sense of "*non-belonging*" of peripheral health personnel such as the AMS in relation to the

regional health system. The advent of locally elected governments with administrative autonomy is perceived as having had a negative impact on the working conditions of the AMS and, perhaps, on the entire primary care level in Amazonas, particularly for the municipalities of the interior of the state (see Chapter 7, p. 109-115).

Such impact on the CHW programmes and in primary care level in particular was documented in the 1980's in low-income countries as a consequence of structural economic reforms and diversion of financial resources from PHC to the payment of the external debt (Walt, 2001). However, for the particular case of Amazonas state, this happened in the middle 1990's due, not to economic or financial constraints, but because of a lack of coherent intergovernmental articulation in the context of state reforms. The political decentralization process in Amazonas has produced confusion in the competence and responsibilities of the different levels of government in areas of public interest such as health, which has not been functionally decentralized. Beyond this, the political culture of government is not conducive to law abiding authorities, and the struggle within party politics makes intergovernmental agreements more difficult.

Although decentralization is one of the characteristics of the Venezuelan State promulgated in the Constitution, the decisions regarding the primary level of health care and the eventual concurrence of intergovernmental competences and responsibilities are yet to be defined in Amazonas.

Decentralisation will have to be tailored for the capacities in regional health systems. District political governments need to be progressively involved. They are needed to support the primary care plans designed at regional level, whilst a district level of health is being built up. Weaknesses in task allocation, training, supply and supervision at the peripheral level need to be reversed. The negative impact that the political decentralisation has produced with loss of capabilities of the Rural Health Posts and increasing levels of confusion and frustration among the front line service providers, ought to be overcome.

The inadequate supervision and support of the AMS is one of the challenges to be faced by the regional health system and municipal governments. The AMS should maintain their multipurpose comprehensive profile and the regional health system will have to closely evaluate the feasibility of the tasks and roles assigned progressively to integrating community representatives and the AMS themselves.

8.4 The role of the Venezuelan State and health, the thesis aim, and dissemination of results

From the policy perspective, health can be conceptualized as a right, a good of consumption or an investment (Zwi and Mills, 1995). Each view influences how roles of different actors are perceived, notably the role of individuals, the market and the state. Health conceptualised as a right provides the basis for a strong government role in promoting its achievement and equitable access to quality health care (Zwi and Mills, 1995).

The state role in relation to health care should not be seen just as provider, funder, manager or regulator of health services: A central role of the state is "*...to manage the processes through which the meaning of the health system to society, and so its contribution to broader societal value, is established"* (Gilson 2003).

The Venezuelan Constitution of 1999 endorses health as a social right and clearly defines the role of the state as guarantor. It also incorporates notions of health promotion and prevention as priorities of the health system. This includes community and individual participation as a right and duty in the decision-making process and also cultural pertinence of health programmes and services.

This moves the Venezuelan legal framework for health forward and in agreement with the organisation and functioning of modern health systems (Feo and Siqueira, 2004). It places the design of health system and policies at the heart of

participatory democracy with increasing governance at the community level (Meads *et al.*, In press).

There is no doubt of the support the Constitution gives to tackling the deep problems of the social exclusion of indigenous populations regarding health. It opens legal and political space toward a less medicalised and less curative care oriented system. This favours inter-sector social development programmes as the most comprehensive concept of PHC. But there has also been experience of how the rhetoric does not match practice.

For indigenous communities and organisations health can be assumed as a political field in which to demand long term responses to the current situation of indigenous people within the national society. These responses ought to include services not designed or offered exclusively from a non-indigenous perspective.

If an intercultural approach includes the recognition of other knowledge and ways of doing things, then new strategies have to be set in motion to build the capacity of indigenous people to more actively involve them in the design, management and control over the health services. The creation of, and initiatives taken by the National Coordination of Indigenous People's Health (NCIPH) within the MoH, are promising in this regard. There are still doubts, however, over the ambiguities of PHC policies like *Barrio Adentro* being applied to indigenous areas and to the risk of increasing dependence on biomedical official interventions.

The extension of access to medical attention, the focus of *Barrio Adentro* as implemented nation-wide, does not satisfy the aspiration and expectations raised by the legal framework of cultural pertinence, and cultural appropriateness within the health services. It limits the possibilities of community involvement in rural development projects, as it was clearly expressed in an AMS statement "*we are not Barrios, we are indigenous communities*" (See Chapter 7, p. 119).

The AMS are progressively demoralised because of the lack of support and supplies weakening a strong sense of belonging that has characterised the

programme and the health system in previous decades. Demoralisation has also been fuelled by the lack of participation in decision making. Hecker (1997) points to three main factors preventing indigenous health workers from attaining a key role and more control and responsibility within the health services: the low standard of training they receive, their low literacy and numeracy levels, and their lack of participation in decision making. In this study, the AMS reported that they were satisfied with the training course, it was registered an increase in their educational level in the last twenty years, but in their statements they regretted the lack of knowledge updating activities and of opportunities to intervene in the development of the current changes (See Chapter 7, 123).

Initially, when this study was designed, *Barrio Adentro* the main ongoing health care reform in Venezuela, had not been implemented. This happened in Amazonas a few weeks before the beginning of field work. This added to the complexity of the context of the study. For the research, for the programme, for the Directorate of Health in general, these changes came too fast. The project was used as an opportunity to facilitate dialogues between the regional health officers from different levels, AMS and Cuban doctors. It helped to open space for information and discussion, to better understand, on the one hand the roles of the AMS, and on the other hand, the content of *Barrio Adentro*. Meetings were held among the AMS, the regional health system, a number of reports were presented to several levels of the MoH. Communications were sent to local journals and to academic meetings to disseminate results and generate discussion (See Annex 8).

On 23 and 24 September of 2004 a *Workshop* was organized in Puerto Ayacucho, under the title of *"Auxiliares de Medicina Simplificada and Primary Health Care in Amazonas"* with the objective of gathering together: health officers; statutory authorities and decision-makers, from different levels of the public administration; the AMS from different generations; and indigenous organizations. The purpose of this meeting was:

1. To understand the criteria of the National Coordination of Primary Health Care concerning the role and status of the AMS within the reforms being implemented.

2. To determine opinions, concerns and demands of the AMS in relation to their situation and to find ways in which to articulate the AMS programme within the *Barrio Adentro* reform.

3. To disseminate the preliminary results of this study.

A total of 54 people attended. Twenty active and one retired AMS, regional Cubans and Venezuelan coordinators of the *Barrio Adentro*, representatives of the National Coordination of Primary Health Care, the current Head of the Coordination of the Indigenous People's Health of the MoH, representatives of regional and national indigenous organisation (*Organización de Pueblos Indigenas del Amazonas*, ORPIA, and *Conejo Nacional Indio de Venezuela,* CONIVE), a Governor of the State representative, as well as members of local NGO's.

Four roundtables for discussion groups were set up: 1) AMS: Where and what for?; 2) A new training programme and an occupational career for the AMS; 3) AMS and *Barrio Adentro*; and 4) AMS and Indigenous Rights.

At the end of the workshop, national and regional authorities collected the opinions, claims, and demands of the AMS. The main themes were:

- The AMS remain an important pillar of PHC in Amazonas, contributing to the cultural pertinence of health services in primary care, and to guarantee the Right to Health of Indigenous People.

- The AMS claimed their rights to be included in redefining the Programme and in the design, implementation and evaluation of the training material and course. Where cross-cultural communication skills are required experienced AMS should be included as trainers.

- The AMS claim that every professional, whether Cuban or Venezuelan, working in Amazonas ought to receive an induction before starting to work for and with indigenous people. The *Barrio Adentro Mission* ought to be adapted for these particular areas.

A year after the conclusion of the fieldwork and the Workshop, doubts still remain regarding the status of these community health workers and the course of the health reforms in Amazonas.

The speed of change from *Barrio Adentro* offers an invaluable opportunity to translate into practice the findings from this study, and to keep searching and researching for better alternatives for the health care of indigenous people.

CHAPTER 9: Conclusion and Recommendations

The AMS deserve to be given more attention in the design and implementation of primary care policies in indigenous areas of Amazonas. The role and experience they have had as service extenders and as intermediaries between traditional medicine and biomedicine, between the indigenous communities and the health system can provide great opportunities to address the concerns of the populations for improving the health of indigenous people. Moreover, these roles as service extenders and intermediaries will help to support the AMS, community and health system link to the current Venezuelan legal framework of health, health care and indigenous rights. A new conceptualisation of health promotion for indigenous people is needed and tasks and duties of the AMS must be redefined without cutting their curative role.

9.1 Recommendations

9.1 1 Policy and Programme

At the National Level

1. The National Coordination of Indigenous People's Health (NCIPH) needs to set up a multidisciplinary team including experienced AMS, to call together national and regional indigenous organisations to conceptualise *Health Promotion* in indigenous areas giving attention to the legal framework of health and indigenous people's rights. This concept should be then integrated into all health programmes and levels of care of the National Public Health System. Health programmes and health care services should provide a means to help to develop: ethnic identity; cultural values and spirituality; the effective recognition and use of native languages within health services and programmes; and the effective recognition and use of traditional medicine.

2. The NCIPH needs to take an interest in the follow up of this study in Amazonas and to promote similar studies in other indigenous states or areas in the country to identify professional profiles of the AMS in different ethnic groups. This information should be used to inform the selection/election criteria for future Community Health Workers.

3. The NCIPH should set up a multidisciplinary team to design and develop general national guidelines for the incorporation of medicinal plants to be used at the primary care level in indigenous areas.

At the Regional Level

1. Guidelines and training for front-line care providers such as the Auxiliaries should be further developed in preference to the creation of a new cadre of Health Promoters.

2. Regional initiatives should be fostered **to redesign and develop a CHW programme for Amazonas** with a profile as basic service extenders *and* agents of change:

    a. **Extenders**:

        i. To strengthen their preventive tasks prioritising immunisations and Maternal and Infant Care activities.

        ii. To redefine the curative component according to the epidemiological profile of the main diseases in the area maintaining access to and delivery of basic treatment for frequent diseases. To provide first aid provision in rural areas in Amazonas.

        iii. To provide skill and resources to extend the participation of the AMS in control programmes for the main endemic

diseases, such as malaria and tuberculosis, including basic microscopy and treatment.

b. **Agents of Change**: To be actively engaged in the construction of the Public Regional Health System through community participation and with cultural and linguistic pertinence, taking forward the concept of *Health Promotion for Indigenous People* that should be defined at the NCIPH.

3. To design, develop and pilot a new Manual and a Training course for CHW not as a programme but as a whole level of health care, with a participative approach involving educationalists, health professionals, social anthropologists, indigenous organisations, communities' representatives and experienced AMS.

4. To engage trainers for the course that include experienced AMS and personnel with intercultural pedagogical skills.

At the District Level

1. To actively engage the district government authorities in support of the AMS candidates during training and supervision and to supply the RHP-I of their area according to the regional plans.

2. To design work plans to link the Regional Health Authorities with District governments and through a study of their role in PHC to establish further agreements toward the creation of a District Health Level structure.

9.1.2 Research

Public health practice in Amazonas needs more research initiatives aimed at integrating ethnographic approaches in multidisciplinary projects. This is required to help decision-makers understand the socio-cultural characteristics of the populations being served.

Exploring the interaction of traditional medicine with PHC is an important line of research to better understand the level of demand and use of traditional medicine and biomedicine in rural, periurban and urban settings. The process of intermediation between health professionals, AMS and communities, such as the dialogues and interaction produced in the clinics, could help to provide better implementation for health education and service provision in intercultural settings. The design of projects to study the quality perception or satisfaction of indigenous communities with health services and programmes, particularly with the AMS programme, is recommended.

A Health Policy Analysis of *Barrio Adentro* as the basis of the Public Health System in Amazonas is an important line of research, from decision-making to implementation and monitoring. Another important area for study is to better understand the structure and culture of the regional health sector and regional government for the implementation and sustainability of health policies and programs, and for the eventual future process of decentralisation of the health sector.

9.2 Contribution of the thesis to the international knowledge of CHW

This study has visited one of the earliest community health worker programmes in the world. The programme was hailed as a successful experience in community based health services and provided impetus for the introduction of the PHC concept into international health policy in the late 1970's. The thesis provides long-term insights into a national programme, from the conceptualization and formulation of the CHW programme to its evolution and development over a time-span of more than four decades. The prolonged permanence of this health care service is exceptional. Themes that emerge associated with its success that are important for international policy include: the transmission of organizational values despite changes in the political and social context and the important role of charismatic leaders.

The thesis is unique in the international context in providing a focus on the current situation of the CHW programme among indigenous communities from the perspective of the indigenous CHW themselves. Through their perceptions, motivation and experiences the study portrays the relationship between the nation-state and its indigenous minority populations at a moment in Venezuelan history when important contextual changes are occurring. These changes are being translated into reforms within the health sector and include recognition of indigenous people's rights. Yet, questions arise about how the current health reforms, from decentralization to the increased numbers of physicians in indigenous rural areas will affect the roles of the CHW and the programme itself.

Few studies have focused their attention on the professional identity building process of the CHW in general, and this thesis makes an international contribution to the understanding of this process specifically among indigenous workers. It also contributes to the exploration of the relationship between professional

identity, clearly identified with a biomedical curative role, and the self-identification of these workers as indigenous, an exploration that reveals their role as intermediaries between the biomedical and traditional system, and between their communities and the health care services.

Future international research needs to focus on the interface between these workers and communities as well as on their links with the health system. Comparisons with other national programmes and with those specifically implemented among indigenous peoples in Latin America and elsewhere, are important. This is particularly urgent and relevant in cross-cultural settings such as indigenous areas where there is an aim of integrating indigenous perspectives and practices in the provision of culturally sensitive and socially inclusive health services in order to create a more equitable society.

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ANNEXES

Annex 1. Health and Indigenous Issues in the Constitution of the Bolivarian Republic of Venezuela, 1999[28]

(From) PREAMBLE

The people of Venezuela, exercising their powers of creation and invoking the protection of God, the historic example of our Liberator Simón Bolívar and the heroism and sacrifice of our aboriginal ancestors and the forerunners and founders of a free and sovereign nation; to the supreme end of reshaping the Republic to establish a democratic, participatory and self-reliant, multiethnic and multicultural society in a just, federal and decentralized State that embodies the values of freedom, independence, peace, solidarity, the common good, the nation's territorial integrity, comity and the rule of law for this and future generations; guarantees the right to life, work, learning, education, social justice and equality, without discrimination or subordination of any kind; promotes peaceful cooperation among nations and furthers and strengthens Latin American integration in accordance with the principle of nonintervention and national self-determination of the people, the universal and indivisible guarantee of human rights, the democratization of imitational society, nuclear disarmament, ecological balance and environmental resources as the common and inalienable heritage of humanity; exercising their innate power through their representatives comprising the National Constituent Assembly, by their freely cast vote and in a democratic Referendum, hereby ordain the following:

[28]Excerpts from an unofficial translation obtained from http://www.vheadline.com/readnews.asp?id=6831 19th, September 2005.

(From) FUNDAMENTAL PRINCIPLES

Article 4: The Bolivarian Republic of Venezuela is a decentralized Federal State on the terms set forth in this Constitution, governed by the principles of territorial integrity, cooperation, solidarity, attendance and shared responsibility.

Article 9: Spanish is the official language. The use of indigenous languages also has official status for indigenous peoples, and must be respected throughout the territory of the Republic, as constituting part of the cultural heritage of the Nation and humanity.

(From) Chapter V

(From) Social and Family Rights

Article 83: Health is a fundamental social right and the responsibility of the State, which shall guarantee it as part of the right to life. The State shall promote and develop policies oriented toward improving the quality of life, common welfare and access to services. All persons have the right to protection of health, as well as the duty to participate actively in the furtherance and protection of the same, and to comply with such health and hygiene measures as may be established by law, and in accordance with international conventions and treaties signed and ratified by the Republic.

Article 84: In order to guarantee the right to health, the State creates, exercises guidance over and administers a national public health system that crosses sector boundaries, and is decentralized and participatory in nature, integrated with the social security system and governed by the principles of gratuity, universality, completeness, fairness, social integration and solidarity. The public health system gives priority to promoting health and preventing disease, guaranteeing prompt treatment and quality rehabilitation. Public health assets and services are the property of the State and shall not be privatized. The organized community has

the right and duty to participate in the making- of decisions concerning policy planning, implementation and control at public health institutions.

Article 85: Financing of the public health system is the responsibility of the State, which shall integrate the revenue resources, mandatory Social Security contributions and any other sources of financing provided for by law. The State guarantees a health budget such as to make possible the attainment of health policy objectives. In coordination with universities and research centers, a national professional and technical training policy and a national industry to produce health care supplies shall be promoted and developed. The State shall regulate both public and private health care institutions.

Chapter VIII

Rights of Indigenous People

Article 119: The State recognizes the existence of indigenous peoples and communities, their social, political and economic organization, their cultures, practices and customs, languages and religions, as well as their habitat and original rights to the lands they ancestrally and traditionally occupy, and which are necessary to develop and guarantee their way of life. It shall be the responsibility of the National Executive, with the participation of the indigenous peoples, to demarcate and guarantee the right to collective ownership of their lands, which shall be inalienable, not subject to the law of limitations or distrait, and nontransferable, in accordance with this Constitution and the law.

Article 120: Exploitation by the State of the natural resources in indigenous habitats shall be carried out without harming the cultural, social and economic integrity of such habitats, and likewise subject to prior information and consultation with the indigenous communities concerned. Profits from such exploitation by the indigenous peoples are subject to the Constitution and the law.

Article 121: Indigenous peoples have the right to maintain and develop their ethnical and cultural identity, world view, values, spirituality and holy places and places of cult. The State shall promote the appreciation and dissemination of the cultural manifestations of the indigenous peoples, who have the right to their own education, and an education system of an intercultural and bilingual nature, taking into account their special social and cultural characteristics, values and traditions.

Article 122: Indigenous peoples have the right to a full health system that takes into consideration their practices and cultures. The State shall recognize their traditional medicine and supplementary forms of therapy, subject to principles of bioethics.

Article 123: Indigenous peoples have the right to maintain and promote their own economic practices based on reciprocity, solidarity and exchange; their traditional productive activities and their participation in the national economy, and to define their priorities. Indigenous peoples have the right to professional training services and to participate in the preparation, implementation and management of specific training programs and technical and financial assistance services to strengthen their economic activities within the framework of sustainable local development. The State shall guarantee to workers belonging to indigenous peoples the enjoyment of the rights granted under labor legislation.

Article 124: Collective intellectual property rights in the knowledge, technologies and innovations of indigenous peoples are guaranteed and protected. Any activity relating to genetic resources and the knowledge associated with the same, shall pursue collective benefits. The registry of patents on this ancestral knowledge and these resources is prohibited.

Article 125: Indigenous peoples have the right to participate in politics. The State shall guarantee indigenous representation in the National Assembly and the deliberating organs of federal and local entities with a indigenous population, in accordance with law.

Article 126: Indigenous peoples, as cultures with ancestral roots, are part of the Nation, the State and the Venezuelan people, which is one, sovereign and indivisible. In accordance with this Constitution, they have the duty of safeguarding the integrity and sovereignty of the nation.

The term people in this Constitution shall in no way be interpreted with the implication it is imputed in international law.

Annex 2. Guides for Interviews

Annex 2a. Guide for interviews presented for the up-grading

(October 2003)

For Simplified Medicine Auxiliaries

How they decided to become Auxiliaries?

How they were selected?

What their goals were?

What do they think the training Programme contributed with them?

Will you briefly explain your educational and training background?

What do you think about the Manual and training material?

What are the memorable (bad – good) experiences during the training and during performance?

How did they feel when finished the training course?

When was the last supervision you received?

When was the last updating course you had?

How many programmes do they run?

Which health programme do you like the most/least and why?

From 1 to 10: How much time do you spend on Promotion, Preventive and Curative work?

How do you feel with your work an duties?

Do you think you are in better or worse position to understand the health problems of your communities than the doctor? Why?

How is the work related to the rest of the PHC system in Amazonas?

How did you feel and what you do when the rural doctors come to your communities?

How many times in the last three months you have been visited by the rural doctor?

How do you feel and what you do when other workers of Control programmes as malaria come to your communities?

How are you related with the Regional Direction and Control Programmes Coordination?

How important are the following actors to your work:

- Rural Doctors
- Malaria inspectors
- Health officers
- Statutory authorities (majors)
- Indigenous organisations
- Traditional healers

Do you think other actors are influencing your work as Auxiliary? If yes who and how?

What are the main problems of the Regional Health System? And what are the main health problems of your communities?

What goes on in the regional Health System that prevents you to from questioning or solving this problems and getting corrected?

How do you relate with traditional healers?

How much do you think the healers help solving problems in the community?

How do you relate with:

- Missionaries
- Local government and politicians
- Military
- Teachers

Do you know the new constitutional indigenous rights?

How do you think new constitutional an legal frame work could affect your performance?

Do you think that health programmes and services should be adapted to indigenous population? Why? If yes, How?

Do they see themselves first as care workers or community representatives?

For the interviews and Focus Groups with Medical Doctors:

Regarding the Auxiliaries:

How do you see SMA?

Do you understand what the SMA are supposed to do?

In the scale of 1-5, how useful do you think they are for the health system?

In the scale of 1-5, how useful do you think they are for their communities?

(1=nothing 5=very valuable)

Are you supportive of CHW in their activities? If yes, How?

Do you think you are in better/worse position to understand the health problems of your communities than the Auxiliaries? Why?

How important is that the Auxiliaries are indigenous? Why?

How important are these actor to your work:

- Auxiliaries
- Health officers and Programmes Coordinators
- Local and Regional Government authorities
- Traditional healers

What are the main problems of the Simplified Medicine Auxiliaries? And what goes on in the regional Health System that prevents you to from questioning or solving these problems?

Do you relate with traditional healers? If yes, How?

Do you know about the constitutional indigenous rights?

If you do, how do you think they can influence/affect your duties?

How do you think this will affect the performance of Simplified Medicine Auxiliaries?

Do you think that health programmes and services should be adapted to indigenous population? Why? If yes, How?

For the interviews with health officers and for document analysis:

Specific questions to address in interviews and document analysis will include:

How are the Programme and the Auxiliaries characterised by the health officers?

How have they been involved in the programme?

What actors/factors prevent or promote that involvement?

What factors/actors affect the performance of the Auxiliaries?

Has perception, priorities and issues changed over time?

Annex 2b. Guides for interviews developed during field work

For the interviews with AMS:

a) About who the AMS say they are:

Identity as Health Workers and Indigenous (Professional and Personal/ Ethnic Identity):

Personal Identity to be explored since the very introduction of the session with ice-breaking questions, opening space to introduce themselves and the communities where they work.

Personal and professional motivation could be approached by questions such as:

- What made you become an Auxiliary? Events and persons related to this decision.
- How did you decide to become an AMS?
- What do you remember about the course?
- What are the memorable (bad – good) experiences during the training and during performance?
- What/how was your relationship within the group?
- What was common (different) among your colleagues?

Issues around Ethnicity and Traditional Medicine are expected to appear spontaneously. If they don't, then explicit questions could be asked:

- What can you say about working in indigenous communities?
- Do you use traditional medicine? Examples of cases where you use it.

- How do you relate with traditional healers?

Sources of Authority and Knowledge: explore formal and informal ways to acquire experience and knowledge. A proposed technique is to focus the conversation on topics of the Manual:

- What do you think about The Manual and training material?
- Should the manual be updated?
- What have you learned after the course (by yourself) (that is not in the manual)?
- Tell accounts of what have been learn after the course (formative experience and not anecdotes).
- Tell us what can enhance your "status" condition and respect as Auxiliary.

b) About the AMS Roles

Tasks and duties and sources of authority could be elicited by direct questions:

- Mention the five most important activities of the Auxiliaries
- Tell us about the work load of these activities.
- This was elicited by discussing the usual time-table or work scheduled found in the boards of the Health Posts.
- Tell us what can enhance your "status" condition and respect as Auxiliary.

c) Regarding the Relationship with the Health System and responses to Health Reforms and Constitutional changes.

The strategy is to get into this topic departing from open ended questions about the principal changes on the role of the Auxiliary to get into desired concrete answers

- How was your health post when you started? What has changed?
- What drugs did you have then?
- What are the memorable (bad – good) periods during your performance?
- Who do you usually relate with for the purposes of your work?
- How do/did you relate to the Regional Directorate and Control Programmes Coordination?
- What goes on in the regional Health System that prevents you from questioning or solving this problems and getting it corrected?
- Since you have been working as an Auxiliary what things could have change your situation?

Finally a reflexive answer could be elicited by asking for opinions about the modification and/or elimination of the Auxiliaries Programme, or transforming them into Health Promoters and/or using specific "objects" as a Preamble to the Constitution, an Article of the Constitution regarding traditional medicine, a *Barrio Adentro* flyer etc, and followed by direct questions

- How do you think the new constitutional and legal frame work could affect your performance?
- Do you think that health programmes and services should be adapted to indigenous populations? Why? If yes, How?

For the interviews with Medical Doctors:

Ice-breaking questions about their impressions and experiences with their new job in Amazonas. Regarding the Auxiliaries:

- Tells us about your routine and how the AMS fit in it.
- How useful do you think they are for your work and for the health system?
- In the scale of 1-5, how useful do you think they are for their communities?
- What are the main activities/tasks of the AMS in this Health Post?
- What are the main activities/tasks of the AMS in their RHP-I?
- Do you remember a good/bad AMS? Why?
- Are you supportive of CHW in their activities? If yes, How? If No, Why?
- What are the main problems of the Simplified Medicine Auxiliaries? And what goes on in the regional Health System that prevents you to from questioning or solving this problems?
- How do you think this will affect the performance of Simplified Medicine Auxiliaries?
- Do you think that health programmes and services should be adapted to indigenous population? Why? If yes, How?
- What do you think about the programme being transformed or eliminated?

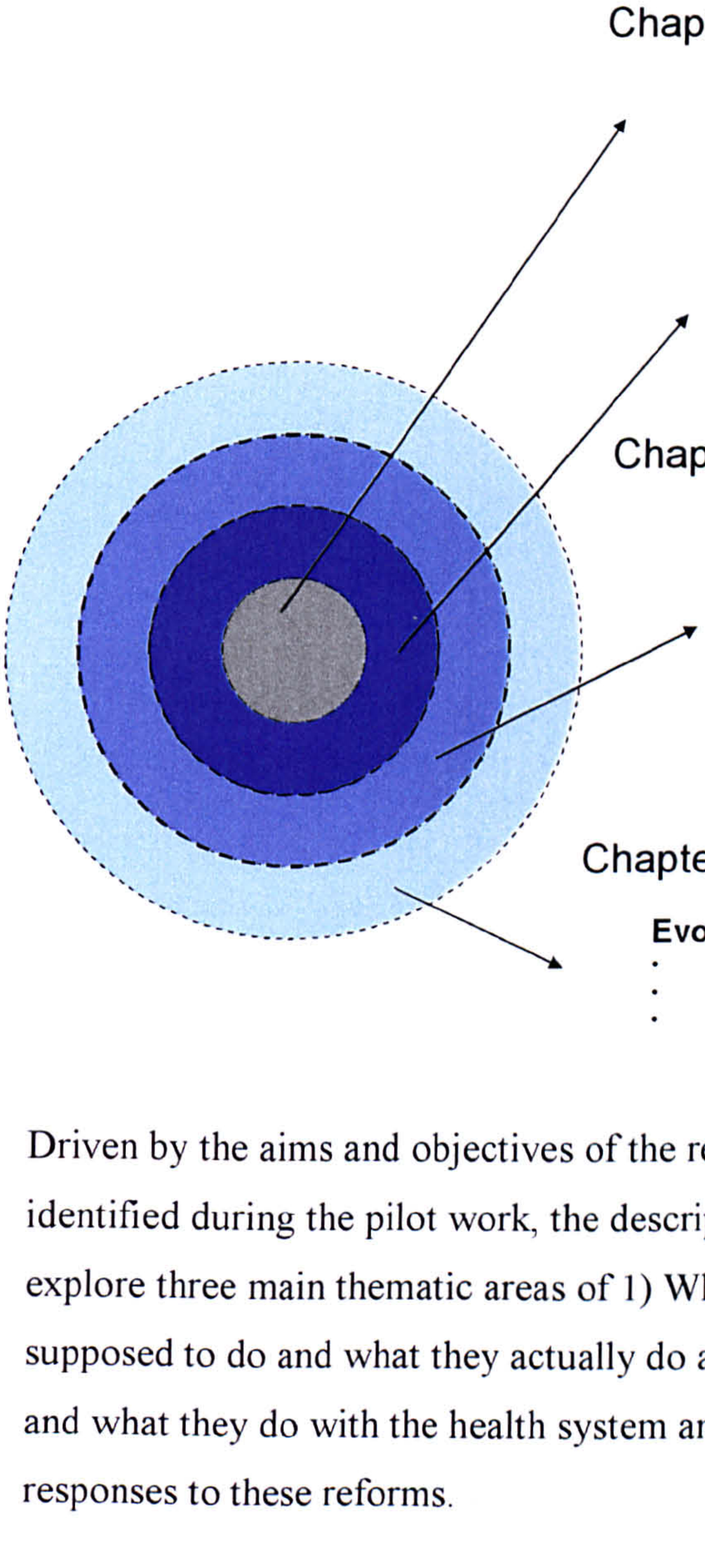
For the interviews with health officers:

Specific questions to address in interviews will include:

- How are the Programme and the AMS characterised by the health officers?
- Current role the assign to the AMS and why.
- How have they been involved in the programme? What actors/factors prevent or promote that involvement?
- Has perception, priorities and issues changed over time? How and why?
- Implications of the legal framework and reform in the role of he AMS
- Transformation or Elimination? Why? How?

Annex 3. Layers of Description

Figure: Graphical presentation of the Layers of Description



Driven by the aims and objectives of the research and by the salient issues identified during the pilot work, the descriptive study was set up to depict and explore three main thematic areas of 1) Who the AMS are, 2) What they are supposed to do and what they actually do and, 3) the relationship of who they are and what they do with the health system and health system reforms, and the AMS responses to these reforms.

Who they are and what they do were intimately intertwined, with common themes emerging through the iterative analysis of the information gathered during interviews and observation. The relationship with the health system was

reconstructed through a story telling approach identifying salient period, issues and themes in the statements of the interviewees complemented by the documentary analysis.

1) **Who the AMS are as health workers and as Indigenous**: *Professional* and *Ethnic Identity* were the two main themes to explore. *Professional Identity* was explored through questions related to the *motivations to become AMS* and about their *sources of knowledge and authority.* Experiences recalled about their *training course* and the operating *Manual* of the programme were then explored. *Ethnic identity* was explored through their self-presentation and questions related to their relations with colleagues-peers, commonalities and differences referred, and about their references to their communities and relationship with traditional medicine and traditional healers.

2) **What the AMS are supposed to do,** "ideal role" was contrasted to their **actual role:** investigating and comparing the document analysis, what they say they do, what they most value and what was observed. When asked about the most important ordinary tasks *prevention and promotion, curative activities and access and use of drugs*, and their recent integration to infectious diseases control programmes in the *basic microscopy* emerged as themes. Intermediary role also appeared as relevant theme with different dimensions, when referring to their *relation with traditional medicine and biomedicine and between the community with the health system as translator-interpreters and advocates.*

3) The **relationship of the programme with the health system** was explored through the interviewees perceptions of changes within the system and the wider national context that were referred to have influence on who AMS are and what they do. This is presented a narrative firstly of the reactions to the new Constitution and secondly of the evolution and

development of the programme at the national and regional level highlighting the perspective of the interviewees, particularly from the AMS, explored around themes of *supervision and supply.* Relevant periods in the programme history were identified: The *launching period,* the *decentralisation* process and the *current health reforms.* A typology of responses to the implementation of current health reforms was identified.

Annex 4. Identification Coding system, Description of the Interviewees and Original Quotations and Translations

Annex 4.1 Identification coding system

In the thesis excerpts or quotations from the interviewees are presented italicised with explanations, when necessary, in brackets. The interviewees are identified by a code. AMS were identified by the initials of the Municipality they work at (AT= Atures or MA=Maroa, in Amazonas, and ZU=Zulia, to identify the only AMS interviewed from this State); followed by initials of Ethnic group (Pi= Piaroa, Hi=Hiwi, Ku= Kurripaco, Pia= Piapoco, Ba= Baré, Wa= Warekena, Ya= Yanomami, Yu=Yupka); and the year of training. E.g., **[AT Pi 92]** = AMS working in Atures from the Piaroa ethnic group trained in 1992). Health Officers where identified by HO, followed by their level Na= National, Re= Regional, and their profession M= Medical Doctor, N= Nurse. E.g. **[HO Re N]**= Nurse Health Officer from the regional level. Rural Medical Doctors are identified by the initial **RMD**.

Annex 4.2 Table: Description of the AMS interviewed

AMS Code	Gender	Age	Ethnic Group	Type of Health Post	Year of Training	Level of education approved
Atures District						
[AT Hi 85]	M	43	Hiwi	RHP-I*	1985	11
[AT Hi 79]	M	46	Hiwi	RHP-I	1979	6
[AT Pi 92]	M	38	Piaroa	RHP-I	1992	8
[AT Pi 02]	M	26	Piaroa	RHP-I	2002	11
[AT Pi 99]	M	26	Piaroa	RHP-I*	1999	9
[AT Hi 85-2]	M	44	Hiwi	RHP-I	1985	8
[AT Hi 85-3]	M	43	Hiwi	RHP-I	1985	8
[AT Pi 89]	M	38	Piaroa	RHP-I	1989	6
[AT Pia 85]	M	36	Piapoco	RHP-I*	1989	8
[AT Pi 97]	M	32	Piaroa	RHP-I*	1997	11
[AT Ku 85]	M	43	Kurripaco	RHP-I*	1985	8
[AT Hi 86]	M	38	Hiwi	RHP-II	1986	9
Maroa District						
[MA Ba 73]	M	53	Baré	RHP-I	1973	9
[MA Ba 73-2]	F	49	Baré	RHP-II	1973	9
[MA Ku 73]	M	57	Kurripaco	RHP-I	1973	6
[MA Ba 02-2]	F	29	Baré	RHP-II	2002	11
[MA Ba 02]	M	30	Baré	RHP-II	2002	11
[MA Wa 01]	M	34	Warekena	RHP-I	2001	7
[MA Ku 01]	M	31	Kurripaco	RHP-I	2001	9
Others Districts						
[Ya 01]	M	28	Yanomami	RHP-I	2001	9
[AT Ba 68] **	M	61	Baré	RHP-I	1968	6
[Zu Yu 73]	M	57	Yupka	RHP-I	1973	6

* AMS working with medical doctors from *Barrio Adentro* since October 2003
** AMS Retired

Annex 4.3 Original quotations and translations

Chapter 5

" Yo tenía la idea de superarme y pensé que esa era una gran oportunidad" [AT Ba 68].

"I had the idea of bettering myself and I thought that [the AMS course] was a great opportunity" **[AT Ba 68]**.

"Durante todos esos años estuve trabajando con mi padre, trabajando agricultura, eh.. pesca, trabajando artesanía pues, y entonces en esos tiempos no había ningún tipo de trabajo para mi comunidad... en esos años, cuando tuve oportunidad, yo presentaba talleres en Maroa, cuando venían a dictar talleres, yo siempre estaba al tanto, presente, en lo que era de salud. A mi me gustó mucho la carrera de salud, de ser Auxiliar" [MA Wa 01].

"During those years I used to work with my father in agriculture, fishing, handicraft,[because] there were no jobs (salary posts) for my community. In the mean time I took every health course that was offered in town, I was always present when the courses were related to health, I [have] liked the health career, to become an Auxiliary" **[MA Wa 01]**.

"Yo ya saqué mi sexto grado, y el capitán y los demás miembros estaban buscando una persona como voluntarios para hacer ese curso de Medicina Simplificada. Entonces muchos no querían ser de Medicina Simplificada: Lo que querían ser es profesores, porque le pagaban mejor y tenían mediodía de trabajo. Entonces me oferté, diciéndole "bueno, voy a ir, voy a hacer mi curso ...Había visto muchas heridas, de allí me vino la vocación. ...Prefiero

yo ser, aunque sea, Medicina Simplificada para al menos ayudarle a al que necesita de mi servicio..." [AT Hi 85].

"...I concluded primary school and the captain and other members of the community where looking for volunteers to do the Simplified Medicine course, but many didn't want Simplified Medicine, what they wanted was to be teachers, better paid, and with just a half-day work schedule. But I put myself forward, I wanted to go...I had seen many wounds., that's how the vocation got to me,... I'd rather be an Auxiliary, to at least offer my services to those in need" **[AT Hi 85].**

"... En los año 70 yo veo la necesidad humanitaria ...eran muy pocos médicos, eran muy pocos los trabajadores de salud.. ..Y también quiero dejar algo palpable, que nuestros indígenas morían como si fueran como cualquier animal, ... como cualquier pollo que se enferma y se murió, cuando realmente existía la parte curativa, cuando realmente existía la medicina, entonces mediante esa parte yo me inspiraba y me decía, bueno yo tengo que ser alguien..." [AT Hi 85-2].

" ... In 1970's I saw the humanitarian need [in these communities], there were few doctors, there were too few health workers. ...And I also want to make something clear (palpable), that our indigenous people were dying as if they were animals, like any chicken that gets t ill and passes away, when it actually existed the curative part, when actually medicine existed. I got inspired in this and told myself: I have to be someone [and became an Auxiliary] **[AT Hi 85-2].**

"El curso valía la pena. Valía la pena porque uno salía un Auxiliar sumamente preparado, en todos los sentidos, en la mañana uno tenía clase con los instructores y en la noche uno tenía clase con los médicos que

trabajaban en el hospital. Y los Auxiliares salíamos excelentes trabajadores" **" [AT Ba 68].**

"*The Course was worth it. We were really well trained, in many senses, we had classes with the [nurse] instructors during the day and [talks] with medical doctors from the hospital during the night. We came out of the course as excellent [health] workers"* **[AT Ba 68].**

"Eh, primero teníamos que respetar el reglamento eso no estaba permitido para nosotros fumar cigarros en la escuela, tomar ron o aguardiente. Nosotros respetábamos todo el reglamento, porque en verdad nosotros queríamos salir bien preparados de allí, y logramos nuestra meta.." [MA Wa 01].

"*Well, we first had to respect the rules, no alcohol, no smoking at the school, and we respected all the rules because we really wanted to be well trained. And we achieved (our) goal....*" **[MA Wa 01].**

"... Yo aprendí mucho en La Escuelita, ósea, además de la disciplina. Allí eran muy estrictos, casi como en la milicia, ... No nos permitían fumar cigarro, en cambio en la milicia si nos permitían fumar cigarro, allí no. Bueno para mi era mejor así porque algunos que no fueron para el servicio militar y llegaron todos indisciplinados, allí a La Escuelita. La profesora les puso esa disciplina, que cumplían normas. Allí en La Escuelita para ellos era muy duro pues que no tenía esas costumbres, entonces yo se lo decía a ellos que cada institución tiene sus normas que cumplir...." [AT Pi 92].

"I learned many things at "Little School", besides discipline. There they were really strict, almost like in the Army. We were not allowed to smoke, something that we could do in the Army and here we were not allowed ...And for me it was

better like that, because many of us had not been in the Army, so they arrived with no discipline to "Little School", so the Teacher (la profesora) put discipline. It was hard for [my classmates], as they were not used to it.... I told them that every institution has its rules to follow" **[AT Pi 92].**

"El año 84 me casé, y me iba a visitar, mi esposa, y el señor X decía que aquí no era para hacer visita. Me trataban como un adolescente, tenía que yo rebajarme que no me dieran mi carta de despido dentro de la escuela; tenía que yo rebajarme para pasar pues el curso" [AT Hi 85].

"*In 1984 I was already married, and my wife used to come to visit me and [the instructor] said that the School was not for visits.... They treated me as a teenager, I had to diminish myself (rebajarme) if I did not want to get fired. I had to diminish myself to approve the Course*" **[AT Hi 85].**

" El Manual que tengo aquí no habla palabras científicas sino palabras sencillas. Yo creo que por eso lo llaman "Manual de Medicina Simplificada". Esto es un médico, a la vez un abogado. Con este libro nosotros consultamos y vemos que es lo podemos para nuestros pacientes..." [AT Hi 85-3].

"The Manual I have here doesn't talk scientific words but simple words, I guess that's why it is called "Simplified Medicine Manual" ...This is a doctor, [and] a lawyer at the same time. With this book we make consultations and figure out what we can do for our patients" **[AT Hi 85-3].**

"Yo era el médico, yo era el partero.... pero si tenia un acompañante para mi trabajo. Ese acompañante era el Manual del Programa de Medicina Simplificada, donde cada enfermo tiene su recomendación ..." [AT Hi 79].

"I was the doctor, I was the midwife...But I had a companion for my work. That companion was the Manual of the Programme, where every sick-person has his/her recommendation..." **[AT Hi 79]**.

"Los Auxiliares de Medicina Simplificada somos personas muy especiales. Es el único personal después del médico que trabaja con vidas. Cualquier error que pueda cometer un Auxiliar, en suministrar un mal tratamiento por vía oral o por vía de inyección, y le quite la vida a un paciente, pues lamentablemente ese personal tiene su castigo. No es como otras instituciones, por ejemplo un educador, o un agente de policía. Esa es la gran responsabilidad de los Auxiliares" [AT Ba 68].

"*[We] are very special, [we are] the only personnel besides the medical doctor that work with human lives...any mistake that an Auxiliary could make when giving medicines either oral or intravenous, and kills someone, then regrettable [the AMS] will be punished. It is not like other institutions, like a teacher or a policeman...it is a big responsibility that of the AMS*" **[AT Ba 68].**

"Si no hubiese Auxiliares el centro hospitalario estuviera colapsado, ves. Muchas veces aquí yo me río por que pasan los muchachos y siempre me dicen doctor.." [AT Hi 85-2].

"If there were no Auxiliaries the hospital would have collapsed, right? I often laugh because the kids in town call me doctor....." **[AT Hi 85-2].**

"Cuando está un medico debo cambiarme de mi circulo, ósea a ponerme en el el médico y él es quien va a mandar y tengo que cumplir lo que el me ordene..." [AT Pi 89]

"when the doctor is here I change my circle, to put myself in his, and he is the one who leads, and I have to follow the orders" **[AT Pi 89]**

"nos quitaron autoridad, autoridad de ser como Medicina Simplificada , ya no podemos consultar con el manual, ya no podemos tener opciones de aplicar ningún medicamento .." [AT Hi 85].

"they [the Cuban doctors] took away our authority to be Simplified Medicine [Auxiliaries]. We can not consult the Manual any more, we don't have the option to give any drug..." **[AT Hi 85].**

"Primeramente yo soy CG, soy natural de San Carlos de Rió Negro, pertenezco a la Etnia Baré, ...yo nunca he tratado de ocultar lo que soy... perteneciente a la Etnia Baré y pienso que ningún AMS debe negar su identidad...y además su etnia ... Para mí es un orgullo que la persona me llame indio... Me eduqué con mucho sacrificio pero con una gran esperanza, de superación de preparación, de poder ser alguien en la vida y ese, y ese alguien en la vida, yo lo he logrado" [AT Ba 68].

"I am GC, from Rio Negro, I belong to the Baré ethnic group...., I have never tried to hide what I am... I think no AMS should deny his identity and his ethnic origin...., I'm proud of being called an Indian because I got education with much sacrifice but with a great hope, of bettering myself, to become someone, and I have succeeded... " **[AT Ba 68].**

" Era puro indígena, allá no había ni si quiera un Colombiano, ni siquiera un Brasilero, pues, puro indígenas, no había criollo. Éramos Guajivos (Hiwi); Warekenas, Piaroas y Yabarana, poquito a poco nosotros fuimos

agarrando esa confianza o osea nos conocíamos muy bien pues, Eramos como hermanos..." [MA Wa 01].

"*...There were just Indians; there wasn't even a Colombian or a Brazilian, just Indians, no whites (criollos). We were (Hiwi), Warekenas, Piaroa, Yabarana...little by little we became to know each other very well, we became brothers"* **[MA Wa 01]**.

"Bueno, para mi debería haber siempre un persona de esta comunidad en el ambulatorio, porque la comunidad tiene otra cultura y el médicos vienen de la universidad con otra experiencia, para cambiar la cultura, ..." [AT Pi 92].

"*For me...there should always be a person from this community in the health post, because the community has other culture, and doctors come from the University with their experience,.to change the culture"* **[AT Pi 92].**

Chapter 6

" Yo, como Auxiliar, es curar al paciente, ese es mi trabajo .." [AT Pi 92].

"Mine, as an Auxiliary, is to cure the patient, that's my job..." **[AT Pi 92].**

".. bueno después, que me dieron el cargo .. bueno me alegre mucho, puse mas empeño y puse mas trabajo y reuniones con la gente y les he dado charlas para prevenir las enfermedades, malaria, que se eliminen charcos, cauchos, todo eso y les decía en caso de diarrea y les decía hervir el agua.. ponerle cholitas a los niños, barrer las casas asear bien las casas.. Les di consejos a todos..." [AT Pi 99].

"...when I gained the post I was so happy and I put more work in it, and meetings and talks about how to prevent malaria, to get rid of puddles, tires, all that, to prevent diarrhoea, ..., to boil the water, to give sandals to the kids, to sweep the houses, to give advice to all of them..." **[AT Pi 99].**

"Lo que yo entiendo de promotores, es repartír el suero oral enseñar a guardar el agua, cositas así ves no se le ve sentido.." [MA Ku 99].

"...promot[ion] is [to deliver] Oral Rehydration Salts, to teach people how to store the water; little things like that, that you do not see the sense of it....." **[MA Ku 99].**

"... eso es trabajo de un Auxiliar ...dar charlas educativas. Ese es el trabajo del Auxiliar de Medicina Simplificada prevenir, prevención....Yo por ejemplo no hago las reuniones con la comunidad porque si usted convoca una charla pocos van, habrá una persona que está aburrida, que no le presta atención a uno. Yo tengo que aprovechar el momento de la consulta, mientras ellos se sientan a hablar con uno...." [AT Hi 79].

"..that is the Auxiliary's work ...to give educative talks ("charlas educativas") ...that's work of the Auxiliary, to prevent, prevention...(But) myself, for example, I do not run meetings with the community. If you set up a meeting, just a few attend, and do not pay me attention, and some get bored. I have to take the opportunity when people come to the clinic, when they sit down to talk with (me)" **[AT Hi 79].**

" Bueno yo... creo que el auxiliar queda muy rebajaito, bastante con los esfuerzo que él ha hecho, que ha aplicado, que ha administrado medicamentos. Entonces yo quedo molesto" [AT Hi 85]

"...well, I think that the AMS would be much downgraded (muy rebajadito), too much with all the effort done, having administered medicines, [if transformed into Promoters] I will feel very annoyed.." **[AT Hi 85].**

"Porque el Auxiliar no es solo para promocionar salud, sino para hacer atención primaria. En mi concepto de lo que es un promotor, no lo va hacer ... Oye cercenarles eso a las comunidades es grave.... estamos quitándole equidad a las comunidades entonces donde va haber esa atención curativa? al menos que vayan al chamán, pero tampoco el chamán es para todo.." [Ho Re M].

"Because the Auxiliary is not just to promote health but to provide primary care. In my criteria this can not be done by Health Promoters...[Regarding an eventual transformation] it's serious, we are taking out equity from the communities. Then, where is that curative assistance going to be available? In this case they will go to the shaman but neither can he do everything..." **[Ho Re M].**

"..., aquí había pastillas, medicina, pero no podía tratar al paciente mientras yo no tenga el resultado. Ahora no. Ahora yo puedo diagnosticar y dar el tratamiento. Ya es muy necesario, es beneficioso para la población, tener un microscopio.." [AT Pi 92].

" [Before being trained as microscopist] I had the medicine to treat the patient but I could not treat him/her without a [parasitological] result. Now I can do the diagnosis [of malaria], and give the treatmen. Now is very necessary, it is beneficial for the community, to have a microscope..." **[AT Pi 92].**

" Yo creo que para una persona es importante, por ejemplo, si yo soy indígena debo practicar mi medicina tradicional, esto no quiere decir que yo soy enfermero entonces voy a tener que practicar solamente la científica, no. Debo practicar las dos...también eso me hace importante, que yo estoy aceptando las dos.. Primero la científica, por que yo presto servicio para la ciencia, verdad? .. y la tradicional porque yo soy descendiente de un grupo indígena Debo tomar en cuenta que las dos son importantes.." [AT Hi 85-2].

"... I believe that for a person it is important, for example, if I am indigenous, I ought to practice my traditional medicine, that doesn't mean that I, as an Auxiliary, have to practice just the scientific medicine, not at all. I must practice both of them. That makes me important, the fact that I am accepting them two. First the scientific because I render a service for science, don't I?, and the traditional [medicine] because I am an indigenous descendant, I must take into account that both of them are important **[AT Hi 85-2].**

"..Un paciente viene a la consulta, y le pregunto que es lo que tiene, y me dicen "tengo fiebre, tengo dolor de cabeza", yo le hablo cariñosamente a mis pacientes. Les digo "mira, está esta mata, y bébase esto que se la va a quitar la fiebre", y me dice "No, que no me quita", bueno, está bien, hay que respetar su decisión. Si viene un niño o una niña con sus representantes, y si no le gusta, bueno, le doy su vasito de Acetaminofén y le hago como la tienen que dar.... Así soy yo con mis pacientes.." [AT Hi 85-3].

" [If] a patient comes to the clinic and I ask him what he has... He says," I have fever, I have headache", and I talk tenderly to my patients – "Look, there is this plant, you drink this and that will eliminate the fever", - if he says "no, no, that doesn't work [for fever]" well, it's ok, I have to respect his decision. If a child comes with his parents and they don't like [plants] well I give him a little glass

with acetaminophen and explain them how is to be given ...This is how I am with my patients" **[AT Hi 85-3]**.

" Por eso yo digo que ambas medicinas tienen que ir avanzando. Porque un curandero te puede curar, vamos a suponer, un daño, pero con la medicina científica no lo puedes, un médico no cura eso, médico cura lo que diagnostica lo que él cree, lo que él considere que sea. En cambio, un daño es cosa que el médico tradicional lo cura y el médico occidental no puede..." [AT Pi 92].

"*...that is why I say that both medicines have to move forward, because a traditional healer (curandero) can cure, for instance, a bewitchment (daño) but with scientific medicine you cannot, a doctor does not cure a bewitchment. Doctors cure what they diagnose, what they believe it is, what they consider...but a bewitchment, that is something for a traditional healer to cure, the western doctor cannot...*" **[AT Pi 92].**

" Hasta el presente yo no he tenido problemas con ellos, ahora, es más, son recomendaciones que yo hago antes de yo referir los pacientes al hospital. La recomendación que les doy siempre bueno, "si quiere vas con un chamán", para no meterte en ese conflicto entre la familia .. si pasa algo uno es culpable para toda la vida de uno ..." [AT Hi 79].

"*....I have never had problems with them[shamans . I also even suggest to my patients, before referring them to the hospital, the recommendation I give them is "If you want, go to the shaman..". For me not to enter in conflict with the family. If something happens [in the hospital] I could be called guilty* for *all my life....*". **[AT Hi 79].**

" Muchas veces uno como etnia Hiwi, va a una consulta tanto en el ambulatorio, tanto en el hospital y como el indígena no sabe expresarse, no sabe donde es que le duele. Siempre en castellano es difícil desenvolverse. Es fácil decir "véndame un pan" si. Pero verse uno por dentro de si mismo, para explicarle a un médico, es muy difícil. Y ahora que, este personal que está hablando acá, en el campo, en la realidad que espera que el paciente quede satisfecho cuando acuda hacia mi, o que esté un medico bien.... Y yo entiendo el dolor, y entiendo donde és...." [AT Hi 85].

***"...**many times one of my ethnic group Hiwi goes for consultation either to the hospital or health post and doesn't know how to express her/himself, s/he doesn't know where it hurts. In Spanish it is difficult to manage [the situation]. It is easy to say "sell me bread". Yes, but to see inside you , and explain to the doctor, that is very hard. And we as Auxiliaries in the field, in the reality, [we] expect that each patient who comes to me or to the doctor is satisfied. And I understand the pain and understand where it is located"* **[AT Hi 85].**

" Guatias no tiene el mismo dolor que sentimos nosotros. Mira aquí, aquí mismo en el Hopsital, enviamos enfermo grave, grave, y no lo atienden, "Espere un momentico ahí en las puerta", y ha sucedido varias veces. Como nosotros algunos no entendemos..... Por eso es que nosotros queremos entrenar a nuestro paisanos, ojala haya medicos paisanos para que entiendan, para trabajar aquí en el hospital. Tu crees que no va a tener el mismo dolor que tiene?. En cambio ellos siguen contratando Guatias... otros Yukpas sentirían igualito, como lo sentimos nosotros.. los Guatias no tienen el mismo dolor.." [ZU 73].

"Guaitias [white or non-indigenous] do not feel the pain as we Yupkas do. Look here in the Hospital, we [AMS] refer patients seriously ill, seriously, and they do not receive immediate attention. "Wait here at the door" they say. And that has happened many times, because many of us do not understand. That's why we want

to train more of us. I wish some day we could have Yupkas as doctors, to speak our language here in the hospital. They'll feel the same pain as we do. But they [the government-the health care system] keep hiring non-indigenous doctors, ..., if there were other Yupkas working, they will feel the same pain as we do, but whites don't feel the same pain" **[ZU 73]**.

"Porque si yo tenía pues unas dudas de lo que el médico daba, entonces tenía yo que pelearle por mis por mis pacientes. Porque si le vas a dar un medicamento que no es, entonces yo soy el responsable porque mi paciente va a decir que como yo entiendo la cosa.. y tengo que pelear por mis pacientes, pues.." **[AT Hi 85]**.

".. *If I had doubts with the medicines the doctor was indicating, I had to fight for my patients, ...(because) if a drug was not appropriately indicated (by the doctor), then I am responsible, ...the patient would argue that I am the one who is supposed to understand (what the doctor is doing), then I have to fight for my patients..."* **[AT Hi 85]**.

Chapter 7

" bueno yo creo que influye allí en trabajo mí: La salud es un derecho para nosotros y no solamente salud, como te dije, la educación también, y a medida que nosotros vamos avanzandoy vamos aprendiendo que los indígenas también tienen sus derechos, cualquier problema que yo teng, como dij, ya tenemos derechos y aprovecharía pues las instituciones..." **[AT Pi 99]**.

"...well, I think it [the constitution] has an influence on my work. Health is our right, but not only health, as I told you, also education. And as we move forward we keep learning that indigenous people have also their rights. Whatever problem I have, we have rights and we should take the most out of the institutions..." **[AT Pi 99]**.

"La ley que sale escrita ahí en la Constitución es el orgullo mas grande que tenemos, sale del Estado Amazonas otros Estados Delta Amacuro, El Zulia, Apure, Bolívar ..... sin la ley no somos nada, sin la constitución no valemos nada .....En mi trabajo no hay ningún cambio... no le prestan atención a las leyes, no le prestan atención a las leyes no se practica, no se le ve. Yo lo observo así porque se que tengo un derecho a salud, de participación....si me presentara ahorita a la Dirección Regional diciéndole "Que el artículo tal del ochenta y dos y tal del derecho tal"...que me responden ellos?. Me dicen: "No hay ..." [AT Hi 79].

"*...that law that is written in the Constitution is our highest pride, it comes from Amazonas, Delta, Zulia [States with indigenous people]),....without the law we are nothing, without the Constitution we are valueless,... (But) in my work there is no change at all...they (the regional health system) do not pay attention to the law, the law is not put into practice, you can't see it. I say so because I know we have the right to health and to participate (but) if I go now to the Regional Directorate of Health [saying] "according to this Article X, and the Right Y", what would they say?: "there are no (medicines)"....*" **[AT Hi 79].**

"Ya no nos tomaban en cuenta, ignorados, no había supervisión, no había recursos para supervisar, no nos ponían atención. Como era de Enfermería... entonces se decidió en 1995 cuando nos dan a Atención Médica, tenía más peso, para conseguir las cosas, para conseguir todo, y los médicos se involucraran más con el programa, supervisaran" [HO Re N].

"*We were ignored, no supervisions, no resource to supervise, [I think it was] because [the programme] was part of the Nurse Department...then it was decided in 1995 to ascribe it to the Medical Department, [nationally and regionally], that*

had more power to find resources, to find everything, and for doctors [getting] more involved in supervisions.." **[HO Re N]**.

"..Antes uno recibía toda la facilidad para trabajar por El Manual, tenía motor con una voladora, con una dotación de combustible y medicinas. Ahora tiene uno que salirse de la regla, del Manual. Ahora disminuyó la supervisión, disminuyó la dotación de medicamentos, ya no vienen casi los médicos. El ministerio se supone que cumplía esta atribución. Y aparece la alcaldía y la alcaldía te pelotea con el ministerio su función de dotación y supervisión ..." [MA Ba 73].

: "*...In the past we used to receive [from the Ministry] enough resources to work according to "The Manual", ... a boat, outboard motor, fuel, medicines..... [Nowadays] you have to go outside of the rule, to go beyond the Manual...Now the supervision has decreased, the drug supply has decreased, doctors rarely come. The Ministry was supposed to take care of that ... The Municipalities appeared on the scene, and they [the Municipality and the Ministry through the Directorate of Health in the region] play ping-pong with their supervision and supply responsibilities*" **[MA Ba 73].**

"Hay muchas personas que se van no buscando educación para los hijos, sino que están persiguiendo la política, porque ellos quieren vivir de eso, de la política, ellos piensan que van a vivir bien donde esta la masa política" [MA Wa 01].

"*Well... there is many people who flee [to the capital town of the Municipality] not [just] looking for education for their kids, they are looking for the party-politics, they want to make a living out of politics, to live from it...they think they are going to live better where the political mass (masa política) is*" **[MA Wa 01].**

" Yo soy coordinador de MVR que es el partido de gobierno local, y yo soy coordinador que le estoy dando vida a la poquita gente que están quedando ...les digo yo que no se vayan buscando la masa política, por eso, si yo no meto, ¿Por qué hay maestros municipales? ¿Por qué hay planteros municipales? ¿Por qué hay bedeles municipal? ¿Por qué hay obrero municipal? Si yo no meto a la política la gente de aquí no tuvieran trabajo, les estoy dando oportunidad a la gente para que trabaje..." [MA Wa 01].

"I am the coordinator of the [a national party] in this community.. I am giving a little life to the few people remaining [here]. I tell them not to leave pursuing the political mass, ... if I wasn't here there wouldn't be a Municipal teacher, a Municipal Generator Operator, Municipal Janitor, Municipal Worker. If I don't get into politics there wouldn't be [these] jobs for them, I am giving chances for them to work ..." **[MA Wa 01].**

"....antes nos mandaban directo de ahí de Puerto Ayacucho y nos llegaban bien. Y después de que tenemos este municipio, aquí cambió todo. Ese es el error, el municipio, ese es el problema que hay, que no anda. A ahora todo parece disperso y bueno, no nos mandan mas..." [MA Ku 73].

"...we used to receive our supplies directly from Puerto Ayacucho, it got here fine, [but] after we have this Municipality it changed it all. That was the mistake .....the Municipality is the problem, it doesn't work. Now everything seems dispersed and they don't send more [supplies]...." **[MA Ku 73].**

"Los médicos cubanos están en todo el Estado ahorita, y están dentro de la instalaciones de salud , En dentro de la instalaciones de Salud, en Manapiare en Atabapo en Río Negro, están viviendo dentro de la casa que normalmente

es la casa del médico venezolano .... se está compartiendo la casa mas no se está compartiendo el trabajo... trabajo compartido en cuanto a estadísticas, a pacientes valorados entre ambos, no es compartido, en mi ambulatorio lo mantenemos separado y al libre albedrío del paciente con quien quiere consultarse..." [RMD 1].

"Cubans doctors are now all over the state, working in the premises of the Ministry in the region ...[in rural areas] they are living in the houses that traditionally were the Venezuelan doctors' houses, ***sharing the house but not the work.*** *In terms of statistics, and the clinical practice, we do not share, we keep it separated... the decision is on the patient, about which doctor s/he wants to be attended by..*" **[RMD 1].**

"Después que llegaron los médicos..... oye les dije "Estos son mas superiores que yo..Pero he trabajado con ellos.. me he relacionado bien con

ellos..que simpre estaré en el Ambulatorio, pero yo no quiero olvidar de usar medicinas, ser Medicina Simplificada ..." [AT Pi 99].

"After the doctors arrived, well I told the people that they are more superior than I am, but that I still keep working, relating well with [the doctors] and that I will be always in the health post...but I do not want to forget how to use medicines, to be Simplified Medicine" **[AT Pi 99].**

" Lo he abandonado un poco, porque tal como dice ayer por culpa del gobierno, yo no solicito medicina, no me preocupo en molestar a la alcaldía. Yo primero me interesaba mucho y poco a poco entendí como dominaban los distritos y ellos se aprovechaban de mi..... Me faltan cinco años para jubilarme ...estoy viendo reputación de los cubanos, ellos me llamaron y no fuí.... si otra vez gana el presidente hare reunión con la comunidad y

pensamos llamar a los médicos cubanos para saber ver si es verdad que ellos atienden bien, cuando ellos lleguen yo no quiero seguir trabajando de Auxiliar..” [AT Pi 89].

“I have abandoned it a bit, I blame it on the government, I do not ask for medicines, I do not bother the Municipality, I do not bother the regional Government ...[When I began as an AMS] I was really interested but I started to realize how everything was run [in the health sector], ... they took advantage of me ...I still have five years before retirement, and I have been observing how the Cubans work. They have called me [for the training] and I have not gone. But if the President wins [the referendum] I will make a meeting with the community to call for the Cubans ... in case they come I do not want to continue as an Auxiliary..” **[AT Pi 89]**.

“Siempre son y serán bienvenidos. Yo no me siento incomodo, como tampoco me siento tranquilo. El medico es la persona indicada, por ser la persona que estudió la carrera de medicina. Nosotros ofrecemos la ayuda mutua, la cooperación, la unión de esa mano entre el médico y el Auxiliar. Aqui somos Hiwi y el auxiliar está sobre todo para traducir, sobre todo a los ancianos que no saben hablar, y ayudar al médico en la visita domiciliaria verdad?. Para que el mismo pueblo entienda, ya que ellos son extranjeros, decirles a ellos, “mire ellos también son humanos son iguales que uno, tienen que tener confianza así como usted acude al médico venezolano igualito eh.. ellos también sufren, ellos también lloran así como nosotros sufrimos. Ellos también les da hambre”. Es importante de llevar ese acercamiento usando la palabra ...” [AT Hi 85-2].

“[They are] always welcome, I do not feel uncomfortable, I do not feel quiet either, ...the doctor is the right person for the job, s/he studied the medical career, but we offer cooperation, integration between the doctor and the Auxilliary ....., we are Hiwi here, and as Auxiliaries we are mostly to translate,

mainly to the elder, to help the doctors in their visit to the houses...and to explain to our people, because they are foreigners, to explain to our people that they are humans too, that they have to be confident, the same as with the Venezuelan doctors, that they [Cubans] also suffer, and cry, they feel hunger, it is important to promote that rapprochement using the oral-word..." **[AT Hi 85-2].**

Annex 5. Ethical Clearance LSHTM

LONDON SCHOOL OF HYGIENE
& TROPICAL MEDICINE

ETHICS COMMITTEE

APPROVAL FORM
Application number: **1058**

Name of Principal Investigator	**Gregorio Leopoldo Sanchez-Salame**
Department	**Public Health and Policy**
Head of Department	**Gill Walt**

Title: **Community Health Workers among Indigenous people in Amazonas, Venezuela; their role in a shifting context**

Approval of this study is granted by the Committee.

Chair
Professor Tom Meade T W Meade

Date .....12 November 2003

LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE, KEPPEL ST., LONDON, WC1E 7...

Approval is dependent on local ethical approval having been received.

Any subsequent changes to the consent form must be re-submitted to the Committee.

Annex 6. Ethical Clearance CAICET

CENTRO TRUJILLANO DE INVESTIGACIONES PARASITOLÓGICAS
JOSÉ WITREMUNDO TORREALBA
AV CARMONA / SECTOR LOS ILUSTRES / APARTADO POSTAL 100. TELÉFONO. 58-272-2363503
TRUJILLO 3102 – A / VENEZUELA

UNIVERSIDAD DE LOS ANDES

jwT

DECLARACIÓN DE BIOÉTICA

En la condición de Integrante del Comité de Bioética del Centro Amazónico para la Investigación y Control de Enfermedades Tropicales (CAICET), el suscrito José Vicente Scorza PhD., Parasitólogo, hace constar ante la Dirección del CAICET, Dra. América Perdomo, que ha estudiado el proyecto de Tesis Doctoral que el proponente, Dr. Gregorio Sánchez, Investigador del CAICET somete ante la London School of Hygiene and Tropical Medicine para la opción de Doctorado en Salud Pública de la Universidad de Londres.

En esencia, el proyecto reconoce la existencia de Auxiliares de Medicina Simplificada que desde hace cuarenta años han prestado servicios básicos de salud a la dispersa población del ahora Estado Amazonas y en donde, al lado de los Auxiliares, intervienen médicos graduados en las escuelas de medicina de las Universidades Nacionales, en establecimientos del Tipo Ambulatorio Rural en 22 Medicaturas Rurales, y personal médico adscrito al Hospital de Puerto Ayacucho, en un proceso de centralización de la actividad médico-sanitaria, dirigido por el Ministerio de Salud y Desarrollo Social.

El proyecto, concebido para la elaboración de entrevistas individuales donde el entrevistado conoce la intención del estudio y participa voluntariamente en su desarrollo, no interfiere ni lesiona el albedrío de los convocados, y por el contrario, aspira precisar la relación de estos servicios de auxiliares con el incipiente sistema integrado por personal universitario. Del análisis de estas entrevistas y de la capacidad del Dr. Gregorio Sánchez saldrán, necesariamente, conclusiones y recomendaciones para hacer más eficiente la acción de los Auxiliares y su vinculación con el Sistema Regional de Salud.

El suscrito, recomienda la aceptación del proyecto del Dr. Sánchez en la seguridad de un afianzamiento y actualización del trabajo encomiable que los Auxiliares, por décadas, han venido desarrollando dentro de sus culturas amazónicas y valores humanos de nuestra población indígena.

Dr. José Vicente Scorza
Profesor Titular

Annex 7. Informed Consent

Informed Consent
Community Health Workers among indigenous people in Amazonas, Venezuela: their role in a shifting context.

The Coordination of Health Services from **CAICET** has prepared this research study that is being **funded by the Pan American Health Organisation (PAHO)** which aimed at better understanding the situation of **Primary Health Care for indigenous people in Amazonas** Venezuela and particularly the relationship between the **Simplified Medicine Auxiliaries and the Regional Health System**. For this reasons individual and group interviews are going to be held with Auxiliaries, Medical Doctors and Health Officers of the Regional Direction of health in Amazonas.

As you are directly involved with the programme we would like to invite you tom participate in a individual (group) interview that will be held on _____.

If you accept to participate and come to the interview travel, meals and housing expenses will be covered by the project

Your contribution will be very important to better understand the Simplified Medicine Auxiliaries Programme in Amazonas State. **This is not an exam or knowledge evaluation**, there will not be comparison between the attendant's contribution. We are just interested about your opinions and experiences. The information gathered will be exclusively used for the purposes of this research.

Interviews will be recorded and transcript by members of the research team at CAICET, your accounts will be identified by a code exclusively known by the research team. We are committed to keep your identity anonymous and to ensure the confidentiality of any information received. **Anonymity and confidentiality** will be kept during the dissemination of results of this research. Transcripts will be stored in CAICET and eventually used for studies in the future under the responsibility of the Principal Investigator.

If you agree to participate in this study as an interviewee please sign this sheet. **If you wish to stop being interviewed in any moment we will accept your decision** and the interview will be stopped and the information gathered will not be processed or used. Withdrawing the study will not have any consequence for you.
If further on you have any question you can contact **Dr. Gregorio L. Sánchez, Principal Investigator of the project** at Telf: 0248 5212223
I have read the information sheet concerning the study and have understood what will be required of me. My questions concerning the study have been answered by Dr. Gregorio L Sánchez . I agree to take part in this study.

Name and Last name	**ID**	**Signature**

Witness

Name and Last name	**ID**	**Signature**

Consentimiento Informado

Proyecto: *Auxiliares de Medicina Simplificada en las poblaciones indígenas de Amazonas: Su papel en momentos de cambio*

La Coordinación de Prestación de Servicios de Salud del **CAICET** ha elaborado una propuesta de investigación que será financiada por la **Organización Panamericana de la Salud (OPS)** cuyo propósito es conocer mejor sobre la situación actual de la **Atención Primaria de Salud para la población indígena de Amazonas** y la relación de los **Auxiliares de Medicina Simplificada con el Sistema Regional de Salud**. Para esto se realizarán entrevistas personales y grupales con Auxiliares de Medicina Simplificada, Médicos y personal Técnico Administrativo de la Dirección Regional de Salud

Como usted esta directamente relacionado con el Programa queremos invitarlo a paraticipar en una entrevista individual (colectiva) que se realizara el día _____.
Si usted acepta participar y venir a la entrevista los gastos de traslado, alojamiento y comida que la entrevista suponga seran costeados con recursos del Proyecto.

Su aporte sera muy importante para conocer mas y mejor sobre la Atención Primaria de Salud y el Programa de Auxiliares en el Estado Amazonas. **No es una evaluación de conocimientos** ni se harán comparaciones entre los participantes. Estamos interesados en sus opiniones y experiencias. La información será utilizada con propósitos de investigación.

Las entrevistas serán grabadas y luego transcritas por miembros del equipo de investigación del CAICET, su intervención será identificada por código del conocimiento exclusivo del grupo de investigación. Nos comprometemos a mantener el **anonimato** suyo como entrevistado y mantener la **confidencialidad** de cualquier información personal recibida. El anonimato y la confidencialidad se mantendrán al comunicar los resultados de este trabajo. El material trascrito sera conservado en CAICET y eventualmente utilizado en futuros estudios bajo la responsabilidad del Investigador Responsable.

Si usted esta de acuerdo con participar en este trabajo como persona entrevistada firme este documento. **Si** posteriormente, en cualquier momento de la entrevista o del estudio y por cualquier causa, **usted nos manifiesta por que no desea seguir siendo entrevistado entonces nosotros aceptaremos su decisión** y no se realizaran mas entrevistas o conversaciones ni se hará uso de la información que haya sido recibida. El hecho de retirarse o de no querer participar en el estudio no tendrá repercusión alguna

Si usted tiene alguna duda puede comunicarse con el **Dr. Gregorio L. Sánchez, Investigador Responsable del proyecto** Telf 0248 5212223
He leído la información concerniente a este estudio y he entendido lo que se requiere de mi en el mismo. Las preguntas relativas al mismo me fueron respondidas por el Dr. Gregorio L Sánchez . Acepto participar en las entrevistas y se que puedo retirame de ellas si asi lo decidiera.

Nombre y Apellido	**C.I.**	**Firma**

Testigos

Nombre y Apellido	**C.I.**	**Firma**

Annex 8. Dissemination of Results

Breve Cronología del Programa de Auxiliares de Medicina Simplificada (PAMS)

1961. En su ponencia *"El problema de la medicina Rural en Venezuela"* presentada ante el II Congreso Venezolano de Salud Pública, José Ignacio Baldó propone la *delegación de actividades curativas y de fomento de salud en personal no* profesional ó "peritos sanitarios"
La Federación Médica Venezolana rechaza la propuesta.

1962. Después de un estudio exploratorio, se dicta el 1er. Curso para Auxiliares de *Medicina Simplificada en Tama Tama, Estado Amazonas a misioneros* anglosajones.

1963. José Ignacio Baldó presenta ante la Asamblea de la Federación Médica Venezolana los fundamentos, bases y doctrina del PAMS y los alcances al momento.

1964. Se dicta el primer Curso para Supervisores de Programa en los Estados Amazonas, Apure, Aragua y Táchira.

1965-75 Se extiende la cobertura del PAMS a nivel nacional. Su impacto es notorio. Venezuela obtiene reconocimiento internacional

1978 La Organización Mundial de la Salud y la UNICEF lanzan en Alma Ata "Atención Primaria de Salud" (APS) como estrategia para alcanzar la meta de "Salud para Todos". Venezuela es reconocida como experiencia modelo

1986. Se registran en Venezuela 1883 Ambulatorios Rurales Tipo I con AMS activos

1997. Se registran en Venezuela 2084 Ambulatorios Rurales Tipo I con AMS activos y con cobertura de 1.700.000 habitantes en áreas rurales dispersas entre ellos gran parte de la población indígena del país

1999. La Constitución de la República Bolivariana de Venezuela consagra el derecho a la salud integral que tienen los pueblos indígenas considerando sus prácticas y culturas.
Se retoma APS como estrategia para garantizar el Derecho a la Salud

2003. *Barrio Adentro se asume como la Política de Salud del nuevo Estado venezolano* y a los Consultorios Populares como base de la APS teniendo como prioridades su implementación en "selvas y áreas donde residen los indígenas", entre otros.

2004. Se requiere articular a los AMS en la Política de Salud de Barrio Adentro, *particularmente en áreas indígenas.*

CAICET

PAMS

Taller

Auxiliares de Medicina Simplificada y la Atención Primaria de Salud en Amazonas

Puerto Ayacucho, 23 y 24 de septiembre de 2004

Programa

"Solo existe una medicina nacional, y el derecho a la salud obliga a aplicarla con las mismas directrices y principios, tanto en el medio rural como en el medio urbano, la doctrina es la misma..."

José Ignacio Baldó,
XVIII Asamblea Ordinaria de la
Federación Médica Venezolana, 1963

Programa

Jueves 23

Instalación

2:00 pm	Palabras del Director Regional de Salud. Dr. Eugenio Torres
2:15 pm	Palabras del Sr. Carlos Gómez, Baré Auxiliar de Medicina Simplificada del Edo. Amazonas (Jubilado)
2:30 pm	Palabras del Sr. Abraham Romero, Yukpa Auxiliar de Medicina Simplificada del Edo. Zulia
2:45 pm	Palabras de la Socióloga Yissenny Viloria. Institutos de Altos Estudios de Salud Pública "Arnoldo Gabaldón"
3:00 pm	Palabras de la Lic. Amelia Silva/ Aimé Tillet. Coordinación Nacional de Atención Primaria.
3:30 pm	Receso
3:45 pm	Presentación de Resultados Preliminares del Proyecto *"Auxiliares de Medicina Simplificada en Amazonas: Su papel en momentos de cambio"*. Dr. Gregorio L. Sánchez. CAICET
4:15 pm	Discusión

Viernes 24

8:30-8:45 am	Dinámica de las mesas. Antropóloga Jeyni González
9:00- 10:45 am	Mesas de Trabajo
10:45- 11:15 am	Receso
11:15- 12:30 m	Plenaria
12:30	Almuerzo
2:30 pm	Conclusiones y Compromisos
3:30 pm	Clausura Dra. Noly Fernández, Wayuu Coordinadora de Salud para los Pueblos Indígenas en la Misión Barrio Adentro, Estado Zulia. Dr. Gregorio L. Sánchez. CAICET

Sánchez, Gregorio & González, Jeyni. 2004. "Auxiliares de Medicina Simplificada y Atención Primaria en Salud en el Estado Amazonas", La Iglesia en Amazonas, Año XXIV, No. **106**: 15-21.

INDICE

LIV Convención Anual AsoVAC
5to Congreso de Investigación de la UC

Valencia, 24 de septiembre de 2004

Estimado Investigador:
Jeyni Samarí González Tabarez
Centro Amazónico para la Investigación y Control de Enfermedades Tropicales (CAICET)
jeynigonzalez@yahoo.com
Presente.-

Nos dirigimos a usted con la finalidad de informarle por esta vía, que su trabajo titulado: **"Auxiliares de Medicina Simplificada en Amazonas en el Contexto de Nuevas Políticas de Salud"**, ha sido **ACEPTADO** para ser presentado en la ***LIV CONVENCIÓN ANUAL DE ASOVAC Y V CONGRESO DE INVESTIGACIÓN EN LA UNIVERSIDAD DE CARABOBO***, a realizarse en Valencia del 14 al 21 de Noviembre del presente año.

Al respecto, próximamente, se le informará los detalles relacionados con la presentación del trabajo de acuerdo a ubicación según Área y Subárea: sesión, fecha, hora y lugar.

Atentamente:

Dr. Luis García
Coordinador
Comité Organizador

Dr. Cruz Manuel Aguilar
Coordinador
Comisión de Arbitraje

CDCH-UC: Comisión de Arbitraje. Av. Bolivar Norte CCP El Camoruco, piso 11, Ofic.. 01. Valencia, Edo Carabobo
Tlf: 0241-8210137/0241-8239413. email: asovac-cdch@uc.edu.ve
Código: 03-0-1-28-I-O-0353-734

II CONGRESO NACIONAL DE ANTROPOLOGÍA

31 de octubre al 5 de noviembre de 2004
Mérida-Venezuela

Mérida, 13 de septiembre de 2004

Ciudadanos
Gregorio Sánchez
González, T. J
Kielmann, K.
CAICET-UCV

Estimados colegas:

Cordialmente me dirijo a Ustedes en la oportunidad de informarle que su ponencia titulada: *Imposición, Cooperación o repuestas innovadoras? El Caso de los auxiliares de medicina simplificada en el Amazonas,* ha sido aceptada para ser presentada en el simposio: Educación propia indígena e intercultural: Nuevos caminos que es coordinado por el Dr. Omar González Ñañez y la Lic. Zoraida Añez y que se celebrará en el marco del II Congreso Nacional de Antropología en la ciudad de Mérida entre los días 31 de octubre y el 5 de noviembre del presente año.

Agradeciendo su valiosa atención y con la esperanza de vernos pronto en la ciudad de Mérida-Venezuela, nos despedimos

Atentamente,

Dra. Jacqueline Clarac de Briceño
Por el Comité Organizador

Museo Arqueológico de La Universidad de Los Andes, Maestria en Antropología-LUZ, Maestria en Etnología-ULA, Centro de Investigaciones Etnológicas-ULA, Centro de Investigaciones Antropológicas-UNEG, Escuela de Antropología-UCV. Dirección Postal: Edif. del Rectorado, Avda. 3, Mérida. Edo. Mérida, Venezuela. Telefax: 0274-2402344. e-mail: cantropologia2004@yahoo.es

Health Unlimited

Friday 10 December: Human Rights Day

Conference Workshop and Public Meeting

08.45 **Research paper presentations and discussion** *(Manson Lecture Theatre)*

Theme 3: Traditional knowledge
Chair: Prof Jeff Reading

Dr. Gregorio L. Sánchez, Amazonic Centre for Research and Control of Tropical Diseases (CAICET), Amazonas, Venezuela. Indigenous Community Health Workers, their role in the current context in Amazonas

Dr Michael Knipper, University of Gießen, Germany: Indigenous culture, socioeconomic change and health. Reflections after a medical-anthropological fieldwork in the Amazon region of Ecuador.

Prof. Renato Athias, Universidade Federal de Pernambuco: Indigenous Traditional Medicine among the Hupdah-Maku of Tiquié River (Brasil)

10.15 Break

10.30 Didier Lacaze, Independent Public Health Specialist: Relationship between Indigenous People's Health Situation and Traditional Medical Systems in the Amazonian Region – can the loss of traditional medical knowledge and practices have more impact on health than we tend to believe?

Prof Jack Dowie, LSHTM: Western science and traditional knowledge – no gap to bridge.

12.00 Lunch: Indigenous Theme in LSHTM Refectory

12.30 Informal discussion of Global Health Watch Chapter (Optional) *(Room 4)*

13.30 **Workshop** *(Meet in Manson Lecture theatre for room allocation)*

'Action, research and policy: developing a new agenda for a new decade'

Identification of future indigenous health research and policy needs.

15.30 Break

Translocalidad: Diálogos sobre la cultura y el cambio en el Siglo XXI

Translocalité: Dialogue sur la culture et le changement au XXIe siècle

Translocality: Discussing Culture and Change in the 21st Century

PROGRAMA / PROGRAMME

La Société Canadianne d'anthropologie / The Canadian Anthropology Society

The Society for the Anthropology of North America

La Facultad de Ciencias Antropológicas

Universidad Autónoma de Yucatán

Mérida, Yucatán, México

3-8 mai – May 3-8 – Mayo 3-8

2005

DATE: 05/05/2005 Jueves / Thursday / Jeudi

SESSIONS:
8:00 to 9:45

Audiovisual
Session: TRANSLOCAL ISSUES IN HEALTH PREVENTION AND CARE / TEMAS TRANSLOCALES EN EL CUIDADO DE LA SALUD Y LA PREVENCIÓN. *Chair*: Rachel de Vries.

8:00-8:15. Jen Pylypa (Carleton) Global problems in Local Contexts: The Anthropology of Dengue Fever Prevention in Thailand and Mexico.
8:15-8:30. Gregorio Leopoldo Sánchez, Karina Kielmann and John Porter (CAICET-Venezuela /LSHTM) Indigenous Community Health Workers and Pluralistic Health Systems: The Case of Auxiliares de Medicina Simplificada in Amazonas, Venezuela.
8:30-8:45. Sergio Quesada Aldana y Gaspar Cabello Real (SANA) La cultura del agua, la salud y los cambios en la identidad cultural.
8:15-9:00. Rachel de Vries (Guelph) Questioning "Culture": The Analysis of HIV/AIDS in the South.
9:00-9:15. Hannah Gilbert (McGill) From the 'Healthy Laborer' to 'Laboring for health': Perspectives on Colonial and Postcolonial Health Promotion in Africa.
9:15-9:30. Luis Alberto Vargas, Florencia Peña (ENAH) and Rosa María Ramos. Políticas públicas y sobrevivencia durante el primer brote de crecimiento en México (1980-2000).
9:30-9:15. James Trasher (North Carolina-Chapel Hill) Consuming Dissent: Making sense of Anti-tobacco Industry Prevention Messages During Neoliberal Time.

Videosala
Session: THE TRAVELS AND TRAVAILS OF JAMES CLIFFORD'S ANTHROPOLOGY: A TIME AND MOTION STUDY, PART I. *Organizers*: Udo Krautwurst and Blair Rutherford. *Chair*: Blair Rutherford.

8:00-8:15. Petra Rethman (McMaster) Internationalism: The politics of a Dream.
8:15-8:30. Jean Mitchell. Remembering Ho Chi Minh: Narratives of Tonkinese Indentured Labourers in Vanuatu.
8:30-8:15. Doreley Carolina Coll. Transcultural Metonymy: The Brazilian North-East in a suburb of Rio de Janeiro.
8:15-9:00. Bob White (Montreál) Marginals, Elites and Mobility in the Cosmopolitan Fantasy of Jean Rouch.
9:00-9:15. Udo Krautwurst (Prince Edward Island) Discussant.
9:15-9:30. Discussion.
9:30-9:15. Discussion.

Jardín Literario
Session: BORDER CROSSINGS: REFLECTIONS ON MULTISITED ETHNOGRAPHIES OF SCIENCE, TECHNOLOGY AND MEDICINE. *Organizer and Chair*: Janice Graham.

8:00-8:15. Janice Graham (Dalhousie) "Biologicals Are Illogical": Making Radiopharmaceuticals Fit Into Regulatory Systems.
8:15-8:30. Craig Candler (British Columbia) Transcendent Life (and) Science: Medicine, Ecology, and Flexible Biotechnical Citizenship in a Northern Thai Village.
8:30-8:15. Sharon Batt (Dalhousie) Multi-Sited Ethnography in a Global Wired Village: Following the Money Behind Patient Advocacy Using ANT and Electronics.
8:15-9:00. Christina Holmes (Dalhousie) The Botany of Translocality: Transgenic Plants, Actor Network Theory and Multisited Etnography.
9:00-9:15. Jean Dennison (Florida) Blood, Race, DNA: Self-Fashioning and Scientific Facts.
9:15-9:30. Janet Atkinson-Grosjean. Discussant.
9:30-9:45. Discussion.

Sánchez, Gregorio Leopoldo, Karina Kielmann and John Porter (CAICET-Venezuela / LSHTM) *Indigenous Community Health Workers and Pluralistic Health Systems: The case of Auxilares de Medicina Simplificada in Amazonas, Venezuela.* This paper argues Auxiliares de Medicina - Simplificada (Community Health Workers, AMS) in indigenous areas of Venezuela provide services that cannot be replicated by biomedically trained doctors. In the current climate of political change, social mobilisation and indigenous rights, AMS can provide important roles in the creation and development of primary health care policies for indigenous people through their accumulated experience (since 1962) as intermediates between: a) local health beliefs and biomedicine, b) families and health posts, c) communities and the state. These roles are an essential contribution to the recognition of pluralistic medical system and indigenous people's right to health.

Sánchez, Juan and Anabela Sánchez (U Autónoma de Nuevo León) *Asuntos de diseño en la investigación de alumnos transnacionales.* This paper explains the weaving together of sociological and anthropological research strategies to pursue the CONACYT investigation, and our ideas about how and why these methods are complementary. Methods include student surveys, student interviews, teacher interviews, and site observations at several hundred schools. The paper compares the different types of data that the different research strategies yield, discusses the logic of data triangulation, and directly addresses who access to sites was negotiated. The paper also considers how this research design contributes to solving the larger problem of studying hard-to-reach and vulnerable translocal populations.

Sánchez González, Mayra Ofelia (UADY) *Construyendo la identidad de género en niños y niñas en edad preescolar.* El ser hombre o ser mujer representa para la mayoría de los seres humanos un rol a desempeñar. La forma específica de cumplir con ese rol varía de acuerdo al contexto sociocultural en el que hombres y mujeres se encuentran inmersos. Justamente con la adquisición de elementos culturales, a través del proceso de socialización, niños y niñas adquieren una identidad de género y aprenden las formas de vestir, actitudes, etc, adecuadas para cada género. Este aprendizaje inicia en el seno familiar, continúa en la escuela y posteriormente en los diferentes espacios sociales en los que se desenvuelven.

Sánchez González, Mayra Ofelia (UADY) *El juego de niños y niñas: una perspectiva anthropologica.* El juego se puede abordar desde múltiples disciplinas. Desde una perspectiva antropológica se aborda el aspecto sociocultural del mismo. A pesar de que el juego no es exclusivo de la etapa infantil, en esta se da su máxima expresión. Los niños y las niñas en edad preescolar juegan de diversa forma, principalmente porque ya han adquirido una identidad de género. Los infantes en sus juegos pueden reflejar o no, construir o deconstruir la realidad en la que se encuentran, debido a las características propias del juego que permiten que sea un espacio que admite múltiples posibilidades.

Sandford, Karrie (McMaster U) *Corporal punishment vs. Child abuse: A Feminist Theoretical Analysis of Children's Experience.* This paper explores geographically varying legal policy concerning the corporal punishment of children by looking into the recent debates surrounding Canada's spanking law, or section 43 of the Canadian Criminal Code. Feminist theory with its "dual feminist criteria of contextualization in historical and current conditions giving rise to discrimination and of remedying inequalities will be a tool for the critical evaluation of the ways assumptions about children are implicit within the legal, and often moral arguments, and how reflection on our implicit assumptions might improve children's recognition as persons, and draw attention to their individual and relational experiences of discipline.

Santiago-Irizarry, Vilma (Cornell U) *How to Cure: "Folk" Perspectives and the Politics of Choice Among Contending Models of Treatment.* This paper explores the implications of proposing advanced medical models vis-à-vis alternative treatment techniques and strategies to health conditions that affect subordinate populations. Drawing on ethnographic fieldwork in psychiatric institutions and in community based substance abuse and AIDS prevention programs, I examine how clients and patients negotiate the tensions emanating from the implementation of a variety of curative models within a continuum that ranges from the strictly "medical" to the "folk" whether based on institutional policy decision or local (communal) responses.