Health-care workers caring for children: The Early Childhood Development Program in La Paz, Bolivia.

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ABSTRACT

Background: Bolivia has a high child mortality rate and many children’s living conditions are inadequate. In order to reach the Millennium Development Goals non-governmental organizations play an important role when the governmental efforts are insufficient. ChildFund Bolivia works with the Early Childhood Development [ECD] program in order to reinforce the development, growth and health for children under the age of eight. Aim: The aim of this study was to illuminate factors that affect the care given by health workers working with the ECD-program in the urban area of La Paz, Bolivia. Method: An empirical study with qualitative method was performed, using participant observations with an ethnographic approach. The data was analyzed through inductive content analysis where different themes were developed. Results: The results are presented in five themes, Creativity, Different needs, Environment, Continuity and Love and passion. All five themes showed sign of significant health promotion strategies that conform to Nola Pender’s Health Promotion Model. Conclusion: This study illuminates how ChildFund’s health workers in La Paz care for children through the globally used ECD-Program. This contributes to the shared global objective to reach the Millennium Development goals by enhancing children’s opportunity to grow and develop. Health workers cared for the children with multiple strategies within the common method of the ECD-program. Implications for clinical practice: The outcome of this study might give people better knowledge about similarities and areas of diversity in pediatric nursing care worldwide, hence enjoy better knowledge in global nursing.

KEYWORDS: Early Childhood Development, Children, Health Promotion, Global Nursing, Ethnography
SAMMANFATTNING


NYCKELORD: Early Childhood Development, Barn, Hälsofrämjande, Global Omvårdnad, Etnografi.
Antecedentes: Bolivia tiene una tasa alta de mortalidad infantil y las condiciones de vida de muchos niños son inadecuadas. Para alcanzar las Metas del Milenio, las organizaciones no gubernamentales (ONGs) juegan un rol importante cuando los esfuerzos del gobierno son insuficientes. ChildFund Bolivia trabaja con el Programa ECD (Programa para el Desarrollo de la Niñez Temprana) a fin de reforzar el desarrollo, el crecimiento y la salud para los niños menores de ocho años. Propósito: El propósito de este estudio fue mostrar factores que afectan el cuidado otorgado por los trabajadores en salud que operan con el Programa ECD en el área urbana de La Paz, Bolivia. Método: Fue desarrollado un estudio empírico con método cualitativo, usando observaciones participativas con un acercamiento etnográfico. La información fue examinada a través del análisis de contenido inductivo en el que temas diferentes fueron desarrollados. Resultados: Los resultados están presentados en cinco temas, Creatividad, Necesidades Diferentes, Medio Ambiente, Continuidad y Amor y Pasión. Todos estos cinco temas mostraron señales de estrategias de salud significantes que conforman el Modelo de Promoción de la Salud de Nola Pender. Conclusión: Este estudio muestra cómo los trabajadores en salud de ChildFund en La Paz se preocupan por los niños a través del globalmente utilizado Programa ECD. Esto contribuye al objetivo global compartido para alcanzar las metas de Desarrollo del Milenio mejorando la oportunidad de crecimiento y desarrollo de los niños. Los trabajadores en salud se preocuparon por los niños con múltiples estrategias dentro del método común del Programa ECD. Implicaciones para la práctica clínica: El resultado de este estudio podría brindar a la gente un mejor conocimiento acerca de las similitudes y diversidad de áreas en el cuidado pediátrico en enfermería a nivel mundial por lo tanto, disfrutar de un mejor conocimiento en la enfermería mundial.

PALABRAS CLAVE: Early Childhood Development, Niños, Promoción de la salud, Enfermería mundial, Método etnográfico.
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INTRODUCTION

In a globalized world nurses must be able to widen their perspective and not only look at the nursing needs within a nation but also the needs throughout the world. By building cross-national collaborations we can improve the nursing science by learning more about ourselves and others. The health-care prerequisites a wealthy country like Sweden enjoy is not the reality everywhere in the world. The diverse preconditions individuals have or lack make us perfect educators for each other to widen the global perspective and improve nursing care. The will to better understand and learn these cultural nuances planted the seeds to this paper. The researchers strive to become nurses with a global nursing perspective and believe that collaboration with foreign partners can bring us closer to that objective. ChildFund Alliance is a universal cooperation which binds countries together. Their work focuses on improvement of health and development for children all over the world no matter national belonging. The world´s future lies in the hands of children and investment in their health and development is one of the most cost-effective investment that can be done. ChildFund Bolivia is using the program “Early Childhood Development” to promote and strengthen children´s health, development and growth. This study intends to explore how ChildFund´s health workers manage to give care to children at an early stage of life in the healthcare settings of La Paz, Bolivia.
BACKGROUND

Global nursing
The globalization of the world means a paradigmatic shift in the nursing profession as well as the way we see health and the meaning of it (Upvall, Leffers & McKim Mitchell, 2014). We do not longer look upon health as static, a presence or absence of sickness, but rather in a dynamic way as something that is defined within the context of society (ibid.). World Health Organization [WHO] (2014) states that health has become a shared responsibility and that it involves equitable access to essential care and a collective defence against threats on a transnational level. As the largest group of health care providers in the world, nurses provide a great benefit to the welfare and health of communities and individuals worldwide (Breda & Wright, 2011). Historically, nurses have made great impact on global health; such as Florence Nightingale did through her efforts in the Crimea (Upvall & Leffers, 2014). Upvall and Leffers (2014) define global health nursing as: “Individual- and/or population-centered care addressing social determinants of health through a spirit of cultural humility, deliberation, and reflection in true partnership with communities and other health care providers.” According to this definition the authors state that nursing is fully capable of facing the global health challenges.

Abowitz and Harnish (2006) argue that globalization and an increased global awareness have revitalized the transnational discourse. Transnational citizenship is described as when a person not only identifies with her nation but also with nations and communities of people beyond the nation-state boundaries. One of the mainstays of transnationalism is the emphasizing of humanity. Breda and Wright (2011) argue that by becoming a transnational citizen, nurses can more fully understand other forms of cultural traditions and knowledge. Global nursing collaborations offer great opportunities for this. These may take place through international health organizations, religious organizations, volunteer organizations etcetera (ibid.). Globalization do however also affect health care and nursing on a national level (Locsin, 2000). International migration increases cultural diversity, which presents a challenge to the health care practice (Locsin, 2000). Locsin states that emphasizing cultural similarities rather than differences brings us closer to understanding human beings as persons. Nurses must be aware of global health issues, including nursing practice in other countries, in order to understand the cultural nuances necessary for human well-being. A global perspective on health and nursing widens the views of health care as well as the understanding of ourselves and others (Locsin,
(Breda & Wright, 2011). The Millennium Development Goals

The Millennium Development Goals [MDGs] are the results of the Millennium Summit in September 2000, where the largest assembly of world leaders in history took place at the United Nations [UN] headquarters in New York (Millennium Project, 2014). By adopting the UN Millennium Declaration, the leaders committed their nations to a new global partnership in order to reduce extreme poverty in its many dimensions through time-bound quantified targets. The eight goals to be met by 2015, (See figure 1)

![Millennium Development Goals](figure1.png)

UNICEF (2014) argues that even though the Millennium Development Goals are set with the intention to improve the lives for all humankind, they are primarily about children. The first six goals are directly related to children and achieving the remaining two will mean significant improvements in their lives. In lack of essentials like clean water, food, health care and sanitation, children are most vulnerable. Additionally, in order to realize the basic human rights that the Convention on the Rights of the Child means, the Millennium Goals must be met (UNICEF, 2014).
Bolivia [Estado Plurinacional de Bolivia]

Bolivia is a country located in the center of Latin America with a size twice as big as Sweden and a population of 10.5 million inhabitants (Pan American Health Organization [PAHO], 2014). La Paz is the administrative capital city with about 1 million inhabitants but Sucre is the formal capital of the country (Landguiden, 2014). The official languages are Spanish and 36 other native languages. Two thirds of the population belongs to indigenous groups. Aymara and Quechua are the two dominant groups among 30 Indian cultures in the country (Landguiden, 2014). Bolivia is known for its rich indigenous culture, which strongly influences the country’s national level of identity (ChildFund, 2010).

Bolivia declared its independence from Spain 1825 and has since then been pervaded by an unstable political state, with approximately 200 changes of government (Kumm, Rojas, Schmidt & Retsö, 2014). Despite Bolivia’s great natural assets of oil, minerals and natural gas, the country is considered one of the poorest in Latin America (Landguiden, 2014). Bolivia has a large foreign dept, neglected agriculture and is highly dependent on foreign aid (ibid.). The poverty is most extreme and severe for indigenous people and people living in rural areas (Silva & Batista, 2010). In 2006 the socialist politician Evo Morales was elected as the country’s first indigenous president and since then the political situation has changed to the better for the indigenous people (United Nations Population Fund, [UNFPA], 2012).

Family bonds are important and in the rural areas of Bolivia it is not uncommon that several generations of the family live together (Landguiden, 2014). In general mothers give birth to 3.5 children but there is a distinction with a higher number of births per mother in rural areas than for mothers in urban areas (Gapminder, 2014, Landguiden, 2014). Approximately 263 000 children are born in the country every year (UNFPA, 2012). Barnfonden (2014) describes how 7 000 of them don’t survive their first month and how another 7 000 don’t reach the age of one. Many Bolivian children face a tough reality already in their first years and according to ChildFund (2014) three out of four children suffer from physical, emotional or sexual abuse within their home. More than half of the children in the age between 6 months and 5 years suffer from malnutrition (ibid.). The child mortality rate is one of the highest in Latin America with a number of 41 deaths per 1000 living five-year-olds compared to the same Swedish rate of 2.9 (Gapminder, 2014). In order to diminish these numbers the Bolivian government has made reinforcements to improve maternal and children’s health (UNFPA, 2012). Health care and dental care is free of charge for pregnant women and children up to the age of five years (ibid.).
The access to healthcare is however still limited for the Bolivian population; a majority are excluded from the public healthcare system (Christoffersen, 2014).

**ChildFund**

ChildFund was founded in 1938 by Dr. J. Calvitt Clarke to help war orphans in China, and was then called China’s Children Fund (ChildFund International, 2013). After World War Two the organization expanded to meet the needs in Korea, Japan, Burma and the Philippines. The name of the organization changed into Christian Children’s Fund in 1951. The engagement spread to more countries and connections with local leaders were made, in order to make effective lasting changes in entire communities (ibid.). In 2002 the 11 organizations joined together under the banner of ChildFund Alliance, which became a global network of child-centered development organizations (ChildFund Alliance, 2014). The role of the alliance is to ensure that the members are accountable to high levels of integrity and quality in programming, governance, fundraising and finance (ibid.).

Today, ChildFund works with 18.1 million children and family members in 58 countries in the Americas, Africa, Asia and Western Europe (ChildFund International, 2014). The founder, Dr. J. Calvitt Clarke, started the person-to-person child sponsorship in order to keep the donors connected. Sponsorships have played an important role in ChildFunds work and the idea still drives the organization today (ChildFund International, 2013). ChildFund has helped children in Bolivia since 1979 (ChildFund International, 2014).

**Early Childhood Development Program [ECD-program]**

During a child’s first living years the brain develops basic and vital skills such as personality, intelligence and skills to learn and nurture oneself (UNICEF, 2014). During this time the brain develops rapidly and if the nurturance is disturbed or the child is exposed to a stressful environment this can have long lasting consequences in the adulthood (Evans, 2001). Children in developing countries suffer from higher frequency of developing deficits regarding nutrition, health, fine and gross motor skills and cognitive and socio-emotional development (UNICEF, 2014). Early Childhood Development programs are used worldwide to ensure or reinforce children’s welfare by working with all these six themes (Schady, 2006). By doing so the children’s development are taken accounted in a holistic way, and provides them with better possibility to grow and develop. According to UNICEF (2014) Early Childhood Development-
program is also an investment for countries sustainable development. Investments made early in life has shown to give a high rate of return both to families, societies and countries because of the won health and labor capacity. The program is therefore very cost-efficient.

ChildFund Bolivia works with the ECD-program all over the nation (ChildFund Bolivia, 2013). The main targets are to:

*Prevent, develop and sustain children under eight’s development and growth so it levels with what is appropriate for their age.*

*Build and strengthen possibilities in families to support and take care of their children under the age of five.*

*To implement methods and materials in their centers for children under eight to stimulate learning and preparedness for future education.*

*Create local partnerships so the work can be sustainable in matters of human resources, material and finances.*

*Improve and enforce the cooperation with the health establishment, education establishment and other supportive systems concerning children’s rights* (ChildFund Bolivia, 2013).

In order to reach these goals ChildFund Bolivia works in caring centers outsourced in different areas in Bolivia (ChildFund Bolivia, 2013). There are three caring centers administrated by ChildFund working with Early Childhood Development in the urban La Paz area (S. Maldonado, personal communication, 5 November, 2014). The caring centers have educated and paid technicians, youth leaders and volunteers working with the ECD-program. These people make several annual evaluations of children under the age of eight. The evaluations play an important role in the screening to discover children suffering from development or growth deficiencies. The children’s health, fine- and gross motor skills, nutrition, socio-emotional- and cognitive development is evaluated to see that it matches what is expected for their age. Aside from the evaluations, the caring centers offer education to parents, tutoring for school children, and other activities to enhance the child’s normal development (ibid.).

**Nola Pender`s Health Promotion Model**

In the Health Promotion Model created by Nola Pender health is defined not as the absence of disease but as “an evolving life experience” that involves the “actualization of inherent and acquired human potential through goal-directed behavior, competent self-care, and satisfying
relationships with others” (Schub, 2014). The theory assumes that individuals actively seek to regulate their own behavior (Pender, Carolyn & Parsons 2011). Health promotion in Pender’s Health Promotion Model [HPM] is explained as humans’ motivation to change a behavior with the desire to increase well-being and actualize human health potential (Nursingtheories, 2014). Pender’s Health Promotion Model focuses on the overall wellbeing and health related quality of life for people by increasing their health-promoting activities (Schub, 2014). Such health-promoting activities or behaviors can be improved diet, getting adequate rest, and conducting regular exercise (ibid.).

Schub (2014) and Pender, Carolyn and Parsons (2011) explain that the HPM is rooted in three human behavioral theories:

**The theory of reasoned action**, which stresses that people are more likely to change a behavior or take part in activities if the changed behavior or activity is thought to bring a desirable result.

**The theory of planned behavior**, which states that it is more probable that individuals take part in activities were they feel they have control over the situation or action.

**Bandura’s social-cognitive theory**, which argues that people’s confidence in what they can perform directly effects their ability to do so.

These above factors are then indirectly influenced by individuals’ previous experiences and personal characteristics (Schub, 2014). This means the individual’s biological, psychological, and sociocultural factors, such as personal confidence, perceived benefits of action and family relationships.
PROBLEM DEFINITION

In a globalized world, nurses must widen their perspectives in order to improve nursing as care and science. Research and collaborations across borders are therefore relevant when tackling global health issues, such as the promotion of children’s health and the achievement of the Millennium Goals. In order to realize the basic human rights that the Convention on the Rights of the Child means, the Millennium Development Goals must be met. In Bolivia, many children suffer from malnutrition, abuse and insufficient development and the country has a high child mortality rate. The governmental actions and reinforcements are insufficient and the problem is being cared for by non-governmental organizations such as ChildFund. Because of these haltering governmental interventions, ChildFund Bolivia uses the ECD-program all over the country to reach out to families and children in need of care.

AIM

The aim of this study is to illuminate factors that affect the care given by health workers working with the ECD-program in the urban area of La Paz, Bolivia.
METHOD

Design
This empirical study was made with a qualitative method, using participant observations with an ethnographic approach during a period of eight weeks in La Paz, Bolivia. According to Pilhammar, Andersson (1996) this holistic method of observing makes it possible to study caregivers working methods and habits. The aim with the study was to discover the methods and habits that ChildFund’s health workers apply in their work. Hence the ethnographic method was chosen. Since the result in this ethnographical study spring from empiric data-collections the study have an inductive approach, which is essential in the ethnographic study in order not to leave anything out (Priebe & Landström, 2012).

Entrance to the field
The first contact was established 9 months before arriving to La Paz. Barnfonden; the Swedish subsidiary to ChildFund was the primary contact. Through them, information was received on the work performed by ChildFund Bolivia. Further contact with the managers of the ECD-program in La Paz was established through Barnfonden. The contact at Barnfonden is therefore the gatekeeper. Carlson (2012) describes how the gatekeeper is the person that “opens the doors” needed to put the researcher in contact with managers or other responsible for the field that is to be studied. Correspondence was kept with the managers regularly before and during the stay in La Paz. Several meetings took place before entering the field, where the purpose with the study was presented and suitable locations for observations were discussed. Permission to perform the study was given orally and written through a project plan signed by the manager, the researchers and the researchers´ mentor at the Red Cross University College (attachment 1).

Sample group
The sample group consisted of health workers working with the ECD-programs in three caring centers in La Paz urban area. The participants were project managers, ECD-technicians, volunteers and youth leaders. Project managers worked in ChildFund’s office or in the caring centers offices where they charged over the ECD-staff and the ECD-material. Technicians had previous education in psychology, nursing or pedagogy with additional education in Early Childhood Development. The volunteers were Bolivian people that had committed to work with ChildFund at least one year. Youth leaders were juveniles who usually had benefitted from the ECD-program themselves and now assisted the technicians and volunteers in their work.
The outlined participants in the health centers; technicians, volunteers and youth leaders were then individually chosen by the manager in each health center and was presented to us before each field study day. Age, gender, or former education was diverse within the sample group but not taken in account as a criteria of exclusion. Health workers from ChildFund working with other projects on the health centers were however excluded from the study. Everyone who was observed and used as informants was doing so with full knowledge of our purpose before being included in the study.

**Field**
The data was collected in three different caring centers in the urban area of La Paz. ChildFund Bolivia´s office was also visited. When discussed in the study, the locations are called Location 1, Location 2 and Location 3. The centers where located in different parts of the city and covered different needs regarding to the locations they had.

**ChildFund Bolivia Headquarters**
Here information about the ECD-program, ChildFund Bolivia and practical information about the caring centers that would be observed was received. The office was visited before, during and after the field studies at the caring centers were made.

**Location 1**
In Location 1 the observations were made in two different classrooms and contained ECD-evaluations and tutoring. The informants were volunteers and ECD-technicians. Observations of ECD-evaluations were also made at a village school close to Location 1 where they worked once a week. Total time spent at Location 1 was three days.

**Location 2**
The observations at Location 2 were made at different locations since their work was spread over three different areas of La Paz. Facilities were shared with a school on one location and another facility was borrowed. The third facility belonged only to Location 2. The sample group consisted of ECD-technicians and youth leaders and the activities observed were parental education, tutoring and ECD-evaluations during two afternoons and one morning.
Location 3
Location 3 had its own facilities and was the biggest caring center visited, with 856 children enrolled. ECD-technicians and volunteers were observed. The health center offered day care, tutoring, parental education, evaluations and home visits. All these activities were observed during three whole days of observation.

Data Collection
Different methods of data collection were used in this study; participant observation, informal interviews and document analyzes.

The main source of information was gathered from participant observations, which is described by Carlson (2012) as when the informants are aware of the researcher’s role and the study that is being made, but the researcher does not actively participate. A total of 39 observations were made during nine days at the three health centers. The observations differed in time from 15 minutes up to 2 hours and no restrictions were made to exclude observations during any hours of the day. Field notes were written simultaneously when it seemed suitable to do so, or retrospectively in close connection to the observation. An observation template was used while writing the field notes (attachment 2). Focus laid on what was done and said, in what manner it was done and said and how the researchers experienced the atmosphere during the observed activity. At the end of each field study day the field notes were discussed between the researchers and reflections were added, before the notes were written out fair.

Informal interviews took place during or in close connection to the observed activity with the purpose to gather deeper understanding or clarification of the situation.

Documents were received from the managers at ChildFund Bolivia, consisting of information on the ECD-program and how it shall be implemented as well as the manuals used for ECD-evaluations. The information received through the documents were used to deepen the researchers understanding of ChildFund Bolivia’s work with the ECD-program. According to Pilhammar Andersson (1996) documents can be used to describe the informants as well as the organization that is to be observed, which has been done in this study.

Researchers’ role
Carlson (2012) describes how the ethnographic observer should be present without being intrusive. During the first visit at ChildFund’s office the opportunity to visit three caring centers
was presented. The visits were offered both as an opportunity to observe and to volunteer at the caring centers. During the field study no declines were made if situations occurred where the researchers were asked to help or participate. The researchers did however not wear the same uniform as the observed health workers. Consequently, the researchers sometimes took part in the care by carrying material between gatherings, helping children to follow instructions, following children to the bathroom or keeping them calm. However, the majority of the field study was performed in the roles of participant observants. A low-keyed profile was kept and the activities were observed without taking any part besides from being in the room.

Data analysis
Pilhammar Andersson (1996) describes how data collection and data analysis always are made collaterally during an ethnographic study. Carlson (2012) describes how the first analysis is made of the field notes, since the researcher seeks patterns that describe the cultural activities that have been observed. The initial field notes were long and sprawling but were narrowed down as the field study proceeded as the researchers could see patterns in the observations. The final data analysis was made with a content analysis (table 1). The field notes were carefully read by the researchers, as recommended by Carlson (2012) in order to become familiar with the material. The text was then decomposed, which according to Pilhammar Andersson (1996) is when sentences and expressions are removed from their context. Each observation was coded with a word explaining what the activity was. Keywords were then written next to each code, demonstrating the meaning bearing units that were found. The underlying meanings of this were categorized in different categories where each category had one color. Finally, the meanings were brought together in 5 different themes; Creativity, Different Needs, Environment, Continuity and Passion and Love.

Table 1: Example of how data was analyzed.

<table>
<thead>
<tr>
<th>Code</th>
<th>Meaning bearing unit</th>
<th>Meaning</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classroom activity</td>
<td>The ECD-technician instructs the older children to practice writing and mathematics.</td>
<td>Exercises to improve children’s skills so that they are better prepared for school and its demands.</td>
<td>Different needs</td>
</tr>
</tbody>
</table>
Ethical aspects
As suggested by Pilhammar Andersson (1996) this ethnographic study is made with decisiveness and tendency to do no harm or to disclose any of the participants. Ethical considerations have been done on three undertakings; ethics regarding choice of topic, data sampling and the presentation of the collected data.

The choice of topic sprinted from an interest to learn more about global care. In The code of ethic for nurses (International Council of Nurses [ICN], 2012) it is stated that care should be given equally and with respect for all individuals no matter ethnic or cultural background. In order to meet the diversity of needs in an equal and respectful manner the nurses must involve ethic consideration and education regarding different ethnic- or cultural backgrounds (Bäärnhielm, 2007). Because the research and writing in this paper is done in a country where other cultural rules apply, the cultural context that would be encountered was studied before entering the field. A language course was performed as well as a preparatory course held by Sida about studies abroad.

The sampling of data has been done according to the World Medical Association [WMA] Declaration of Helsinki. Participants were informed, literally and orally about the purpose of our presence. According to the WMA Helsinki of Declaration (2013), approval for the research is needed from all informants, thus anyone who was believed to have the possibility of giving informed consent did so before becoming an informant (WMA 2013). According to Pilhammar Andersson (1996) it can be difficult to ask all observed individuals for signed informed consent. Signed informed consent can therefore be retrieved from one person responsible (Pilhammar Andersson, 1996), which in this study was done by the program manager at ChildFund Bolivia (see attachment 1) In addition, the purpose of the study was always orally presented to the staff before the observations started. This was done to give the informants the possibility to accept or decline participation. Moreover, a written explanation in Spanish was handed out if further questions needed to be answered (attachment 3). All communication in the health centers was made in Spanish.

The presentation of the collected data is coded so that no people can be identified or connected to actions or answers. This should be made to ensure confidentiality and privacy of the participants (WMA, 2013). All field notes, on computer and in printed form, was disposed when it had been analyzed. According to the WMA Helsinki of Declaration (2013) all informants
should be given the possibility of being informed about the outcome of a study. The abstract of this study was therefore translated to Spanish.

RESULTS

The following themes represent the factors affecting the care given by the health workers. They are both external factors affecting the care such as the surroundings but also internal factors such as personal skills.

Creativity
Technicians and volunteers showed a wide range of creativity when they nursed for the families and the children in the caring centers. In this study the word creativity represents the ability to create, rethink and adapt to different situations.

Firstly, the health workers showed creativity when they created tools or toys for the children when they taught or did ECD-evaluations. In the caring centers the children got to perform different kinds of pottery. This was a way of practicing fine motor skills, which is one of the development factors ChildFund wants to enhance within the ECD-program. The material that was used could for example be recycled ice cream sticks, old bottle caps or broken clips. The recycled ice cream sticks were made into a Christmas tree, the old cap was used as a little bowl for glue and the broken clips were used as pencils. It seemed that material that could have been disposed instead was used again but in a slightly altered area of application. A wide and creative perspective was used by the health workers and because of that material could be recycled and used in different ways depending on what was needed.

During evaluations children were supposed to pick out different shapes and place figures in order of magnitude. In the three different caring centers somewhat different tools were given to the children. One of the tasks in the ECD-evaluation is to describe geometrical shapes. Depending on what material the health workers had to their disposal they altered the situations and created suitable solutions. On one occasion at a home visit, a volunteer was observed instructing a child to point at shapes in her house. The clock could represent a circle and a book represented a rectangular. On another occasion when the evaluation was made in a classroom, the health worker painted the shapes on a paper and on a different occasion they had wooden figures the child could pick out. Depending on the situation and what was available the health workers solved the situations with great creativity.
Health workers also showed creativity in their ability to rethink if they got stuck. The ECD-evaluations demand the child to be active, follow instructions and answer different questions. It happened that some children were shy, stubborn or simply did not understand the instructions and therefore were unable to carry out the evaluations. The observations showed that the health workers used creative methods such as charm, persuasion, patience, firmness and giving second chances to approach these children. If a child was shy the health workers showed a lot of patience. For example, the health workers tried to make the child comfortable by making jokes and never hurried if the child took a long time to answer. When the children were stubborn or on rare occasions reluctant to the evaluations the health workers tried to find other similar tasks the child would like. If the child seemed to have difficulties to understand the instructions they were repeated and described in another way. If a child did not like to count on the fingers the task was changed so the child drew a number of spots on a paper and then had to count the spots instead. If the child did not want to collaborate at all the family was given a second chance to do the evaluation later the same day or the day after.

Finally creativity was displayed when the health workers adapted their working strategies to different situations and people. Some caretakers or parents were very young, others middle-aged. The families that the ECD-workers met had different cultural backgrounds regarding education and indigenous belonging. The health education and the tutoring or practicing classes for both parents and children were designed to be multi-applicable, fun and diverse. If it was in the end of a tutoring class and the children were tired the health worker took them outside to sing so they could get some energy and end the class in a positive way. When health education to parents was given, pictures and posters were used to create greater interest. The health workers used different creative methods such as group discussions, pictures, songs, movement and pottery to offer a wide range of fun and interesting activities. Different activities were used depending on what the situation and the energy levels were at in the groups.

Different Needs
The needs were diverse in and between different locations and groups of families and children. The observations showed that the health workers saw the needs of the community as well as of families and particular children. The managers and health workers on the caring centers seemed to focus on what was acute and or important in that specific area. On one location the work was mostly focused on daycare. The communal daycare is very expensive, and the families in the particular area did not afford to send their children there. The caring center therefore offered
classes for children aged 1 to 5 years old. The workers had also discovered that many of the children did not eat breakfast at home and therefore gave all children breakfast at the center. The children that were undernourished received extra snacks in between meals.

A need that was covered in all locations was the need of tutoring. Many children that went to school needed help to improve their skills in order to meet the demands they faced in school. Younger children that had not started school yet needed help preparing for it. These children received both individual help as well as help through class activities.

The need for education and encouragement to the parents was visible in several of the locations. Communal organized parent advisory groups were very rare, and the health workers fulfilled an important need by arranging meetings for parents. On one occasion we observed an educational meeting where an ECD-technician taught dental hygiene to a group of mothers and their children. Beside the education, this was an opportunity for the mothers to talk and exchange experiences with each other. The ECD-technician encouraged the mothers and emphasized how important and influential they are to their children by saying: “The work of a mother is an important job! You are their protectors and can show them how to do it right!” Several meetings like these were observed, each with a different theme. When mothers were unable to come to the caring centers the ECD-technicians performed home visits, combining evaluation with parental education.

Health- and dental care in Bolivia is free for all children up to the age of 5, but for many families the distance to the hospitals was too long. At two of the caring centers they therefore had a doctor coming in once a month to meet the need of health care. This is one of the examples when the caring centers covered needs that the government failed to do. One of the workers responsible for the ECD-program confirmed this by saying: “We don’t want to outrival the government, but we have to see to the needs that aren’t fulfilled in the community.”.

**Environment**

The ECD-program is held in different locals in the urban La Paz area. Some of the facilities were well equipped with material adapted for children and parents and others were temporary improvised to meet the requirements of the day. The physical environment differentiated between the caring centers and also regarding the different activities in the same caring center. For example one caring center had classroom activities where the children practiced fine motor skills in a well-equipped room with furniture adapted for children and posters with educative
messages. The same caring center held lectures to parents outside in a football field where they had to drown out noise from dogs, cars and other activities going on in the surrounding. The manager of “Local 3” explained that the facilities where they work are sponsored from several other contributors beside ChildFund. They had the biggest caring center and offered diverse and adapted environments for the children. One of the technicians in “Local 2” explained that they only survived because of the sponsorship from ChildFund. “Local 2” offered basic facilities and sometimes shared their working space with a school.

Sometimes the locals where the ECD-program was held offered environment suitable for the activity. On other occasions it seemed as if the locals were far too small, sometimes with stale furniture worn out to the brim. In other places it offered updated posters, toys and special constructed furniture. The diverse physical environment affected the care that was given both to the better and to the worse. The physical environment in the local effected the psychological environment in the facilities. For example, if a room was physically small and crowded the atmosphere in the room got more hectic. One of the ECD-technicians that was interviewed explained that; “One of the main struggles or difficulties in the work is the crowded and cramped working areas.” This quote was made concerning the ECD-evaluations and the working area where they were made. On some occasions when ECD-evaluations were made, the children and their families answered private questions in a room filled with several other families and staff. This exposed the children and their families and the respect for privacy and confidentiality seemed to be ignored. Other families could interrupt while an evaluation was going on and even sit at the same table when questions about friendship, home situation or the event of pregnancy was discussed. The ECD-workers did however show the family respect and courtesy by giving them time and full attention even though many other families waited or required attention in the same room. It seemed that the ECD-workers could make up for the sometimes substandard physical environment by creating a decent psychological environment by being attentive and patient.

As mentioned the caring center’s environment also included well adapted locals where children had children’s furniture, different material and plenty of space to their disposal.

**Continuity**

ChildFund Bolivia is well established in La Paz and the caring centers that were included in this study have a steady number of people coming to them for care. People who came there
relied on the daily, weekly or monthly continuity of the gatherings, activities or classes ChildFund offered. The care was given frequently, which created a better chance for the families to follow the advice they received from for example educational meetings. Because of the regularity in their work they are able to create trustworthy relationships with the children and families. Some of the parents had been beneficiaries themselves and now their children got the same support as they used to get. The parents could continue receiving support but now through parental education. The continuity of work also leads to collaborative opportunities with health establishment, education establishment and other supportive systems concerning children’s health in the areas they are active. When asked how the mothers received information about their meetings, one of the ECD-technicians answered: “We are provided with information about mothers in need of more help from the community’s women’s healthcare clinic.”.

In order to keep track of the children’s development- and growth status regular evaluations were made three times a year. If any of those evaluations showed that the child needed more observation the evaluations were held more frequently until the child was at the adequate level for his or her age. The evaluations also worked as a screening tool because of their frequency. Since the children were checked both regarding development and growth, nascent malnutrition or concentration deficits could be detected early and appropriate measures could quickly be taken.

The care that the ECD-workers gave was following the same method in all of ChildFund’s caring centers. The method is built on the material that ChildFund provides the caring center’s with and it seemed as if it was well used and appreciated by the ECD-workers. One of the ECD-technicians said: “The evaluation material from ChildFund is good to use because we used to use Nelson Ortiz scale, but is doesn’t cover it all, and then the other material makes it more complete, taking the growth in account too.” Since the material that the caring centers was using is produced by ChildFund after serious research about the ECD-program, the material is supposed to be evidence based. Since it is also applicable and used in all caring centers this leads to a common, organized and long lasting strategy with the ECD-program. To ensure quality in the work the ECD-technicians had supplementary education three times every year.

All together the ECD-program provided continuity for the parents by being ongoing and frequently having gatherings, for the ECD-workers by supplying several annual educations and for the children by continuously keeping track of their growth and development through the ECD-evaluations.
**Passion and Love**

This theme manifested itself in all observations that were performed. All health workers shared the passion and love for the work they did as well as for the families and children involved. Firstly, this was seen in how they handled and met the children. The health workers handled the children with great warmth and care, both verbally and physically. They called them by their name or by loving nicknames such as “my love”, often using a soft voice. Physical contact between health workers and children was common and occurred in natural ways, such as hugs and kisses or a pet on the head. In situations of evaluations or in classes, the children received lots of compliments and encouragement. On one occasion an ECD-evaluation of a child with cerebral palsy was observed. The ECD-technician took him in her arms and while holding him close she spoke with a soft voice: “you are a son of God.”.

Secondly, this theme manifested itself in how the health workers looked upon their work. When asked, all health workers said that they really liked their job and many of them had worked for the organization for many years. One ECD-technician expressed the joy in seeing results of the work she did by saying: “I’ve been working here for over twenty years now. It’s amazing to see some of the children that I’ve had in the program to grow up and become successful. For example, there is one girl who is a doctor now. She has come back and have lectures for us sometimes”.

**DISCUSSION ON METHOD**

The purpose of this study was to illuminate factors that affect the care given by health workers working with the ECD-program in La Paz. When looking for cultural patterns and communicative behaviors ethnography is an appropriate method (Hammersley & Atkinson, 2007; Willman, Stoltz & Bahtsevani, 2011). It is further argued that the ethnographic method is beneficial when studying health professionals due to its holistic understanding of culture and social patterns (Thomson, 2011). The choice of method for this study can therefore be argued as suitable for the purpose, which according to Peterson and Lindskov (2012) means that the study has credibility. By observing the health workers in their work and during a complete day of work the result is holistically presented. It is holistic in the sense that it covers everything that was encountered in the observations. According to Pilhammar Andersson (1996) this is essential in an ethnographic study.
The aim with an ethnographic study is to describe the field from the informant’s perspective (Pilhammar Andersson, 1996). The observations were made with an attempt to separate personal opinions from the observations. Thus personal thoughts such as being uncomfortable or happy were noted in a separate box in the observation template. According to Carlson (2012) it important to make interpretations of situations from the perspective of the informant, the *emic perspective*, when explaining what has been observed. When a phenomenon is explained in the manner of the observed group, the perspective is emic (ibid.). This can according to Pilhammar Andersson (1996) be done by quoting the informants. In order to preserve the emic perspective, quotations were used in field notes as well as in the presentation of the results. Pilhammar Andersson (1996) also describes how informal interviews is a good complement to the observations, and that they are suitable to perform in close connection to the observed activity. Informal interviews were performed on several occasions. By doing this in close connection to the observations the health workers were able to explain, add or justify actions that had been observed. This gave the observations further emic depth by amplifying the informant’s perspective. The *etic perspective* is the perspective of the researcher in how the results are being connected to theories and models of explanation chosen by the researcher (Pilhammar, Andersson, 1996). While doing the content analysis the result was interpreted and analyzed with Nola Pender’s Health Promotion Model. This treatment of the result provided an etic perspective.

On most occasions the researchers’ kept the observing role, hence the research and participant role was separated as Allan (2006) recommend in an ethnographic study. To maintain the separation the researchers’ role was explained to all participants. The uniforms usually worn by the health workers was not used in order to enhance the observational role. In addition, the position in the room was considered with the intention of staying out of attention as much as possible. When health workers asked for help this request was however never declined. The support given could be assistance in caring for the children or help to prepare the health worker’s activity. On some occasions, the children in the health centers seemed to make no difference between the health workers and the researchers. This was displayed when the children referred to the reseachers´ with the same titles as to the health workers. If the researcher steps out of the observing role and starts participating in the care he or she becomes a *member* (Pilhammar Andersson, 1996; Carlson, 2012). By becoming a *member* the researcher loses the etic approach and starts acting as one in the group (Pilhammar Andersson, 1996). Hence, on occasions the researchers became members. Pilhammar Andersson (1996) states that being a
member can lead to blindness before the result. However, the researchers were always aware of when this occurred and noted this in the field notes. In order to keep the etic perspective the participation in the work was rarely made by both researchers at the same time; while one participated the other one observed.

The group of people observed in this study were health workers working with the ECD-program. Kjellström (2012) describes that the researcher must be aware of which sample group best fits the research question, and after considering this the criteria’s for the sample group was defined. Since the purpose was to illuminate the work with the ECD-program, it corresponds well with the chosen sample group. This strengthens the study’s validity.

Because of the wide collection of data the results can be sprawling (Pilhammar Andersson, 1996), which was the case in this study when the result was first analyzed. In order to make sense of the material without making exclusions, the final data analysis was made with a structured content analysis. It is argued that a detailed and structured content analyses gives better understanding of the material (Carlson, 2012). This was also the case in this study and the purpose of the study got to develop from the findings in the observations. In order to deepen the analysis the researchers also read and analyzed each other’s material. Danielson (2012) states that the results from a study made with a qualitative content analyzis never can be generalized. It can however be transferable to similar contexts, groups and situations (Danielson, 2012). ChildFund is an international organization and the ECD-program is used by a variety of health promoting organizations globally. It can therefore be argued that the results of this study can be transferable to other contexts where the ECD-program is being used.

The International Council of Nurses (2012) instructs that nursing should be adapted to the cultural context it is given in and in ChildFund Bolivia’s health centers Spanish is the commonly spoken language. According to Bäärnhielm (2007) people find it easier to express themselves if they can do it in a language they feel comfortable with. Because of that, all communication was made in Spanish in order for the participants to understand the purpose and feel at ease while giving information. That Spanish is the third language for both researchers is considered a weakness. The communication sometimes lacked fluency, words or expressions had to be explained and occasionally questions from both parts were misunderstood. Enqvist (2007) does however state that body language and voice stands for 90 % of the communication between people and such information does not follow the same rules as languages. In this study
body language was frequently used with the belief that a friendly smile or heartwarming laughter is universal.

The results in this study are based on what was presented and communicated by people working with the ECD-program. When their verbal and non-verbal communication was presented the researcher tried to be as impartial as possible and leave as much as possible of one self’s pre-understandings as Pilhammar Andersson (1996) suggests. The results of an ethnographic study are always affected by the researcher’s prejudgments and pre-understandings (Carlson, 2012). The researchers’ pre-understandings consisted of some knowledge in children’s health and development as well as a shared interest in global nursing. Before entering the field the researchers’ searched information on the situation in the country as well as on ECD and the work performed by ChildFund. This was made in order to better understand the field that was to be observed. According to Savage (2000) it is impossible to completely leave one’s pre-understandings. An ethnographer can only try to stay as objective and impartial as possible while observing and presenting results (ibid.).

Sweden is one of ChildFund Bolivia’s main financial providers. In addition, visits from Sweden and other Western countries are uncommon at the caring centers in La Paz. This may have affected how the participants in the study behaved in the presence of the researchers. If so, it shall be seen as a weakness in the study. The purpose of the researchers’ presence was however always explained and the researchers were always presented as nursing students. In addition, even if the children in the caring centers often showed great interest, the researchers seldom experienced any change in behavior of the health workers. Carlson (2012) states that the presence of the researcher always affects how the participants behave.

The observations were made during a period of nine days without interruption, a time period decided in advance. This is explained by Carlson (2012) as the compact time frame which is suitable when the objective is to give a complete picture of the observed setting. The researchers never left the field’s cultural context while collecting the data. The fact that the researchers only spent three days at each caring center can be seen as a weakness. However, the model of work was the same at all locations. It can consequently also be seen as a strength that the observations covered all caring centers in La Paz that work with ChildFund’s ECD-program, in the way that it can offer a more generalizable description of the work. Being more than one researcher can also be seen as a strength since the outcome of the study is not solely based on one person’s observations.
DISCUSSION ON RESULT

The observations in this study are presented in five themes; Creativity, Different needs, Environment, Continuity and Love and passion. The themes are the result of ChildFund’s health workers effort to diminish children’s suffering and create environments where children are able to grow and develop. The observations indicated that the global caring program of Early Childhood Development was used in all observed caring centers. All five themes showed sign of significant health promotion strategies that conform to Nola Pender’s Health Promotion Model.

Creativity in this study is defined as the ECD-workers ability to create tools and toys for the children in their educative and evaluative work. Creativity is also defined as their management of situations and way of meeting barriers of different kind.

Health-workers meet many thousands of people during a professional lifetime (Andersson, 2007). Every single meeting will be unique and demands flexibility and creativity from caregiver/health-worker (ibid.). Mistry, et al. (2012) state that people working with the ECD-program have diverse working tasks that require the health workers ability to meet different situations. Davis, Corr, Ummer-Christian, et. al (2014) also confirms this by stating that ECD-workers use different methods and group interactions to promote children’s wellbeing. In order to meet different situations the health workers creatively must alter their approach when they are conducting educative work, evaluative work or meeting families and children.

Creativity shown by the health workers concerning creating tools and diverse activities will be discussed. Ewles and Simnett (2007) argue that activities help individuals to thoughtfully receive information. Such activities can be practicing skills, writing, and painting among many other activities (ibid.). The activities that the ECD-workers did with both parents and children contained different and creatively developed activities to maintain their interest. According to Ewles and Simnett (2007) the limitations to what can be given as an activity are few as long as they are relevant for the taught topic. Further they describe the importance of diversity in activities and that the most effective way to keep a group interested is to create tailored activities (ibid.). One of ChildFunds targets with the ECD-program is to implement methods and materials in their centers for children under eight to stimulate learning and preparedness for future education (ChildFund, 2013) and so they did by giving different tasks and altering the tasks regarding to the group.
Following the health workers creative ability to manage different situations and barriers will be discussed. Johansson (2007) describes that caregivers need multiple strategies to encourage children to participate actively. The children and families that the health-workers met came from different indigenous backgrounds even though they were Bolivian. Breda and Wright (2011) argue that international health organizations are able to provide global nursing that is culturally sensitive and adapted which was observed when the ECD-workers managed to meet families with these different backgrounds.

Children are honest and rarely polite in the meeting with caregivers (Breda & Wright, 2011). It is important that the caregiver is creative, alert and attentive to what the child is expressing in order to use a suitable strategy to approach the child (ibid.). The health workers that were observed showed creativity when they managed to persuade grumpy, shy or unfocused children to participate. For example, if a child was grumpy the ECD-workers used humor to make them in a better mood and therefore more willing to participate. Ikegami and Agbenyega (2014) states that positive feelings in the meeting with caregivers help the children to be more align with them. This means that when the health workers were able to alter a negative meeting with a grumpy child into a positive meeting they might have made future participation more likely, which is also what is assumed in Pender´s Health Promotion Model (Nursingtheories, 2014).

Concentration, creativity and alertness to what the child express is essential to acquire the child’s trust (Johansson, 2007). By attentively listening and creating opportunities for the child to lead the situation the child’s self-esteem and sense of control grew (ibid.). According to Pender´s Health Promotion Model Theory enhanced self-esteem gives better chances to conduct future health behaviors and stay out of illness (Schub, 2014). It is important to let the child make decisions about their collaboration and health progressively from early age so they learn decision-making gradually (Johansson, 2007). The HPM theory also states that individuals who feel they are in control over their situation and able to make decisions on their own are more likely to participate in actions (Schub, 2014). Creativity was shown by the ECD-workers when they attentively listened to the child and let the child’s mood indicate which working strategy they would use. Therefore the ECD-workers’ creativity resulted in enhanced self-control and ability to make decisions about health for the children as Johansson (2007) also describes.

The theme Different Needs is defined as how the health workers managed to discover and fulfil a variety of needs of families and children in their work.
Children’s development is holistic, meaning that it consists of a variety of different co-dependent dimensions (Evans, 2001) and in order to ensure that children reach their optimal development, early childhood is the most effective time to intervene (Gyungjoo, McCreary, Mi Ja, Chang Gi & Soo, 2012). The health workers managed to discover and fulfil different needs of children in different ages such as nutrition, fine and gross motor skills, cognitive stimulate, tutoring and medical care. One location provided daycare, since the need for this was strong in the community. Gyungjoo et al. (2012) state that fewer days spent in daycare means a risk for underdevelopment to children in low-income families. Their home environment may be poor and unsafe and the children may lack material for learning and play at home (Gyungjoo et al., 2012). It can therefore be argued that the intervention of affordable daycare is health-promoting in long-term. The discovery that many children did not receive breakfast at home made one caring center provide breakfast to all children. Studies of school breakfast programs have shown great improvement in the nutrition status of children at nutritional risk (Carroll, 2014). Eating breakfast regularly is also known to improve children's academic performance (ibid.). Evans (2001) also emphasizes the strong link between learning and nutrition stating that a child will not be able to learn if hungry. One of the eight Millennium Goals is to achieve universal primary education (Millennium Project, 2014). In order to meet the demands that they faced in school many of the children needed tutoring to improve their skills. Consequently, the health workers performed an intervention with the direction to achieve the Millennium Goals. The health workers saw the need for education and encouragement to the mothers in the community. This corresponds well with one of ChildFund Bolivia's main targets with ECD; to strengthen families’ possibilities to take care and support their children under the age of five (ChildFund Bolivia, 2013). Mistry et al. (2012) state that psychological resources are crucial to children’s development and health. These resources include the abilities and skills that caregivers have to address parenting demands (ibid.). The observations revealed how ECD-technicians through encouragement and education enhanced the mothers’ skills to provide better care for their children. Evans (2001) also emphasizes the importance of parental education by stating that monitoring of children’s development and growth is a waste of resources, unless the parents are educated on how to provide the child with better nutrition. ECD-technicians did home visits when mothers were unable to come to the caring centers. According to Evans (2001) parental education through home visits have been proven efficient on a long-term. The ECD-technicians were seen teaching health-promoting behaviors such as dental hygiene to the mothers while emphasizing their importance and influence on their children. According to Nola Pender’s Health Promotion Model Theory people are more likely to engage and commit in health-
promoting behaviors if their family and close ones do as well (Nursing Theories, 2014). It is therefore possible to believe that the children are more likely to enhance the health-promoting behavior of brushing their teeth if their mothers do as well.

*Environment* in this study is referred to the physical space where the ECD-program took place. The result showed that the physical space affected the atmosphere where the ECD-program was performed.

According to Nola Pender´s Health Promotion Theory environment may have direct or indirect influence on health behavior (Nursingtheories, 2014). The theory also assumes that individuals constantly are affected by and affect their environment (ibid.). This means that the facilities ChildFund used to perform their ECD-program have significance for the families´ health outcome. Mistry, et al. (2012) also argue that institutional resources such as education centers play an important role for the child´s health promotion and development. Further the authors state that the investment in educational centers working with the ECD-program vary. The caring centers that were observed received different amounts of contributions depending on the amount of sponsors. This might explain the different environmental settings the caring centers offered. In order to understand the healthcare-setting it is important to use a global perspective to understand the cultural context (Locsin, 2000). Bolivia is one of Latin America’s poorest countries and facility-standards are generally affected by the country’s financial situation (Silva & Batista, 2010, PAHO, 2014). Pender´s HPM explain that external environment can increase or decrease commitment to or participation in health-promoting behavior (Nursingtheories, 2014). This was seen when the atmosphere in the facilities was affected by the size or number of people in the environment observed. On these occasions the ECD-workers tried to make up for the lack of environmental resources by creating a good atmosphere. According to Bricher (1999) caregivers creates a good atmosphere with children when they build relationships with them. By doing so the child find the environment secure and might even forget about the ongoing procedures surrounding the child and the caregiver (ibid.).

One of the health workers in the caring centers expressed frustration about the facilities where the ECD-evaluations took place. According to Sikma (2006) caregivers require a caring and supportive environment in order to provide care. Sikma (2006) explains that one of the factors to create a caring and supportive environment for the caregivers is to provide working areas and tools that are adequate for their work. The frustration that the health worker expressed probably sprung from the feeling of not having working areas adequate for the ECD-evaluations. The area might have been seen as unsatisfying because of the lack of integrity it
provided. Casey et. al (2010) describe how worrying mothers might transmit their worry onto their child, which could be an indication that some examinations might be better for the child to do separated from their parent. Other studies about family centered care does however argue that children feel most secure when they have their caretakers present when they are given care (Abraham & Moretz, 2012, Bell 2014).

*Continuity* in the result is presented as frequency in offering gatherings, supplementary educations and ECD-evaluations for families, ECD-workers and children.

Spratt, Philip, Shucksmith et al. (2010) argue that caregivers who work in environments close to the people they care for have better chances of winning their trust. Bricher (1999) adds to this by saying that to slowly invest in the relationship between the caregiver and the child gradually build bonds of trust (ibid.). Since ChildFund’s health workers regularly have meetings and see the families they can built trustworthy relationships with them. The Health Promotion Model states that health care providers are essential benefactors of interpersonal influence that can increase or decrease commitment to health-promoting behavior (Schub, 2014). To have health-workers giving continuous care brings quality to the care according to Williams (2014). The continuity of their presence therefore probably increased the family’s health-behavior. One of ChildFunds targets with the ECD-program is to improve and enforce the cooperation with the health establishment, education establishment and other supportive systems concerning children’s rights (ChildFund Bolivia, 2013). Because of their continuity of presence in the community they were able to build relationships with the community based establishments too. By creating these relationships the ECD-workers were given important information about families with needs. Because of this the families could get regular support about how to conduct health behavior and therefore according to Pender’s HPM were more likely to stay out of illness (Nursingtheories, 2014). It is stated that investment in health during early childhood have long term health effects (Evans, 2001). Continuous interventions like the ECD-program does however also directly reduce child and maternal mortality rate (ChildFund, 2013). These are two of the millennium development goals according to UNICEF (2014).

The Bolivian government is trying to improve maternal and child health (UNFPA, 2012). The access to healthcare for many Bolivian families is however still inadequate with a majority of people being excluded from the public healthcare system (Christoffersen, 2014). Here the continuous ECD-evaluations, which are performed three times annually, play an important role in discovering children with development or growth insufficiencies.
ChildFund offer their coworkers annual supplementary education. In order to ensure the care for patients, caregivers need to review their practice regularly (Williams, 2014). The supplementary education that the ECD-technicians received was made to reinforce their working methods. ChildFund aims to implement common strategies for health workers within the ECD-program (ChildFund, 2013). By offering supplementary education the ECD-program content is repeated, which bring effectivity and stability to the work according to Zhenni, Xue, Rui, Changmin and Pengqian (2014).

The theme *Passion and Love* is defined as how the health workers expressed love towards the children and families as well as their passion for the work.

Zhenni, Xue, Rui, Changmin and Pengqian (2014) state that work passion plays an important role for health workers in how it provides stability and effectivity to the team. Lack of work passion may lead to low work efficiency and emotional exhaustion, which will influence the quality of the treatment and care given to patients. The main influencing factors for lack of work passion are stress, lack of learning and training opportunities and personal development opportunities (ibid.). The health workers work passion can therefore partly be explained with the education they received from ChildFund three times a year.

In situations of evaluations or in classes the children received lots of compliments and encouragement from the health workers. This corresponds with Nola Pender’s Health Promotion Model Theory, in which it’s argued that commitment and action is increased if a behavior is associated with positive emotions or affect (Nursing Theories, 2014). A study performed by Rathvon (1990) showed that children who received encouragement became more enthusiastic about their studying and the teachers felt more positive about their teaching. It can therefore be argued that the encouragement delivered by the health workers both helped the children to achieve the tasks given to them, as well as creating a positive atmosphere for both children and health workers.

The health workers were seen handling and meeting the children with great compassion and love. A study performed by Fitzgerald (2006) suggests that love in nursing is uncontrolled by conscious thought and that the feeling arises from deep within, without being available to the consciousness. Love motivates the nurse to answer to an identified helplessness of the patient and enables the nurse to be for the patient as a first priority (ibid.). Consequently, the love
expressed by the health workers cannot be explained in other words than something that occurred in each individual situation.

CONCLUSION

This ethnographic study illuminates how ChildFund’s health workers in La Paz give care to children through the universally used Early Childhood Development Program. The program contributes to the global objective to reach the Millennium Development goals by enhancing children’s opportunity to grow and develop. Health workers cared for the children with multiple strategies within the common method of the ECD-program. Their health promoting care concerned children and their caregivers. As regards to where the health workers practiced, they were able to meet different needs while maintaining their health promoting approach. Sign of love and respect for children and towards working with the ECD-program was consequently showed by the health workers in this study.

IMPLICATIONS FOR PRACTICE

Global nursing have to consider a wide variety of cultural, religious, ethnic, political, gender, age and economic nursing encounters (Hirschfeld, 2008). The researchers believe that, in order to make those considerations awareness through observations of diverse environments can help us to better understand each other. In a world with an increasing globalization it is important to be aware of the health demands outside the Swedish borders as well as within the nation (Bäärnhielm, 2007). The Swedish healthcare is changing and is today meeting a more diverse group of people with different traditions and experiences (ibid.). The outcome of this study might give people better knowledge about similarities and areas of diversity comparing Bolivian and Swedish pediatric caregiving. According to Bäärnhielm (2007) better knowledge about social rules and manners minimizes the risk of being disrespectful or overstepping boundaries. The authors of this study believe that this is of great importance when working as a nurse. The world is becoming more globalized and opportunities to learn nursing strategies and create common nursing ethics that makes our practice better is important to improve nursing science (Hirschfeld, 2008).
SUGGESTION FOR FURTHER RESEARCH

The authors strongly believe that the ECD-program is a successful method to improve children’s health. When caring resources are initiated early in a child’s life the consequences of those interventions are substantial on a long term (UNICEF, 2014). By doing more research on the topic and its outcomes the ECD-program could be more frequently used and known worldwide. The Red Cross University College in Stockholm states that the nursing education they offer has an international perspective (RKH, 2014). This field study’s outcome is rich in foreign caring experiences that will be shared at the university. Sharing research made in other caring settings than the Swedish might give the nursing education a better global perspective, hence more research abroad would probably benefit nursing education everywhere, as the globalization of the world fortunately blossom.

THE AUTHORS’ CONTRIBUTIONS

The thesis is performed in a foreign context, meaning that the authors have been based in the country where the data collection was made during eight weeks. Data collection, analysis and writing have been made together on all occasions and the authors have contributed equally throughout the work with the thesis. Different parts have been written individually, all texts have however been reviewed and discussed by both authors.
REFERENCES


ChildFund (2010, June) *ChildFund at Work in Bolivia* [Video]. Retrieved from https://www.youtube.com/watch?v=gMSJoypvomY8


Spratt, J., Philip, K., Shucksmith, J., Kiger, A., & Gair, D. (2010). 'We are the ones that talk about difficult subjects': nurses in schools working to support young people's mental health. *Pastoral Care In Education*, 28(2), 131-144. doi:10.1080/02643944.2010.482145


Project plan for a Bachelor’s Essay, 15 credits in Nursing Science at the Swedish Red Cross University College.

Title: Important factors when promoting child health in ChildFund’s project Early Childhood Development in La Paz, Bolivia.

Background

ChildFund Bolivia works with a program called Advanced ECD (Early Childhood Development). The aim of the program is to create better opportunities for children under the age of eight.

The purpose of the study is to investigate how the health workers in La Paz, Bolivia, promote children’s health through ChildFund’s project.

During fall term 2014 we plan to study how health workers and ECD-technicians work to improve, maintain and discover insufficient health amongst children. The study and the data collection will be the basis for our Bachelor’s Essay, 15 credits, in Nursing Science at the Nursing Education program at the Swedish Red Cross University College.

The Study is approved by the Swedish Red Cross University review board for empirical student projects. D-nr 38/2014

Realization

We will use an ethnographic approach while performing this study. The information needed is intended to be collected through participant observation, interviews and questionnaires. The data collection will be done in La Paz in the context of ChildFund’s work.

The intended sample group will consist of ECD (Early Childhood Development) technicians and health workers. Meanwhile observing, interviews will be performed.

Informed consent will be collected from everyone included in the study. All the informants will be informed, literally and orally about the aim with the observations, interviews and questionnaires.

The authors of the bachelor’s essay will analyze and present the materiel under supervision of the college tutor. The University College will administrate the materiel. The authors have a right to publish the study if not a different agreement is met. We will report the results of the study back to the concerned activities.
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La Paz
Date: 5/11/14

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Date:

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Programs Manager
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Tel. +468 58751600
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<td>Date, time and weekday.</td>
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<th><strong>Observed activity and people involved</strong></th>
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<th><strong>Course of event</strong></th>
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<td>What happened?</td>
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<td>Who did what and how?</td>
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<td>Who said what to whom and in what way?</td>
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<th><strong>Atmosphere</strong></th>
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<td>How did the researcher(s) experience the atmosphere of the observation?</td>
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<td>Stressful/calm, friendly/unfriendly. Did alternations occur?</td>
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**Information about us**

We are two nursing students from the Red Cross University College in Sweden. We are writing a Bachelor Thesis about how ChildFund Bolivia works with the ECD program. We will observe and participate in your work in order to learn more about how you work. The information received will be treated anonymously and the result will be presented so that single people cannot be identified.

We are grateful for this opportunity and hope our presence will be without disturbance.

Anna Lindström

Louise Hellberg

**Información de nosotras**

Somos dos estudiantes de enfermería de la Universidad Sueca “Cruz Roja”. Estamos escribiendo nuestra trabajo fin de grado sobre como ChildFun Bolivia trabaja con el programa ECD. Vamos a observar y participar en su trabajo para poder aprender más sobre su metodología de trabajo y su contenido. La información recibida será tratada de manera anónima y los resultados serán presentados de manera que individuos particulares no puedan ser identificados.

Le estamos agradecidas por esta oportunidad y esperamos no disturbab con nuestra presencia.

Atentamente, le saludan:

Anna Lindström

Louise Hellberg