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Title: Personal and Political Histories in the Designing of Health Reform Policy in Bolivia

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Abstract

While health policies are a major focus in disciplines such as public health and public policy, there is a dearth of work on the histories, social contexts, and personalities behind the development of these policies. This article takes an anthropological approach to the study of a health policy's origins, based on ethnographic research conducted in Bolivia between 2010-2012. Bolivia began a process of health care reform in 2006, following the election of Evo Morales Ayma, the country's first indigenous president, and leader of the Movement Toward

Socialism (*Movimiento al Socialism*). Brought into power through the momentum of indigenous social movements, the MAS government platform addressed racism, colonialism, and human rights in a number of major reforms, with a focus on cultural identity and indigeneity. One of the MAS's projects was the design of a new national health policy in 2008 called The Family Community Intercultural Health Policy (*Salud Familiar Comunitaria Intercultural*). This policy aimed to address major health inequities through primary care in a country that is over 60% indigenous. Methods used were interviews with Bolivian policymakers and other stakeholders, participant observation at health policy conferences and in rural community health programs that served as models for aspects of the policy, and document analysis to identify core premises and ideological areas. I argue that health policies are historical both in their relationship to national contexts and events on a timeline, but also because of the ways they intertwine with participants' personal histories, theoretical frameworks, and reflections on national historical events. By studying the Bolivian policymaking process, and particularly those who helped design the policy, it is possible to understand how and why particular progressive ideas were able to translate into policy. More broadly, this work also suggests how a uniquely anthropological approach to the study of health policy can contribute to other disciplines that focus on policy analysis and policy processes.

Keywords: health policy, policymaking, history, health reform, social change, narrative, Indigenous Movements, Bolivia

Introduction: On The Histories of Health Policies

Health policy has been studied in fields from political science to public health to anthropology, yet there is a dearth of work on the histories behind the design and formation of these policies (Grundy et al. 2014; Walt et al. 2008; Greenhalgh 2008). In their July 2014 article in *Social Science & Medicine*, Grundy et al. (2014) suggested the need for more attention to the evolution of health policies. The authors aimed to bring discussions of history and sociopolitical circumstances into the analysis of policy development, suggesting, “The historicism of policy formation (policy turning points) demonstrates that policies do not operate in a vacuum but in contrast originate from past time and are contextualized in place” (Grundy et al. 2014: 151). They argue, “Rather than viewing health systems simply as technical constructs engineered by technical planners and decision makers, health systems can also be viewed as dynamic social constructs shaped by the control parameters of changing political and social conditions” (Grundy et al. 2014: 151). In this article, I expand the ways histories of health policies are studied through an ethnographic approach, with specific attention to the intersections of personal and political histories in a policymaking process. In Bolivia, a number of progressive political and social reforms emerged following the election of Evo Morales Ayma, the country’s first indigenous president and leader of the Movement Toward Socialism (*Movimiento al Socialismo* or MAS). Morales rose to power through the momentum of indigenous social movements following years of neoliberal rule. The stated platform of the MAS emphasized decolonization and human rights, with a focus on cultural identity and indigeneity in a country that is over sixty percent indigenous. I examine the origins of a single national health reform policy developed at this time, The Family Community Intercultural Health Policy (*Salud Familiar Comunitaria Intercultural*, or SAFCI), which emerged out of and as a reaction to complex political and social circumstances

85 in the country. SAFCI is a progressive, participatory model of health care provision and
86 management that incorporates indigenous models of health into its premises. This policy is
87 unique within a global trend towards neoliberal and market-based models of care. One of the key
88 questions I seek to answer, then, is how and why did it emerge in this manner? An ethnographic
89 approach can enrich an understanding of how policies such as SAFCI are formed in particular
90 historical milieus and provide greater insights into how those involved in policy processes shape
91 ideas embedded within policies based on personal experiences and theoretical frameworks.

92 Policies are intrinsic to many of the institutions that anthropologists study, though they
93 have not always been the central objects of the discipline's work (Belshaw 1976). However, a
94 recent theoretical body of work in the anthropology of policy takes an "interpretive approach"
95 where anthropologists seek to understand the meaning of policy to those involved, asking
96 questions such as "How do people engage with policy and what do *they* make of it?" (Shore,
97 Wright and Peró 2011: 8). Following this interpretative approach, interventions by sociocultural
98 anthropologists have critically examined the interactions within which policy is "made," policy's
99 different meanings in different contexts, how people relate to policy, and the complexity and
100 ambiguity of policy processes (Wedel et al. 2005; Shore and Wright 1997; Shore, Wright and
101 Peró 2011; Horton and Lamphere 2006; Greenhalgh 2008; Nichter 2008). Unique to this
102 approach is that anthropologists question objects that are often "taken-for-granted." In the study
103 of policy, this means questioning assumptions about "what constitutes a policy" (Wedel et al.
104 2005; Shore and Wright 1997: 5). In the literature, anthropologists do not allow for a single,
105 fixed, or official definition of policy, rather asking questions such as "What do people do in the
106 name of policy?" with the understanding that the concept of policy itself is full of multiple
107 meanings depending on where it resides or who is speaking of it (Wedel et al. 2005: 35).

“Policymakers” in this approach are “mediators” in policy processes, and therefore are not only embedded in formal bureaucratic roles, but are also stakeholders, participants, resisters, and silenced actors (Wedel et al. 2005). As such, Wedel et al. (2005) suggest, “An anthropological approach attempts to uncover the constellation of actors, activities, and influences that shape policy decisions and their implementation, effects, and how they play out” (39). I use this theoretical framing to explore what people do in the name of designing policy and change in a health care system, particularly within the larger context of a national paradigm shift in political ideology.

As part of this work, some anthropologists critique the idea that policies exist as finished texts that can be implemented through processes viewed as rational and linear (Shore, Wright, and Peró 2011). They call for studies of policy that attend to the “making, working, and effects of public policy as problems of modern governance” (Greenhalgh 2008: xiii). In following this approach, I study narratives of the creators and mediators of policy, and the unfolding of a policy process. To do so, I examine both the national histories implicated in the formation of a health policy, and the personal and social histories of producers of political knowledge. The anthropological concept of “studying through” is useful here, as it is the idea of following the origins of a policy to those impacted by policies, including the “relations between actors, institutions and discourses across time and space” (Shore and Wright 1997: 14; Wright and Reinhold 2011). I suggest that a study of a health policy’s complex and multiple histories demonstrates ways policies are populated with voices, experiences, memories, personalities, and future projections, even when these are made invisible in legal forms of policy. In this conceptualization, policymaking comprises a key component of what Shore, Wright, and Peró (2011) refer to as “policy worlds,” or the idea that “policies belong to- and are embedded within-

particular social and cultural worlds or ‘domains of meaning’” (1). Studying these domains of meaning, and those who produce them, illuminates the emergence of a policy’s content. By examining the Bolivian policymaking process and those who helped design the policy, it is possible to understand how and why particular progressive ideas were able to translate into policy. More broadly, this work also suggests how a uniquely anthropological approach to the study of health policy can contribute to other disciplines that focus on policy analysis and policy processes.

Methodology

This article is the result of fifteen months of ethnographic fieldwork in Bolivia conducted between 2010-2012. Research activities were approved by the Human Subjects Review Board of the University of California, Berkeley. Participants provided oral consent and were given pseudonyms to protect anonymity, except for well-known public figures. Research methods consisted of interviews, participant observation, and document analysis. I was based in La Paz, the seat of the Bolivian government, but also conducted fieldwork to meet stakeholders and observe policy processes and health programs in rural areas of the Department of La Paz, the Department of Potosí in the highlands, and the Department of Beni in the Amazon. Data used in this article is drawn from interviews with eleven members of the policymaking team, ten stakeholders from domestic and international NGOs that assisted in the policy process or worked in communities that served as models for the policy, four traditional healers from a civic organization in a community that was used as a model, and four urban doctors from a hospital in La Paz. I personally conducted all interviews in Spanish, asking about the history of the

153 policymaking process, the person's contributions, challenges, policy content, and
154 implementation. Two Bolivian research assistants transcribed all interviews.

155 I did participant observation at nine health policy events to observe community
156 participation, and in four communities and their community clinics that were used as models for
157 aspects of SAFCI. These observations helped me understand how policymaker discussions of
158 these models reflected what was happening on the ground, and to see how policy was
159 implemented in places that were central in the development of SAFCI. I assessed policy
160 documents to examine the language of SAFCI's premises. My data originates from descriptions
161 of sites, events, and interviews, all of which informed my understanding of the political
162 movement and stakeholders involved. While this article focuses heavily on voices from the
163 policy team, future work on this particular health policy will address other stakeholders more
164 directly. I conducted all data analysis myself, using grounded theory analysis of fieldnotes and
165 interview transcriptions (Strauss and Corbin 1998). I translated the interviews quoted, with
166 consultation from native speakers and a professional translator. I identified themes and assessed
167 commonalities across interviews, writing memos to document the content of themes. This
168 research comprised a part of my larger dissertation project for a PhD in Medical Anthropology
169 on the design and circulation of health reform policy in Bolivia.

171 **Health Care Reform in Bolivia and the SAFCI Policy**

172 Bolivia's health care reform and the SAFCI policy emerged as part of a broader
173 movement of social and political change, and as a reaction against the nation's colonial past and
174 a neoliberal political movement that began in 1985. During the neoliberal era, privatization and
175 economic restructuring spread throughout the country, emphasizing decentralization and

municipal autonomy in order to displace power (Kohl 2002: 454). Instead, this municipal autonomy strengthened local power, and discourses of indigenous identity became fundamental to a resistance movement that included widespread protests against resource privatization in the water and gas sectors in the early 2000s (Albro 2005: 438). Cultural heritage was used as a justification for these fights, inextricably linking political movements to a language of indigenous rights (Albro 2005). Evo Morales built his rise to power within the MAS party on this momentum by adopting the language of indigenous rights, and referring to Bolivia as an “indigenous nation” (Albro 2005; Postero 2010).

As part of the MAS’s work towards creating an equitable society based on indigenous inclusion, the government undertook a variety of political reforms, including health, education, and land (Winchell 2016; Goodale 2008). These reforms were coupled with the creation of a new national Constitution, developed in response to indigenous demands and to alleviate problems including a long history of marginalization of indigenous people, especially in rural areas. The new Constitution’s poetic preamble calls for a “refounding” of Bolivia under the premises of respect and equality. First, Bolivia’s idyllic past is articulated as being fractured by colonialism:

In immemorial times mountains arose, rivers were displaced, lakes were formed... We populated this sacred Mother Earth with different faces, and since then we understood the current plurality of all things and our diversity as beings and cultures... we never understood racism until we suffered it in the terrible times of the colony (Constitution of the Plurinational State of Bolivia 2009: 1).

The preamble continues with a discussion of the indigenous fight for independence, power, land, and territory to build “a new State:”

A State based in respect and equality among all, with principles of sovereignty, dignity,

complementarity, solidarity, harmony and equity within the distribution and redistribution of the social product, with the predomination of the search to live well; with respect to the economic, social, legal, political and cultural plurality of the habitants of this land; in collective coexistence with access to water, work, education, health and household for everybody (Constitution of the Plurinational State of Bolivia 2009: 1).

This message was reflected in the health reform movement that emerged simultaneously, supported by a Constitution that demanded a new health care system based on principles of equality, access, and respect for indigenous principles. Indigenous activists sought to address the position of indigenous medicine in particular, which was significant within this “refounding” given a history that included a ban on indigenous medicine that lasted until 1984 (Nigenda et al. 2001). Once indigenous medicine was decriminalized, the first organization of indigenous doctors was founded by Walter Alvarez Quispe, a Kallawaya doctor (Babis 2014: 291). This organization, the Bolivian Society of Medicine, played an important role in instigating political change. Babis (2014) suggests that this convergence of civil society organizations and political and cultural change led to a “Health Social Movement,” setting the stage for the role of indigenous participation in the new State’s health policy (Babis 2014: 287). As a result, the new Constitution incorporated several articles related to health, including the right to health and the valorization of indigenous cosmovision, or spiritual worldview, within the health care system (Section 1 Article 30, Section 2 Article 35).

The history of the resulting health policy process was shared in many of my interviews. Though this history comprises background to this article, I rely on interview material as no formalized account exists. In 2005, prior to the elections, the MAS conducted a qualitative study of Bolivia’s health needs to build evidence to formulate their platform. As a result, the MAS

envisioned a Unified Health System (*El Sistema Único de Salud* or SUS) to guarantee the right to health care to all Bolivians. Upon taking office, Evo Morales appointed Dr. Nila Heredia, a former political militant, physician, and expert in public health, as Minister of Health and Sports. In order to develop a new national health care system and policy, Dr. Heredia formed an interdisciplinary team of doctors, public health specialists, social scientists, and indigenous healers and activists. Many team members spent their prior careers working in rural community health programs, in health-related NGOs, or in civic organizations. There were also many stakeholders from around the country who participated by sharing their stories, experiences, or conflicting perspectives, particularly from rural health programs used as models for aspects of the health policy. Principles from SAFCI were developed from these stories and models, integrated with the knowledge and experiences of this core team, and influenced by the 1978 Declaration of Alma-Ata, an international agreement regarding the importance of primary care.

Core members of the Ministry of Health and Sports (*Ministerio de Salud y Deportes* or MSD) were chosen for having similar ideas about the premises of SAFCI. However, given the multiple stakeholders involved, policymaking was inevitably contentious, with the main debates centered around the role of indigenous medicine in the health care system. Many urban clinicians wanted to maintain a biomedical and hospital-based model of health care, as I learned in interviews conducted in an urban hospital in La Paz. One cardiologist explained his view that traditional medicine is part of Bolivia's history, but should not be implemented within the health care system. "No! No! No!" he exclaimed, "We cannot have traditional birthing rooms or herbs in the hospital. We need to advance technologically, not go back in time." This view contrasted with those who wanted an intercultural focus coupled with an emphasis on social determinants of health outside hospital institutions. Another area of debate came from some of the *cajas*, or the

worker's health insurance organizations, which provide 30% of all health care in the country. Many feared the government would centralize health services under the SUS. After vocal and uproarious debates and negotiations, the dominant views expressed by the MSD team and their activist counterparts, which prior to this government would have been marginalized and silenced, were written into policy through a process called "systematization." The team brought together the ideas and experiences shared and wrote them into a legal document over months of meetings. At the time of my fieldwork, the legal SUS was still held up in Congress and had not yet been implemented, in part because of financing. SAFCI, however, was legally formalized in June of 2008 through Supreme Decree No. 29601.

SAFCI focuses on primary health care and social determinants of health in the family and the community, health prevention and promotion, and participative health management (Johnson 2013; Alvarez et al. 2015). The legal policy is an eleven-page document. I also analyzed a number of other versions of SAFCI, including didactic versions, versions for community leaders, and PowerPoint presentations. SAFCI did not live in any one text, but rather proliferated through a number of different documents meant for different audiences. Consistency across the documents I collected manifested in the presentation of the formal premises, which were: Community Participation (*Participación Comunitaria*); Intersectorality (*Intersectoralidad*); Interculturality (*Interculturalidad*); and Integrality (*Integralidad*). The written materials also often framed the philosophy behind the policy, definitions of key concepts, and discussions of implementation through two approaches: participatory health management (*gestión comunitaria*), and clinical care (*atención*) (Johnson 2013: 317). Differences between documents included the use of images, the ways different audiences were addressed, and normative versus practical emphasis.

I will focus on two SAFCI premises in particular: interculturality and community participation. The premise of interculturality was one way policymakers incorporated the resuscitation of indigenous health knowledge into the health care system, and is a unique attribute of SAFCI as distinct from other primary health care system reforms (Johnson 2013: 317):

Intercultural health is the sociocultural approach to medical practice with people from distinct cultures (health personnel, traditional healers, users, and others), where each facilitates a horizontal dialogue based on respect, recognition, valorization, and acceptance of different medical knowledge. (Ministerio de Salud y Deportes 2016)

The second premise that will be discussed is community participation:

Family Community Intercultural Health assumes effective social participation in decision-making from the autonomous and organized involvement of urban and rural communities...including planning, execution, management, monitoring, evaluation, and social control of health actions for decision-making from within and outside health facilities” (Ministerio de Salud y Deportes 2016)

This premise reflects the philosophy behind SAFCI’s development and a focus on planning and implementation. When I was in Bolivia there was little data on SAFCI’s implementation. In some areas, I observed SAFCI’s implementation in intercultural clinical spaces and local health committees. However, in the Beni Department in the Amazon, I saw no signs of SAFCI. It is thus important to note discrepancies between the forward-thinking ideological content of the policy and the unevenness of its implementation, given constraints that included lack of government funds, a heavy reliance on NGOs, a paucity of doctors willing to work in rural areas, and a prioritization of highlands indigenous groups.

Results

During interviews with members of the MSD team, the people closest to the process from start to finish, I heard similarities in the ways they talked about designing health policy: they shared narratives of personal memories and experiences that were intimately connected to moments in and perspectives on Bolivia's history. These experiences were reinforced by their earlier careers and through the community participative processes they engaged in during the policy process. Furthermore, their multiple positionalities defied bounded categories of the "personal" and the "political," and bureaucratic "insider" or "outsider." This intermixing of the personal and political was a fundamental way policymakers narrated their involvement in the formulation of the policy's progressive content. An examination of these imbricated histories responds to Grundy et al.'s (2014) suggestion, "health policy analysis needs to be informed by a deeper understanding and questioning of the historical trajectory and political stance that sets the stage for the acting out of health policy formation" (150). I present results organized around the following themes that emerged from interviews and participant observation: in the first section I look at personal intersections with and reflections on national political histories and a national narrative of indigenous movements in Latin America. In the second section, I examine the role of expertise and personal experience in policymaking. I show how these shaped SAFCI. In the third section, I provide an in-depth examination of one aspect of the policy, the concept of "*vivir bien*," or "living well," and how it reflected these histories.

Personal Intersections and Reflections on Political Histories

313 Dr. Francisco Díaz, a physician member of the policy team, told me one afternoon as
314 we spoke in a small office at the MSD that Bolivia's history was full of "sociopolitical
315 rupture." He linked these ruptures to the pathway the MSD traversed in designing policy.
316 Indeed, every time I asked about the history of the policy and process, I was thrown into
317 historical narratives of indigenous movements in Latin America in general and of Evo
318 Morales' government more specifically. This history was not linear or progressive, but full of
319 stalling, derailment, and rupture through stories of Bolivia's past, and ways that policymakers'
320 personal experiences intersected with this past. These were often framed as signposts toward a
321 future the policy was to realize.

322 Policymaker Dr. Víctor Tamayo, doctor and leader of an organization focused on
323 municipal representation, discussed the history of the national "problem" the team faced. He
324 suggested the root of health disparities in Bolivia began in colonial times:

325 Since the moment of the foundation of our country, the day that we became Bolivians,
326 indigenous people were not considered to be people, because the Pope said that
327 indigenous people did not have a soul. This message from the Vatican led to the
328 exploitation of indigenous people in the mines. Since that moment they did not have
329 rights and they were not considered people.

330 Many involved in the process felt an obligation to make reparations for this past through
331 political reform, or hoped for this reparation from the government. These views manifested in
332 the resulting aims of the policy, as well the emphasis on rural indigenous communities. Dr.
333 Díaz expressed this theme of reparation when he discussed centuries of colonial exploitation in
334 Bolivia. "Many indigenous people died as slaves in the mines during this time. This whole
335 process led to social discrimination, and what we call the social debt of 500 years."

336 Policymaker Dr. Renato Palacios, an indigenous physician and medical anthropologist,
337 explained,

338 When the Spanish came, they first attacked our knowledge as if it was the devil, and we
339 were put through evangelization and Hispanicization, and they took from us the
340 majority of our knowledge. And now we get to think, how are we going to reconstruct
341 our own history?

342 Members of this team put forward a conception of both health and health policy that could be
343 part of a reconstruction of history, a reparation, particularly given the long subordination of
344 indigenous health practices to Western medicine. The “debt” these policymakers felt led to the
345 creation of a vision that attempted to separate from this past.

346 Neoliberal approaches to health care were also a focus during discussions of the
347 sociopolitical circumstances leading to the policy’s design, with clear distinctions made between
348 past and future. Dr. Díaz linked neoliberal-era problems with “neoliberal approaches to health.”
349 When asked, “What did this approach consist of?” He responded,

350 Health was a strictly individual issue. I answer for my health, you answer for your
351 health, she answers for her health...all of the health problems were solved on the
352 market, between supply and demand...The discrimination of indigenous people was
353 fatal...they did not have money, and there was no policy of inclusion.”

354 The policymaking process sought to undo neoliberal policies in Bolivia. In doing so,
355 policymakers often created a distinct sense of historical epochs between neoliberal/post-
356 neoliberal. However, in practice, many programs and approaches that emerged with SAFCI
357 made use of aspects of past approaches. Anthropologist Brian Johnson considers these tensions
358 the “paradoxes” of the reform (Johnson 2010: 140). For example, there is heavy reliance on

359 NGOs to implement health programs in the midst of discourses of “decolonization.”
360 Furthermore, the premise of interculturality requires equal exchange, respect, and dialogue
361 across cultures, but deep inequalities still exist. As such, it is important to remain critical of
362 language used to discuss change, and to be cognizant of distinctions between a progressive
363 policy’s ideology and the concretization of these ideas through implementation, even if these
364 processes are iterative. Yet, I found when examining how policy came to be made, these
365 discourses contrasting past, present, and future were often at the core of its formulation, and
366 are therefore important to attend to.

367 Connections with Bolivia’s history were also drawn due to policymakers’ personal
368 involvement as actors in this history. Dr. Nila Heredia, at the time of my study the Minister of
369 Health and Sports, was a political figure because of her work as a socialist militant during pre-
370 democracy days. When I asked about the process of designing the policy she immediately
371 jumped into a story of Bolivia’s political history and how it intersected with her experiences.
372 She began with a discussion of the Hugo Banzer dictatorship when many of her fellow
373 militants were “disappeared” for their work. Dr. Heredia herself was captured in 1976 by
374 government forces and tortured in prison. Soon after democracy was implemented in 1982, she
375 took a position as a faculty member in the School of Medicine at the Universidad Mayor de
376 San Andres (UMSA), and later became director. Dr. Heredia told me that her experiences
377 working at the university shaped her ideas about patient care, dynamics of urban and rural
378 health care, oppression of indigenous people, and economic disparities. For her, these were key
379 themes, or what she called the “conceptual base” that she brought into conversations in 2006
380 when she formed the MSD team. Following her work at the university, in 2004 she became
381 director of the La Paz Health Services Department (*El Servicio Departmental de Salud de La*

Paz or SEDES). As Evo Morales rose to power, Dr. Heredia provided advice surrounding the MAS's approach to health. She formed the policymaking team to improve what she had begun to elaborate, "To help make my ideas more complete." Dr. Heredia's personal experiences, which created her call to political action, were deeply connected to the national movements that brought forth political change in the health care system.

Expertise and Personal Experience

Members of Dr. Heredia's policymaking team demonstrated how their professional and personal experiences shaped their contributions to SAFCI. Many shared a theoretical view on the causes of illness in society, while others shared personal stories that shaped their contributions to policymaking. Dr. Diego Ichazo, a pediatrician and public health specialist, recalled that the team was formed of a group that came from the "Same school of thought." When I asked about what this school of thought consisted of he explained,

It was a team that basically came from the same school, the school in a fight against the biomedical model, the school against those who think the clinician is the center of everything, that the hospital is the center of everything, that does not recognize the conditions of life. It was this team that discussed these ideas and slowly, slowly, elaborated the SAFCI policy.

The intellectual discipline that addressed these problems, and that policymakers subscribed to, came from sources from Latin American Social Medicine (LASM). LASM focuses on understanding the social determinants of health and the economic inequities that create the conditions of ill health (Breilh 2003; Menéndez 2003; Laurell 2003; Waitzkin et al. 2001). This theoretical and methodological scholarship is positioned against approaches focused on health

405 care as a commodity, as it examines the political-economic production of ill health (Breilh 2003).
406 The policymakers' aim was to overturn histories of racial privilege and health care privatization,
407 focusing on social determinants of health through the premise of integrality which accounts for
408 how housing, employment, environment, and education facilitate health or create conditions of
409 illness. Yet Bolivian policymakers were also working against a biomedical paradigm of
410 medicine. Interculturality is not formally part of LASM, but in Bolivia, culture was understood
411 to be integral to health. This inclusion demonstrates a uniquely Bolivian approach to LASM.

412 My data suggests policymaking team members' experiences with Bolivia's health care
413 environment intersected with these theoretical foundations and significantly shaped their
414 contributions to the policy's design. Many participants had long histories as "insiders" working
415 in rural community health or on projects that emphasized community participation, and thus
416 brought a deep understanding of the role of local context in shaping health programs and
417 approaches. At the time of my research, Dr. Mónica Herrera, a physician, was the director of
418 health promotion and education at the MSD. During our interview, I asked her to describe her
419 participation in designing SAFCI. She explained,

420 The background is that the policy was born fundamentally from the systematization of
421 eighteen years of lived experiences. If I had not lived those experiences, personally, I
422 would have been lost in books and those sorts of things.

423 Dr. Herrera told me her real learning occurred when she lived and worked with rural
424 communities in Potosí. She explained, "This comprehension, this focus, it is not from the
425 university...I had to learn this in the field." When I asked, "What did you learn?" she
426 explained,

427 I believe that it is a little sensibility to the other, no? If you have the knowledge it can
428 be used to serve others. I traveled walking to C. Sometimes I walked for six hours,
429 eight hours, from community to community, visiting house by house. I did this because
430 it interested me, and I wanted to understand how the health of the people was, how they
431 lived, what factors influenced their health... This is a change in mentality, it is a focus
432 on public health, integral public health... We were trained with a biological focus,
433 centered on cells, organs, systems.

434 Dr. Herrera's experiences shaped her input during the policy process. I asked her to share
435 specific contributions based on her work. She discussed one particular experience that focused
436 on the premise of interculturality. Her team from a Bolivian NGO undertook a "diagnostic"
437 study to understand why women did not go to the doctor for maternity issues. Their approach,
438 reminiscent of an evidence-based policymaking practice, sought out people's needs and
439 concerns within the health care system. This approach provided a model for the policymaking
440 process that developed years later. They asked a woman why she did not seek health care in the
441 clinic:

442 'Is it because your spouse didn't want it?' 'No'. Your father' 'No.' "You?" 'Yes, it is
443 because I don't want to.' Well we were wondering why, and after many interrogations,
444 she said something that worried me greatly. She said, 'I cannot go to have my baby at
445 the health post because our post is very clean. Everything shines, everything is clean,
446 and I cannot come and dirty the post with my blood...' Uy! This was a very hard
447 response, that pulled me back and I said 'ciao public health, ciao education,
448 everything.' I had been focused on superficialities and I had not understood what their
449 perception was. It hit me very hard.

450 Dr. Herrera referred to these personal experiences when she contributed insights about
451 intercultural approaches to care to the policy. I saw this premise of interculturality
452 implemented when I conducted participant observation in rural areas of the country: the
453 incorporation of indigenous midwives into clinics, the redesign of birthing rooms to include
454 earth-tone walls, wooden floors, and ladders women could use to give birth standing up, and
455 greenhouses for herbal medicines. Dr. Herrera's experience assessing and implementing these
456 types of programs shaped the approach she contributed to SAFCI. However, her response to
457 the woman's narrative also demonstrates the entrenchment of discourses of hygiene and
458 indigeneity rooted in colonial history. Recommendations for addressing these concerns by
459 creating intercultural spaces formally acknowledged these racial framings of indigeneity (e.g.
460 indigeneity as "dirty"). As such, I observed that some solutions did not fully work to undo the
461 ways that indigenous women understood themselves as hygienically marked (Briggs and
462 Mantini Briggs 2003).

463 Other policymakers I spoke with explained how their personal participation in multiple
464 spheres of social and civic life shaped their approach to policy. Jaime Condori, an indigenous
465 Aymara man and a sociologist, worked for many years as an activist for indigenous rights, was
466 brought onto the policymaking team, and then worked for an NGO implementing SAFCI in
467 rural areas outside of La Paz. "What were your contributions to the SAFCI policy?" I asked.
468 Jaime responded,

469 In reality, I was involved in everything, but I would say I contributed most in regards to
470 participation and interculturality, from my point of view, not based on work in health,
471 but rather from my experience as an indigenous person, because I lived in the slopes, in
472 *barrios*."

473 “Can you describe the experiences you feel contributed to making the policy?” Jaime
474 explained,

475 I have a lot of sensitivity...it makes me very sad when I see an injustice, but even more
476 so an injustice reflected in the people...it reminds me of my mother, it reminds me of
477 my father, of my grandparents...That, I think, is the source that illuminates everything
478 that I am. The academic part, the political, the ideological. I’m pretty radical and it’s
479 this sensitivity...that’s what has pushed me...I have experienced the problems my
480 family has quite personally...It’s just that I know the countryside, so that has made me
481 develop a lot of sensitivity in my thinking.

482 Jaime saw his contributions as deeply integrated with his life story. His activist background
483 helped him contribute to the premise of community participation. I observed this premise
484 enacted at policy events that rooted policy in people’s localized experiences. A language of
485 expertise was cast as a way to expand the actors involved. “Here, everyone present is an
486 expert,” Dr. Herrera told a group of representatives from community health programs and civic
487 organizations around the country as she paced the aisles of an auditorium in Cochabamba
488 during an event, “Retrieving our Experiences in Implementing the SAFCI Policy.” She
489 reiterated, “You are the experts. We aren’t just looking *at* theory because your experiences
490 create new theory for us.” The policy model that emerged from a desire to “repair” the past
491 contained the possibility for the recognition of different health experts. Indeed, I heard the
492 articulation of community ownership over the policy when I went to rural communities in
493 Potosí whose health programs served as models for SAFCI. At one, a traditional healer and
494 leader of an indigenous health organization told me, “SAFCI, it is ours, it came from here.” He
495 explained, “It came from a process that has a history and context. It was born with a

background and strong roots. The communities identified what they needed to live better, to live well.” Whereas policy is often considered to be impersonal and abstract, I saw how this policy’s design was historicized, personal, and inclusive. There were many applied results of this work: one aspect of the policy’s implementation in practice was the inclusion of a social scientist alongside traveling health teams comprised of doctors, nurses, and dentists. The policy also led to the creation of a medical residency program, the SAFCI Residency, which teaches and implements a social medicine approach in rural Bolivia. Furthermore, SAFCI demanded that participatory community health committees form to make local health decisions.

Returning to “What We Were:” Temporality and the Concept of “Living Well”

For many stakeholders in the process, policy and policymaking were about constructing a better future in relation to the pasts they narrated. There were many ways understandings of history shaped SAFCI. These include premises I already discussed such as interculturality, integrality, and community participation. Another example was the incorporation of the concept “*vivir bien*,” or “living well” into policy. *Vivir bien* is a term that was adopted from the language of indigenous cosmovision, *suma qamaña* in Aymara, or *sumak kawsay* in Quechua, and imported into political rhetoric and documents in Bolivia, including the Constitution. The language of the formal SAFCI document begins with a response to the problems of the past with a vision of the future that calls on this concept of *vivir bien*:

The purpose of the health sector is to contribute to the paradigm of *vivir bien* (living well) and to the eradication of poverty and inequity, eliminating social exclusion and improving the state of health.

518 For some at the MSD, *vivir bien* represented an alternative to the past and a vision of the
519 future. For example, policymaker Dr. Tamayo, told me,
520 *Vivir bien* is an alternative paradigm to capitalism. The model we are fighting against
521 is...market-oriented and biomedical. That model is the bad one, the biomedical one, the
522 Western one, the exclusionary one...The thing that challenges that is the SAFCI model,
523 guided by the paradigm of *vivir bien*.

524 The concept of *vivir bien* has been discussed at length by David Choquehuanca, an Aymara
525 activist who also served as the Foreign Minister under the Morales government. He suggested
526 in a report,
527 We want to return to *vivir bien*, which means we are now beginning to recognize the
528 value of our history, our music, our dress, our culture, our language, our natural
529 resources, and after validating these we have decided to recover everything that is ours,
530 and return to what we were (*Diario La Razon* 2010).

531 Health policy, guided by the concept of *vivir bien*, was framed as a way to return to “what we
532 were,” a view of the past that became a possibility for the future.

533 This concept of *vivir bien* was referenced in discussions about a “new health
534 paradigm,” as a way to provide a new approach to defining the concept of ‘health’ in the health
535 policy. Xavier López, a leader at an NGO in Potosí told me,
536 You realize SAFCI does not come from nowhere...It began with those who said ‘These
537 are our necessities: we need to make a health post, we have to deal with the issue of
538 schools, we need to deal with the issue of production.’ They identified these as what
539 they required to live better, to *vivir bien*.”

540 Dr. Heredia also commented on *vivir bien*’s relationship to health policy,

541 *Vivir Bien* is a message, and health is involved in all of its intersecting logics about
542 what life is...that message [*vivir bien*] allowed us to create a beautiful policy...*vivir*
543 *bien* is something that belongs to the people...This is why it is a policy that has
544 everything the people want. It has to be made by the people and at the same time
545 provoke the people to see how we can build this idea of *vivir bien*.

546 Many policies anthropologists study create distance between those who make them and those
547 who are impacted by them, while the aim of SAFCI was to create a sense of national
548 ownership (Wright and Shore 1995). Furthermore, while the legal documentary form of policy
549 might obfuscate its origins, my ethnographic approach demonstrates how SAFCI took shape
550 through the intersection of histories, life experiences, philosophies, and models, all of which
551 had a fundamental impact on the formation of progressive content.

552 553 **Discussion**

554 My work suggests that the personal, the historical, and the political are deeply
555 intertwined in policymaking processes. Policy emerges from a multiplicity of origins and
556 voices, yet in order to be written, to circulate, the heteroglossia is turned into a legal, normative
557 document (Bakhtin 1981). Bowker and Star (2000), in their examination of how classificatory
558 systems are produced, suggest that narratives that take a standard form are at their origins
559 multivocal, a result of complex negotiations, processes, and conflicts (44). They write, “The
560 very multiplicity of people, things and processes involved mean that they are never locked in
561 for all time” (Bowker and Star 2000: 49). By unlocking this multiplicity, my work responds to
562 questions about what *is* history in a political environment, and why it is important in
563 policymaking, even if these origins are hidden in documentary entities.

Medical anthropologists have long sought ways to contribute to policymaking and policy analysis. My work makes three interventions towards this aim with regards to: (1) the ways this case from Bolivia can help us understand critical questions about how a progressive health policy emerges; (2) how the study of health policy in particular contributes to the anthropology of policy; and (3) anthropology's broader contributions to other disciplines involved in policy analysis and studies of policy processes.

(1) When considering health policy reforms in international context, Bolivia's SAFCI policy emerged as a progressive, community-motivated, and ideologically-driven approach. Many health care systems around the world are dominated by neoliberal and market-based approaches, e.g. the Affordable Care Act in the United States. Even in anthropological studies of health reform, the focus is often on economics, bureaucratic institutions, and their impacts (Lamphere 2005). Bolivia's health policy, and the study of its making is thus distinctive and instructive for thinking about how alternatives emerge, and how a country with limited resources can build momentum towards an inclusive political ideology that is grounded in community participation and a sense of community ownership over health. Understanding the social and historical context, the forward-thinking personalities, and the engagement with indigenous movements that formed the foundation of SAFCI can provide insights into how progressive views emerge and translate into policy.

(2) As discussed in the introduction, anthropology has come a long way in interrogating "policy" as an object of study. Health policy in particular is a site where the discipline can combine work on policy with medical anthropology's insights about relationships between bodies, health practices, and power. People engage with the State through health care institutions and policies, but are often consumers of health and health care not participants in

processes that determine what ‘health’ and ‘health care’ could mean. Yet these are fundamental concepts involved in how national wellbeing is understood, defined, and addressed. Health policy as an object of study in particular is an important site for studying political change and the ways that repairs to the national ‘body’ following traumatic histories might be undertaken.

(3) Finally, this work offers the possibility for cross-disciplinary collaborations and for anthropology’s contribution to the study of policy more broadly. There are other fields that consider similar issues, particularly health policy analysis and evidence-based policymaking. Evidence from qualitative needs assessments have been used to make policy recommendations, and models have been proposed for how to formally analyze policies and policy agendas. Approaches focus on areas such as the relationship between actors, context, and content (Walt and Gilson 1994), and on actor power, ideas, context, and issue characteristics (Schiffman and Smith 2007), with studies following the dynamism and constantly shifting pathways through which policies emerge (Brugha et al. 2004; Walt et al. 2008). Walt and Gilson (1994) suggest, “much health policy wrongly focuses attention on the *content* of reform, and neglects the *actors* involved in policy reform...the *process* contingent on developing and implementing change and the *context* within which policy is developed” (Walt and Gilson 1994: 354).

Anthropology can provide rich data to inform the development of policies, and ethnographic research can contribute with a profound focus on the individuals and groups that are at the center of policy processes, as well as an understanding not just of the contexts within which they work, but of how actors view and reflect on these contexts to shape the ideas incorporated.

Importantly, and policy analysts and anthropologists are often in agreement on this point: the focus should be on a multiplicity of actors, as well as the conflicts and diversity that exist amongst stakeholders. I already discussed some conflicts above. I also found that

different actors contributed unique experiences depending on their background, creating a diverse and multi-disciplinary approach in the process. For example, doctors and public health specialists on the team helped educate people about the shift from biomedicine to a focus on social determinants of health and cultural medicine, sharing experiences from community practice. Those from the social sciences gathered evidence through qualitative studies and mediated the process. Activist participants made connections with community organizations, and emphasized the role of participation in processes of change. And NGOs were embedded in communities, and shared models of health care provision and regional knowledge. These stakeholders were fundamental to the process. Furthermore, would-be political “elites” given their role in government were also “insiders” due to having experiences and lives rooted within the communities they aimed to serve through the policy (Buse 2008). Anthropology makes visible the intricate interweaving of voices and positionalities in these processes.

Finally, Walt and Gilson (2014) suggest “it is difficult to capture temporality in the policy process” (Walt and Gilson 2014: iii15). This, too, is an area where anthropologists can enrich the study of policy. As I demonstrated, there is the possibility for studying the work of temporality in policy processes by attending to historical context, the ways histories were experienced, narrated, and iterated upon, and the ways past, present, and future are entangled. I examined how problems of the past were framed and addressed, even as aspects of these problems were sometimes replicated. These engagements with time and attention to ruptures, both personal and historical, were necessary in working towards envisioning a new and better future for the nation.

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