7

Aid Relationships and Power Dynamics in the "Community Action for Health" Project

This chapter discusses the types of relationships between the actors in the "Community Action for Health" (CAH) project in Kyrgyzstan based on the findings from previous chapters. It builds around the findings regarding stakeholders' roles throughout the project realization process described in Chap. 5. It also considers the evolution of structural factors, including aid predictability and flexibility of providers, as well as the capacities and aid dependency on the recipients' sides, presented in Chap. 4. These two chapters constitute the basis for applying the analytical framework about power dynamics in relationships among stakeholders elaborated in Chap. 2. Informed by the findings and analytical frameworks laid down in these chapters, this chapter defines the following types of aid relationships (Table 7.1). It also elaborates on the impetuses these aggregated analytical categories of actors may have for pursuing the selected types.

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Table 7.1 Aid relationships between actors in the "Community Action for Health" project

Actors	Reference	Type of relationships
The Swiss actors—community-based organizations (CBOs)	Donor–civil society organization	"Empowerment" approach
Ministry of Health/Health Promotion Units/local authorities—CBOs	Recipient state–community	"Utilitarian" approach
The Swiss actors—the United States Agency for International Development (USAID) and the Swedish International Development Cooperation Agency (Sida)	Donor–donor	Unequal cooperation
The Swiss actors—Ministry of Health/Health Promotion Units	Donor–recipient state	(Contingent) Equal cooperation

7.1 Donor–CSOs: The "Empowerment" Approach

I conceive of the relationships between the donor and civil society organizations (CSOs), which in the case of the CAH mainly refer to community-based organizations (CBOs), as an "empowerment" approach because of the equal participation of both actors throughout the project, structural factors favorable to this approach, and altered power dynamics between the provider and the recipient of the assistance.

First, in the CAH, both the "donor" and CBOs participated equally throughout the project. Ideally, the "empowerment" approach presumes the active role of CSOs throughout the period of the development assistance, but their role may vary in practice. The Swiss Red Cross (SRC) dominated the initiation phase of the project by suggesting the idea of community involvement in health care and establishing the Village Health Committees (VHCs) for this purpose. Furthermore, it was the SRC and not the participants themselves who suggested the Participatory Reflection and Action (PRA) approach and developed the assessment criteria used by the project participants. Yet, the SRC largely pursued a supportive role by offering relevant technical and financial support, following the needs and demands of the community-based organizations and the issues they

encountered. It also initiated a process of annual self-assessment for the VHCs and the Health Promotion Units (HPUs) to emphasize their role in evaluating the project, something more commonly conducted by external consultants.

The community members played an equally significant role in the project. Their interest and agreement to participate in the initiative were essential to the advancement of the CAH beyond the pilot areas. Thus, in the following stages of the project—design and implementation—the VHCs took the leading role in the project by defining the issues of importance to them and implementing their solutions. These roles were consonant with the idea of empowerment as the "process of gaining influence over [the] conditions that matter to people" (Fawcett et al., 1995, p. 679), presuming the abilities of community-based organizations to express their concerns, set priorities, and participate in negotiations and decision-making process. By defining the issues and taking initiatives into their own hands, the CBOs were the source of initiative for the project and not merely its "passive" recipients (Rasschaert et al., 2014, p. 7).

However, the project initiation by an external actor, which also suggested the approaches followed by communities (e.g., PRA approach and assessment criteria), contrasts with the definition of the "empowerment" approach in ideal terms, which presumes the active role of civil society organizations throughout the development assistance. Yet, structural issues, such as illiteracy (Jana et al., 2004), gender-related biases (WHO, 2008), the political situation, and poverty (Fawcett et al., 1995), prevent civil society organizations from taking this active role throughout the assistance. Thus, the domination of the SRC in the initiation and evaluation phases points to structural issues hindering the ability of community members to initiate a project such as the CAH or suggest an assessment framework for their activities.

Yet, in the case of the CAH, these issues cannot be put down to illiteracy or economic hardships, as most of the population in the country (over 99%) is literate (UNESCO Institute for Statistics, 2023), and the organizations thrived in spite of the economic issues at the local and national levels. I argue that the structural issues stemmed from path dependency from the *Semashko* health care system inherited from the Soviet Union, which foresaw little space for public participation and initiative in health.

Despite the formal changes, both state and population continued living in practice within the old, paternalistic health care system, and therefore had limited perspectives on possible alternatives. My reasoning largely matches the analysis of health projects in Costa Rica by Morgan (1993, pp. 5, 15), who suggested that the "induced" or "sponsored" community participation could also be an outcome of a lack of citizen involvement in health projects.

Second, in addition to the equal involvement of VHCs throughout the project life cycle, the "empowerment" approach toward the CBOs was possible due to favorable structural factors. Remarkably, conventional gender roles in society contributed to the participation and retention of women in VHCs. These roles, for instance, include the assumption that a household's health is viewed as a woman's "responsibility" and that women (in contrast to men) are not associated with a role of breadwinner. The capacity of CBOs was further assured by the outstanding leadership of members who continued pursuing the organizational objectives amid misunderstandings from other community members or local authorities. Furthermore, the volunteer status of VHC members altered the hierarchy between the donor and CBOs by making the donor dependent on the willingness of community members to engage in the project, and, in so doing, evening out the aid dependency of CBOs on the donor. Certainly, the community-based organization members did receive minor incentives for taking part in the project, such as reimbursement of any project-related travel costs, training courses, seminars, and coffee breaks. However, these incentives were not the reason for community engagement—the reason was their willingness to work.

Equally, the flexibility and predictability of the Swiss aid assured the responsiveness and longevity of the project, providing a sense of security to stakeholders involved in this initiative and offering the time necessary to establish and build the capacities of community-based organizations. Flexibility and responsiveness were the foundation for the active roles of communities in the initiative. In total, the capacities of CBOs, the mutual dependence of stakeholders on each other's willingness to work, along with the predictability and flexibility of aid resulted in circumstances in which hierarchic relations between the provider and recipient of aid rendered themselves irrelevant.

Third, the altered power dynamics are another reason for defining the relationships of the "donor" with CBOs as an empowerment approach. Despite the dominance of the financier in specific phases, the relationships between the SRC and CBOs were characterized by the existence of the "power to," qualifying it as the "empowerment" approach. The "power to" manifested itself through a combination of the systems of thought and transformation of tacit knowledge into discursive, which empowered communities by attributing a decisive role to them, and a supportive one to the donor.

The systems of thought on the relationship with community members advanced by the SRC created the "power to" empower the CBOs. Following Haugaard (2003, pp. 107–108), the systemic biases and specific meanings "do not simply exist out there," but are rather supported by knowledge based on the "particular interpretative horizons." This way, stakeholders use and promote specific interpretations to create power for themselves or other actors. In the case of the CAH, the Village Health Committees benefited from the social consciousness the SRC and the project coordinator endorsed in relation to the role of communities in health, resulting in their decision-making and expert roles.

The SRC and the project coordinator advocated for the *decisive role of communities* in defining the issues targeted by project activities, which found its reflection in the active participation of community members in the initiation and design phases of the CAH. As demonstrated in Chap. 5, community members surveyed households and mobilized the local population to determine the pressing health care problems. The community members also brainstormed possible solutions to these problems. As a result, the issues targeted by the CAH were defined *by the communities themselves* and not induced by a donor. The SRC aimed to provide community members, who later joined the VHCs, the space to discuss the issues at hand and suggest possible solutions. This space presumed the altered roles: the donor and state representatives involved in the project were the ones listening, and the community members were the ones who spoke (Schüth, 2011b). This attitude, in combination with the nondominance approach, emboldened community members by placing them in the position of experts, those who knew the local needs and potential solutions.

By assigning the expertise to CBOs, the SRC altered the conventional perspective of donors, including their staff members and external consultants, as those who share their expertise with local people. In so doing, the staff members aimed to overcome the tradition of subordination of local expertise and knowledge to their international counterparts (Sending, 2015). This decisive role and the expertise of communities were supported by the transformation of tacit knowledge into its discursive form. Following Haugaard (2003, p. 108), stakeholders may be supportive of the existing social structure due to tacit knowledge rooted in practical consciousness, but changing this knowledge into a discursive form may "empower the powerless," who would use this knowledge to question the existing order. In the case of the CAH, this transformation of practical or tacit knowledge into discursive knowledge occurred throughout the project cycle.

During the initiation and design phases, the supportive role of facilitators, composed of both SRC and state representatives, included providing a space for discussions and encouraging community initiatives. Positioning the local communities as "those who know," the facilitators not only listened to, but actually encouraged the discussions. One of these encouragement tools was, for instance, comparing the community members' brainstorming on "how to stay healthy" to the Alma-Ata declaration on Primary Healthcare (1978) (Schüth, 2011b, p. 32). In addition to encouraging the community members, this comparison reaffirmed their position as "experts." This way, practical consciousness based on the tacit knowledge of the brainstorming exercise during the PRA sessions turned into discursive knowledge resulting from the community members' realization of their roles. The discursive knowledge complemented the formalized systems of thought, advancing the expertise of communities and their decisive roles in community health.

This realization about the roles of the local community and community-based organizations in health care continued during the implementation and evaluation phases. The VHC members used the means and knowledge obtained during the seminars to target the issues outlined by their communities. By applying this practical knowledge, the VHC members also realized their roles in targeting these problems and changing lives in their communities, which contributed to their willingness to continue their work. Despite the local self-governance representatives being adamant

about the purpose of CBOs and their work, particularly at the beginning of the project, the community members proceeded with their activities (Chap. 5). I argue that it was the transformation of tacit knowledge into discursive that emboldened community members in their work. Self-reflection during evaluation, endorsed in the community capacity-building indicators adopted by the SRC, continued to emphasize the roles of VHCs also during the evaluation phase. Notably, the same tacit knowledge could have disempowered community members had it been used to support the existing hierarchies between the "donor" and CBOs.

This transformation of knowledge was supported by the systems of thought through which the SRC took the supportive, rather than leading, role in the project. As vividly demonstrated in the implementation phase, it provided necessary means and training to VHCs. Notably, the SRC could have also used these resources differently to increase its "power over" the community-based organizations, but it chose to advance the VHCs' position instead and create the "power to." This points to an important distinction between power and resources. The presence of resources does not automatically equal power, as power is about *using* resources. As Dahl (2005, pp. 273–276) noted, actors may use the same resources differently.

The SRC used the resources to highlight the nondomination principle, which was equally critical during the implementation process as it was during the design and initiation phases. My interviewee suggested that the project implementation involved and emphasized the importance of all participants and their contributions (IO Partner 5). The emphasis on non-dominance was particularly strong in the case of communities. The VHC representative endorsed the project coordinator's idea. The interviewee reflected that VHC members had differing levels of education, but were asked not to correct each other. Neither the SRC nor other VHC members corrected anyone who misspelled, for instance, while writing on the board. CBO members corrected the spellings later in their own notes, based on the protocols they received from training facilitators at the end of the seminar (CSO 5). This seemingly simple yet introspective idea nourished community participation and prevented possible building of hierarchy based on educational level.

Overall, a combination of a system of thought and transformation of tacit knowledge into its discursive form laid the foundation for changing the conventional power dynamics, characterized by "power over," to aid recipients' "power to." These altered power dynamics, in combination with the favorable structural factors and the equal engagement of an aid provider and recipient throughout the project, contributed to the formation of the "empowerment" approach of the Swiss actors toward community-based organizations in the CAH.

Why were the community members interested in cooperating with the SRC? I suggest two reasons for this, namely motivation for change and the opportunity for self-development. The interviewees noted that community members joining the VHCs were interested in "changing something," "not just existence" (CSO 1) but rather bringing "at least something good for the village" (CSO 5). This motivation to bring positive changes to their communities is the primary reason behind the VHCs' relationships with the SRC and with all other donors and state organizations.

Furthermore, the willingness to bring changes is related to another reason driving the community members, namely self-realization. Interviewees closely working with VHCs remarked/observed that having "some authority" motivated them to learn (CSO 1), and members often say that "instead of doing nothing, better work for free, everyone needs health" (CSO 4). The motivations of VHC members outlined in the testimony of the second interviewee suggest that women do not perceive their household work as labor. Still, outside their households, women in rural areas often have limited opportunities to participate in decision-making processes. A VHC representative opined that participation in the CAH offered opportunities for training and meetings at district, regional, and national levels for women that rarely left their village (CSO 5). These women were eager to take advantage of the knowledge and skills the project offered. According to another VHC representative, as a result of their work with the VHCs, many women were elected onto the local council (*kenesh*), got jobs in local government institutions (*aiyl okmotu*), or became nurses at primary health care facilities or cooks in schools (CSO 2). Thus, engagement in the project offered knowledge and skills women used to advance themselves.

What were the reasons for the SRC to engage with the community and pursue their "empowerment" approach? Community involvement in the CAH was paramount, since the goal of the project was to contribute to

community capacity-building. Besides, the emphasis on community participation was consonant with the principles of the Swiss Agency for Development and Cooperation (SDC) and SRC, which financed and implemented the project, respectively. Still, instead of approaching community members as "free labor" (Earle et al., 2004) for project objectives, SRC approached them from an "empowerment" perspective. This was due to the project coordinator, Dr. Schüth. Having previously worked on a similar participatory community development project in Bangladesh (Schüth, 2011b), the project coordinator stressed the principle of "non-dominance" among SRC team members, the community, and state representatives.

The role of the project coordinator brings to light the significance of an individual, among other things, in understanding the outcomes of the organizational work. His background and perspective on community engagement were decisive to the "empowerment" approach pursued by the SRC in the CAH. Through his work, he established a close relationship with the communities. As one of the external evaluators noticed: "Indeed, it seems as if some villages will soon have little boys called Tobias" (Kickbusch, 2003, p. 13). The project coordinator spent thirteen years in the country and administered most of the CAH, leaving shortly before its completion. The VHC members were "upset" when the project coordinator was leaving the country, as they "considered him as their own son" (CSO 4). The community-based organizations interviewed for this research expressed their appreciation of the project coordinator's work and efforts (CSOs 2 and 7), emphasizing that "his work will never be forgotten" and the VHCs will not cease in their efforts (CSO 5).

7.2 Recipient State–CSOs: The "Utilitarian" Approach

The Ministry of Health, the HPUs, and local self-governments (LSGs) had a "utilitarian" approach toward community-based organizations, with collaboration primarily driven by promoting their own agendas rather than supporting VHCs and approaching them as equal partners.

Notably, stakeholders' roles during the project and structural factors did not point to a "utilitarian" approach. Both actors participated equally throughout the project realization process (Chap. 5), which could have been the basis for equal aid relationships. Similarly, the impact of structural factors on aid relationships was rather mixed. State organizations were not providers of aid during the CAH, but the continuous training and facilities they provided may suggest their roles as providers *after* the end of the project. In this sense, the recipient state offered limited flexibility in its assistance, which was largely limited to the areas the state itself prioritized (e.g., training), or the areas it could offer within the confines of its limited budget (e.g., office spaces or some funding). Political and economic instability in the country has also hindered the predictability of state support, though the areas prioritized in the national health care programs, such as "*Den Sooluk*" (2012–2018), were somewhat "secure" for the duration of the program. In terms of capacity and dependency, community-based organizations demonstrated exceptional leadership, endurance, and independence, contrasting with the frequent staff rotation and aid dependency on the side of the recipient state. These mixed outcomes from structural factors, in combination with the stakeholders' roles throughout the project, are open to interpretation.

The "utilitarian" approach owes to the power dynamics formed between stakeholders. The recipient state exercised two forms of power in relation to CBOs, namely the "power to" and "power over." The former occurred due to social consciousness, whereas the latter was contingent on the (non) transformation of tacit knowledge into its discursive form.

The recipient state provided the "power to" to CBOs through systems of thought. As noted in the project cycle, the government emphasized prevention over treatment and citizens' responsibilities for their own health. This idea, in a way, constrained the role of the state in health by providing a window of opportunity for community participation. Indeed, the idea of CAH was broader than state activities driven by retrenchment, but still the project complied with the state agenda. The systemic bias toward community participation in the project was based on the interpretative horizon advocated by the government, which provided power to population involvement in health (Haugaard, 2003, pp. 107–108). The VHCs, supported by the SRC and HPUs, used this opportunity to define

and implement community initiatives in health. Similarly, the community-based organizations received acknowledgment and support through governmental decree, which solicited LSGs to collaborate with community-based organizations. The VHCs used this opportunity to expand and legitimate their activities through cooperation with local authorities.

The relationship between the tacit and discursive knowledge was decisive in creating the recipient state's "power over" community-based organizations, at the expense of supporting CBOs' "power to." Following Haugaard (2003, p. 108), the use of knowledge driven by practical consciousness results in the "power over," whereas its transformation and internalization into discursive knowledge create the "power to." The nondominance principle, which contributed to the SRC's empowerment approach toward CBOs (see the previous section), equally resulted in the relationship of CBOs with the recipient state being characterized by the "power to" and not "power over" VHCs.

However, the outcome was contingent on state actors' internalization of the nondominance principle beyond their mere compliance with this idea due to donor recommendations. This process scales down to an individual perception of this principle, emphasizing the relevance of and the difference between the analysis of actors at individual and organizational levels. At an individual level, support from the key employees from the Ministry was critical to the countrywide roll-out of the CAH, as these individuals advocated for increased community participation in health (see Schüth, 2011a). Similarly, VHC training, particularly at the end of the donor funding in the CAH, largely depended on the HPUs working with them, or rather their individual commitments to community empowerment. This significance of individual perspectives is also traceable to LSGs. As one interviewee noted, the community members manage to achieve more in locations where the LSGs support the VHCs' work (CSO 5). Emphasizing this significance of internalization of the norm at the individual level, this book makes no generalizations, but it highlights that in cases when this internalization occurs, the state actors pursue the "empowerment" approach toward community members, and where it does not, the "utilitarian."

Without internalization of the norm and transformation in a discursive form at an individual level, tacit knowledge will result in state organizations exercising "power over" the CBOs.

The Ministry of Health's agenda, not that of the communities, prevailed in the relationships between these actors. One vivid example of ministerial agenda guidance can be found in the cutting of the number of training areas after the end of CAH. During the project, the HPUs provided a broad range of training to the VHCs in the areas relevant to their work. After the end of the CAH, training shrunk to four areas prioritized by the national health care program: TB, HIV/AIDS, cardiovascular diseases, and mother and child health. The VHCs received no training outside these four areas, even though other issues might have been equally important to their communities or to their organizational capacity. In this regard, an interviewee closely working with the VHCs claimed that the Ministry "used" the CBOs to achieve its indicators on preventive activities without "acknowledging" the VHCs or their work. This way, although reporting on the engagement of VHCs, the Ministry does not provide institutional support for the VHCs' organizational capacity (CSO 1).

This cooperation, following the approach/agenda of the recipient state rather than that of communities, qualifies the relationships between the Ministry and the VHCs as a "utilitarian" approach toward the CBOs. The CBOs were "passive" recipients (Rasschaert et al., 2014, p. 7) of training courses and a "means" of implementation (Morgan, 2001, p. 221) for the Ministry, which was guided by its own agenda rather than the agenda of the VHCs. This style of relationships is drastically different from the "empowerment" approach of the SRC toward the VHCs, where the community-based organizations expressed their concerns and set priorities, acting as the key decision-makers.

Without the transformation of tacit knowledge into discursive, HPUs pursued a "utilitarian" approach toward community-based organizations. As part of primary health care, the HPUs have an increased workload, which, combined with low salaries, may contribute to pro forma rather than actual work with communities unless an individual HPU member decides otherwise (see Chap. 6). The "empowerment" approach toward CBOs also depends on the extent to which individual medical professionals internalize the principle of nondominance or maintain the hierarchical

doctor-patient relations consonant with the *Semashko* health care system inherited from the Soviet Union. The project cycle offered a glimpse into issues, including the protective attitude of medical professionals questioning the exercise of VHCs and their activities in health. Thus, at an organizational level, HPUs may have limited incentives for pursuing the community empowerment approach.

Overall, the recipient state's "utilitarian" approach toward CBOs is primarily an outcome of power dynamics between these stakeholders. Interestingly, all other things being equal, internalization of the empowerment and nondominance norm at the individual level seems to be decisive in transforming the tacit knowledge into a discursive form, and thus creating the "power to" in place of "power over."

Correspondingly, the relationships between the LSGs and community-based organizations depended on the extent to which the former considered CBOs equal to them or merely instrumentalized VHCs for the sake of their own objectives. Engaging with the VHCs is essential for the work of the local authorities since the VHCs not only have the capacity for dissemination activities, but also have a certain status in their communities. One interviewee noted that not a single activity organized by the LSGs takes place without the VHC, which also helps the local authorities mobilize the local population (CSO 2). The community-based organizations express their concerns and participate in the LSGs' decision-making processes. However, their ability to set priorities on the agendas of the local authorities remains unclear. The VHC involvement in meetings seems to be limited to supporting the activities of the local self-government. In these circumstances, the VHCs remain the "means" of implementation (Morgan, 2001, p. 221), which qualifies the relationships between the two actors as a "utilitarian" approach on the part of the local self-government toward the community-based organizations.

What are the actors' interests in the "utilitarian" approach? Through cooperation with the VHCs, the Ministry of Health improves the performance of the national health care program by increasing the awareness of the population about the diseases relevant to the four areas prioritized in the program. Through the VHCs, the Ministry has the possibility to outsource disease prevention measures and health promotion activities from overloaded and understaffed primary health care personnel to the

population itself. For the VHCs, the HPUs have remained the main source of training since the end of the CAH. Although they are not receiving training in other areas, the VHCs continue to improve their knowledge of the prevalence and prevention of the four diseases prioritized in the national health care program, which contributes to their expertise in disease prevention and health promotion. These reasons explain both the VHCs' and the Ministry of Health's interest in pursuing a "utilitarian" approach to the CSOs. HPUs, in their turn, engaged with the VHCs as part of their responsibilities.

Surely, the VHCs could have also benefited HPUs by providing outreach to local communities. Equally, the local authorities have a limited capacity for outreach among the community members in their villages (CSO 1). Therefore, the VHCs served as mediators between the recipient state and the local population. For the VHCs, collaboration with local self-governments offers limited financial incentives due to the budget deficit, but does provide administrative support for community activities. Notably, the VHCs were not financially dependent on any institution representing the recipient state.

7.3 Donor–Donor: Unequal Cooperation

In terms of structural factors, there is no explicit hierarchy in the relationship among donors, in contrast to donor–recipient relations. The unequal cooperation between donors formed primarily as a result of uneven involvement in the project and power dynamics.

Donor participation in the CAH was uneven. Absent during the initiation and design period, USAID and Sida joined the project during the implementation phase to support the countrywide roll-out of this initiative. Yet, the two donors had different forms of engagement: while USAID implemented the program activities in collaboration with the SRC trainers, Sida financed the SRC activities in the agreed areas without direct participation in the project. Despite this difference, both donors complied with the SRC's approach to communities, including the principle of "non-dominance" and evaluation of the VHCs and their work according to the criteria developed by the SRC. Thus, both implementation and evaluation

phases were primarily guided by the SRC, with two actors following its framework.

This inequality also found its reflection in the power dynamics between the three donors, which combined attributes of both "power over" and "power to." In this context, the former is related to the preeminent position of some organizations, whereas the latter concerns the ability of organizations to work with each other.

First, the SRC exercised "power over" two other organizations through what Haugaard (2003, p. 108) called "reification." Reification occurs if stakeholders reinforce power relations because these relations are based on more than "simply arbitrary convention" (ibid.). In the case of the CAH, the reification concerns the "evidence-based" nature of arguments in favor of the SRC's approach. Though not explicitly focused on community engagement in health, the SRC has nevertheless demonstrated the effectiveness of its approach. These kinds of achievements supported the *evidence* for the "Jumgal model" (see Chap. 5) and contributed to USAID and Sida's compliance with the SRC's approach, including the nondominance principle, during the design and implementation phases as the project expanded beyond the selected regions.

Second, the "power to" was a result of the social order related to the ownership of the recipient country and harmonization among donors. It facilitated the collaboration between development partners guided by the global agenda on aid effectiveness. The principles of "ownership" and "harmonization" that would become almost synonymous with effective aid were accentuated in the Paris Declaration on Aid Effectiveness (2005) and the following Accra Agenda for Action (2008) (see S. Brown, 2020). The significance of these two principles is vividly demonstrated by the support USAID and Sida offered following the Ministry of Health's call for the expansion of the Jumgal model. The project life cycle vividly demonstrates that the commitment of the recipient state to provide Health Promotion Units encouraged donors to support the CAH. This response is consonant with the principle of "ownership" recalled in the Paris Declaration (OECD, n.d.). Similarly, a rapprochement between development organizations during the evaluation phase helped avoid duplications. Donors continued monitored project achievements, also by involving external consultants. Yet they seem to have agreed to retain the

community capacity-building criteria developed by the SRC as the key approach to evaluating the VHCs and their activities in health.

At the same time, the social order has also contributed to the SRC's "power over" other organizations due to its awareness of the areas the recipient state was willing to expand. The idea of community participation in health has been discussed since the 1950s and culminated in the 1970s with the adoption of the Alma-Ata declaration (1978) (Morgan, 1993). This social order on community participation in health contributed to the emphasis on empowering local community members and community-based organizations. This bias has also allowed the SRC to implement the project and encouraged two other donors to join its expansion process in their efforts to contribute to the reform of the Kyrgyz health care system. Implemented in combination with reification, the "power over" created through social order was still different. Thus, in contrast to the evidence-based rationale of reification, the power here was an outcome of development organizations following the global agenda on community participation.

In both cases of social order creating the "power over" and the "power to," development organizations confirmed the meaning of community participation in health and the recipient state's ownership over the assistance. Both endorsed the Jumgal model, resulting in development organizations supporting the CAH as the initiative pursued by the Ministry of Health and giving the leading role to the SRC based on its experience and expertise on the desired topics.

Why did these three donor organizations engage in unequal cooperation? USAID and Sida agreed to unequal cooperation because of the SRC's expertise in community involvement. Overall, donors vary in their capacities, in their awareness of the context in recipient countries, and in other characteristics; however, the power dynamics between the donors are relatively equal (Chap. 2). A "dominant" donor only emerges if the other donors are "less motivated" or "financially less able" to compete (Bueno de Mesquita & Smith, 2016, p. 2). The leading role of the SRC in the CAH was related not to funding, but rather to its expertise in community involvement, which was also acknowledged by the Ministry of Health. Developing community capacity was the main area of activity for neither USAID nor Sida. Implementing the "ZdravPlus" (2000–2005)

and "ZdravPlus II" (2005–2009) projects in five Central Asian countries (Abt Associates, 2023), USAID capitalized on primary health care development. As the core financier of the Sector-Wide Approach, Sida aimed to support health care reforms in Kyrgyzstan. In this way, the development of community capacity was only part of USAID and Sida's activities, which may explain their interest in going along with the SRC's approach instead of developing a new one. For the SRC, USAID and Sida involvement provided the necessary finance for the countrywide expansion of the pilot program.

7.4 Donor–Recipient State: (Contingent) Equal Cooperation

Both stakeholders participated throughout the project realization process. However, the formation of the type of aid relationships between them largely depended on the structural factors and power dynamics.

The relations between the SRC and the Ministry of Health, including the HPUs,[1] combined both the "power to" and the "power over." The SRC supported the ministerial social order, creating the "power to," but reification contributed to the SRC's "power over" the Ministry. Yet, the relationships between stakeholders also largely depended on the transformation of knowledge state representatives received from the SRC.

The Ministry of Health advocated for a new social order in which the population, and not only the state, was responsible for health. Following Haugaard (2003, p. 91), the social order creates power through predictability emerging from actors' "structuring" and "confirm-structuring" specific meanings. In other words, the social order is built on predictability assured through actors acting in compliance with ideas that support this social order (Haugaard, 2003, p. 90). The project life cycle and, more specifically, the initiation phase of the CAH vividly demonstrated the shift in the governmental agenda toward delegating part of the state's

[1] I do not include the local self-governments here as they did not directly work with the SRC. Affected by the decrees from the government, they have worked with CBOs but had only limited interaction with the SDC and SRC.

responsibilities for health care to its citizens. The Ministry conducted reforms according to the social order of increased population responsibility for its health (see Government of KR, 2006; WHO/Europe and UNDP, 1997). The government commenced optimization reforms in the hospital sector to increase primary health care funding. This emphasis on prevention over treatment and individual responsibility over health was also consistent with the Alma-Ata Declaration (1978) and the Ottawa Charter for Health Promotion (1986). The Charter highlighted that health was the responsibility of an individual and community, and not just one of the health sector alone (WHO/Europe, 1986). The Declaration stressed primary health care and called for the participation of individuals and communities in health care to overcome health inequalities within and between countries (WHO/Europe, n.d.).

The CAH was consonant with the social order the Ministry advocated for. The CAH aimed to "enable rural communities to act on their own for the improvement of their health" and support the state health care system "to work in partnership with communities for improving their health" (Kessler & Renggli, 2011, p. 24). These objectives were in harmony with the state agenda and international documents mentioned above. Through its objectives and activities, the CAH confirmed the social order promoted by the Ministry. The VHCs' activities allowed a nationwide expansion of awareness-raising campaigns and subsequent prevention of diseases significantly affecting the population, also according to the national health care strategies. In addition to cost-saving (see Chap. 6), these activities supported overloaded medical professionals in primary health care and expanded the coverage of prevention activities to rural areas, in which access to health care is particularly pressing.

However, in contrast to the state initiative, the project stipulated broader community participation in, and not only responsibility over, health. Having its roots in these international declarations, the state reforms were still driven by efficiency concerns. As one state official engaged in reforms at that time noted, several hospitals were demolished to reduce the excessive spending on maintenance, because they took up most of the public health financing (State Partner 1). Though highlighting responsibility, the state documents did not indicate the participation of communities or populations in health (e.g., Government of KR, 2006).

The CAH, in contrast, foresaw community participation in health. This difference in framing was crucial to community engagement and subsequent agenda-setting in health. This way, the community members and organizations were not mere implementers of state or donor-defined objectives, but also had the opportunity to define their own agenda.

In addition to supporting the Ministry's social order (the "power to" mentioned above), the SRC also had the "power over" the Ministry through reification. As discussed in donor–donor relationships in this chapter, the "Jumgal model" was a demonstration of the effectiveness of community participation in health. It demonstrated the effectiveness of the SRC's nondominance approach and became evidence in favor of it. This "evidence-based" rationale was the basis for reification, a situation in which stakeholders reinforce power relations, even if these relations are unequal, based on the belief that these relations rest on more than "simply arbitrary convention," in this case referring to science as the source of reification (Haugaard, 2003, pp. 104–105). It is important to remember that though consistent with the state agenda, the CAH went beyond it. In addition to targeting priority areas in the national health care program, the VHCs also pursued their own objectives (e.g., capacity-building) and problems their communities defined as significant. Thus, though supportive of state medicine, these activities also increased requests community-based organizations sent to state institutions, including the local self-governance organizations (see Chap. 5), which may not be ideal in the circumstance of a budget deficit.

Combined with reification, the tacit knowledge created the SRCs' "power over," though its transition to discursive also contributed to the "power to." The Ministry followed the SRC's approach in the project implementation and evaluation phases. Trained according to the principle of nondominance, the HPUs trained the VHCs accordingly and evaluated the VHCs using the community capacity-building criteria developed by the SRC. In so doing, the Ministry and HPUs "confirm-structured" the systems of thought on community participation advocated by the SRC. On the level of "practical consciousness," the knowledge the HPUs received from the SRC contributed to unequal power relations in which the recipient state followed the approach suggested by a donor. However, a transition of this knowledge into a "discursive form" empowered the HPUs and the

Ministry (Haugaard, 2003, p. 108). Accordingly, the HPUs did not apply this knowledge following donor recommendations or regulations from the Ministry. Instead, the HPU representative applied this knowledge due to personal vision or motivation. This perspective is likely behind the statement of an HPU representative, who noted that medical professionals "should not be teachers" but rather "equal to" the population they treat (CSO 5). Resulting from a personal vision or motivation and not inculcated from outside, the knowledge becomes discursive and enables the HPUs to build relations with communities. This significance of a personal perspective was also vivid at the end of the project, as the HPUs continued training community-based organizations without the SRC's support.

Overall, the relations between the SRC and the Ministry of Health, including the HPUs, combined both the "power to" and the "power over." However, the transition of tacit knowledge into discursive was critical to equal cooperation between the donor and recipient state. Thus, if the state representatives applied the knowledge based on personal vision and commitment and not following the regulations from "outside," this knowledge became discursive and empowered the recipient state instead of the donor.

Notably, the structural conditions, including predictability and flexibility of aid, capacity, and aid dependence of state institutions, did not have definite implications on the type of relationships formed between the actors. On the one hand, the Swiss aid was predictable and flexible, reflected in the duration of the CAH (thirteen years) and adjustment to the "wishes" of the Ministry of Health at the beginning of the project. On the other hand, the capacity of the recipient state, on the part of both the Ministry and the HPUs, remained somewhat limited (see Chap. 4). The state institutions also relied on the SRC's expertise in working with communities due to the lack of prior experience in this area. Thus, the structural factors could have contributed to both equal and unequal forms of aid relationships.

What was the Ministry of Health's interest in pursuing equal cooperation, which was contingent upon knowledge transformation? The Ministry intended to strengthen primary health care in the country and get citizens to take more responsibility for their own health, which is also reflected in the national health care reform programs. However, the Ministry had limited interaction with the population and no previous experience in

working with communities. Acknowledging the success of the "Jumgal model," the Ministry requested the nationwide roll-out of this program and agreed to provide the HPUs for this purpose, following the SRC's request. The ministerial decision to establish the HPUs is remarkable, given the budget deficit in the country (and particularly in health care). This may, however, also have been a response to the SRC's flexibility and responsiveness to ministerial requests, particularly at the beginning of the project. Notably, the renovation of hospitals exclusively had not been part of the SRC or the SDC's vision (Schüth, 2011b, p. 23), and yet, despite this, the donor had supported the maintenance works in the Naryn region as demanded by the Ministry.

To understand the Ministry of Health's interest in committing itself to the CAH, it is also important to consider the relationships between the Ministry and the SDC, which financed the project. The SDC is one of the three donors, along with the German Development Bank and the World Bank, providing financial assistance for health care in Kyrgyzstan. The relationship of the Ministry with the donors, particularly with those providing the financial assistance, is unequal (see Isabekova & Pleines, 2021). According to a development partner, budgetary assistance allows development partners to promote their "parallel" projects (IO Partner 9) or the projects implemented along with the budget assistance. This way, the position of the SDC may have been a foreground for the Ministry to include the CAH in the Sector-Wide Approach. This inclusion contributed to coordination among development organizations and "more efficient use of available resources in support of the CAH model" (Gotsadze & Murzalieva, 2017, pp. 13–14).

Why did the SRC pursue equal cooperation? The main reason behind the SRC's interaction with the Ministry of Health and the HPUs was the sustainability of the CAH beyond the period of donor funding, which required the acknowledgment and commitment of the Ministry to the project activities. Another reason was the idea of "ownership," which intended to show the engagement of the recipient state and its ownership over the project, following the social order described in the "donor–donor" section of this chapter. Similar reasons guided stakeholders in the grants provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria (see Chap. 10) to be introduced in the following chapter.

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