

The strategies of social inclusion in Venezuela: an approach to the experience of social missions

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Abstract: This paper is a current approach to the Venezuelan social policy against poverty and social exclusion, whose center are the called “social missions”, by exploring the experience of “Barrio Adentro” mission (the main one, as an instance), in a case of study carried out with qualitative methodology in communities of Zulia state, oil-region of vital strategic importance (economic and political) for the country, whose capital is Maracaibo city, the second highest population density. While the findings are not extended to the rest of the nation, both because it does not include communities of other states, and the nature of qualitative research that explores in depth the social phenomena; while their findings are not generalizable, they are considered indicative of some important trends, this is significant given the lack of diagnoses and assessments regarding social missions and in particular of “Barrio Adentro” (program for preventive health care), even under the focus of research reported.

Key words: poverty, social exclusion-inclusion, social policy, Barrio Adentro social missions.

Resumen: El trabajo hace un acercamiento desde la praxis a la actual política social venezolana de lucha contra la pobreza y la exclusión social (cuyo centro son las denominadas misiones sociales), a través de la exploración de la experiencia de la misión “Barrio Adentro” (BA), orientada a la atención primaria-preventiva de la salud. BA constituye la principal de las misiones, por lo cual se toma como unidad de análisis. Bajo un enfoque cualitativo de investigación se efectúa un estudio de casos en comunidades urbanas en situación de pobreza crítica del Zulia, estado-región petrolero, de vital importancia estratégica (económica y política) para el país, cuya capital (la ciudad de Maracaibo) es la segunda con mayor densidad poblacional. Aunque los hallazgos no son extensivos al resto de la nación, tanto porque no incluyen comunidades de otros estados, como por la naturaleza misma de la investigación cualitativa (que si bien indaga con profundidad los fenómenos sociales, sus resultados no son generalizables), éstos se consideran indicativos de algunas tendencias importantes, lo cual resulta significativo ante la escasez de diagnósticos y evaluaciones sobre dichas estrategias sociales y en particular de BA, más desde el enfoque señalado.

Palabras clave: pobreza, exclusión-inclusión social, misiones sociales-Barrio Adentro.

Introduction¹

The so called *missions* (misiones) are the base of the current social policies of the Venezuelan government, in the context of the political project called *Bolivarian revolution*, the schema of *participatory and protagonist democracy*, and the development model formulated as *endogenous-socialist*, proposed as an alternative to neoliberalism. As they do not appear early in the government (February 1999), but after four years (February 2003), the missions have as a declared purpose to *consolidate* the process of inclusion, equity, and social justice, by means of bringing poverty-exclusion down, and therefore the improvement of the quality of life of the popular sectors, traditionally excluded from some fundamental social rights.

This objective framework, even if normatively promoted from the beginning of Chávez administration and ratified in the new National Constitution (better known as Bolivarian Constitution, approved by the end of 1999), as well as in every governmental plan and program of these ten years of administration, becomes relevant in the light of the new strategies; but, nonetheless these very strategies are underscored in the political-presidential discourse as a flag of the government action and the latter destines large amounts of money to finance them, six years after their setting up have been neither sufficiently evaluated in an integral manner by the government nor by academic and research institutions.

The government not only offers (frequently in the very voice of the President, most of the time in his “Aló Presidente” television-radio program) *coverage figures* (number of enlisted in the nascent non-formal educational system; number of medical consultations and deaths prevented in the incipient “new” health system; tons of first-need food sold at low prices in popular markets, etcetera). On the academic side, some studies have been carried out, yet partially, in isolation and with prevalence of quantitative criteria; however, they usually present their results as valid for the country as a whole, in spite of lacking a broad sample study, capable of making the dynamic of the missions at national level evident (with representation for all the federal states, or at least for the most important cities).

They state definitively *how much* the impact would be on the national indexes of poverty, infantile mortality, health-nutrition, schooling rates, etc., results that are not accurate as in the global social statistics the *whole* Venezuelan population is included (not only the people technically considered *poor and excluded*,

¹ The reflections and results exposed in this work come from the research project: “Social missions, poverty and exclusion: the experience of Barrio Adentro in Zulia” funded by the Consejo de Desarrollo Científico y Humanístico (CONDES) of the University of Zulia, under the responsibility of professor Neritza Alvarado.

actual beneficiaries or not of the missions); in addition that on the behavior of said variables simultaneously influence other programs and governmental, so it turns out virtually impossible, from that general qualitative perspective, separate *which* and *how many* impacts can be counted for in favor of the missions in the objective population to which they are destined, not in the whole Venezuelan population. What is more, these work do not always account for the *voices* that directly emerge from the terrain, which express how the programs are being set up by the local administrators and how these programs are perceived by the involved, especially by their addressees, either understood as “beneficiaries” or “participants”.

This work responds to the concerns raised by the need to thoroughly recognize how the social missions are doing in the different Venezuelan regions, at that local-parish level where they develop; whether they are socially effective in the sense of fulfilling their including and change-generating objectives, focused from a *qualitative* perspective beyond the mere statistical data and that incorporates the viewpoint of these actors.

In this order of ideas, the work tries to make a contribution, avoiding the manipulation of information through the polarization of prejudices or the partial expression of opinions, guided by radical affections and disaffections of the government in power, which conspire against the ethic of the researcher and against the scientific character of any serious study. Because of this, in the attempt to wane from the start said bias, the two main municipalities of the considered geographic entity, one whose population is largely opposed to the government—in electoral terms—and another, whose inhabitants openly speak in its favor, in the same terms. The experience is reconstructed faithfully and respectfully regarding the testimonials of the key informers, as they were expressed.

The study is a summary of the results of a broader research (see footnote 1), in which an approximation to “Barrio Adentro Mission” (Misión Barrio Adentro, MBA) (MBA, a program oriented to primary-preventive community health assistance), in the cases of the municipalities of Maracaibo and San Francisco, the most important in Zulia State. Said State is an oil-producer region-State whose contribution to the national GDP is circa 70%, because of which it is economically and politically strategic for the country. Its capital city is the city of Maracaibo, the second most densely populated.

Even if it is an *exploratory-descriptive* micro-sociological study, only performed in six urban communities in critical poverty situation, in six different civil parishes (henceforth parish), whose findings are not extensive to the rest of the nation given the nature of the qualitative research, which in spite of deepening into the social phenomena its results are not generalizable, these are considered indicative of

some significant tendencies; which is valuable in facing the aforementioned scarcity of direct diagnoses and evaluations on such social strategies and in particular of “Barrio Adentro” (BA) under the qualitative approach of research.

The pertinence of this work can be found not only at domestic level (Venezuela) because of the mentioned reasons, but also at international level (other Latin American countries and other countries) to the extent that the actual strategy of the missions, by and large, and of the BA program in particular, can be taken as a reference within a perspective compared with other social programs. Hence, the special interest of the author in disseminating the results through a periodical publication with international scope. However, for the effect of best understanding this research, especially for the readers and non-Venezuelan referees, it is necessary clarifying the following:

1) It is not in the objectives of this work to develop a theoretical-conceptual framework that provides better elements of this nature to dimension and discuss, in the Latin American and global context “the sort of social policies” which a government, such as the one with the characteristics and political presence of that of Hugo Chávez, carries out. Since this has been performed by the author in previous researches, it is suggested to the interested in studying or deepening into this particular topic to read the references recommended at this footnote.²

2) In the same sense, even if the BA program is aimed to assist social problems, such as health in a considerable part of the Venezuelan population (popular strata), neither is it part of the objectives to produce an interpretation of the *healthcare policy* of this government, in the context of the process inherent to the *Bolivarian revolution* and much less in the framework of globalization and the neoliberal economic model.

3) Likewise, even if it is clear that healthcare, as a social phenomenon is multi-causal and multidimensional, with strong social, political, cultural and economic links and because of this an integral intervention is necessary, whose first attention level goes beyond the ambulatory medical assistance, in this work we review the dynamic of MBA only on the primary-preventive-ambulatory, for at the time of performing the study (year 2006) only the first stage had been developed (which corresponds to this level), out of the four in which it had been planned, as it is stated further in the text. This is to say, *such* was the scope of the program. In Ibero-America there is abundant and qualified literature, free to access for any user, on this other topic of the holistic attention to health and everything related to it, so such an approach should *not* be expected in this work, where there is no space for this and even the author is not an expert in this health topics.

² See Alvarado (2003, 2004, 2006, 2008), Mujica and Alvarado (2004).

4) In general, *it is not interesting* for the ends of this research *to theorize on health, on models of development, styles of government and social policies*, so *deliberately* we overlook a “theoretical framework” and “state of the art” on these issues as a context to the problem that is approached, because it struggles with the principles of qualitative research, which imposes not to start from preconceived theories and concepts, and even from hypotheses, as these appear in any case at the end of the research. Hence, the object of this study was proposed as an *approach from the praxis (not from the theory)*, and because of this very reason the work turns out to be descriptive indeed (it is not its purpose to have other scope).

5) In this same sense we do not make any affirmation of “only”, “overwhelming” *truths* whatsoever, with “refined”, “finished” explanations on the stated topic, because what we attempt is to *explore from the empirical reality* the *general* orientation of a social policy that calls to attention at international level, as it is innovative after the neoliberal inheritance of compensatory programs localized in Venezuela and Latin America, which by definition cancelled the possibility of community organization-participation in the management of problems linked to their situation of poverty-exclusion, with social co-responsibility. Because of this reason, in spite that the work is a micro-sociology exercise (with the study of few cases or communities), it may be useful for comparative ends (not necessarily of imitation or replica) in other latitudes.

6) Although the work was concluded by the end of 2006, many of its results are still valid in 2009, as it has been verified in later polls (coordinated by the author) carried out in the communities between 2007 and 2009.³ The findings of the first approach are externally disclosed due to the limitations inherent to Latin American periodical publications, which collapse them and cause an unavoidable delay in the process of knowledge generation and their dissemination.

With this horizon defined, the *objectives of study* were, definitively, *to explore, identify and describe* in six communities Cerros de Marín, Teotiste de Gallegos, Los Altos II, (Parishes Olegario Villalobos, Coquivacoa and Francisco Eugenio Bustamante, respectively of the municipality of Maracaibo);

³ In this year 2009, the author carries out the research titled “Socialismo del siglo XXI, pobreza y exclusión: Misiones Sociales y Consejos Comunales”; likewise inscribed in the graduation workshops (Cátedras-Talleres de Grado) in Escuela de Sociología de LUZ, advised by the author, the following works were completed between 2006 and 2007: “endogenous development, Social Missions and Social Capital in Zulia: the case of Barrio Adentro” (Desarrollo Endógeno, Misiones Sociales y Capital Social en el Zulia: el caso de Barrio Adentro) and “Attitudes of Barrio Adentro beneficiaries” (Las actitudes de los beneficiarios de la Misión Barrio Adentro).

Betulio González, El Manzanillo and Sector 11 of Urb. Popular San Francisco (Parishes Domitila Flores, Francisco Ochoa and San Francisco, respectively, of the municipality of San Francisco),⁴ during the period between 2003-2006, *the process of execution* of BA mission (its *modus operandi*, factors that block or favor its management, possibilities of continuity, achievements and unsolved problems) and *social impact* (qualitative changes in health conditions and quality of life, poverty and exclusion) in the reference population. The objective was to discern which their coverage (benefits and limitations) and their consolidation possibilities, sustainability and short and middle term tendencies will be.

From a qualitative-ethnographic perspective we used the case study method, with the development of fieldwork, in which we applied direct-participant observation (whose registrations were noted down in a diary or field notebook), and semi-structured, open and in-depth interviews with 33 key informants, which were recorded. This information underwent the respective procedures of systematization, processing and qualitative analysis, and it was later contrasted with the informants within a process of systematic devolution of knowledge to the communities, once the research was concluded.

Missions as the axis of the Venezuelan social policy

In the official discourse missions are conceptualized as “mass strategies aimed at guaranteeing the fundamental rights of population, with emphasis on the most excluded sectors” (<<http://www.pdvsa.com>>). In this sense, according to the definition of the very president of the Republic, in his military jargon, they become a strategic and tactical imperative: “a mission is a order that cannot but be fulfilled at any price. One of the fundamental elements of this concept is that integrality and such a thing is not obtained by a mere proclamation, one has to work on that” (Chávez, 2004a).

By and large, “they are mass scope programs, directed to educate, heal and train the Venezuelans, mainly those who dwell in poor or difficult to access zones” (Chávez, 2004b).

Missions are a modality different to the traditional of organizing the management of public policies, in the sense that “one of the fundamental elements for their planning, execution and monitoring is the active and protagonist

⁴ In which 17 interviews were held: six group interviews to 22 direct beneficiaries (each group with between three and five people), eight personal interviews with parish and local coordinators of BA healthcare committees in each community and three Cuban doctors; in total, 33 key informers.

participation of the organized communities”, in addition to “have extraordinary resources and their coordination is inter-institutional” (<<http://www.pdvsa.com>>).

Distinguishable in this organization figure is the emphasis on their direct communal management, inside a parish-becoming process that does not have sub-national governments as mediation, this is to say, neither the municipal level (municipal councils or governments), nor the regional (state governments), but it goes to the local in close connection to the central level (presidency of the Republic and institutions of ascription). They do not follow, thereby, a traditional decentralizing process; consequently, neither do they respond to the traditional, interlaced and bureaucratic institutionalism of the large ministries, but they come from emerging structures, which coexist simultaneously with the first. This is the nature and sense of the missions in the current Venezuelan context and also the reason why the political opposition deems them as “parallel and extra-institutional structures”.

The government counter-argues that the organizations of the community, endogenously managed, are also institutions and they are not extra but intra, since they are and function “inside the barrio”,⁵ which provides them with absolute pertinence. From the perspective of the government, the missions represent an alternative answer to the obstructive threats of preexisting administrative organizations to reorient public management toward socially inclusive ends and at the pace required by the Bolivarian process, taking into account the structural problems which as “critical knots” have always conspired against the efficacy-efficiency-effectiveness of official intervention (especially in the social sector, traditionally de-articulated) caused by bureaucracy, clientelism, corruption, sectoralism, resistance to new policies from a considerable part of the functionaries who have worked in public administration for decades, opposition of some unions still controlled by traditional parties, etcetera.

The first characteristic feature that stands out in an approximation to the missions is their connection to the sociopolitical occurrences of the country as from the beginning of President Chávez administration, marked by a high polarization and political unrest, as it is a project loaded with promises of radical changes, with a revolutionary discourse, frontally opposed to neoliberalism, directed at the poor or popular sectors, and their inclusion and participation in the national public life, as subjects of law.

⁵ It is worth mentioning that this last appreciation corresponds to what Durston (1999, 2000) refers to as community social capital, in which the formal institutions and society institutions or informal institutions are included.

This way, as from the political crisis in 2002 (after the coup on April 11th) the government announced “new” economic and social measures to face the crisis; as for social policies, the measures only became a (financial) strengthening of the social programs of assistance nature focused on the poorest groups. It is logical to suppose that in such a moment, after the coup, very delicate for governability, the adhesion of the popular sectors was sought by means of compensatory programs, with wide acceptance among the objective population, according to social surveys carried out during the second mandates of Presidents Carlos Andrés Pérez (1989-1993) and Rafael Caldera (1994-1998), administrations openly neoliberal.

After said contingency, the most distinguishable event was the oil-patronal commercial halt convoked and executed by opposition representatives between December 2002 and February 2003, to urge the dismissal of President Chávez, via resignation, since they did not manage to overthrow him in the coup. The aforementioned halt was staged by the CEO's of *Oils of Venezuela Anonymous Society* (Petróleos de Venezuela Sociedad Anónima, PDVSA) —openly opposed to Chávez, who grouped in an organization they called “people of the oil” (Gente del Petróleo)— which, being the main basic industry of the State, functioned with private-enterprise criteria and with too much autonomy in relation to the government, to the extent of saying that it had become “a State within a State”, trying to control the political power. Also protagonists of the halt were the entrepreneurial leaders of the chambers of commerce and industry, especially FEDECAMARAS (whose president, violating the democratic institutionalism and the national Constitution, self-appointed and took self-sworn as president of the Republic after the coup in April 2002, which only lasted 48 hours); as well as by the so called “heart” of the Confederation of Laborers of Venezuela (Confederación de Trabajadores de Venezuela, CTV), which grouped the old unionist bureaucracy, controlled by the traditional parties.

That long patronal halt was likewise faced and defeated by the government; once it was overcome, in February 2003 the government announced a “program of action for the conjuncture”, heavily fostered by food scarcity and the unrest that risked both the popularity of the president and his continuity in power due to the presidential recall referendum, foreseen in the national constitution and summoned for 2004 (effectively executed in August that year and from which Chávez emerged the winner).

In such a context the action of the government, from the viewpoint of economic policy, was centered on the recovery of GDP (which because of that oil-patronal commercial sabotage unprecedented in the history of the country,

which wreaked havoc to the economy), and from the social viewpoint, it was centered on the new mass programs called *social missions*, oriented to partially and progressively replace the focalized-paternalist social policy by one another declared *universal* and based upon social participation. Within this context the “Barrio Adentro” pilot program was set into motion, then it later became the schema to follow in the creation of new programs in different social areas, baptized with the name of *missions*.

This new orientation turned to be more coherent with the constitutional precepts and programmatic objectives of the project of *Bolivarian revolution*. Principles such as *social co-responsibility*, *universalism*, *equity*, *empowerment*, *social balance*, among other, which will be achieved by means of the addition of “more molecules of social policy than economic policy” to governmental action, were proposed from the first presidential campaign (1997-1998) by Chávez and his party, in their calling to “the poor”, whom the president directly addresses without mediating figures in this relation. Said principles became part of the new juridical-normative ordering of which the new Constitution is its highest expression, including of the first time social-civil participation as human and social fundamental rights. With the figure of the missions these precepts are exalted once again, yet their objectives seemed impossible to edify with the inherited administrative structures, more so because of the urgency in their setting up (Lander, 2007).

In 2006 Chávez won once again the presidential elections, being reelected for a third period (2007-2013). From a communal-socialist perspective, from that year on (and stronger as from 2007) the government fosters greater organization and powers to the local-communal management, with the creation of a new figure known as “Communal Councils”, which has been fostered from the approval of a law that creates and regulates them (by mid 2006), as a mechanisms of direct transfer of power to the communities (to decide on their own projects and administrate their budgets), within the principle known as *citizen empowerment*. Communal councils (whose national coordination is ascribed to the Republic presidency) would act closely connected and in concordance with the social missions, and together with the mechanisms that make the social-communal economy dynamic (cooperatives, associative enterprises, social production enterprises, among other) and have under their control the responsibility to solidify the bases of the socialist society and economy in the Venezuelan fashion.

With the conglomerate of missions existing in 2003, added to those that would come later, already from December that year President Chávez thought of constituting a megamission (which he would name “Christ” Mission), which would encompass all the missions under the motto “Zero poverty in 2021” (Mota, 2004).

This macro mission was only announced, it has not been concreted; nonetheless, the president frequently reiterates in his public allocutions that missions are the main tool for this goal of “Zero poverty in 2021” and they will not be sacrificed by anything in the world.⁶

Sheltered by high oil incomes, the government introduced in 2005 a change in the Law of the Central Bank of Venezuela (*Ley del Banco Central de Venezuela*), which authorized the partial use of the international reserves of the country to finance new social programs, from the creation of two funds: the Fund of National Development (*Fondo de Desarrollo Nacional*, FONDEN) and the Fund for Economic and Social Development (*Fondo para el Desarrollo Económico y Social*, FONDESPA). The partial reform of this law was the strategic resource the government found to manage that the exceeding incomes (when the international oil price was above the estimated in the national annual budget) were deposited one part in the FONDEN to finance developmental plans (basic industries, infrastructure, transport, housing) and another in FONDESPA of PDVSA.

The resources that finance the missions basically come from here; this is to say, they do not come from the ordinary budget of the ministries but directly from PDVSA, thus this strategic-State enterprise acquired an emergent role of social co-responsibility, which the government called the “social role of a new PDVSA”. This company started being directly controlled by the government in 2003, as the patronal halt was overcome, in which authorities popularized as the “oil counter-coup” to the opposition.

This appropriation of the public sector the executive makes explains why the missions do not depend on any ministry but on the central government (Presidency and PDVSA); even if at some stage of the execution process of the missions the ministries play a part (for instance, the Ministry of Popular Power for Health and Social Protection [*Ministerio del Poder Popular para la Salud y la Protección Social*] in the appointment of national and regional coordinators of the missions is the ace of Barrio Adentro, or the Ministry of Popular Power for Participation and Social Development [*Ministerio del Poder Popular para la Participación y el Desarrollo Social*, MINPADES] in the case of Communal Councils), but this participation is not a linkage in terms of the functional dependence of the programs. Because of these reasons sectors of political opposition to the governments called the

⁶ To observe a detailed chronology of the objectives and related organisms of the all the missions, see Alvarado (2004, 2006, 2008), D’Elía (2006), Lander (2007), Maingon (2006), Maingon (2008), Vera (2008), among other authors, and also the official website: Government online (<<http://www.gobiernoonlinea.ve>>). Each mission has its own website.

missions “parallel, extra or para-institutional structures”, whilst the government simply presents them as “endogenous-emergent” structures or organizations that are needed and whose pertinence is demonstrated for social inclusion and participation.

In any case distinguishable in this process is the hegemonic role of the State-government in the creation-promotion-setting of social policies and participation. To do so, new figures in the shape of new organizational spaces of communal action are generated (missions and Communal Councils, mainly), by means of which the popular sectors are provided with competence to directly organize and manage public policies (in this case social), starting from the design and execution of their own community projects as well as the administration of the budget for these projects. They are even assigned the task of monitoring or “social comptrollership” of them (in the law that creates and regulates the Communal Council), in agreement with the aforementioned principles of *co-responsibility* and *empowerment*, basic in the political project of *Bolivarian Revolution*, not only present in the national Constitution but in all the plans and government programs, from their inception to the present day.

In this sense, the new social institutionalism that moves the new social policy in Venezuela is supported upon the nascent community organizations and is represented in the social missions, Communal Councils and the organizations of social economy (on their own axes of the endogenous-socialist model). This is to say, more than to a horizontal, participant, regaining movement from bottom to top, they respond to vertical decisions (made from top to bottom) in the manner of “implantation of initiatives” (Hintze, 2008; Alvarado, 2008).

Even if the Bolivarian Constitution is a general juridical-normative framework of broader amplitude in social rights, and in the official documents that orient the action of government are present the principles of co-responsibility and co-management, in this sense the process of *empowerment* is not a protagonist yet. A challenge in this respect, in views of making said precepts a reality, is to advance toward the configuration of a State-government/society (popular sectors) horizontal relationship in terms of association-cooperation rather than subordination-subalternation between public institutions and organizations of the community. In this order of ideas, a learning process is necessary in these collective actors to forge their capability to interpellate the State as and also appropriate the policies that involve them and the power to auto-direct them.

This configuration of new knowledge and capabilities claims for another sort of time; as Hintze (2008: 50) states:

The equation (still unsolved) between political times-technical times tensioned by the constant transformation towards new intervention forms, new actors, new institutionalisms, echoes on the construction of connection between public organizations and ventures. This makes it necessary to include a third term into the equation: the role of the social times necessary to construct the collective actor capable of effectively appropriating the management and control of the policies as it is proposed by this rich regulation that propitiates popular participation.

In virtue of the political dynamic and the economic capacities of the State-government, the current social policy has managed to cover large population groups, traditionally excluded (in areas such as education, healthcare, access to underpriced food, among other), which were not directly benefited from the so called “universalist” policies valid in Venezuela until 1988, which changed direction in 1989 with the neoliberal formulas of selectivity-focalization.

Nonetheless, even if between 1999 and 2002 period during which the current government maintained the compensatory style of the neoliberal social policy, as from 2003 it would not be accurate to call it “focalized” (in spite of being directed at popular or poor sectors), as it has been constantly broadening in terms of coverage and social expenditure. Neither can it be said that, nowadays, that it is a brand new universal social policy (since it does not fully incorporate other population groups, such as the middle sectors). In this sense, the government speaks of “progressive universalism” (Barros, 2008; Alvarado, 2008) and brings along the criteria of *progressiveness*, which is one of the principles assigned to social policy as from the first official documents.

Barrio mission; normative aspects of the program

Barrio Adentro, “the mother of all missions” was initially conceived as a pilot plan of integral development of the communities, set into motion on April 16th 2003, by means of a cooperation agreement signed by the Municipal Council of Caracas with the Cuban government, in the frame of the Venezuela-Cuba Integral Agreement. It began as a trial on the stated date in the Libertador Municipality of the capital city, it was raised to the category of *mission* (mass coverage in all the municipalities in all the states of the country), by presidential decree by the end of 2003.

From the start the program has been developed with the participation of Cuban medical doctors⁷ (a doctor per 250 families) and the gradual aggregation of some other Venezuelan who have sponsored the mission and are willing to undertake a postgraduate course in community integral medicine, under the tutorship of a Cuban doctor, as for praxis in the consulting room. These professionals have settled in the most vulnerable and poorest communities, even the most intricate, hidden places of the country and disregarded in healthcare, thus the name *Barrio Adentro*.

MBA is founded upon the concept of integral health, which goes beyond the old reductionist vision that exclusively associates health to medical attention as part of the approach of curative medicine. Within this mission health is related to social economy, sport, environment, education, culture, food security, etc.; hence, the importance assigned to communal participation as a motor for organization and changes. The pressing need to have healthcare services mainly oriented to promote and prevention with a family approach is put forward in order to avoid the loss of human capital, as well as the unaffordable expense of medical treatment services for popular sectors (<<http://www.misionbarrioadentro.gob.ve>>).

The vision of BA is centered on the model of public management that seeks to guarantee sustainable human development, with the satisfaction of social needs of the population, founded upon the principles of primary attention within a new national public healthcare system. Even so, it has as a declared objective:

To guarantee the access to healthcare services for the excluded population by means of an integral model of health management oriented to achieve better quality of life. [...] It also looks for the implementation of a model of participatory management, which responds to the social needs of the excluded population groups [...] and strengthen the ambulatory network increasing its response capacity through the setting, consolidation and extension of popular consulting rooms, emphasizing the promotion of quality of life and health (Álvarez and Barcos, 2005: 33).

At the same time, MBA allowed empowering capacities and abilities of human resources, articulating the social policies that answer the social needs of the population. According to the government, this mission was characterized by approaching social factors and local endogenous development; it goes beyond a mere extension of assistance services, as it would propitiate the commitment of the subjects individually and collectively, in conjunction with all the social and economic beings connected inside a new State-society relation (Álvarez and Barcos, 2005: 21).

⁷ At first the government summoned the Venezuelan doctors to partake this program who openly opposed backed by their unions. From this denial, the collaboration of the Cuban government was asked, which immediately sent its community doctors.

Initially in its mission modality this program was planned to be executed in three stages; *Barrio Adentro I* would be directed to integral attention, healthcare promotion and preventive medicine and to establish a primary network, which implied keeping people healthy and to detect any disease as soon as possible. This first stage addresses the most needed population sectors; it provides them with popular consulting rooms and proposes to offer free medical attention 24 hours a day, and what is more free medication (<<http://www.barrioadentro.gob.ve>>).

Barrio Adentro II (BAII) contemplates the restoring and rehabilitation system of the healthcare sector by means of recovering the ambulatory centers. Its commitment is to go beyond the first stage of the mission in order to ensure that all the country population had access to a high quality free healthcare system. From the integral healthcare centers involved in this stage were born; these are Integral Diagnosis Centers (CDI) or establishments where second level attention is provided, i.e., places where both emergency medical attention and fundamental diagnosis studies are offered 24 hours a day, 7 days a week. CDI's offer familial or general medical services, and have a more advanced control in the nourishment of children, youths and elderly in the communities where they are located and their whereabouts. The services supplied by BAII in CDI's consist of: admission room, echograms, x rays, clinical laboratory, endoscopy, electrocardiography, ophthalmology, intensive care units, life support and medical transport. CDI's also include integral rehabilitation rooms (SRI), with emphasis on physiotherapy (<<http://www.barrioadentro.gob.ve>>).

Barrio Adentro III (BAIII) is based on an integral vision of hospital attention, which includes the formulation of the models of assistance and management, as well the modernization of infrastructure and technological equipment of the existing public hospitals. On its own BAIII comprises three stages: the first one to be developed in the years 2005-2006, in which 79 hospital centers would be recovered and modernized to provide better services. It was expected to recover 42 hospitals during the first six months, remaining 37 hospitals in a second phase. For the second stage (2007-2008) the remainder 220 hospitals would enter into execution (<<http://www.barrioadentro.gob.ve>>). Later on (2007), the last stage was announced (*Barrio Adentro IV*); in this stage, it was intended to build new hospitals (still waiting for investments).

In general, as it has been formulated, BA mission is oriented to transcend attention to people, families and communities with health problems in the poorest sectors of the country. It calls to the organized participation of communities, in a shared management process, based on co-responsibility and voluntary work, which seeks to break with the hindered bureaucratic system of traditional healthcare

administration and to establish a new National Public Healthcare System, with emphasis on integral healthcare and quality of life, on preventive, communal integral medicine, and direct, free and immediate attention in the communities, with an endogenous character. According to its design BA is called to become:

the great model of attention and management in healthcare, which has participatory and protagonist democracy as a foundation; it is conceived as the articulating axis of all the social policies and in such a sense it is proposed as an objective to build organic social networks that allow the communal positioning of the State institutions to increase the quality of life of the inhabitants of poor barrios” (Álvarez and Barcos, 2005: 26; <<http://www.barrioadentro.gob.ve>>)

Radiography of Barrio Adentro from the praxis

We now summarize the main findings of the fieldwork carried out in the aforementioned communities, according to the explored information areas, in agreement with the objectives of the project.⁸

*Execution process*⁹

In this part we inquired on the *modus operandi* of the mission, from the arrival of the first Cuban doctors, dentists, and sport trainers, to the beginning of the construction of the first consulting rooms and Integral Diagnosis Centers (CDI's), trying to discern how the mission is structured and organized for its functioning, the mechanisms established, the infrastructure and logistic conditions, financial resources and qualitative factors that may be facilitating or hindering their current functioning, fostering or restricting the scope of the program. In this sense, according to declarations from the coordinators, doctors and direct beneficiaries, from the start to the present day, the situation is as follows:

⁸ These findings are accounted for with textual testimonials from key informers in the *in extenso* work from the research presented to the funding entity. Due to space reasons they were not included here; however, the interviews, in full text, are available at the Department of Social Studies of the Institute of Economic and Social Researches of LUZ. The interviews can also be asked via e-mail to the author.

⁹ Further information on this topic can be found in the report of results of the project, available at CONDES and from Institute of Economic and Social Researches of LUZ.

The setting into motion of the program

The initial installation of the first Cuban doctors, as well as the dentists and sport trainers, was at first made without close lineaments as for demands to execute the program, improvising, whenever and wherever it was possible: in private households, in sheds, churches, communal buildings, etc., administrated by local organizations and leaders and approved by the very communities. Largely, the first consulting rooms were placed in private households, which also hosted the doctors. These doctors were lodged with severe space limitations and in general precarious conditions, as this took place in very poor, insalubrious barrios and even dangerous (high delinquency and insecurity).

Not only did the first Cuban doctors bear physical discomforts, but also rejections, even violence and physical and verbal aggression in the communities, from people against the Venezuelan government and the Cuban political system. With patience, will and conviction for the mission which they have been appointed to they faced the smear campaign against them, they put up with this initial aversion and mistrust, and showed that their work as doctors was to assist the healthcare needs of the population assigned to them, without distinctions. So little by little, they became accepted and respected.

In the setting-up stage, the doctors organized (it is still so) their 8-hour shifts in two parts: in the morning, from 8 to 12, attention in the consulting rooms (external consultation), and in the afternoons, what they called “activities in the field”, this is to say, a walk in the community and house consultations to assist critical or disabled patients. In both moments they carry out, with the help of the defenders of health, their toil of orientation and education in preventive healthcare.

Execution according to stages

The first stage of the mission (organization of consulting rooms and healthcare committees) started with noticeable differences in infrastructure, budget and logistics. Officially, it was declared that the consulting rooms in private households would be of temporary nature and as soon as possible the respective facilities would be build; however, by mid 2006 most of the consulting rooms in the considered municipalities remained in the same spaces (nowadays there are some in this situation).

It was observed that even without having finished the consulting rooms of Barrio Adentro I, at the same time in some of the communities CDI's and parish CRI's, which are part of the second stage of the mission, were under construction. This is to say, there was an overlapping of stages, which means there was no planning for the second stage, the logical course of action would be to conclude the

first stage and supply the consulting rooms with all the necessary for local primary attention, before starting the second stage, taking into account the precarious infrastructural conditions in which the first stage developed. BA III had greater stagnation, as in none of these parishes the construction of the Centers of High Technology (Centros de Alta Tecnología, CAT) had begun; as a matter of fact, across Zulia State a single CAT had been built (in the city of Maracaibo), whose operations started in 2006 (it is still so).

Structure and institutionalism

In the fieldwork we verified that indeed BA is structured in a non-traditional manner, in the sense that their community coordinators (parish and local) are not appointed by “the finger” from the top or from the established official institutionalism (Ministry of Popular Power for Healthcare and Social Protection), but some of them appear as an instance of the social work that was agglutinated in the municipalities, parishes and communities around this novel initiative. In almost all the cases of the key informant coordinators in this study, the parish coordination of the healthcare committee is also the coordinator of the local healthcare committee in the community; initially from said voluntary work, they were later also ratified in the assembly of parish coordinators, summoned by the regional coordinator of healthcare committees of the different parishes of the municipalities and then in the community assemblies in each neighborhood.

The presence of the formal-official institutionalism (Ministry of Health) only appears from top to bottom in the initiative of the mission (program design and decision to implement it in all the states) and the appointment of the regional or state coordinators, who represent the national government; as for the rest of the organizational structure, it has a community and autonomous tinge. In this structure and emergent institutionalism noticeable is the absence of representation at municipal level, as there is not a figure such as municipal coordinator, but a regional, parish and local coordinator, which responds to the initiative of the government to delegate to the parishes primary healthcare attention.

Likewise, the internal structure of the local healthcare committees is also atypical: it works based on several committees on diverse matters, each one with a heading coordinator, besides the very coordinator of the healthcare committee, in the framework of the integral healthcare concept (emphasizing prevention and quality of life). These committees are not fixed or standardized for all the communities, but are organized according to the punctual social needs and problems in each neighborhood and/or sector detected in communal censuses and underscored by the very community in street assemblies.

Hence, it is common that as part of the healthcare committee in a community where there are problems to regularize the tenancy or proprietorship of land, for instance, a Committee of Urban Land is grouped or else a Technical Board of Water or of Energy, which may not exist in other community with no problems of this nature.

The Cuban doctors have their own organization modalities, their own (Cuban) medical coordinators at regional and parish level; it is a separate structure. In each consulting room the doctor, with their adjoined medical staff (dentist, trainer, also Cuban), worked with the support of the local healthcare committee coordinator, the defenders of health and social promoters (in the case where the latter exists), as for medical attention and promotion of disease prevention. Nonetheless, the doctors do not become involved in other troublesome areas of the communities and only account for their very activities to the Cuban medical coordination, as it is further specified. In practice, these two operative structures (that of the community and that of the Cuban medical mission) are independent, as two alien worlds, which only converge in the community where the doctor interacts with the local coordinator of the healthcare committee and with the defenders of health, in the aforementioned activities.

Articulation forms

From its inception, BA articulates other initiatives of the community, according to the needs that arise in its everydayness. BA even works as a link to other social missions: the healthcare committee in each community applies for the Robinson Mission I (Misión Robinson I) (where the number of illiterates is or was accounted for), and then applies for Robinson II (so that these people complete primary education), and or Ribas Mission (secondary education), and Sucre Mission (university studies). According to the case, it also procures the solution of problems by means of the organization of cooperatives that are ascribed to Vuelvas Caras Mission, etc, being differential the presence or absence of these missions in the communities according to the needs that each has and also according to the organization capability and management of each neighborhood and/or sector. Due to these reasons, it is said that BA is “the mother of all missions”, because it even makes room for the shaping of the new figure represented by the Communal Councils, which are being organized since 2006, out of the BA healthcare committees.

In relation to the mechanisms of internal articulation of BA (between the healthcare committee and the rest of committees that structure the mission), both the coordinators of the healthcare committees and the interviewed doctors declared

having been in touch with one another, and work in teams in the consulting room and in the field activities. It was observed however, that the heaviest workload falls upon the coordinators of healthcare committees, who frequently also act as social promoters and general managers, for they have to solve the problems that may appear, not only those directly linked to the consulting room requirements, but also with any problem, diverse in nature, that affects the community.

In regards to the *external articulation* (of the mission with instances that are not part of the local BA structure) we found the following: in the case the local coordinators of healthcare committees are at the same time parish coordinators there is no disarticulation conflict between the local and parish, for even in the aforementioned neighborhoods the parish coordinator lives there, they are part of the community and keep in touch with the local coordinator. Between the following instance (the regional, bearing in mind that in BA the municipal is not considered) there is also contact and coordination with the parish sphere, in the sense that the regional coordinator of the healthcare committees (whose office is in CIED de PDVSA¹⁰) meets once a week there with the parish coordinators of all the municipalities, where they discuss the marching of the mission, the existing problems and possible solutions. The parish coordinators receive lineaments from the regional coordinator, information that then they sand down to the local in the different communities of the parish.

About *other social missions* in the communities, even if BA works as a linkage for these to operate, once they have been installed, they have their own coordinator and work independently from BA. Neither are work meetings held nor is joint and coordinated work performed between the other BA coordinators with the executors of these missions. The coordinator of the healthcare committee tries to be always informed, as they are about all the community issues, however it is a nonbonding matter, hence there is scant articulation of BA with the rest of missions, and of these with each other.

By and large in the studied communities, even if BA and other missions work as alternatives for social inclusion in problem-areas in said communities; they have not generated (in the 2003-2006 period) resonance between neighbors toward mobilization for more dynamic and self-managerial collective action, in views of solving the social problems linked to poverty and social exclusion. This is to say, inside these neighbors there are no figures or innovative organizations that work as support for the missions, beyond the inherent to the structure preconceived for them; this is the same in every municipality and parish in the country, i.e., beyond the planned committees and directions.

¹⁰ International Center of Education and Development of Petróleos de Venezuela S.A.

In *external articulation*, as for the relation of BA with the community organizations that existed before the missions (basically neighbors associations) the following situations were found: 1) *collaboration*: when these associations are supporters of the government and some, which being non-supportive, give preference to collective wellbeing and add to the work of BA and other missions in what they consider is beneficial for the community; 2) *open confrontation and interference*: in the cases of associations of radical opposition to the government and everything related; 3) *indifference*: in the case of associations also ideologically opposed to the government but which have realized they have lost power in the community, and in this case they neither cooperate nor obstruct, they have simply retreated and isolated, with a growing tendency to disappear.

Finally, in this aspect of *external articulation*, as for *extra-communal public institutions* that represent sub-national governments (municipal councils, state government), in the case of the communities under study which belong to the Maracaibo Municipality there has been support from the city hall (with official orientation at the time of the fieldwork); however, this support, solid at the beginning, has experienced a weakening to the extent that BA has consolidated, as it was expressed the interviewed coordinators. In the case of the communities in San Francisco Municipality, whose municipal council was openly opposed to the national government (at the time of the study), the initial interference has maintained along the three years and in some cases reinforced, since the council has stopped supporting the BA healthcare committee on activities that are responsibility of the municipal committee, for instance in vaccination campaigns or in fumigation against dengue. The same position is kept in the national government, as they disregard activities in the communities that correspond to it if they are moved by BA.

Decision making

Even if the program design establishes the implementation of BA under the figure of heads interconnected in a healthcare committee, with horizontal structure and working in democratic networks, linked at the same time in the same manner with their parish and regional peers, where the community would have the first and last word in decisions, in practice the appointment of coordinators does not go at first a communal or citizen assembly, but as a last instance. Maybe because of the improvised and urgent manner in which the mission started, where many things went against time, the general coordinators of BA in the federal entities (not only in Zulia, but in the entire country) and the regional coordinators of the healthcare committees, as other coordinators, were appointed by the Ministry of Health and

later ratified by PDVSA, when this company started to fund and administrate the mission. As a matter of fact, these coordinators in Zulia have their offices in CIED of PDVSA, located in the city of Maracaibo;¹¹ ever since, said modality of appointments may have become instituted by means of habit.

Then the parish coordinator has the power to appoint the local coordinator of the committee out of the community leaders that voluntarily offer to take the post (in some cases the very parish coordinator becomes the local coordinator in their barrio) and finally, the community is called to an assembly for the definitive approval; this is to say, what should be the first step is the last, because of this decision making in practice is neither really horizontal nor totally democratic and communal.

Monitoring and social auditing

Once the program enters in the Venezuela-Cuba Agreement, BA functions under an operational and organizational duality: the Cuban and the Venezuelan, with scarce articulation between them, as it was already exposed. Due to the same reasons, both instances have their own mechanisms of monitoring and accountability, which is basically statistical in the Cuban side. Thus, the monitoring begins with the activity of the doctor in the consulting room and in the field activities. Daily, the doctor keeps a record of the number of consultations, the sort of ailment or disease assisted, the age and sex of the patient, the number of emergencies assisted, the number of deaths prevented in these emergencies, etc., and systematizes them in a weekly report that should be sent to the Cuban parish doctor, and this at the same time to their regional peer, and then from here the report goes to the Cuban national medical coordinator and then to the national government; and they become the national stats presented by President Chávez in his public allocutions and that the Ministries of Health, Communication and information and other governmental instances register in their respective websites.

¹¹ It is worth mentioning that out of all these regional coordinators the only one who conceded and interview, after three months insisting via institutional requests, was the community regional coordinator.

From direct observation in everyday experience in the communities during the execution of this research, it was verified that Cuban doctors are quite reserved with these stats,¹² they do not show them to the Venezuelan parish and local coordinators, much less to the people alien to the community. So, not even the coordinators of the healthcare committee know the statistical results of the daily, weekly, monthly activity of the doctor and which the scope of BA is.

There is another monitoring carried out by the doctors and it refers to the control of the recovery of the patients whom they describe a permanent or lengthy treatment, such as diabetics or hypertensives, especially the elderly. The doctors monitor their arterial pressure everyday and coordinate with the trainer the sort of physical exercise that can be practiced by those who belong to the circles of grandparents circles and take this routine. The doctors also verify these people do not miss consultation when they have to, and if any of them misses consultation they go to their house while they are out in the field or send for them with the healthcare defender; the doctors are attentive as well to their keeping of treatments and diets. A similar procedure is carried out with the disabled who cannot walk or attend the consulting room because there is no one to take them; the defender delivers their medications to their households and the doctors controls them there. The same occurs to critical and terminal patients (for example, people with cancer).

As for *accountability* on the Venezuelan side, the procedures are not formally established or are neither very specific nor rigorous. The regional coordinator of healthcare committees follows the lineaments of the national coordinator and reports on the number of modules built and/or finished in each parish and municipality and other activities of the healthcare committees.¹³ The local coordinators of the committees, who largely are also—in the case of the communities under study—the parish coordinators, directly communicate with the regional coordinator using the telephone, when they need to interchange an

¹² By and large, the Cuban doctors seemed to be suspicious and reticent to offer information or interviews, as a matter of fact they have instructions to conceal it. They argue that they have lived very unpleasant situations with the ill-intended people and media, politically opposed to the Cuban and Venezuelan governments, which infiltrated with lies in the communities, distorting and manipulating declarations and information, even the stats, they offered at the beginning of the mission. As a matter of fact, in this research only three out of six doctors of the communities under study could be interviewed (thanks to the intervention of the local coordinators), however the interviews could not be recorded and not even take notes.

¹³ For this part no further information could be obtained because the regional coordinator of healthcare committees did not concede an interview.

opinion or receive an approval for a decision in the community; in some cases, they go to the neighborhood, but the most frequent is that the local coordinators address the office in PDVSA, without the intervention of formal mechanisms. The same procedure takes place in the case of the communities in which the local coordinator is not the parish coordinator.

As for *social auditing*, as expressed by the coordinators, it is them the ones who carry the audits out (basically the coordinator of the healthcare committee and the defender). Even if in this committee there is a post as “social comptroller”, this post is scantily dynamic, it does not include permanent activities of this kind, unless a serious irregularity arises and the comptroller is called to intervene, check the problem and inform the population. Neither do the neighbors, the community as such, take care of the social auditing; they do not have said habit at a large scale. Some limitations

Even if at the time of the study, BA had never paralyzed its activities in its three first years of functioning, some still unresolved problems indeed hinder it and remain as challenges for the mission, as on their solution will depend the sustainability of the mission in the short and middle terms. According to the testimonials by the key informers, among these limitations one finds:

a) The issue of budget

Although the national Executive supplies large amounts of resources to the mission and most of the work in the communities is non-remunerated voluntary (participation of the coordinators, defenders, promoters) and given the very massive nature of it and the onerous of its requirements (medical supplies, equipment, facilities), the problem of insufficient budget has been permanent and said budget is basically destined for building and supplying the modules for the popular consulting rooms (stage I of BA), the Integral Diagnosis Centers (CDI), of the SRI or the Rooms of Integral Rehabilitation (stage II of BA), as well as the conditioning of the Center of High Technology (CAT).

In such manner that in 2006 some expenses of the mission were still afforded by the communities (appliances, stationery supplies, costs inherent to problems linked to the consulting rooms); what is indeed permanently guaranteed by the national government is the supply of medications and medical supplies, as well as the payment for the Cuban doctors (a laughable amount of 400000 VEF or 200 USD, i.e., less than a minimal wage in 2006). Despite most of the doctors in these communities works in very precarious consulting rooms and with scarce budget, they do not point out these aspects as obstacles for the development of their functions. The attention focus in this sense is placed on other factors (of socio-cultural nature), which in their opinion are indeed blocks, as it is explained below.

b) Bureaucratic appointments

As it was said before, one of the problems that according to the BA parish and local coordinators affect the most its execution dynamic is that the (Venezuelan) regional coordinator of the healthcare committees is appointed from Caracas (Ministry of Health), without any inquire in the states, municipalities and parishes, because said appointment not only responds to political criteria and antidemocratic practices that go against the precepts of the project of *Bolivarian revolution* and the national Constitution, but also every time there is a change of coordinator the activities of BA slow down in regards to decision making, because it is not an expedite procedure; the appointment may take several weeks and even months to become effective, and in the parishes and communities there is no autonomy to decide in the meantime. The coordinators consider that said functionary should be elected democratically, through consensus, by all the parish coordinators in all the municipalities of the region, paying attention to their profile and the capacity demonstrated in the performance of activities inherent to the mission, and that the appointed person would not necessarily have to be a doctor.

c) Opposing instances

Finally, the coordinators point out that between the obstacles the lack of collaboration with BA that frequently borders on sabotage, from the Government of the State and the municipal council San Francisco municipality, and that some groups of opposing people in the communities due to strictly political differences. This causes that the local coordinators have a heavier workload than that implied in BA (and missions in general), as they have to referee alternative mechanisms, which are outside these governmental spheres, in order to solve problems that are their direct responsibility. They consider that if there were a sense of responsibility (or co-responsibility), of collaboration and awareness of a common good, above the political-ideological interests, and they helped or facilitated the work of BA (at least not sabotaging it), the mission would be strengthened.

Expectations, sustainability and mission perspectives

At the level of expectations, the hopes for improvements in health conditions and quality of life are focused, both on the coordinators and beneficiaries (especially these last) on CDI's, as they would enable a better attention than the primary offered in the popular consulting rooms, for 24 hours, even in major emergencies, and diverse diagnoses. Likewise, the coordinators showed optimism in the immediate future in relation to the Communal Councils (an emerging figure which as from 2006 started to be structured in the communities) fostered by the healthcare committees, in which it is expected to concrete old aspirations through projects

elaborated and managed by themselves, with access to the budget and direct administration of the funds given to them, which consider the best manner to solve problems that affect their quality of life and prevent filtrations in the sub-national governmental spheres, such as the government of the state and municipal councils.

As for *sustainability* and *perspectives* of the mission in the future, we asked the key informers on whether the current limitations may limit its continuity in time, paying particular attention to whether it would be capable of maintaining once the Cuban doctors went back to their country, taking into account that they have a family and a life there and cannot be on mission in Venezuela for an indefinite time. In this respect the coordinators declared that BA is already an institution planted in the community; the community would not let it go, and that the necessary would be made to prevent this and also to strengthen it every day. And they did not express any concern but confidence in that once the Venezuelan replacements were ready (students and doctors in formation, undergraduates and post-graduates in communal integral medicine) the mission would continue with the same spirit, values and principles set by the Cuban staff, because they are preparing with that willingness for social and humanitarian service and faith in the communal.

The beneficiaries also believe in this and state that the consulting rooms where there is a postgraduate resident Venezuelan doctor under the tutorship of a Cuban, working together, they as patients did not establish differences, they feel they are equally well diagnosed by either doctor and express the same degree of confidence, appreciation and valuing for both doctors.

Social impact of Barrio Adentro (qualitative changes)

In this part we focus on results and effects (qualitative changes) that the interviewees directly related to the mission. According to the objectives and methodology of the study, it is not attempted here to present numerical results as for the amount of consultations given, emergencies assisted, deaths prevented, activities in the field performed, etc., particularized per community and parish, because we had no access to those stats, since the Cuban doctors are not authorized to disclose them. At the level of impact we find the following:

Sense of inclusion; perception of healthcare as a human and social right:

BA is perceived by the beneficiaries and coordinators as a dream come true. They declare that when the first doctors arrived, they could not believe they were to stay among them. They consider it an achievement and an advantage to have gratuitous healthcare service in the same community, near their households, with access to medications free of charge and the possibility of being diagnosed in their very houses outside the consulting schedule, even at nights and early mornings.

They express that having a family doctor (and a permanent in the critical cases) in the neighborhood gives a lot of security and tranquility, as it eliminates the anguish produced by the impotence of not being able to properly take care of their health because of lack of economic resources, because they even lacked money to afford transport, not to mention medications and keep with the treatments for the time prescribed. It was even worse in the case of special diagnosis exams or surgical interventions, where the high costs prevented them from accessing even public hospitals, massive, collapsed and which lacked almost everything and this caused the patient to be charged for the medical supplies; indeed, this situation was graver in private medical clinics.

In this sense the advantages of BA attention in relation to the attention offered in public hospitals is distinguishable, because in addition to the free service, BA offers direct, immediate and personalized attention, where the careful attention of the doctor, their warm and peer-to-peer treatment are part of the mission kindness. This positive valuing of the Cuban medical and paramedical staff is common in the perception of *all* the interviewees, either from Maracaibo Municipality (supporter of the federal government) or from San Francisco Municipality (opposed to it).

Likewise, from the testimonials of the beneficiaries and coordinator distinguishable is the positive valuing of President Chávez, as well as a high acceptance of the social policy, especially of the missions. They state that Chávez has been the only president who has thought of the poor and for the first time it is considered they also have rights, that health for instance is a social and human right for everyone, in which they refer to the National Constitution. Because of this they declare feeling socially included for the first time in their lives. It is noticeable that this not only occurs among beneficiaries that stated being “chavistas”, but also among those who do not share the political project of the government did defend and even justified the presidential figure blaming the failures on the “people around the president”, ministers and other functionaries, who according to them are “incapable, disloyal and corrupt”.

Voluntary community organization-participation in management (incidence of socio-cultural aspects)

In this respect some factors stand out because of their negative influence on a social impact at a large scale of BA in healthcare and quality of life. These factors go from scarce participation of the community and weak management to alimentary and life habits that are against the prophylaxis favorable to education in preventive healthcare; and also the dynamic of the households, where women have a very restrained role, being frequently the objects of verbal, physical and psychological mistreatment from the husband; alcoholism and drug addiction of some members

of the family that affect the emotional and mental health of them members of the family and echoes in their physical health.

The perception of insufficient participation of the community is also underscored by the parish and local coordinators of the healthcare committees as the main obstacle that BA faces (and the rest of social missions); and even though the intensity varies from one community to another (according to the tradition of organization they have and the organizational density they have at present), it is also their main concern, as in some communities the initial achievements were lost because people did not defend them.

Even if some of the consulted coordinators inform that as from the implementation of social missions, especially BA, the communities seem to be gradually awakening from a lethargy that lasted many years, and there are new leaders and people that now question, they are attentive to the solutions given to the communal problems and before they did not do it. There were more agreements than differences between the interviewees (coordinators, beneficiaries and doctors) in respect to the act that the organization of the popular sectors with the new project for the country and social policy has not had any substantial change (at least at the time of interviews), it is still restricted, it is largely limited to access goods and services offered by the missions (basically attend consultation and receive medications in the case of BA).

Although the objective population of the programs has information on what the missions are (in this case they know the services and benefits of BA well, in at least two of its three stages), as well as the prerogatives that the Bolivarian Constitution grants them as citizens in relation to social rights, such as health; in practice they work rather with the traditional logic of user or passive recipient-beneficiary than as subjects of law, which agrees with the rentier-paternalist culture or custom of receiving perks from the State, under the shelter of “the law of the least effort”, not with self-managerial and co-responsible, participatory and protagonist activities and the mottos of “civil empowerment”, which also decrees the Constitution and the plans and policies of the government.

Closely linked to this result, even if there are emerging leaders with no previous participation or formal experience as a sustained responsibility in community work (who have sensitized and discovered those potentials of leadership from the missions, and have devoted to BA in a sort of voluntary apostleship), the interviewees consider that voluntary work is still scant and insufficient in the communities. Because of this the execution and operative monitoring of the mission falls on few people: on the coordinator and the defenders of healthcare (besides he doctors), more markedly on the former.

Now nonetheless, with the figure of civil assemblies, the community is addressed and more frequently informed, the participation of neighbors in these street assemblies is only ample in the case of transcendent and extreme decisions, of “life and death”, which compromising the interests of the community also directly compromise the individual interest and are frequently called by the coordinators because it is a formal requirement they need to state in an act they have called an assembly, register a determinate number of signatures to account for, or give fundament to the petitions before extra-community institutions during the process of solution management for specific problems.

Collective consciousness

Directly related to this, according to the testimonials by coordinators and doctors, despite the values of solidarity, reciprocity, co-responsibility, cooperativeness, etcetera, underscored in the national Constitution and the social policy of against poverty and social exclusion, a collective consciousness that privileges the common interest and breaks individualism and egotism has not occurred at large scale in popular sectors (at least in the communities under study), and that would be the explanatory base of the aforementioned limited organization, voluntary work and community participation. Even if these anti-values would not be exclusive to popular sectors, being the *par excellence* addressees of the political discourse and governmental action (especially social policy), another result would be expected.

Community integration

Both beneficiaries and coordinators stated that BA has enabled the members of the community to know each other and partially integrate, at least more than before, when all neighbors were alien, with no communication between them. Visiting with the Cuban doctors every corner in the neighbors and carry out the community census per household, allowed the coordinators and healthcare defenders not only learn how many people there are and the magnitude of the community needs, but also who they are. Now these leaders know the people (and the people know them), almost by their names because they interact in the activities of preventive healthcare inside and outside the consulting room, in the personal delivery of medications to some patients, at the street assemblies, etc.

The patients that integrate groups such as the circles of grandparents or hypertensive or diabetics and also dance therapy state that they also find BA useful as a bridge to know each other and socially interact during the group sessions; however, beyond these meetings which they attend of their own accord, the bond do not extend to the community as a whole, in terms of confidence,

collaboration, solidarity, belonging and common wellbeing. In all of this converge poor organization and participation of the community in the management of solutions for their problems.

Health, life conditions, poverty (partial changes)

The coordinators of the healthcare committees express that BA has generated positive changes in the community health; the best instance of this is that when the mission began the popular consulting rooms were crowded, then affluence of patient decreased because they became sick less frequently as they had medical control and looked after themselves better. Previously there was, according to these opinions, a lot of neglect in people because as they did not have a prompt and totally free access to healthcare services, and given the “trauma” implied in mass public hospitals and ambulances that lacked medical supplies, the ailments increased and the diseases became chronic. They also state that the Cuban doctors have discovered cases of people who had been diabetics and hypertensives without realizing it, they lived normally, with neither nutritional control nor treatment.

The direct executors speak on how BA emerged with the recovery and/or stabilization of the health of many elderly people (diabetics and hypertensives in many cases), and the changes that their condition as family members experienced. Before BA grandparents were relegated in their homes, sick, without mobility, with no affection, representing a burden for the households, and even a nuisance for the members. From Robison mission (which occupied the time of many of these illiterate people, as they were taught to read and write), and BA, with the configuration of circles of grandparents (which mobilized them, in medical-alimentary control and interactions with their peers in the community), there has been improvement in the quality of life of these grandparents. Some who were on a wheelchair or with many physical and circulatory pains that prevented them from walking, nowadays they have regained mobility, are independent from that point of view, and they are seen (according to the coordinators) with another face and willing to live.

On their own, the doctors verified that in comparison the situation in 2003, when the mission began, even if there is a lot of work ahead in preventive healthcare, there is lower incidence of pathologies that at first presented a high number and frequency, for instance, cases of intestinal parasitosis and the consequent intestinal infections, diarrheas and dehydration in children; and cases of vaginal mycoses in women who had never had this issue assisted. According to the doctors, now mothers know what to do in situations of children with diarrhea, and before the symptoms become critical, they take their children to with doctors and administrate oral rehydration therapy.

Consequently, despite the doctors state that infantile mortality from this sort of pathologies has decreased in the communities in their charge, it is not a totally controlled or solved issue. Likewise, the doctors report that the population has been receptive to receive attention for minor ailments (such as cough, head and abdominal aches) with natural remedies that the doctors have taught the people to use and that they can prepare at their households, becoming less demanding and dependent on syrups and pharmaceutical remedies, thus keeping these ailments from complicating and being in the need of other type of intervention.

The doctors testify that general mortality has also decreased because there is permanent and free attention, as well as attention to minor emergencies in the consulting rooms and at the households; in the case of mayor emergencies, the patient is sent to the BA doctors who work in hospitals, where they are immediately assisted, in such manner that the number of prevented deaths would be significant. They expected that with the setting into motion of CDI's and CAT's mortality would be lower by the day.

The patients affirm that undoubtedly they enjoy better health thanks to BA, because in the past they did not even know how to look after themselves, or had lost all hope to recover from affections that kept them from leading a normal life. This appreciation is common among patients who underwent eye and other surgeries in Cuba, in the framework of the Venezuela-Cuba Agreement, mainly in Miracle Mission (ascribed to BA), who recovered or strengthened their sight. The beneficiaries add that the changes are not only perceived in their physical health, but also in the emotional, as they know they have a doctor in their community, free medication and immediate attention for any ailment they have, they are not stressed any longer thinking of facing neglect in hospitals and not having the economic resources to afford medical attention.

The beneficiaries also point out that the orientation received both from the doctors and the healthcare coordinators and defenders on the adequate habits of alimentation and personal and home hygiene (dogs and cats vaccination, elimination of infection and disease sources, dengue for instance) has also contributed to improve individual and collective health. And they emphasize additional information: good treat, humane attitude, confidence and appreciation, without distinction whatsoever from the Cuban doctors, have been factors that in the opinion of more than one patient have helped to take better care of themselves, in addition to regard them as good professionals. In this sense, here a positive valuing and high acceptance for the Cuban doctors are both underscored.

Due to the aforementioned reasons, the results indicate that despite that in the communities where BA functions people "are still poor", according to the

local voices there have been advances in inclusion (right to healthcare) and partial changes in health conditions and quality of life in the community, compared with the previous situation. A helping factor (in the opinion of the coordinators) has been that in the framework of BA health is understood as an integral concept, which goes beyond not being sick and that has to do with the quality of life as a whole, as it involves other dimensions with an influence on it, such as having a healthy environment, availability of potable water, correctly disposing fecal matter, having acceptable housing, productive employment, and in general leading a deign life. There is still a long way to go for this to be so, however, in the perception of the interviewees there has been progress.

In spite of these achievements, the interviewed doctors coincide on stating that the advances in preventive healthcare have been slow, that BA has not fully impacted in a sustained way the nefarious habits the people drags from a lifetime and that directly harm them, in terms of prophylaxis and alimentation-nourishment; they explain that despite the orientation and promotion of healthcare which have been carried out, there is resistance to change habits, such as drinking unprepared water (they do not boil it, or only do it for small children), lack of a balanced food intake (high sugar consumption, fried snacks and fizzy drinks, for instance), high consumption of salt and refined sugar (a generalized custom in children who eat candies, for instance), scarce oral health (toothbrushing once a day, incorrect toothbrushing techniques), high consumption of alcohol and drugs largely among masculine population; disinterest in physical exercise as a helping factor for good health and prevention of cardiovascular problems, obesity, etc.

Apart from other socio-cultural factors that affect the familial and communal dynamic, the emotional-mental health and quality of life of the people, such as mistreatment, and domestic violence (toward children and women), insecurity, delinquency and extra-familial violence, as well as deficit of sexual education and orientation, responsible for the high incidence of pregnancy in adolescents, precocious and irresponsible parenthood, and sexually transmitted diseases.

Interacting with the beneficiaries made it possible to derive their opinions that it is not out of ignorance, for instance, that water to be drunk is not boiled, since they state that both the doctors and defenders have oriented them on the implications that for the health of adults and children brings along not to boil water for human consumption, but merely because they do not like the taste of boiled water, in addition to be something the dislike doing; and this bad habit, linked to their likes, preferences and ease, is placed before the protection of health, so that it is a cultural and educational issue deeply internalized, an indication that the old and mistaken precepts of the curative medicine are still active in the psyche of the

people. Therefore, even if there have been favorable changes, the impact of BA on the conditions of health, life and quality of life is restricted by the weaknesses in the formation-consolidation of a preventive healthcare culture, which transcends the theoretical sphere of the concept and enters the community praxis.

Individual and social self-esteem

At level of the subjective-qualitative, related to the psychosocial, which indeed is not accounted for in the statistics of the doctors but that according to the perception of the coordinators are a consequence of BA and other social missions, remarkable are cases of people who once assisted by the missions positively changed their vision of life and behavior. One of the coordinators told a story of a young woman from her community who had her dentition in a bad condition and deformed her facial features, she seemed timid, melancholic, but once she had her dental defects corrected by BA, her physical image and dressing stile changed, she no longer seemed introverted, now she greets the neighbor as she passes, she socialized better. The aforementioned coordinator points this out as an improvement in self-esteem. Some interviewed neighbors in this community verified the case.

Other instances, mentioned in other communities, are referred to grandmothers that previously were totally inactive at their households, feeling a burden and a nuisance with scarce attention from the family, and from their enrolling to Robisson I mission and started to leave their houses to attend lessons, they met and interchanged with other people, they enrolled in the BA grandparent circle, they became more confident as they learnt they were still capable of learning, felt useful and occupying part of their free time socially sharing a moment with other grandparents, for instance celebrating their birthdays together.

Conclusions

From the approaching performed in this work to social missions as axes of the current Venezuelan social policy aimed at poverty and social exclusion alleviation, an important conclusion is that President Hugo Chávez and his government largely owe their political-electoral success (especially among the poor, which are still most of the Venezuelan population) to this new social policy schema. However, when this variable is referred to (success of administration, according to government; failure or weak performance, as for inclusion and social impact, according to the opposition), it is generally focused from both the quantitative-numerical point of view (number of benefitted people and statistical behavior of poverty and the fundamental social indicators) and its sustainability along time, which is understood by the opposition basically in financial terms (future unavailability of budget, given the high volatility of the oil revenues that fund the social programs).

Nonetheless, in the concrete case study here approached with a qualitative research perspective (experience of Barrio Adentro Mission), it was clear that in the mission execution process and its effectiveness or social impact and sustainability there are more subtle aspects, which are located in the qualitative sphere (even subjective); they are frequently omitted in the analysis and much less evaluated, and also would be part of the success/failure-continuity/consolidation of the new social programs as well as their possible institutionalization as State policy and not of a single government.

This last becomes weighty mainly bearing in mind that in spite of the criticisms to these programs, the political opposition in the 2006 presidential campaign (elections won once again by Chávez) promised not to eliminate the missions but “improve and broaden them”. Even the candidate who ran against Chávez (Manuel Rosales, at that time governor of Zulia State) in his very administration (once the electoral success of the mission was verified in the 2004 presidential recall referendum) incorporated a series of social programs very similar to some of the national government missions, which turned into a large number of votes from the popular sectors of the State.¹⁴

This topic acquires relevance as for the sustainability of Barrio Adentro mission; according to the perspective of the key informers (mainly the direct executors), the strengthening and permanence, with successful results, would not be so compromised by the unavailability of budget (which from the start has been limited), for at local level the coordinators deal with the most pressing problems by means of self-management. Neither would it be dependent on the replacement of the Cuban medical staff (when these professionals finish the period of their mission and go back to their country), as there is acceptance among the beneficiaries for the Venezuelan doctors, and there are students being trained (a new major in Venezuela) on Community Integral Medicine.

In this sense, its sustainability would be largely threatened by other limitations (of educative-cultural nature) upon which the mission has not yet been able to sufficiently influence, for instance the organization-participation-volunteering in the communities (which is scant and week), and the insufficient internalization of the concept of preventive medicine, for which there is still a collective or generalized awareness, so there persist inadequate habits of hygiene, alimentation-nutrition, etc., that still harm the health of popular sectors. In addition to fragile bonds of solidarity-reciprocity, of capability to think of “the other”, as a manner

¹⁴ A characterization of the social programs of the Government of Zulia State can be found in its website: <<http://www.gobernaciondelzulia.gov.ve>>.

of individualism-egotism culture prevails, of the comfort or least effort and even corruption, which negatively influences the integration of community and its capacity of collective struggle.

The forging-consolidation at a large scale of this culture of participation and communal self-management (and in general of the protagonist collective actor that the new strategies of social inclusion in Venezuela demand, in the framework of the Bolivarian-socialist revolution process) would not be either dependent on the creation on new juridical mechanisms (for the existing regulatory framework is sufficiently broad and inclusive), but on the consciousness of these new actors of the active role that the vey process demands from them in the new times, in the broader context society is, which they are part of, under values of solidarity-associability that allow them to develop, decisively supported by the State, potentialities and capabilities for the tasks they have to undertake (Hintze, 2008; Alvarado, 2008). Since there is a learning process (that is not decreable), this demands a lengthy temporal horizon, different from the political and its strategic immediateness.

The broadening-consolidation and institutionalization of the current strategies of social inclusion as *State policies* rather than governmental ones, which thus far has depended on the political presidential goodwill and on the economic and institutional support of the State-government, would depend, on its own, on the consolidation of new social actors and their maturing as such, on its capacity to communicate-negotiate with the State and on the appropriation of the policies that relate them; definitively on their acquisition of a participatory-protagonist role (it may be valid to say hegemonic) in terms of what is known as *empowerment*, as in this new process of State-government/society-popular sectors relationship is crossed by the complex problem of power distribution and the making of fundamental decisions (Alvarado, 2008; Hintze, 2008; Barros, 2008).

The maturation process of the emergent social institutionalism not only needs the formation of collective actors from the bottom (communities, local direct executors), but all the public agents involved in the missions (functionaries linked to the new ministries and other institutions ascribed to the programs) in this principle of co-responsibility—co-management, but in the manner of a shared culture, not of a classic subordination-hegemony relationship. In this cultural change the main challenge is for the State, in terms of the new promoting role that it is compelled to fulfill; one of the prerequisites is that the State-government representatives accompany and monitor these processes, together with the communities and not leave them in the hands of the community *social comptrollership* (which at this time does not function properly); since the communities still lack that specific culture at large scale.

To sum up: this article exposes that on the sustainability of BA, of other social missions and of the communal councils influential are other factors that go beyond the financial sphere and the question if the structures that set into motion the new programs of social inclusion are “parallel” or “para-” or “extra-institutional” (which is troublesome for the political opposition). Neither does the crucial issue seem to be exclusively in the *numbers* (*figures* of actual coverage *vs* expected coverage, which express certain level of incorporation of popular sectors as beneficiaries of the missions; an issue that disquiets both the government and opposition), and if president Chávez remains in office, for his opponents, who aspire to replace him, realizing the “political-electoral hook” incarnated in the missions, have promised to give them continuity should they reach the presidency.

The decisive factor, without disregarding the previous, would be to a good extent the consolidation of the qualitative-cultural changes towards the long term, capable of turning the new initiatives into mechanisms alternative to neoliberalism, to the extent that they help to the dismantling of its ideological bases and the fulfillment of new constitutional precepts, a process that has been occurring inside many complexities, resistances and conflicts. In short, the consolidation of a process of this nature and the success in alleviating inequity or inequalities involved in poverty-social exclusion in Venezuela would be preceded by a *cultural revolution*, as a prerequisite for the political revolution, more so bearing in mind the socialist-radical character which has been formulated with it.

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Sent to dictum: April 23rd, 2008

Approval: June 3rd, 2008