Decolonization and Its Paradoxes

The (Re)envisioning of Health Policy in Bolivia

by
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In one of the most traditionally hierarchical and "colonial" of the Bolivian state apparatuses, the official health sector, attempts since 2006 by Evo Morales and the MAS government at radical restructuring have proved innovative but inconclusive and divisive. Reflecting a series of conflicts and contradictions, a number of often fundamentally competing scenarios are at work: the institutionalization of traditional medicine, the reinterpretation of previous primary health care and community participation models, social and "socialized" medicine, and the durability of a deeply ingrained vertical health system. The challenges and risks inherent in what at heart may be a struggle between cultural and political factions and ideologies among the government's public health authorities and planners are emblematic of many paradoxes in the effort to decolonize the Bolivian state as a whole.

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Since Evo Morales and the Movimiento al Socialismo (Movement Toward Socialism—MAS) came to power in Bolivia on January 22, 2006, an unprecedented series of structural innovations has been implemented by the new government. These include significant reformatting of the state bureaucratic apparatus, the quasi-nationalization of numerous industries, projected land reforms and possible future expropriations of large landholdings, and, most significant, the approval by national referendum of a new constitution. In the overriding framework of cultural reforms through which the majority indigenous and mestizo populations have attained political power after centuries of subjugation, the process has led many observers—Bolivian and foreign alike—to concur that a genuine revolutionary revival and national "refounding" is well under way in the new "Plurinational State of Bolivia."

Throughout this "process of change" (as it is referred to by the MAS government), national policy and political discourse have revolved around the dual concepts of "decolonization" and "interculturality." Virtually overnight, these conceptual pillars have moved beyond the rarefied worldview of small groups of national and international academics, intellectual social activists, and progressive development agencies to become the guiding doctrine of official state policy. The peculiarly national brand of interculturality and the

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accompanying recognition of the need to decolonize the Bolivian state are recurrent themes in almost all government discourse: the concepts have, in effect, become institutionalized.

This article examines the ongoing processes in the proposed and actual radical restructuring as exemplified by that of the official health sector. "Paradox" is meant to imply the inherent contradictions in the design and implementation of what is still a developing formal state policy and the resultant exacerbation by the reforms of tensions present in Bolivia for generations. In this struggle between cultural and political factions within the government's public health directorship and the personnel entrusted with implementing policy on the ground, conflicts result from a juxtaposition of factors: newly formulated state policy objectives, the abstract guidelines of postcolonial and (inter) cultural theory, and the bluntness of Bolivian reality. Thus, the rapidly evolving (re)envisioning of health and the health services—a policy area on the frontline of the debate over the course of decolonization in Bolivia today—offers insights into the overall national experiment in the construction of an indigenous state.

DECOLONIZATION IN THEORETICAL CONTEXT

Before discussing any proposal of decolonization, it is important to understand what it means to be "colonized." By identifying Bolivia as a "colonial state" and referring to the majority indigenous population as "subalterns," the MAS and sympathetic intellectuals place the discussion in the court of postcolonial and subaltern theory. And, as numerous theorists (e.g., Quijano and Wallerstein, 1992; Mignolo, 2001; Young, 2001) have noted with regard to the special "postcolonial" conditions of Latin America, this categorization requires precise definitions. According to Quijano and Wallerstein (1992) and later others (see Lander, 2000, for a discussion), the history of Latin America reveals that *coloniality*—the essential nature of being "colonial" in the relationship between powerful and weak nations within the "interstate system"—has intrinsic historical links (since the sixteenth century and European expansion) to ethnicity and racism, and does not disappear after formal independence; rather, it "continues in the form of a social-cultural hierarchy of European and non-European" (Quijano and Wallerstein, 1992: 550). This political, economic, and cultural structure of subjugation and power, grounded in a racialized Eurocentrism, thus constitutes its own brand of modernity and makes its own rules.

In a broader Latin American context, theories of "internal colonialism" hold a prominent position. In the work of early theorists including Fanon (1963; 1967), Memmi (1967), González Casanova (1976), and Bonfil Batalla (1990), as well as more recent subaltern studies scholars such as Guha (1982; 1983), Spivak (1985), and Chatterjee (1993)—in turn influenced by Gramsci, Foucault, and Said—and the reinterpretations of diverse Latin American intellectuals, internal colonialism is a form of socioeconomic-cultural domination based in capitalist hegemony and racism, and historically exercised by local and regional governing elites over subaltern groups. In internal colonialism, with its ideological assumption of the inherent superiority of one group to another,

the emphasis shifts from outside colonial powers to national power bases and their control apparatuses over relegated domestic populations. These dominant institutions frequently have ties to external economic models, but power is manifested through local structures and dynamics.

In Bolivia, these theoretical currents helped shape a militant indigenous revitalization against a quasi-apartheid colonial state dominated by a European and *criollo*-descended minority. Fausto Reinaga, whose *indigenista* texts are highly influential in these discussions, denounced historical social, economic, cultural, and racial divides, in both theory and practice, between the "two Bolivias"—"a mestiza-Europeanized and a *kolla*-autochthonous Bolivia" (1970: 174, my translation)—and advocated an "Indian Revolution" in which "the policy of the indian is a total struggle for the liberation of his people" (1971: 143) and the overthrow of the *criollo* elite, by violence if necessary. The militant community-organizing work done by the *katarista* movement, primarily on the Aymara altiplano during the dictatorships of the 1970s, drew on Reinaga's work in calling for an end to the "colonial state," and this has influenced indigenous political movements to this day, including the MAS (Rivera Cusicanqui, 1984; 2006). As further developed by the latest generation of Bolivian decolonization theorists (e.g., Ticona, 2005; Patzi, 2006; Mamani Ramírez, 2007; Quisbert Quispe, 2007), internal colonialism takes on a more immediate aspect, containing a mixture of defensiveness and aggressiveness, particularly in the wake of the MAS electoral triumph. On the one hand, the significant successes of the social movements and the "indigenous government" are seen as under attack from reactionary interests—including the right-wing elites of the so-called Media Luna (Half Moon) eastern lowland departments (states), with their calls for a highly racialized and economic self-interested political autonomy. On the other hand, Evo Morales and the MAS are criticized for not having proceeded far enough in attacking the entrenched colonial state and are accused by some of having been co-opted by it.[1]

It is in this theoretical context that the MAS government situates its active policy initiatives. Decolonization, in a country that has been formally independent for nearly 185 years, thus becomes an experiment in national soul-searching and (re-)creation in a variety of aspects of daily life—from education to law, entertainment, and health.

DECOLONIZING THE NATION

COLONIALITY AND INTERCULTURALITY

In the MAS strategies for state decolonization, the notion of interculturality is fundamental. A simple and oft-quoted definition of the term identifies the integrated relationships between persons or social groups of diverse cultures or worldviews and, by extension, the attitudes of bearers of one culture toward the elemental norms of another. This is fundamentally a dialectical relation between two poles—one's own identity and that of the "other"—that should optimally occur in an environment of respect, reciprocity, and honest exchange of beliefs and practices, resulting in mutual growth, enrichment, and transformation (Albó, 2004). However, interculturality is not to be confused with

multiculturalism, here perceived as the shared occupation of a common space by people of different cultures, and frequently limited to interrelationships on narrow terms and conditions and oriented more toward assimilation than toward integration—hence, very likely only a further propagation of a colonialist model (Fernández Juárez, 1999; TARI, 2003; Albó, 2004). In Bolivia today, multiculturalism is simply a given; interculturality, in contrast, is an active process of transformation.

There are, however, dissenting views. Some hold that in Bolivia today an abstract interculturality becomes tangible only in the coexistence and constant conflict of a very unequal balance of power between the indigenous and the nonindigenous. Viaña, Claros, and Estermann et al. (2009: 7–8) argue that true interculturality is virtually impossible if inequality and coloniality persist, and that true decolonization is likewise impossible without an effective process of interculturality. They conclude that the unequal balance of power that continues in Bolivia—social, political, economic, gender, linguistic, cognitive—impedes any genuine "respect" or "dialogue" on the part of those in control: the structure itself remains intolerant and propitious only to a mono-cultural dialogue. Thus, the ultimate objective of the intercultural discourse should be to move beyond talk about respect and tolerance, and open up channels of genuine exchange and power sharing between differing visions. Consequently, the discourse of "true" interculturality is synonymous with the discourse of "true" decolonization, whereas "multiculturalism" is primarily an essentialist discourse for concealing inequalities and neutralizing the decolonization process (Rivera Cusicanqui, 2006: 10). At this point, the intercultural argument becomes increasingly controversial in that it potentially threatens the entrenched interests of certain power sectors.

THE NATIONAL DEVELOPMENT PLAN

Six months after taking power in Bolivia, President Evo Morales and the new MAS government issued their official social development strategy, the Plan Nacional de Desarrollo: Bolivia Digna, Soberana, Productiva y Democrática para Vivir Bien (National Development Plan: Bolivia Dignified, Sovereign, Productive and Democratic to Live Well). The plan declares at the outset that "the history of Bolivia . . . . has been marked by colonialism and neoliberalism" and that the country (especially since the mid-1980s, considering structural adjustment policies) has been dominated by "transnationals and international organizations of the powerful nations," while "external colonialism grew . . . and the 'national bourgeoisie' listened only to the orders of foreign countries" (MPD, 2006: 21, my translation). Because of the dependency, inequality, diminished rights, and poverty that resulted, it continues, the government "has initiated the process of dismantling colonialism and neoliberalism and, at the same time, initiates the construction of a new society of a plurinational and communitarian state." Specific national strategies include the following areas: economic, "sociocomunitarian," international relations, and "social power," all with the stated objective of "the construction of a new socially and productively inclusive society in which technological advances are combined with the knowledge of our ancestors,

based in the energy and the capacity derived from our cultural identity" (MREC, 2007).

At the core of the plan is the paradigm known as "Para Vivir Bien" (To Live Well), also frequently and colloquially referred to, as the cultural context demands, in Aymara (Suma Qamaña), Quechua (Sumaj Kawsay), or Guaraní (Ñande Reko). Adopted as a theoretical guiding standard for most governmental policy and programs, To Live Well exemplifies the MAS's use of an indigenous discourse to promote state ideology—in itself perhaps a form of interculturality. Simply expressed, the notion is that of living comfortably and with dignity within one's means, without excess. As described by Javier Medina, one of the most prolific intellectual proponents of the concept (2006; 2008: 10, my translation),

> "Quality of life" is a deeper reflection upon the "human condition." It considers that cultural identity, the physical, mental, and spiritual ties to one's *llacta* [people], one's land, is of equal importance to the raw materials of life. The loss of common values, the disintegration of communal structures, and the alienation from the spiritual world can affect the individual more than the lack of physical items. . . . The struggle against poverty is more than just improving the economic base and access to public services.

Similarly, in the official strategic plan of the Ministerio de Salud and Deportes (Ministry of Health and Sports—MSD), To Live Well is "a demand for the humanization of development, so that it is transformed into one of collective decision making and action from a society that is an active subject and not a passive receiver of vertical initiatives," and is based on a "cosmocentric vision that transcends the typical ethnocentric development contents" and postulates "progress as beginning with mutual discovery and horizontal contributions and not imposition and authoritarianism" (MSD, 2009b: 5).

Although innovative, this somewhat esoteric concept translates, in practice, into what has become a ubiquitous slogan for governmental programs, particularly for health. It is used as a backdrop in the media promotion of most official programs and serves as the link between the modernity of the MAS government's social and economic programs and the imagined indigenous precolonial past that is held up as an ideal for national identity. In this way, To Live Well may be seen as a contrasting model evoking the pre-MAS state—which was, in the official conceptualization, the colonial state—to emphasize the fact that the nation did *not* live well in the past.

STATE INSTITUTIONALIZATION

In March 2009, Bolivia took a step toward formalizing (or institutionalizing) the complementary discourses of interculturality and decolonization by creating the Vice Ministry of Interculturality and the Vice Ministry of Decolonization, both under the Ministry of Culture. For interculturality, the stated functions of the Vice Ministry are, among other activities, to "foment an intercultural dialogue between the various nations and indigenous peoples" and "promote interculturality as an instrument of development" (VMI, 2009). For decolonization, the functions of the office are to "coordinate the implementation of decolonization

programs and projects," "foment the participation of the indigenous original campesino nations and peoples, intercultural communities, and Afro-Bolivians in the public management of the Plurinational State," and "develop policies for the prevention and eradication of racism and cultural intolerance," all as part of "the struggle against intellectual, social and economic colonization, which continues to live on in some parts of the nation" (VMD, 2009). However, both offices are poorly funded and staffed and lack firm proposals for long-range implementation; as such, they remain relative theoretical showpieces.

THE (POSTCOLONIAL) TRANSFORMATION OF THE BOLIVIAN HEALTH CARE SYSTEM

HEALTH DEVELOPMENT STRATEGY

In late 2005, prior to the national elections that would bring Evo Morales to power, the MAS undertook a diagnostic study of the health situation in Bolivia. The results would later form part of the National Development Plan of 2006, in which the health sector is framed as a vestige of historical coloniality (MSD, 2006: 37):

> The state has a social debt concerning health with the Bolivian population accumulated since the colonial past [and] aggravated in the past 20 years by neoliberal health policies that have resulted in the privatization of the health sector, the mercantilization of services, and the establishment of an individualistic health culture. . . . The health system has not responded to the needs and demands of the Bolivian population; on the contrary, it has reproduced the inequalities and inequities of the economic structure.

The plan goes on to identify a number of prevalent structural problems: pathological and epidemiological differentials among the population, based in socioeconomic determinants related to poverty and unequal access to health services (for example, 77 percent of the population without practical access to services, 26.5 percent malnutrition in children under 5, and maternal mortality at 320 per 100,000 live births, the highest in South America); an inefficient health service that fails to take into account cultural and ethnic differences; poor management of the national health service network, with little or no cooperation between social sectors and dependence upon international financial aid that carries ties and conditions; and a lack of satisfaction with the services on the part of an unmotivated, alienated, and disempowered population (MPD, 2006: 37–38).

As a way out of this situation specifically directed at "the promotion and constitution of a space of organization and sociocommunitarian mobilization in order To Live Well," the plan proposes that the state guarantee equitable access to health services and active participation of the population in the process. This is to be achieved by (1) dismantling colonial structures and developing an intrinsically *sovereign* national health system that includes the incorporation of traditional medicine; and (2) eliminating the market-driven (neoliberal) economic apparatus, and replacing it with a communitarian and intercultural system based on social participation and coordination between social sectors. Five specific policies make up the overall strategy: a single

intercultural, communitarian health system; state proprietorship and sovereignty over the health system through the consolidation of financial, judicial, and human resources (while allowing the right to private health services); social mobilization; health promotion, to be implemented through coordination among social sectors; and solidarity, focusing on the causes and outcomes of extreme poverty, especially malnutrition and domestic violence (MPD, 2006: 40–42). These programmatic lines are echoed in the MSD's (2009b) Institutional Strategic Plan and complemented by strategies for disaster relief and climate change. The desired outcomes of both documents are a restoration of state responsibility for maintaining integral health and the quality of life and a revalorization of health as a priority of the population at large.

The process formulated in the ministerial planning documents would later be incorporated into the new constitution, in which the guaranteed universal provision of social services (health and education) receives priority. Several articles make specific reference to health and health services (República de Bolivia, 2008):

> The state . . . will protect the right to health, promoting public policy oriented toward improving the quality of life, the collective welfare, and free access to services by the population. (Article 35)
>
> The state has the undeniable obligation to guarantee and support the right to health. . . . Priority will be given to health promotion and disease prevention. (Article 37)
>
> The state will guarantee public and private health services; it will regulate and monitor the quality of attention by means of sustainable medical audits that evaluate personnel performance, infrastructure, and equipment. (Article 39)

In addition, other articles in the constitution address such issues as health insurance, medications, medical negligence, and traditional medicine.

As the key player, the MSD has been reconfigured into three vice ministries. The Vice Ministry of Health is primarily occupied with the core public health work of the MSD and the respective Servicios Departamentales de Salud (Departmental Health Services—SEDES), one for each of the nine departments, that implement policy at the regional level, including epidemiology and statistics, immunizations, nutrition (the most celebrated being the Desnutrición Cero [Zero Malnutrition] plan, with the objective of eradicating child malnutrition by 2015), infectious diseases, maternal, child, and reproductive health interventions, etc. The Vice Ministry of Traditional Medicine and Interculturality is of particular interest here and will be discussed below. The Vice Ministry of Sports, located in offices distant from the MSD buildings, is largely ignored in a programmatic sense by the central MSD administration and appears to be slated for reorganization into another ministry. All three vice ministries operate under the same guiding norms and principles.

COMMUNITY INTERCULTURAL FAMILY HEALTH

The cornerstone of the restructured health system is the Salud Familiar Comunitaria Intercultural (Community Intercultural Family Health—SAFCI) model. Under development and implementation since 2006 but not yet an actual law, SAFCI was formally adopted by Supreme Decree 29601, signed by

President Morales in 2008. This establishes it as the "official health policy of the MSD, with the objective of improving the health of the individual, the family, and the community." In theory, SAFCI should eventually be applied at all levels of the national health system—from the national (ministerial) to the departmental (SEDES), the regional (district), and the municipal and community. It is based on four guiding principles, approximately drawn from the National Development Plan: social participation, intersectoral cooperation (between education, housing, agriculture, justice, etc.), interculturality, and the idea that health is integral to all other aspects of family and community life. The ultimate objective is a Bolivia "mobilized for the right to health and life—To Live Well" (MSD, 2009c).

The historical precedents for SAFCI may be found principally in the Declaration of Alma-Ata on primary health care, promulgated by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in 1978. With a strong focus on the social determinants of disease and illness, the declaration holds that communities have a right to participate in the planning and implementation of their health care, that all social sectors should participate equally in the promotion of health, and that traditional medicine should be incorporated on an equal basis into biomedical systems (WHO, 1978). In other countries and at other times there have been similar experiments and experiences.[2] In Bolivia, nongovernmental organizations (NGOs) have periodically attempted to implement primary health care systems, with limited success. What Bolivia has done since 2006, however, is to re-create and reinterpret primary health care and other previous community-participation models, with two additional considerations: interculturality, in both its theoretical and applied forms, and the defining element of political will. The first of these considerations gives the Bolivian model its programmatic uniqueness, as primary health care is (re)imagined through the intercultural lens, Bolivian-style; the second largely determines the outcome of the experiment. However, one of the main hindrances to smoother implementation of the SAFCI model (aside from political differences, as discussed below) is the continued lack of a clear theoretical and operational understanding of it at most levels of the health system, especially at the regional and community levels.

SAFCI, implemented through strategic alliances between communities, social organizations, and institutional actors (local governments, health services), social mobilization, and shared communication and education, has two foci—participatory management and medical attention. Participatory management[3] involves community- and municipal-based organizational structures. At base level, organically chosen and elected Local Health Authorities (one per community) act as advocates for local health needs, rotating annually; groups of these representatives together make up Local Health Committees, directly affiliated with particular health posts or clinics. The committees are charged, together with local district health personnel, with the planning, execution, administration, monitoring, and evaluation of all health-related activities in the community or barrio. As an echo of the traditional Bolivian union system of elected *dirigentes,* in theory they have a significant degree of decision-making power and control over the local government health services, including budget and performance evaluations. In practice, as of late 2009

the great majority of communities and municipalities had yet to form local authorities or committees, and only a relative scattering of municipalities had progressed to the next level, that of the Municipal Social Health Council; the succeeding two levels—Departmental Social Health Councils and the National Social Health Council—remained largely unrealized. (The relative exceptions are in Potosí and Tarija, where the departmental councils have recently been put on paper but are still largely nonfunctional.)

The second SAFCI focus, medical attention, involves the actual health services, and both interculturality and decolonization are key in this regard: the reforms are directly related to the perceived necessity of a change in outlook and behavior on the part of medical personnel and the quality of attention provided. Rudeness and disrespect for clients and misunderstanding and rejection by physicians of traditional medicine and the cultural beliefs of the population have long been identified as the most frequent obstacles to a fluid physician-patient dialogue (see, e.g., Crandon-Malamud, 1991; Arnold and Yapita et al., 2002; Dibbits and de Boer, 2002). SAFCI calls for recognition of the strengths and limitations of both biomedicine and traditional medicine as part of an "exchange of knowledge and practices . . . between two medical cultures . . . in order to achieve articulation and complementarity between these actors, equally sharing the solution of problems and ensuring quality attention" (MSD, 2007: 39). This requires a significant ideological shift on the part of those with deeply ingrained beliefs and prejudices on both sides of the medical divide; to this end, the MSD proposes a sort of "cultural-sensitivity" workshop approach, which has yet to produce tangible results. The consensus, even within the MSD, is that the medical-attention aspect of SAFCI is a slow starter and calls for more concerted efforts (Juan Carlos Delgadillo [MSD], interview, La Paz, November 5, 2009).

Two central SAFCI programs have been established to "reorient" physicians and change attitudes within the medical establishment. The first is the formation of mobile teams (Equipos Móviles SAFCI) made up of a physician, a nurse auxiliary, a dentist, a sociologist or social worker, and a driver, each team based permanently in a municipality and rotating among its rural health posts. In many ways, these teams are improved versions (with a community empowerment component added) of an earlier MSD experiment, the Extensa BRISAS health brigades, which would spend a few days in a given municipality and report directly and competitively to a somewhat parallel MSD structure financed by the World Bank. These brigades did not, however, include a sociologist or social worker. In the mobile team structure, this person functions as an (intercultural) broker between the medical personnel and the community, including any local traditional medicine providers, assists in local organizing (for example, with the Local Health Committees), and conducts relevant applied research. Fifty-two mobile teams were working throughout the country by late 2009, predominantly in the highlands. Since these are the areas generally more sympathetic to the MAS, however, this concentration adds the element of political difference, identified as one of the limitations to achieving more comprehensive coverage.

The other key program is a specialized medical residency (Residencia Médica SAFCI), which in 2009 had 220 residents either in training or in the field. This involves a three-year commitment to work in a rural health post

under the supervision of a regional second-level hospital; in addition to the clinical medical curriculum imparted (with a focus on family and community health and primary health care), it involves training in ethnographic techniques (qualitative interviews, participant observation), the history and cultures of indigenous peoples, the precepts of traditional medicine, the keeping of detailed family health histories, and the active organization of community participatory-management structures.[4] Along with an affiliated postgraduate certificate program in intercultural health at the central state university in La Paz, this program aims at changing the outlook and behavior of the "typical" Bolivian physician.[5]

SOCIAL AND "SOCIALIZED" MEDICINE

A central current running throughout the MSD and one to which the SAFCI model is related is that of "socialized" medicine. An explicit goal of the first minister of health under the MAS, Nila Heredia, was to create a state-run single-payer health service guaranteeing attention free of charge to the entire population. While she did not achieve this during her tenure in office, she did lay the foundation for it. As a complement to the previously existing programs of universal maternal and infant health insurance, which provides free care to all women beginning with their pregnancy and covers both mother and child until the latter is 5 years old, and universal coverage for those over age 65 (both of these programs dating to the Gonzalo Sánchez de Lozada administrations, 1993–1997 and 2002–2003), the MAS government has initiated an insurance program that proposes to cover all citizens up to age 25 for essentials and a wide range of elective care. Gas revenues will supposedly support eventual complete universal coverage of the entire population, but they have not yet proved sufficient to do so.

An additional key component of a more comprehensive system, aimed at salaried workers, is the planned merging of the various and competing institutional health insurance programs, known as *cajas,* to which a beneficiary belongs through employment and for which a percentage is deducted from the monthly paycheck, into a single super-*caja* that would include everyone who is formally employed (approximately 30 percent of the labor force). The not-so-veiled intention, however, seems to be to phase out the caja system entirely once the hypothetical universal health care system is in place. At any rate, all attempts to date have been stalled by considerable opposition from the unions representing both insurers and affiliated physicians, who fear a loss of revenue and institutional autonomy, if not a significant degree of control.

Other related programs offer monetary bonuses (*bonos*) to select populations. In 2009 the government established the Bono Juana Azurduy de Padilla, which pays women directly for prenatal checkups during pregnancy, delivery in a state medical facility, and infant medical checkups until age 2. If a woman completes the entire schedule, she can receive up to approximately US$261. The US$25 million cost of this bonus for the first few years comes from gas revenues and a credit from the World Bank; however, because of the declining income from gas sales and higher than expected enrollment among pregnant

women, there have been doubts about the ultimate solvency of the program. Although there may be some justification for the bonus in terms of the promotion of maternal and child health and the program has achieved international recognition,[6] it has predictably been sharply criticized as blatant populism by the political opposition, especially during the electoral year of 2009. (Also under opposition scrutiny are other high-profile actions such as the donation of 719 ambulances as part of Spanish and Venezuelan cooperation to all 327 municipalities throughout the country—nearly 600 of which, however, have yet to be delivered.) The bonus has also received not-so-predictable criticism from some progressive health care and development workers, who see it as a step backward toward mercantilism and dependency from long-standing efforts by social movements and progressive NGOs to raise awareness and empower women with regard to health knowledge and health-seeking behavior (Alicia Aliaga [MSD], interview, La Paz, October 15, 2009).

Integral to the implementation of the health care system's goals of universal free coverage is the participation—in "socialist solidarity"—of volunteer Cuban medical personnel. By mid-2009, an estimated 900 physicians and 800 paramedics were working in 243 of the country's 327 municipalities (MSD, 2008). Usually placed for two-year rotations in remote regions or crowded barrios, with their nominal salaries paid by the Venezuelan government, they have earned predictable ire from their local counterparts. Ostensibly based in complaints from the Bolivian College of Physicians about allegedly uncertified and unqualified Cuban personnel and periodic flare-ups of politically interested accusations of Cuban and Venezuelan "involvement in Bolivian internal affairs" and even "espionage," this opposition has much more to do with simple professional competition: the Cubans provide medical attention free of charge, and unemployment remains high among Bolivian physicians.[7] In general, however, the volunteer doctors have earned themselves an overall positive reputation among the general population, based in large part on the success of Operación Milagro (Operation Miracle), the provision of free operations for cataract blindness, which by early 2009 had reportedly restored functional vision to approximately 319,000 persons (MSD, 2009a). In addition, the Cuban cooperation donates medical supplies, finances hospital and health post construction (nationally, 42 second-level hospitals), and provides scholarships for low-income (primarily indigenous) Bolivians to study medicine in Cuba.

TRADITIONAL MEDICINE

Institutionally, the most prominent innovation has been the Vice Ministry of Traditional Medicine and Interculturality, whose theoretical and practical objectives are enshrined in the new constitution: "It is the responsibility of the state to promote and guarantee the respect, use, investigation, and practice of traditional medicine" (Article 42). The Vice Ministry is charged with the promotion of traditional medicine, which is seen as emblematic of a historical and sovereign medical system, and its active incorporation into a sanitary structure complementary with biomedicine; the establishment of academic programs for its study and promotion; its regulation, certification, and accreditation, based on appropriate use and proven knowledge of beneficial practices; and its

protection as a cultural resource and heritage codified in law (MSD, 2006: 6–7). Internal coordination problems, inadequate funding, and frequent turnover of (limited) personnel have, however, made tangible programs and concrete results few and weakened the Vice Ministry's advocacy power.

However, the emphasis in the MSD on the importance of recognizing and incorporating traditional medicine on equal terms is an integral aspect of the SAFCI model and therefore is present (at least theoretically) in most programs. The most frequently stated concrete means for achieving the fusion of traditional medicine and biomedicine involves the use of local medicinal plants, including their pharmaceutical industrialization and commercialization; the promotion of nutritious indigenous crops that have fallen out of widespread popular consumption (e.g., grains such as quinoa and amaranth); mutual referrals between physicians and traditional medicine providers (*curanderos,* or healers, and traditional midwives), as appropriate; and the incorporation of traditional practices into common biomedical interventions (for example, nongynecological positions during labor and birth and the "calling of souls" prior to direct medical intervention) (MSD, 2006: 9–11).

The most notable practical experiences to date regarding this articulation have been in regional (SEDES-based) programs rather than nationwide: in Oruro, for example, a participatory planning program symbolically based upon the ancient Andean *chakana* symbol; and in Potosí both a postgraduate degree in intercultural health and a certification program for traditional healers through the central hospital.[8] It is also at the regional SEDES level that the most tangible progress in regulating and accrediting traditional medicine providers is seen, in lieu of more concerted and concrete efforts by the Vice Ministry. Local validation programs have been established to set standards: the Potosí, Chuquisaca, and Tarija SEDES have shown the most notable results. Tarija, for example, requires that all traditional providers who wish to be officially accredited comply with specific requirements—proven years of experience, recognition by the community, written authorization by local authorities, etc. (*El Nacional,* September 4, 2009).

CHALLENGES, CONTRADICTIONS, AND PARADOXES

INSTITUTIONAL OPPOSITION

Official efforts to achieve the proposed decolonization of the Bolivian health field are still "in process." Despite the discourse and emphasis on interculturality and decolonization from external and internal power structures, biomedicine continues to maintain an indisputable dominance in the practical operation of the state health system, relegating traditional medicine to its historical minimized status. A few professional institutions—for example, the national College of Physicians and the Oruro Nurses' College—have openly condemned the SAFCI model as threatening undue control over their activities, presumably from community and barrio representatives. Thus, it is still very much a question of power (or the *lack* of power) in the respective sociopolitical and cultural context. These confrontational attitudes are somewhat

mitigated by assertions (e.g., by the College of Physicians) of, for example, openness to working with traditional-medicine practioners, but the actual appropriation and commitment is minimal. It may thus be seen by many establishment physicians and nurses as something of a one-way street; for indigenous community healers to cross the line and learn some basic biomedical applications is generally perceived as acceptable and nonthreatening and, indeed, to be encouraged. However, few physicians have recognized and accepted traditional health workers as equals in an alternative and complementary medical system (although among some of the SAFCI medical residents there is evidence of moderate success in this regard). This is a fundamental divide that often manifests itself as rejection of and opposition to all related official health policies on the grounds that they threaten the integrity of the biomedical profession.

POLITICAL OPPOSITION, DOMESTIC AND INTERNATIONAL

More overt and clear-cut opposition comes from the political rivals of the MAS, particularly in the Media Luna departments of Santa Cruz, Tarija, and Beni. In these areas the departmental governors, both subtly and overtly, discourage any cooperation with SAFCI policy not on public health grounds but because it is perceived as "MAS politics." In the extreme case of Santa Cruz, in the SEDES there is open rejection of SAFCI and an unofficial order not to cooperate with the SAFCI residents or mobile teams working in the department. The SAFCI workers do not, unfortunately, help their own case much by maintaining a nearly parallel organizational structure: receiving their paychecks directly from the MSD in La Paz rather than from the SEDES and local health districts and reporting their statistical data only to La Paz. The discouraging fact is that, because fewer physicians from the lowlands apply for the residency, those eventually assigned to these regions are very frequently from the highlands and have greater personal trouble becoming integrated into the local communities—indeed, there is the possibility that in composition and training the residency is overly "highlands-centric." In the case of the southern department of Tarija, however, the opposition has been more adaptable: SAFCI is tenuously in place, but its various components have been given different names—"Local Health Caretakers," for example, instead of "Authorities"—as if to deny any ultimate authority of the "MAS institutions." Similarly, in many parts of other eastern departments, in rural health districts where the model (specifically, the participatory management component) is recognized as potentially positive for community planning and health center functioning, the essentials are cautiously implemented provided that the name "SAFCI" is not used and no political sensibilities are offended.

Although a number of international cooperation agencies (most prominently the WHO and those of France, Japan, and Spain) assist and frequently fund parts of the differing MSD and SAFCI components, the United States Agency for International Development (USAID) was initially another source of politically oriented opposition. The United States had been for decades a major financer of the Bolivian health services, annually supplying it with financial assistance and supplies ranging from vaccines to paper and pencils.

In early 2006, however, in the name of national sovereignty, the new MAS government requested the closure of the USAID-operated Proyecto de Salud Integral (Integral Health Project), which since 2000 had achieved virtual decision-making power at the national level. With the subsequent loss of active political influence on health policy, USAID's relations with the MSD slid downhill into unilateral planning and less-than-subtle resistance to the new health model and programs. In early 2007 USAID ordered a pull-out of all its directly financed and administered health projects in the highland (predominantly MAS) departments and a relocation to the lowland (predominantly opposition) departments, strongly discouraged any involvement with MAS-controlled municipalities, and prohibited any contact, let alone coordination, with "foreign personnel" (i.e., Cuban physicians). In addition, rival programs were established, among them a postgraduate degree for physicians called the "Family and Community Health Master's Degree," paid for with USAID scholarships and coordinated with the national College of Physicians. This was transparently a political attempt at competition with the SAFCI residency, and virtually all of the scholarship recipients were located in the lowland departments; originally planned as a two-year program, it was abruptly closed down after only a year because of pressure from the MSD.

From 2007 into 2008, USAID maintained a somewhat sullen silence and studied ignorance of the new health structures that were gradually being implemented. Once the SAFCI Supreme Decree was signed, however, making the model unavoidable—a development that occurred, coincidently, at the same time that Washington–La Paz relations were progressing from bad to worse, resulting in the Bolivian government's forced closure of politically questioned U.S. programs in general (USAID coca-related alternative development, Drug Enforcement Agency presence, the "democracy initiative") and the expulsion of then-Ambassador Philip Goldberg—it became apparent to a suddenly more enlightened USAID that to avoid being thrown out of Bolivia entirely it would be best to coordinate whenever possible. The result was increased financing for programs supporting MSD goals and a sudden and semienthusiastic jump onto the SAFCI bandwagon, involving active encouragement of the incorporation of local health-management norms into USAID-financed projects and smoother relations with the MSD at the technical (if not always political) level.

BUREAUCRACY AND RIVALRIES

The new MSD policies in general have also suffered from bureaucracy and internal politics. The most visible consequences of this are the frequent turnover of key personnel. The first MAS minister of health, Nila Heredia, the architect of many of its programs and reforms and for the most part highly respected and praised, was nevertheless forced to resign for somewhat murky reasons, apparently to mollify the political opposition by placing more *cambas* (citizens from the eastern lowland departments) in high-level positions (Jorge Jemio [Federación de Asociaciones Municipales], interview, La Paz, November 6, 2009).[9] The initial replacement for Heredia lasted only a few months, however, and left because of a lack of political support and personal initiative; the

succeeding minister, Ramiro Tapia, held on for considerably longer, throughout 2009. Other central positions have also seen constant changes, generally due to internal political favoritism, which have seriously affected institutional continuity and clarity: for example, there have been three vice ministers of health, six directors of health promotion, three directors of epidemiology, and four chiefs of community health and social mobilization.

The most debilitating situation, however, has been at the Vice Ministry of Traditional Medicine and Interculturality. Following the untimely death of Jaime Zalles, the first vice minister and a renowned ethnobotanist, after only a year and a half in office, the succeeding vice minister was soon dismissed for incompetence (and alcoholism). His replacement was also forced to resign because of legal questions concerning embezzlement and false identity. In addition, the process of appointing functionaries has proved mysterious: supposedly, all of them were established traditional medicine practitioners, but all except Zalles were judged illegitimate (in terms of experience and practice) by the very organizations (e.g., the Bolivian Society for Traditional Medicine) that represented them. Thus, the appointments seemed to owe more to old-style partisan politics.[10] The unfortunate result has been a nearly moribund Vice Ministry, with a reduced staff, few results to show, and no clear functional ties to obvious allies in the Vice Ministries of Interculturality and of Decolonization; there are even rumors that a complete shutdown may be at hand—an ironic outcome, if so, for what is supposedly one of the showpieces of the intercultural and decolonized MSD.

INTERNAL CONTRADICTIONS

Aside from these difficulties and challenges, other contradictions in the implementation of programs persist. Among them is the enduring centralization of the MSD in La Paz and of the departmental SEDES, while the new health model calls for a significant shift to the municipal and local levels. How this apparent inconsistency will play out—for example, how much real control the Local Health Committees will have, especially when confronted by entrenched and possibly uncooperative local health post bureaucracies—remains to be seen. Another question is a practical one: both communities and municipalities need concerted technical assistance in implementing the SAFCI model—electing authorities, forming committees, accepting respective responsibilities, etc.—and simply understanding how SAFCI is supposed to work and how it should fit into municipal program and budgetary planning. Yet many state and regional governments have neither the finances nor the personnel to operate at these levels, and some are simply uninterested in or opposed for political reasons to doing so. The end result is that the responsibility falls on the various NGOs operating in Bolivia, if they are so inclined. It is thus paradoxical that the Bolivian state, in its desire to "de-neoliberalize" and decolonize, finds itself relying on internationally based institutions or those with international financing, many of which have played leading roles in the neoliberal history of international development,[11] to implement one of its leading decolonization policies.

The possible contradictions between the socialized and the intercultural health models are more profound. It is here that the potential divergences

between "cultural" and "political" interests become most apparent. At one extreme and pushing for greater influence within the MSD is a minority "culturalist" (predominantly Aymara) faction of the MAS that adheres to a hardline, quasi-autarkical view advocating the supremacy of precolonial indigenous practices and political structures, including health care, and the exclusion of *q'ara* (white, European-descent) individuals and precepts from political power (MSD official, interview, La Paz, October 12, 2009). At the other extreme is the establishment of a purely "socialist" medical system, exemplified by the Cuban volunteers and influence. Thus, and while taking into account the continuum between these positions, there would ultimately appear to be an internal ideological contradiction and practical conflict brewing that may or may not pose a danger to the intercultural model itself. This has to do with the nature of the interculturality paradigm partnered with cost-free and widespread medical attention. In many respects, the MSD seems to be moving toward the gradual adoption of the socialist health model on the basis of both public health concerns and political affinity.[12] Yet, the Cuban model is hardly intercultural; it is a thoroughly biomedical, physician-based, vertical structure, albeit with popular participation. This, combined with the latent distaste for an intercultural system among much of the Bolivian biomedical establishment, could very well doom the intercultural component. In the face of an entrenched medical system, decolonized or not, interculturality could slowly and inexorably become institutionalized, controlled, and defanged, a mere discourse accepted on the terms of those (the physicians) with the most to lose and the most to gain with regard to power and influence.

Another perspective is offered by dissenting yet would-be ally voices exemplified by the Bolivian historian Carmen Loza (2008), who go so far as to question the legitimacy of the intercultural paradigm itself: Loza views it as an imported, stealth concept designed only to provide biomedicine a kinder, gentler façade. The ultimate objective, she argues, is to lure people into the state services and into biomedical hegemony. The SAFCI model is thus designed with this intention; its structure is vertical, and the traditional medicine practitioners will always be at the bottom, mere assistants to the physicians who claim to respect other forms of curing but will never relinquish their privileged positions. Former minister Heredia—both an ardent socialist and with strong intercultural leanings—recognizes this danger. Traditional medicine practitioners must, she says, be incorporated into the state system, but they also need to feel safe, certain that they will not be mistreated or have their materials or techniques appropriated or stolen and that they will be recognized, respected, and treated as equals (interview, La Paz, September 9, 2009).

For Bolivia today, then, the *intercultural* state is key to the concept of the *decolonized* state and vice versa. "Intercultural health" requires the recognition, acceptance, and articulation of both health models, the biomedical and the ethnomedical. According to the official rationale of interculturality, neither model is superior to the other; they have equal status, albeit relative: many illnesses (e.g., cancer, AIDS) are deemed appropriate for the "scientific" doctor at the health post or hospital and others (e.g., soul loss) are not. Both the biomedical and the ethnomedical provider (the latter looking more toward the social and community body to diagnose illness) must recognize their

limitations.[13] Although this ideal has yet to be fully achieved, these converging realities are a crucial part of the official intercultural experiment, haltingly applied in Bolivia today, and they will be even more prominent in the near future if the official state policies are maintained—and there is indisputable evidence that they will be, with inevitable tinkering and refining, following the decisive MAS reelection victory in December 2009. For example, in the still uncharted territory of the new autonomies gradually being implemented in Bolivia, including indigenous autonomy, in which the traditional community will theoretically hold equal political status and power with the decentralized civil government, interculturality will become the undisputed institutional norm in all aspects of society, including health and health services, as the "indigenous original campesino peoples" steadily decolonize themselves from the historical Bolivian nation-state.

DECOLONIZATION FROM WITHOUT AND FROM WITHIN

In August 2009, two similar events were held in La Paz: the First National Forum for the Health of the Peoples and Nations of Bolivia and the National Conference on Municipal Health Management. Both events brought together delegates from across the country, approximately 200 persons at each, the majority indigenous, along with representatives of the MSD and other state offices, the WHO, human rights groups, and social organizations. At both there were speeches, panel presentations, group discussions, and the sharing of experiences on such topics as intercultural health, the social determinants of disease, community participation, and municipal and community control and administration of health services. At their respective conclusions, their redacted declarations were similar, calling for a national health policy based on social determinants and on health promotion, universal free health care, popular control over the health system, and intercultural health promotion. The high-level MSD officials participating in both events pledged to analyze and integrate these conclusions, at least in part, into official public policy. Again, the question of political will is crucial here—the official will to support change and to accept the active participation and decision-making power of the community and the barrio.

There are many interests at stake in the push to implement an intercultural, decolonized health model in Bolivia. Significant changes are occurring with the encouragement and the participation of the state, and the process appears to be irreversible in many respects. Yet, questions persist for the health field and others. Many within the state apparatus, for personal, ideological, or political (power) reasons, subtly reject the intercultural focus and any talk or actions of decolonization: these voices alone may slow the proposed process, for "there can be no discourse about decolonization, no theory of decolonization, without decolonization in practice" (Rivera Cusicanqui, 2006: 7). Indeed, structural innovations such as SAFCI are likely to prove impossible to successfully implement as envisioned without dramatic shifts in the still racialized and "colonized" social context of Bolivia. Ultimately, it remains for the MAS government to demonstrate that, despite the challenges, inconsistencies, and

paradoxes, its concept of decolonization goes beyond politics and discourse to constitute a viable option for change.

NOTES

1. The most prominent representative of this current is the monthly newspaper *Pukara.* Often featuring articles with decolonization themes, the editors typically denounce the MAS as a sellout if not a traitor to the cause of true indigenous liberation and as having betrayed its historical and cultural origins through the veiled continuation of neoliberal policies and programs.

2. In Latin America, Cuba, Nicaragua, Ecuador, Brazil, and Venezuela. The recent (since 2002) Venezuelan Misión Barrio Adentro program was to a certain degree adopted by Bolivia as a framework, with the addition of the interculturality component (see De Vos et al., 2007).

3. Participatory management is specified in the new constitution: "The state will guarantee the organized participation of the population in decision-making and in the administration of the entire public health system" (Article 40) (República de Bolīvia, 2008).

4. Financial difficulties have, however, often hampered personal commitment and professional implementation of the residency program. At one point in 2009, after not having received salaries for six months, residents were on the verge of striking until they received an input of French development assistance.

5. An additional and fundamental objective of the MSD is to revamp the basic curriculum of the national medical schools, but resistance from entrenched faculty members has proved daunting.

6. By the Organization of American States and the United Nations–affiliated International Center for the Training of Authorities and Leaders.

7. At one point in 2006, the College of Physicians went on an extended strike in protest of the Cubans' presence in the country, demanding their immediate suspension and expulsion. There was, however, no official reaction whatsoever, and the Cubans stayed at their posts, while the Bolivians soon quietly and unceremoniously ended their actions, if not their objections, and returned to work.

8. The Potosí programs may be seen as an early, limited, semiofficial effort to "standardize" and accredit ethnomedical interventions in order to regulate traditional medicine providers (see Campos Navarro, 2004), but questions remain concerning their impact and efficacy, both practically and ideologically. For example, some traditional medicine providers who had previously worked alongside physicians found themselves relegated to the hospital's janitorial staff following program termination; also a reflection of poor sustainability issues, once Italian financing was discontinued. The Oruro program, however, is still functioning. Its premise (directly correlated with the "To Live Well" paradigm) is a methodological fusion of revitalized Andean cultural and communitarian visions with development models predominant in the individualistically oriented Westernized context. The *chakana* cross figure (from the pre-Incaic Tiawanaku culture) is used as a model on the basis of its symbolic and mythological representation in Andean cosmology of parallel and ordered dualities (heaven/earth; masculine/feminine) and its four dimensions, which may be interpreted for present purposes as energy/spirituality, political organization, economic production, and art/technology (see UNDP, 2007; UNICEF, 2007).

9. Other (albeit unsubstantiated) reasons often cited for Heredia's dismissal include pressure from the militant and powerful civic groups in El Alto, who accused her of not being radical enough (e.g., for not severing ties with suspect foreign aid providers such as USAID), and suspicions that she was simply too ethical for the job, opposing the MSD's ties to tax revenues from the local Bingo Bahiti casino chain as being "Mafia-tainted"—thus, Heredia was sacked due to Bingo Bahiti political influence.

10. Zalles himself was, however, questioned by the stricter "culturalist" factions not for professional reasons but because of his nonindigenous roots, Western education, and Catholic seminarian background.

11. For example, with regard to the health field: the Declaration of Alma-Ata, although signed by all UN members, was implemented by only a few. Once its potentially "subversive" nature (i.e., community empowerment) was fully understood, ostensibly similar alternative strategies

such as "Child Survival" programs were adopted. Instead of taking a wide-ranging, holistic approach to health as did the declaration, incorporating social determinants and recognizing local social, cultural, political and economic contexts, these models focused on specific health issues in "safe" isolation and primarily in terms of technological solutions (see Werner, 1997).

12. However, there are also pockets of subtle resistance to the *Cubans* in the Cuban model. As one MSD official in La Paz told me, although the MAS physicians in government are generally pro–Cuban (and pro–Chávez Bolivarian) Revolution, they are not all pro–Cuban-doctors-in-Bolivia. This is unrelated to the more common issues of professional jealousy over work availability, earnings, or popular sentiment: rather, in this instance, it has to do with the way the Bolivian officials perceive the recent Venezuelan experience with Cuban public health influence, primarily with Misión Barrio Adentro. There, in this perception, the Cubans were absorbed so thoroughly into the Venezuelan system that they shaped it to their own style, rhythm, and norms— that is, to their own medical culture. In the end, the Venezuelans grew to depend exceedingly upon the Cubans and their expertise, and their own local cultural sanitary history was lost. "We want a *Bolivian* revolution," said the official in La Paz (interview, La Paz, May 15, 2007).

13. For discussion and analysis of the possible convergences, coordination, and fusion between biomedical and ethnomedical systems in the Bolivian context, see, for example, Crandon-Malamud (1991), Bastien (1992). Castellón Quiroga (1997), Fernández Juárez (1999), Bradby and Murphy-Lawless (2002), TARI (2003), and Fernández Juárez (2004; 2006).

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