The Making and Circulation of Health Reform Policy in Bolivia

by
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Abstract
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Our lives are ruled by health policies; they are involved in determining the food we eat, the medications we take, the medical care we have access to, and how we pay for it all. Health policies are typically designed and debated in bureaucratic offices, where participation is limited to physicians, technocrats, and politicians who get called “policymakers.” The ideas they come up with are inscribed into documents, and are often complex, unapproachable, and difficult to understand. My goal in this dissertation is to begin to disrupt this standard story of policy. By focusing on what I will call the origins and mutations of a single health policy in Bolivia called Salud Familiar Comunitaria Intercultural (Family Community Intercultural Health Policy, or SAFCI), I tell what we may call, to use Igor Kopytoff's (1986) phrase from his writing about things, not just a cultural biography of a policy but of "policy" itself. This health policy in Bolivia was designed through what was considered to be a collaborative process, and aimed to shift the focus of healthcare from a previous approach that centered around curing disease in the individual to a new approach that involved preventing illness and promoting health amongst the family and the community. The policy also emphasized cultural conceptions of health and healing in a country that is over sixty percent indigenous. Because of the unique process that led to its design, and the forms and ideas that emerged and were bounded as policy, a study of this policy in particular is useful for making visible problems that emerge much more generally, both in policy and in ways that anthropologists attempt to study policy.

Through my work I complicate the idea that there is such a thing as policy, with preset boundaries and pre-given sites of enactment, as well as its reification and circulation in policy documents. Given the centrality of health policies to constituting the subjects and objects that medical anthropologists study, I argue that challenging the reification and marginalization of policy issues can shift the types of stories that medical anthropologists can tell about ways that "health" constitutes a fruitful and problematic locus of efforts to construct "the State" (Gupta 2012), biological citizenship (Petryna 2003), and life itself (Rose 2007). I argue that we need to suspend the belief that we know what policy is, where it is located, how it circulates, the
languages used to describe it, and the very stakes of this type of inquiry itself in order to expand the scope of policy and its study.

Some of the questions this dissertation seeks to answer are “What is a policy?” and “What is a policymaker?” and how do these get mediated through understandings of “health” as part of a vision of the Bolivian state? I interrogate the sites and narratives where ideas of each were produced. What are the possibilities and what are the limits of attempting this work in the field of health, particularly when health policies are meant to deal with bodies, environments, health practices, and medical expertise? What are the actual practices involved in the ability to make and use policies, and how do these practices continue to form and adhere to “policy”? What is at stake for medical anthropology more broadly if we rethink the concept of policy itself in this way?
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Introduction

What is Health Policy?

Our lives are ruled by health policies; they are involved in determining the food we eat, the medications we take, the medical care we have access to, and how we pay for it all. Health policies are typically designed and debated in bureaucratic offices, where participation is limited to physicians, technocrats, and politicians who get called “policymakers.” The ideas they come up with are inscripted into documents, and are often complex, unapproachable, and difficult to understand. When considering formal health policies, they are many times seen as boring, static, and decontextualized, such as the notorious 1,200 page document that encapsulates the United States’ recent health reform policy, the Patient Protection and Affordable Care Act. As such, anthropologist of policy Kitty Corbett (2005) writes, “Typically, ‘policy’ is represented as something that is both neutral and rational: a mere tool that serves to unite means and ends or bridge the gap between goals and their execution—in short, a legal-rational way of getting things done” (Corbett 2005: 37). Policy analysis in public policy and public health involves creating cost-benefit models, economic projections, and decision-making analyses. The intricacies of the ways debates around making health policy unfold and why are rarely the focus. We know little of the origins and visions involved, the ideas about what health is and how it gets defined and by whom, as well as the personal stories behind its authors. Why should this be the case? Health policies are deeply significant to our lives: they institutionalize conceptions of “health” and “healthcare,” creating the frameworks and metastructures through which our health is understood. They create understandings of what it means to be healthy, and how approaches to health might be implemented in practice. How is it that something that appears so lifeless can be involved in determining and shaping our health and life itself?

My goal in reiterating this standard story of policy and policy analysis is to begin to disrupt it. By focusing on what I will call the origins and mutations of a single health policy in Bolivia, I tell what we may call, to use Igor Kopytoff’s (1986) phrase from his writing about things, not just a cultural biography of a policy but of "policy" itself. I hope to complicate the idea that there is such a thing as policy, with preset boundaries and pre-given sites of enactment, as well as its reification and circulation in policy documents. Given the centrality of health policies to constituting the subjects and objects that medical anthropologists study, I suggest that challenging the reification and marginalization of policy issues can shift the types of stories that medical anthropologists can tell about ways that "health" constitutes a fruitful and problematic locus of efforts to construct "the State" (Gupta 2012), biological citizenship (Petryna 2003), and life itself (Rose 2007). Further, as recent efforts to counter anthropological taboos on the ethnographic study of policy more generally have suggested (Greenhalgh 2008), unthinking standard stories of policy is of much broader anthropological concern. Here I build on these efforts at the same time that I take inspiration from Latin American media theorist Jesús Martín Barbero (1993) in suggesting that to study policy—which means to interrogate notions of publics, "the State," and power—we need to suspend the belief that we know what policy is, where it is located, how it circulates, the languages used to describe it, and the very stakes of this type of inquiry itself. Here, by expanding the scope of policy, I hope to start again, and suggest that we need to begin with "befores" that emerge even before policies are officially born.

Bolivia in particular provides a remarkable example of a place where an expanding scope of health policy and health policymaking processes was overt, and was embedded, often
transiently, into the aims of the government. The Bolivian government, led by President Evo Morales, engaged in a policymaking process as an attempt to design a revolutionary health policy, one that was meant to completely change the terms upon which health was understood and thought, and to act as reparation for a long history of colonialism, violence, and racism. This policy, the focus of my fieldwork in Bolivia, was called *Salud Familiar Comunitaria Intercultural* (Family Community Intercultural Health Policy, or SAFCI). It was designed through what was considered to be a collaborative process, and aimed to shift the focus of healthcare from a previous approach that centered around curing disease in the individual to a new approach that involved preventing illness and promoting health amongst the family and the community. The policy also emphasized cultural conceptions of health and healing in a country that is over sixty percent indigenous. Because of the unique process that led to its design, and the forms and ideas that emerged and were bounded as policy, a study of this policy in particular is useful for making visible problems that emerge much more generally, both in policy and in ways that anthropologists attempt to study policy.

This policy, and its origins and mutations, are thus particularly interesting and insightful for my broader project of constructing a cultural biography of health policy. Based on my fieldwork in Bolivia, I suggest that policies always tell us origin stories, they reframe temporal linearities into collages of ideas, documents, memories, and stories, they involve both materials and immaterialities, they can encompass a sense of vitality, they can be beautiful, and they can also do and reproduce ugly things. What, then, I ask, would the anthropology of policy look like if we do this work to suspend the idea that we know what policy is, the supposedly boring static documents and decontextualized ideas, and rather watch how people make the concept, in relation to health, through a variety of practices? Health reform in Bolivia was not just about changing health statistics, though that was part of the aim, but also about creating a new health paradigm, about changing the way health and nation were understood. As such, my way of approaching policy involves creating an ethnographic method for studying policy as a modern form. Even given this Latin American exceptionalism, there are lenses that I propose in the study of health policy in general, where, when putting ethnographic analysis and description to their making and circulation, they can be understood to be grounded in visions, origins, and reframings of health, well-being, and care.

My approach to studying policy did not start out this way, and in fact changed through the course of my fieldwork. When I began my research I thought I would just follow a health policy document as my object of study: how its documentary form was made and circulated. I intended to follow on the theoretical trails of scholars of documents who write about the texts and documentary manifestations of bureaucratic processes and policies. Because of the ways I aim to expand the scope of the study of policy, I am indebted to and build on these scholars’ work on documents, as I aim to expand the notion of documents themselves, allowing the term to shift and morph, and to include more than paper (Riles 2006; Hull 2012; Feldman 2008; Navaro-Yashin 2007). I found that a policy Document, singular, did not exist, and rather I encountered a multiplicity of documents, performances, presentations, and discussions that circulated as policy. Paper documents were decentered in most discussions, where health policy gained meaning and momentum based on the visions and ideas about health and nationhood that it was based on, the personalities of the policymakers and other unlikely experts involved in its production. I examined the complex ways these ideas and forms moved, circulated, and were reproduced. The work I did was thus about following the trajectories of the ideas about health, nationhood, and healing that were bounded and constructed as health policy. I explored how they took shape as
health policy, and how they were made intelligible as policy, rather than evaluating successes or failures. In this dissertation, then, I look at how a concept of health policy itself is constructed, what forms or ways of thinking about and working with health get called health policy, what packages they travel in, where they travel, and who facilitates this movement. I argue that the origins, ideas, and multiple forms of what came to be called health policy in Bolivia aided in the circulation of certain kinds of knowledge and practices related to health and nation-building, where policy emerged as something multiple and at least partly open, rather than as something completed, closed off, and decontextualized. I suggest, further, that all health policies might have some of these features and that expanding the scope of policy’s study can help illuminate how policies work as they circulate, and, perhaps, help them to be more effective in practice.

My work also builds on and advances the work of medical anthropologists on other related topics. Medical anthropologist Margaret Locke (2002), in her work on organ transplantation, has, in a way, looked at differentials that manifest because of policies. In Lock’s work, she shows how a policy about organ transplant drastically altered the definitions of life and death. She looks at different sites, where, for example, in the United States what counts as “dead” is defined by surgeons and bioethicists, while in other places it is a more open to public debate. Lock’s work suggests the importance of thinking about policy debates within and through medical anthropology, even when these debates are not framed as policy debates. The impacts and intricacies of health and health-related policies are involved in determining many of the ways we experience living, dying, health, wellbeing, and healthcare, as well as all of the other practices, concepts, and regulations that get constituted and circulated within these terms. Lock helped define these key issues around policy debates in medical anthropology. My work will further expand the discussion by examining health policy development in Bolivia that allows us to rethink the scope of where policymaking takes place, overturn ideas about linealities in policymaking processes, and locate the many different actors involved. Bolivia provides an example of an attempt to create a revolutionary change in health and healthcare provision through the designing and circulation of health policy that is meant to redefine health and wellbeing in the nation. However, its unique features and the ways I studied them ethnographically can call into question the larger assumptions we make about health policies and their analysis in general.

In order to explore these issues and provide an ethnographic method for the study of health policy, I divide this dissertation into two sections, Origins and Mutations, as a way to demonstrate and define how I began to understand and interpret policy. Through my work, I hope to suggest these analytics as new ways to understand and analyze health policies. In Origins, I use new analytics for the study of the making of health policy through an examination of heteroglossia, or multivocality, at the foundation of policy (Bakhtin 1988). I also build on James Holston’s (1989) work in Modernist City, where he seeks to understand the historical and ethnographic origins of a utopian design, and some of the contradictions that emerged as the vision was implemented. For Holston, a “modernist project” has three components: It involves a relationship between past and future, with an intention to achieve a radical break from the present. A modernist project also involves contradiction and the openness to change, what I call mutation. Finally, a modernist project suggests that multivocality is actually built into processes of transformation (Holston 1989). In proposing a new way of conceptualizing policy, I use tools that illuminate the ways I began to see policy. I examine narratives of memory and history. I explore discussions of utopias, beauty, and visions. I suggest ways that notions of difference and indigeneity were used that complicated these visions. Furthermore, I follow different kinds of
expertise and how these experts were understood and defined. In many of these analyses I suggest that a concept of the nation was being redefined through this multiplicity of redefinitions of health and their entextualization into *national* health policy.

Scholarship on policy often assimilates a foundational binary projected by practitioners into its core analytic logic, one that pits policies, as abstract and decontextualized sets of principles, terms, and institutional processes against their "implementation," the point at which they are seen as gaining materiality, embodiment, and precarity. This binary overlaps with similar problematic oppositions such as theory and practice, mind and body, global and local, and so forth. Just as reflecting on the origins of a policy helps me challenge the first half of this binary, by looking at the material social lives of policies, my concept of *mutations* enables me to recast ways that policies circulate as much more than the "implementation" of a previously-formulated, abstract object. As such, in *Mutations* I build on my work on origins, and propose another way that I began to understand policy, through a concept of mutation, particularly when considering the circulation, revision, and implementation of health policy in practice. My understanding of mutation and how it relates to health policy circulation builds on the work of Derrida, and his suggestion that there is no such thing as an identifiable singular origin, such that difference always emerges in repetitions which point to this lack of singularity, or what he calls iterability. I suggest that, due to its complex origins, health policy is never a singularity but is always already a mutated, heteroglossic form. Further, the moment this mutated form is spoken, circulated, or implemented, it becomes like a repetition, manifesting difference that reflects and reifies aspects of its multiple origins. This mutability, however, is always up against certain authoritative structures that bound aspects of policy so that it might be recognizable as policy. This dynamic creates a tension between the centripetal forces of policy’s origins and mutations, and the centrifugal forces of attempts to standardize or homogenize policy’s premises and intentions, whether because of intended audiences, channels of circulation, or forms that policy takes (Bakhtin 1988; Tsing 2005). Sometimes health policy’s repetitions and differences circulate freely, while other times they produce something akin to Freud’s conception of uncanniness, or the incomplete, imperfect double, and are policed by certain authorities.

Through these processes of mutations and attempts at creating boundaries, I suggest that health policy, from its origins, is always involved in constructing a notion of policy itself, both in its content as well as in the process of circulating as and being a policy, even after it is “formally” enacted. In this way, policymaking, implementation, and evaluation are embedded in the continual process of making and conceptualizing notions of policy, both the mutations and the attempts at stabilization. As the way I have built on Derrida’s invocation of iterability would suggest, circulating and reproducing policy are part of the construction process of health policy itself. In all of these ways I began to see and interpret health policy as something with vitality, reflecting the idea that health policy involves a consideration about how life becomes expressed through health and healing, and how it might be managed and dealt with. Vitality emerged through my analysis of affect, aesthetics, and mutability, which allowed policy to emerge as something not mechanistic, but rather full of life and at its core meant to be life-supporting. Health policy, I argue, is both a form that can incorporate the entextualization of notions of health, well-being, difference, and visions for the future of a nation, but also carries with it people, places, histories, memories, practices, affect, and vitality that overflow into policy’s implementation.
Research Origins

My own origin story with this topic began in Cuba in 2009, when I was doing research on a medical humanitarian aid program between Cuba and Bolivia. I met a group of Bolivian medical students studying at the Latin American School of Medicine (La Escuela Latinoamericana de Medicina, or ELAM), the famous Cuban medical school where foreign medical students from all over the world are trained as part of the Cuban government’s medical humanitarian project. I was intrigued by what these students told me about new developments in the healthcare system in Bolivia. They explained that there was a new health reform policy being developed due to the work of a government led by the country’s first socialist president, Evo Morales Ayama. Excited by the prospect of studying a health reform policy in its early stages of development, I traveled to Bolivia for the first time in 2010 as part of a National Science Foundation field school in the Bolivian Amazon. On the banks of the orange mineral-tinged waters of the river, the Río Maniquí, twenty-three hours by bus down the harrowing “Death Road,” and then eight more hours by motorized canoe from the center of government in La Paz, was a rural Tismané community called Santa Maria. It was there, where health concerns ranged from water-born diarrheal diseases to snake bites, that I began to explore what this national health reform consisted of and where its limits were, where its framing ideas were circulating and where they were not circulating, and how they moved. Ironically, the first place I went was the most distant from the central focus of my work, as the Bolivian government is based in La Paz. Healthcare in this Amazonian region primarily took the form of a combination of rare visits from traveling NGO workers mixed with “la medicina de la montaña,” or herbal medicines from the jungle.

When I returned to the highlands, to La Paz, the seat of the Bolivian government, after my time in the Amazon, I began to hear about new ideas about health, healthcare projects and programs, and new health laws discussed all around me. The contrast between these two sites helped me to begin to consider some of the unevenness and dystopias that are embedded into health reform and its implementation, even one that is framed as universal, revolutionary, or a “right” (Razon 2013). The discussions in La Paz centered around the terms of the national policy and discussions about a Sistema Único de Salud, a Unified Healthcare System. The government’s vision, built into the constitution, was to provide universal healthcare, as a human right, to all Bolivians. Yet what was most striking in my discussions and interviews about health policy was the depth of emotion and affect attached to the idea of health policy as something that could “heal” or repair the past. I had many conversations with one of the policymakers who will become a recurring character in this story I tell about policy’s making, Dr. Víctor Tamayo. A man of medium stature with dark hair, Dr. Tamayo was always clad in a business suit and glasses when we met. He was the vision of a formal, bureaucratic policymaker that I imagined going into this project, yet his words undid this standard vision. He took me through his personal and affective experiences of policy as he told me of his work, bringing a vitality into policy and policymaking that unfolded as he journeyed me through Bolivian history and his own deep memories of times before. During one conversation he told me, “The soul of the new healthcare system is the SAFCI model.” I asked him to explain what he meant by describing the healthcare system as having a “soul.” He told me of the building process that went into making the policy, what he considered to emerge from the “local level.” He explained,

1 All names have been changed in this Dissertation to protect anonymity
What was confirmed from my experience, from all that I have lived through, is that the construction of the policy came from the local level. That is...there may be many beautiful laws...But ultimately we trust in the ability of the people, of the families, to lead this process, whether in the community or in the neighborhood. This is what in the end results in state-building.

In this early conversation, he shared experiences of a collective process that involved the sharing of stories and experiences in health as a way to, as he put it, “Rescue the feelings of the people.” Indeed, the Ministry of Health relied on the work of teams of sociologists and other social scientists to seek out and attempt to understand the “local” perspective in order to create the design of policy, rather than just producing it as something theoretically informed. Further, when I asked Dr. Tamayo about his own personal contributions to the process he told me, “It is difficult to speak in the first person because it was a team effort.” In this discussion, Dr. Tamayo began to express some of the nonlinearities in an approach to policymaking that involved the telling of stories and experiences from a variety of “authors,” with no singular origin and no singular sense of authorship; policymaking from this perspective emerged from a collective process of storytelling.

Indeed, many of the interviews I did with policymakers disrupted the possibility of a linear time to policymaking. However, there are certain processual linearities, political moments, that I will lay out just this once in order to set the foundation for those that undo these same linearities through the policymaking and circulation processes that I will follow throughout the rest of this dissertation. In what follows, I point to key political figures, moments in time, and political dynamics that emerged across most of my interviews, though not necessarily always in this order. As anthropologist and ethnography, I piece their stories together, while always reflecting on the positionality that I had that allowed me to do so. In 2006, Evo Morales was elected president of Bolivia, the first indigenous person to take this role in South America. Upon taking office, he appointed Dra. Elena Ortiz, a former political militant, member of the socialist party, physician, and expert in public health and Latin American Social Medicine, as Minister of Health. Morales tasked her with the job of envisioning and designing a new national health system and policy. This call to create a new healthcare system was framed around a discussion of creating a new health paradigm for the country that could be aligned with the socialist party politics to provide universal healthcare. This party used a discourse of indigeneity and indigenous revival to discuss changes in both the political and social spheres. The focus on indigeneity was built on the idea that the country’s approach to health should incorporate indigenous cosmology when considering how to define health and healing in a nation that they called “plurinational.” Responding to this call, Dra. Ortiz formed an interdisciplinary team made up of doctors, public health specialists, and social scientists, many of whom had spent most of their careers working in rural community health programs or health-related NGOs. This team met frequently at a time when there was social movement emerging in the country to demand a new constitution for the Bolivian state. The new constitution incorporated several articles related to health, including the right to health and the revalorization of “indigenous cosmology” within the public healthcare system (Section 1 Article 30, Section 2 Article 35). The constitution, through its requirement for “universal healthcare,” necessitated a new health care system design, formally called the Unified Healthcare System, or el Sistema Único de Salud. However, this new health care system, which has yet to be formalized legally, required a new national health policy to determine its premises and pathways to implementation.
In the process of formulating the health policy that would anchor a new Bolivian health care system and new definitions of health, health policy itself and the ideas surrounding it were the ongoing work of an expanding and expansive network of actors. The Ministry of Health team aimed to incorporate many voices, and ideas within policy were shaped by professional and personal understandings not simply of health, but of its complex ties to social, economic, and political conditions of inequality. Many members of this team were schooled in Latin American Social Medicine, a field that focuses on understanding the social determinants of health and the economic inequities that create the conditions of ill health (Menéndez 2003; Laurell 1982; 2003; Breilh 2003; Waitzkin et al. 2001). They also had their own experiences to frame the national health problems they sought to address. Furthermore, in the process through which the policy came to take form, many players and voices were invited to participate; it was built through a complex and conflicted process of negotiation, model-making, and the sharing of experience.

The team came to a policy process and design that hinged on the gathering of models of “successful” health programs through a series of events and forums designed to facilitate policy’s design. These successes were not judged through statistics or economic modeling, however. Rather, representatives told stories and shared experiences as the approach to a metric of success. With the support of the national government, and a mandate to incorporate community participation in political processes related to health, the team created a series of nine regional conferences where representatives from the programs shared their experiences and health needs, offering their voices and experiences as an emerging tableau of medical testimonies that were to replicate the scope and diversity of an officially “plurinational” Bolivia. Many programs that were offered as models were ones that members of the Ministry of Health had connections with prior to their work in the government. And of these programs, most were supported by either domestic or international NGOs, making NGOs crucial co-producers in the gathering of content and recommendations that ultimately comprised what health policy would look like in Bolivia, as well as how it was shaped as it circulated. After these nine regional conferences, representatives from each region met in La Paz, the seat of the government, in 2010, and shared testimonies of the successes and challenges discussed in the regional conferences. Elements of these experiences served as models for aspects of the policy that emerged, while others bolstered the aspects of policy that the Ministry of Health team had already decided to include through their experiences. This policy incorporated premises that required a focus on the health of the family and the “community,” rather than just the individual. Further, it mandated the incorporation of “traditional” conceptions of health and healing into the healthcare system, which I will discuss at length in this dissertation. The policy was also anchored on the idea of community health management, or gestión, which required participation and a multisectoral approach to care, expanding the concept of health to include housing, environment, culture, water, roads, and other social and cultural determinants of health.

This policy was meant to be implemented throughout the country’s healthcare systems, which included the large public system where the majority, or almost sixty percent of Bolivians sought care, as well as to potentially involve the nationalization of the much smaller worker health insurance and social security sector, the caja system, which made up almost thirty percent of the healthcare provision in the country. The remaining ten percent or less of Bolivians sought healthcare in the small private sector. Even with this breakdown, the health policy, conceptualized around “community” health from its originary design process, and with a focus on indigenous cosmovision and plurinationality, originated from and was circulating the most vigorously in rural areas of the country that were governed by indigenous authorities, sometimes
overlapping with or working alongside municipal governance structures. The policy was particularly focused on places defined and bounded as “indigenous communities,” where ideas about reparations for histories of racism, inequality, and ill-health were understood by many people I spoke with to be manifested through the design and implementation of the policy.

These types of discussions about the aim of the new healthcare paradigm were reproduced in many interviews, news reports, and bulletins about the health care system prior to the Morales government. For example, members of the Ministry of Health Dra. Mónica Herrera and Dr. Víctor Tamayo made a statement in a 2008 Ministry of Health Bulletin following a national health reform conference,

The neoliberal policies of the last twenty years have implemented gradual (but continuous) processes of privatization and the monetization of the health sector, deepened by an individualist attitude in the provision of services. These have increased social exclusion. This health system…uses a western paradigm that centers on attention to pathologies rather than on their prevention, in such a manner that the forces of the state were directed to cure diseases and not prevent them, nor realize health promotion. This approach has deepened inequities and differences in access to and the exercise of the right to health.

Their broader framing of the health care system prior to the Morales government not only placed health squarely within the responsibility of the state, but also helped set up a discourse of necessity for a new healthcare system and new health policy as a historical action positioned against colonialism, neoliberalism, and western paradigms of health. The health care system was linked to the ethos of the government that Morales brought, where the system to be created would reflect the party’s discussions of a new future for Bolivia. This work of the government sought to create a stark divide between the past and the present, through the creation of a state that would be called “plurinational.”

Walsh’s work on plurinational state building helps to elucidate the distinction between the homogeneity of conventional approaches to state formation, and what “plurinational” and “intercultural” mean in current approaches to state building in countries like Bolivia. Part of this project, according to Walsh, is to write a future of the nation that is separate from the past. She writes, “The present efforts in countries like Bolivia and Ecuador to transform State, shed it of its colonial, neoliberal and imperial weight, and re-found it from below –from the diversity of peoples, cultures, and historical practices- are transcendental” (Walsh 2009: 65). But what is transcendental in this process? It is not just that “plurinationality” represent the variety of “differences” in a country, from geographical to cultural. Rather, according to Walsh, it requires a “re-founding of the state” (Walsh 2009: 70). This re-founding cannot just be functional, or solely involve the addition of cultural diversity. Walsh writes,

The re-founding has to also confront the continued use of the idea of race as a matrix of power…and similarly, it has to open up the possibility of rethinking the country from logics and systems of living that are limited to the modern European model. Such re-founding must not simply add diversity to the established structures…but has to rethink those structures plurally and interculturally thus encouraging politics of convergence, of conviviality, of complementarity and of a new and different form of unity” (Walsh 2009: 70-71).

According to Walsh, Bolivia tackled this challenge of re-founding the state by focusing on decolonization, finding ways for pluralism to be expressed, allowance for different nations within the country to work equally within the state, and cohesion around the idea of creating an
intercultural society (Walsh 2009: 73). These aims were reflected in many of the processes involved in the health reform, as well as in the premises that emerged.

**Disrupting Linear Models of Policy**

There have been significant interventions into the study of policy and its design and implementation by sociocultural anthropologists. These scholars have suggested that ideas about what constitutes “official policy” are often taken for granted and reified as confined to a certain materiality of a document, or the mechanisms that are inscribed into formalized texts and then implemented. For example, Corbett (2005) writes, “There is also a tendency to view policy, if not as a linear process, then as a neat, logical, orderly, and rational set of flows and procedures that move rationally and systematically from formulation and design to execution and evaluation” (Corbett 2005: 38). Greenhalgh, as well, discusses this model of the policy process put forth by disciplines such as public policy. She writes, “That process is represented as an orderly set of procedures that move linearly from agenda setting to policy formulation, implementation, effects, and evaluation,” and calls this the “stage model” of policymaking that is typical of fields such as policy studies that try to construct “ideal models of the policy process” (Greenhalgh 2008: xii). In this framing, the origins of these policies and the effects of their implementation become the object of study (Greenhalgh 2008). For example, Greenhalgh’s work is a call for anthropologists to study the “making, working, and effects of public policy as problems of modern governance,” suggesting that more attention to the making of policy is required (Greenhalgh 2008: xiii). In this view, policy is a kind of governance, a way of understanding the workings and manifestations of state power. Greenhalgh’s work focuses on the intersection of governmentality studies and STS to look at the ways that population science shaped the one child policy in China. I build specifically on Greenhalgh’s concept of the “policy assemblage,” and her critique of linearity in the process, as she writes of a “heterogeneous association of elements—actors, institutions, knowledges, and so forth—that come together for a time to produce particular policy problematization” (Greenhalgh 2008: 9).

Furthermore, many anthropologists of public policy have examined the impacts and implementation of policy (Horton 2006; Lamphere 2005). For example, Biehl (2004) looks at the development outcomes and pharmaceuticalization of AIDS policy in Brazil that create new forms of governing, Fassin (2007) examines the responses to and impacts of South African AIDS policies, while Wedel (2001) looks how aid policies in Eastern Europe act like “chemical reactions” that are transformed in the process of implementation. However, these studies look primarily downstream rather than at the imbricated processes of the production of policy and its implementation. Other policy studies in anthropology focus on how authorities relate to local populations through policy-making and in turn, how policies are used to govern populations. Briggs & Mantini Briggs (2003) look at how authorities determined a policy approach to a cholera epidemic in Venezuela that framed certain subjects through racist logics, while Merry (2003) studies how a U.N. human rights policy creates sites of local cultural production. Studies that do examine policymaking often focus on policy shortcomings, such as Nichter’s (2008) discussion of the use of “master narratives” in policymaking, Van der Geest’s (2006) argument that policy-makers focus on the creation of documents rather than implementation, or Janes’ (2008) suggestion that policy is often made as a model to be widely applicable, thus failing to specify local factors or the important relations between “policy-makers” and “policy-subjects” (see also Hardon 2005). I build on the work of these scholars, but attempt to also expand the
scope of what policy is, where it is made, and how it circulates by disrupting and making untenable certain binaries around process.

I did in fact come to my work thinking about policy in linear terms, as something that involved a particular kind of rationality and a mechanistic, step-by-step approach to design and implementation. Yet, from the moment I began my research, these linearities were disrupted as I saw iterative approaches to these processes. Further, policy was often described overtly as something cyclical, or more subtly in ways that disrupted bounded and oppositional notions of policymaking and implementation. In particular, this cyclical nature of policy processes was discussed whenever I tried to make a distinction between policy making and policy implementation. After attending a health policy conference in a rural municipality in the altiplano, a few hours from La Paz by bus, I began to question these distinctions more deeply. At the event, government officials from the Ministry of Health and the Vice Ministry of Traditional Medicine and Interculturalism gathered together community members, traditional healers, NGO workers, doctors, and government representatives to discuss the specific treatments of common illnesses in the region. Throughout the day participants worked to identify the symptoms of these illnesses, recommend treatments and herbal remedies that could be used, and debated their approaches. The government intended to take their recommendations and produce a guide for the altiplano region of the country. They planned to produce two other guides for the midlands and lowlands regions of the country, as well. At this event, which took place in a small community clinic in the municipality, I met Luis, a young biochemist working to analyze medicinal plants at the Vice Ministry of Traditional Medicine and Interculturalism. This vice ministry was created in 2006, in coordination with the process of developing Bolivia’s national healthcare reform. The vice ministry was involved in the development of the Bolivian Society of Traditional Medicine (Sociedad Boliviana de Medicina Tradicional, or SOBOMETRA), the creation of a census and registry of traditional doctors and midwives, as well as the development of new laws and regulations of products and practices of healers (Sikkink 2009). Representatives from the Vice Ministry were involved in many of the health meetings and conferences I participated in during my fieldwork.

Luis, a scientist from the Vice Ministry of Traditional Medicine and Interculturalism who attended the workshop agreed to meet with me the week following the event to discuss his work and what the vice ministry would do with the information gathered. In our discussion, I asked him about all of the documents that were being produced as part of and surrounding Bolivia’s health reform policy. He would not let me continue to see these design elements as somehow prior to policy, but rather discussed the policy process as “cyclical,” with no clear distinction between the writing and implementation of policy. He told me,

As you said, there are many things written, no? There is the policy, the plan, the law of traditional medicine, the Sistema Único de Salud, all of these are written. But the subtlety is in how to articulate these laws so that they can be put into practice. The law is general, you cannot ground it, it is like the Bible. You have to interpret it to conform to your vision, as you understand it. I can understand the SAFCI policy based on my point of view, because it is general.

I was taken aback by this comparison: Policy is like the Bible? The emphasis on interpretation and the possibility for a multiplicity of implementations was significant. In another conversation with a former Ministry of Health technocrat, Dr. Víctor Tamayo, who was part of the policymaking team that helped to design policy, he affirmed this position, telling me, “The policy itself is in the minds of the people.”
While policy is sometimes understood to be a readymade object whose effects can be studied and critiqued, here I track how an understanding of what “policy” was made through the study of the construction of a concept of health policy in Bolivia. It involved a multiplicity of voices; that is, “policy” emerged as the provisional resolution of an officially mandated heteroglossia that was linked to the demands of representing not only many individual and community voices, but also was linked to the many positions of Bolivia’s official plurinationality, which itself was an ideal. There was also the possibility for a personal relationship with policy that was enabled by policy’s forms and premises. This approach to policy affirmed the Bible analogy that Luis made. For example, the Old Testament sets out a series of premises, but these are, by Jewish law, meant to be, and actually designed to be debated, interpreted, and discussed. Built into the form of law is the possibility for its interpretation, and it is actualized in practice and through debate, though always referring back to the originary forms and ideas. Further, during the Reformation, translations made by Martin Luther and others involved forming a personal relationship to the Bible that was different from the Church’s (Whitmarsh 2015). There was a value placed on heteroglossia and multivocality in designing policy as integrated into the processes of circulation and implementation.

Bureaucratic and official processes incorporated a heteroglossia, making “policy” the work of a polyvocal “author” that in some ways was seen to represent “Bolivia” based on the constructions of difference that were incorporated into its premises. Not only was the policy “made” as a provisional outcome of an official process that incorporates a multiplicity of viewpoints, it circulated in ways that made it open to practical mutation. Policy was not the end, but also was a beginning, not simply of the healthcare system and redefinitions of health, of which it was the legal prerequisite, but also for the opening of a range of possible interpretations. Its usefulness, and its anticipation of different readers and users made it also multiple in its projected audiences. This was thus not simply a question of health policy as a document being open because it can be read in different ways; rather it was about the ways in which health policy as a form itself was conceived of and designed as something that would be open and flexible in practice, within the boundaries of certain formal structures.

In attempting to undo linearities in policy processes, then, I also move beyond a focus on mechanisms of power and mechanisms of policy, and rather examine the realm of the affective and the aesthetic through an examination of the particular affective language that emerged around policy in narratives by policymakers, approaches to the expansive origination of policy, and a study of the materials and immaterialities that circles as policy. “Policymaking” in this sense involves both the practice of collecting and documenting these assemblages, but also the making mobile of the excesses that are produced. This excess, including the affective and the aesthetic dimensions of policymaking, reformulates policy as a way to refound the nation. It makes possible the idea that reparations can be made by redefining health, wellbeing, and care in the country. The five chapters that follow reflect some of the ways that these views might expand how we think about policy and the ways policy might be studied, ethnographically. I look at the ideas, debates, aesthetics, histories, memories, and partnerships that shaped the concept of policy that emerged in Bolivia, and the types of representation of difference and the future that emerged. What vision of policy emerges from this work? There are many layers to how policy was made, understood, and circulated in Bolivia. Policymaking itself involves a complex intertwining of the past, present, and future, including the relationships, memories, histories, and ideas about the population. In Bolivia, the creation of a concept of policy took many different forms, from aesthetic to symbolic to bureaucratic, and was connected to the particular ways in
which the Bolivian state was thinking about the notion of health, with references to a utopian state-building project. As such, constructions of notions of difference became part of the framing of health that entered into the making of policy. In the rhetoric of the Morales administration, inscribed into the new national constitution of 2009, the social body of the state was not a singular social body but was internally diverse, or plurinational. By denying the analytical category of policy and studying how it is constantly made and remade, we learn more than about policies and their role in modern governance, but also about broader issues of nation building and notions of health and healthcare.

Research Approach

Annelise Riles writes of an “unwinding” as she stood alongside Japanese bureaucrats to understand their stories about innovation, and found that her own storytelling mirrored theirs; there was a relationship between their unwinding and her own production of anthropological knowledge (Riles 2004). I engage in this same unwinding as I pull the pieces of my research, the stories I heard, the experiences I participated in together into the narrative presented in this dissertation. The stories I heard about the beginnings sent me on the trail of other stories, raising a deep question about origins that followed me throughout my fieldwork. Constructing policy in Bolivia involved ideological constructions in regards to what a “policy” is, what its borders are, and what is involved in its cultural construction. It also involved discursive practices, or the actual practices that entered into the ability to make something as policy, and the practices of actually using and interacting with policy in everyday life. The work of policymaking, then, is in many ways a modernist project, where the Ministry of Health team imagined, through the incorporation of experiences of their pasts, a way to make a better world for Bolivians through the construction of a health policy, documented in an inscription practice called sindematización (Holston 1989). Then, as will be discussed in the following chapters, through the circulation and revision of the ideas that emerged, they attempted to remake the world in its image through the mobility of the concepts they produced. The circulation of these concepts as policy took them, and me, on a journey, of sorts. Policy in Bolivia was in no way singular, even as it was systematized into documents; rather it proliferated, mutated, and was inserted into different sites, whether clinics, meetings, truck rides, offices, or images.

My research in Bolivia took me to conferences, offices, and on a sort of journey through the country to understand who was involved and how and why. I went to all health related events I could find. I analyzed the documents and electronic media I was given. I saw a list of authors and I found as many of those people as I could and interviewed them to get their oral histories of policy and policymaking. I followed these people around as much as I could and let them send me to other people, places, and events. This pastiche of a methodology suggests that there is no order, that the story could be told in many ways because policy emerged as a multiple set of ideas, models, practices, put into action by different people. These journeys took me to sites of design, implementation, revision, and mutation of policy, as well as through very particular constructions of difference, health, and indigeneity in Bolivia, leading me to question what exactly health policy is, who is a policymaker, and how the multivocality, mutability, and excess that I was quickly finding to be part of this process were folded into or adhered to something that could be called policy. This methodological approach allowed me to examine, ethnographically, different aspects of health policy. What constructions of policy, policymaking, and policymakers
emerged? Who were the authorities? What work is done to produce policy within a moment of national change?

Roadmap

The first two chapters of this Dissertation focus on Origins. In Chapter One I look at the origins of policy from the Ministry of Health policymakers' perspective, focusing on their oral histories. Through these oral histories I found that at the foundations of policymaking and policy are histories, memories, affect, discussions of difference, and utopian visions. I examined how policymakers used the past to project their vision of the future, as well as how the multiplicity of voices and origins got systematized into the form of policy that could circulate nationally, which suggests the way the more standard cartography of policy is actually made. I locate some of the "dystopias" in their utopian vision, as well, in order to suggest that both the pasts, the visions, utopias and the realities and dystopias all circulate with policy. Chapter Two looks at the co-production aspect of the origins of policy and policymaking. As part of the policy design process, the Ministry of Health policymakers sought collaboration from nine invited communities in the process of designing policy. I examine my visits to two of these communities that were invited, as well as one community that was not involved at all. I found that in the invited communities they relied in varying degrees on NGO assistance and expertise, which problematizes the utopian vision of a break from the past that the policymakers expressed through their oral histories. I discuss what these partnerships teach us about co-production, authorship, and authority in policymaking. I also suggest ways that the past is always inextricably embedded in future visions. In Origins I suggest that policy is formed by a multiplicity of voices, actors, positionalities, and experiences. As such, there is no "singular" policy, it contains an inherent multiplicity. Even in utopian visions the past is always present, and cannot be seen as an epochal shift even if it is presented as such. In both of these chapters I look at how authorship and authority are flexible and shifting, leading to the origins looking the way they do: mutated.

The remaining three chapters focus on Mutations, and the structures and authorities that attempt to limit mutations. In Chapter Three, building on my examination of multiplicity in policymaking and policy’s origins, I introduce the concept of mutation as a way to discuss how this multiplicity was reflected in policy’s implementation and revision. Mutation is the idea that flexibility and adaptivity are both inherent in the design of the policy, such as in adaptive premises or practices of revision, and in the implementation of policy. These mutations were demonstrated at health policy conferences I attended where ideas about policy and experiences with policy were debated and revised from the perspective of communities that were involved in implementing it in differing ways. These iterative processes demonstrate the ways that making and implementing policy are integrally linked and cannot be understood in stageist ways. However, even though I saw a tendency towards adaptivity and mutability, there were still also authoritative structures that were put in place by the premises of the "ideal type" of the policy, and the policymakers who facilitated these conferences. In Chapter Four I examine a system sector-based mutation in policy within the worker social security insurance system, suggesting that mutation can work in unexpected ways. Most of the worker insurance agencies opposed the government’s policy because they feared that the government would centralize all of the insurance organizations. There was one insurance organization, however, the Caja Petrolera, that was actively adopting a version of government policy into its work, mutating it to fit its own aims and requirements. This chapter explores the different ways they "mutated" policy, and what
it looked like in practice. I use Freud's concept of the Uncanny to talk about how, in trying to produce a double, there can be an incomplete doubling, which creates an uncanny that is never an exact double. I also use Hayden's work on the "proper copy" to suggest that this version was considered by some to be an "improper copy," which I found through discussions where certain Ministry of Health officials policed the borders and boundaries of policy. This unexpected mutation suggests that when policy is designed to be adaptive the mutations might go in directions that are not wholly accepted, demonstrating some of the authoritative boundaries of policy itself.

Finally, in Chapter Five I look at the “aesthetics and audiences" of policy and the multiple and mutable forms it took in circulation. I found that mutations were not limited to the theoretical and practical usages of policy, but also to the aesthetics of the forms that policy took, from personal journals to legal versions to teaching versions to oral versions. I examine how the different aesthetics allow for different audiences to be created as users of the policy, or become involved with policy in different ways. Policy had the potential to be accessible to a large number of people in diverse positions, based on the ways that its forms were produced. Yet, the forms that circulated also manifested aspects of the unevenness of the policy, based on where they circulated, how they were interacted with, and what work they did to fulfill the policy’s political aims. How might this study of aesthetics and technologies of policy’s circulation suggest new ways to think about the communication of health policy to a variety of people? I suggest that the aesthetics of these forms might shape the ways they travel, where they travel, and how they are taken up or understood. I conclude by suggesting that policy can be understood as a vitalist form, rather than as mechanistic, linear, or static. Bolivia, as an example, might teach us about what is common across policies, as well as show us what is unique about this particular policy I study. I bring in examples from the United States health reform policy, the Affordable Care Act, in order to suggest how these analytics for an ethnographic study of policy might be useful or interesting.

Some of the questions this dissertation seeks to answer, then, and that will be discussed in each chapter, are “What is a policy?” and “What is a policymaker?” and how do these get mediated through understandings of “health” as part of a vision of the Bolivian state? I interrogate the sites and narratives where ideas of each were produced. What are the possibilities and what are the limits of attempting this work in the field of health, particularly when health policies are meant to deal with bodies, environments, health practices, and medical expertise? What, then, are the actual practices involved in the ability to make and use policies, and how do these practices continue to form and adhere to “policy”? What is at stake for medical anthropology more broadly if we rethink the concept of policy itself in this way? This work, then, is not about a policy, but about the making of a policy, and, beyond that, about the making of the possibility of conceptualizing and producing something as a policy. What gets called “policy” and how? Who is involved in this labeling and making and what are the authoritative boundaries in the process? How do different people produce particular types of ideas, documents, stories, theories, histories, and memories as policy?
Part 1: ORIGINS
Chapter 1: “There is Always a Before”: History, Memory, and Utopian Desires in the Making of Health Policy

Preamble, Bolivian Constitution, 2009

In immemorial times mountains arose, rivers were displaced, lakes were formed. Our Amazonia, our Chaco, our highlands and our plains and valleys were covered by greenness and flowers. 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. This is how we formed our towns, and we never understood racism until we suffered it in the terrible times of the colony.

The Bolivian people, of plural composition, since the profoundness of history, inspired in the battles of the past, in the indigenous anti-colonial uprising, in independence, in the popular liberation fights, in the indigenous, social and union marches, in the water and October wars, in the battles for land and territory, and with the memory of our martyrs, built 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.

We left the colonial, republican and neoliberal State in the past. We assumed the historical challenge to collectively build a Social Unitary State of Plurinational Communitary Law, which integrates and articulates the purposes of advancing towards a Bolivia that is democratic, productive, carrier and inspirer of peace, compromised with the integral development and with the free determination of its people.

We, men and women, through the Constitutional Assembly and with the originary power of the people, manifest our compromise with the unity and integrity of the country.

Complying with the mandate of our people, with the strength of our Pachamama and giving thanks to God, we refound Bolivia.

Honor and glory for the martyrs of this constituent and liberating feat that has made possible this new history.

Introduction: “Siempre Hay un Antes”

In the poetic preamble to the 2009 Bolivian Constitution, created based on the demands of an indigenous social movement, a vision of a “new history” emerges from the presence of traces of the past that lead towards a utopian vision. The preamble sets forth a mythology of
creation and references to Pachamama, or Mother Earth, as well as the abomination of this creation due to the trifecta of colonialism-republicanism-neoliberalism. The presentation of the constitutional premises that follow provides a way forward as a reparation of this past, a “refounding” of Bolivia. Within the articles of this Constitution are the requirements for a new healthcare system. The legal policy meant to implement this system, “Salud Familiar Comunitaria Intercultural” begins in a similar fashion to the preamble with a response to the problems of the past with a vision of the future:

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.

Intrigued by these entextualized discussions of past, present, and future, during my fieldwork I sought to understand these words and what they meant to the changes in the healthcare system in Bolivia. I began to seek out the authors of these words, a team of Ministry of Health workers, who I call the “policymakers” because of their role in redesigning and refounding Bolivia’s healthcare system, and asked for their narrative histories of policymaking. The narratives of these people reflected the suffering in the nation’s past and a way out of this past towards a new future for the nation through health policy. This chapter is a reflection on origins and future visions that were woven around policy and policymaking in policymaker narratives. Some of the questions I ask are who are the originators of policy, what made them policymakers, and what might their narratives about the origins of policy, and the ways they tell their stories, illuminate about policy itself? I ask these questions to contribute to the larger project of my dissertation to propose new analytics for the ethnographic study of policy. Policies are typically circulated devoid of the stories, visions, emotions, and humans who made them. Perhaps there are lists of contributors or authors, but the personal visions in the creation of policies that are meant to produce a change to the healthcare system, or a completely new kind of system, are very rarely the focus; by following the origin stories I can begin to answer the question: Why should they matter?

It was surprisingly easy to locate these individuals. I heard about them at all of the health-related events I went to in the early stages of my fieldwork, their names swirling through conversations I had about policy. Finally on a sunny morning in January I sat across from Dr. Víctor Tamayo in his office at the Ministry of Health and Sports in the cobble-stoned Sopocachi neighborhood of La Paz. At the time he was the General Director of Health Promotion at the Ministry. In some ways health policymakers in Bolivia were absolutely typical of what you might expect of policymakers: they wore suits, they had offices in government buildings, they went to meetings, they produced documents, they were interviewed in newspapers, and they had important titles. Policymaking seemed, in fact, to occur at exactly the sites one might imagine. However, collecting their stories of the process, their personal experiences, and their emotional and theoretical connections to the work they did illuminated unexpected aspects of both what makes a policymaker and the process of policymaking. Dr. Tamayo told me a story that would soon be familiar, as it was similar to those of others I spoke with. Prior to joining the Ministry of Health in La Paz, he worked for years in rural areas of Bolivia as a physician, and helped build municipal-level political participation throughout the country. He was invited to join the Ministry of Health team in 2006, due to these experiences, by the Minister of Health at the time, Dra. Elena Ortíz.

“Can you tell me about the process of designing the SAFCI policy, beginning in 2006,” I asked, using the abbreviated legal title of Bolivia’s health reform policy, which the Ministry of
Health named “Salud Familiar Comunitaria Intercultural” or SAFCI. I suggested the year 2006 as a starting point, because it was the year I knew that the team was formed. At the time, I could not see how deeply my own definitions of policies and ideas about what sorts of narratives could and should be told about them were shaped by a linear perspective and by the narrative temporalities that it naturalized. He was quick to correct me, “2006 is not the only beginning of this, it began before. There is always a before: these befores are the fights against the dictatorship, the popular participation, and the lack of attention to the indigenous.”

The words “There is always a before” stayed with me as I interviewed other members of the Ministry of Health team to gather their oral histories of the process. I was attentive to the ways they constructed ideas of policy and policymaking through their narratives. Nearly all seemed to have a strong desire to discuss the past. Derrida writes of a “metaphysics of presence,” or a presence in the present moment that is infused with traces of the past that get pulled along. These traces conglomerate, overlap, and diverge. In my study of policy’s making, I could not help but question, as Derrida has, “Where and how does it begin…?” (Derrida 1997: 74). Derrida suggests that posing questions of origin brings us to greater complexity, writing, “A meditation upon the trace should undoubtedly teach us that there is no origin, that is to say simple origin; that the questions of origin carry with them a metaphysics of presence” (Derrida 1997: 74). When I came to Bolivia I thought I would focus primarily on the designing of a document, following a text. However, in my interviews, the subject of the “befores,” of history, and emotional responses to these histories, kept emerging, and policy became much more than a document, in both its origins and circulation. This led me to reconfigure the scope of policy, and the scope of my ethnographic study of policy. What are the boundaries of this concept we call policy? Why do we not typically ask questions of policy about biographical history, memory, and affect that went into the visions policies project? One key way to think about these questions is through the subject of the “before.” What comes before policy, and how does this before continue to remain relevant in policy, for policymakers, and for the people the policy is circulated to and used by? Does this before re-narrate a past? Does this before constitute an after? What condition of possibility does the future become given particular framings of the past? Through these questions, “policymaking” and “policy” were both extended for me, through an understanding of the “befores” members of this team narrated for me, and the visions of the future these beforees produced (Strathern 1988). Before they ever mentioned meetings to inscribe a document, policymakers discussed other times and other places, all part of constructing certain conceptions of the past that would justify the kind of policy that they created. I came to the field with the idea that policy is impersonal and unemotional. This conception of policy was completely unhinged for me because of my time with these people.

When I met with another member of the team, Dra. Herrera, I asked her the same question about the process of designing the Bolivian health policy, keeping the notion of the “befores” Dr. Tamayo mentioned in mind. She told me in an impassioned voice, her eyes moist with emotion, “It is totally ours, part of our experience, our reality, our necessity, our perception.” Dra. Herrera was clearly speaking not just for the policymakers, but also for certain members of Bolivian civil society. I wondered what could “ours” mean in a “plurinational” country where it seemed there would be the impossibility of any policy being “ours” to everyone? How did this framing of ownership relate to the origins of policy, the befores? In

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2 Es totalmente nuestro. Partido de nuestra experiencia, de nuestra realidad, de nuestra necesidad, de nuestra percepción
particular, I found that policymakers wove together histories that incorporated references to an “ours” that linked to indigeneity. These references both produced a concept of indigeneity, but also suggested who they felt should experience a sense of ownership over both policy, as well as new understandings of “health” in the nation. A study of policy’s origins, then, requires a discussion of how difference was understood, discussed, and incorporated into political systems in Bolivia, and how it was used as a means for representing a ruptured past and desire for a different future. While the multivocality and multidimensionality of policy’s making was invisibilized in the official documents, notions of difference that emerged from these stories were incorporated in its premises and inscripted into the language of law, allowing for a policy to circulate as a singular entity by label, but to represent and take multiple forms and be adaptive. As such, I will examine how, as it circulated, policy interpellated the same notions of difference that went into its making.

In this chapter I will show that visions of the future, narrative histories, memories, and affect are infused and woven into policy’s making. Part of this process was “becoming a policymaker;” there were specific types of people who were understood to make good policymakers and members of the team in Bolivia at the time. These people had very particular ways of understanding Bolivia’s past, due to their experiences. These framings of the past were required for their projections of and design of a different future. Like Derrida’s idea of constative performance, they created a vision of the future, offering a way forward as a response to the dystopias of the past. These manifested not just as national dystopias, but also personal dystopias, as stages to overcome (Derrida 1994). The vision that they created had no singular origin because it was based on a multiplicity of stories, voices, and experiences, and so was already mutable. The designing of policy was also based on stories and experiences from people outside of bureaucratic offices, who were invited to contribute to the process, mediated by the Ministry of Health officials. The model that emerged replicated some of the foundations of its making, including discussions of past, present, and future and particular constructions of difference, which could at times seem to replicate the dystopias of the past. However, I suggest these framings might also be understood as strategies in creating a particular kind of future. Therefore, the vision of the future was tied to reparation of the past, and the overt addressing of the violence and suffering of the past. Policy was thus a utopic vision that offered a way forward through a new way of conceptualizing health. The founding of health policy was tied to visions of what the policy was seen to be able to create. Policy thus emerges as a form imbued with memory and history; it is about desires, visions, and reparations.

I suggest that this way of analyzing what health policy is and where it comes from pushes against certain conceptions of linear time. Often policy is talked about as a stageist cultural model. Attention to the narratives of policymaking, however, illuminate a different sense of time, fashioned around ruptures, strategic uses of the past, utopian visions, ideas about revival, and a multiplicity of origins. Reinhart Koselleck writes, “All testimony answers to the problem of how, in a concrete situation, experiences come to terms with the past; how expectations, hopes, or prognoses that are projected into the future become articulated into language…how, in a given present, are the temporal dimensions of past and future related” (Koselleck 2004: 3). For Koselleck, past, present, and future are hinged upon each other, and they always transect the present. Modernity produces a relationship between past and present, what he terms the space of experience, and present and future, or horizons of expectation. The present, then, becomes a unique site through which to analyze the complex renderings of both past and future. Policy and
policymaking in the present created the possibility for a particular relationship with the past and future. If policy had a history, it also grew out of a complex intertwining of memories, affect, and retellings of histories. And, for this policy’s makers, the concept of policy they worked to create, as an ideological document meant to express a certain vision, was also an intervention into Bolivian history. This in many ways is a modernist project of the state, where Ministry of Health team members imagined, through their narratives of the past, a way to make a better world and future through the construction of a health policy.

My many conversations with Dr. Tamayo, Dra. Herrera, and other members of the Ministry of Health team led me to grapple with questions about what constituted these “befores,” what was meant by “ours,” and how these together produced a conception of how “health” and “policy” were understood in Bolivia. Based on my collection of a striking collage of stories, expressions of emotion, and memories I found that the conception of policy that these Ministry of Health workers produced was anything but impersonal, and rather was completely infused with affect, desire, and history, as well as very particular productions of notions of difference as part of a narration of Bolivia’s past, present, and future. This same representation of affect and desire is expressed in the preamble to the national constitution that begins this chapter: the words are poetic, while communicating a very particular historical trajectory and utopian political aim. Between the mandate in the constitution and the narratives of making policy, these produced a kind of vitality or revitalization of the past as the basis for policy. These were then inscribed into policy through a practice called systematización, where the team brought together the ideas and experiences shared and wrote them into a formalized document, the type of document that we hear of in the news, for example, but rarely read. I thus have to question what might be gained from resuscitating the multivocality that exists behind a seemingly static document. This is important work, I suggest, not just to understand the heteroglossia that informs the designing of an entity called a national health policy, but also because of the significance of understanding what happens in policymaking processes that might have a profound impact on the implementation of new or different conceptions of health. For, as Bowker and Star suggest, reflecting on strategies of classification and categorization, “The very multiplicity of people, things and processes involved mean that they are never locked in for all time” (Bowker & Star 2000: 49).

**Vivir Bien, a Unified Health System, and the Utopias of a Beautiful Policy**

Many times during my research I was jarred by a strange phrase, one that I kept coming back to and asking people about throughout my fieldwork. It mostly came up in informal conversations, but sometimes in interviews: some of the people I spoke with referred to Bolivia’s health policy through a discussion of aesthetics, as a beautiful policy “la política bella,” “la política hermosa,” or a lovely policy “la política linda.” I was surprised by the bringing together of these two concepts, but this surprise was perhaps based on my own preconceptions of what a health policy is: boring, rational, static. I began to ask others about this phrase, what they thought of it, what it meant to them. Was this a commentary on the design of the policy, its physical form, or something about the ideas contained within it? How could policy be beautiful? Dr. Fernando Montés was part of the Ministry of Health team that originated Bolivia’s health reform and helped design the Residencia SAFCI, a residency program that emerged alongside the government’s formal health policy that trains doctors in the approaches to the policy’s implementation, with a focus on rural community health. I asked Dr. Montés about this idea of a “beautiful policy.” His response was intriguing. For Dr. Montés, the idea of a “beautiful policy”
referred to an ideal type, a utopia. He told me, “We accept that this [policy] is an ideal. We know that it is an ideal, it’s like the Marxists who say everything is a utopia.” This aesthetic claim about policy was tied to its potential to repair the past through a new paradigm for understanding health and healing in Bolivia.

Health policies often involve plans to replace or revise existing systems, whether through new approaches to health care coverage, health care access, or health care payment. However, in formal policy analysis, these visions are often framed around economic analyses, policy modeling, and projections. These projections question whether policy will be effective in implementation, in other words, projecting the social life of a policy as involving a linear transition from two opposing states. But what other visions are part of policy’s founding premises? In Bolivia, in attempting to create a revolutionary healthcare policy, the revision of the system involved the attempt to produce a paradigm shift in health, an entirely new approach to the concept of wellbeing that became a “beautiful” vision for some. The first section of the Supreme Decree of 2011 states, in its own form of technical language, “SAFCI, as a model, signifies a paradigmatic change in health, which can be understood integrally and with a focus on the social determinants of health” (Decreto Supremo 2011: 5). The political approach to this vision, called for in the constitution, was the creation of a unified health care system, called El Sistema Único de Salud (Article 18). The idea emerged from a MAS study about the social situation in Bolivia, conducted in 2005, right before the elections, to assess what their health platform should consist of. Once implemented, this unified healthcare system would guarantee the right to health to all Bolivians, as an “inalienable right guaranteed by the Plurinational State” (Ley de Sistema Único de Salud). “The SAFCI Policy” was designed as the policy to implement the elements of this system. Article 2 of the Ley de Sistema Único de Salud states:

In compliance with the constitutional mandate, it creates a Unified Healthcare System that guarantees the right to health and universal access to healthcare for all of the inhabitants of the territory of the Plurinational State, as universal, free, comprehensive, equitable, intracultural, intercultural, participatory, with quality and social control, including traditional medicine.

At the time of my fieldwork, the legal Sistema Único de Salud was still held up in congress and had not yet been implemented, in part because the government could not fund it. The health policy, “Salud Familiar Comunitaria Intercultural,” or “SAFCI” was, however, legally formalized, and was, as a policy, meant to be incorporated into all of the health services in the country and manifest the ideology expressed in the proposed Ley de Sistema Único de Salud. In interviews I heard the Sistema Único de Salud described as “the big picture,” while “SAFCI” was described as the “methodology” to implement the changes to the health care system. However, during my fieldwork I never once saw an economic model or a policy projection, but I did hear countless accounts of the type of society that policy was intended to produce, the type of future imagined for Bolivia, and stories of successes and difficulties in health programming. These ideas were explicitly written into policy. However, to understand where they came from I suggest it is important to provide an ethnographic study of policy that attends to origin stories. Any vision of the future is tied to the specific ways that the past and present are understood and narrated. I examined how these were shaped into the form of policy that emerged. Policymakers imagined a future and what might be called a “utopia” for Bolivia, even amidst a reality where the system itself could not be implemented.

In both Foucault’s (1986), and Birkholz’s (2006) work on utopias, the idea of the utopia involves a comparison of some future possibility or ideal space to a certain conception of the
real. Ingman and Thomas (1975) suggest this aspect of utopia in their discussion of the distinction between *topia* and *utopia* made by U. Mannzeim in *Ideology and Utopia* (1936) as a reaction to Thomas More’s fictitious place, Utopia. *Topia* refers to “any conventional system” while *utopia* is “any serious plan for its replacement” (Ingman & Thomas 1975: 2). It is in this way that a utopia can be conceived of as a place in the future, and be given a form of distance from a current position that must somehow be overcome. Further, in *Of Other Spaces* Foucault refers to this same issue of the relationship between utopia and the real when he writes, “Utopias…are sites that have a general relation of direct or inverted analogy with the real space of Society. They present society itself in a perfected form” (Foucault 1986: 4). For Foucault, the aspects that constitute a particular utopia can be seen as elements people apply to them or fill them with, and they can be shifted because certain actors decide which elements they contain as a way of mirroring or reflecting some aspect of the “real space of Society.” The intention in the act of creating or representing a utopia is to fill it with elements that will give it direction for action or a call to action. Thus, through the constitution of a utopia it is possible to measure a represented utopian space’s distance from “the real,” as well as the sense in which both the utopian space and the real can be seen as representations. At first glance, too, Birkholz’s utopia also contains the idea of a becoming, of a future possibility, suggested when he writes, “Utopia concerns the ‘possibility of transforming life in this world’… Just as crucial as utopia’s location elsewhere, then, is utopia’s temporal displacement—its activation of the future tense. For basic to its constitution, agree its critics, is utopia’s promise of providing some ‘way out of’ the ‘contemporary predicament’” (Birkholz 2006: 591). Similarly, health policy reform in Bolivia was framed by many as a “new paradigm,” as a way to respond to and heal the past.

Along with the idea of the *Sistema Único de Salud*, another utopian vision that was expressed in conceptualizations of the building of a Bolivian health policy was the ideological framing of how to redefine “health” and “wellbeing” in the country. The concept deployed the most often in these conversations was the idea of “vivir bien,” loosely translated as “living well.” *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 2009 National Constitution, the documentary artifacts of the new health policy, and nearly every health policy conference I attended. The shaping of a new health paradigm around a concept adopted from indigenous cosmovision was a significant part of the making of a new concept of health policy in Bolivia. For some at the Ministry of Health, *vivir bien* represented an alternative to the past and a vision of the future. For example, policymaker Dr. Victor Tamayo, told me,

*Vivir bien* is an alternative paradigm to capitalism. The model we are fighting against is the assistential (care-based) model, which is market-oriented and biomedical. That is the bad one, the biomedical one, the western one, the market-oriented one, the exclusionary one, all of that. The thing that challenges that is the SAFCI model, guided by the paradigm of *vivir bien*.

This use of *vivir bien* as part of the poetic language of policy mirrors the poetic devices of the policy. It calls for a future possibility framed around the openness of the meaning of *vivir bien*. The concept of *vivir bien* has been discussed at length by David Choquehuanca, an Aymara activist who also served as the Foreign Minister of Bolivia under the Morales government. He has suggested,

We want to return to *vivir bien*, which means we are now beginning to recognize the value of (valorar) our history, our music, our dress, our culture, our language, our
natural resources, and after validating these we have decided to recover everything that is ours, and return to what we were.”

Policy, guided by the concept of *vivir bien*, was framed as a way to return to “what we were.” Further, “what we were” is a view of the past that becomes a possibility for the future. In my interview with then-Minister of Health Dra. Elena Ortiz, she commented on Choquehuana’s vision, and clarified this message as to how it relates to healthcare in Bolivia. She told me, *Vivir Bien* is a message, and health is involved in all of its intersecting logics about what life is…so, if our idea is for everyone to live well, that would be like a socialist society, living well but in a broader sense, in a more harmonious sense, right? Less materialistic.

So, it’s only logical for the ideas we had formed to coincide and to be expanded with this notion of *vivir bien*. In the past we never imagined a harmony with nature, but that message [*vivir bien*] allowed us to create a beautiful policy, I would say, because it doesn’t only explain this tenet, but it also shows the importance of the utopia of the people, and at the same time their contribution to this *utopia*, right? It’s important for people to accept this idea, this seems crucial to me. *Vivir bien* is something that belongs to the people, so they are united not only more easily but also in a more thought-provoking, more interesting way. This is why it is a policy that has everything the people want, it has to be made by the people and at the same time provoke the people to see how we can build this idea of *vivir bien*.

Dra. Ortiz narrated a policy process structured by what might seem like an authoritative top-down discourse of living well. However, the vision depended on people recognizing the concept as their own, their feeling ownership over it, where they might arrive at the same idea that the technocrats of the government put forth as a structuring vision for the future of the nation. *Vivir bien* was an idea that was adopted from a nationalization of a concept that emerged from indigenous cosmovision itself. This process of adaptation and iteration was one I witnessed in various areas of policymaking: ideas, concepts, and practices from around the country, whether philosophical, cosmovision-based claims like *vivir bien* or practical approaches to healthcare implementation, were pulled up to the national level, generalized, and then reiterated and implemented back to the same people and places they came from. In her narrative, Dra. Ortiz discussed this dynamic: the policy must be made by “the people,” and provoke them to work towards the vision of the state, which is structured by the philosophy of “the people.” By examining this framing of *vivir bien*, I suggest the importance of understanding the principles at the foundation of the ideologies that a particular health policy projects, as well as their political and sociocultural genealogies.

In examining these types of immaterialities in policy design, I add to discussions by theorists of documents (Feldman 2007; Hull 2008, Navarro-Yashin 2007; Riles 2006) who are interested in their materiality. I build on this work by examining how immaterialities are produced alongside materialities. Here, I focus on the immaterialities, like *vivir bien*, that adhere to, travel with, and enliven documents. Policy in fact resisted materiality in its fullest expression, and was constructed and constructed itself as an immaterial force. The result was the creation of a conception of policy imbued with notions of revival and salvation, as well as a vitality based in its foundational premise *vivir bien*. In this framing, I suggest that both the multivocality in its making and ways that policymakers spoke of policy as a revivalist document prohibits it from being mechanistic. There is a vitality in the conglomeration of ideas, voices, memories, and concepts that is meant to help incorporate the health policy framing of “*vivir bien*” in different contexts through different interpretations.
As such, everywhere I went, *vivir bien* was referenced in discussions about a “new health paradigm,” as a way to provide a new approach to defining health. To study health policy ethnographically in Bolivia thus entailed, in part, an ethnography of the locations and meanings inhabited and generated by *vivir bien*. These discussions sometimes anchored *vivir bien* to conceptualizations of “tradition,” in terms of ways of life that were associated with a pre-colonial past; other times *vivir bien* was discussed in regards to ideas about interrelationships and community, and yet other times it had to do with a future, a nation-building project. Throughout my fieldwork, I pushed people to explain to me how they understood health, how they understood healing, and what *vivir bien* meant to them. I was trying to get a sense of some of the particular ethics and aesthetics attached to the origins of health policy through the concept of *vivir bien*. In what follows, I provide some examples from people I interviewed about how they defined the concept. For example, for him, *vivir bien* means “Good health and education, food, houses, nature, access to medicine, and sharing among all people.” Dra. María Valdivia, the Director of SAFCI at the Caja Petrolera, a workers health insurance provider, told me, with tears, “You feel, I feel, you get sick, I get sick, we need to *vivir bien*. It is emotional for me because it comes from the heart.” Pilar Sánchez, the director of the National Confederation of Women, Campesinas, indígenas, originarias Bartolina Sisa (or the Bartolinas), and who was part of the constitutional design process and the policy design process told me, “If we can change the structures that have been around for many years, and enforce it in each state that is thinking about getting rich by plundering and not respecting Mother Earth, if we can become more simple so that no girl or boy has to cry because they can’t buy a book, if we can live in dignity as human beings, this is *vivir bien*.” Xavier López of the NGO Causananchispaj in Potosí told me, “You realize that SAFCI does not come from nowhere, it arose from a process. It is not like other places that say here is the little doctor to do SAFCI. No. It began with those who said ‘These are our necessities: we need to make a health post, we have to deal with the issue of schools, we need to deal with the issue of production.’ They identified these to us, as what they required to live better, to *vivir bien*.” And policymaker Víctor Tamayo said, “There is the theory, and there is the practice. The bad is the individualist paradigm and all of the problems that neoliberalism has imposed. These problems are confronted by this paradigm of *vivir bien*. The model of SAFCI is a model, like any model, that is perfectible, debatable, and continues to develop.” The Director of Caja Petrolera said, “For me, SAFCI means integration, of everyone, all of the health personnel with the society, working together towards *vivir bien*, working together for what people need to help their health, and not only for health, but also for other things, this is for me what it is, interrelations.”

There were certain similarities in understandings of *vivir bien* that I noticed, such as an expanding sense of what health is. There were also differences based on a person’s social location, such as the focus on specificities of history by the director of the Caja Petrolera, versus the focus on a focus on areas such as healthcare access, food, and housing by the yatiri. I found that there was no singular, stable meaning of *vivir bien*, and that this mutability inherent in interpreting the concept reflected exactly some of the intentional ways that policy was designed to be interpretable and open based on a person’s context and experience. The lack of a singular *vivir bien* mirrored the lack of a singular policy or policy origin story.

In Birkholz’s conception of utopia, there is an idea of future possibility embedded into utopic visions. Similarly, health policy reform was framed by many as a utopic vision, a “new paradigm,” as a way to respond to and heal past sociopolitical ruptures. I look at how policymakers framed the past, present, and future, where their narratives of the past, both
personal and national, infused the policy that emerged and the vision they had about health and the future of Bolivia. The policy that emerged incorporated a kind of repetition of their experiences, and, as it circulated, produced repetition and difference as well (Derrida 2008). A vision through the utterance and performance of experiences, and through the ideas, positionalities, and memories that they represented. The lack of singular origin made policy itself both multiple and iterable. Policy was also a utopic vision that offered a way forward, as a response to the dystopia of the past. It was through the oral histories of the policymakers that we can begin to see how this vision was designed and why, as well as an idea of what they felt policy would be able to do and create for their specific nation-building project. The vision they created, in part due to a particular framings of difference in the country, as well as their own positionalities, was a vision of the future that was tied to the need for reparations of the past. Policy, as a utopic vision offered a way forward, but was anchored to dystopias and roadblocks through languages of the past and a system that could not make it out of congress.

Personal Memories, Ambiguous Positionalities: Becoming a Ministry of Health Policymaker

The process of creating a utopian vision of a paradigm shift in health occurred based on the representation of certain understandings of the past, and required certain types of people embedded in these particular understandings of the past to design the shift. In an interview with policymaker Mónica Herrera, who was at the time director of health promotion and education at the Ministry of Health, she repeated a number of times in reference to the health policy, “It was born from below, it was born from below.” When I pushed her further, asking her about the process of designing the policy, trying to tease out the difference between political participation by Bolivians and her own experiences of participation, she explained,

The background is that the policy was born fundamentally from the systematization of eighteen years of lived experiences. If I had not lived those experiences, personally, I would have been lost in books and those sorts of things. I used to believe that the best that I could do was to have the knowledge of the university, the masters, and all of this, and apply it and adequate it with the realities that we encountered, in order to create new theories.

Personal narratives of policymaking often began with a discussion of “becoming a policymaker.” The types of questions I asked about the past opened up a space where people could discuss the inspirations and motivations that brought them, along with their contributions and visions, to the table. These personal experiences illuminated some of ways that temporalities, both pasts and futures, were embedded into the design of policy. For example, policy functioned as both a utopic vision, one of a reaction to a fractured past, and as a politics with a poetics (Silverstein 2005). It also demonstrated the ambiguous positionalities of policymakers, as they defied any reified categories of “personal” and “political” in their discussions. They demonstrated that there were often no clear boundaries between categories of authority, such as indigenous, social, and official. This lack of boundaries between social categories reflects James Boon’s discussion of hierarchy having a “double apex and double nadir,” where he suggests that categorizations and divisions amongst positionalities need to be troubled, as my research suggests. He writes, “hierarchy does not simply ‘stratify’ pure over impure, but poses high priests of the impure along with high priests of the pure. Hierarchy implies a double apex (King and Priest) and a double nadir as well” (Boon 1999: 204). It was
through their experiences and positionalities that policymakers brought in question the types of authorities that might be involved in redefining health in the nation. Whereas in some places this job falls to physicians who work to define what is meant by the “absence of disease,” in Bolivia, policymakers within the Ministry of Health were not just physicians, but also social scientists, indigenous activists, public health specialists, political figures, and community health workers.

As such, Ministry of Health policymakers I spoke with had very particular experiences with health, health ideology, and a sense of Bolivia’s history in their work towards making a policy. The bounding off of a space of expertise through the formation of the policy team in the Ministry of Health was one way in which policymakers were “made.” The kind of person who was chosen to be a policymaker was in many ways an embodied manifestation the vision of policy that was being formulated, based on the constitutional requirement to refound the Bolivian state. Each team member I spoke with provided a narrative retelling of their own entry into the group. Their stories of entry into the process also highlighted the types of expertise and ideological perspectives that were valued for designing policy in Bolivia. Becoming a policymaker was about learning to be a person who could define “policy” in particular ways, with the ability to tell particular types of stories about making policy.

Dra. Elena Ortíz, a political figure in Bolivia because of her work as a socialist militant during the pre-democracy days in the country, was appointed leader of the team by Evo Morales due to her position as Minister of Health from the beginning of the Morales administration, as well as her work in health and with the MAS party prior to his election. I interviewed Dra. Ortíz at a café on El Prado in La Paz. Ortíz spoke in a direct manner, looking me in the eye throughout our conversation as we drank our coffee. This was not the first time I met Dra. Ortíz. I saw her at nearly every health policy-related event I went to, introducing conferences, giving lectures, posing for pictures, or talking to people in audiences. I met her personally for the first time in Dr. Tamayo’s office. It was towards the end of one of our long, engaging interviews. When he told me she would be coming by, I nervously asked him whether I could stay and meet her, and whether I could ask her to sign my copy of the health policy she helped design and author. Thinking back to this request, I imagine it must have seemed strange. But I had come to see the policymakers as my own form of health celebrity because of what I was finding when I they took me into their pasts. When I asked her to sign the document and pose for a picture with me, her warm smile expressed the gratitude of recognition. Amidst the debates, constant meetings, travel, and political positioning, she seemed to welcome a moment of being acknowledged as a person behind the policy vision, rather than as someone who just needed to advocate for it, circulate it, or sell it. Her inscription itself was infused with visions, of how my research on Bolivian health policy might lead to some contribution to policy elsewhere: “With affection for Alissa. With hope that the Bolivian experiences contribute to vivir bien for all of the people of the world.”
A few weeks later during our interview, I asked Dra. Ortiz about the process of designing “Salud Familiar Comunitaria Intercultural.” Like others before her, she immediately jumped back in time to provide me a view of her personal political history and her work in areas related to health in order to narrate her passageway to authoring the new health policy for Bolivia, and the forming of the policymaking team. For Dra. Ortiz, the origins for Bolivia’s policy concept emerged from experiences from her life history, and were also dependent on a variety of institutions and groups, those inside the university, the medical body, and indigenous social organizations (organizaciones sociales). Her story was signposted by specific moments of struggle, and her involvement in these struggles in Bolivian history. I tell her story here because it is powerful, but also because every team member I spoke to had their own story that they connected to the making of the ideas that were the foundation of the concept of policy that emerged in Bolivia.

At that time in Bolivian history, many of Dra. Ortiz’s fellow militants were “disappeared” or killed for their work. Dra. Ortiz herself was captured on April 2, 1976 by government forces during the Hugo Banzer dictatorship and tortured in prison in Cochabamba. Soon after democracy came to Bolivia in 1982, she took a position as a faculty member in the School of Medicine at the Universidad Mayor de San Andres (UMSA), and then later moved up to be director of the Medical School. While at the Medical School she began working with teams of students and other faculty to evaluate and propose changes to the medical school curriculum, paralleling the changes taking place in the nation at that time. Dra. Ortiz told me that her experiences working at the university began to shape her ideas about patient care, dynamics of urban and rural health care provision, and economic disparities in health care access. These ideas were later formally shaped through her studies of Latin American Social Medicine and her participation in the organization Asociación Latinoamericana de Medicina Social (ALAMES). For her, these were key themes, or what she called the “conceptual base,”
that she brought into conversations in 2006 when the Ministry of Health team was formed. Following her work at the university, in 2004 she became director of El Servicio Departmental de Salud (SEDES) La Paz, the office of departmental health services. At the point in our conversation where Ortiz discussed her work at SEDES, she also referred to an important historical moment in Bolivia’s national history, the 2003 Gas Wars, which emerged surrounding the question of how to pipeline natural gas in Bolivia. The Gas Wars led to indigenous uprisings and strikes, ending in the resignation of the neoliberal-era President Gonzalo Sánchez de Lozada. Ortiz referenced this moment of national rupture and change to frame the national sentiment at the time she entered SEDES, where indigenous people were actively taking a role in protesting and politics in Bolivia.

This political movement gained momentum, and in 2005 led to the positioning of Evo Morales, an indigenous Aymara cocalero from Oruro, as candidate for the presidential election, signifying a deep change in Bolivia politics. Ortiz told me that she assisted in Morales’ campaign, providing advice for his party, el Movimiento a Socialismo’s (MAS), approach to national health policy. Following Morales’ election, Ortiz was installed as national Minister of Health of Bolivia. It was then that she began to form an interdisciplinary team made up of professionals who worked in public health, doctors, sociologists, activists, and members of Bolivian social organizations (organizaciones sociales). Some of the team members, like Dr. Fernando Montés and Dr. Renato Palacios, were students of Ortiz’s at the university, while others were friends working in areas of public health. They came together to assist and support Ortiz’s work of reimagining health and healing in Bolivia, in many ways as a reaction the past they had witnessed. Ortiz noted that this rethinking incorporated aspects of her leftist political views with insights from her days at the Medical School. She formed the team to work on, discuss, and improve what she had begun to elaborate, “To help make my ideas more complete,” she told me. Policy, for many of the policymakers, was about constructing a better future, one that could repair the traumas of the past for the nation. But, in some cases, these traumas were connected with personal experiences, as well, creating an inextricable link between the personal and the political that was infused into the making of policy. Ortiz’s stories of her personal “befores” were deeply intertwined with national “befores.” Her “befores” created, for her, the call to action that are required of the utopics discussed by Birkholz.

But what exactly makes a policymaker? And why is it important to understand the personalities and experiences of policymakers when studying policy? In many interviews, these team members would provide me, unsolicited, with a list of the qualities and contributions of other team members. Some were noted for their long experiences working in “el campo” and brought stories about experiences implementing “intercultural” health care. Some of these people had long histories of work in community participation and a deep understanding of the role of municipalities in the country. For example, Dra. Herrera told me that her real learning occurred when she lived and worked with rural communities in the Potosí Department of Bolivia, telling me “This comprehension, this focus, it is not from the university. And to us, to me personally, I had to learn this in the field.” I asked her “What did you learn?” She explained,

I believe that it is a little sensibility to the other, no? If you have the knowledge it can be used to serve others. I traveled walking to Caiza. Sometimes I walked for six hours, eight hours, from community to community, visiting house by house. I did this because it interested me, and I wanted to understand how the health of the people was, how they
lived, what factors influenced their health, if they had water, if they had food to eat, if they made their children go to school, how their families lived, and what their problems were…This is a change in mentality, it is a focus on public health, integral public health. And this entails a change in mentality, because we were formed with a biological focus, centered on cells, nothing more, cells, organs, systems… But the chronic problems, the problems of maternity, that we cannot resolve right now with western medicine, the mental problems. We want to also see the articulation with traditional medicine, the rituals, the naturalism.

Dra. Herrera felt that her experiences of realities of life for Bolivians in areas that, at the time, had very little access to health care, shaped the vision of “articulation” that she put forth and that became inscribed into policy. In her narrative, her understanding of “health” is not just about curing diseases; she talks about water, food, schools, traditional medicine, and how people lived, what she called an “integral public health.”

Other policymakers had less active experiences in the field, and were rather recognized for their contributions to the form and structure of the document. “No single person could have built SAFCI,” one told me. This team had a unique charisma, one that I observed when I saw them interact with each other and audiences at the many health policy conferences I attended. There was an energy that I observed amongst them that was so engaging, and they made the concepts they were circulating come alive for all of the participants, who ranged from medicos tradicionales and midwives to NGO directors and Western doctors, which was the way policymakers often referred to clinicians in the public healthcare system. They knew, based on their discussion of problems with previous approaches to healthcare in Bolivia, that they had to make the concepts and the document speak to these different audiences, usually all within the same room. They were able to do this in part because of the vision that they infused into the process and the document, based on their expanding sense of a concept of policy that could include immaterialities such as affect, history, and memory.

However, while policymakers may have shared a similar vision, their positionalities were multiple, and often without clear separations between typically-bounded spheres, such as NGOs, “indigenous activists,” and government technocrats. Rather, policymakers often transgressed these seemingly bounded domains. Jaime Condori is one example: he is an indigenous Aymara man who worked for many years as an activist for indigenous rights, was brought in as an expert onto the policymaking team, and now works for the Spanish NGO Medicos del Mundo helping to implement policy in rural communities outside of La Paz. What follows is an excerpt from our interview:

AB. What were your contributions to the SAFCI policy?

Jaime: In reality, I was involved in everything, but I would say I contributed most in regards to participation and interculturality, from my point of view, not based on work in health, but rather from my experience as an indigenous person, because I had lived in the slopes (las laderas), in barrios. It was always about activism, since university.

AB: Can you describe the experiences you had, as you put it, as an indigenous person, in the barrios, as an activist, that you feel contributed to making the policy?

Jaime: I have a lot of sensitivity, a lot of sensitivity…I get sad, it makes me very sad when I see an injustice, but even more so an injustice reflected in the people. Why?
Because, personally let me tell you, it reminds me of my mother, it reminds me of my father, of my grandparents. That basically pushes me. That, I think, is the source that illuminates everything that I am. The academic part, the political, the ideological. I’m pretty radical and it’s this sensitivity…that’s what has pushed me…I have experienced the problems my family has quite personally…It’s just that I know the countryside, you know? I know the countryside because I’ve lived in the countryside. So that has also made me develop a lot of sensitivity in my thinking, in my academic contribution, in my technical contribution.

For Jaime, his entry into and contributions to policymaking were deeply personal, based on his living conditions as a child, and the experiences of his family.

There was also a particular theoretical perspective that played a role in the origins of policy, and shaped the ideas of the policymakers. Many of the policymakers, due to these experiences and their training, shared a particular philosophical and theoretical view on health.

Dr. Diego Ichazo, a doctor and policymaker, recalled that the team was formed of a group that came from the “Same school of thought.” When I asked him what he meant, he explained,

There was a team formed by the doctor [Elena Ortíz] with the same thoughts with respect to many problems and aspects that we discussed internally…But, 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.

In Dr. Ichazo’s discussion of the school the team came from, he discussed the problems that they were trying to repair, which reflected the problems denoted in the Bolivian constitution, anchored to health through the concept of vivir bien, and the revitalization of the past. Indeed, the policymakers on the team understood policy as something that could fix, heal, or repair the past, and they were the visionaries behind the creation of the future possibility for the nation. The approach to healing the past, of course, depended on the view of the past that the members had. These views they expressed to me in our formal interviews, but I also saw them expressed in their interactions with others.

The school of thought, or intellectual tradition that Dr. Ichazo and other policymakers referred to and drew from involved discussions about “global” health from sources from Latin America (Breilh 2003; Laurell 2001; Menéndez 2003). In particular, they pointed to Latin American Social Medicine as a model of health that, in a country with limited resources, focuses on the political-economic production of ill health through material inequities and ideological processes (Breilh 2003). This theoretical and methodological scholarship is incorporated into debates about health policies and reform in Latin America, and was positioned against the global health literature that focuses on health and health care as commodities. Some of the most significant health reforms in Latin America, for example in Mexico, have been designed by scholars of social medicine, a paradigm that Bolivian policymakers incorporated. These connections opened up new conceptualizations of the ways that categories of health and care are understood and produced in different cultural contexts. For example, Breilh (2003) argues that the critical epidemiology focus of public health scholarship in North America emerged from positions of racial privilege. In the Bolivian case the public health sector was undergoing shifts to incorporate cultural perspectives with the stated aim to overturn histories of racial privilege and as a reaction to privatization.
These experiences, ideologies, and practices informed the contributions of the policymakers, their work together as a team, and the specific outcomes of the policymaking process. Their reliance on a variety of opinions and experiences within the policymaking sphere was mimicked through the emphasis on experience that was incorporated into the policy premises. These included the requirement for interdisciplinary health teams to include a social scientist to work alongside doctors, nurses, and dentists, the creation of a medical residency program that would teach and implement a social medicine approach in rural parts of the country, and the requirement that a multiplicity of voices would be needed to complete policy in practice.

Whereas policy is understood, typically, to be impersonal and is documented in a way that makes it seem far from human touch, through my interviews I got a sense of how personal and biographical it is. This is not unique to the Bolivian health policy: all policies involve people who participate because of certain experiences they have had, whether political or health-related. Here, I want to illuminate these stories in order to question what we can learn about how a concept of policy is made by attending to its biographical foundations. While these were eliminated from the materiality of the legal documentary form of policy, they were the traces and immaterialities that helped create the model, as a poetic model, and, I suggest, traveled with the model, infusing policy with mutability, and bringing an iterability and sense of repetition to the practice of documenting, implementing, and revising policy.

Narratives of Historical Rupture: Constructing Notions of Difference as Revivalist Vision

*The trick is just as we see violence in the care to see care in the violence.* (Whitmarsh 2014: 876)

As I have shown above, the policymaking team was made up of a group of thinkers with diverse foundations but with similar conceptions of how healthcare reform should be designed and look. Many of these foundations provided elements of what I consider to be the “immaterialities” in the making of a concept of policy in Bolivia that emerged from this group. These included not just personal memories but also historical narratives that they shared, and the language they used to do so. The past took a certain form in order to lead to the design of the vision of the future. The constructions of difference surrounding indigeneity that I heard were a significant part of the framing of the past and the vision of the future that policymakers worked with in order to craft a new health paradigm. As such, this framing also reflected the national project of building a plurinational state. The themes of revival and rescue that they used, as well as the notion of *vivir bien*, incorporated particular constructions of notions of difference in regards to race, location, and indigeneity. On the one hand, these constructions of difference were supported by an emphasis on a national rhetoric of plurinationality, indigeneity, local participation, and the revival of traditional practices. However, indigenous populations were also talked about in ways that discursively reproduced some of the same framings of these populations by the colonial and neoliberal philosophies that the policymaking team sought to undo.

In medical anthropology, there is a robust discussions about the ways populations are “categorized and acted on” based on approaches to racial or cultural difference (Whitmarsh & Jones 2010; Foucault 1979; Rose 2001; Fassin 2009). Some scholars have looked at how inequalities in regards to constructions of difference are positioned and used in state policy, such
as work on racial profiling and discrimination during a cholera epidemic in Venezuela (Briggs & Mantini-Briggs 2003), the exclusion of the mentally ill from formal state institutions in Brazil (Biehl 2005), or an examination of the AIDS epidemic by looking at histories of racism and structural violence in Haiti (Farmer 2004). I consider the ways that constructions of notions of difference surrounding indigeneity in Bolivia, historically the target of racism and structural violence leading to major health inequities, was used as a marked category of difference to make positive changes in the nation through the expansion of health care options. The Bolivian state’s legitimization of indigenous knowledge and culture places these into circulation alongside western biomedical knowledge, which is significant in light of the historical marginalization of these groups (Gustafson 2009). An examination of the ways indigenous health models are now incorporated into public health programs and aid is significant for thinking about the government’s approach to reconfiguring historical inequalities through medicine and how this is put into practice. In Bolivia, categories of difference in the population are creating expanded definitions of care, rather than the exclusionary practices that are a central focus in this literature. Yet, certain categories of different are still used in ways that reproduce historical inequalities.

Povinelli (2002) in particular has written extensively about interpellations of difference and indigeneity through claims to multiculturalism in Australia. She writes of indigeneity in Australia, “The concept, as opposed to the actual socially embedded persons, seems to be providing the nation an experience of ‘before nationalism,’” and an experience of a time before the failures of compromises of national projects. But rather than offering a counternational form, the concept of the indigenous seems to be purifying and redeeming the ideal image of the nation” (Povinelli 2002: 26). For Povinelli, there is an “authenticity” of culture that indigenous people in Australia are supposed to identify with as part of a nation-building project. Similarly, in Razon (2013), the Bedouin in Israel served a similar role of representing the past ancestors for new Jewish immigrants. Indigeneity was conceptualized as something of the past, not a revitalizing tool. Povinelli writes, “They deploy a language of love and shame, of haunted dreams, of traumatic and reparative memory, of intimacy and desire. Dominant and subordinate social groups draw each other into an intimate drama of global discourse and capital, of national identity, of history and consciousness. And as they do, shame and reconciliation, a public collective purging of the past, become an index and requirement of a new abstracted national membership.” (Povinelli 2002: 29). Povinelli suggests that claims to multiculturalism and reinforcing notions of difference can raise new and productive connections.

Similarly there is a romanticized, folkloricized vision of indigeneity that emerges in some of the narratives by policymakers. Yet, I suggest that the framing of indigeneity was based on certain desires, and also created possibility, in a generative way, as it became a strategy to enact a revolutionary health policy (Whitmarsh 2015). Instead of merely critiquing these positions, then, I stay close to what people say about race and indigeneity, and pay special attention to what people mean when they invoke constructions of difference. In what ways are these constructions useful in the larger project of designing policy as utopian vision, and in what ways does attention to difference create a dystopics to the vision? How do constructions of difference actually allow for mutations that produce a flexibility or adaptivity within policy itself? What possibilities do these constructions of difference enable, and what do they achieve? What desires are embedded within these discourses of indigeneity. I turn to James Clifford, who writes about recent transformations in conceptualizations of indigeneity. Clifford calls for an “attitude realism,” which he suggests is “an attitude of critical
openness...a way of engaging with complex historical transformations and intersecting paths in the contemporary world” (Clifford 2013: 13). There are, according to Clifford, “paradoxes and tensions of our historical moments with agendas that are positioned and relational, pushing against, while drawing on, partial perspectives. The result is a more realistic, because multiscaled, dialogical and unfinished, understanding of contemporary sociocultural worlds” (Clifford 2013: 45). I am particularly drawn to Clifford’s term, “articulation” as a way to describe the type of social change occurring in Bolivia. Articulation is particularly useful for my work here because it is a word that was used to describe the approach of the health policy-“articulación” between “cultures” and between medicines. It is not always about resistance but also about interaction, dynamism, and emergence. Similarly, articulation, for Clifford, in regards to resistance, “does not imply total rejection, for it is simultaneous with the activity of moving into the new spaces” (Clifford 2013: 46). He writes, “The language of articulation helps us focus on forms of power and conditions of maneuver, on specific material and semiotic connections, without foreclosing possibilities of delinking and reconnecting. It understands the world of cultural politics, its antagonisms and alliances, interpellations and resistances, as both materially constrained and open to invention” (Clifford 2013: 46).

The historical narratives that policymakers told, as part of the “befores” of policy, incorporated this tension between framings of indigeneity and difference and producing visions of the future that policy could achieve. Dr. Francisco Díaz, a member of Dra. Ortiz’s policy team, told me one afternoon as we spoke in a small office in the Ministry of Health in La Paz, that Bolivia’s history is full of “sociopolitical rupture” (quiebre político social). He linked these ruptures to the pathway the Ministry of Health team traversed in the designing of policy. Indeed, every time I asked a policymaker from the team about the history of their process, I was thrown into a vision of national history that was not linear or progressive, but full of stalling, derailment, and “rupture” through stories of Bolivia’s past, and personal memories that reflected aspects of this past. These together were framed as signposts toward a future that the policy was to realize, and primarily revolved around particular framings of difference in Bolivia, especially in regards to indigeneity.

Dr. Tamayo, for example, discussed the history of the national “problem” that the team faced, or the root of health disparities in Bolivia that he suggested emerged in colonial times with the subordination of “indigenous people.” He told me,

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

Dr. Tamayo’s discussion of a colonial rupture was, according to his narrative account, the moment that he located the beginning of Bolivia’s existence as a nation, and the beginning of discrimination against indigenous people that eventually necessitated the future-thinking approach of the policymakers. Dr. Diaz, too, noted the centuries of colonialism and silver exploitation in Bolivia that was used to develop Europe. “Many indigenous people died as slaves in the mines during this time,” he told me, “This whole process led to social discrimination, and what we call the social debt of 500 years.” Dr. Renato Palacios echoed this explaining,

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

Embedded in these narratives was their approach to reconstructing a lost history, often discussed as “our history,” but understood as an indigenous history, as an attempt to deal with the social debt of exploitative pasts. The response this team put forward was a conception of both health and health policy that could be part of this reparation, particularly given the long subordination of indigenous health practices to western medicine. These dystopic ruptures of the past were constructed through the use of the language of indigenization. The “debt” these policymakers felt, from the positionality as national technocrats, led to the creation of a vision, a utopias that attempt a separation from this past. But the no-place of the utopia is embedded into these discourses of the past, as the framing of utopia requires the incorporation of dystopia. A policy meant to circulate to everyone, as a utopia, was actually designed to be meaningful and circulate to a specific portion of the population, defined based on these notions of difference.

This discussion of the historical trajectory towards the development of policy emerged in public presentations, as well. In the health policy meeting in January of “Recuperando Nuestras Experiencias para la Implementación de la Política SAFCI,” Dra. Herrera spoke to the audience of the history of health care in Bolivia leading up to and justifying the development of “The SAFCI Policy.” She used a slideshow to illustrate key points with bullets and images. She told the group, “It is all a history and what we are doing today is also history. We do not know how it will turn out.” She illuminated particular historical moments as the policy’s generative attributes, therefore publicly bringing historical narratives into the frame of what policy is. This narrative approach allowed her to represent policy as something that was necessitated by the ruptures of the past, made inevitable as part of an historic process by which not only indigenous practices needed to be rescued (rescatando) but also the dignity and inclusion of indigenous people was at stake.

She walked up and down the aisles in her characteristic charismatic oratory fashion, and entered directly into a discussion of the colonial era in Bolivia. She told the group, “At the time, there was no focus on indigenous people or care for their health. People died because there were no public health policies. This was the epoch of the elite, a time of individualist, hegemonic biomedicine.” By focusing on, and even recreating the category of indigeneity in this way, Dra. Herrera incited the crowd to draw connections between the colonial era and “hegemonic biomedicine” as moments in a broader history of exclusion, told through the failures of healthcare and the political logics through which its withholding was materialized. She told of a past full of inequities and sickness as a way to justify and legitimize the work of the policymakers to redefine what health means, through an attention to the notions of difference that she and other policymakers were involved in producing and reproducing. This served as a narration of a debt in health, both as a reparative process by which the state operates, as well as a debt to the outcomes of classist and narrow first world health ideology.

Policymaker Dr. Díaz focused primarily on neoliberal-era reforms, beginning in 1985. He told me that their policymaking process sought to undo the neoliberal era policies in Bolivia. His narrative created a distinct sense of historical epochs between neoliberal/postneoliberal, as an approach to framing the past. Díaz linked neoliberal-era problems with what he called “neoliberal approaches to health.” When I asked him what this approach consisted of, he told me,
Health was a strictly individual issue. I answer for my health, you answer for your health, she answers for her health…all of the health problems were solved on the market, between supply and demand. There was no policy of inclusion, and there was a lot of discrimination. Hospitals sought to gain money from sick people, and the focus was exploitative, on capital gain. The discrimination of the originary people was fatal…they did not have money, and there was no policy of inclusion.”

There was a foundational binary that exists in many of these discussions that erase collective forms from the past and individualist, capitalistic forms from the present. The approach being rejected was discussed as the “neoliberal approach,” where the opposite was framed as the “past,” a pre-history time where indigenous medicine was just “medicine” because it had not been encountered by the imposition of “western medicine.” However, by even positing “traditional medicine” in the first place as something to return to already requires and presupposes the historical ruptures and difference (Menendez 2003). The vision of the future cannot help but incorporate elements of the ruptured “befores,” for example, the NGO structures of neoliberal governance, terminology such as “popular participation” and “interculturalism,” and the continual existence, and typically unquestioned authority of western medicine. Crafting a future around befores that are constituted by notions of indigenous and racial difference creates a future that is overlapped with these same framings of indigeneity, as well as the inevitability of neoliberal structures to implement healthcare programs in the country.

In their approach to designing policy, policymakers incorporated specific understandings of healthcare provision based on these notions of difference. For example, Dr. Renato Palacios, another policymakers and director of the Residencia SAFCI, a medical residency program for Bolivian medical students to train in SAFCI community rural health, framed difference when he said,

Well, first there are different experiences across the country. Some have a social focus, while others have a medical approach, another a historical approach, another approach with a focus on life experiences.

What Dr. Palacios acknowledged here was that there was not just one conception of health that was recognized, particularly not just biological health. Rather, understanding different approaches to health and healthcare, and incorporating a kind of specificity were part of the process of creating a conception of policy that would be relevant in Bolivia.

Dra. Ortiz also discussed difference, “We had a scheme of participation that was enriched by the people. The Aymaras have a different mindset than those from Chaco or the Amazon, and these differences are great, they have different experiences.” Both Palacios and Ortiz bounded different “ethnic” groups by region, language, and cultural identification in a homogenizing way. Even in discussions about how policy ideas came into being based on a recognition of cultural difference, certain racialized notions of indigeneity emerged through the very language that was used to discuss the work done. In particular, in discussions about bringing “traditional medicine” into Western clinics, I often heard a reproduction of a conception of indigeneity as poor, not care-seeking, rural, or unclean. For example, Dra. Mónica Herrera went into detail about one particular experience she had in Potosí. She and her team from the Bolivian organization Caucañanchisaj did a “diagnostic” study to understand why women did not go to the doctor for pregnancy-related issues. Their approach, seeking out people’s needs and concerns, was a foundation for the policymaking process that developed years later. Even when attention to indigeneity was highlighted, ideas of who gets to ask,
answer, analyze, and make decisions remains folded in, as it was the leadership of Causananchispaj who asked all the questions and framed the research study. She told me that they asked a woman,

‘Is it because your spouse didn’t want it?’ ‘No’. Your father’ ‘No.’ ‘You?’ ‘Yes, it is because I don’t want to.’ Well we were wondering why, and after many interrogations, she said something that worried me greatly. She said, ‘I cannot go to have my baby at the health post because our post is very clean. Everything shines, everything is clean, and I cannot come and dirty the post with my blood.’ This is what she said. ‘I cannot dirty the sheets, nor the floor where I can almost see my face, with my blood. I can dirty my house, but not here. I am embarrassed.’ Uy! This was a very hard response, that pulled me back and I said ‘ciao public health, ciao education, everything.’ I had been focused on superficialities and I had not understood what their perception was. It hit me very hard after approximately ten years with the people… and on the other side, there was a violence in their treatment by the staff, who had no comprehension of their culture.

Dra. Herrera’s narrative contains complex discourses of hygiene and indigeneity, where recommendations for how to address concerns imposed by coloniality formally acknowledge and reproduced these discourses of hygiene (Briggs & Mantini Briggs 2003). This was manifested, for example, through the design of birthing rooms with earth tone walls, wooden floors, and ladders to give birth standing up that were implemented as a result of Dra. Herrera’s study in the region. In Bolivia, health policy was framed as a reaction to the western, biomedical model, the construct that much of critical medical anthropology and STS had questioned. An intercultural approach involved reimagining and recreating western clinics rather than getting rid of them. Western medicine, as a presence, was accepted as an inevitability, and the approach of policy was to use it in new ways and incorporate it with other models of health and healing.
However, embedded in her narrative is also desire. These experiences had an impact on Dra. Herrera’s way of understanding health and her personal sense of self. Experience gathering became a moment where she was able to recognize the failings of her own practice, and, simultaneously, the moment she was able to understand a certain approach to addressing Bolivia’s past through a new paradigm in health care provision. In order to manifest her desires for a new health paradigm, the premise of colonialism and racism required that she reproduce these colonial racialized and gendered narratives about indigeneity, as a way to justify the foundations in the production of the policy. In creating a vision of the future that was an alternative to this past, she fractured the utopian vision by incorporating these framings of the past in the vision itself, which were required, in her narrative, to reach that vision. The future, the utopian vision, therefore, is not a radical departure from the past, as in a stageist sequence. Rather, it is imbued with traces and reframings of the past. The utopian, then, is always already a no-place in that its very vision requires the integration of the past.

These notions of difference were in fact built directly into the conception of policy that the policymakers produced. All of the policymakers I spoke to emphasized the notion of *interculturalism* in health care, one of the premises that was written into the document “The SAFCI policy,” and the one that they claimed set it apart from any other policy in the world. In Bolivia, the political concept of interculturalism came into use through the language of the neoliberal Sanchez de Lozada administration that was in place in the early 1990s. Interculturalism was used by the state to describe ethnic citizenship and the interactions between ethnic groups, and has since been taken up by indigenous groups to make demands on the state (Postero 2006: 5). Gustafson (2009) and Johnson (2010) examine the use of this term in Bolivia. Gustafson explores the topic of education reform in Bolivia in the mid-1990s. Called EIB (or Educación Intercultural Bilingue), this reform sought to create the legal framework through which children could study in their own languages within Bolivia. According to Gustafson, interculturalism moves beyond the western-centric conceptualization of multiculturalism, providing a more relevant way to think about citizenship within the Latin American context. He writes, “The focus on ‘inter’ distinguishes a view of dialogue and exchange across cultural boundaries, away from the American and European ‘multi-’ which highlights tolerance between distinct yet separate groups” (Gustafson 2009: 22). Further, he writes, “The former (multiculturalism) seems to suggest a hierarchy of cultures, something like a national space dotted with immigrant cultures (or ‘multis’). The latter hints at a more fluid notion of a society, nation, or citizenship comprised of equals, shaped through dialogue among and across the differences constitutive of Latin American nationalities and modernities” (Gustafson 2009: 163). Gustafson suggests there were two different understandings of interculturalism that existed in Bolivia during the 1990s. One version emerged from the neoliberal state as a top-down policy, while the other was used by indigenous popular movements. The indigenous perspective asserted that people not only wanted inclusion in the state, but also wanted to rearrange issues of legitimacy, territory, and authority by actually transforming the Bolivian state itself. This use of the concept of interculturalism to transform the state involves a projection of an alternative future, rather than a future that is already scripted, as the top-down interculturalism tried to impose.

Furthermore, in Walsh’s conceptualization of a critical interculturality that the policymakers were attempting to produce, this interculturality is “a political and social project that requires a structural, institutional and relational transformation. This form is reflected, in some sense, in the new Bolivian Constitution, where interculturality works cooperatively with
the plurinational state, thus together providing the engine in the process of constructing a
different society” (Walsh 2009: 74). This is opposed to “functional interculturality” which
“recognizes difference, but fails to consider that the construction of the nation is based on those
same differences. In this way, it proposes pluralization and decentralization without major
changes to the structure, the institutionality and the monocultural logics, thus confining
interculturality to the sphere of municipalities and departments within an integrationist frame”
(Walsh 2009: 73-74). She writes, “At other times…it only points to the recognition
and the inclusion of diversity within an ill-fated state model that does not confront the profound
structural inequities, and that does not abandon its neoliberal agendas” (Walsh 2009 74).
Critical interculturalism was integrated into the utopian vision as a way to respond to the
“befores,” the traces of the past.

Production of difference were embedded not only in policymakers’ narratives, but also
in the MAS government’s premises of plurinationality, decolonization, and indigenous
cosmovision. These led to the creation of a policy that was meant to heal the ruptures of the
past, while also reproduced some of these same historical ruptures because certain distinctions
about race, and the inherent reliance on a dichotomy and relationship between “Western
medicine” and “Traditional medicine” were embedded into the premises of the policy itself and
the vision of the future. The utopia is therefore inherently reliant on the dystopia. There is an
inability to create a future that is divorced from the past. In this sense, the poetics of policy are
inherently historical. Even as the policymakers attempted to produce radical change, their work
was also infused with the past and relied on the past to make their claims. The utopia was
disrupted when it encountered the elements that it was framed against, yet it required these for
its construction.

Using Whitmarsh’s (2014) method for looking at the ambivalence of institutionality
provides a way to think about the institutional project of the policymakers and their work of
policymaking. Whitmarsh writes,

Being properly responsive to the ambivalence of institutionality not only means not
effacing the violence in the caring authority relation, but also not effacing the caring in
the violence of the authority relation. Institutions facilitate normalization and fashion
and enforce taboos—they demand obeisance, they fetishize, and they mask the power
they instill. But they also nurture, affiliate, and desire. What makes them perverse is
that they do this not despite the violence they enact, but through it.” (Whitmarsh 2014:
865).

Whitmarsh’s approach can allow us to see how, in working to create a utopian vision of a
“care-giving” policy out of certain framings of the past, there is always violence in the caring,
because it requires attention to, replication of, and recognition of the past. Yet there is also
caring in the violence, in the aims of making and circulating the policy and its aims. What
emerges is the “no-place,” an always already fractured vision that is both caring and violence.

Envisioning Futures, Repairing Pasts

What was the purpose of this play with time and difference that policymakers produced
in their narratives of policymaking, and their framing of policy as something that could be
“healing” to a past fraught with ruptures? I spent a lot of time during my fieldwork attempting to
understand what conceptions of the past people were working with to try to regain, to “revive,
“and what conceptions they were attempting to surpass. I asked Dr. Díaz, a Ministry of Health policymaker about this, to which he replied,

For the first time we are including and respecting traditional medicine and the cosmovision of the people. We are recognizing their concepts of health and the idea of the harmony between people and nature. We are trying to incorporate their form of understanding the world and their place in the world. We are respecting, revalorizing, and recuperating their ancestral knowledge, and respecting what is part of their culture. These are beautiful beliefs. They classify sicknesses in terms of cold and hot. There are yatiris, quilliris, and carisiris, as well as hueseros. They produce medicine. It is a system in and of itself.

Along with applying a certain aesthetics of beauty to tradition, in Dr. Díaz’s narrative, there is a very particular framing of indigeneity and the authenticity of tradition. He bounded traditional medicine completely from western medicine, making it something that can now be incorporated, now that it has been recognized by authorities as part of the future, part of the utopian vision of the state. Specifically, the idea of “re,” (respecting, revalorizing, recuperating), similar to “re-founding” in Walsh’s conceptualization, implies a loss, and the need for saving. Recuperation, according to Dr. Díaz, involves both a process of inclusion and a new approach to the future of health policy. While in his narrative there is also a romanticization and folkloricization of indigeneity, he uses a language that mirrors the discussion of “utopia” by Dr. Montés, showing the ways these romanticizations might be useful or productive in a state-building process that was meant to incorporate and reflect plurinationality.

Anthropological writing on history and memory, including writing on the practice of engaging in Truth and Reconciliation Commissions, is a way to examine the potentially reparative work policy can do through the envisioning of a different, utopic future. Through the framing of these ruptures in Bolivia’s past, discussed in both historical and personal terms, policymakers’ narratives created a very particular view of the past in order to establish the possibility for a different kind of future for Bolivia- one that they suggested that they were actively engaged in producing through the construction of the health policy. In this way, health policy was framed as a “decolonizing” document (Johnson 2010), one that would set the country towards a different kind of future, one that was opposed to this fraught past. Policy could be understood as something that could heal. Further, they used their experiences of these ruptures and the needs produced by these ruptures to shape the design of the policy, and to legitimize its defining premises, all framed around the constructions of difference in regards to community participation, health, and healing that emerged out of their experiences.

According to Dr. Tamayo, Bolivia’s national pain and suffering was due to the wrongs that were inflicted on indigenous people, and therefore visions of the future that they created involved reparations for these debts. This was produced through discourses of renewal, expressed through a word that was used over and over again: rescatar. Rescatar was used to describe a kind of revival of past practices, which also, simultaneously, involved the (re) of notions of difference through their framing of “indigeneity” in Bolivia. What follows are some of the ways that I heard the word rescatar used:

“The issue of traditional medicine in Bolivia is part of a long history, it is one of the few rescuable themes from the point of view of precolonial health.”

“The people began to say first ‘we would not like health to be solely focused on the
First, ‘we want the health network focused on the family.’ Second, ‘we want to make health in the communities, we can decide as a community, not as individuals, but rather collectively,’ and third “we want to rescue and revalorize all of our ways of thinking and feeling around health.’ Therefore, we are posing a logic in health that is based on the family, the community, and interculturalism.”

“What they want is to work on rescuing the ancestral knowledge of each region. Obviously, some types of diseases and ailments cannot be cured with traditional medicine, and that is where mainstream medicine enters. But that is what interculturalism is, respecting the knowledge and customs of each region.”

These reparations could occur through the new health paradigm, through the “rescue” of traditional notions of health, healing, and medicine. There is a temporal association made here between “traditional medicine” and “the past,” even as what is called “traditional medicine” exists today in every corner of the country. In fact, it only became understood as “traditional” through the imposition of “western medicine,” creating an always-hybrid notion of medicine in the country (Menéndez 2003). Through these narratives, I found that the concept of policy that they helped give form to incorporated a production of hope about a future for Bolivia that they desired.

Anthropological work on the voicing of suffering through Truth and Reconciliation Commissions has created links between the voicing of suffering and national-scale healing surrounding what has been called the “discourse of verbalized truth” (Shaw 2007: 192). Shaw argues that it is through this voicing of the past that suffering is made visible. The policymakers responded to my interview question about the history of the policymaking process by speaking the history, both about process and about moments leading up to the process. Through their narratives they particularly focused on the categories of “poor,” “indigenous,” and “underserved” people in Bolivia. Hayden White (1978) produces a useful analogy between psychotherapy and historiography. He writes, “The greatest historians have always dealt with those events in the histories of their cultures which are ‘traumatic’ in nature and the meaning of which is either problematical or overdetermined in the significance that they still have for current life, events…which have lost their original function in a society but continue to play an important role in the current social scene. In looking at the ways in which such structures took shape or evolved, historians refamiliarize them, not only by providing more information about them, but also by showing how their developments conformed to one or another of the story types that we conventionally invoke to make sense of our own life-histories” (White 1978: 87).

However, anthropologist Brigittine French (2009) in particular offers a critical approach to representations of survivor testimony, which, through this “making visible” of suffering has been suggested to be able to empower victims and lead to national-scale social change (French 2009: 92). French proposes what she calls a “discourse-centered approach,” which aims to understand the power relations that are replicated through the process of giving testimony (French 2009: 94). I focus here particularly on French’s conception of the ‘discourse-centered approach,” suggesting that it is a useful way to think about the policymakers’ narratives about the policymaking process, and particularly about the ways in which they reproduced difference in their narratives. These narratives often took the form of testimonies, and thus I can analyze them as testimonies that were meant to frame and link national ruptures and memories with the
healthcare system and policy as an approach to national-scale healing. French takes a linguistic approach to these narratives of suffering, looking at both pragmatics and entextualization to suggest, as Silverstein and Urban (1996) do that there are many “intertextual transformations of discourse.” In discourse-centered approach she also suggests that a researcher “pay close attention to the transformation of survivor narratives as they move in and out of various contexts in the multilayered process of reporting of human rights violations. This is important because these transformations are tied to both meaning and power. The process of transforming discourse as it shifts contexts is known as entextualization, which occurs when social actors take discourse out of one context and insert it into another (Bauman and Briggs 1990).

When applied to survivor narratives, focusing on the entextualization of survivor testimony highlights that these narratives are neither a priori nor universal forms of telling. Rather, they are “particular instances, synopses of experience, told at given times for specific audiences and located in distinct spatial and temporal contexts” (Ross 2003: 102). As testimonies are elicited, translated, recorded, and re-presented in truth commission reports, social actors and contexts change. Consequently, so do their meanings that are reinterpreted by individuals who are often not survivors” (French 2009: 98). In Bolivia, much of the testimony was given by the policymakers for the indigenous poor. This testimony and the majority of the testimony used in the policymaking process was therefore secondhand. While representatives were brought in to share the experiences from around the country, not all suffering voices that wanted to be heard were listened to. For example, during a trip to a rural area in Potosí where policymakers Antonio Ortero and Mónica Herrera had worked as part of a Bolivian NGO called Causananchispaj, I heard complaints of these silences. People in the communities I visited, as well as the current leaders of the organization, told me that while representatives were sent to the conferences, not everyone was able to participate, and it was only a select few.

Policymakers told these stories of the past in order to be able to legitimize their creation of a particular sort of future for Bolivia through the designing of a new health policy. Through this work, they created a new conception of what policy itself might be. History was discussed as something that needed to be “dealt” with. The new health policy in fact incorporated approaches that were associated with the ruptures that the policymakers set out to undo, demonstrating that there was no clean or clear distinction between supposed “epochal” shifts in Bolivian history. Moments framed as rupture were often replicated, and carried traces of the past into the present and the visions of the future, including and especially, notions of difference. The policymakers attempted a modernist nation-building project which shaped their approach to envisioning the future. Yet, this modernist project can never wholly split apart from the past, and certain remnants of the past unmake the utopian vision at the moment it is thought, as it becomes the no-place once policy is spoken, written, and circulated.

The conception of policy that these Ministry of Health policymakers constructed thus emerged because of the ways that they understood and represented Bolivia’s past, including notions of indigeneity and difference, as part of a nation-building process. The aesthetics and affect of policy, then, are tied to a “beautiful” vision of rescuing the past and healing historical rupture. These were inextricably linked to their orientation towards the future of the nation and the redefining of health. Here it is important to consider what is the “nation” and what does healing the nation mean for policymakers. Healing takes place through crafting a past that needs to be oriented towards a future. The concept of “nation” thus matters to the concept of “policy.” Chakrabarty discusses the injustice of mediating the multiplicity of human lived experiences and temporalities through a single historical trajectory where one dominant image, for example, of
“health” and “healing,” are cherished at the sake of all others. It is the possibility for history to unfold in a way more similar to branches on a tree rather than a single trajectory toward a singular idea of a modern nation. It is only in this way that futures, plural, can become fully open, expansive, and inclusive, both as projections from particular experiences of pasts. It is in this way that “other temporalities, other forms of worlding, coexist and are possible” (Chakrabarty 2009: 95). Chakrabarty calls this the “affective histories of the nation,” where there is no one complete or correct understanding of the nation, but rather “heterogeneity in the very constitution of the political” (Chakrabarty 2009: 18; Chakrabarty 1999: 44). Bolivia’s policy in particular is imagined as a revolutionary model, a modernist vision for a future of Bolivia that is seen to lead to the emergence of a new health paradigm. This new paradigm is defined by difference, as it is meant to reflect the “realities” of “the people,” primarily framed as “indigenous people.”

**Locating Dystopias within Utopias**

The above narratives of the past, visions, and discussions of revival demonstrate some of the ways in which policymakers in Bolivia were working to redesign conceptions of health and well-being through the designing of health policy. However, I also want to point to some of the ways that utopias reflect and contain aspects of the “real space of society.” Birkholz (2006) suggests a way in which a utopia might contain within itself a contradiction when he suggests that the utopia is not just an imagined “alternative” or the possibility of transformation, as discussed above, but also a “perspective,” which might be understood as shifting. There is a contradiction that is “inherent in the concept of utopia—the ‘good place’ (eutopia) that is also ‘no place’ (outopia), per Thomas Moore’s initiating pun—there is an essential doubleness” (Birkholz 2006: 590). For Birkholz, the utopia is in fact contradictory, and shifting, since “The really perverse thing about utopia is that, once articulated, it begins immediately to produce a desire for dystopia” (Birkholz 2006: 614).

Similarly, there are aspects of the healthcare system and policy that reflect the real in the utopian vision, where failure, in some senses, is always already part of the vision. Some of these I have discussed above, such as the fact that the Sistema Único de Salud has been held up in congress, and will not be implemented in the foreseeable future given the economy of the nation, which is outside of the utopian vision the policymakers put forth. Further, the notions of difference expressed in policymaking reflect racism and indigenization that still occurs throughout the country, and these conceptions of difference, while framed as a way to recover or respect indigeneity, also serve to continue to reproduce certain separations or notions of indigeneity. Finally, there are elements of the healthcare system that were implemented during the neoliberal government that remain deeply embedded in the healthcare system, such as certain funding structures for members of the population in order to encourage their participation in the western healthcare system. Through Bono Juana Azurduy and SPAMM, maternal and elderly care are covered through a payment system. There is also a private healthcare system and a worker’s insurance system that exists, which will be the focus of another chapter. Finally, there is the uneven representation in policymaking, given that the policymakers primarily came from altiplano experiences, and thus this unevenness is inscribed in some ways into policy.

As such, despite the utopian and inclusive vision of policy, it still remains under critique. For example medical anthropologist Brian Johnson (2010) examines the Bolivian state’s idealistic use of the idea of decolonization to restructure the health care system in
Bolivia. He argues that the Bolivian government has instituted certain practices in the name of decolonization, such as redefining primary health care and participation and focusing on what they call “intercultural” approaches to health or a “militant indigenous revitalization” (Johnson 141: 2010), while simultaneously working within existing vertical national frameworks that defy the possibility for a true decolonization to occur. Johnson’s tone is reserved about the current and possible successes of this process, noting, as he quotes Rivera Cusicanqui (2006), “There can be no discourse about decolonization, no theory of decolonization, without decolonization in practice” (Johnson 2010: 155). However, I look here at the way that the historical epochs were framed by policymakers as part of the policymaking process and history, and how their references to these as ruptures served to frame their work as policymakers. These policies do come to impact lives, which is what I argue for, and they carry affects and memories and emotions, and histories. The dystopias of the utopian vision are reproduced in circulation, and are embedded into the vision of the utopia because of the histories that went into its making.

“Vender su Charque:” Systematizing and Invisibilizing

In order to be written, to circulate, at some point this heteroglossia of discussions, histories, memories, and voices had to be turned into a legal, normative document called “The SAFCI Policy?” Bowker and Star (2000), in their examination of how classificatory systems are produced and circulated, suggest that narratives that take a standard form, such as a health policy, are at their origins multivocal, a result of complex negotiations, processes, and conflicts (Bowker & Star 2000: 44). Yet, these complexities are often silenced, made invisible, and unified in the production of a document. Literature in linguistic anthropology similarly explains how certain practices of speaking and writing mask this multiplicity and the social, historical, or political depth to discursive interaction in an attempt to center and unify discourse, what Bakhtin calls the centripetal force and Urban and Silverstein call centering (Bakhtin 1981, Agha 2006, Urban & Silverstein 1996). For example, Bakhtin (1981) suggests that rather than seeing language as merely a system of unitary norms, what he calls the centripetal force of language, we might understand that language incorporates multiple ideological world views, a heteroglossia, or what he calls the centrifugal force. A policy document can manifest in “unifying” centripetal language that masks the heteroglossia and the centrifugal forces of the voices. But these forces always co-exist.

There are always attempts to standardize, homogenize or create singularity to construct “depersonalized” documents, such as the conventional way of thinking about policy, and the way that most policies circulate. However, I argue that we might always be able to seek out or find traces of the voices that led to the particular forms and specificities that never let policy be absolutely voiceless or singular, and that are available to users of documents like health policies. There is a de-contextualization practice, through the act of writing and then circulating this writing and language about this writing, in the idea of systematizing voices into a document form. There is also a recontextualization process in allowing the policy to maintain its open-endedness, the voices, and multiplicity as it circulates (Bauman & Briggs 1990), or, as Urban and Silverstein suggest, a centering and recentering of discourse.

Why is systematization important, then? I encountered a metaphor that seemed to answer this question in one of my interviews. Charque is a kind of dry meat that can last for many years. In 2010 I spent six weeks in the Bolivian Amazon as part of a team of
anthropologists participating in an NSF-sponsored field school on anthropological methods that came with its own variety of ethical problems for a cultural and medical anthropologist trained at UC Berkeley. As part of this field school we camped in a rural Tsimane community called Santa Maria and for my research question, I explored whether this community had heard of or been exposed to any elements of the national health reform, given that Amazonian Bolivians are the most underrepresented in policymaking and governmental procedures. We brought charque with us because we could hang it from the rafters in the hatata-roofed hut that we used as our kitchen and it would last the entire time we were there. We cooked with it, dehydrating it in water and serving it with yams, plantains, or rice cooked over the fire. The dried charque did indeed last throughout our entire time there, and could have lasted longer.

When I asked policymaker Antonio Ortero about how the writing of policy actually took place, given the dynamism of participants, events, histories, and memories involved in the process, he noted the meetings where the team would “vender su charque” or sell their charque, to sell their ideas to the group. This phrase refers to the idea that policymakers were selling, or proposing, something that they felt strongly about, that could last for many years. After hearing their narratives about how they came to their ideas, it makes sense to me that they would feel so strongly about the premises that they were, in a sense, pitching. Ortero told me that those present shared their experiences and made recommendations for how their ideas could be used to create a national policy. The group together defined the components of each element, with the help of international NGOs, social organizations, and other community participants, and began to create documents in the workshop from each experience they invited from around the country. This part he called the “Writing of the document.” After this they created the Supreme Decree for the policy, which was later revised again by the team.

However, even as a standardized document was produced, traces of its making remained, in the conception of “health policy” that they created that circulated along with the document, and, I argue, infused other aspects of a policy’s trajectory, particularly its circulation, implementation, readability, and utilization. These immaterialities helped produce the mutations that I will suggest are inherent in, and produced by policy in repetition and circulation. As national standards were put into place and made mobile, the multivocality that produced its categories, both the health policy premises and the notions of difference incorporated within its lines, trickled out and were re-situated in particular sites, meetings, and implementation practices. I thus have to question what might be gained from resuscitating the multivocality that exists behind a seemingly static document. This is important work, I suggest, not just to understand the heteroglossia that informs the designing of an entity called a national health policy, but also because of the significance of understanding what happens in policymaking processes that might have a profound impact on implementation and revision. For, as Bowker and Star suggest, “The very multiplicity of people, things and processes involved mean that they are never locked in for all time” (Bowker & Star 2000: 49). What might breathing the vitality back into policy help us understand about policymaking as a process, policymakers as people or groups of people, and policy implementation, as a practice that can never be separate from the design and its makers? However, when homogenizing and standardizing, it is not just the utopian visions that get folded in, but also the failures, ruptures, notions of difference, and these circulate with the policy, as well, and shape where it goes, how it works, and how it constantly produces utopian/dystopian dyads wherever it goes.
Conclusion: Chronotopes in Policymaking

James Holston reflects on the problem of origins in *The Modernist City*. His task in this text was to “deconstruct this mythological account” of the designing of Brasilia (Holston 1989: 60). City planners and designers presented the design of the city of Brasilia as if it had no history, which, according to Holston, was a subversive act. His work reinvigorated the history of the process. In Bolivia, similarly, health policy was in a sense overwhelmed by its history—the history was told in different ways as the health policy traveled to conferences, meetings, and clinics, and was embedded into legal forms, such as the constitutional preamble. My work in this chapter has been to rehistoricize policy’s origins, a form that is always already historical, but often conceals its own historical roots and is surrounded by people, processes, and bureaucracies that want to conceal its roots as well. In a way, then, this work is a mythology of a health policy, a document that is meant to transform society, where its design is connected with an imagined future, a utopian future, for the nation (Holston 1989: 60). When I go back to read the various versions of “The SAFCI Policy” that I have collected, I read it differently than I did when I began my fieldwork, before I spoke to any of the people discussed here. I can locate the voices of the policymakers in the document, the various stories they took me through—both personal and historical, though they are decontextualized to the point that they have become a generalizable national document.

Indeed, “The SAFCI Policy” in general looks quite similar to various models and approaches to health care provision, such as Latin American School of Medicine, aspects of the Cuban health care system, and the Mexican system, to name a few. The policymakers did draw from these theories of medicine and health care provision in their work, and upon first glance a person reading the document might just view it as an adaptation of pre-existing models. Knowing the stories and ideas and process that the policymakers went through to actually make the decisions to make this particular approach to health care provision and a new health paradigm the Bolivian national model. This was not just a policy for Bolivia because it was an approach to health care that is in style or circulating widely in Latin America at the moment of its design. Rather, as I have shown through my description of the policymaking process and my discussion of the ideas and theories and stories and testimonies that make up its foundation, this policy was designed using approaches to health care and healing that the policymakers knew worked on the ground in Bolivia, and it incorporated the kind of flexibility needed to be simultaneously decontextualized enough to make up a general policy document that can be circulated throughout the nation, while mutable enough to be re-contextualized as it entered and was applied and used by specific sectors of the Bolivian population, as framed in the notions of difference that they infused into the policy, whether indigenous groups, or urban or rural dwellers.

In Bakhtin’s (2002) work on chronotopes, he discusses the importance of studying arrangements of time and space in language and narrative. There is a chronotopic frame to policymaking that involves certain configurations of time and space, including the personal, national-historical, and sociopolitical pasts. Time was used strategically to represent a past to be overcome and a future to be desired, or the utopian vision. Yet, past and future were not singular, just as there was no singular origin. They were multiple, reflecting the multiplicity of voices and experiences involved in policy’s making. While the policy process, design and implementation, sometimes seemed to follow a linear temporality, the stories of its making were outside of linear time. There were certain moments in time, historical events, that were consistent across narratives, but the places where these temporalities were experienced shifted depending on who
shared the narrative, as well as the ways they impacted the contributions of the different 
participants. There was also a discussion of the transgressing of past, present, and future in their 
narratives. This is similar to Koselleck’s suggestion that the past and future are interconnected 
around a particular framing of present conditions. As such, each policymaker came with their 
own framing of the past and present conditions, and yet shared an imagination of the future and 
of health based on the framing of the constitution, their experiences, and their work as 
policymakers. As narrative historians of the time, policymakers produced the past as a structure 
upon which to build the future. The chronotopes of policymaking that I explored here include 
visions of the future, constructions of certain conceptions of the past, and the anchoring of these 
around a present moment of possibility. Without the narrative oral histories, we miss the entire 
affective and personal realm of policymaking, which was significant in the design process and to 
policy that emerged. While policy needs to be molded into a particular shape in order to 
circulate, it is also produced in a way that is inherently heteroglossic and mutated, and can, 
therefore, continue to bring with it and replicate this multiplicity as it circulates. There will 
always be more memories, more affect, more histories to attach to policy as it moves and creates 
ew experiences, new violences, new spaces for caring.
Chapter 2: Strange Partnerships and Blurred Authorships: Sites at the Origins of Policy

Introduction

“It is ours, the model, it is from Cotagaita,” Hernán, a Quechua médico tradicional said as I sat in the crowded main room of the Alternative Health Center (Centro de Salud Alternativa) in Cotagaita, a small community in the Potosí province of Bolivia. I sat in a circle of chairs with Hernán and four other Quechua midwives and médicos tradicionales, Xavier López, the director of the Bolivian NGO Causananchispaj, as well as a journalist friend who traveled with me from La Paz to do a story on maternal health in Potosí. This was what Hernán responded when I asked the group about their role in helping the Ministry of Health design their “SAFCI policy.” When I visited their community and others in Potosí I felt that I had a sense of what he meant by “it is ours,” from all of the research I did prior to this trip, which fell near the end of my research. The Potosí province, and particularly Cotagaita and Caiza D, served as exemplary models that the team from the Ministry of Health collaborated with and used as inspiration when they were in the process of designing the health policy. Even though there were nine representative health programs, Potosí, in particular was especially important in the process, as two of the policymakers had years of experience working in the region in rural health. This work was done through Causananchispaj, which policymaker Mónica Herrera and Xavier López formed together, and where policymaker Antonio Ortero had worked. Many of the elements that came to be made into and bounded as “policy” were inspired by the work of these communities and this NGO. As such, there was an overlapping of authority, where NGO, State, and community figures overlap and were sometimes one and the same, involved in the co-production of policy.

To reach the Centro de Salud Alternativa in Cotagaita, I had to coordinate with Causananchispaj directly, as the organization was involved in most of the health-related activities in the region, and was therefore positioned as a gatekeeper to the communities they worked with in Potosí. I first met with Xavier in La Paz, after receiving his contact information from Mónica Herrera. We met at a café to discuss my project, and he asked me many questions about my intentions; I could tell he was protective of the work they were doing. We then arranged the visit by phone. I set up interviews with the employees of Causananchispaj, and Xavier helped me arrange a driver to take me to the rural communities. He would accompany me on this trip in order to facilitate my interactions with the communities. Cotagaita’s climate was in stark contrast to Potosí: warm and floral, set deep in a valley. People there were primarily Quechua, wearing knee-length skirts and straw hats to shield themselves from the intense sun. We drove past the large western health center to the smaller Centro de Salud Alternativa next door. I was taken into the main room that held a cabinet full of dried herbs in glass jars and some palmadas made up of herbal remedies. In the attached room was a small consultation space where patients were attended to. I was introduced first to Gabriella, a midwife in traditional Quechua dress, who, with her spouse, worked to build this center over the last ten years. We were joined by four others, one woman and three men, all médicos tradicionales.

Gustavo, a médico tradicional, tall with grey hair and a commanding voice, and vice president of the central health committee of Cotagaita, echoed Hernán, saying “The SAFCI model grew from here” (De aquí ha crecido el modelo SAFCI). He explained that they were the first municipality that was equipped to work with médicos tradicionales, and later, on a tour of their facilities, he showed me their laboratory for creating tinctures and herbal remedies, a cramped space with rows of jars and bottles, and piles of dried plants. For Hernán, these
elements of traditional medicine formed the foundation of the model that the group worked on, and that they contributed to the Ministry of Health’s process. Throughout the discussion, Xavier facilitated, interjecting at certain points with questions that served to emphasize successes of the group. But how does the work of this community come to be considered part of the origin story of policy? What gave this group a sense of ownership, or at least partnership in the design, over what Hernán called “the model,” the feeling of having been involved in its making? And how does the NGO Causanchispaj fit into this picture of community health and traditional medicine in a country governed by a socialist party, with Ministry of Health professionals that have such deep critiques of “neoliberalism?”

In order to do the work of repairing the past and creating a new conception of health in the country, the policymaking team sought out voices from people around the country to contribute. As part of Bolivia’s national process of engaging with the “ruptured past,” political participation, a tenant of the neoliberal government, was resignified by the MAS government, and became a way to forefront their usage of indigenous and other “lay” experiences and voices in political processes. Policymakers were directly connected with some of the programs, others were invited independently due to their work with other organizations. Dr. Díaz explained, The methodology was to go to the people and ask, using a participative methodology, What is your problem? How would you like to solve your problem? Under that methodology we got proposals from the nine departments and we had a general assembly where all of these proposals were presented and systematized. Their approach was an attempt to create a “decolonizing” policy that would also demonstrate the need and capacity for policymaking to be a decolonizing practice, a form of postcolonial nation-building. Out of these sessions, the team identified a number of common problems that people were dealing with. These included dissatisfaction with the fragmented nature of the healthcare system and lack of universal access, the lack of participation, the lack of focus on prevention and promotion, and the heavy focus on biomedicine. As Dr. Díaz told me, “It was all an Westernized (occidentilizado), biomedicalized (biomedicalizado) hospital-based system. Outside of the doctor and outside of medications, there was no health, and this the people called the ‘biologist focus of health’ that only worked on rehabilitation and recuperation, prevention and promotion were nothing.” The complaints from the people led to the five premises at the foundation for their design process. Díaz told me,

Based on these problems, we created the policy. The first is universal access to free health services at the point of care. The second was social mobilization and social promotion. Now, we have joined some, there were five problems, but three together. The third is stewardship and recovery of health sovereignty. So for these three policies to be implemented we have two central themes: the unified system of community health, and 

salud familiar comunitaria intercultural, SAFCI, you see? Then, in the cross-political axis: decolonization and class, gender, and ethnocultural equity.

Indeed, many of the policymakers referred to these specific contributions from the nine provinces in their interviews. Jaime Condori explained that they chose the representative experiences based on their successes and the fact that they were representative of specific approaches. He told me,

They wanted to recover, to nourish the process with the perceptions of the people, the desires of the people, and they held meetings with the people, workshops with the social organizations and they began to apply this methodology to understand what health was, what these organizations dreamed of. The communities raised the theme of
interculturality, integrality, and social participation. The input of leftist activists, if you can call them that, has been a focus on intersectorality and health promotion...we had to speak to the vision of the people.

This idea of using participation from “communities” to “nourish” policymaking was consistent with the discussions of revival and healing as the vision for these redefinitions of health and policy in the nation. It was also consistent with ideas about who the policy was actually aimed at, as those whose health and beliefs it was meant to recover.

I traveled to Potosí, and to other parts of the country, on the trail of these health programs that were invited to participate in the policymaking process. Out of a curiosity to understand not just spaces where policy emerged from, I also went to some sites that did not participate, that were not involved in the process to explore the unevenness in participation and programs and why this might be. In what ways does the process of involving these community health programs fit in with the policymakers’ utopian visions, and in what ways do they reflect or manifest the dystopias or failures of this vision? I wanted to talk to the people who participated in these programs and contributed to the conferences to see if I could locate aspects of the policy vision in the work they were doing, to understand the origins of policy from this perspective. While the utopian vision of policy that was put forth involved a radical break from the past, the programs I encountered were deeply part of these pasts. These were embedded into both the origins of policy and policy in implementation. At all of the sites I visited that served as examples for the policy were coordinations with NGOs that helped facilitate the implementation of the models they used that were adopted into policy. NGO participation was deeply embedded at the origins of policymaking, from the role of policymakers to the participation of communities that served as models for policy premises. However, in this chapter I will explore how some shifts in power dynamics allowed these partnerships, in differing types of dynamics, between NGOs, communities, and the State, to fit, to make sense, with the new vision of the state.

The vision of policy, as a utopian vision that can break from certain moments of the past, such as colonialism and neoliberalism, was from the very beginning an impossibility, a given failure. The programs that inspired the utopic vision were embedded in fractured pasts, from the institutions they relied on, the complexities of authority, and the discourses of difference. As such, dystopics were an essential part of the utopics, and in some ways reflect the realities of trying to design and implement policy. For Foucault, the aspects that constitute a particular utopia can be seen as elements people apply to them or fill them with, and they can be shifted because certain actors decide which elements they contain as a way of mirroring or reflecting some aspect of the “real space of Society.” The intention in the act of creating or representing a utopia is to fill it with elements that will give it direction for action or a call to action. Thus, through the constitution of a utopia it is possible to measure a represented utopian space’s distance from “the real,” as well as the sense in which both the utopian space and the real can be seen as representations. Policy as a “way out” is impossible.

Bolivia’s policy in particular is imagined as a revolutionary model, a modernist vision for a future of Bolivia that is seen to lead to the emergence of a new health paradigm. This new paradigm is defined by difference, as it is meant to reflect the “realities” of “the people,” primarily framed as “indigenous people.” However, Birkholz (2006) suggests a way in which utopia might contain within itself a contradiction when he suggests that the utopia is not just an imagined “alternative” or the possibility of transformation, as discussed above, but also a “perspective,” which might be understood as shifting. There is a contradiction that is “inherent in the concept of utopia—the ‘good place’ (eutopia) that is also ‘no place’ (outopia), per Thomas
Moore’s initiating pun—there is an essential doubleness” (Birkholz 2006: 590). For Bikrholz, the utopia is in fact contradictory, and shifting, since “The really perverse thing about utopia is that, once articulated, it begins immediately to produce a desire for dystopia” (Birkholz 2006: 614).

The policy model itself was designed through the “dystopias,” which created the simultaneous existence of utopia and dystopia (or, perhaps, not-utopia). The model itself always already contained the conditions for its own transgression, its own failure, given that it was formed out of a repetition, a multiplicity.

I suggest that an examination of the origins of policy programs illuminated some strange collaborations and codependencies in the unexpected positionalities of authorities, and sites of coordination between communities and NGOs and NGOs and the state. All of these elements were involved in reconceptualizing the Bolivian state through the lens of health and health policy. NGOs, civil society, and the state were involved as co-producers in the vision of the state. Whereas often health policy reforms are dominated by politicians and physicians to make decisions about how health is defined and how healthcare should be implemented, in this case, there was a confluence of state and non-state actors. In Bolivia there were specific kinds of partnerships that might respond to Fisher’s (1997) suggestion that a situated ethnographic study of NGO relationships might demonstrate a situation in which, as Fisher writes, “NGOs are presented as the solution to problems of welfare service delivery, development, and democratization.” (Fisher 1997: 441). The dynamic relationships with NGOs at the foundation of policymaking that I saw in Bolivia complicates the ways that anthropologists define and understand neoliberalism when the state itself is actively involved in producing definitions and refractions of neoliberalism. An examination of the partnerships formed at the intersections of these relationships that were formed and re-formed between communities and NGOs, NGOs and the state, and the state and communities leads to a troubling of straightforward narratives of the “public” and the “private” and epochal framings of neoliberalism and post-neoliberalism that made up the utopics of policymaker visions.

In my examination of some of these programs that served as models for the origins of policy, I look at the ways people spoke about the health programs that served as models for policy, and the strange partnerships that I witnessed at these sites that continue to raise questions about the inherent dystopics, the mutations of utopian visions. I also look at how these partnerships trouble positions of authority and questions of authorship of policy, continuing my discussion of the lack of strict boundaries between positionalities in policymaking. This dissertation asks the reader to assume that we do not know what policy is or how to analyze it. I rather suggest that we must seek to understand how certain practices, ideologies, and models were bounded, labeled, and circulated qua policy. I look, therefore, not just at practices of making policy, but also at the making of the possibility of conceptualizing and producing something as policy. It is only through the systematization of these experiences, when they are recognized and moved into the national space by policymakers, from a position of authority, as discussed in the previous chapter, that these become something that are more widely recognized as policy.

In taking on these questions, I complicate the separation of the spheres “NGO” “Community” and “government,” as well as any clear separation between “local” and “national,” as in Bolivia these boundaries were not taken-for-granted (Rabinow 1995). I follow Fisher who writes, “The challenge is to consider nongovernmental organizations as one specific possible form of collective action and human community and to set the stage for a comparative analysis of the different configurations these forms of collective action have taken and are taking in a
complexly woven field of translocal flows” (Fisher 1997: 459). And what of spaces that did not serve as models for policy? What can they tell us about policymaking and a different kind of dystopics? In envisioning the future, it must be a future for all of Bolivia, as a plurinationality—but as I saw in sites like the Amazon, these possibilities were sparse and differentially implemented just as differences were produced in discussions about policymaking. These were replicated in the origins. Dystopia and Utopia are not dichotomous, and are embedded within each other.

NGO Participation in Health

In my interviews with policymakers, many discussed the nine invited communities at the health policy conventions, all of which had NGO support in their health programs. For example, in a conversation with Antonio Ortero, Director of Community Health and Social Mobilization at the Ministry of Health, I asked him about the different actors involved in crafting policy. Antonio is a sociologist by training, so I often found camaraderie in his understanding of my anthropological training. He also seemed to break the stereotype for the policymaker image that I had developed, as I never saw him wear a suit, only jeans and shirts. He is tall with a messy head of dark hair, probably due to the motorcycle helmet that sat on the shelf of his office. He referred to these case study examples, “In the majority of cases, it is noteworthy that these experiences were supported by international organizations, by NGOs or by a foundation. It was not an experience of the state, they did not rescue (rescataban) the experiences of the state.” While this may seem in some ways very different than the more centralized, technocratic policymaking approach that I discussed in the first chapter, some of the policymakers themselves came directly from these organizations, and others went to work at these organizations after they left the Ministry.

Antonio felt that the state at the time had no successful public or government-run health programs on which to model their visions for the new national policy. Rather, the team sought successes at sites where NGOs partnered with communities to implement projects. This was ironic given that NGOs were prevalent precisely because of the neoliberal drawback of the state that the policymakers critiqued. What was unique according to Ortero in these cases was that, according to his view, the NGOs that provided the exemplary models did not merely apply a mission in a top-down way, but rather were all, in various ways, involved in “needs gathering” within the communities as a way to frame their projects. The policymakers, in fact, were able to find inspiration for policy that in many ways involved a replication of NGO work, and thus a utopian vision that requires its failure to exist.

Knowing that Antonio was trained as a sociologist, as he made clear in our interviews when he was speaking to me as someone from the Ministry of Health and when he was giving me a sociological perspective, I decided to ask about this issue of hierarchies of power between state and NGO based on what I observed in Bolivia,

AB: In some of the literature about the relationship between NGOs and the state there are discussions about the positions of power between them, where the NGOs work outside of State power. But in this case it appears that there are experiences that were supported by some of the NGOs at first, but now, with the SAFCI policy, a policy of the state, there is a change in the dynamic because the NGOs are required to follow a policy of the state.
Antonio: Of course the dynamic has changed completely because before, let’s say, it was a proposal made by local actors supported by different NGOs. Now it is a proposal of the State. So, since the NGOs have always worked at the local level, right, it’s easier for them to understand and they continue supporting us, which doesn’t mean that they completely understand, right, because there are always guidelines, and that was always what the discussion was about in the case of the State of Bolivia, and even more so in healthcare.

Yet later in the conversation Antonio also said,

However, they were our experiences even though we used help from NGOs. It was a dynamic that started with the exchanging of proposals from NGOs, and then these became proposals of the state. In this way, because they came from work by NGOs in Bolivian rural areas, they are totally Bolivian. And now all NGOs are obligated to comply with the line of the state.

While Antonio was clear about the role that NGOs played, he also emphasized that these experiences were totally Bolivian because they involved the partnership and interaction between the NGOs and the communities they worked with. That he could not quite delimit the boundaries of “state” “civil society” and “NGO” demonstrates some of the ambiguous positionalities that were at the root of health policy in Bolivia. His tracking back and forth between what makes a “state” and what makes a “non-state” entity shows the ambiguity of authorship at play, and how complexly intertwined and overlapping these entities could be. He also strategically bounded these entities when considering different aspects of the implications for authorship of the policy document from his authoritative stance from within the Ministry of Health. His slippage between grounding the process in NGO work, work of Bolivians, or work of the policymakers shows the deeply imbricated relationship between the two.

In the anthropology of non-governmental aid, there are many critiques of development agencies and projects, as well as competing approaches for how to view these types of development organizations. Anthropologists have looked at the encounter with development agencies as a replication of a colonial encounter, and as a container for technologies or “strategies of power” (Ferguson 1997; Escobar 1991; Ferguson 1994; Mosse 2013). Some consider in particular the ways NGOs conceal their political projects (Ferguson 1994). These approaches primarily use a Foucauldian theorization of governmentality to look at the discourses of development and strategies of power involved (Mosse 2013). In a different approach, others have looked at participation and development in regards to community-initiated development and power within this (Mosse 2013). There has been a shift to thinking about development as a “category of practices”, and “development as a “practice of politics” (Li 2007b), where, according to Yarrow (2011) “Development is ‘not a coherent set of practices but a set of practices that produces coherence’” (Yarrow 2011: 6). This is similar to theorizations of the state that denaturalize the state as a singular entity, for example, as Gupta has argued with respect to constructions of “the State” in Indian development practices (Gupta 2012).

Following this idea of looking at the work of NGOs as a “category of practices of politics” I want to suggest an approach that conceives of the ways NGOs might be deeply embedded into politics in such a way that there is a blurring of actors, intentions, and projects. I follow Fisher in suggesting that there is no such thing as “two essentialized categories—civil
Fisher suggests, that there is a “heterogeneity of histories and processes from which NGOs emerge and within which they operate…shifting the emphasis from a set of organizations to a fluid web of relationships reveals the connections of NGO actions to numerous levels and fields and draws our attention to the flows of funding, knowledge, ideas, and people that move through these levels, sites, and associations (Appadurai 1991; Lash & Urry 1994)” (Fisher 1997: 450).

There are multiple and overlapping subjectivities that lead to the way that policy is formed, or “co-produced,” where co-production refers to the idea that knowledge is always produced by a variety of actors and expertise (Corburn 2005). In his book Street Science Jason Corburn (2005) looks at the use of both local knowledge and institutionalized scientific knowledge to solve environmental and health-related issues facing a community in New York City, with a focus on community-based ways of knowing. According to Corburn, local knowledge implies “the practice of knowledge-making by certain people through experiential learning rather than fixed information” where “place should be understood as a ‘material and social space, a habitus, infused with different meanings and transected by relations through which particular ‘cultural capitals’ are formed and transformed” (Corburn 2005: 58, 48).

Corburn’s work shows that both the problem-framing and data collection required that local knowledge and disciplinary science come together as parallel yet interacting experts. This process, Corburn suggests, revalues traditional or local forms of knowledge and reduces the hierarchization of knowledge. Corburn shows how environmental health practices can be better understood if data is produced by bringing together local knowledge and disciplinary science and allowing them to mutate each other through comparison and interaction. Further, Jasanoff (2004) suggests, “the co-productionist idiom can shed light on the constitution of varied social orders, such as international regimes, imperial or comparative politics, science and democracy, and the boundary between public and private property” (Jasanoff 2004: 41). Work in the anthropology of global health also seeks to explain these ambiguities, or, as Clarke et al. suggest, “the blurrings of certain boundaries in the creation of new social forms—public/private, government/corporation, expert/lay, patient/consumer, physician/insurer” (Clarke et al. 2003). In the following sections I will discuss three vignettes that exemplify some of these issues of authorship, vision, and the blurred boundaries between actors involved in conceptualizing policy in Bolivia. These examples exemplify the multiplicity of origins of policy based that I began to lay out in the previous chapter, as well as some of the dystopic qualities and failures that constitute the utopian vision of the policymakers.

**Vignette 1: Designing Policy with Potosí**

Potosí is a cold mining town at 13,420 feet above sea level, with colonial architecture and winding cobble-stoned streets in the shadow of the Cero del Oro mountain. After arriving and settling in, I met with Xavier at the office of Causananchispaj to make arrangements for the next day. Sara, my journalist friend, and I met Xavier and our driver Oscar, a kind older man in a red Toyota truck, at 7:30am. We quickly grabbed breakfast of *rollitos*, bread rolls and coffee, and then packed into the car to begin the trek to Chillum, a community in the Caiza D municipality. We drove through the city, and as we passed through the neighborhood of San Pedro, Xavier explained that Causananchispaj had gotten their start with a project in the city in this zone, San Pedro. As we continued to drive, he pointed out tubes carrying water across the mountains that are maintained by water committees within each community.
Causananchispaj began its work in communities in Potosí in August of 1991. While the organization is domestic, it receives aid from international organizations such as Trocaire, Christian Aid, and Ayuda en Acción Bolivia. Their work spans 55 communities in 10 ayllus in Potosí (Website, Causananchispaj). Historically, indigenous societies in Potosí and other parts of Bolivia were made up of ayllus, or units of territorial, ethnic, and cultural conglomeration. These ayllus formed the foundation of processes of social movement in order to resolve problems in the community (Alemán and Alemán 2010). Causananchispaj’s stated mission is, “To be facilitators in the process of comprehensive development and self-management that the indigenous Quechua ayllus of the zone of intervention face,” and they engaged in a participative process to understand what I heard called in interviews the “needs of the people.” Their approach was based on gathering the problems that ayllu members brought forth, beginning with the contamination of the water due to the mines. They focused on community participation and co-production in the design and implementation of projects to resolve problems identified by the communities, such as water contamination due to mines and the desire to focus on traditional medicine.

When Causananchispaj was originally formed, it worked with five ayllus in Potosí that formed a coalition to request clean water and wells, as well as to demand regulations on the nearby mines based on the contamination of the rivers in the communities since 1977. The ayllu authorities explained, in meetings arranged by Causananchispaj, the impact of water contamination on their food, environment, land, and health, and formed a committee for the fight against contaminated water (Alemán and Alemán 2010: 54). They sought funding to implement their projects in order to improve the quality of the water, and created a precedent of social movement and participation for other ayllus in the area. In 2004, the same group mobilized to seek electrical coverage and a telegraph network in the rural communities through social participation, and then sought to improve health through changes in the healthcare system, including a new health clinic, the implementation of community management in health, and the implementation of intercultural health, or “processes of reference and counterreference between the medicines” (Alemán and Alemán 2010: 148). This work was made possible in part because one of its co-founders, Crisologo, came directly from the communities, and so had a unique positionality of being able to transect the interests and be a spokesperson in a way that blurred distinct boundaries between spheres of “community” and “NGO.”

When I met with Xavier at the small Causananchispaj office in Potosí, he shared some of this history of the organization’s work by showing me media such as DVDs, maps, and books that highlighted the projects they engaged in, in what seemed like a way to prove his own role in the authorship of these programs. In one of our conversations he emphasized the dynamic of partnership with the communities through his commentary on what he considered to be their unique approach to aid and development. I asked Xavier,

AB: What happens in communities that don’t have support from an organization like Causananchispaj? There are so many communities and ayllus in the country, and only some have this type of support. Do they have political representation or is this example of Causananchispaj very unique in its approach in the community? Twenty years seems like a lot of time for time for an NGO to work with the same communities.

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3 Ser facilitadores de los procesos de desarrollo integral y autogestionario que los ayllus indígenas quechuas de la zona de intervención encaran
Xavier López: Clearly, it depends a lot on the focus. The professionals of Causananchispaj were approached by the communities to learn with them, to change things together. We weren’t there as foreigners. We didn’t view things from the perspective of an international corporation, or international organizations from foreign countries that say ‘oh you poor people, we will work from our desks on this project.’

There are billions of dollars spent but they don’t get results because they have not been planned with the communities, they have not been conceived of by the communities. The work is not based on their needs, it is based on the needs of others, you understand?

Then, they have wasted billions of dollars which have really benefited the bureaucrats of these organizations the most. They have failed to understand the real problems of poverty and the poor. We have used participation, and involved them, that is the difference. We only get ten thousand dollars a year, imagine that…the project, the program, is done with very little, but large-scale actions have happened when people participate interculturally. This is the big difference. You can do so much when the people participate from the foundations, from below. Planning arises from the bottom up, from the families to the community to the ayllu to the municipality to the prefecture to the government to the country.

The idea “We weren’t there as foreigners” is important in thinking through the blurred authorities involved at the origins of these programs. Xavier was an NGO worker, someone who contributed to the form of policy, and also had family roots in these communities. I found that this kind of overlapping in authority positions was common; people’s positionalities were constantly shifting and taking new form as they moved their way into different spheres of Bolivia sociopolitical society. By watching the work of these partnerships I began to see how the possibility of producing something as policy emerged in Bolivia based on these overlaps, as a kind of co-production. It was the work and social relationships at the center of these partnerships that allowed for a series of models of community health to become part of “policy.”

We drove for an hour along a winding paved road. The orange-red slopes of the Cerro del Oro were in sight for most of the beginning of the journey. It is probably the most famous mountain in Bolivia. Potosí had been the central city for mining beginning in the colonial days, and still has an active mining community. Throughout this part of the drive the landscape was both strikingly beautiful, colorful, with rolling hills and desert shrubs, and also foreboding, as mining equipment and trucks dotting the landscape. We passed buses full of men with hard hats on, preparing for a long day’s work underground trying to eek out what is left from the mountain in often-perilous conditions. We continued onward and the terrain became noticeably more rural, as the machinery of the city and the mining operations gave way rolling hills, beautiful blue skies, and shrubby plants. We curved around once more and then reached a crossroads, a sign for Cruce Caiza D. We left the smooth paved road for a dirt road that we traveled on for the next hour and a half, winding our way into a valley towards Chillma, a community in the Caiza D municipality. Sometimes we drove on very narrow roads at the edge of cliffs, while other times the road widened out, given my nerves a break. Xavier told me that the road had been built years ago by a group of NGOs. Along the way we passed terraces used for agriculture and the communities below that farmed them. Brown adobe houses were nestled into the hills.
Chillma came upon us quickly, built along a river. An old colonial church is the first point you can see from the road. The older part of the community, around the church, is made up of brown adobe houses. Up a hill is the older health post, a small two-room building that was empty when we arrived. The larger and newer health post and school were back up the road where we came from, big concrete buildings painted orange. Chillma had long been a ritual center of the ayllu. Once the health post was built people began to gather and live there, and they began to hold regular meetings with doctors. Later, with the assistance of Causananchispaj, they constructed a radio network so people could communicate between communities in order to work on community action. Deborah Yashar’s (2005) work in Contesting Citizenship in Latin America: The Rise of Indigenous Movements and the Postliberal Challenge examines key elements involved in successful social movements in Latin America with an emphasis on Bolivia, Ecuador, and Peru. Yashar notes the importance of transcommunity networks and political associational space as a platform for political organization as key elements in successful indigenous social movements, (Yashar 2005: 8). These nations are home to movements where indigenous people reformulated the relationships between state and society. There are a number of networks crisscrossing Chillma: they are connected because of their ayllu history, their health post, their radio network, and their relationship with Causananchispaj. How did these networks help facilitate particular kinds of relationships between the Bolivian state and society in a way that led to the development of a model of a national health policy?
Once we parked and got out of the truck, we were joined by two men waiting to greet us, Roberto, an indigenous authority from the local Consejo de Salud, Chillma’s community health leadership committee, and Constantino, a municipal authority. The consejo de salud is a type of committee that was developed in Potosí, and in other parts of the country, though often under different names, such as comité de salud (health committee) or without a committee structure, represented by local health authorities who are promotores de salud (health promoters). These committees are made up of local authorities, and often replicate the indigenous authority structures in the community, with people taking overlapping roles. Policymakers who had experienced these types of community organizations adopted the committee model as a formal requirement for participation in the implementation of health policy throughout the country through the gestión (health management) premise of policy. The leader of the consejo, Roberto, was an elderly Quechua man with a chiseled face, wearing a baseball cap to protect himself from the bright sunlight. After introductions I told them about my research. I asked them about the work the community has been doing in health. In a manner reminiscent of the policymakers, he delved into a narrative that connected the past and the present as a way to discuss their work. I call these the “before…now” statements, as I heard them repeatedly during my visit in Potosí: the past is a key actor in response to any questions about the present.

Before there was silence here, no one lived here, it was like a cemetery because there was no road and people died, it wasn't good. Once the licenciado [Xavier] came, they brought important health personnel. I was a promotore de salud [health promoter] before. Before ten families lived here in Chillma without light or roads, but now there is a road, so slowly it has improved the health of the people. We have the old and the new health post. We have improved a lot. Every month now, every 13th of the month, we have a meeting with the comites de salud and promotores. The promotores now know how to care for health, because sometimes the nurse is not here.”

The “before” he referred to was a time when the community had the lack of medical assistance. Constantino chimed in,

Sometimes we don’t have enough nurses, they are sent from Potosi where they are trained in what to do, and the Ministry of Health sends nurses directly. But seven years ago we didn't have anyone. We now have our own work and materials. Before there was no communication, now there is communication. There is communication about hunger. There is communication between five communities. Now people have knowledge of how to participate in the health post, before they did not. The health post now holds workshops to teach the children.

He continued to discuss other areas they have worked on, including building schools, roads, and working on nutrition. Roberto followed up,

Before we were forgotten by the authorities from the department and the mayorship, but now we participate and have improved the road, health, energy, water, and houses. We did this with the help of Xavier. They work within our culture.

Beyond the temporal contrasts they made, Roberto’s and Constantino’s conceptions of “health” were not just about curing illnesses or even traditional medicine. They included other elements such as lights, roads, and nutrition, replicating the theoretical ideology of Latin American Social Medicine that policymakers referred to. This expansive way of thinking about health, through the social determinants of health, was embedded both theoretically and practically into the work of these communities in coordination with Causananchispaj. This work then entered the policy through the premises of health management (gestión) and social participation, which mandated
that communities determine locally the specific areas of their lives and wellbeing that impacted
and shaped their health, creating an adaptive policy (Wilkinson 2011). In my visits to community
health budgeting meetings to see how these were expressed I witnessed people talking about
anything from the local economy, traditional medicine, economies around traditional herbs, ideas
about how to protect themselves from sun damage, roads, garbage, and food, and connecting
these to their participation in implementing the health policy. The expansive sense of health that
emerged from the work of the communities at the foundations of policy, and from the theoretical
and experiential training of the policymakers, shaped the design of policy itself, and the
conception of “health” that was inscribed within in.

During our discussion, we were approached by a group of six women of all ages dressed
in bright colors. Two of them carried babies in fabric slings around their backs. They were
curious about our visit and wanted to say hello to Xavier. We moved to an area in front of an
adobe house where we could sit. In a similar manner to Roberto and Constantino, these women
narrated their present conditions in relation to the problems of the past. The oldest woman in the
group was a traditional midwife, a partera. “What work are you doing with traditional
medicine?” I asked the group, curious about this aspect of healthcare in the community given its
relevance to the health policy and what I knew of the community’s contributions. The partera
told me “At one time I thought I had lost my knowledge, and forgotten my practice. I now go to
workshops where I learn about traditional medicine as well as the strength of biomedicine.”

Further, just as some of the policymakers incorporated discourses of hygiene in their narratives
of indigeneity, I found that these ways of self-narrativizing were replicated in the words of the
women, denoting a particular racialized way of seeing the self that was embedded into the
discourses of change and the discussions of the models used at the origins of policy. For
example, one of the women told me that many babies died in the past, but now there is
prevention and they know what to do to take care of the babies, “Before we were forgotten,” she
said. I was told that they now learn how to care for their babies in workshops. I asked them what
they learn in these workshops, and one answered that they teach them how to care for children
and feed families, how to clean, both personal cleanliness and cleaning their houses, and how to
feed their children. She said that there are now laws, “Before we lived like animals, now there
are laws to improve health and education.” The way the women discussed themselves and their
learning through these workshops, sponsored by Causananchispaj, mimicked the ways that
policymakers also discussed difference and indigeneity, using colonial languages of hygiene to
describe their lives before and after the work of Causananchispaj. In Now We Are Citizens,
Nancy Postero (2007) writes of a similar way of representing the past and present when she
discusses the emergence of indigenous citizenship in Bolivia. She recalls a discussion with
Pablo, an indigenous man, writing, “His diachronic framing of indigenous citizenship (before we
were animals, now we are citizens) points out the hold that history has on the present. Conflict
between Indians and the state is not new; it has been at the center of Bolivian politics since
colonial times” (Postero 2007: 9). Yet in this case, the conflicts are shifted, as the state is imbued
with actors from the community and non-state entities.
In these discussions with members of the Chillma community, two things were apparent. They discussed the changes in their community in regards to health through similar temporalizing narratives that presented a dystopic past and a better future. Yet, what they considered to be “better” was based on an expanding conception of what health is, supported because of the work of Causananchispaj. This work created a hybrid of classical development work with local engagement. These hybrid aspects of the work of the community in conjunction with Causananchispaj were incorporated into the framework of the Ministry of Health team in designing the “new health paradigm.” Causananchispaj was embedded in the definitions of health, healing, and community that emerged from these sites and were adopted into government policy. Health policy had its origins in the work of these partnerships, and their ways of conceptualizing health, and policy authorship, celebrated these coalitions and collaborations. This all occurred in the midst of critiques of neoliberalism, which typically involves a drawback of the state that is then replaced by NGO support. A vision of a Bolivian Sistema Único de Salud that is publicly run by the government was a utopian vision; a Bolivia that required these complex partnerships and authorships was the dystopia, the failure, at the heart of the utopia. Yet, the vision itself was only possible because of these co-productions and co-dependencies.

While in Chillma, I was curious to see their clinic, as it was one of the models for the premise of intercultural medicine that was written into policy. We walked up a steep dirt hill to get to the entrance. I met the nurse, Cristina, who Xavier asked to show us around and tell us about the health post. Cristina is an auxiliary nurse who has worked in the Caiza D municipality.
for six years. I was most interested in seeing the birthing room in the clinic, as I recalled my interview with Dra. Herrera, and her discussion of the striking experiences she had while working with Causananchispaj when trying to understand prenatal and maternal health issues. Cristina took me to see the *sala de parto* [birthing room]. We walked into the main women’s exam room which holds an ancient looking black and metal gynecological table, complete with stirrups. Within this room was another smaller room, connected with a doorway, that was painted orange and dimly lit. The small room contained a single bed, low to the ground, a wooden end table, and a wooden ladder with a black cushion next to it. Cristina told me that this is what women hold onto if they are giving birth in “the traditional way.” I asked her to describe the differences between the two *salas de parto* that existed side-by-side, nearly overlapping each other as women would still need to walk through the “western” room to get to the “traditional” room. Cristina told us, “The western room is biomedical and used by a western doctor, while the traditional room is what a woman from the community usually seeks out, unless there are complications. The traditional *parto* is more private, and the women find it easier to have their babies there.” She explained that since building this room, more women came to the hospital to have their babies rather than staying at home, as they are more aware of their risks. However, this healing space and others I saw during my fieldwork heavily prioritized western conceptions of healing: the clinics were primarily set up for western medicine, with what I would consider to be “add ons” for traditional medicine, a room or a handful of rooms, a cabinet for traditional herbs. It was hard to find examples where there was what I would consider an even intercultural exchange between western and traditional medicine.

She also explained that there is the incentive for women to come to the clinic from the government, because they only receive a payment, called *Bono Juana Azurduy* if they have their babies in the hospital and come to regular check-ins. This payment was first developed by the neoliberal government of Bolivia as a way to incentivize women to go to the hospital to have their babies and seek out prenatal health care. The *bono* covers women during their prenatal care and continues through the first two years of life of their child, provided they go to the clinic on a regular schedule. While the Bolivian government aims to incorporate this award, and others, such as that for the elderly, into the *Sistema Único de Salud*, there is still a hybrid and ambiguous system in place, as these relics of the old system and health paradigm that they were seeking to surpass were still at the foundations of the health care system in Bolivia.

The type of projects and work that I saw and heard about in Chillma and other communities and municipalities in Potosí, paved the way for the incorporation of NGO presence into partnerships with the state, and was solidified when Ministra Elena Ortiz invited Dra. Mónica Herrera and Antonio Ortéro to participate on the Ministry of Health team. This incorporation of actors from and elements of the Causananchispaj model showed the Bolivian state’s incorporation of these partnerships into the policymaking process, where leaders of an NGO could be state actors, and the work of an NGO could become significant in the design of a public policy. Following the incorporation of Herrera and Ortéro into the Ministry of Health, further partnerships were formed with NGOs, as the Ministry of Health policy team sought other successful experiences from around the country to incorporate into the policy design. However, what tied together all of these experiences was that they all required NGO support; the programs that were public or government run were not deemed successful enough to participate. The incorporation of actors, ideas, and models demonstrates the ways that NGOs were, from the beginning, integral in the making of the Bolivian health policy and continue to be integral today in its continual making, circulation, implementation, and revision. How then does this upset the
visions of a future that is a break from the past that the policymaking team told me of? Or Ortero’s insistence that even with these partnerships the policy was clearly Bolivian through and through?

The particular activities, experiences, and processes of Causananchispaj over more than twenty years were re-narrativized, through the participation of some of its founders and technical workers, as relevant to and scalable to the whole nation. However, there is also a resistance in this, a struggle about what should go along with authorship. They feel that the government took the model from them, yet they now submit proposals to receive funding for new projects and do not get what they asked for, for example, the group I spoke to in Cotagaita wanted to license and sell their plants. Dina, one of the midwives, said “We were the first but we cannot get anything, we have a dream to complete this here since we were the first for SAFCI, as a model.”

Vignette 2: A Temporary Project in Ancoraimes

Policymaker Dr. Fernando Montés suggested that I visit Ancoraimes because it was the community where he had worked, and was invited as a model and collaborator for policy’s design. Ancoraimes was only a few hours from La Paz, so made for a relatively easy journey. I met my Aymara teacher Gladys at Iglesia San Francisco one chilly morning, and we went to El Cementerio to try to figure out which network of taxis and buses we would need to take to get to Ancoraimes. Gladys, an indigenous Aymara woman studying linguistics at UMSA, accompanied me at times when I traveled to rural communities around La Paz. During our three hour ride, Gladys and I talked to the driver, who was from Carabuco, a nearby community, about the health care situation in the region. Given that I had heard of Ancoraimes from the policymakers I interviewed, and read about their contributions to the policymaking meetings, I expected to find a thriving example of the health programs being perfectly implemented, as I had in Potosí.

As it turned out, our driver José provided perhaps the most detailed information about the situation in Ancoraimes. He explained that the Consejo Rural Andino was an NGO with project managers from all over the world. When they worked with the community, they focused on general topics in health and nutrition, speaking about quinoa, wheat, and other crops that could be produced in the community. They also touched on the issue of “usos y costumbres” (practices and customs of the indigenous community), and trained people to be community health workers with workshops, held health fairs on pregnancy and childbirth, discussed vaccinations, and did health orientations. They constructed rural hospitals and used the “carpeta familiar,” a family folder, to keep track of health information, such as the number of pregnancies and pregnant women in the community.

However, José explained that the project ended because there was a problem between the mayorship and the NGO. They were not in agreement about the approach and authority because the mayorship decided that they wanted to be in charge of healthcare and health programs in the community. José felt that healthcare had deteriorated since the Consejo left. He told us, “Unlike before, now the health personnel just practice in the hospital and don't seek out the sick.” When I asked about community participation in health, about whether it continued after the NGO left, he told me “the people only way for help. They don’t have the economic motivation or the right teams to participate. They have no incentive to participate.” Here, a tension between community leadership and international leadership fractured the partnership, leading to its demise.
With this pessimistic view on community health in Ancoraimes, I prepared for what we would find when we arrived. Ancoraimes is a beautiful little community of mostly mud adobe houses nestled between the hills and Lake Titicaca, surrounded by a nearly-dry river and some eucalyptus trees. The air was fresh from its proximity to the lake, a startling blue against the brown earth. We walked along a dirt path to the entrance of the clinic, a large white stucco structure with a metal gate and trees at the entryway. We entered the clinic, which was built around an open hallway that felt like a greenhouse, with small rooms that included offices, a dentist room, and exam rooms. When we arrived there were two men and a woman, all auxiliary nurses, sitting at tables folding bandages. I did not see any patients or anyone waiting to use the facilities. I introduced myself and told them about my project. Hector, the nurse at the hospital, confirmed what José told us. He explained that the project that they contributed to the designing of policy was an old project called the Consejo de Salud Rural Andino, a local NGO that is still part of the PROCOSI network, but no longer works in Ancoraimes. He told me, “It was an NGO that worked everyday with the people, and worked with the community to improve health. All of the attention was in the community, and was on atención familiar. They went directly to families and identified families by numbers.” In 1994 this NGO constructed the health post, and in 1995 they began to work with the nurses on this approach to family health. Another nurse I spoke with, Pablo, had been with the hospital for ten years. He told me about the process that the Consejo de Salud Rural Andino undertook when they first began their work in Ancoraimes. Like
Causananchispaj, they conducted a small study to begin where they found out how many people live there, their names, where they live, and how they live. Pablo told me “It was just like the *carpeta familiar* that is now being implemented by the Ministry of Health as part of the SAFCI policy, which creates a family history for each family in the community.” The Consejo created archives of each community using this method, and checked in with pregnant women every three months, and adults twice a year. These elements were direct contributions to the policy that I had heard about in the Ministry of Health in regards to the elements the work in Ancoraimes had inspired.

I asked the nurses about the work they are currently doing with the policy, and they told me that they only loosely dealt with it at this point, primarily due to the NGO’s disengagement from the community. *Consejo de Salud Rural Andino* according to Hector, “Had autonomy because they were an NGO,” which meant that there was no necessary long-lasting partnership like the one I had seen in Potosí. Isidro discussed this drawback of the NGO, due to problems with the local authorities in the community, and the impact it had on the community,

The Consejo Rural Andino set up this form of work in the community, but after no one spoke of this project anymore. The project was temporary. NGOs come to the communities and present projects, and they have done this many times, and want to facilitate projects, but if a person from the community works on the project it is only temporary. People would rather work in an area that is more secure. When the project was running many people from the community participated as *promotores de salud*, between thirty or forty community members participated. Now, it is just the state saying this is SAFCI.

I recalled the conversation I had with Dr. Montés about his work during the seven years that he spent in Ancoraimes, how this work served as his own inspiration and contribution. Even in its failure, this program served as part of the vision. I had asked him,

AB: Could you tell me about your experiences participating in policymaking? Did you personally make any contributions?

Dr. Fernando Montés: I had several sources of inspiration, but the part I was able to contribute was my experience living in rural areas, primarily in Ancoraimes where we developed and applied work with the family. We did visits to the families in the community, to their houses, in order to see the conditions in which they lived, which is an essential requirement in order to take action towards preventative health care. It is an essential requirement, but not unilaterally, rather in a participative way.

He continued to emphasize the learning experience he had while visiting families, where he experienced their use of traditional medicine. He told me,

We are professionals of western knowledge, and we received our education from school to university. This is our problem, because we valorize what is cognitive and productive, nothing more. Because of this, our paradigm is individualist. In Ancoraimes there was not this understanding or comprehension. This work opened me up to being more accepting, and to speaking the language itself, because that is the core of this concept, right?

What of the disparity in Montés’ vision of the program and what Ancoraimes is doing now? That the policymakers, in creating a utopic policy, used models that were failures, or that could not be maintained, without certain structures of power demonstrated some of the failures that were
embedded into the design itself. Policy was constructed through complex origins and contributions, not all of which were successful.

These examples, Chillma and Cotagaita in Potosí and Ancoraimes in La Paz, demonstrate cases of places, with their successes and failures, that served as part of the origin stories for policy. Embedded in these stories were NGO participation, both domestic and international. These NGOs helped provide the implementation of the health programs that were used by government actors as models that could be inscribed into and labeled as health policy, and they were later largely responsible for implementing the formalized government package, the “SAFCI policy.” NGO’s significant involvement in the design and implementation of health policy that I witnessed in Bolivia requires some rethinking of the role NGOs play in policymaking and the traditional power relationships assumed within literature on humanitarian aid and NGO support.

The Bolivian state’s actions in relationship to NGOs helped to make this relationship strange by requiring that NGOs comply with the premises of the very policy that some of them were involved in helping to produce in order to continue working in the country. It is strange because it is a policy meant to break from the past, but the past is still embedded in the vision given its reliance in design and implementation on NGOs. This reliance is more ambiguous than a straightforward narrative of aid power dynamics.

Further, anthropological theorizations of “the state” suggest the kind of state that was being crafted through this work and the ambiguities in authorship and partnerships in the making of policy. This work destabilizes the state as an actor or singular entity, and instead focuses on bundles of practices and rationalities that constitute “the state” (Gupta 1995; Abrams 1988; Mitchell 1991). These scholars have suggested ways to locate the state ethnographically through an investigation of actual practices and encounters that demonstrate how the state is produced (Holston 2008), experienced, and known, with a focus on “the intersection of local, regional, national, and transnational phenomena” (Gupta 1995). This literature examines social movements and NGOs that extend a study of the state beyond government sites (Trouillot et al. 2001). National policy-making in Bolivia was a collaborative process amongst a multitude of actors all involved in producing the state, or “re-founding” in Walsh’s conceptualization, through the lens of health. This involvement, or what took the form of a kind of partnership with NGOs, was not uncomplicated. Antonio told me,

But in our eagerness to say that we have to make municipal plans, some NGO’s have seized this idea with a lot of skill in this area and they have released municipal plans, but since they haven’t done it with the input of the people, they have designed municipal plans that strengthen the healthcare system without an intercultural emphasis and without a focus on social participation. So it is precisely this weapon that can result, well, in a boomerang effect, in a loop, right? Some have framed this potentially problematic reliance on NGO involvement as an “internal contradiction” (Johnson 2010). Brian Johnson, in his article Decolonization and its Paradoxes, focuses on this NGO support, writing, “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 international-based institutions or those with international financing, many of which have played leading roles in the neoliberal history of international development, to implement one of its leading decolonization policies” (Johnson 2010: 153).

However, I suggest that the Bolivian state’s partnership with NGOs at the origins of policy and its circulation requires a rethinking of certain traditional power relationship between
giver and receiver of aid, and through this, a rethinking of how policymaking is done and who is involved in its authorship, as well as the power dynamics involved in authoring policy. Bolivia makes this relationship ambiguous by incorporating NGO programs into the design of policy itself, and by integrating NGO actors into the policymaking process. Further, following the implementation of the policy, NGOs are required to comply in order to continue working in the country. The involvement of NGOs, both domestic and international, in the making of “policy” in Bolivia, and the implementation of this concept, is only problematic as an “internal contradiction” in the language the state uses to conceive of itself as post-neoliberal or decolonizing, where public and private are split. The way the policy is conceptualized in practice, however, does not allow for such a firm dichotomous boundary, another manifestation of its mutability to different forms of ownership, implementation, design, and its multiple manifestations. NGOs were essential actors in creating practices and forms that were bounded off as “policy,” and also in the delivery system of this policy, providing much of the technical infrastructure, as evidenced by the failures to deliver the policy at sites I visited where NGOs did not exist.

The relationship, therefore, was not always one of a divide between public and private, or state and non-state, but rather could at times be one of partnership, adjustment, articulation, and hierarchization. NGOs in Bolivia were not the same as the state, but some of their actors spanned a variety of spheres, and they often did the work of the state. The state acts as a coordinator or project manager, and in fact needs and requires the NGOs in order to work. The state is thus made up of a dispersed network of organizations that are both public and private that must constantly coordinate in policy’s making and implementation. There is a humanitarian partnership between the state and NGOs, and the policy could not come into being or exist without this partnership because NGOs were essential in the production, distribution, and implementation of policy. This is not a relationship where the “private” is usurping the public’s responsibility; rather, the state does not have the capacity to facilitate and implement the process alone due to economic reasons that were raised in numerous interviews and conferences. There was thus a framework of coalition-building, with the state working to organize without having to do the work of delivery. In this sense, the state, as an entity seeking sovereignty through its socialist regime, manages the remnants of neoliberal governance. The conception of policy that emerged replicated certain neoliberal structures while simultaneously decolonizing them through the shift in power dynamic and sovereignty. This role of project manager that I witnessed during my fieldwork implies a position of authority, but not that one institution does or should do all the work- rather it required a network of institutions.

This framing of the NGO role as part of making a conception of policy in Bolivia is against a tradition in anthropology of thinking about neoliberalism as the drawback of the state, and particularly the work of James Ferguson who discusses the state’s replacement by non-state agencies, where sovereignty is reorganized (Ferguson 1994). Rather, what I saw in Bolivia was closer to Aihwa Ong’s (2000) work on graduated sovereignty in Southeast Asia, where the state invites corporations to run it, and they perform operations of the state because the state allows it. There is the relinquishing of sovereignty which in and of itself becomes a sovereign act. In Bolivia, there is an internally differentiated and hierarchized network of actors who came together to form a conceptualization of “policy,” and are situated as part of the policymaking and circulation processes to divvy out the roles of implementing the policy. The state here takes on a role of principal coordinator. The difference between public and private is not that they are inside or outside of the state. Rather, they play functional roles in the multiple ways that “policy” as a
concept is made. This is a humanitarian dynamic where the state is not pulling back, but rather is taking on a different sovereign role in the management of neoliberal institutions.

Yet, this coordinator position exists because of a dystopia in the system; the state is not able to attend to everything, unable to apply the Sistema Único de Salud. One of the first NGOs that I encountered during my fieldwork was PROCOSI, or “El Programa de Coordinación en Salud Integral,” founded in 1988, and exemplifies some of the foundations in neoliberal governance and shifts in dynamics that an organization in Bolivia might go through in these political shifts. Furthermore, the work of PROCOSI also demonstrates some of the dystopics of the vision. Brian Johnson is a North American medical anthropologist who lived and worked in Bolivia for over 25 years, and, at the time of this research, worked for PROCOSI. Brian and I developed a camaraderie during my fieldwork, and I had many long conversations with him about his work with PROCOSI and the Ministry of Health. Brian’s discussion of PROCOSI’s relationship with the Bolivian state exemplified some of the shifts that have occurred in the development of what I consider to be a “public-private partnership.” He explained that PROCOSI was heavily funded by USAID, and the original project design had nothing to do with the government’s health policies; rather it focused primarily on local health promotion. USAID and the Bolivian government had many problems regarding their involvement with the military.

Up until 2007 PROCOSI had a tense relationship with the Ministry of Health because of their USAID connections. As USAID began pulling out of the country due to political conflicts with the Bolivian government, PROCOSI met with the Ministry of Health, and Dra. Mónica Herrera provided them with a rundown of their ideas at the foundation of what would become called the “SAFCI policy.” In August of 2007 PROCOSI signed an agreement with the Ministry of Health to focus on SAFCI, and they started the Proyecto de Salud Comunitaria, which began their long-term work in coordination with the Ministry of Health. Since this partnership, PROCOSI became the umbrella organization for over 27 private organizations and NGOs that focus on improving health through a focus on the social determinants of health (website, interviews). Through PROCOSI, there is the distribution of functions throughout a network of institutions in which there is still an official divide between state and non-state actors, but the role of NGOs has shifted from being the institutional form of civil society, which is the voice of civil society against the state, and rather becomes part of the technical apparatus through which the state can accomplish its sovereign objectives.

In a more recent expulsion of USAID in May of 2013, this act was discussed by Bolivian government officials, “The expulsion of USAID should be seen as... an act of sovereignty,” Juan Ramon Quintana, director of a Bolivian government development agency and a former top presidential aide, said at the time.” (CNN). Sovereignty was framed as the ability to exert power and authority over NGO and development assistance that was not in accords with the beliefs and visions of a state that was built upon a rhetoric of new visions and reviving cosmovisions.

Policymaker Fernando Montés told me that historically NGOs were problematic because each had its own mode of intervention and its own approach to working in health. Before 2006, each NGO and international corporation had their own priorities without consulting with the needs of the country. Some focused on mothers and children, others focused on primary care, others on pathologies, while still others on epidemiology. They didn't respect the authority of the Ministry. However, with the MAS government, NGOs have to comply and align with the new health policies. They need to work with the reality of the country, not just financing what they want to. They need to align their work with the Ministry of Health.”
What was significant in my conversations with a number of NGO workers at PROCOSI was their discussion of their work based on their understanding of their partnership with the Ministry of Health. Brian explained,

NGOs are important in disseminating SAFCI, and the Ministry of Health is using them. They weren’t originally part of the project, but they became part of it. The legacy of PROCOSI is not going to be that people are trained, sicknesses are caught, the standard NGO stuff. The legacy will be the development and dissemination of SAFCI.

During my fieldwork, representatives from PROCOSI were often at the health policy and health planning events I attended. I met with four different key staff members of PROCOSI’s main office in La Paz during my time there to try to understand their role in the policymaking process, and the dynamics of their relationship with the Bolivian state. Isabel, one PROCOSI staff member told me,

PROCOSI is a network that has an institutional obligation to support and strengthen the existing health policies. All of the projects that we undertake are always linked to the work of the Ministry of Health and are meant to strengthen their policies, of which, in this case, the most important is SAFCI. PROCOSI has contributed significantly in the implementation of SAFCI, because the Ministry maps out the strategic courses of action and the whole technical approach as the governing body, but when you get to the operational level with the community, there is where the organizations figure out the way to do it. And in every place it is different.

However, there was a sense that they felt that, even though they were working towards the Ministry of Health’s policy vision and implementation, that the state itself was not capable of doing the work on its own. For example, Isabel called the policy “their policy,” creating a separation in ownership. In fact the work of PROCOSI was deeply embedded in the designing of the policy, beginning with a series of program visits that Mónica Herrera took, in coordination with PROCOSI’s programs in the Santa Cruz province in 2006. Victor of PROCOSI also told me,

Since before the policy the role of PROCOSI was to implement the policies that the Ministry had decided on. But in the process of implementing, because the Ministry doesn’t have many resources, then there was funding from the NGO’s that had all those resources for implementing policies, programs as protocols, etc., especially at the community level, so PROCOSI implemented them. And that implementation, that real-life experience was transferred into results of various experiences with suggestions for new methodologies, with suggestions for new strategies, new tools, new techniques that obviously helped the implementation. So PROCOSI has always tried to organize meetings to make public precisely these experiences, especially to the Ministry. So that is its role, to implement the policies especially in the rural areas, and above all, with community participation.

In one meeting with Mariana, a specialist in public health at PROCOSI, she explained upfront, “The NGOs of PROCOSI in reality implement the programs of the Ministry of Health in the area of health.” When I asked her to explain the actual practices they undertake to help implement these programs, Mariana responded,

Well, as you know, the State can’t attend to all the country’s needs, right, so that’s why the NGO’s are there. The NGO’s have a budget, they have qualified technical staff, they are always in the communities providing support, working with the healthcare staff, with the municipalities. That has an impact, right, because for example, the SAFCI policy or
law is launched, but the healthcare staff who are directly responsible for implementing it in the municipality aren’t qualified, right? There are a few who are qualified but they don’t even have the willingness or the attitude or the budget or the time to begin to work with the SAFCI, which is what the NGO does have.

In these narratives is the discussion of a situation in which the state is unable to attend to all of the necessities of the policy, or incapable in implementing it, perhaps reflective of the fact that the programs it was based on were non-state programs, as well. Mariana finished, “It takes more time, more staff, and more resources to cover all of these places. Actually, it is the responsibility of the Ministry of Health, but they will never achieve it.”

The way that Mariana discussed the work of the NGO was almost like a mediator between the state and the communities, particularly those that resisted the state policies, primarily in areas that were less supportive of the MAS government and Evo Morales’ election. In this sense, she still noted a certain power of the NGO to “make the authorities aware” because the law was “not accepted,” where the NGO has to “work against.” Yet simultaneously their work requires community participation, creating a significant paradox in the sites where the policy has not been so readily accepted or circulated. Certain NGOs in Bolivia, then, are deeply embedded as partners or hands of the state that are used to implement the Ministry of Health’s desires. This actually serves to replicate some complex power dynamics between NGO and communities, which the state then becomes complicit in through its partnerships with, and demands of the NGOs.

Vignette 3: Where there is no NGO: Santa Maria, Beni Province

Other dystopias enter the frame, as well, reflecting some of the unevenness at policy’s origins that shaped its unevenness in implementation. Bolivia’s health landscape is not just made up of partnerships between communities and NGOs. There are also sites that did not participate altogether, and do not have these partnerships embedded in their work in health, with no voice in the process. The Bolivian government conceives of itself as “plurinational,” and is aiming to create a Sistema Único de Salud. However the utopian vision is one that is infused with not just failures in the notions of indigeneity embedded into policy, or the failures in programmatic partnerships with NGOs. There are also failures in representation, as the policy itself heavily favors Aymara and Quechua cosmovision and health programs, with much less representation from the lowlands and Amazonian regions of the country. Dividing invited representation up by province did not necessarily mean that every indigenous group was represented in the policymaking process, as the provincial boundaries of the state are not the only subdivision that exists, and are subdivisions that were imposed, rather than a return to a time before these impositions.

As I already mentioned, during my first summer in Bolivia I was part of a National Science Foundation field school to learn quantitative anthropological methods. We were based in a rural Amazonian community, Santa Maria, which was home to the Tsimané indigenous group. The faculty who led the program had been doing longitudinal studies in the Tsimané region for many years. To get to Santa Maria we took a terrifying twenty-three hour car ride from La Paz down to the lowlands on the “Camino de la muerte” or death road. We stopped overnight in a truck stop town called San Borja on the edge of the river, and then took an eight hour motorized canoe ride down the Maniquí River, its banks lush with Amazonian greenery, the water tinged orange from minerals.
To get to Santa Maria we had to carry our supplies up a steep embankment, which would get slippery when the rains came. We lived and worked in two structures, a hatata-roofed, wooden-walled sleeping area where we slept in bug tents, elevated above the dirt to avoid mildew and stay clear of the multitudes of bugs, and another structure that served as our kitchen and classroom, though we rarely used the kitchen except to store our food and boil water. Most of our cooking took place over wooden logs that were brought together to rekindle the fire and spread apart to cool the embers when we weren’t cooking. Our days began early, and were spent engaging in classes and activities.

My research question for the group work centered around the correlation between knowledge about Bolivia’s new health policy and health programs and people’s use of the western medical system, evidenced through the use of books to record children’s’ vaccinations, visits with the doctor, owning a state-provided carnet that allowed women to collect bonos, or funds to help support their young children. Amidst these activities I also sought the answers to other questions. Bolivia’s political system notoriously favors Aymara and Quechua indigenous groups, as they are more represented in urban centers and make up the majority of indigenous people in the country (Albró 2006; Johnson 2013). The Amazon, and the lowlands in general, have less political representation, and are often cited as places that are “left out” of the design and implementation of state policies and processes. This is problematic for the structuring logic of the policy that attempts to represent and be accessible to all indigenous groups in the country,
and all areas of the country. The vision of a *Sistema Único de Salud* and universal care was made an impossibility based on the unevenness in representation and participation throughout the country.

Indeed, Santa Maria, unlike many of the rural altiplano communities I visited, had no health post. There were two community members who had been trained as *promotores de salud*, but from discussions with people in the community and these two *promotores* I found that they were primarily the keepers of the *botequin*, or medical kit, but distributed medicines that they received from the state immediately, leaving none for emergencies. In Santa Maria and the surrounding Tsimané communities, health news was primarily broadcasted over the radio. There were once- or twice-monthly visits from doctors from an NGO that was twenty-four hours away by canoe and primarily came to provide vaccinations and checkups. One morning after our breakfast a flurry of activity and commotion erupted as a canoe full of doctors arrived for the monthly vaccination event and the gathering of data that would be statistically “significant” for the country. Children and adults were given the H1N1 vaccine, even though there were questions about whether that was needed in this area, and babies were hung by their waists on a scale, their numbers quickly entered into the doctors’ records and the mothers’ vaccination and doctor visit *carnets*, required so that women could get money from the government.

Vaccination campaign in Santa Maria, photo by Alissa Bernstein

While I was in Santa Maria I heard rumors of another doctor, who may or may not be certified, but also visited the communities to provide care. In discussions with members of the
community I found that people primarily used *la medicina de la montaña* except when the doctors passed through or there was a distribution of western medicines. There was no talk in Santa Maria of interculturalism or health policy, though this trip was in 2010 so quite early in the legal process. People were, however, familiar with the bonos: Bono Juana Azurduy, SUMI, and SPAM, all medical programs of the pre-Evo Morales government that provided care and finances for pregnant women and children under two (Bono Juana Azurduy), public medical care for children and adults (SUMI), and medical care for the elderly (SPAM). In emergencies, the people of Santa Maria and other communities were left with a canoe to make the 24 hour non-motorized journey down the river to San Borja, the closest health post. Many people in these communities died of diarrheal diseases and snake bites, as medical care was too far away. As part of the NSF field school, we were asked to perform basic medical care using the book *Where There is No Doctor*. While I and another student abstained from this responsibility given our ethical concerns with the practice, I saw that besides there being “no doctor” here, this was also and example of “Where there is no NGO” in the way that there was NGO support in areas supported by Causananchispaj or Medicos del Mundo. In Bolivia, there were many places like Santa Maria in the Beni, that were not part of the origins of policy in terms of participation, but are part of the origins of policy in terms of a their positionality within the country. Policy’s origins incorporated all that was part of Bolivia’s past, including the differences, the unevenness, and the more recent sociopolitical ruptures, including ruptures that were reproduced by the Morales government itself.

**Conclusion**

In this chapter I have sought out more of the origins of policy, and have demonstrated that amongst the strange partnerships and blurred authorships in the process. I suggested that certain kinds of failure were already designed into the policy, required by the political circumstances at the time. While in Bolivia the utopian vision involved a break from the past, to make the state’s project about “Bolivians.” However, these NGOs were sometimes deeply embedded in Bolivian society and were even sometimes co-owned by Bolivians who transgressed authoritative positions. Even when they failed, NGOs were embedded in and shaped the system, inextricably. The state, then, had to figure out ways to reshape this partnership to fit with the new vision of health and policy in the country. NGOs are involved in ideas about what makes a community, what makes a family, and what makes an individual, as well as helping to define the concept of “health” in the country. The vignettes discussed above demonstrate the widely varying types of programs, participation, and activities that were considered to be part of the “origins” of policy, as well as the dystopics of the fact that there is no equal or equivalent implementation around the country- from Potosi to the Amazon, the capacity to work with and contribute to health is very different. What kind of nation is being made, being “re-found” when representation is so uneven? How were the policymakers okay with the idea that not everyone would be covered in the same way, even as they projected a vision of equality? (Razon 2013).

The above vignettes demonstrate some of the complex partnerships and interactions between NGOs and the state in Bolivia that produce and manifest different conceptions of policy through their implementation programs. They also demonstrate the different strategies and approaches to health that were implemented through these partnerships that were then bounded as models and performed on a national stage to be made into a concept called “policy”. Embedded into this concept were complex dynamics around how to situate a nation that was
attempting to frame itself as post-(neoliberal/colonial) yet still relied heavily on some of the structures of the past to implement its newly reframed conception of “health.” And indeed, in Latin American anthropology, there is a tendency to frame studies of ‘neoliberalism’ and ‘post-neoliberalism’ as distinct epochs, where post-neoliberalism is theorized as a form of resistance (Postero 2006; 2007, Gustafson 2009; Yashar 2005; Goodale 2006). However, this framing of the contemporary has become less tenable, both because of critiques within the discipline (Ong 2006), and also in relation to actual historical developments, including the emergence of this dynamic interaction in Bolivia. This chapter has examined an approach that eschews an epochal claim in favor of a situated analysis of the phenomena that emerged in the production of a new health movement. Here, new socialist health policies strategically made use of the actors and institutions of health aid organizations and transnational funders as a way to complicate any straightforward approach to a ‘post-neoliberal’ moment. This is an examination of the Bolivian state and of the institutions of neoliberalism that serve as partners or mediators between politics as ideologies or theories, and politics in practice and the methodologies of their implementation. In some ways, then, the state is strengthened by these actors (Chalfin 2008, 2010; Junge 2012; Morrell 2012; Sharma 2006), while in others it allows a space for the state to use the partnerships and yet still assert critiques over their work. This contributes to an anthropological project of defining and thinking through neoliberalism, because it looks at the social relations that produce this dynamic- from the partnerships, the camaraderie, to the critiques and the hierarchies of power that are reproduced. By examining these NGO partnerships and their successes and failures, I was able to watch how they were involved in making the concept of “policy” and bounding off certain spaces, models, and practices qua policy. Bolivia’s health NGO network is deeply involved in the policymaking, circulation, and implementation processes- situated at every step, and in fact integral to the history of the policy’s design and its design in process at the time of this research. I argue, in fact, that the policy itself could not be “made” and cannot be circulated without this NGO network, which is a relic from the neoliberal past, a “before.”

Furthermore, in regards to my larger project of thinking ethnographically about policy and policymaking, I want to suggest that this approach to adopting local models into national-level policy approaches is not uncommon. I suggest that these types of adaptations require ethnographic examination. What can ethnographic study of these types of originary programs that shaped the development of national policy tell us about the ways that health policy will unfold in practice? How might an ethnographic understanding of these foundations provide insights into some of the difficulties, successes, and complexities that might emerge at the national scale?
Part 2: Mutations
Chapter 3: Mutable Mobiles and the Circulation of Policy

A signifier is from the very beginning the possibility of its own repetition, of its own image or resemblance. It is the condition of its ideality, what identifies it as signifier, and makes it function as such, relating it to a signified which, for the same reasons, could never be a ‘unique and singular reality.’ From the moment that the sign appears, that is to say from the very beginning, there is no chance of encountering anywhere the purity of ‘reality,’ ‘unicity,’ ‘singularity’ (Derrida 2008: 91).

It is necessary that heteroglossia wash over a culture’s awareness of itself and its language, penetrate to its core, relativize the primary language system underlying its ideology and literature and deprive it of its naïve absence of conflict” (Bakhtin 1981: 368).

Introduction: Policy that is “Not fully written”

What are the conditions through which a policy vision, infused with the complex origins I have discussed, is made mobile, and how are the multiplicities and liveliness of the originary visions maintained or complicated as it circulates? What gives policy meaning, what makes it conceivable or recognizable as policy? When does it get restricted and why? I have already challenged how we think about the origins of policy as part of my project to construct a cultural biography of policy; here I will begin to explore what happens when policies move, suggesting, based on my study of origins, that they are not just implemented as already-formed abstract objects. Rather, I examine what elements and structures were needed for policy to be recognized and used as policy. I also look at what elements were purposefully made to be flexible based on the multiplicity of origins of policy and the policy’s visionary aims to be a reparation for the past, and thus accessible to the plurality of Bolivian civil society. Policy, as I have suggested, was formed through a tension between centripetal and centrifugal dimensions; these dimensions were fundamental to policy as it circulated, as well. As such, flexibility, or mutability, as a metalanguage, was incorporated both as an inherent element in policy’s originary design, an element required for policy to be recognized as policy as it circulated, as well as an aspect of policy that needed to be managed or bounded. My approach to examining policy seeks to undo the foundational binaries often applied to policy as either abstract principles or embodied, material implementations. Following the dynamics involved in making and reshaping the material social lives of policies demonstrates that the ways policies circulate as more that merely decontextualized, completed objects.

I return now to my conversation about “a beautiful policy” with Dr. Montés. During that conversation he told me that the ideal of “The SAFCI Policy” is like a utopia. He also shared a discussion of what is required in practice to make their revolutionary policy vision a reality. He told me,

“A utopia is not achievable. Obviously, they are dreams. For us, that is the challenge of building in a grassroots manner, which is to say it will not be built by four technocrats, it will not be built only by people who claim to know medicine, who are experts in medicine...Our challenge is to build it here and we are beginning this construction. Who is it that creates transformation, change?...The important thing is to share these philosophical and technical aspects that were developed with the whole population,
because the construction, I repeat, is collective. It is not the construction of some. We have not yet fully implemented the SAFCI policy, but this is part of the process of change. It is a path that we are traveling on, and on the way we are making a methodology...there are no formulas, it is not fully written. On this path we are writing realities that present themselves; This is the most important, no? That diversity, the diversity of opinions and people. These are also like our country, full of territorial and cultural diversity...We know the objective, we know where we are going...What we have now is an opportunity.

In Dr. Montés’ narrative is a vision of collective methodology which involves the possibility for policy’s interpretation and construction in process and through practices of implementation. In inviting the possibility for collective work he expands the question of who is involved in the process of making policy, and where this process happens. The people he spoke of are not just authoritative figures from the government or “western” medical practitioners. They are part of the collective, the polity, and, more specifically, a polity that he defines as the people for whom the policy was meant as a reparation. This approach to policymaking could fulfill the policy’s aesthetic vision to be a reparation and revival, to remake and refound the past through a new vision of the future. Dr. Montés’ way of framing policy conceptualized it as both a symbolic, ideological object, as well as part of an interactive state-making project. Montés expressed a vision of a path that is populated by a diversity and pluralism that, he claimed, is “like our country.” In doing so, he narrated a view of Bolivia as territorially and culturally multiple. Policy, “not fully written,” was understood as an opportunity to incorporate this multiplicity as part of what many of the policymakers considered a revolutionary process. As Gupta (2010) would suggest, policy became the privileged site for making “the state.” This work could only be completed through implementation. In implementation policy could reflect the different realities that existed throughout the country. As Manuel Ruiz, a staff member at Causananchispaj, explained to me, in a sentiment that echoed Dr. Montés', “SAFCI is a ‘dead letter,’ (letra muerta) made up of texts, but the historical and social processes built on these in implementation give it depth. SAFCI is a policy whose implementation depends on others.”

This approach to processes of policymaking comprises what De la Cadena (2010) calls a “pluralization of politics” (360). De la Cadena, who works in Peru and Ecuador, writes of creating a new concept of politics, that involves, “transforming the concept from one that conceives politics as power disputes within a singular world, to another one that includes the possibility of adversarial relations among worlds: a pluriversal politics” (De La Cadena 2010: 260). As part of the ideals of the policy, then, policymaking was not meant to be confined to bureaucratic spaces, as was demonstrated in the origin stories I discussed. It also required an attention to a diversity of opinions, people, and circumstances involved as it circulated. This diversity was represented by certain flexibilities discussed as part of the law that would allow this form of adaptation in implementation to take place. However, other dimensions of policy and its circulation also restricted interpretations and adaptability in order for policy to maintain its symbolic form and boundaries as policy. In this chapter, then, I look at some of the legal inscriptions of policy and its premises. I examine the ways these concepts, premises, and laws were attended to, mutated, worked on in practice, and how they were bounded to maintain their form as policy.

Health policy conferences and events in particular were spaces where these dimensions of policy manifested. The conference (usually encuentro, or “encounter,” sometimes congreso) was a key space where ideas about health, healing, and policy were discussed, debated, and made in
relationship to the “utopia” of policy that existed in legal, philosophical, and visionary form. At many of these conferences that I attended, representatives from all over the country and from different sectors of the healthcare system came together to share and discuss their experiences. In particular, many health policy conferences I attended were platforms where those involved in creating local or municipal interpretations and implementations of health programs deemed “successful” were invited and congregated by the Ministry of Health in coordination with other organizations. These conferences were a way for the Ministry of Health to use their own measures to both assess and track the successes and difficulties people were having while working with the policy. They were also a way to involve collaborative participation in making changes, revisions, and new guides for implementation that were co-produced and grounded in “local” experiences with the policy. This work was then circulated back to the government in iterative fashion. This process reflected the tensions between centralization and decentralization, norm and guide that were part of discussions that occurred throughout my fieldwork. Conferences were notable sites for ethnographic study because, as opposed to places I visited where I would see just one manifestation of policymaking and implementation, conferences provided a juxtaposition of many, and allowed for a view of the plurality of approaches to emerge, as well as insight into the various authoritative structures within which the plurality would become bounded. During these conferences, policy sometimes seemed to have one unified form and meaning, because of its official title, its place on many of the documents that were produced, and the legal norms that were discussed. At other times, the ways people spoke about policy and its implementation made it seem as if it was multiple and differentiated. Policy conferences were sites where I saw the interplay between the seemingly “authoritative” boundaries of ideal-type policy and a metalanguage of mutation that was designed and expressed through the formation of an active policy concept and active policy participants, both embedded into the law and required by the multiplicity of origins and experiences of policy.

One of these health policy conferences I attended in La Paz was called “Provincial Health Congress: With Health, La Paz, Vivir Bien for All” (“Congreso Departamental de Salud: “Con Salud, La Paz, Somos Todos Para Vivir Bien”). The conference was held in a large skyscraper on El Prado, the main thoroughfare in La Paz, with sweeping views of the hills dotted with brick buildings that merged in the valley into a series of highrises that made up the downtown area of the city. At this conference, as in many others I attended throughout my fieldwork, the purpose was to discuss successes and challenges people were having when implementing the government’s policy in order to create guides for interpretations of aspects of the policy, and to elect a provincial health council (consejo social de salud). Participants were divided into “mesas” or roundtables to discuss premises of the policy that they worked with. This subdivision process served to restrict discussion, while the event itself was also described as a way to allow participants to discuss their very particular relationships with and implementations of aspects of policy. I participated in the “social participation” (participación social) mesa. We sat in a circle of chairs, and began our discussion about experiences with implementation practices in health management and community participation. A man, Simón, dressed in a maroon poncho with the traditional Aymara hat, who was also a president of a local Consejo Social de Salud raised his hand, stood up, and told the group he wanted to talk about the importance of "interculturalism" in the health centers. The moderator chided him, “This is the mesa about social participation, the interculturalism mesa is downstairs, we have to talk about social participation here.”

Simón quickly sat down, with an ashamed look on his face. I was next to him and saw him write in his notebook “participación social” and underline it three times, as if to inscribe
this tense interaction and the boundaries of the categories that were imposed on his intervention. His whole body language seemed to turn inward, even though he had been quite outspoken in earlier parts of the meeting. I almost whispered to him “But I think social participation can include questions of interculturalism,” but another woman stood up and came to his defense with the exact sentiments as I was about to express. She spoke about the problems that occur when these different premises, aspects of the same policy, are separated so distinctly from each other. To illustrate her critique, she provided the group with an example of a problem that she witnessed when there are local indigenous authorities, indigenous community leaders, or indigenous groups in a community that do not overlap with the elected health leadership committees or health authorities, or exist in parallel to the government-established leadership. She told the group that this aspect of health management and social participation needs to be examined through the lens of interculturalism, as health management itself involves valorizing other cultural practices, which include leadership and participation practices. In her view, implementing the policy requires intercultural awareness of existing authority structures in the community in order to implement social participation most successfully. This interaction at the **mesa** demonstrated an example of a way that premises and policy were being both interpreted, mutated, and policed through discussions at these conferences. These types of debates and discussions over meaning, policy, and implementation were embedded in policy’s origins, and became an integral aspect of the policy circulation and revision process itself.

As such, policy, I suggest, can be understood as both formal and substantive: a formal norm with authoritative boundaries and a substantive space of “play,” as Holston has discussed in his work on citizenship in Brazil, and the rights-seeking practices and citizen demands surrounding housing (Holston 2008). The boundaries between formal and substantive were blurred at sites where I spent time participating in iterative approaches to the designing, making, and implementing of policy in practice. Furthermore, these iterations and revisions were in fact demanded by the policy’s premises. The distinction between law and its implementation was elided, because implementation was not the replication of the law in real life but rather the realization of law through practice, debate, and revision. It was articulated in ways that referenced some of the constructions of difference that were being produced at the time in Bolivia: different spatio-national scales such as localities, municipalities, provinces, and different cultural nations, reflected in the Bolivian state’s framing as “plurinational.” I look at the processes through which the premises and ideas built around concepts of policy were left open for debate based on these notions of difference in the nation. I also examine the work that the authoritative boundaries of the legal norms and the proper name policy do, the power that they have. I look at when they are left intact, and when they become adaptive.

In this chapter I introduce a concept of **mutation** as an analytic through which to examine the repetition and differences that were produced through policymaking, implementation, and circulation. I offer a reading of this concept as a way to talk about the different languages of flexibility that manifested through the concept of policy and policy implementation that I participated in and observed in Bolivia. I also examine how mutability was restricted in order to discuss the boundaries that were required to make policy recognizable as policy. These tensions between mutability and boundedness demonstrate a fundamental dialectic between centripetal and centrifugal dimensions of policy. I use the work of Peirce in semiotics to examine this dialectic. I show how mutability looked differently as it was mapped indexically, iconically, and symbolically, as policy was both something symbolic that was designed to be instantiated anywhere, but also restricted in regards to its referential parameters and the poetics required for it
to be called policy. These restrictions occurred even as it was indexically located in specific places by particular people.

There are four policy events that I will weave throughout this chapter to provide examples for how mutability and authority were negotiated in regards to health policy in Bolivia. The first is a 2011 national-level conference called “National Conference on Municipal Health Management 2011: The Challenge of Vivir Bien: A Social, Integral, and Autonomous Process.’ The second, another national-scale event also in Cochabamba, but in 2012, was called, “Retrieving our Experiences in Implementing the SAFCI Policy. The third was a Provincial-level conference to share health experiences and elect a consejo departamental de salud, a provincial health authority committee, in 2012. And finally, the fourth was a municipal-level event in a rural municipality called Santiago de Callapa in the La Paz Province in 2012. I weave examples from these conferences through a discussion of the legal premises of policy and interpretations of these premises. I provide vignettes that exemplify the different manifestations of the dialectic between centripetal and centrifugal forces in policy’s circulation and implementation. I examine what concept of policy emerged through both legal inscriptions and dynamic conferences, and how the process of “collective construction,” as Dr. Montés called it, worked in the building of a policy concept through practices of implementation, debate, and revision.

On Mutations and the Semiotics of Policy

My theorization of the concept of mutation is a way to discuss aspects of policy’s flexibility. While “mutation” is often used as a biomedical term to discuss changes that occur in genes that produce a new or different form, I find it to be a useful term to ground my argument that policy is never actually stable or singular in form, but is rather always open to changes in form from the moment it is instantiated as policy and as it circulates and encounters difference. Policy also contains within it the inherent possibility for mutation, as its laws and premises are meant to be interpreted and adaptable. I construct this term for my usage as a way to analyze policy through a discussion of Bakhtin’s (1981) concept of “authoritative discourse,” and the ways that seemingly objective categories produced through authoritative means and designed to be mobile, encounter and respond to heteroglossia. This creates a fundamental tension between the centrifugal and centripetal dimensions of policy. I also bring in a reading of Derrida’s notion in Of Grammatology of the repetition inherent in the signifier, and his critique of the proper name in Levi-Strauss as a way to expand how we think about the ways policies travel and are iterated. I suggest that policy, when reproduced, implemented, debated, or revised, is itself involved in constructing a notion of policy itself, even after something is formally enacted. Finally, I bring in a Peircian semiotic analysis of policy’s dialectical forces in order to think about mutability and restrictions within policy as it manifests in its iconic, indexical, and symbolic dimensions.

Policies function like “authoritative discourses” in their proper name form or through their pre-determined categories (Bakhtin 1981). There is an authoritative significance in the stability of some of these categories, as, in Bolivia, they were useful, and in fact essential, for the national plan that the policymakers, as part of a health “revolution,” or paradigm shift, were trying to achieve. In this sense, the utopian model, represented through the proper name policy, was an ideological representation. Yet, in the Bolivian health policy process, and, I suggest, in ideological constructions of policy in general, these models required other forces to give them
substance and meaning. I found that these elements were constantly being reconstructed and reformed in practice, and then reified as they were turned into new guides and systematized into new instructions. These model representations and the negotiations that occurred surrounding them can be understood through Shirley Brice Heath’s (1982) concept of “literacy events,” where there was “group negotiation of meaning from written texts…when books or other written materials are integral to interpretation in an interaction” (Heath 1982: 74). These literacy events relate both to the sociocultural circumstances in which they occurred, and involved elements that I witnessed that included negotiations around “labeling, what-explanation, affective comments, reason-explanations, and many other possibilities (Heath 1982: 74). Some of these categories were open, even as they existed as ideological structures, because those structures themselves required openness and mutability. They allowed for interpretations of what health, culture, and health practice mean within particular contexts. The concepts that made up the seemingly stable categories incorporated within them the possibility for being more than these categories, for having excess (Strathern 1988). In this way, the circulation and potential for adaptability of policy was inscribed into policy itself. These policy processes challenged the “authoritative discourse” of the categories of the proper name policy, and allowed certain kinds of heteroglossia to be incorporated and exist simultaneously. There was an openness, but one that was framed within certain conceptions of what it means to be a health policy, and what spaces and participants were authorized to debate this policy.

But how does this process unfold? Derrida’s conceptualization of repetition provides an intriguing way to think through this aspect of my analysis of policy. Derrida’s discussion of repetition is based on an analysis of the relationship between speech and writing in language. Derrida suggests that signifiers always already incorporate the possibility for repetition. As such, there is no such thing as a singular sign, as, from the moment it is stated it is already multiple (Derrida 2008: 91). Derrida’s understanding of the impossibility of a singularity to the sign helps us understand repetition in policy in this context, because, from the moment policy becomes a possibility, it can already never be singular. The way I conceive of repetition in relationship to the concept of policy I saw developing in Bolivia was reflected in how Dr. Montés discussed the relationship between a utopic vision, or a political ideology, and collective construction, which can be understood as implementation and revision through practice that began even before the policy was formally implemented. Repetition, or the revision or implementation of a model in practice, was part of the originary form and design of policy. This repetition, I suggest, creates mutation in two ways. First, there is repetition of a model which involves a kind of shift that attempts the reproduction of the whole or aspects of the first form of the model, where this repetition always produces a difference or lack in relation to what was seen as the purity of the original model, as is expected by the model itself. Second, in suggesting that there is a difference or lack in the repetition, I want to argue that what might be understood as the original also contains a difference, because the utopian form itself already necessitates the condition of possibility for its own repetition, and thus the mutation of its form or an absence of singularity. Absence or lack in the way I am considering it does not necessarily mean less or have a negative connotation, it just means difference, which in itself reflects the Bolivian vision of “plurinationality” or plurivocality. In this sense, policy as a utopian and revolutionary vision required multiplicity and difference and can only ever be repetition with difference. Deviations through repetition represent the fulfillment of the utopic vision. Thus, it is the very capacity of the model to be reproduced, incompletely doubled, or replicated that means that it already constitutes within itself the condition for its own mutation or reinterpretation. There is an
impossibility designed into policy as utopia that is part of what gives it its ability to be flexible and repetitive in practice.

It is in this destabilization of the original that it might be possible to understand policy’s repetition in terms of the creation of a network of differences. Thus, when a model is generated materially in an institutional form, such as a formal policy document, and then exported into different places, in the process of repetition the specificity of the original emerges, both in its inability to completely replicate, as well as in the inherent disruption contained within its original constitution. In what ways, then, might this repetition point to a paradox at the heart of the concept of policy in the way it is typically conceived of? Because of the presence of the possibility for repetition in the model, the model itself always already contained the conditions for its own transgression and mutation. I suggest replication and repetition do not just change the original, but also have infinite reverberations. There is no possibility for unity or singularity in the repetitions of policy, but rather a network of differences. This paradox that exists in policy as a no-place, an impossibility, means that policy was never created as complete and required reproduction, revision, and circulation to be recognizable as policy. Returning to Dr. Montés, he suggested the idea that policy is not done, and that leaving it open is part of the work of the policy. It is policy that is imagined as a static or completed entity that is, in this case, a failure. In this way, policy is constantly constructing the notion of policy itself, both its content and its process. This iterability does not end when something called “The SAFCI Policy” is enacted. Rather, implementation and revision are elements of the process of making a notion of policy. Reproducing policy is part of the construction process itself.

An analysis of one of the semiotic trichotomies in the work of linguist Charles Peirce can help to clarify the way this Derridian mutability to policy might be conceptualized when thinking through the tensions between centripetal and centrifugal forces within policy. This approach looks at policy, as a sign, and how it denotes certain objects. While the work on semiotics by Derrida and Peirce is very different, there are some similarities. Particularly, I build on their work and the areas where they overlap by bringing together readings on repetition and difference as a way to examine the semiotics of policy. Peircian scholar Barnouw (1986) writes, “Derrida’s use of Peirce’s idea that signification is essentially an unending process and one essentially without a beginning as well. This means that interpretation is always already involved in what we take for an immediate given, in perception or intuition, and by the same toke, that meaning attained always remains open to and in need of further interpretation…” (Barnouw 1986: 74). Further, both suggest that meaning requires difference. Pettigrew (1995) writes, “Peirce’s and Derrida’s treatments of the relation of signs and the problem of meaning entails a notion of difference” (Pettigrew in Colapietro & Olshewsky 1995: 365). In examining the semiotics of policy, I turn to where Peirce suggests,

An analysis of the essence of a sign . . . leads to a proof that every sign is determined by its object, either first, by partaking in the characters of the object, when I call the sign an Icon; secondly, by being really and in its individual existence connected with the individual object, when I call the sign an Index; thirdly, by more or less approximate certainty that it will be interpreted as denoting the object, in consequence of a habit (which term I use as including a natural disposition), when I call the sign a Symbol (4.531).

In Peircian terms, Policy functioned like a sign in that it had dimensions as an Icon, an Index, and a Symbol through which mutability and restriction were manifested. Iconically, policy contained elements that were restrictive of its form, and that copies in implementation were
required to fulfill in order to be recognized as “policy.” However, these copies were never complete or perfect, as Derrida (2008) and Hayden (2010) would suggest, thus bringing forth difference and mutation. Indexically, policy was rooted in specific times and places, people, and communities, where contexts were never singular or bounded but were always multiple. The “local” was embedded in a ‘national’ projection of a plurality of locals, which created an inherent multiplicity of local indexicality. Finally, policy as a symbol created a language of “policy” and its premises that could be instantiated anywhere. However, there were certain restrictive parameters to these instantiations and mutations. As such, policy was both open and mutable, but also confined and restricted because of the rules of the form of policy that were made and reified, for example in policy conferences. Policy as a symbol was both made to be multiply replicable, but also was always in the process of managing its mutability so that it could maintain the elements of its symbolic form that were seen as necessary for recognition.

“The SAFCI Policy,” in one conceptualization framed as beautiful, or as a utopia, was thus never unique or singular because it was always meant to be replicable, though with mutation, and therefore always potentially substitutable in order to be able to signify. The object that the sign “policy” refers to is multiple, based on the multiplicity and liveliness of origins that I have already discussed. Policy refers therefore not to a ready-made object but rather, the sign is in constant referential tension between the centripetal aspect of policy as an attempted unification, as Policy and the centrifugal aspect of a multiplicity of origins that arose from a plurality. There is both the possibility for openness, interpretation, and adaptation, as well as a process of bounding where certain areas of mutation are coalesced into a recognizable form, often mediated by bureaucrats and Ministry of Health authorities. These boundings helps to frame and contextualize and contain debates about health centripetally, even as they are simultaneously open-ended, intercultural, and centrifugal.

In what follows I integrate an examination of some of the premises of the policy and the laws that circulated, and how they were taken up in health conferences in order to frame the discussion of policy’s centripetal and centrifugal forces. This dissertation would not be complete without some discussion of what the ideal type policy consisted of. Mutations made policy expansive, as mandated by its originary design and its premises, yet certain barriers and restrictions around aspects of policy restricted it in in order to make it recognizable as the “revolutionary” Bolivian health policy. I integrate examples from the four conferences that demonstrate these aspects of policy, as having iconic, indexical, and symbolic dimensions, and the mutations and restrictions at work within these.

Policy Conferences as Fieldsites

Policy conferences in Bolivia took many different forms: they were small gatherings in rural communities, they were provincial meetings, and they were national invited sessions. At all of these conferences, however, I saw policy discussed, debated, and circulated, all part of collaboratively working on how policy was understood, what it meant in practice, and what it could mean for the nation and its “re-founding.” At these conferences, policy’s implementation was not judged based on economic modeling or measuring the absence of disease; rather the measures of success that I saw involved the collection of stories, visuals, and examples of participation. These were some of the ways that people discussed how they became healthier through working with the policy, and thus, how the nation itself was becoming healthier, as part of the co-production process they were engaged in through the policy. Conferences were also
places where people shared the difficulties they had with implementing policy, helping the government to consider approaches to its revision or alteration in practice. These conferences and events incorporated some of the same actors that participated in originating policy: government representatives from the Ministry of Health and other related ministries, NGO leaders, community members, doctors, and “traditional” healers.

An examination of these conferences provides a view into the ways concepts of “policy” came into being through circulation in Bolivia, and, I argue, how they were also connected, symbolically, with emergent conceptions of health, healing, and nationhood. The title of these sorts of events were important in reflecting the vision behind the process, and creating boundaries around policy, and what kinds of exchange, people, and ideas could be incorporated into understandings of policy and policymaking work. For example, one event I attended included the word “encuentro,” or an encounter or meeting of people, which was chosen as the label rather than another term such as “conference” or “convention.” This strategic choice of title was significant given the type of collaborative work the Ministry of Health aimed to do. At this event, Gerardo Mendoza, a representative of UNICEF who was invited to participate on an introductory panel about municipal-level health policy implementation, spoke to this topic of the words and concepts used to title the events about health policy, and their significance. He explained,

Encuentro, it is a collective theme, about exchange and reflection, which is a reality for family and community health (salud familiar comunitaria). This word has a much more profound meaning, however. It is the capacity to build practical social agreements to achieve wellbeing and vivir bien in the health field. This encuentro is focused on municipalities to show that municipalities are not isolated, but rather form a part of a nation.”

In his discussion, he both examined the ways that the title of the meeting reflected the premises of policy, as well as making a connection to vivir bien as a “practical” national aim. He expressed a theme that I saw at many of these conferences, where municipal interpretation of policy was understood to actually create national policy more completely through the differing approaches to attempting to achieve vivir bien.

Conferences were also places where policy’s symbolic dimensions were expressed, as policy became a symbol for a variety of related topics such as reparations of the past, a new health paradigm, and a revolutionary model. There was also often a reference made, in the title of the events or their description, to vivir bien. A Ministry of Health bulletin report wrote about the conference, “With the motto: ‘The challenge of vivir bien: A social, integral, and autonomous process,’ participants at the event will learn valuable experiences, lessons learned, and the ways in which each community has, through its own experience, environment, and reality, carried out SAFCI.” This bulletin announcement adopts this word from indigenous cosmovision that was integrated into government politics, and crafts vivir bien as a challenge, something to be attained. It suggests that the method for its attainment is demonstrating variations in policy’s circulation and implementation. Success was not replication and sameness, but rather autonomous processes. These conferences often focused on how to achieve vivir bien through health were

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4 Con el lema “El desafio del Vivir Bien: un proceso social, integral y autónomo”, los participantes del evento conocerán valiosas experiencias, lecciones aprendidas y formas a través de las cuales cada comunidad desde su propia vivencia, entorno y realidad, lleva adelante la SAFCI.
often messy, gritty, sometimes boring, and absolutely imperfect. They involved hours and days in overcrowded rooms sitting at tiny desks, listening to loud debates about semantics, and watching flurries of PowerPoint presentations that often blurred into each other given the repetition of subject matter. All of this took place within categories that were typically predetermined by the Ministry of Health. This work was followed by tedious list-making and revision. The messy scribbles, Excel documents, and later, the write-ups that resulted were representative of the imperfections, but also represented and reflected a process of iteration. Yet this messiness also reflected the aesthetic ideals of a beautiful policy: to be collaboratively debated and revised in this way was part of a process of resuscitation and revival. A beautiful policy, in the sense it was discussed in Bolivia, had to be messy to reflect the incorporation of a multiplicity of views on health and wellbeing.

Even amidst this messiness, conferences proceeded in a linear fashion that I will describe here, even as throughout the rest of this chapter I will not follow this linear ordering of stages of conferences in order to demonstrate specific ways that policy in repetition was made mutable and how it was bounded. Conferences often started with speeches by leaders of NGOs or government ministries. These types of authorities anchored theoretical framings of policy and its formal premises by focusing on local determinants of health, suggestive of a Latin American Social Medicine model that was popular amongst members of the Ministry of Health. Following introductory talks these conferences often incorporated roundtables or group work to share experiences, knowledge, and interpretations. These roundtables were followed by the sharing of this work and its recording by government representatives. Within these conferences, policy functioned like a Latourian circulating reference, where policy appeared to be an object that was actually moving. I focus attention on the types of materialities and contexts it traveled through, and the different work it was able to do through those contexts. Mutability was part of a metalanguage of flexibility that I heard at the health policy events I attended, as well as part of the different experiences with the policy that were shared by participants.

The Ideal Type Policy

Based on the systematization of the work of the policymaking team, an ideal type entity, an icon of Policy, called “The SAFCI policy,” or la política SAFCI” was discussed and circulated by the Ministry of Health. This official title, as a proper name and authoritative discourse, made it seem as if it was one package that could circulate the same, everywhere. However, this sense of unity was constructed through the work of documentary inscription and discursive repetition, as the label was not only applied to the manuals, laws, PowerPoint presentations, and guides that circulated, but also was a verbal signifier used to bound the constantly morphing conversation about health and reform that occurred at different sites throughout the country. In this way, the unity of the concept of “The SAFCI Policy” was useful as a poetics: it provided a way for technocrats and the people they were in conversation with to talk about and delineate aspects of a conversation or the themes to be raised in a conference. The premises of this iconic dimension of policy had their origins in the community work of the policymakers, but were also concepts that circulated through other health policies in Latin America, due to the Latin American Social Medicine model. In this way, policy’s iconic dimension seemed to restrict policy, in that it created a poetics that all copies, manifestations, or conversations must fulfill in order to be called “policy,” at all levels of implementation. However, policy is also meant to be circulated, which inevitably invites copying. Even though
this iconic dimensions attempts to restrict policy and the poetics of its replication, the copies manifested mutability according to the foundational premises of policy that required interpretation and adaptability. Thus the copies were never perfect and were actually never meant to be.

For my study of the circulation of policy at policy conferences, an understanding of the legal premises and documents that shaped both participation at conferences, and interaction with the ideas of the policy in other spaces where it was discussed, debated, and implemented, is important. These iconic premises shaped the work of conference participants, the ways that roundtables, or mesas, were divided, and the type of participation that occurred surrounding policy’s circulation. These premises also show some of the ways that the tensions between centripetal and centrifugal forces of policy were in fact embedded into the originary design of policy itself, one that simultaneously called for mutations through interpretation as well as imposing certain restrictions in order for policy to be recognizable qua policy. How was it that policy and its premises were able to replicate and be recognizable in different contexts, but also mutable to these contexts simultaneously? All of the legal premises attached to the sign, policy, can be examined as having iconic dimensions, with attempts to restrict meaning in that they create a poetics that other copies and uses must incorporate in order to be recognizable as policy, no matter what scales the interpretations are occurring at. However, many of the laws and political mandates related to health policy contained within them legal premises that incorporated within them the requirement for iteration and difference through interpretation. A concept of policy existed, through these legal references, that involved designating expansive spaces of policymaking that could exist outside of bureaucratic offices by allowing for local determination of how policy might look in practice.

Indeed, these boundaries around concepts and the attempt to structure mutation was apparent at most of the events I went to. Some of these practices involved the delimiting of policy guides by what were called “ecological” regions of the country, others involved the bounding of the kind of information that was provided to conference participants. For example, I was almost always given packets of information, including many documents labeled “SAFCI policy,” whether the didactic version, or, at one event, a copy of a version about doing health management (gestión). This management version was illustrated with pictures of people from different indigenous groups, and also functioned as a workbook where information about the work being done could be entered by participants at the conference. I did not return to these documents again during the conference, as the entire time was wrapped up in conversations, PowerPoint presentations, verbal debates, and the collective creation of guides, displayed on screens using overhead projectors. Yet, the gift of these documents suggested the existence of certain ideals, or the legal boundaries of the policy the group would be debating. The circulation of these documents at events like this maintained certain boundaries to the discussion, to what was being covered. Yet, the fact that they were rarely used suggests the emphasis placed on verbal discussions of policy and the importance of debate in place of the analysis of texts, which will be the topic of the final chapter of this dissertation.

Autonomy and Decentralization

Discussions of “The SAFCI Policy” were often discursively linked to discussions of other connected laws that were understood to help give health policy its form and strength in implementation. Most significantly, the new state constitution, in addition to its articles related to health, incorporated mandates for regional and indigenous autonomy and respect for indigenous
cosmovision as a premise of a plurinational state (see Chapter 1). Decentralization, according to the law, was meant to “strengthen the plurinational and autonomous character of the state” (Article 271 of the constitution). Specifically the constitution contains articles that mandate the free determination and respect for the cosmovision of indigenous nations and people, within the overarching unity of the country. One of the laws of particular relevance that emerged from this constitutional mandates in regards to how health policy was conceptualized in Bolivia was the Ley Marco de Autonomía y Decentralización, implemented on July 19th, 2010 by the Morales administration. This law emphasizes regional autonomies and their self-governance, and is particularly focused on two types of national subdivisions: municipal autonomy and the indigenous and originary groups within the country. This law demonstrates an aspect of the indexical dimension of policy, as it attempts to ground policy in the specificities of place, “indigenous” group, and local governance, while always referencing the national policy project, performatively and in practice. These contexts were never singular, given the plurality of subdivisions and the emphasis on plurinationalism. The “local” was therefore part of a national project of projecting a plurality of locals.

Article 6 of this law defines these subdivisions, and what their administrative decentralization and autonomy consist of. It suggests that municipalities and other subdivisions in the nation have the autonomy to govern and determine policies in ways that fit the realities of the local communities that make up the subdivisions. This law is supported by the increasing division of the nation into greater numbers of municipalities, as historically Bolivia had only 30 municipalities, whereas as of 2011, there were 337 municipalities, and federal funds were given to municipalities to be distributed based on the needs of a given community, in accordance with this law (Johnson 2010). As part of the decentralization practices of the Morales government, municipalities are involved in local determinations and decision-making practices, often in the form of community budgeting meetings, that allow for a trickle-down of resources, for example, for health projects. The smallest subdivision in the country is communities, which make up municipalities, which make up the largest subdivision in the country, provinces. The Ley Marco de Autonomía y Decentralización built a politics of flexibility and difference into political processes in the nation, allowing for the performative indexicality of policy by participants in a multiplicity of positions and locations. Article 7 of this law reads,

Article 7. (Objective). The goal of the system of autonomies is to distribute the political-administrative functions of the State in a balanced and sustainable fashion across the national territory so that citizens can effectively participate in decision-making processes, the deepening of democracy, and the fulfillment of collective necessities and of the socioeconomic development that is vital for the country. This national law also gives “local autonomy” in determining how policy works and looks. This involves municipal interpretations of policy and is one of the platforms through which policy is interpreted and redesigned to fit vernacular needs. Policy, based on this legal designation, both works to centralize and to decentralize. It is meant to bring all provinces of the nation under the same model, but this model itself asks for these differently designated subdivisions to reinterpret policy in practice. The multiplicity of times, places, and people through which policy can be rooted complicates and multiplies “local” indexicality. Or as Peirce writes, “In so far as the Index is affected by the Object, it necessarily has some Quality in common with the Object, and it is in respect to these that it refers to the Object…it is not the mere resemblance of its Object, even in these respects which makes it a sign, but it is the actual modification of it by the Object” (Peirce 2012: 102).
These iconic and indexical dimensions of policy—policy that both restricts but also requires mutability such that there is no identifiable origin—were emphasized in speeches at conferences I attended. The first event I went to while in Bolivia specifically emphasized municipal interpretations and implementations of policy. The event title reflected this emphasis, called the “National Conference on Municipal Health Management 2011, The Challenge of Vivir Bien: A Social, Integral, and Autonomous Process.” This event demonstrated some of the ways that this mutability within policy as law and ideology in repetition were being understood and put into practice as part of the metalanguage of the health sector, expressed at the national level. I was invited to attend the conference by some of the Ministry of Health team members, after speaking to them about my work. The purpose of the conference was for municipal authorities, health personnel, representatives from rural communities, and NGO workers to share successful experiences with the implementation of the SAFCI Policy based on their particular experiences and health environment. The sharing was based on the presupposition that the experiences of the policy and of implementing it would be different, a framing of indexical mutability that rooted policy in particular places and practices. Difference and mutability were seen as successes that would help to redefine the processes of implementation in the future through the creation of new guides.

This particular event took place at Casa Campestre, a large convention complex 10 km by taxi outside of the city of Cochabamba, eight hours by bus at lower altitude from where I was living in La Paz. Casa Campestre is a majestic lodge built into the environment with wooden and stone structures and palapas with tables surrounding a pool. The climate was perfectly temperate and warm, compared to the frigid air of La Paz, and there were trees and vines everywhere covered in bright pink flowers. The air felt so thick compared to the 12,500 feet I had been living at that I savored its texture, even though I was still at over 8,000 feet above sea level. The space felt more like a resort than what I imagined as a site for a conference about health policy. I waited for an hour in line to give my name and organization, UC Berkeley, to the conference administrators, and they printed out a tag for me to wear around my neck. Most of the over 400 attendees were involved in the health sector, whether administratively, as doctors or traditional healers, or representatives from NGOs.

The main conference room was set up with a long panel table on the stage in front with tags that said the names of the organizations that would be represented on the opening panel: Two international NGOs: Organización Panamericana de la Salud (OPS) and UNICEF, the Bolivian Ministry of Health and Sports, and PROCOSI. Two Bolivian organizations representing municipal and cultural associations also had a place at the panel table, the Federation of Municipal Associations of Bolivia (FAM), and the National Council of Ayllus and Markas of Qullasuyu (CONAMAQ), an organization that advocates for self-governance and self-determination amongst “originary nations” in Bolivia. I name these presenters because the choice of these opening talks was significant, and was similar to what I saw at many of the conferences I attended. By putting this collage of NGO authorities, municipal authorities, and indigenous social organization authorities on the opening panel, the symbolic terms of the discussion in regards to authority for defining policy and its boundaries, were positioned in front of the audience. This dynamic would continue throughout the talks and sessions over the next three days.
The emphasis on municipal determination was discussed during an introductory speech at this conference. I also observed a way in which the iconic dimension of policy was constructed as something mutable. Alfonso Estrella from the Pan American Health Organization created a connection between municipal subdivisions and social determinants of health. Amando told the group,

The work of the municipality is essential, since at this level they can identify the determinants of health within each area and determine the health issues in each place in order to create specific and localized solutions…It isn’t just the responsibility of hospitals, doctors, or governments. All areas need to work together to live well every day (vivir bien cotidiana).

But then another participant chimed in with a different interpretation of this determination towards vivir bien, stating, “Each community has its own heritage” (Cada comunidad tiene su propia herencia), intertwining cultural heritage with the “local determinants of health” discussed by the first speaker. Estrella’s speech and the participant’s comment reflected the dynamic that the country, and the concepts within the policy, were engulfed in: negotiating the boundaries of a unified nation-building project, and national-scale legal premises, while mandating local, autonomously-determined approaches to health and interpretations of policy. Everything from the way that health was being redefined to the terminology used to describe the event were involved in producing this dynamic. His reference to vivir bien at once made the statement reflective of a national ideology and symbol. Through this multiplying and mutating indexical dimension of policy, an openness for interpretation through the repetition of policy in implementation was built into the concept of what a policy is in Bolivia; the iconic dimension of policy, then, even in attempts to restrict policy under a proper name and through certain premises, was inherently manifesting the multiplying indexicality of policy, as well.

This mutability in the indexical dimension of policy was also manifested at another national conference I attended where I saw the ways that conceptions of the “local” were
embedded into a national aim and projection of plurinationality, which involved the importance of incorporating many different “locals” into the framing of policy. This national projection of a multiplicity of locals complicates and multiplies the “local” indexicality. At a national conference in 2012, during an introductory session, Dra. Herrera of the Ministry of Health, asked the group to share their specific local experiences implementing policy. It was as if the multitude of different “locals” were shaping the national symbol of plurinationalism through policy. She asked the group, “How do you do this in Tupiza,” a community that focuses on intercultural health. Someone in the audience responded, “Language.” Dra. Herrera asks where this is important and the woman says “In the clinic.” Dra. Herrera responded “Very good” and continued to ask specific questions about the work different people do and why they do it. While Dra. Herrera invited participation to manifest these “locals,” she also dictated the boundaries of the questions asked and it was her response to the answers that people in the group hung onto. However, her knowledge of what every single group in the room was doing with health created a feeling of interpersonal relationship.

Dra. Herrera, as national policymaker, had over eighteen years of lived experience working in health promotion, and was integrally involved in creating a national-scale health policy. Her awareness of local nuances and specificities was striking and blurred boundaries between “national” and “local as at another moment in time she could have been in this very audience providing examples of the successes and failures of her own work in Potosí with the Causananchispaj. As such, she performed the ideology contained within the policy in her approach to dealing with the group, which required the ability to link it, and in fact infuse it, with the mutations that emerged in practice at the local level. When the audience was invited to comment, I heard responses to the tone she set in the room with statements that reaffirmed what she told them, “It is our construction, our product.” Others used the space to voice their complaints about lack of financing, the lack of education in health, and particularly cultural health, and disagreements that emerged in their implementation of policy. These disagreements were understood as useful for the nation, as they would help create better policy guides. The multiplicity of community projects and interpretations of policy in implementation referenced the national project of policymaking, resembling the iconic elements and connected because of the premises and Dra. Herrera’s guidance.

Policy Premises in Practice

Within the policy were premises that formalized the requirement for mutability, and also circulated as part of the poetics of the iconic dimension of policy. Policies are meant to be replicated, and thus also require certain recognizable forms. These were discussed in both legal manifestations of policy and conference discussions: interculturalism (interculturalidad), community participation (participación comunitaria), and health management (gestión). In conversations these concepts were often noted as ways to ground (aterrizar), adequate (adequar con la realidad, for example), or articulate (articular) with the realities, needs, and interests of people in different parts of the country- whether these realities were framed around conceptualizations of indigeneity, adaptations made by NGO workers, or practices done by medical doctors (western and traditional), or others. These concepts of adequation (to make equal to, the sense of being equal to what is required) and articulation (to arrange, fit together, to correlate) in particular necessitated that a conception of policy in Bolivia be mutable. This mutability reflected the ways that a concept of policy could be created and recreated through
discussion and implementation. Deviations from the impossibility of a legal, philosophical form, then, represented success, as the concept of policy itself was articulated in practice. I highlight the tensions and interactions between the formal and the substantive, the authoritative boundaries and the requirements for mutability in what follows.

I focus on two key premises that explicitly called for this type of mutability in practice by indexically rooting policy in specificities of time and space: *interculturalidad* and *participación comunitaria*. These concepts were policed in order to maintain their form, and were also enabled to overlap and interact, as demonstrated by the earlier example of Simon’s intervention at the policy roundtable. Both of these premises articulate ways that different experiences with policy and notions of difference could manifest within and shape the concept of policy in Bolivia. I quote these premises from a documentary versions of policy that I saw circulating the most often, and then look at how each was manifested and was constructed in practice in conferences I attended, where the lines between them could be blurred, as Simon demonstrated in the introductory example I provided, and when they were bounded to maintain their recognizability. Symbolically, these premises were a language of policy that could be instantiated anywhere, but they were also restricted by the boundaries of the premises, even as indexically they were required to be rooted through mutability. These premises thus had an authoritative significance in policy conferences, as they were pre-determined categories and terms that structured the conversations that would ensue (Bakhtin 1988). As such, participants at conferences were often divided into tables, or “mesas” by theme related to the proper names of “The SAFCI Policy” premises: *salud familiar*, *salud comunitaria*, and *salud intercultural*. The existence of the Proper Name, “The SAFCI Policy” and its premises were thus imposed to bound particular understandings of policy onto the group and make the work they were doing conceivable as policy. This practice of subdividing the conference created a division amongst participants around premises that were already formed in advance. These categories immediately bounded off some spaces of possibility by formally imposing the broader topics for discussion onto participants, yet the topics that were imposed were areas that required flexibility in interpretation and implementation.

**Community Participation**

The premise of community participation, its legal language quoted below taken from a Ministry of Health policy document, demands the participation of the community in health decision-making and other health actions. Community participation, however, was understood to provide very different interpretations of policy’s implementation in practice. As such, this premise inherently referenced a multiplicity, even as an iconic representation was meant to restrict policy’s form. The premise reads as follows,

Community Participation: This is the ability of urban and rural communities (indigenous, native, peasant, intercultural, and Afro-Bolivian) to participate directly in the decision-making processes related to the planning, administrative execution, monitoring, and regulation of the actions of the healthcare sector so that the communities’ needs and issues are identified and prioritized through legitimate and organized representation (SAFCI 2009: 11)

Lynn Morgan’s (1993) seminal work on community participation in health in Costa Rica examines the local and international actors and ideologies of the ideals of Alma Ata that suggest the importance of participation. Morgan argues that participation was never meant to work, that it was designed of fail, given the local and transnational power interests involved. When
participation did work, Morgan suggests that it was seen as a threat to governments. I argue that, even at the level of the everyday, within left wing democracies such as Bolivia, this is a different story, a different context. This means that we can look at the everyday practices of participation, and the successes by recognizing that, while there are authoritative boundaries surrounding aspects of health policy, these boundaries framed a space of negotiation and participation. Popular participation in health policymaking relates to the creation of a space to negotiate, debate, and revise up against the boundaries of state framings of policy. According to Albró, this represents a “traditional” approach to politics, where, “These spaces of deliberation, it is clear, refer fundamentally to the historical precedent of the collective and face-to-face politics of traditional and popular ‘base organizations’…new popular options for the reform of national government are based on ‘assemblies of the neighborhood, the union, the ayllu, the factory’.” (Albró 2005: 402). The approach to popular participation used by the Bolivian government attempted, in some ways, to mimic “traditional” approaches to participation rather than neoliberal framings of participation, even as these did not always succeed. In this conception of replication that produces difference, or the idea that people can be ideologically involved with different aspects of the policy at different times or in different ways, there is also the replication that produces centralization and sameness, particularly in regards to the nation and the idea that the policy is unified throughout Bolivia. As such, expertise was not just for the policymakers or planners, disrupting a conception of participation and its segmentation that Paul Rabinow writes of in French Modern. Policymaking also involved community empowerment, participation, and mutation.

One of the ways that I saw discussions around participation manifested was through a language of expertise at policy events that indexically rooted policy in the specificities of the “local,” particularly local people’s experiences with health policy. As such, this language of expertise was cast as a way to expand the actors involved in policymaking. “Here, everyone present is an expert,” Dra. Mónica Herrera of the Ministry of Health said as she paced up and down the aisles of the auditorium in Cochabamba at the 2012 event “Retrieving our Experiences in Implementing the SAFCI Policy” (Recuperando nuestras experiencias para la implementación de la política SAFCI). A petite woman with short curly dark hair, a business suit, and an emotive voice, she sometimes stopped in front of someone or at the edge of an aisle, and she often called people out by name. She told the group, representing fourteen communities from across Bolivia, of one participant’s successes, and asked for others to chime in with their own. She got in people’s faces, her voice crescendoing. She was the quintessential motivational speaker, as she reiterated, “You are the experts. We aren’t just looking at theory because your experiences create new theory for us.” She paused for effect. What she was suggesting is that policy, in the way they conceived it in the Ministry of Health, is to also be made in practice. There is the expected destabilization of the original leading to a network of differences that are produced by the multiplicity of actors and theories involved in implementing policy. Dra. Vargas continued,

In this meeting what is most important is to define an agenda to construct public health policies…Communities can choose to strengthen or not strengthen the area of traditional medicine, for example, depending on where they are because it is not the same in all of the municipalities, it depends on the context of a place whether they will focus on cosmovision.

At the moment the policy model was created, then, it contained the possibility for new theories and new experts to arise. Further, demonstrated here was the ways that premises could interact:
community participation was a way to determine the framing of interculturalism. She emphasized that it was not necessary that every community have expertise in or carry out the exact same practices. In this sense, participants were not debating a document that was already completely formed, but were instead engaged in the specific ways that it was formed, iterated, and shaped in practice. This approach was significant to the ideals and ethics of the policy, which called for the incorporation of popular participation into the process, where beauty was defined by the ideal of participation. The “local” was represented through the manifestation a multiplicity of locals.

In this discussion was also a particular framing of scale that raises Appadurai’s concern of the ways that people become “incarcerated by culture.” Certain people in the room, while interpellated upfront as “experts” at the national scale, were asked to represent the “local” experience while others were authorized to jump scale, like Ortero, through his moderation of the discussion. Briggs and Mantini Briggs discuss this in terms Appadurai’s concept of being “incarcerated” by place, of being “unable to escape the constraining effects of a rigid and narrow worldview—and institutions are taking advantage of this strategy for containing bodies and the politics of race” (Briggs & Mantini Briggs Cholera 2003: 314). However, I suggest that while this focus on specificity of the local could be in some senses seen as this type of “incarceration,” at the same time, the policymakers, too, rose to their positions from this local level due to their experiences. They shifted scale in terms of their current positionality in the Ministry of Health, yet they had reached their positions in the Ministry of Health because of the value placed on their local-scale experiences in health. These people were not brought into health politics because of abstract, theoretical notions of health care provision in the country; rather, they shifted to abstraction due to their on-the-ground experiences. Additionally, the experiences of indigenous communities in sites that are considered “local” are hybrid spaces, as they are infused with involvement with global forces, from NGOs to municipal, provincial, and national involvement. Anything that could be construed as “cultural incarceration” is already fraught with hybridities and ambiguities. Whitmarsh (2008) asks anthropologists to challenge their distinctions between scales, in his case, global and local categorizations, writing, “Local value and practices become operationalized factors mutating or tweaking these global variables, where global logics are reified as stable categories of analysis, and the forming of an assemblage privileges the anthropologist” (Whitmarsh 2008: 60). Whitmarsh argues that scholars must look for contradictions in every category, including the local and the global. A focus on ambiguity, according to Whitmarsh, destabilizes the possibility of ideal types maintaining the power that scholars give them. In his work, Whitmarsh shows that there are multiple meanings given to asthma, for example, where asthma as a category is produced relationally. Whitmarsh writes, “By focusing on the contradictions and ambiguities anthropologists can dislocate their presuppositions about global forms or points of reference and allow meaning to emerge” (Whitmarsh 2008: 60). As such, the “global” and “local” forms of policy was mutated through these ambiguities and the contradictions in both categories emerged.

The work of community participation was further exemplified in roundtables at policy conferences, both in the types of experiences shared about working with policy and in the work done at the events to produce new interpretations and guides. At the 2012 event in Cochabamba, I chose the mesa with the theme intercultural health (salud intercultural). We met in the small room with white speckled tiles, windows draped in gold curtains, and chairs with arm tables around the room. There were around thirty people in the room at any given time, a mix of men and women, some wearing indigenous dress, others in suits or slacks. The Ministry of Health
representative running the *mesa* was Antonio Ortero. His conversational way of talking with the group brought a feeling of being on a team together. I stayed with this group for the whole conference because I wanted to follow their process from start to finish, from the sharing of experiences to the collaborative, participatory process of writing out the national guidelines and mechanisms. Presentations were structured by Ministry of Health guidelines, what seemed a typical NGO or World Bank approaches to sharing information through charts and group work (Nguyen 2010). The initial categories were determined in advance, evidenced by the repetition in the presentations. Presenters shared PowerPoint slides that covered the same general topics: they began by sharing community demographics and local health issues, discussing local determinants of health. Each presenter then split off into certain mutations in their approaches to and understanding of policy, including the specificities of community decision-making and approaches taken to integrate intercultural practices into the health care system that were adequate to the given community’s needs and cosmovision. These presentations served to show how a variety of different work rooted in the experiences of specific people and places could also performatively define policy as a national project, a state-making project. These “locals” and the way they indexically related to policy, were part of the multiplicity that made up and was required by policy’s visionary form.

As such, in the presentations at events I saw how mutability emerged indexically in practice through a community participation approach, demonstrated by the wide variety of interpretations of health and healthcare that I saw discussed within the terms of the same iconic policy or with reference to the same premises. For example, one group was focusing heavily on medicinal herbs by building a *vivero* or greenhouse next to the clinic. They had created a guidebook for all of the medicinal herbs in the area. Another group was more focused on the dynamic between western doctors and *médicos tradicionales*, holding workshops and facilitating encounters with the community between the different medical practices. They had created a diagnostic book that incorporated images and colors as a way to cross-diagnose across medical practices. These “localisms” in policy that resulted from community participation were documented by the Ministry of Health. Policy looked very different as it was reproduced by different people and in different areas of the country. However, amidst this work and language of flexibility and mutation, there were also boundaries and limits to mutability that were enforced in a variety of ways, beginning from the moment I entered event spaces and the terms and documents I was given. In fact, throughout the whole process that took place during the events, the question of adequation kept arising, as people who had made policy mutate in implementation were asked to both define their approaches to adequating the policy, particularly through community participation and interculturality, while simultaneously being asked to produce the guide and adequate to the conception of the “national” which was more general.
Even as a symbol of a new national vision meant to be instantiated anywhere, policy and community participation were also restricted in particular ways. In the intercultural mesa, the Ministry of Health leader of the panel, Antonio Ortero, used his authoritative position as policymaker to make clarifications in a way that served to generalize the specificities of each presentation’s experiences to the audience, making them thus recognizable as policy within the boundaries of the government’s vision. While his guidance and leadership throughout the process did make clear the distinction between the Ministry of Health leaders and the conference participants, even as all were interpellated as “experts,” the technocrats themselves were known for their work in other positions, from NGO to community activists to doctors. Further, while participants involved in this type of conference discussed, articulated, filled in blank tables, and debated, they were not just debating an existing, finalized policy. Rather, they were actively involved in creating a concept of policy itself, within the bounds of the imposed categories. Amidst a discourse of participation, and narratives of flexibility, there were certain authorities, primarily those representing the government, who were involved in designating a space for interpretation and mutation, as well as its boundaries.

To do this he summarized each presentation, expressed the importance and uniqueness of each experience, and discussed how they all differed from each other and why. He pulled out what he felt was important from each experience and why, to begin the process of creating the guide of mechanisms, a process which he facilitated closely. This was a process of distillation where a multiplicity of experiences came to be collapsed into singularly recognizable forms, based on the policy’s symbolic requirements and iconic elements. This work occurred primarily during the interactive phase of the event, where the energy in the room shifted from the formal PowerPoint presentation space to a free-for-all of voices, arguments, and gentle, moderated chaos. It was here that I saw the encounter between the mutability and authority expressed at its fullest. I witnessed the participatory and collaborative designing of a guide for intercultural health that could circulate nationally, based on the systematization of the group’s experiences.

Even with Ortero’s structured moderation, the energy in the room was electric, with people jumping in to state their opinions at every step. Antonio set up a projector that was attached to his computer in the front of the room, projecting a chart entitled “How to adequate health services.” The chart had blank squares that were to be filled in by the group with mechanisms for how to implement intercultural medicine based on their experiences working with the policy. Immediately, a hand raised in the audience to add a new beginning, rather than “build/increase awareness of health personnel around interculturalism in health” as Ortero had written. This participant suggested, and many agreed, that “make visible the norm” should be first, or the sharing of the legal policy premise as a first step. Antonio added this line on the chart.

As we worked, Antonio voiced the policy’s requirement for local specificites, “I want to know what you do in your specific municipality. This isn’t general, we want specific examples of what you do and how you do it,” while simultaneously maintaining certain parameters to regiment the mutability and interpretations that emerged through the discussion. Even with his authoritative voice, there was a feeling of excitement that permeated as people negotiated the points on the screen over and over. There was no sense of trying to get this done just to get it done. Everyone seemed genuinely invested in what was put onto the spreadsheet, the order, and the way it was written, as well as what words that were used. There were often debates over a single word, such as definir (define) versus identificar (identify) in los procedimientos a
People were very specific and precise about what language was used and how, and what it meant for the process to make a linguistic choice. For example, one man brought up the issue of definitions, noting the importance of how the different kinds of traditional healers, for example, *yatiri*, *koirí*, or *kallwayo* were defined, given that these different terms existed in different parts of the country and could mean different things. He told the group, “It is a fundamental priority to make the distinction clear, just as there is a clarification between cardiologist or odontologist.” Another participant raised the point of how differently “*sala de parto*” (birthing room) is defined in different parts of the country, and that there are different understandings and practices in each area. Ximena, a Bolivian anthropologist who worked at Medicos del Mundo, responded, “Each community has to contextualize it to their reality, since the person who defines the space is the one who uses it.”

The purpose of gathering specificity was to create generality, but a generality that would reflect the flexibility of experiences, where policy could be a symbol of both the iconic and indexical dimensions that I have discussed, while also becoming something that could be replicated and have future manifestations. The group was involved in producing a general document meant to circulate nationally. The foundation for the general, systematized document, as was true with the first iteration of the policy design, was the incorporation of experiences of those involved with practicing and implementing the policy.
Interculturalism

The second premise I explore from the policy explicitly asks for a recognition of the different models and systems of medicine and social actors to be respected and involved in the process of implementing policy.

Interculturalism: Within the framework of the present model, it is the social and grassroots approach that is based on dialogue, respect, recognition, assessment, and interaction of the different medical systems and social actors of the healthcare system, and that revives processes of cooperation and interconnectedness in order to better the quality of healthcare. (SAFCI 2009: 10)

This concept of interculturalism was the focus of many policy panels and roundtables I attended, and its interpretation ranged from specific discussions about practices related to intercultural medicine to the more philosophical discussions of interculturalism in the context of the history of racism and colonialism in Bolivia. One speaker, Jesus Laredo, gave this type of philosophical interpretation of interculturalism, on the topic of “critical interculturality.” Similar to Walsh’s discussion of critical interculturality, he told the group,

Critical interculturality doesn’t begin with dialogue, it begins with the question of what are the conditions and factors of this dialogue? So what does this have to do with the area of health? It requires the construction of certainties. For example, one certainty is that the division between the body and the mind that western medicine often maintains was dismantled when in the 1980s they found hormones- peptides- that are produced in the brain, neurotransmitters that are produced in the brain and impact the immunological system. This got rid of the separation between mind and body. The fundamental theme in health is to get rid of the structures of domination, such as institutional structures, towards traditional medicine. You need to understand the factors and conditions of discourses that divide the mind and body, or western and traditional, for instance. What are the aspects of colonization that reproduce this domination and the structures of power that reinforce this minds?

This narrative about eliminating structures of domination and institutional structures of power came following talks that were themselves directly from international institutional structures that would seem to directly represent the structures of domination Laredo noted here. Laredo’s idea reflected the origins of policy, as he suggested that moving away from past structures of power would allow for the flexibility through participation that is required by interculturalism. The restitution of culture is imagined, in this narrative, as part of the task of “health.” The concept of health, through health policy, was expanded to include a political intervention into the past in the making of a different kind of future. All of these layers referred to the different scales and possibilities for mutation that were designed to be integral parts of how policy was understood in Bolivia, necessitated in part by laws that served as the policy’s foundation, but also by the philosophical visions of the state and state-makers. As I suggested, the “original” model itself was never singular or, but contained difference within it that necessitated mutation of its form.

This concept of interculturalism, and the project of its implementation were connected to, and in many ways symbolized the implementation of the concept of vivir bien, which, as I have already discussed, asserts that “living well” locally leads to the health of the populace, the nation, as a whole. Vivir bien in implementation requires mutation and indexicality to move towards manifesting its authoritative, national-scale, utopian ideals. And, in order to “live well” locally, very particular renderings of heritage were wrapped up in the types of mutations in policy discussed. These involved representations of notions of indigeneity, cosmovision, and tradition.
For example, one conference presented told the audience, “Bolivia is an intercultural and diverse country, and has the impetus now to recover the traditional, which is a new perspective on health. This is a beautiful opportunity to go with the spirit to share and exchange particular experiences to strengthen the SAFCI policy.” The diversity of Bolivian experiences of policy and the particularity of these experiences were seen as elements that would strengthen policy, as they were required by policy, allowing it to be remade and improved through practice. In particular, cultural plurality was given the utmost weight here, with no mention of other kinds of pluralities, such as gender, age, or socioeconomic status.

I observed this focus on interculturalism as a way to work on policy in practice at a municipal health policy event I attended in Santiago de Callapa. The event was co-hosted by the Ministry of Traditional Medicine and Interculturalism and Medicos del Mundo, a Spanish NGO, with the stated intention of “Improving the health of populations by promoting sustainable human development and strengthening the development of the cultural sphere, the institutions, public policies, and articulation of the social and cultural fabric,” written on the event flyer. During my fieldwork I spent a few months working during the week in a town called Patacamaya alongside Medicos del Mundo. Not only was work in Patacamaya a model for aspects of the policy, two members of the government policymaking team, Jaime Condori and Alejandra Ríos, were employees of the NGO, under the leadership of Pedro Cabrillo, a Spaniard. After gaining the necessary permissions, I spent the next two months, four to five days a week, traveling with the team to rural areas of the in the La Paz Department that made up “Red 12” of the health network, spending nights in the small dormitory rooms in the offices in Patacamaya with the team. Then-director of Medicos del Mundo in Bolivia, Pedro, explained their work to me in relationship to the government policy, “We are focusing on trying to strengthen the policy within the public health care system.” He explained that the philosophy of Medicos del Mundo as an organization in Bolivia was to support the public health system. Whereas in other countries, Medicos del Mundo has often had to influence change in certain policies that are not functioning well, in Bolivia they are helping to implement it in areas where they work because Medicos del Mundo was convinced that this is a policy that was “appropriate” in the country.

Patacamaya itself is split in two by the main cross-country road to Oruro, and is relatively more built up because it is situated on this national thoroughfare. It is also an entryway to a series of unpaved networks of roads and paths that lead network of rural communities that make up Red 12. The landscape in the altiplano served as a constant source of awe during these commutes. Each day we wound through fields of different colored quinoa, people harvesting potatoes, desert shrubs, small pools of water and one larger river that we crossed, herds of alpaca and cows, all the time with the mountains on the horizon. Carved reddish brown hills, passing through rivers that were just dry enough, shrubs, views of Sajama and the snowy mountain range around it, little pools of water, flat-top dessert mountains, and open-space dessert. Communities would all of a sudden emerge out of the landscape- some as small as six houses, others larger with paved plazas and designated health centers. Larger communities had a mixture of architecture, with some mud brick houses, some red brick structures, and some cement or colonial-style structures, while smaller, more rural communities would be made up of small adobe structures.

Martin, the Medicos del Mundo driver, Raquel, Ximena, and I drove to Callapa, a 40 minute drive through an amazingly beautiful desert landscape on the road to Chile. Callapa is a small community made up of red adobe brick houses, and a health center that is painted yellow with a gate around it and two small ambulances in front. Raquel introduced me to the group of
around thirty, mostly Aymara participants made up of community members, traditional healers, and midwives. I walked around the room and shook everyone’s hands and kissed them on the cheeks, the typical Bolivian greeting. In this meeting, the Vice Ministry of Traditional Medicine and Interculturalism sought to understand the model of traditional medicine in Red 12, as well as in other parts of the country, in order to “validate” their work, learn about their knowledge of diseases and their cures, and understand the types of plants used for herbal medicine in this particular region. The Viceminister of Traditional Medicine and Interculturalism, Rodrigo Mamani, who welcomed the traditional healers, doctors, and members of social organizations with the informal “hermanas y hermanos” that was often used at these meetings, explained, “The traditional practice has thousands of years behind it in medicine and practice. We are here to share experiences as part of a commitment to the articulation between both medicines.” This process would occur not just in Patacamaya and the altiplano highlands, but also in the other regions of the country, in order to create guides for the national scale. The idea was that different regions would interpret and understand health and healing in different ways, and due to flexibilities in the policy, they would be able to incorporate all of these into what constitutes policy at the national level.

The process of sharing the community’s work involved the demonstration of their work with health and traditional medicine, and the recording of this work by officials from the government. For example, we began with a tour of the facilitates, with particular attention to the vivero or greenhouse where the grow herbal medicines. The greenhouse was constructed in 2009 as part of the implementation of SAFCI in Callapa, as a way to express the complementarity between western and traditional medicine, as it was adjacent to the western clinic. Further, a laboratory was built into the clinic to turn the herbs into tinctures and palmas. The greenhouse was large, with a yellow tarp covering and mud walls with small windows on one end and a door on the other. Inside was warm and humid, and full of medicinal plans with small hand-painted wooden signs with yellow pain writing to connote which plans and herbs they were. An older woman, an indigenous traditional healer explained the different uses of the different plants, for example one she said is to eat for vitamins, stomach problems, and used by the partera. The project was supported by the government under the SAFCI policy, and by Medicos del Mundo. The government was now returning, through this encuentro, to assess the successes and gather knowledge from the community, and others representing different mutations to the implementation of SAFCI, in order to package it and delimit the project’s boundaries, and then redistribute it as a guide that could circulate nationally.
Vivero, photo by Alissa Bernstein

Vivero, photo by Alissa Bernstein
Mutability also manifested within the indexical dimension of policy through the sharing done in Callapa around discussions of disease and curing. The facilitator of the meeting wrote the Spanish and Aymara names of the most common diseases in the region in marker on white poster paper that were hanging around the walls of the room. For example, Stress, or “Estresado” in Spanish, and Laktiusu in Aymara were written on the wall and the group went through a lengthy discussion and debate about its components and its cures, in order to share their specific ways of understanding and treating the ailments. A list was created of treatments, which included the herbs vaiz valerana and rosa blana; as well as a category for rituals, which included “llamado de ‘ajayu’ and “mesa de despacho.” The list of people who could treat this ailment was also listed, the “yatiri” in Aymara, or the médico tradicional. The community contributed to and altered the lists through their debate. For example, they added the following under “Stress:” kota chichi (moler y hacer toma gusanitos de agua), kote estrella y chini (murecie lago), consejo (musico terapia), rezos (revelacion); and suplico y ala benza. There was discussion around each of these additions, that involved sharing stories and experiences in practice. For example, a woman told the story of her father’s cure to a painful heart and stress through music therapy. After her story, the whole group agreed that this was most important for healing stress. When I asked participants about their experience in this process, they talked both of how they felt their knowledge about how to cure diseases could be useful for the nation, even though they were hesitant to share everything, especially the information about healing that they considered to be “secrets.”

Following this event I asked Luis, of the Vice Ministry of Traditional Medicine how they would use the information gathered at the workshop. He explained that they were seeking to understand the techniques for curing the sicknesses that are the most frequent in the country. They will use this information to make protocols for traditional medicine, which is why they sought specific information about both plants and rituals. They would then create three different guides for the three ecological zones of the country, with the goal that each will have their own guide and develop their own studies so that NGOs or health institutions of each area of the country can know what to do with traditional medicine. Interestingly, here, it was assumed that the mutations in policy implementation and approach would just be segmented into the three “ecological” zones of the country, rather than the consideration for the thirty-six autonomous groups that make up Bolivia’s pluri-Nation. These were also problematically neatly segmented into a “traditional/western” binary. Luis explained,

Luis: The final objective, as part of SAFCI, since everything is under the SAFCI Policy, is to create this part that is much more about technique, about the medicines. This country can’t just involve work with conventional medications, they also need to recuperate practices and knowledge of each region. In order to make this guide we need data from various communities, not just Callapa. We need data from other regions and other municipalities, because while the alitplano is one, there are different ways of curing region by region…

AB: As part of SAFCI?

Luis: Yes as part of SAFCI, or within SAFCI. All this is within SAFCI, especially the part about medical attention and medications, because we can’t only work with conventional medicine, this would go against the policy.
These examples of community work with premises of community participation and interculturalism at the events I attended exemplify how, from the moment that the sign, “SAFCI” appeared, there was no purity or singularity of form. From the very moment it became a possibility, in fact, built into its possibility and its premises. It was designed to have the potential to be adaptive, while this mutability was expressed in different ways iconically, indexically, and symbolically in attempts to re-bound policy in various ways to be nationally recognizable as policy.

Many of these activities are part of standard classroom or workshop procedures, so standard that they might seem mundane. Yet, within these everyday procedures was the possibility for a kind of representative democracy where authorship was understood to be dispersed, both throughout the originary document and the processes of revision and implementation. What emerged was the attempts to give some matter of “voice” to certain participants in a “plural” nation. The rhetorical dispersion of expertise was made throughout the social body, and people were called on to speak as a way of reorganizing the document’s authoritative structures. The authoritative structures were understood to come from community health experiences, from people’s capacity to organize, within Bolivia’s particular form of democratic politics. Through their participation, certain practices and understandings of health and difference became part of the concept of policy that circulated, reflecting the ideals and ethics of the policy. In fact, in enacting their participation, participants were fulfilling the guidelines of the policy while simultaneously debating and working on these exact ideals. This macro-micro work fulfilled the aesthetics of a policy that is produced through repetition. The flexibility itself was structured through the valuing of certain kinds of heterogeneity, particularly cultural heterogeneity, which had implications for the kind of heterogeneity and ideals that were designed into it. Other kinds of heterogeneity, such as gender, age, or even explicit references to socioeconomic status were not at the forefront in these discussions, and were also not explicitly part of the policy vision, either. This demonstrates that the mutations of policy themselves were in some ways structured around certain conceptions of the vision of the future of the nation, as cultural plurality was at the forefront at the expense of other types of internal diversity of the nation.

Raquel, a Bolivian anthropologist who had been involved in work with Medicos del Mundo, and worked on interculturalism, discussed the concept with me philosophically. She was very intense, with strong views about policy in Bolivia, many pessimistic, even as she spoke with a big smile. Her concern was that the way policy was being conceptualized and implemented in Bolivia was too theoretical and experimental. Raquel’s question to me, when we discussed articulation, was “articular qué a qué?” (Articulate what with what?) She asked, “Which one will be beneath/subordinate (bajo) to which norm?” She suggested that there was a double discourse in the work around the policy, based on the desire for improvement in certain health indicators. In this case, traditional medicine, she suggested, has to be adequated in spaces of healthcare services, which leads to the reproduction of hierarchies. She told me, “They can’t impose norms across different people and adequate the idea of traditional medicine as the same across all of them.” She suggested the importance of focusing on context of the community and the contextualization of what interculturality actually means in a particular place. “They need to adequate atención depending on the context, and not create a guide from one or two groups to be used across the country,” she told me. I believe Raquel was suggesting that concepts such as “interculturalidad,” and even “The SAFCI Policy” or policy itself, are both immutable and mutable mobiles simultaneously. One example of this, discussed by Charles Briggs (2010) is the
idea that a case of cholera reported in Haiti today is the same as cholera diagnosed in Bangladesh. He suggests that “The stability of the category of cholera is important for the World Health Organization to be able to make a report that seems to be applicable to all parts of the world” (Briggs 2010). This mobility across contexts also implies the existence of discrete or bounded cultural systems between which translation can occur. Interculturalidad becomes a stable category that represents cultural diversity and plurinationality, thus representing inherent mutation in the model while hitting up against the bounds of a structure imposed by government processes and authorities.

In particular, “culture” was conceived of as a source of pluralism, in contrast to a sense of homogeneity that was implied in constructions of “Western medicine.” Whereas Western medicine was understood as a foundation that existed everywhere and timelessly, “cultural medicine,” called “traditional medicine” had both particular sites, like the ones I visited in Potosí, such as “salias de parto,” traditional birthing rooms, or “viveros,” greenhouses where herbal medicines are grown. Traditional medicine was also ascribed different temporalities. For example, traditional medicine was often conceived of as practices, born from the past, that needed to be revived or recovered through this focus on locality and indigeneity. By projecting onto health policy this idea that Western medicine was not adequate for the realities of these “cultural” subdivisions and local determinations, culture was thus framed as a space of multiplicity and fragmentation, against a static, overarching, and timeless modernity.

The laws and premises of participation and interculturalism were often discussed in relationship to the process of adecuación cultural, articulación con la realidad, or other forms of making something seen to be general, like a policy, fit the spaces in which it entered at the various scales within the country. But I suggest that this “making fit” was not about creating something new alongside something general, but rather the concept of policy itself incorporated the possibility of its own mutation in order to achieve adecuation. Anthropologist Bill Maurer (2005) begins his work on Islamic banking with a question of abstraction. Abstraction, he suggests, is essential in the way value and standards are made in economic systems, and how alternatives are formulated. This idea of abstraction for Maurer is related with the idea of adecuación, or the attempt to make one’s concepts in accords with reality. Yet he questions what happens when adecuación fails to work, and rather creates resonances, relations, and translations. Meaning is thus not pre-given or referentially produced, but rather is emergent and based on these relations, translations, contradictions, and mutations. Oscillation is exemplified by the “merographic effect” discussed by Maurer, a term he draws from Strathern. Merographic work involves constantly shifting perspectives based on constantly multiplying contexts and thus the constant creation of more knowledge. I argue that the creation of new iterations, guides, and revisions happen because the concept of policy in Bolivia was always undergoing this “merographic effect” in repetition as it circulated and was adecuada at different sites and by different people. This openness was an aspect of the utopian vision of “revalorizing” the past, as it allowed for the possibility of reintegrating people’s different conceptions of health and healing into health policy.

**Conclusion**

In Bolivia, the state was increasingly emphasizing the importance of autonomy, specifically of municipalities, provinces, and indigenous “nations.” As a plurinational state, these subdivisions helped to map cosmovision and interculturalism onto the practices of the state.
through the idea that each area or municipality or indigenous group has its own particular needs and social determinants and that health care should target these specificities. My examination of policy’s premises and the laws and practices that surrounded policymaking, implementation, and revision show that policy is never fully abstracted from its origins. Policy in Bolivia was, as its origins would suggest, designed to be interpreted and used as a representation of difference, as long as it was still recognizable as policy. As such, there was a language of flexibility and adaptivity that was built into the ideas, concepts, and laws that circulated as part of, or alongside “The SAFCI Policy.”

Policy’s openness for interpretation were directly linked to these spatial and sociocultural scale-making practices within the country. Further, the concepts of health and healing themselves were required to be mutable, as well, to reflect these specificities, while also bounded and framed by the categories of “western” and “traditional.” Policy similarly was defined by competing forces between stability and mutability, centralization and decentralization, norm and guide. In this way, the utopia and its repetition might be understood as a kind of representation, in that there is a representation of the model, and yet as the model circulates and is situated, it becomes mutated, which mutates the already-always mutated original. There was the concept of vivir bien that I have already discussed, and the different meanings ascribed to it by different people I spoke to. I also studied an assemblage of laws and political concepts that circulated with policy, including a parallel national law, the Ley Marko de Autonomía y Decentralización. There were articles in the new national constitution that indicated towards the creation of a new health care system premised on vivir bien and interculturality. And of course, there were the premises that made up the legal entity of the policy. These premises, as Heath's (1982) work would suggest, were open to group negotiations, and their interpretability was integrated into the model itself.

Policy in this sense is a kind of “cultural model” (Bauman & Briggs 1990) that circulates. In Briggs’ (1986) work on the interview, he writes about how the interview becomes a site where social scientists imagine that they can transparently extract knowledge from people’s minds, assign it a linguistic form, create objects or cultural models that can circulate, supposedly without distortion, and then can be reinserted into books or ethnography, a Latourian (xx) “circulating reference.” There is a similar construction of a cultural model in the construction of policy, where certain histories and memories and voices circulated as cultural models in their systematized, decontextualized form, but are “circulating references” in the sense that they never stopped referencing the multiple, heteroglot formation process that they entailed. As they were implemented around the country, they often reflected and reproduced some of this multiplicity and context again. This work has also expanded the scope of what policymaking, and the ways it also includes the circulation, implementation, translations, and revisions of policy, which reflect back on the originary policy itself. This is the experience of a different way of thinking about a big organizational issue, as policy is often conceived of as structured in a one-size-fits-all way. This work of understanding and expanding the scope of policy and its mutabilities and boundaries in implementation allow it to be more open and expansive.
Chapter 4: Policing Policy: Making the Uncanny in the Caja Petrolera

Introduction: Repetition and Difference “Between Two Waters”

Are all mutations in policy treated as equal? Or is there policing of the boundaries that extend beyond just the premises within policy, to larger interpretations and implications of policy’s repetition? In healthcare systems with differentials between “public,” “employer-sponsored,” and “private,” there will always be differences in how policy is understood, defined, and implemented, as well as in the needs of the populations served. Policy flexibilities and boundaries I discussed in the previous chapter were given the stamp of approval by the Bolivian government based on their integrative work with these versions. Mutations were discussed, debated, and filtered through the government’s systematization process, then circulated widely as national policy, with the understanding that new mutations would emerge in practice, as called for by the adaptability inherent in the policy. However, I also encountered another mutation of policy circulating outside of public healthcare system sites that were the primary focus of policy and policymaking. Bolivia has a small employer-based social security (seguridad social), or insurance, system called the caja system. The caja system at the time of this research covered roughly 30% of Bolivian citizens who worked in the formal sector, while around 60% of citizens used the public system, and less than 10% used private health services. Through this chapter I will examine one particular caja that adapted aspects of the government policy into its work. I build on Freud’s notion of the uncanny in order to look at how the incomplete doubling of a model lead to unexpected and sometimes unaccepted results, particularly when the boundaries of policy were policed by the actors involved in making policy.

Bolivians only have access to a caja insurer if they work for an employer that pays into the caja system for the health insurance of their workers. Cajas are funded through money they receive from their affiliated organizations and companies that pay a percentage of their earnings into the insurance, and they also receive some state financing. Cajas also make up one of the more vocal opposition groups to the government’s health reforms, particularly the idea of the Sistema Único de Salud due to a concern that the government will attempt to centralize all health services. One employee at a caja explained this resistance the very first time I visited the offices. She told me that they are afraid that the government will take the resources from the cajas, and absorb them. She also suggested that there was a disparity in quality of doctors in the caja and the public system; in her view it was much more difficult to be a doctor in the public system than it is in the caja system. In the caja there are laws to protect doctors in regards to how many hours they can work because it is a private institution whereas public doctors in rural areas might be “on call” all the time. The caja system in itself represents a mutation to the government vision of universal care and a unified healthcare system in that it is a system where some people, those who are employed, have access to care and others do not. Some cajas, like the Caja Nacional, staged protests against the Sistema Único de Salud proposal while I was in Bolivia. I witnessed these protests in downtown La Paz, where crowds of doctors in white lab coats staged demonstrations in front of government buildings, outside of the caja hospitals, clinics, and offices, and along El Prado, stopping traffic through the city with handmade signs declaring their resistance to the possibility of unification of the caja system.

The caja system viewpoint was reflected in a statement made in a national newspaper Los Tiempos on November 4, 2011:

We have decided to demand the resignation of Ministra Elena Ortíz for incompetence, for not knowing how to run the healthcare system in Bolivia, and for not defending social
security. Accordingly, next week the workers and leaders are going to intensify our protest measures here in La Paz and if necessary we will wall ourselves until the very end,” asserted Ariel Cáceres, secretary general of the Union of Workers of the National Health Fund (Casegural). The leader denounced the government’s intentions to “make the National Health Fund (CNS) disappear” with the new law of free affiliation for the insured.

Through this statement, representatives from the Caja Nacional expressed concerns of becoming subsumed by the government health care system centralization efforts. They positioned themselves as firmly outside of government policies, renouncing the Health Minister, Elena Ortiz, as representative of the government approach to health.

However, one caja, the Caja Petrolera, took a different approach than the Caja Nacional. Instead of resisting national healthcare reform its leadership strategically aimed to incorporate the government approach into its own work in order to prepare for and be a leader in coming changes to the healthcare system. The Caja Petrolera, founded in 1958, was unique within the caja system because its leadership at the national level decided to implement the government’s policy vision within their network. Dr. Miguel Tejada, a doctor of neurology and a pharmacist by training, actually participated in the policy design process in the Ministry of Health before taking his position at the Caja Petrolera. Dr. Tejada, a short man in his 60s who spoke in a low raspy voice, had a presence that was both friendly and intense. His positionality and expertise, like many others I encountered during my research who were directly or peripherally involved with policymaking and implementation, was ambiguous: he had helped design national health policy but now worked within the insured healthcare system at the Caja Petrolera. When I asked him about the changes within the Caja Petrolera he explained that they are “Between two waters: state and private.” What he meant was that the Caja Petrolera had a relationship with the Ministry of Health, received some funds from the state, but also got most of their funding privately from companies and provided care outside of the public healthcare system. The work they were doing was to negotiate their placement within each of these “two waters.”

At the time of my fieldwork, authorities from the national offices of the Caja Petrolera were working to interpret, adopt, incorporate, and implement the government’s “SAFCI Policy” in the agency’s work. In order to do this they had to design a number of significant mutations to the government’s policy into their approach. Policy designed by the government had its origins in rural community health, and notions of difference based around families, communities, and indigeneity. As such, the approach to health at the origins of the state’s public system conception of policy and its implementations was primarily focused on indigeneity, community health, and intercultural medicine. The Caja Petrolera worked with a very different population: workers within companies or factories, and their families. To make the policy fit this population, the authorities at the Caja Petrolera constructed their own set of premises and documents based off of the government’s materials. The conception of policy that they created and the documents that circulated with it comprise what I considered a Caja Petrolera “version” of policy that was designed to fit within the guidelines of the caja approach to healthcare provision. This adaptation of policy demonstrated another aspect of the flexibility of policy to be mutated to fit different sectors of the healthcare system and different approaches to health coverage in the country. Yet, it was through this version that I also saw the most intensive discursive policing of boundaries by those involved in the government and public healthcare system process. This policing of policy versions raises questions about what constitutes a “proper” version of policy and what authorities keep watch over policy’s boundaries.
Literature on the privatization of healthcare in Latin America discusses these issues surrounding private or social security-related healthcare sectors, particularly as they relate to neoliberal reforms and their impacts on health services and healthcare implementation (Armada & Muntaner 2004), as well as the export of managed care models to Latin America (Stocke...
The government SAFCI policy, in its public health and public system orientation, was familiar to the policymakers due to the “befores” that went into its foundations, and their continual work in the same or similar spaces as the ones at its origins. However, policy can never be fully restricted or within the control of the authors, and can become something at least partially unfamiliar, whether due to its revisions or its changes in implementation. Freud writes, “Among instances of frightening things there must be one class in which the frightening element can be shown to be something repressed which recurs. This class of frightening things would then constitute the uncanny” (Freud 1997: 217). And further, “this uncanny is in reality nothing new or alien, but something which is familiar and old-established in the mind and which has become alienated from it only through the process of repression” (Freud 1997: 217). In defining the uncanny, Freud refers to the phenomenon of the ‘double.’ Through this double, the familiar, safe, primitive, or infantile, what he calls the heimlich, are mimicked, repeat, recur, or return in similar or identical form, but in their return they have the potential to become frightening, unstable, or unfamiliar, or the unheimlich (Freud 1997: 210).

I extend Freud’s notion of the uncanny here to illuminate important dynamics that arise in the repetitions, mutations, and doubling of policy in Bolivia. There is a liminality in the policy in that its flexibility leaves space for the possibility of the unfamiliar, the unknown in the form of new revisions, new guides, or new approaches to implementation. Because these familiar premises, ideas, and concepts contain, inherently, the possibility for mutation, they also carry the possibility of becoming unfamiliar and uncanny. In what ways does the Caja Petrolera version of policy become an incomplete ‘double’ of the State’s policy, and how does this incomplete doubling get expressed and then policed by various actors? For example, in Freud’s analysis of the canny and the uncanny, “Heimlich is a word the meaning of which develops in the direction of ambivalence, until it finally coincides with its opposite, unheimlich” (Freud 1997: 201). The Bolivian state’s policy becomes unfamiliar when it takes a form that is not within the bounds of its originary vision, for example, the aim to provide healthcare for all Bolivians. It thus has, from the beginning, the potential to become unfamiliar through these adaptive differences, for example, the differences from the utopian vision. Particularly, the state is not entirely in control of the cajas, and they function as autonomous entities even as there is a push to centralize them under one system. The Caja Petrolera adopted the flexible policy that the government designed in unexpected ways. It was thus possible for a policy of the state, in collaboration with the communities and NGOs involved, to also become unfamiliar.

Mutating the Model: The Caja Petrolera Version of Policy

The national headquarters of the Caja Petrolera are located on El Prado, the main thoroughfare in La Paz. Each time I visited the offices was a bureaucratic experience: I had to check in with two security guards at the post at the entrance to the building to give them my passport or ID card. In the beginning, they were suspicious and cold, calling the offices to double check that I was actually allowed to enter the building. After a couple of weeks of visiting the office, the coldness wore off and they would come out, shake my hand, kiss my cheek, and wish me a good day. I went through many other bureaucratic formalities to gain access to these offices, including obtaining letters of introduction and seeking permission from authorities at the offices. When I received my final letter permission from the Director of Quality, I was told that my permissions would grant me open access to the offices of the Caja Petrolera and the
Consultorio in El Alto. I could interview whomever I wanted, and move fluidly through these spaces.

The Caja Petrolera began its implementation of government policy in 2010 with four teams called SAFCI Teams, or Equipos de SAFCI, based in La Paz, Santa Cruz, Cochabamba, and Oruru. These teams typically consisted of a doctor, a nurse, a social scientist, and a dentist, with the task of working on health prevention and promotion, two elements that the caja adopted from the policy. In addition to these roving teams of experts, they were also beginning to bring traditional medicine, as a pilot study, into their clinics to fulfill the premise of “interculturalism.” Finally, they were working to create health committees made up of representatives from the different companies that were part of the Caja Petrolera network, in replication of the government model’s approach to health management, or gestión, and the authority structures of the consejos de salud, or local community health committees. The precedent was set for these types of health committees through work in Cuba and Venezuela, where neighborhood health programs, and particularly the project Misión Barrio Adentro implemented this type of model” (Briggs & Mantini Briggs 2009). The Caja Petrolera chose the elements of policy to adopt based on which would fit within the worker health insurance sector, while eliminating elements that did not fit, or adapting them to fit in strategic ways. This approach was in some respects similar to the ways that community health programs worked with the policy’s premises and shared their grab bag approaches to policy in conferences. Theorists of documents have looked at this issue of replication and transformation. Hull writes, for example, “Institutions traditionally operating outside of the state arena can also be transformed because they mimic state documents to legitimate customary practices” (Hull 2012: 258). In my interviews at the Caja Petrolera, I recalled Dra. Herrera telling the group of public healthcare system participants at the conference I attended that some communities would choose to emphasize one area while others would choose to emphasize another, celebrating the possibility for mutability and interpretation.

Where, then, does uncanniness enter into the Caja Petrolera adaptation of the government policy? Uncanniness, according to Freud, is a “phenomenon of the ‘double.’” He suggests, “There is a doubling, dividing and interchanging of the self. And finally there is the constant recurrence of the same thing—the repetition of the same features or character-traits or vicissitudes” (Freud 1997: 210). Freud focuses on the double as it appears in characters who look identical, or even in the subject who identifies her self with another. It is possible to see in this case elements of the psychoanalytic double, particularly in the way that Freud suggests that “the ‘double’ was originally an insurance against the destruction of the ego, an ‘energetic denial of the power of death’” where doubling is seen as a “preservation against extinction” (Freud 1997: 210). But the double is never a replication, but rather a repetition, a difference. I look, then, at what ways does a policy version in the Caja Petrolera take on certain character-traits of the state’s policy, through which it becomes a kind of attempted ‘double’ of the state’s policy, and where it mutated.

The act of turning government policy into something recognizable and usable within the Caja Petrolera involved careful study of both the policy’s premises and the Caja Petrolera laws and guidelines. It also involved a process of origination that looked very differently than the Ministry of Health’s study and sharing of “befores.” This premise-by-premise examination of policy was explained to me by Jorge Escalante, the Director of Prevention and Health Promotion at the Caja Petrolera, as he discussed how they decided to tailor their approach. Escalante sat across from me at a desk, wearing a crisp black suit and emanating officiality, as most of the administrators at the Caja Petrolera did. During our conversation we were interrupted a few
times for him to sign a document or respond to a question, his authority in the office expressed through these interactions. He told me,

We studied the government policies and then selected some points to implement within the Caja. These areas of SAFCI are traditional medicine, and prevention and promotion programs. We decided to assimilate the government policy and assimilate the model into our practices. We created a SAFCI division and a program for prevention and promotion. We did a diagnostic to assess the desires of the public to have the inclusion of traditional medicine in the caja’s services.

In reflecting on the origins of policy that emerged from the Ministry of Health, the origins of the Caja Petrolera version of policy were different from their approach, as they emerged in a more top-down method to making a model fit, or assimilate, rather than through community participation and a discussion of “befores.” There was no mention of history, colonialism, neoliberalism, or indigeneity in any of my conversations with most of the leadership at the Caja Petrolera, even in discussions of traditional medicine. My conversation with Escalante illuminated the issues of designing and implementing government policies within a private organization like the Caja Petrolera.

AB: What do you think the difference is between creating and implementing these policies in the Caja Petrolera and doing this work nationally?

Jorge Escalante: It is very difficult to implement. The caja has its own policies, some of which overlap with the national policies. For the national policy they need baselines and strategies to implement it at the national level, and there are many difficulties in doing this, especially politically. We are pioneers for doing this in the caja. It is not in a complete form yet, but we are starting with some approaches. The other cajas see what we are doing and ask, ‘Why are you doing this, why are you implementing this policy, it is for the public system and you are a social security system?’ But we do it because we have the opportunity to implement it, and other cajas will then try to copy our model. We can serve as a model for the rest.

AB: Why did you decide to use certain parts of the SAFCI model in favor of others, and how did you choose?

Jorge Escalante: The Caja Petrolera had an old code from 1956 and this model is very old, and very ambiguous. This is the 21st century, and there are other models, international models, that can help the patients more. I thought SAFCI was very interesting, and so I took aspects of SAFCI and combined it with the old model and created our strategic plan for the institution. There were problems and debates, and not everyone was in agreement about how it should be done, so we started by making a work schedule and made revisions of articles and created strategies that incorporated both SAFCI and our caja code.

The “befores,” or origins that the Caja Petrolera worked with in their policymaking process involved reference to their prior existing work code; I heard no mention of histories of colonialism and racism in my conversations. The language used in the Caja Petrolera to speak about the policy did not have the revolutionary tone that the government policymakers used, they rather expressed a more practical purpose for integrating a political approach. Part of this
practical representation had to do with the fact that the Caja Petrolera was primarily involved in urban and semi-urban areas of the country, and thus relied on doctors that were not trained in community health and family medicine. For example, Dr. Escalante explained that some of the older doctors in the system had a “vertical” approach to health care and did not see themselves as embedded within a community. These doctors worked solely within the clinic, their patients coming to them for care. Dr. Escalante suggested that the idea of campaigns for preventative care and home visits was outside of their scope of what healthcare constitutes within their practice. Yet, the model the Caja Petrolera was attempting to double originated in community health models, and was built on the idea of the importance of a focus on the social determinants of health. This focus required doctors to ask patients about their houses, water, and their life, their children, and whether they have work or not, or even to visit their patients’ homes.

These types of mutations to the model were apparent in the way that staff members at the Caja Petrolera talked about their use of “SAFCI.” While at the La Paz offices of the Caja Petrolera, I interacted primarily with Dra. Maria Valdivia, who at the time was the Director of SAFCI at the organization. Dra. Valdivia is a petite woman, talkative woman with curly brown hair. She was often in a flurry of activity trying to organize workshops and mobile teams around the country, creating Excel spreadsheets to document the work of the different SAFCI teams, and giving me tasks to do to help her with all of this. I would work on her computer entering data into the spreadsheets, while we conversed back and forth about her impressions of the teams and her thoughts on policy and the government. But like some of the policymakers in the Ministry of Health, affect was embedded into her relationship with her work at the Caja Petrolera in implementing the SAFCI policy. She expressed bursts of emotion at times when we spoke, and she made it clear to me that her commitment to this process was due to her commitment to President Evo Morales, who she affectionately called “brother president,” as she, too, was from the same province of the country, Oruro. When I asked about the process of creating the Caja Petrolera version of policy she explained how they adapted the government documents with the work of the Caja Petrolera, demonstrating the ways that form and content were made flexible as the concepts designated as “policy” were brought into different sectors and different space. She told me,

SAFCI was designed for the rural areas, not for here. Our communities are companies. Our affiliates are the workers, their wives, and their children. For example, workers at Coca Cola suffer from arthritis because they work with their hands, so we have to do work to prevent osteoporosis and arthritis. This is the point, to prevent. SABSA near the airport has to prevent problems of the ear and lungs. They prevent this by eating well, and being in balance with the environment.

I pushed Dra. Valdivia to tell me more about how the Caja Petrolera was defining “community,” as I saw that their definition and understanding was different than those I interviewed at the Ministry of Health, as well as the participants at the conferences. She agreed, and said, “When we were figuring this out I went to the dictionary and looked up the word ‘community’ and saw that it was a meeting of people who live in a common area.” Dra. Valdivia reached for the dictionary on her shelf to show me the place where she marked the definition. “Because of this, we decided to determine what kind of community exists in each company. Our affiliates are from many different companies, and we needed to do a diagnostic of each to understand them.” The discussion of what makes a community in the Ministry of Health’s version of policy has been framed around the subdivisions that exist within the country, typically referring to rural indigenous communities that make up municipalities, often related to the
historical ayllu framing of community, or to ecological zones. Yet, the policy’s mutability could be understood to allow for differing interpretations of what a “community” is, as I saw at the Caja Petrolera. As I demonstrated previously, certain concepts and premises of the policy, though written to be flexible in some ways, were still bounded by the policymakers and their vision of the policy, and definitions and understandings of “community” turned out to be more strictly monitored than other concepts within the policy.

The discursive way of framing the work of the Caja Petrolera in contrast to the work of the Ministry of Health in the public healthcare system was another way that staff at the Caja Petrolera emphasized their approach. Dr. Carlos Estrada, Director of Health at the National Administration for the Caja Petrolera seemed to question the Caja Petrolera’s way of thinking about community. When describing the work of the Caja Petrolera, he told me, “It is a Business SAFCI Model” or “Occupational SAFCI.” I asked him what he meant by this and he explained, SAFCI is different here, it is not exactly in accord with that of the Ministry of Health. This is because our population is not general, but rather it is made up of workers. So it is complicated to go to a company and do SAFCI. If you go to a company, the medical attention is just focused on one area. If you give workshops or information it is only to one aspect of the person. But a person is not only his job. In reality, the person is based in the context of his community, there is a mix in the companies of people from all kinds of communities, but SAFCI is not just about labor, it is comprehensive (integral). This is the big problem. We need to find out the conditions of life these people have based on the communities they come from, not just their company community.

In regards to a social medicine perspective, which considers work and labor a part of health, Dr. Estrada’s comment suggested the expansion of a conception of health to take into account worker health. Yet, Dr. Estrada also recognized the incompleteness, or uncanniness of their model, that it could not quite replicate the intentions of the Ministry of Health policy because of the populations within which they worked. There was a disconnect between that and the larger visionary focus of the policy as a nation-building project. Yet, at the same time, there was the desire to more fully replicate the government’s approach to policy expressed in his narrative an the idea that “SAFCI is not just about labor.”

Thus, at the same time, this ‘double’ of the state is unfamiliar, unheimlich, an incomplete imitation of the state’s policy, in part because it never intends to replace this policy. Yet the policy itself allowed for interpretations, thus creating a paradox surrounding what interpretation or flexibility means, and to what extent policy might be adapted and changed before it is no longer recognizable as the same policy, except by title. Freud discusses this idea of repetition and recurrence as the uncanny when he writes, “There must be one class in which the frightening element can be shown to be something repressed which recurs. This class of frightening things would then constitute the uncanny, and it must be a matter of indifference whether what is uncanny was itself originally frightening or whether it carried some other effect.” (Freud 1997: 217). In what follows I will locate the ways that the Caja Petrolera, as a familiar-unfamiliar, might produce uncanniness in its attempts at interpreting and doubling a policy of the state. I will trace how this doubling and uncanniness unfolds in the interpretations and implementations of policy by the Caja Petrolera, and then examine examples of how these boundaries were policed through a discussion of the idea of the “proper” versus “improper” copy. However, I also found that the uncanniness of the Caja Petrolera version illuminated an incompleteness or uncanniness in the government’s policy implementation, where their interpretations and doubling illuminated mutations in both the originary and the “improper” copy.
Interpretations and Implementations

In using Freud’s *uncanny* to examine this model, the Caja Petrolera retains or mimics certain familiar “character-traits” of the ideal, *heimlich* policy as a way of preserving important aspects of this form, such as the focus on *interculturalism* in medicine or the creation of “community” health committees to focus on health prevention and promotion. Even in the discussion above about “community,” there was an attempt at consistency with the character of the government policy. However, this double reflects the familiar that has become unfamiliar because of the gaps that exist between it and the image produced by the *heimlich* state policy. In the following examples I will show some of the ways that the Caja Petrolera aimed to create, or double, the character of the government policy in their work, attaching to familiar elements. I will also point out the places where this doubling becomes uncanny, when it becomes unfamiliar. I explore each of these examples as a way to understand the uncanniness of the Caja Petrolera policy, and the reasons its boundaries were policed in certain ways.

In the Clinic

In April of 2009 when the Caja Petrolera first began to consider how to implement aspects of the government’s policy in their system. One of the premises they worked with was how to implement “interculturalism,” in their work. In interviews, I found that to many at the Caja Petrolera, this came to be equated with “traditional medicine,” as well as attention to the psychological state of the patient. They first engaged in a diagnostic where they spoke with the health personnel, doctors, nurses, and patients and asked about whether they would be interested in seeing traditional medicine services in the clinics that they ran. When I asked about this diagnostic, rather than the emotional stories and memories that I heard from the Ministry of Health policymakers who sought out highly personal information from the participants in the communities within which they worked, I was provided with statistics about percentages of patients and health personnel who were interested in seeing “traditional” medicine integrated into the Caja Petrolera clinics. Following the diagnostic, they began a 23 month pilot project at a clinic in El Alto, a city twenty minutes away from La Paz, which was where I would spend time exploring their work with the policy.

On a frigid early morning I met Dr. Tejada at the main office of the Caja Petrolera. We were picked up by one of the official Caja Petrolera vehicles, a fancy modern forest green SUV carrying the logo of the Caja Petrolera, with a siren light on top. This was the only time I rode up to El Alto in this way, and I marveled at how different the ride was than the usual minibus or shared taxi that I would take at other times. As we wound our way up the mountain, we had an expansive view of La Paz. It was chilly and even started to snow a bit once we reached the higher elevation. We made a leisurely first stop to get a lunch of a typical almuerzo: salad, soup, meat, rice, and potatoes. After lunch we drove to El Consultorio El Alto de la Caja Petrolera, the Caja Petrolera clinic in El Alto, a first-level primary care clinic. It was close to the El Alto airport in a nondescript building with an optical center in the front. As we walked, the first sign of government policy I noticed was a large poster right next to the check-in area that had information about Traditional Medicine (*La Medicina Tradicional*). The room was full of patients waiting for care, with young children running around amongst them. Dr. Tejada greeted everyone on staff by name, with a hug and a kiss on the cheek, from the security guard in front to the doctors and nurses. He took me on a tour of the facilities, and showed me the different
specialties of the consultorio, including the laboratory, gynecologist, radiologist, and general medicine. He made a noticeable emphasis when showing me the room designated “traditional medicine.” The room had white walls, with a baby scale, an adult scale, and a hospital bed, and was covered in posters about health and images of Bolivian children. The space was very different from the salas de parto and traditional healing spaces that I had seen in “adequated” rooms in other clinics in the rural areas of the country; here the only sign of “traditional” medicine was a poster on the wall. I wondered about how the surroundings, the space of the healing area, would shape the experience knowing how significant space-making was to both at the origins of policy and its implementation. In this clinic, as well as in the community clinics, western medicine and traditional medicine were not equally represented. Rather, traditional medicine was positioned within western medicine, almost like an add-on or addition. In this way, the doubling of the state policy approach to interculturalism served to reflect the uncanniness not only of the Caja Petrolera version, but also the tensions within the government version, as well.

I was introduced to Dr. Isidoro Aguirre, the médico tradicional of the Caja Petrolera, a forceful man with pale eyes. Dr. Aguirre sat across from me at a desk, and introduced himself as an Aymara healer from the Singhani Province. He had experience working with NGOs such as USAID as well as in the Ministry of Health. He met and began working with Dr. Tejada in the early 1980s on projects related to intercultural medicine. In the clinic he sees patients, usually around seven a day, he told me. He showed me the evaluation and prescription forms he uses, both of which looked like the ones the western doctor in the clinic used, except that they were stamped “medicina tradicional.” This called to mind a contrast with the “intercultural” prescription forms I saw at the conferences, where médicos tradicionales and western doctors were shown pictures of different ailments or plants as a way to communicate a diagnosis or prescription.

I was interested in understanding his medical practice within the Caja Petrolera clinic and how it might relate to the versions and interpretations of interculturalism that I saw circulating in the rural clinics I visited. Dr. Aguirre discussed his approach in relation to the other doctors at the clinic.

There is a difference in their approach, My grandmother taught me not to assess a patient with my eyes but rather with my palms. One of the important parts about his practice, besides giving herbal medicines, is health promotion and education, and my primary focus is on nutrition. This comes before sickness; what people eat is an aspect of preventative medicine. People should eat what their ancestors ate. He also emphasized the importance of language, telling me, “If you don’t know the language of your patient they are going to lie. You need to know the language in order to gain confidence. There are 36 indigenous groups and 36 cultures in Bolivia, you have to speak the language to value their culture.” In his discussion, Dr. Aguirre bounded intercultural medicine as involving herbal medicines, health promotion, nutrition, preventive medicine, and language, which replicated many of the ways that intercultural medicine was discussed in community clinics I visited.

Partway through our discussion, there was a knock at the door; a patient and her mother were there to see Dr. Aguirre. After requesting her permission, he asked me if I wanted to observe his interaction with this patient and ask her questions. The Aymara woman was dressed in a bowler hat, a puffy green floral skirt and a shawl wrapped around her, her hair in two long braids down her back. Her daughter, Renata, the patient, who was visiting Dr. Aguirre to get treatment for her diabetes, was dressed in street clothes. The doctor began by speaking Spanish
with Cristina and gave her some pamphlets and information about the Caja Petrolera traditional medicine program. He asked her about her medications and whether she has finished them and what she is feeling. As he spoke, he pointed to different parts of his own body, switching back and forth between Spanish and Aymara. When he spoke about parts of the body, symptoms, or herbal medicines he spoke in Aymara, while when shared information about numbers or requirements he spoke in Spanish. The conversation was primarily driven by Dr. Aguirre, while Cristina responded quietly at times with, “ay, ya.” With all the talk about different holistic healing practices at the Caja Petrolera, aside from his use of Aymara and the prescription of herbal medicine, Dr. Aguirre seemed to have what could be considered a “western” doctor-patient command in this situation, as he spoke to fill most of the appointment while she remained quiet. I also noticed that she called him “Doctor,” using the Spanish.

This was not the only intercultural clinical space I visited in Bolivia. The Spanish NGO Medicos del Mundo participated in constructing “adequated” cultural spaces in the Patacamaya Hospital in Patacamaya. These rooms had wooden walls, kitchens built in with herbs on their shelves, warm-colored earth tone walls, and were dark with no fluorescent lights. In a conversation with Pedro Cabrillos, the direct of Medicos del Mundo in Bolivia, the subject of the Caja Petrolera’s work with interculturalism and adequated clinical spaces came up. We discussed the differences between the rooms at Patacamaya Hospital and the rooms at the Caja Petrolera clinic in El Alto. Pedro suggested that the clinic was consulting in “natural medicine” not “traditional medicine,” and that these are very different. Natural medicine involves the use of natural treatments, but does not incorporate the spiritual element that Medicina Tradicional does. The spiritual theme is not there, according to Pedro. It is not about the whole experience of healing, it is just about using herbs rather than pills. This conversation illuminated some of the ways that interculturalism was being interpreted and implemented differently in different healthcare sites and in different sectors of the healthcare system.

From the patient’s perspective, however, the ability to see a traditional healer in the Caja Petrolera clinic was a relief, reflecting the sentiment I saw over and over at the conferences I attended and during the research I did at the Patacamaya Hospital. Renata told me that she is diabetic and has problems with pain in her hands and knees, and feels cold in her back. She explained that before Dr. Aguirre came to the clinic she had only seen western doctors, but now she has no interest in seeing them. She sees Dr. Aguirre now every month, has changed her diet, and notices improvements. She told me, “The traditional doctor is much better. Science does not always know what to do. He speaks Aymara so I can understand his words more, and he can understand me. I have confidence in Dr. Aguirre, he has helped make my stomach, head, and joint pain better. I am happier with my medical care now.” Traditional medicine here seemed to be defined as herbs that are turned into salves, palmadas, or nutrition and the psychic state that goes along with the physical state. Even though this approach might seem “uncanny” in its spatial layout and the formal interaction between healer and patient, the effect reflected the responses I heard in rural areas of the country to having the option to turn to traditional medicine within the healthcare system: a sense of confidence, an appreciation of language skills, and a feeling of being more at ease with how health and healing were being understood and practiced.

Yet, there were conflicting ideas about what policy’s implementation meant within the Caja Petrolera clinic, as well as who was responsible for working with the policy. While these guidelines were clear for the public healthcare system, which defined roles for different health and government authorities, traditional authorities, and members of the communities, the guidelines were less clear in the Caja Petrolera, and were interpreted differently by different
employees. For example, some discounted its relevance to their own work, representing the incompleteness of its implementation within the clinic, while others reified its use within the clinic. A doctor of gynecology and obstetrics, a grey-haired man in his 60s. I found him to fit the caricature of the older generation of doctor that authorities in the Caja Petrolera had described to me. He seemed to hold himself with a sense of his position in the clinic hierarchy, spoke very briefly, and did not elaborate on anything unless prompted. He almost seemed a bit amused that I was there to talk to him about “the SAFCI policy.” and took notes based on the questions I asked him. He said he had only heard of SAFCI two months ago through two “charlas” or talks at the clinic. He told me, “It is not part of my job to implement SAFCI, it is only the responsibility of general medicine. I know very little about it.” When I asked him about the traditional medicine program he said, “I do not have any knowledge of the methodology used.” I asked him about what he thinks of the Caja Petrolera clinic’s prevention and promotion programs, in line with the policy, and he said that the Caja Petrolera provides vaccination services, gives talks, for example, about the vaccination for HPV for women, denoting “prevention and promotion” as a purely biomedical approach to prevention. He said that the government is not able to apply the _Sistema Único de Salud_ right now, and they need a lot of money to do so. He does not think there will be a change in the _caja_ except for image. When I asked him what he does if his patients do not speak Spanish he explained that he has his nurse translate, because she speaks the “indigenous language.” Within this Caja Petrolera clinic there were very different understandings of how the policy should or could be implemented, and what relevance it had to both physicians and patients alike.

However, others were considering ways in which they could reshape their work and approach to patients through the framing of the policy. A doctor, Gregoria, who sees herself as directly involved with the policy told me she helps identify a patient’s ailment and works on prevention and promotion, such as habits, diet, and exercise. She explained,

> Before SAFCI the doctors would just ask ‘what pathology do you have’ whereas now they ask ‘what environment do you live in, where do you live, do you have light, water, electricity,’ and they pay attention to and try to use the language of the patient. The traditional doctor will look at the pathology that the patient has and ask whether it is psychological. When the patient says her head hurts, it is not just one place, it is an forceful expression of the psyche. The body is part psyche, as well. The doctor thinks ‘Why does she feel bad, what is the cause?’”

For Gregoria, prevention involves talks, workshops, and vaccines. It is no longer only about the direct problem. Again, the association was made between SAFCI and the psychology of the patient, and the mind/body cosmovision connection. Focus on building confidence, the word used over and over was “confianza.” This intercultural approach, not the medicines but the approach to people.

The circulation and doubling of policy manifested the uncanniness in both the government and Caja Petrolera versions of policy. For example, interculturalism, as I have already discussed, was a premise of policy, and a concept that was in some ways open to interpretation and meant to be worked with in different places, spaces, and sectors of the healthcare system. The approach to interculturalism was an incomplete double to the ones I saw in the rural clinics where the space was adequated, and the clinicians were all trained in adopting and adapting the policy in their work. However, the Caja Petrolera model also pointed back to specific aspects of the government model. The Caja Petrolera clinic had a trained obstetrician, though, as he expressed, he had no interest in working with traditional birthing practices and felt
that the policy did not apply to his work. Yet, the rural clinics often only had a midwife (partera) and an auxiliary nurse. Sometimes there was a physician, someone who was part of the Residencia SAFCI, the medical residency program that had been created alongside the designing of the policy in order to create a program to train medical residents in community health, family medicine, and intercultural approaches to health. Yet in most places, there was no physician. I never saw a rural clinic with an obstetrician, and the facilities were often bare, with few resources. The incomplete doubling of the Caja Petrolera model pointed to mutations in both the government policy and in the Caja Petrolera model. There was a discordance in that neither approach manifested a complete version of the utopian model that the policymakers imagined.

The Caja Petrolera Equipo de SAFCI

Another place I observed the Caja Petrolera’s attempted doubling of health policy was in health promotion workshops I attended through the Caja Petrolera. As I discussed above, the Equipo de SAFCI, or SAFCI Team, was one way that the Caja Petrolera approached implementing policy, which was an attempt to mimic the door-to-door teams that emerged from the SAFCI Residency program that was designed by the Ministry of Health. I was introduced to the team associated with the El Alto Clinic. This team was made up of a gruff and introverted doctor, Angela, a nurse, Beatriz, and an outgoing and bubbly psychologist, Alicia. When I first met with them they showed me their schedule, which consisted of visits to the factories affiliated with companies that pay into the Caja Petrolera. They were working with fifteen companies and the companies would each elect a health representative to form a health board, a governing body that helps make health decisions and requests for a given company. The fifteen representatives that formed this board would help make suggestions and changes to areas related to health within all of the factories affiliated with the Caja Petrolera. The pilot project would last between 2011-2014 and after would be expanded to the rest of the country. The approach to creating these health boards mimicked the government’s model of electing and implementing consejos sociales de salud at every subdivision of the country: the community, municipality, province, and nationally. The same idea held: the consejos were formed to make health decisions and demands, create funding requests, and implement health projects using the funding earned.

Angela had studied in a two month course to be part of an Equipo de SAFCI. This program, in a sense mimicked the Residencia SAFCI which was an official part of the health policy, run by Dr. Palacios and Dr. Montés, affiliated with the Ministry of Health. The Residencia SAFCI was a program that emerged as part of the policy that was a two or three year training program for doctors who wanted to specialize in rural community health. Whereas doctors in traditional residency programs might do three months of rural community health work, these residents would spend two years in the field. When I met with Dr. Palacios and Dr. Montés they shared with me the textbook they created for the Residencia. I was struck by the integration of medical anthropology, public health, and Latin American Social Medicine in the text. These doctors were trained in the philosophy of health and healthcare provision that the policymaking team shared with me. The book took residents through the theoretical foundations of the policy, and then they undertook experiential learning in the practical foundations of the policy. I saw that the Caja Petrolera Equipo de SAFCI integrated some of these ideas, particularly the inclusion of a social scientist, Alicia, on the team. Yet, their regional focus was urban and peri-urban, and was thus very different than the rural community health programs through which Ministry of Health curriculum-trained SAFCI residents participated. As such, these deep theoretical foundation in rural community health was irrelevant to their approach. Yet the fact
that the Ministry of Health residency so heavily focused on community health emphasized the particular unevenness in channels of policy’s intended audience and implementation.

One of the many workshops I attended with the Caja Petrolera Équipo de SAFCI demonstrated the doubling of the model and its mutations. This workshop took place at the Pepsi Factory in Rio Seco in the La Paz municipality. Before leaving, the team and I gathered together materials to bring along, including papers to hand out and a laptop containing a PowerPoint presentation, and took a minibus ride to the factory. We arrived at the Pepsi factory and were led in through the front gates. We had to show our identification and leave them at the gate and we were given neon yellow vests to put on. We walked into a room full of around 40 workers in orange vests; all except one were male. There was a projector at the front of the room and a stand selling Pepsi products. The men were talking and laughing amongst themselves.

In order to reflect the holistic approach to health, after introductions, Alicia began by asking everyone to stand up and asked them to do an exercise to help with work-related stress. She stood on a chair and showed them how to roll their shoulders back and to roll their heads around to relieve stress. She then had them do a breathing exercise where they breathed in deeply “Calmly everyone...one, two, three” she said and then they all breathed in and after a few moments they followed her and all released their breath out “strongly, strongly, strongly” she said. It was quite astonishing to watch these hardened workers doing breathing and relaxation exercises. They did more movements and she said “This is very good” and then lead them to all raise their arms “You are flying!” she said. Then it was the last time and they breathed in once more and let it out and took their seats.

The rest of the workshop involved an introduction to the premises of the Caja Petrolera’s rendition of the SAFCI policy and discussions about the health of the workers. The flow chart on the PowerPoint slides that they showed the group about the policy replicated in condensed form some of the Ministry of Health origins. One slide held a comparison of what they called the “Eurocentric approach,” “of before,” said Alicia, to the healthcare approach of “SAFCI,” or “now,” according to Alicia. She explained that there is a big change now, with a slide that took the group through a chain of arrows to demonstrate the progression in healthcare approach, beginning with “individualist, competition, and vertical” and then flowing towards “SAFCI,” as “community, complementary, reciprocity, and inclusion.” The next slide highlighted the Caja Petrolera’s approach to the policy, suggesting that before for health concerns everyone had to go to the clinic, but now, with SAFCI, they can go directly to their companies.
Alicia told the group, “The majority of you are fathers, you have children who need you. You need to be responsible with your health and avoid chronic health problems.” She mentions specific health problems, such as alcoholism and sexually transmitted diseases. The health problems discussed at these meetings were very different than the ones I heard about in the rural communities such as the problems with childbirth, diarrhea, sun exposure, access to roads and water. The *Equipo* mostly emphasized alcoholism, sexually transmitted diseases, and work-related stress. These problems were geared towards the workers at the factory, with no discussion of how it related to their families or the larger communities. I believe that here community really
was being considered the factory, not the more expansive sense of community as defined through
the policy premises. There was an inability to double the *heimlich* policy. The uncanny is
produced because the Caja Petrolera, which attempts to represent the state’s policy, manifests
mutations that were outside of the expected mutations of the government. This uncanniness
emerges in various areas of their approach, including the implementation of traditional medicine
within the Caja Petrolera Clinic and the work in health promotion that the *Equipos SAFCI*
undertook with the companies affiliated with the agency.

The Improper Policy

Policy, as part of a utopian vision of universal health care provision, as well as part of the
participatory vision of mutability, becomes an element of “public knowledge” in that in theory it
is meant to be used by everyone, everywhere. However, some of the mutations of policy
emerged outside of the scope that the government anticipated, and thus pushed at and actually
created the boundaries of flexibility. This tension around the limitations of mutability and
adaptability showed some of the “constitutive limits” of policy as public knowledge (Hayden
2010). The kind of policing of these limits that occurred demonstrated both the kind of
mutability the policy was intentionally aimed at manifesting, based on notions of “indigeneity,”
rurality, and being embedded in the public healthcare system. The policing also represented the
kind of difference policy was not intended to be flexible to, such as employee private health
insurance programs and the private healthcare system. This policing was complicated by the fact
that the conflicting aims I saw around the government’s relationship to the policy. The
government wanted the *caja* system to be part of a single unified centralized system, the *Sistema
Único de Salud*, which would be controlled by the government. However, certain authorities also
discursively regulated and policed the boundaries of the *caja* involvement in adapting policy and
implementing it within their sector of the healthcare system. Cori Hayden writes about the
“proper copy” in her work on global pharmaceuticals and the public domain. She suggests that
“In their rhetorical and normative commitments, they also risk reproducing some of the very
same constrictions and exclusions that we tend to associate with (privatized) acts of enclosure
itself” (Hayden 2010: 87). In some ways, through the enforcing and creation of the boundaries of
a “proper policy,” certain exclusions are produced. Hayden asks “Against what do these
expanding commons/domains expand, and against whom must they be secured? On what do they
encroach and against whom do they erect their fences…The answers to these questions depend in
large part on the idea of the public domain and the commons that animate the initiatives in
question” (Hayden 2010: 86). The idea of the commons involved in the case of health policy in
Bolivia is based on a conceptualization of indigeneity and rurality as separate from the private
and the urban, as the private represents the past, the befores, that the policy is aimed at
overcoming. An uncanny double that could be policed was produced because the utopian vision,
framed around reviving and repairing the past, necessarily had to also involve the private and
employer-sponsored healthcare sectors even as these were spaces to overcome through the
creation of a unified healthcare system.

The Caja Petrolera worked with the Ministry of Health to implement their approach, and
were in constant conversation with them. However, at the same time, in conversations I had
about their work with some of these people, I saw the policing of the boundaries of policy, and a
sense of what the “proper” policy consists of, and what is considered “improper.” There were the
offhand comments I heard from doctors and nurses working in rural community health, such as,
one who said “it is probably politically motivated,” when I asked about the SAFCI program in the Caja Petrolera. These comments came from a position that is in deep contrast to the positionalities of doctors in the urban Caja Petrolera clinics, highlighting a tension in the fact that the policy itself was geared towards rural community health and not urban health centers. In fact, doctors I spoke with at one of the large public hospitals in La Paz told me, “SAFCI, that’s not for me to do, that’s done in the rural areas,” or commented on traditional medicine practices saying, “They can do their incense and ceremonies in the courtyard, away from the hospital.”

From the Ministry of Health I also heard a policing of the boundaries of the policy when I asked Dr. Montés about the Caja Petrolera policy. He said,

To be clear, it’s much more than the complementarity with medicine within the intercultural focus. I wouldn’t dare say that this is SAFCI because SAFCI isn’t only traditional medicine. With all due respect to Dr. Tejada, he is making an effort and doing work that is going to complement both types of medicine. But when we speak about community healthcare we aren’t only talking about the medicine, that’s important to make clear. For example, there is training and there are specialists in family medicine, there have always been, but we are creating specialists in family community intercultural healthcare. In other words, healthcare is to be understood in a much broader and more integrated way. For us healthcare is the same as the problem of nutrition, it is production, it is harmony with nature, it is livelihood. Medicine alone is not the remedy for illness of the kinds that I’m talking about.

Similarly, Antonio Ortero of the Ministry of Health said that what the Caja Petrolera is doing “Can’t really be SAFCI” because they do not have a territorial community, rather it is occupational. Others told me that the cajas do not have an idea of how to provide traditional medical attention because they do not take into account different conceptions of space or the body, or the “states of the body” (estados del cuerpo). An NGO worker I spoke with from PROCOSI told me he was suspicious about the Caja Petrolera’s work, and wondered whether they had any true SAFCI resident graduates on staff, or if they were just bringing in people who had been to a few workshops in order to make a political name for themselves. All of this commentary about the Caja Petrolera’s work circulated to provide an informal boundary policing of the “proper” policy, even as the government itself was in discussions with the Caja Petrolera about their work and interested in unifying the caja system itself under the government.

However, these critiques demonstrated the very particular ways that they were understanding the policy and its intended audiences. Even with discussions of universality and mutability, policy seemed to fit better in some places than others, and was intended for some places rather than others. There was a concern that the health policy would be “reduced” to certain elements, based on the interpretations of a given participant or sector.

Conclusion

Policy begins its practical mutations as soon as it leaves the Ministry of Health, as it is taken up and interpreted by different people. I have seen this in action, from the Director of SAFCI at the Caja Petrolera going line by line through the official policy and then telling/showing me how she's worked to revise it to make it into the official Caja SAFCI policy document, to discussions with municipal health advisory board leaders who are creating their own municipality-specific documents and approaches, or evidenced in the fact that I gathered many different versions of the policy in documentary, digital, and spoken form. The policy was
left open for these interpretations intentionally to allow for it to fit with specific practices by the population. However, within this openness was also a bounding of an idea of where policy was meant to travel given its originary emphasis on rural communities and indigeneity in Bolivia at its very foundations. When other sectors, such as the worker health insurance sector, adopt policy, they hit up against these boundaries, manifesting and illuminating both the failures of repetition and doubling, as well as the failures in the originary model.
Chapter 5: Decentering Documents: The Technologies, Aesthetics and Channels of Policy’s Circulation

“The idea is not to celebrate localism instead of universalism. Instead, it is to keep track as persistently as possible of what it is that alters when matters, terms, and aims travel from one place to another” (Mol viii).

Introduction: “We can touch it, it exists”

While many anthropological accounts begin with an arrival story, this chapter begins with a departure. When I left Bolivia, I quite literally felt the materiality of the multiple forms of the textual manifestations and inscriptions of Bolivia’s health policy on my back: I carried with me a giant backpacking pack full of documents, including at least fifteen different copies and versions of the government-produced documents carrying the title “Salud Familiar Comunitaria Intercultural,” not to mention the numerous copies of laws, guides for implementation, and theoretical texts related to aspects of the health reform. Trying to avoid the baggage overcharge fee of seventy dollars at the airport, I stuffed the books and documents into my carry-on, trying to de-emphasize the bulkiness so that I could carry it on the plane with me. I walked through the airport in El Alto hunched over by the weight, the thin air at 13,000 feet causing me to breath heavily and break out into a sweat, even after so much time spent at this altitude. I cursed myself for never refusing a document offered to me. The documents were alluring, as if carrying the mandate and their materiality itself would give me a key to this form, policy, that I was studying. But what was it about my obsession with documents? Did it mirror the obsession with documents that I saw in Bolivia through the proliferation of this form of circulating policy?

Further, tucked away in a hidden pocket at the side of my pack, the weight unnoticeable compared to all of the documents, was my digital recorder, carrying hours of recordings of conferences, meetings, and interviews where health and policy were presented, expressed, and taught to various audiences: me, rural indigenous community groups, doctors, traditional healers, social organizations, and NGOs, in verbal or performative form. I also had a few tiny Flash Drives in my pack. Often in interviews someone I was speaking with would show me a PowerPoint presentation they had given on their computer. I always asked whether I could save a copy and would pull out my drive, and the transfer would ensue. At conferences I went to, dominated by PowerPoint presentations, I would ask to save copies of these ways of communicating policy on the same little drive. As such, my Flash Drive was proverbially overflowing with policy: the PowerPoint presentations, Excel spreadsheets, and PDFs of information that I had seen presented, whether in larger meetings or one-on-one encounters.

Perhaps these forms of policy were compelling to me because of their many different ways of communicating policy; I was able to see the contours of my thinking about policy and policymaking in Bolivia in a multiplicity of forms that seemed to reflect some of the origins and mutability I have discussed throughout this dissertation. Policymakers wanted to make the concepts of policy speak to different audiences, and one way to do this was to produce a proliferation of forms of policy. For example, pouring back over documents that often appeared similar from their covers or titles, I was surprised to find how many different instantiations were in circulation. These included different versions, whether from different years, or meant for different audiences (such as, for example, a technical version, a didactic teaching version, or a legal version). Further, there were other documents such as guides for implementation of various health programs or models, related laws, such as the law of interculturalism or the law of decentralization and autonomy, and the national constitution. Each
of these manifestations of policy that I brought together in my bag, whether legal, technical, or informal, were involved in producing certain practices, ideas, theories, and models as “policy” in Bolivia, and delimiting the boundaries of what was or was not policy. The multiplicity and mutability at policy’s origins were reflected in its manner of circulation. In every moment that these documents, presentations, and verbal expressions were produced, circulated, and used they were involved in producing particular conceptions of “policy.” But which of these forms were privileged, by whom, and why? Where were they circulating, and where were they not circulating?

For some Ministry of Health policymakers the materiality of their ideas was important given the fragility of the political sphere. Dr. Tamayo of the Ministry of Health told me,

The problem is that it’s so fragile, in other words everything that we’re building can end up amounting to nothing. These processes have gotten to a certain point, but a failure in this national policy, a failure in this process or a change of government, let’s say, can be fatal for the construction of a new system. It’s solid in theory, in knowledge, in everything, it can withstand any critique because we have an answer for every question, but we are at a crucial moment right now.

For Dr. Tamayo, there was power in a model that has been written down. He explained, “I would say that a strength is that we already had a model and we already had a written policy, we can touch it, it already exists.” Tamayo felt that policy was recognizable and solidified as a text, a circulating document, in its materialized form, perhaps explaining why he gave me so many different documents related to the policy when I interviewed him.

However, when I think back to my experiences with the variety of forms, while the paper documents were circulated profusely, handed out everywhere I went, these were not the forms I saw in use in conferences and health meetings. Rather, the ways that policy was proliferated in practice was through a multiplicity of oral-visual presentations and verbal performances, which involved both references to the structures, ideas, and philosophies of policy, as well as mutations to its form to interpellate particular audiences or call for specific kinds of participation. While documents have been privileged in the anthropological study of bureaucratic practices, and are typically associated with studies of policy, here I try to trouble distinctions between the materialities and immaterialities of policy’s circulation. Policy was materialized and immaterialized in the following ways: It was materialized through documents, and guides that I saw, where policy was a circulating text, with an aesthetics that reflected and assimilated its own poetic language. These types of texts, as in a “policy text” is what people often think of when they consider policy’s circulation (Riles 2006; Hull 2012; Feldman 2008, Navarro Yashin 2007). Yet, policy also manifested at the border of the material and the immaterial through PowerPoint presentations and flash drive transfers. Finally, policy was often immaterial, in the talks and presentations I heard. In doing this work, I want to show that documents are broader than just things on paper, thus redefining and extending the concept of documents itself. I will use “Documents” upper case to refer to how the term is used by others, and how it gets reified, and “documents,” lowercase in a broader sense, allowing the term to shift and include more than paper.

In what ways do these forms of policy open space for mutability, interpretation, and knowledge, and in what ways do they close off interaction? Turning to Anna Tsing’s (2000) concept of “flow,” she suggests that things do not just flow unhampered; rather, mobility is made in particular kinds of ways, and things travel in particular “grooves” or “channels.” She writes, “As the creek flows, it makes and remakes its channels” (Tsing 2000: 327). She asks us to
question how circulation is facilitated and when it is prevented, and what type of experiences, reactions, or possibilities circulation has within particular channels, or when making particular channels. For Tsing, “A focus on circulation shows us the movement of people, things, ideas, or institutions, but it does not show us how this movement depends on defining tracks and grounds or scales and units of agency” (Tsing 2000: 337). As such, all of these forms became representative of, or part of policy, circulating as policy, and both solidified complex ideas about things like units and levels, such as houses, clinics, communities, indigeneity, and gender, as well as reflected the vitality and mutability of the policy vision based on where and how they circulated.

The iterability of policy itself facilitated this way that policy, as a form, manifested, which allowed for its mutation in practice. Furthermore, Derrida requires us to question if there ever was something, a “there there” that we could called “policy.” Questioning the multiplicity of forms of policy that emerged allows for a decentering the typical assumptions we make about policies as physical documents. This is particularly important given the immaterial origins, stories, and histories at the foundations of policy, which, as I suggested early on, shape the form that emerges. To what extent, then, might we extend what policy is, as something that requires vitality to exist and circulate. This raises a question of how people experience meaning (Gitelman 2008). The forms I encountered were all policy, and can do the work that Documents are typically understood to do. As such, I engage with theorists of Documents to show what role these forms play, and why physical Documents are not sufficient. I examine how policy circulates, how certain ideas get stabilized and gain traction, and how people find themselves invested in policy. I attempt to not just follow the circulation of ideas and forms of policy, but also the kinds of channels, tracks, and grounds these circulations create, and how they define particular “units of agency” in regards to policy’s intelligibility and use. I also follow Briggs and Hallin (2007) who suggest that communicability allows anthropologists to understand “How effects of power emerge from everyday ideological constructions of how information is purportedly produced, circulated, and received, how individuals and institutions participate in this process, and how statements are infused with authority and value” (Briggs & Hallin 2007: 45). Here, I look at the channels enabled and created by the different forms, the PowerPoint, the physical documents, and the oral presentations, as well as the closing off of interaction because of some of these forms. How are these forms stabilized as policy? I will examine how each of these contributes to the channels of policy’s flow. What roles do the different forms play and why?

My discussion of the forms of policy follows my theorization of mutation. I look at the ways that these different forms incorporate both “authoritative discourse” of the stable categories of policy and heteroglossia, and how these forms are involved in constructing a concept, or notion of policy itself. Some stable categories were useful, and essential to the national plan, such as a focus on a particular understanding of “community” and certain conceptions of indigeneity and difference, all of which were reproduced throughout all the different forms of policy. However, the proper name mutated through repetition. From the moment policy appeared, a singularity was never possible, as I have already suggested. The repetition of the model in circulation always produces difference. There is no such thing as a “purity” of policy as an original model. Further, the utopian form itself, in repetition, demonstrates its absence through mutation based on the possibilities allowed by certain forms of policy and disallowed by others. Policy, based on its manifestation through multiple forms, thus requires a multiplicity and difference. That it can be reproduced as difference demonstrates the conditions of its own
mutation. Reproducing and representing policy are thus part of the process of making a notion of policy itself.

I build on the work of theorists who discuss policy’s, and other state-making projects’ placement in Documents in order to extend the way we think about documents in a broader sense. I went into the field thinking I would follow a document, and how it was made and circulated. However, what anthropologists do is look at what happens to things in practice. I found that the Documents did not have very much meaning outside of the way it moved and circulated. The work I did was not about reading the Documents, or exploring archives; rather, I was following the ideas that were bounded as policy and how they took shape as policy. In this analysis, then, I continue to question why it might be interesting or useful to not take for granted what the form of policy is and rather look at forms that get called policy when they travel in certain packages and when they are taken up by various audiences. I argue that the multiple forms of what came to be called policy aided in the circulation of certain kinds of knowledge and practices, and created particular “publics” to interact with policy as it traveled that were shaped through this circulation (Warner 2002). However, this circulation of policy’s ideas demonstrated the unevenness in its usability and intelligibility, expressed through the forms that were made most readily mobile, and the ways in which they could be work with. In this way, the policy’s multiplicity in form was part of its design and, simultaneously, part of its circulation and intelligibility.

Decentering Documents

Policies are often encountered in the form of paper Documents. Anthropological writing on Documents and bureaucracy helps to show how documents become central to bureaucratic practices. Hull, for example writes, “If the aesthetics approach concentrates on form, and if attention to affect draws analysis to the moments of encounter with documents, the problem for work oriented to signs is the way documents link to people, places, things, times, norms, and forms of sociality” (Hull 2012: 255). Documents in this view facilitate the practices intended by the content of the documents. Riles suggests that these artifacts of bureaucratic knowledge are “aesthetic objects with uses distinct from their qualities as ‘texts.’” (Riles 1998). She writes, “The ‘norms’ are not hidden but are excessively explicit and located on the surface…Rather than uncover the norms latent in the forms (Rabinow 1989) anthropologists might instead seek to visualize the forms latent in the norms themselves” (Riles 1998). Navaro-Yashin (2007) also writes of documents, and the kind of hold and affect they produce on the people who circulate and use them. This work on the power of Documents builds on Weber’s (1978) analysis, focused on how writing and documentation facilitated the successful implementation of bureaucratic control. As such, Harper (1998) has discussed Documents as ‘tools in the construction of fixed and shared meaning’ (Harper 1998: 43). Documents can create exclusions as well. For example, Hull writes, “Fluidity of this documentary traffic should not be exaggerated. Poor and uneducated people unable to master the conventions of bureaucratic documentation (Cody 2009) or recruit for themselves a capable agent remain excluded even check quote from aimed to help them (Sharma & Gupta 2006)” (Hull 2012: 258-2590). Documents, some of this work suggests, are significant in the way the state builds itself, and how the state is understood by society (Sharma & Gupta 2006). Hull writes of Das’ work, “The state exists not simply as a bureaucracy of regulation, but also ‘as a spectral presence materialized in documents” (Das 2004, 250-51)” (Hull 2012: 260). I build on the work of these theorists of Documents as a way to expand the
sites where we might locate policy, including attention to electronic manifestations as technologies of communication and performances of policy. I suggest that this expansion might facilitate new ways of thinking about the circulation of ideas that get called “policy.” Hull, who also encourages this type of project, writes, “By not giving greater attention to the interplay between paper documents and the design, circulation, and code infrastructure of electronic documents, we risk confining ourselves to the documentary equivalent of village life, isolating paper documents from electronically mediated documentary processes making different scales” (Hull 2012: 261).

Scholars of Documents have also done important work in thinking through the topic of repetition through reproduction. For example, Lisa Gitelman, a media studies scholar, begins to question what happens when documents are reproduced. She writes, “Reproduction is one clear way that documents are affirmed as such: one of the things people do with documents is copy them…Although reproduction is one of the functions that have helped people to reckon documents as documents…Documents are epistemic objects; they are the recognizable sites and subjects of interpretation across the disciplines and beyond, evidential structures in the long human history of clues.” (Gitelman 2014: 1-2). Documents might traditionally be understood to make some of the stabilities of policy cemented and clear, as they are reproduced and copied as an epistemic practice. However, in my work, based on the proliferation of forms of policy I saw circulating, I want to decenter paper Documents as primary in policy’s repetition and look at how a variety of forms produced particular stabilities and mutabilities, as they moved through particular channels. I look at what different forms were circulated as policy and why as a way to follow through on my suggestion about mutability and difference in the repetition of policy. Simultaneously, though, I examine why Documents are indeed so persuasive, and when they are important or gain power, as well as what we lose if we stick so closely to the work of documents when analyzing and examining health policy, as a larger project of proposing new ethnographic analytics of policy.

As part of this work, I return to the discussion of a “beautiful policy,” and suggest that the forms of policy that circulated reflected this aesthetics of the vision of beauty as a reparation of the past and a redefinition and reconfiguration of health. I consider, as linguist Jakobson has, that a study of aesthetics must simultaneously look at both form and content. I also build on Annelise Riles’ conception of the “aesthetics of information,” or “the manner in which information is elucidated and appreciated, its uses, and its effects” (Riles 2006: 2). I use theirs and other conceptualizations of aesthetics to examine the ways that the aesthetics of policy, not just documentary, but in all its forms, constituted political spaces, created affective experiences, and interpellated publics that became “users” of the policy based on their interaction with its forms in different ways (Warner 2002). Aesthetics provided a way for repetition as mutation to manifest, given the different aims circulated different forms of policy, even when there was some stability in content. The idea of an aesthetics of policy is about what policy is able to create, not about replicating perfectly any one originary form. The multiplicity of forms of policy reflect the possibility of the beautiful vision, of the plurality of policy’s circulation and adaptation in a plurinational state. However, important to understanding iterability in terms of policy is to also understand why it circulates and is recreated in different ways in particular contexts, or channels, what it is able to create and what limits it in these channels, and the relationship between form and context based on these channels.

By “aesthetics,” I am not following a Kantian genealogy of aesthetics, where aesthetics is considered separate from knowledge, and instead exists as pure judgment. Rather, I use the
approach to aesthetics that sees aesthetics as an inextricable part of knowledge, where form and content are considered to be interrelated. For example, linguistic theorist Jakobson looks at what he calls the “aesthetic function.” For Jakobson, form is intertwined with content, and so the content is significant, aesthetically, as well. If content is significant aesthetically, then the content does not necessarily need to be bounded to certain taken-for-granted forms, such as documents. I also turn to Brenneis (1993) to consider what this aesthetics might be if we move away from a focus on the material versus immaterial. He has suggested that a focus on aesthetics should also include “performance and cultural production” (Brenneis 1993: 293). Brenneis suggests that “the aesthetic is not solely an artifact or reflection of the political, but also plays a critical role in constituting it” (Brenneis 1993: 293). I borrow from Brenneis in my analysis of the various aesthetics of policy that I examine as artifacts - written, imagery, and verbal - that are significant in both the form they circulate in, and in the political content and space they are formed by and that they create. Aspects of the aesthetics of policy’s form include the ways its design, content, representations, and intended audiences become linked to certain political aims and visions. I suggest that in Bolivia, health policy’s multiple forms were inextricable linked to its political aims of creating a utopian vision of a plurinational state, or the “beautiful policy.” A multiplicity of forms were involved in manifesting these visions as a way to make it circulate widely. However, as I demonstrated, this beautiful policy vision, and the dystopias involved in constructing a plurinational state, were inevitably manifested in policy’s forms as well, and, I found, reflected in the unevenness created through the channels of its circulation. This, then, according to Brenneis’ approach, “Directs our attention in new ways to the link between form and meaning, both literal and social. Reference, rhetoric, aesthetic evaluation, and social consequence are inextricably linked” (Brenneis 1993: 295). I look at the way that form and meaning of policy manifested and reproduced some of policy’s visions, both the utopian and the dystopian, and the kinds of social consequences of the channels through which the different forms of policy circulated.

As such, I study policy’s forms, as an aesthetics that manifests the features of the political vision, both its utopias and dystopias. I look at the interrelationship between different designs and representations that were bounded or labeled as policy, as well as who created or circulated these forms. The forms of policy that I gathered circulated in Bolivia through a variety of different channels were not confined to bureaucratic spaces or technical language. Rather, the ways that these forms were presented and circulated made it so they could reach different actors and sectors of Bolivian society and the Bolivian health care system. Part of this mutability reflected the policy’s design process, as the policymakers worked with the ideas and took the approach of incorporating methodology for its implementation into the actual policy itself, building into the policy this potential for mutation in form, as I discussed earlier. This allowed for the policy itself to circulate as at once a document that instructs and creates, a norm, an approach to change, and a guide. I look at what stabilities are inherent in these forms and how stability was produced. In this section I examine four of these types of documentary versions of policy: personal journals, the legal policy document, the didactic version, and the guides. What are some of the uses of policy, including how they are distributed socially?

While Lisa Gitelman writes of both the materiality and immateriality of paper, her approach to thinking through paper is useful for my study of the forms of policy. She writes, “Paper is a figure both for all that is sturdy and stable…and for all that is insubstantial and ephemeral…Likewise, paper is familiarly the arena of clarity and literalism—of things in black and white—at the same time that it is the essential enabler of abstraction and theory, as in
mathematics and theoretical physics. Paper serves as a figure for all that is external to the mind—the world on paper—as well as all that is proper to it, the tabula rasa. Contradictions like these hint at the complexities that documents may present as paper things” (Gitelman 2014: intro). In attending to the aesthetics of information related to constituting policy, these forms and their manifestations were both sturdy and stable, as well as ephemeral and mutable, given that they contained both the stabilizing Proper Name of the policy and its specificities, as well as the ephemeral stories, philosophies, and personalities that are imbued in its making, invisibilized just under the surface of the proper name words.

If we step back from a taken-for-granted understanding of what policy is and look at the multiplicity of forms required to produce and conceptualize certain ideas, practices, and notions of difference in Bolivia as policy it is possible to see how these were continually made, used, and reformed, and remade again, and why. While explicit norms tied together the different versions in circulation, the presentation of these norms and how they could be used was the aim of the different policy versions that circulated. Some of these forms, in their various manifestations, beckoned audiences to respond and delimit their boundaries, as well, by asking for certain kinds of actions, whether participation, recognition, or adaptation. These forms force us to look at the production of the gap between the utopian vision, the Sistema Único de Salud and vivir bien and the realities that are imbued with difference. Yet, I suggest, policies always bring forth copies that are not exact, that could be considered “defective,” or that take on their own direction and meaning. This process was overtly apparent in the study of the SAFCI policy because it was framed so distinctly as “utopian,” yet this is also a general feature of all policies.

Proliferations of Policy and its Uneven Channels

Why did policy circulate in so many different forms? The aesthetics and language of the vision of the policy emphasized a focus on making policy intelligible and accessible, based on the utopian vision for a new healthcare system that reaches and can be used in some way by everyone. This would seem to suggest that policy’s multiplicity of forms manifested the content and political aims of the vision. However, as I have already suggested, the mobility of policy was uneven. A particular framing of “rural communities” and “indigeneity” was used to discuss both the origins of policy and the intended sites of implementation. Policy was thus understood to be most readily intelligible and adaptable to certain regions and sectors of the nation while excluding or making it more difficult for others to access it. Policy’s forms, documents, presentations, and performances, and their aesthetics, thus served as the manifestation of this vision and its unevenness. Policymaker Dr. Tamayo was someone who, in all of his work, tried to construct particular conceptions of policy, the domain of policy, policy’s possibilities, and its circulation. He did this through the stories he told me, the materials he provided me with, and the discussions of “realities” he shared. I look specifically in this chapter at his work in creating a concept of policy, and examine how policy’s domains and circulation were adopted from his construction of policy. In many ways this is the same project as I was attempting to do throughout my fieldwork, and in this writing: to provide an understanding of how certain ideas about policy might be understood from my construction of policy’s origins and circulation. Dr. Tamayo told me,

How it is presented is so hard too, because the act of making a presentation, even with 20 or 50 slides, will never show everything that we feel, everything that we set out to do in making this change. It is difficult, difficult, we are trying but if a person doesn’t have the
same experience, in other words, if they are only familiar with downtown La Paz, for example, they are never going to understand that idea of the right to healthcare that we’re talking about here in the communities. So, we have approaches to explain to them in the academic sphere, we have representations with a lot of drawings for people, the graphs, we have that too, but it’s never enough.

For Dr. Tamayo, the “people” that it would be most difficult to make policy approachable for were “common” urban Bolivians. How could they incorporate everything that went into policy’s making, all of the origin stories, experiences, memories, and philosophies, and circulate them in a way that would be intelligible and express what the intentions were behind these ideas? How could they express this heteroglossia when it had to be encapsulated, or systematized, under a proper name? Tamayo struggled with the flexibility of policy, while trying to also give it a form that could be recognizable as policy by a wide range of actors. I believe that this concern led to the multiplicity inherent in the circulation of policy, discussed in terms of intelligibility, and manifested through the many forms of its circulation. He suggested that one of the reasons the team attempted to present and write policy was for those who did not have the experiences at the origins of the policy, such as urban Bolivians. This was not the typical discussion of rural indigenous people being unable to understand policy; rather it was of urban Bolivians who were at a disadvantage, as they were in many ways also excluded from policy’s origins and vision. In this sense, Tamayo was already presupposing and privileging certain users of policy and connecting the forms of policy to different types of users. It was as if those in the communities policy was based on would understand the foundations while others could not, and would need an “academic” presentation of policy.

For example, Dr. Tamayo suggested that the documents were for the “academics,” and so there was a need to make presentations, graphs, and charts for these audiences. He made the first attempts at documenting these ideas in the diagrams he inscribed into his personal journals during the origin and design process of policy. Dr. Tamayo’s journals were some of the most striking forms of policy that I encountered during my fieldwork, ones that pushed against the ways that policy is often bureaucratized and challenged the communicability of policy along bureaucratic and official channels. His stack of his personal diaries from the last six years carried notes and drawings that tracked the process of the designing of the concepts behind what came together to become Bolivia’s new national health policy. Dr. Tamayo’s journals carried his personal notes from the Ministry of Health’s meetings, and he flipped through the pages to point out drawings and iterations of the team’s work with what seemed to be a kind of loving devotion. These journals felt like a treasured gift to me, to be able to trace the history not only through his words and narratives during our many interviews, but also to get a glimpse into the ideas, designs, drawings, and notes he took at the time of the policy’s design. Even in this space of design, where I knew that the stories of histories, memories, and origins were circulating through these meetings, Dr. Tamayo felt compelled to inscribe certain concepts, giving them stability and authoritative structure and boundaries, showing the technocratic privileging of inscription and documentation.

I often wondered why he showed these to me and allowed me to take pictures of the pages; I think the reason may reflect on the approach to studying policy I was developing during my fieldwork. It allowed him and others involved to express their personal contributions to and memories about making policy. People were often surprised when I asked them about what they contributed, personally, to the policy and process. For Dr. Tamayo, his contributions were in part etched into the pages of these notebooks, giving an aesthetic form to his narrative, as the
visuality of his experiences were certainly important to him, evidenced by the fact that he kept referring back to them, pointing me to charts and designs and scribbles amongst the pages. For others, these memories were oral histories told over coffee, in bumpy car rides, or over desks in high-rise office buildings. Policymaking is generally viewed as a process that occurs in bureaucratic offices, behind closed doors, based on projections, economic analyses, and modeling. In asking for the oral histories of the policymakers and the policymaking process as part of an ethnography of policy, I am arguing that these kinds of stories do matter to scholars of policy and to anthropologists attempting to understand cultural biographies of policy to get a sense of how concepts of policy are developed. He told me,

I’ve been recovering some documents here, these are my first outlines...Here we were discussing, I was explaining my way of seeing things and at that point it wasn’t yet called SAFCI, here is SAFCI, but it was centered on the family, the community, and intercultural aspects. This is the umbrella, as I called it, for the community. And its instrument is the sistema unico de salud (SUS). This is from 2007. The law, I mean the decree came out in 2008. This notebook has every page that recounts that history, and this is why I don’t want to throw it out... I had that knowledge of the local, that is what changed my life. This is a book of anthropology. Here are my first drawings about what it would be to do health management.

In his narrative, Dr. Tamayo suggested that, through policy design, he was speaking for, and designing for the “local;” this is what he considers “anthropology” to consist of. This framing of policy illuminated the type of channels that he felt policy’s practice was meant to flow to, the audiences he felt it was meant to be intelligible to.

As such, there was a solidification of locality in the terms that were represented through the graphics in his notebook, most notably, a framing of “community,” as Dr. Tamayo placed “community” at the foundation of policy in the blow diagram:

This emphasis and framing of community would become a significant channel through which particular forms of policy circulated, and an idea about what constituted “community” was
designed as the “unit” through which policy was meant to be implemented. Community health, in this conceptualization of the policy, was privileged over other forms of health. The site of intervention of this policy was inscribed into its form, and its circulation, as well as in the aesthetics of the “beautiful” aim of reparations for the past violences done to those understood to make up these “communities.” However, this emphasis on a channel framed as “community” reified the impossibility in the utopian vision of a unified healthcare system, because there are certain spaces that are privileged, as demonstrated through the pathways that the policy traveled most fluidly.

In the next drawing, still emphasizing a conception of “community,” Tamayo mapped what constituted for him the individual and the community in drawing out the interactions, according to his vision, between the individual, the family, the community, the nation, and the healthcare system.

Just as I discussed in the previous chapter, the idea of community was given certain boundaries by the Ministry of Health policymakers when they designed the policy, and sometimes these boundaries were challenged, for example by the Caja Petrolera version of policy. These aesthetics in a sense made an individual, a family, a community, and a nation as they were pulled away from the origins and systematized into a entities. Tamayo explained the drawings to me,

Of course, here is where the law was built, here is when we spoke, and each meeting was to explain to them, to discuss it. To understand what the determinants were, here the population is going to affect the deciding factors, this is prevention, this is healing. Here I was drawing these little pictures over and over, this is the community, I told them, because many people see the city as simply a reflection of the municipality. No, I told them, here there is a little clinic, here there is a house, here is the school, this is our downtown, here is where you go for family health. It was like that, and I showed them
...here I spoke about the focus of SAFCI. And here are the principles of SAFCI, as I told them, it has to integrate with many sectors, it has to be intercultural and participatory.

And later they added what was crucial and well, it’s good

The idea of adding “what is crucial” was a bounding off of an authoritative determination of policy’s contours, much like the bounding of mesas and the policing of the Caja Petrolera policy. There was an attempt to represent how community, nation, responsibility, and health were to be understood for the nation. Even with the aim of plurality and indigenous difference, Dr. Tamayo had managed to represent all of these simultaneously in the same image.

This authority was reflected in one of the drawings in these pages, which illustrated the early manifestation of the proper name policy, and some of its stabilities in form. Dr. Tamayo mapped out some of the key actors and pillars as part of this diagram: the policy premises of gestión and atención are described in triangles, and a separate family-tree looking drawing represents the Ministry of Health and Sports and the roles it plays in the health care system. There is an individual figure in the drawing, with arrows from that individual to the different aspects of the policy, such as the “health post,” “community,” “management,” and “research.”

In his drawing, there is a presupposition of an individual as part of these elements, that there is a health post, and that there is a community. There are also very hierarchical structures built in, such as the Ministry of Health with branches below it for other sectors of the health care system, like a family tree. How could this exist at the same time as the emphasis on community? This defining of the Ministry of Health’s authority, at the top of the “family tree” diagram,
seemed to also enforce certain authorities as able to determine what policy is and where it should go in order to then be opened up for interpretation.

It is possible to trace many of the forms and their content that circulated as policy back to Dr. Tamayo’s journals and documentations of meetings where the stories and sharing about health experiences and philosophies had occurred. For instance, many who came into contact with the ideas of the policy also came into contact with a document or presentation related to policy, all of which contained its Proper Name, *Salud Familiar Comunitaria Intercultural* with the Ministry of Health logo stamped on its pages, and containing policy’s stabilized premises, and certain notions about who it was aimed at and why. That the documents themselves came in so many different forms, however, suggests the mutabile potential in policy, as well: the form was meant to be adaptable to different people, places, and experiences, but the materialization of certain essential concepts, in whatever form, were also essential in its circulation.

This idea that policy can take multiple forms follows Bauman and Briggs’ (1990) discussion of the concepts of “entextualization” and “decontextualization” through poetics. That is, entextualization is “the process of rendering discourse extractable, of making a stretch of linguistic production into a unit—a text—that can be lifted out of its interactional setting. A text, then, from this vantage point, is discourse rendered decontextualizable. Entextualization may well incorporate aspects of context, such that the resultant text carries elements of its history of use within it” (Bauman & Briggs 1990: 73). Policy, as it circulated in multiple forms, through a process of entextualization, referred to the very stabilities and mutabilities of the notion of policy itself, becoming reflexive. Or, as Bauman and Briggs write, “Basic to the process of entextualization is the reflexive capacity of discourse, the capacity it shares with all systems of signification ‘to turn or bend back upon itself, to become an object to itself, to refer to itself’” (15, 16). (Bauman & Briggs 1990: 73). Further, decontextualization happens through poetics when language is cut off from the “social and cultural contexts of production and reception” (Bauman & Briggs 1990: 72). I thus also identify ways that policy’s forms and their circulation worked within a dynamic of certain flexibilities and the larger authoritative structures, or, as Bauman and Briggs suggest, “The problem is to identify discursive practices that mediate between the situated use of language within speech events and those larger structures” (Bauman & Briggs 1990: 79). I build on their work in the sense that poetics does both active political and semiotic work. Entextualization involves both regimenting openness at the same time as it attempts openness, both in terms of how the past is constructed and how discourse constructs and invokes past contexts, texts, and voices, as well as how it is recontextualized in the future. This process always requires an audience to receive the poetics, as well as someone or someones to do the work of decontextualization. The conferences and other sites of policy’s circulation demonstrated these elements of policy, where poetics was used to construct pasts, whether in regards to “traditional” medicine or prior bureaucracies, as well as to shape futures that might be implemented. As such, the poetics of the various different policy forms and documents all did this work differently.

Some of these tensions were noticeable in the channels through which the different forms of policy circulated that I will discuss below. The circulation and proliferation was intended to make its mark on all of Bolivian society in order to attempt to represent and circulate the beauty of their vision, while also being something practical and useful. There was an understanding that different audiences would need different representations, which reflected the mutability inherent in policy itself. As such, policymakers tried to create stable entities out of something they knew could not be materialized in this way, represented by the fact that the entity was multiplied
through the variety of forms of policy that all maintained certain familiar authoritative structures. There was a tension between wanting to bound policy and have control over it, both what it says and where it goes, and the vision of maintaining it as something open, with the ability to apply it to different places. This tension was represented in the aesthetics of policy, where different approaches to design and representations were circulating as policy simultaneously as an attempt to express the vision most fully to the most people possible. This is understandable through Brenneis’ “performance model,” as it looks at the variety of communicative media and how the aspects of these, including their aesthetics, references, and sociality, are fundamentally connected. In this chapter I explore three different forms of policy that I saw constituted in Bolivia as case studies to examine the different forms, how they represented, the boundaries and stabilities they encapsulated, and how they traveled and through what channels.

Performing Policy

Policy’s mobility within channels that were defined as “rural,” “indigenous,” and “community seemed to have the most fluidity, reflecting the vision of policy’s foundations put forth in Dr. Tamayo’s diagrams and in the origin stories of the policymakers. Flow in these types of channels created interactive experiences, reactions, and possibilities for openness and interpretation. In these channels I primarily saw conceptions of policy circulated as verbal messages and performances. The aesthetics of this form of policy involved particular ways of manifesting the relationship between content and representation in order to produce certain effects, such as participation, which was a core premise of the policy. Here, policy, through this process of entextualization, was reflexive of its very premises as the act of the performance of its form opened a space for participation and the implementation of this form. The form of policy that circulated in these channels was involved in constructing the policy itself in practice. As such, this form of policy was meant to actually constitute the political in the moment of its representation (Brenneis 1993).

Verbal performances most often occurred in spaces where policymakers, NGOs, health specialists, or community leaders shared and explained the premises of the policy as a way to educate communities, circulate its ideas, and create a kind of public that would be able to use the policy in specific ways. However, given that the premises emerged from these types of places, the practices put forth as policy were also sometimes practices people were already engaged in. Brenneis emphasizes the “event” in performance. Events, he argues, are “Where we experience and shape the world, each other, and our own experiences…’events’ are where what we take to be society is jointly constituted…They also provide invaluable analytical moments: aesthetics, politics, notions of genre and style, performance, reception and emergent experience are deeply entangled” (Brenneis 1993: 294). Further, Brenneis defines the role of the audience, which he considers to be critical. He writes, “Far from passive, even when apparently silent, multiple audiences help shape the form, content, meaning, and implications of any performance” (Brenneis, 295).

The mobility of this form of policy was made based on an assumption of the audience, how this audience would use the policy, and the ways that policy could be made most intelligible and useful. This assumption in some ways reproduced certain conceptions of literacy mapped onto indigenous spaces, as the verbal forms I saw circulated were most often to indigenous participants. However, it also mimicked the presentation style of indigenous community meetings, mapping onto this familiar approach to disseminating information. As Tamayo
suggested, unlike the “academic” audiences that might need graphs and diagrams to make the policy’s premises intelligible, the audiences that the verbal policy traveled to were in a sense interpellated as existing at, or being part of the foundations of policy, since policy was seen to emerge from these spaces. I saw policy flow more easily and fluidly in these types of spaces, in part because of the presenters and their positionalities, and in part because of the aesthetics of this form of policy. These elements reflected both the origins and visions of policy itself.

In order to explore the trajectories of this verbal form of policy, I followed these performances through the work of the NGO Medicos del Mundo in Patacamaya. The rural Medicos del Mundo office that I spent time at was located in a small town called Patacamaya, two and a half hours from La Paz by flota, or the large double-decker buses that crisscross the nation. Patacamaya itself is split in two by the main cross-country road to Oruro, and is relatively more built up because it is situated on this national thoroughfare. It is also an entryway to a series of unpaved networks of roads and paths that lead to rural communities that make up Red 12, the network of communities that I focused on during this part of my fieldwork. Each day Jaime, Teresa, and I were picked up around 7:30 in the morning by the organization’s driver. We would pile into the white pickup truck with the Medicos del Mundo logo on its side, stop for snacks, and then drive for about twenty minutes down a paved road with the snow-covered Sajama looming ahead of us, until we would branch off onto dirt roads. We would then spend hours bumping along, sometimes on dirt roads, other times maneuvering through river beds and fields, talking, laughing, discussing critical theory or health policy, or just gazing out the windows.

The landscape in the altiplano served as a constant source of awe during these commutes. Each day we wound through fields of different colored quinoa, people harvesting potatoes, desert shrubs, small pools of water and one larger river that we crossed, herds of alpaca and cows, all the time with the mountains on the horizon. Carved reddish brown hills, passing through rivers that were just dry enough, shrubs, views of Sajama and the snowy mountain range around it, little pools of water, flat-top dessert mountains, and open-space dessert. Communities would all of a sudden emerge out of the landscape- some as small as six houses, others larger with paved plazas and designated health centers. Larger communities had a mixture of architecture, with some mud brick houses, some red brick structures, and some cement or colonial-style structures, while smaller, more rural communities would be made up of small adobe structures. I went to at least two to three of these events each week while I was working with the Medicos del Mundo team, but will use here a representative example of how these meetings unfolded.
What struck me during events when policy was presented orally were all of the aesthetic aspects of these presentations: the use, through performance, of voice, intonation, and vocal contours as a means for emphasizing ideas that were formalized as policy, while also calling forth a sense of openness and participation. These aesthetic features of oral policy could take form and shape vocally and tonally in a way that provided an interactive experience for those involved. Sometimes these vocal representations of policy’s ideas and the inciting of policy’s use in practice were folded into the same meeting, such as in the budgeting meetings I went to while traveling with the Medicos del Mundo team. Policy was circulated as a performance and as an event to participate in, which reflected the ideals of policy itself. In these meetings, as described below, I was able to follow, in the space of eight hours, the verbal form of policy, and then the ways it was immediately followed by activities to enact and implement policy in order to transform the possibilities of their health context through participatory action. In these events, there was an implicit assumption that the circulation of the policy through its performance could immediately transform a community into an interactive “user” of this policy, or a public that is interactive with the policy.
The meetings would often take place in rooms was decorated with pictures of Evo Morales, Simon Bolivar, and the indigenous flag and banners on the wall, with chairs arranged towards the table in the front. People from the community, indigenous Aymara people, gathered within about thirty minutes of our arrival. After about 25 people- a mix of elders, middle-aged men and women, and teenagers arrived, the workshop started. Typically, these workshops began with a coca leaf ceremony, a welcoming of the space of dialogue.
Then, the participants, over the course of these meetings, were given verbal versions and examples of policy. This repetition of policy was meant to inform them of its premises so that in the second part of the meeting they would then be able to actively work with the premises and ideas in order to engage in a community health budgeting meeting where participants would break into pre-determine groups to represent women, children under five, adults, elders, adolescents, and health establishments. In these groups they worked to identify significant health problems, their causes, possible solutions, program proposals, authorities required, and money needed. These proposals were discussed and voted on during these meetings, and the leading proposals were then sent to the municipal level government that had its own meetings to create a municipal budget based on all of the community health proposals from each municipality that participated. They worked to create a budget, called a POA, that would be funded by the central government in order to trickle this money back down to the local communities to implement their proposals. This idea of community participation and local context were both embedded into the premises of the policy itself.

In a representation of the government’s most treasured aspect of the policy, as well as a discussion of how notions of difference could produced through policy, Jaime defined the principle of “Interculturalidad” to the participants. He told the group, “In Bolivia there are many different cultures, this is known. And here, those cultures are recognized as nations, not just as cultures. What is the meaning of ‘nation,’ brothers and sisters? These nations want liberation and to have their own leaders, languages, and forms of organization. There are various nations, and for this reason the constitution recognizes a state that is “pluri” and the group as a whole responds “nacional.” Jaime then said, “Each of these cultures thinks differently. We need to respect them and their knowledge, including their knowledge of health and curing. Is this good, or not good?, this policy? And then he repeats this in Aymara and the community responds “It is
“good” (está bien)” and then Jaime finished the sentence, “to live well (vivir bien).” This statement framed the policy discussion around vivir bien, and policy’s openness due to the plurality of nations within the country. He suggests a celebration of indigeneity as part of the nation, which is constituted through the health policy he was sharing. He also used this introduction to encourage the group to “think differently,” to think of policy as mutable in terms of the specificity of their specific practices and ideas related to health and healing.

Jaime then worked with the participants during the first part of the meeting to teach them about the policy. In his narrative, which I quote at length below, it is important to notice the ways the relies on the stabilized, authoritative categories of policy, even as he has simultaneously articulated plurality and the open vision of vivir bien through this verbal form of policy, and the possibility for specific knowledge about health and curing. He began by telling the group, “Over the last five years the Ministry of Health has been implementing a new health policy that is called Salud Familiar Comunitaria Intercultural. Before, healthcare was only done by doctors. Now, the policy says that it doesn’t have to be this way. Health is not only sickness, it also includes problems in the municipality, in Canuta.” Here, he immediately suggests an expanded concept of health and healing, one that the community would be able to help define. Jaime, using a strong voice, standing in front of the group, commanded the attention of the participants. In his statement about policy, he discussed the paradigm shift in healthcare that was built into policy, giving authority to “the policy” that can impose understandings of what is acceptable.

Jaime then told the group “SAFCI has two parts: healthcare (atención) and participatory management (la gestión participativa) He wrote each on the white poster paper taped to the wall behind him. He said “In health these are like feet. I am SAFCI,” he said, as he stood in front of the group balancing on one foot, “Can I stand with just one foot? No. I need both legs to stand!” He told the group “Atención in SAFCI involves médicos tradicionales, medications, infrastructure, and doctors, but in gestión it is how the people should participate in the health problems. What are the steps? First, it is planificación…” and the group responded in unison, “ficación”. “Second is la eje…” and they responded, “cución”. “And third is la segui…” and they responded, “miento.” Jaime’s words called forth the group into active engagement with the policy, almost religiously, yet he shared premises he had set up for them already, through the division of group work and through his verbal suggestions about the policy. The political aim of this aesthetic form was to create an event in which participants learned and performed policy simultaneously. Policy was meant to be used in practice, in fact, it actualized its content through this form of performance, reflected in the aesthetics of the form of representation.

When I asked Jaime one evening back at the Medicos del Mundo office in Patacamaya about his oratory approach, he asked to listen to the recordings I made of the meeting. When he listened he told me, “I see my approach as a didactic approach to working with the communities, because often the answers are on the tip of their tongues, so I just have to prod them into saying it. They know, they just need it planted on their tongues.” There is a contradiction here between the idea of a “didactic approach,” one meant to teach and the idea that the community “already knows.” The idea that the policy is already part of these people, of their knowledge, stems from this idea that policy came from the communities, and is meant for them, as a reparation of the past. The policy was understood to be already integrated there because it was built on these ideas. As such, the form of policy that circulated there, through this verbal call-and-response approach, was meant to encourage the reemergence of these ideas about health and wellbeing that had their origins in communities like this one.
Beyond describing the overarching and interactive premises of policy, Jaime also engaged in a bounding of concepts, similar to the work of the mesas at the policy conferences I attended. He asked, “What is the meaning of salud familiar?” No one responded and Jaime said, “It has to do with the family! Before, health was only about the person, but who else is involved in health?” He gave the example the example of malnutrition, and asked “In who does malnutrition appear?” A few people in the group chimed in, “Children”. Jaime affirmed this response and asked, “A child is a person, no? A little person?” and the group responded “Yes!” He then said, “But you can’t just look at the wawa to understand malnutrition, you need to look at the whole family.” He then asked, “What are the causes of malnutrition?” and someone said “Bad foods” and another person said, “Grief in the mother.” Jaime affirmed these answers and asked, “What is good for feeding the baby” and the group responded “the mother”. Jaime had made his point and said “Because of this it is called family health.” He then said, “And what is the meaning of community,” he asked, as he underlined the word “comunitaria” on the poster where he had written salud familiar comunitaria intercultural. Jaime then said, “It is community, because families live in…” and the group responded, “Communities!” Jaime told them that in a community there are many families, and simultaneously he wrote on the board “F1, F2, F3, F4” to represent families, and drew circles around each. He then named different common family names amongst the Aymara, “Quispe, Choquehuana, Condori.” He said, “In each of these families they have problems with nutrition, and all of these families form a…” and the group responded, “community!” “So,” Jaime said, “Nutrition is not just a problem of the family, it is also a problem…of who?” And a woman responded, with emphasis, “The community!” At this point Jaime joked that he would keep track of who is responding to his questions, saying, “all of the community needs to participate to resolve problems relating to nutrition.”

In his dialogue, mother and family were collapsed, and community health was collapsed with these, and made exchangeable for children’s health. In this way, Jaime was stabilizing the exact categories that policymakers, such as Víctor Tamayo, had bounded in the originary designs of policy, which emerged from their experiences that infused the policy’s making. In this circulation of policy there was the making and bounding of concepts of ‘community,’ ‘family’ and ‘indigeneity’ that were embedded into the forms of policy that circulated. There was actually very little space for participants to define these concepts themselves since they were already predetermined in advance, in a similar way to the conference mesas. These terms were seen to be outside of the definition of “health,” as the foundation for the beginnings of the redefining of health and healthcare. In some ways, then, this approach to circulation seems counter to the mutability of policy that was intended, as certain conceptions of it were authoritatively stabilized. Yet the mutability existed in the fact that there was attention to the flexibility in repetition and circulation of the policy’s form, as well as aspects of its adaptability and participatory engagement through this form.

Jaime touched on this adaptability when he asked the community members in attendance, “What are your needs, brothers and sisters? What is the objective of this meeting? It is not the doctors who are deciding the needs of the community. Doctors can say what medications you need, but you also need to be able to say what you need.” He told them that they would first have to identify a problem, giving the example of a child who has diarrhea and asking the group what could cause this. They responded, “Water! Food!” He said then, once the problem is identified, they would be able to propose solutions and make a plan with all of their proposals to get funding for the proposals. He then told the group, “You who are here will be witnesses to this meeting. You will sign the record we create.” He asked, “How will we do it?” and said “We need
to develop a health plan. The municipality can contract someone, for example, so that the health center isn’t empty.” He then went through each piece of his example “for neglect, we can have *cursos de capac...*” and the group responded “…*itación!*”. “Distance? There are projects that will improve the road. The mayor can develop road projects.” He then asked, “With what resources? The state has a responsibility to fulfill your *necesi...*” and they respond “…*dades!*”. Jaime said, “A municipality that is prepared to give resources to these projects is *un municipio salu...*” and they responded, “…*dable!*” For each call and response Jaime had to nudge them a bit to complete his sentences, and gestures with his hands and emphasizing tonally with his voice the big swooping statements. People listened intently and wrote down notes based on what he said into their notebooks. Jaime then explained, “Every level has a plan…the national plan, the municipal plan…and the municipal plan isn’t just the invention of the mayor, it comes from the *pobla*...” and they responded, “…*ció!*”. Following this presentation, the participants worked for the rest of the day on creating a budget proposal, as part of the participatory requirement of the policy, based on the particular problems and needs they identified.

Policy circulated in this way, through verbal form, in order to fulfill its political aim of participative community management. The verbal form of policy’s “aesthetic features” as performance and event were linked to its political aims of creating a population actively participating in health and having the ability to make certain demands for health. This approach privileges “community” as the channel, or space where policy happens. It was seen as the form of policy that was most intelligible when targeting these types of spaces. The infrastructure that facilitated this kind of policy form was at the origins of policy, the communities and their participation, needs gathering, and the assistance from NGOs. In reinforcing community it is, within the aesthetics of this form, reinforcing where it circulates, and who it was meant for. Policy has the possibility of completing itself in this form of circulation.

**The Powers and Limits of PowerPoint**

There were other channels created by policy’s flow that were more formal, such as conferences, presentations, policy events, and interviews. At the border of the verbal and the material, PowerPoint presentations were prolific in these types of channels, and opened up a space for some, more limited interaction while providing a more structured experience of what policy is. There were a number of political aims of these presentations, and PowerPoint’s aesthetic form incorporated the possibility of a multiplicity of representations, depending on the function it was meant to have and the context or channel through which it moved: Was it meant to instruct? To bring forth participation? To convince? All of these possible functions were part of the political aims of policy, and thus embedded into the aesthetics of the form and the events, or contexts, in which it was the primary form of policy that circulated. PowerPoint as a digital form of policy was iterable and adaptable to all of these different aims, even as it maintained the authoritative structures and concepts of the Proper Name policy. PowerPoint presentations are a common way of circulating information about development projects, in academic environments, and other public spaces. However, a focus on PowerPoint also requires an understanding of the symbolic capital involved in access to the technologies required to make and read PowerPoints, as well as those who have the ability to gain access to the particular contexts through which they are presented.

As such, I question how PowerPoint was distributed socially, and what kind of power there was in actually putting together and presenting a PowerPoint presentation. PowerPoints
allows for the reification of certain ideas, as a technology of communication. It is also a form of communication that occurs linearly, as ideas are presented in a forward moving fashion. While verbal performances provide the possibility for jumping around in time, between ideas, or adapting to an audience, PowerPoint makes this movement and improvisation more difficult. Furthermore, the presentation of PowerPoint also inevitably sets up a power dynamic between the presenter and the audience in terms of the direction that information flows, similarly to the verbal presentation by Jaime discussed above. There is powerful interactional control that occurs when one person, the presenter, can move between and discuss slides, while others are passive observers. The slides give presenters a certain amount of agency and control over the information presented, even if it might not always be their work, but rather the work of their organization.

PowerPoint was also an interactive form through which certain stabilities could be mapped, visually and discursively, while additional dialogue around these stabilities could allow for some of the mutability of the policy to emerge. I look at PowerPoint as a way to examine the relationship between a digital media form of policy and the channels, social practices, and work done around this form. Text, media, event, audience, and presenter all interact, where PowerPoint presentations cannot be understood as merely a kind of text. Coleman calls this relationship between digital media and social practices the “prosaics” of media, borrowing from Bakhtin’s work.

How does PowerPoint, as a digital form, become so embedded into the life of policy’s circulation? PowerPoint can represent policy as a heteroglossia, because it is able to shift rapidly, be reproduced using different words, images, or diagrams, and yet still has an authoritative structure to it. The PowerPoint can cycle quickly through concepts, such as a focus on the history “before” and “after” policy, on statistics that relate to policy, or on specific projects that represent policy. PowerPoint allows for a flexibility to policy, depending on the presenter, the audience, and the context. Coleman writes, “Looking at digital media in similarly prosaic terms means uncovering the lived experience of digital media; discussing the conditions in which they are made, altered, and deployed…attending to particular genres of communication…and finally placing attention on the material and ideological functions produced and sustained by digital technologies” (Coleman 2010: 494). How do PowerPoint presentations articulate, aesthetically, the form of policy? What assumptions are built into PowerPoint as a form? Where will they be intelligible? In many ways, PowerPoint required a framing event or dynamic space in order to circulate as policy. As such, the channels through which this form circulated included the interviews I did, policy conferences, and lectures about policy, all spaces where access to media technologies were readily available and a particular dynamic between the presenter and audience was established through the act of sharing the presentation. I will discuss below some of the spaces and ways I saw PowerPoints as forms of policy.

Countless times in interviews in offices, once the person knew I was doing research on the designing of the “SAFCI policy,” they would pull up a PowerPoint presentation on their computer and take me through it to give me a rendition of the premises of policy. PowerPoint became a teaching tool, one that was used as a way to frame the discussion that followed, to make sure that I knew the authoritative boundaries of the concepts of policy they were going to discuss. These PowerPoints were never exactly the same, and often were decontextualized from whatever their original purpose of creation was in order to instruct me, the researcher. These were provided as the structures to the interviews, though the interviews themselves typically went much deeper in the concepts, stories, and histories of policy. For example, the below image
is a representation of policy that was shared with me in the office of the local department of health in La Paz.

This slide very clearly reflects the drawings in Dr. Tamayo’s journal, with “community” at the bottom, and structures of the healthcare system represented above, as “components of SAFCI.” The aesthetics of these authoritative presentations of policy served to designate the political aims of policy. I was interpellated as the “academic” audience that Dr. Tamayo discussed, and required certain graphs and charts and diagrams to demonstrate policy.

Aside from these one-on-one presentations, I most often saw PowerPoint presentations at the conference and health policy events I attended, as a way to animate policy prior to group work, as I discussed earlier in this Dissertation. At these conferences, PowerPoints were used as a way to coalesce a group around the premises of policy. These presentations were designed in order to make policy intelligible based on and related to the purpose of the event, as well as to articulate the structures of policy. For example, at the conference, Congreso Departmental de Salud: “Con Salud, La Paz, Somos Todos Para Vivir Bien,” an event in La Paz on provincial health policy work, a packet of information was given at the conference beforehand that included copies of the PowerPoint presentations that would be given, that circulated alongside a packet called “Health Situation 2011” which included graphs, flow charts, and while participants walked into the conference a video was shown about “maternal death” and information about how to prevent it. In the packet there was also a copy of relevant excerpts from the Decreto Supremo No. 29601. The event began with a general PowerPoint presentation by Diego Ichazo of the Ministry of Health, on the health care system in Bolivia. In his presentation, the PowerPoint suggested its own contextualization of policy, and manifested specificity: the
presentation was shaped around the specific issues, terminology, and interests of the particular audience, while still representing the key elements of policy. Ichazo maintained the visionary aspect of policy by focusing on the “befores” and “afters” of policy, similar to the dialogue of the policymakers, but in significantly briefer form. Below, the first slide represents “before SAFCI,” stating, in list form, that the focus on health was biomedical, focused only on the mother and child, rather than being integral, centered on the individual, with a focus on curative care. Providing printouts of the PowerPoint slides created a hybrid of the different poetics, as well as an attempt to regulate the recontextualizations of policy.

This second slide of the series, in linear progression, suggests that since 2008, with the implementation of SAFCI, there is a focus on indigenous cosmovision and health care provision focused on the ayllu. Here, it is highlighted that “health is everything” (salud es todo) and “health decisions are for everyone.” What is important to note here, in analyzing these slides, is that when referencing “cosmovision” the slide references, in Aymara, indigenous groups (Kallawaya), types of healers (awichas, machulas), and philosophies (equilibrio, armonia). This presentation was aimed at an audience of indigenous healers, western doctors, and social organizations, and used the PowerPoint as a way to call forth this audience. This part of the presentation created a personal experience for many of the participants at the event, in speaking to them through their conception of what a healer is, what health is, and the possibilities for how policy can be understood.
This presentation also incorporated a collage of graphs and chart and “community”-produced work to demonstrate key elements of policy. In the first image, there is a breakdown of healthcare establishments, all encapsulated under a heading of the “western” biomedical system of healing.

In the next image, within the same presentation, there are examples of municipal health planning, including a “mapeo corporal” or a body map drawn of two different “wawas” or babies that show on one, what is called the “sociocultural epidemiology,” and on the other, the “demands for biomedical care.”
However, while people would be working with the premises of the policy in the *mesas* that followed this presentation during the event, PowerPoint presentations also limited participation in the telling, or relaying of policy, as most often people were passive observers to these presentations. In my fieldnotes, at the end of three long days of PowerPoint presentations at this conference I jotted, “I’m sick of PowerPoint presentations….I want to see it!” By “it” I was referring to policy “in action,” in a space, like the verbal performances of policy, where I could more readily see how people were understanding the form of policy, what they could do with it more actively, and how it could be malleable towards their particular needs. PowerPoint, confined to certain channels and spaces such as offices, events, and presentations, and was sometimes meant to call forth action, such as participation and actualization of policy, fulfilling its aesthetic aims, while at other times it was meant to instruct or circulate a profuse amount of information that seemed to be meant to be absorbed but not worked with more practically.

The replicability of PowerPoint, such as the duplication of slides, and its transferability, such as through email or flash drive, further aided in policy’s reification. The experience of PowerPoint, as an event, is constructed to be interactive, as it allows for people to call out thoughts, introduce ideas, respond interactively to the presenter. PowerPoints were animated in these spaces by the presenters, and by the audience’s interactions with the slides and the presenter. However, the animation was different than the type of animation I saw in the verbal forms of policy in rural areas, where policy’s form was aligned immediately with its political aims, as the presentation of form was meant to call forth political participation. In these conferences, while there was animation and participation by audiences, it allowed for a much more passive experience with the policy. I found that it often involved a one-way dialogue about policy, which mimicked the individualist, top-down form that the policy was aiming to dismantle. In some senses, then, while the content of PowerPoint presentations might reflect the aims of policy and policy’s vision, the form of presentation replicated power dynamics around how information is presented and bounded.
Those Pesky Papers

An understanding of the papers of policy are crucial to my argument about the how these forms of Documents get reified in policy, and how they participate in constructing a broader sense of policy documents that I have been discussing here so far. Further, the physical manifestations of documents in Bolivia also decentered some typical ways of thinking about “policy” as document. The physical materializations of policy were multiple in form. These included the legal document, the teaching versions of policy, and the guide versions of policy. Each of these, in its own way, physically materialized policy as a way to create a channel for its Proper Name instantiation. Its multiplicity of physical forms, as forms, seemed to interpellate the possibility for the multiplicity of users that policy required to be fully actualized. The channel that was created by these materials were channels that interpellated the policy into being by making it something tangible, as Tamayo said, “we can touch it, it exists.” The form as physical manifestation gives it a solidity, a stability of existence that it did not have when it was just based on ideas, before it was systematized. Yet, what challenges this mode of circulation is that it performs a purpose that does not actualize the policy vision: it circulates everywhere and widely, but it is not the form that is most useful. In this sense, there is a disconnect between the forms of policy that are defining and shaping policy, and the forms of policy that the bureaucracy circulates at such a prolific level as important to itself.

For example, the legal document, the Decreto Supreme 29601, is a small thirty-six page blue book called “Política de Salud Familiar Comunitaria Intercultural,” with no images, only legal language and a rundown of articles. Yet, this too was one part of policy’s social life, one form that was juridical and bureaucratic, and co-existed with others. This is the version of policy that would be most expected, as it was the formal, official, legal version. I only received one copy of this version during my entire time in Bolivia, and it was never the version that anyone casually brought out when discussing policy. It was given to me at the office of the Ministry of Health, as if to concretize the stability of the ideas that had been systematized into this form. However, it was not as if this version did not matter; it was continually referenced and discussed in a multiplicity of spaces. In some ways, then, this form of document had a referential liveliness to it, in that it gained its meaning in channels where it was discussed, but not necessarily because of its actual physical form.

Further, this bureaucratic document distinctly emphasized the “beautiful vision” of the utopian policy, and manifested this in its language. This vitality is immediately referenced in the first page of the text in the document, under the “Purpose of the health sector.” This purpose is written as such,

The purpose of the health sector is to contribute to the paradigm of vivir bien and to the eradication of poverty and inequity, eliminating social exclusion and improving the state of health, which the health sector will work towards in conjunction with other sectors of development.

Even in this formal text, the new health paradigm, the vitality and beauty of vivir bien, and the visionary goals of the policy are represented. The document also indexes the story of its own founding, incorporating its own narrative history into its legal pages. It states that the changes to the health care system leading to its production were demanded by the Bolivian Population, and that these changes are the responsibility of the state. This version references, in political language, the shift in health paradigm that was so essential in the making of a policy concept in Bolivia. It also references a kind of attention to notions of difference, couched in the language of Latin American Social Medicine, or the “social determinants of health.” However, none of the
notions of difference in regards to indigeneity that I discussed earlier, involved in the production
of policy, are highlighted in this version. The next section in the booklet focuses on “objectives,
principles, and strategies,” again presented in removed, distanced, legal language, with no
particular audience designated. In this section, the key components of “The SAFCI Policy,” are
elaborated, divided by “article:” community participation, intersectorality, interculturality,
integrality, health promotion, and defines each. This version of policy conforms with the
preconceived notions of a static, lifeless policy document that I came to the field with, and that I
asked the reader to suspend going into this project. This type of conceptualization of policy does
exist and circulate in Bolivia. However, as I noted above, it was not the version that was ever
provided to me in conversations, at conferences, or when I went to places where policy was
being debated and implemented. It was a version I picked up at the Ministry of Health offices, a
tiny little representation of something much more lively and playful.

The other documentary forms of policy that I collected were teaching documents and
guides for policy’s implementation. These forms of representing policy, similar to the verbal
form, incorporated within the teaching of policy the possibility for its own political and practical
implementation. What was most striking about these teaching and guide forms of policy were the
use of graphics as a means to represent policy and its implementation, as part of the vision of
policy itself. Goodwin has written about images and graphics in his work on professional vision,
Most linguists analyzing literacy have focused on the writing of words, sentences, and
other written versions of spoken language. However, graphic representations of many
different types constitute central objects in the discourse of various professions…. A
theory of discourse that ignored graphic representations would be missing both a key
element of the discourse that professionals engage in and a central locus for the analysis
of professional practice. Instead of mirroring spoken language, these external
representations complement it, using the distinctive characteristics of the material world
to organize phenomena in ways that spoken language cannot—for example, by collecting
records of a range of disparate events onto a single visible surface” (Goodwin 1994: 610).
The role of these graphics was to simultaneously present a vision, and structure the terms and
premises of the policy. The actual design of the documents themselves seem to call forth a
specific type of user, most often a community user, based on the ways that they were written and
the different graphics used to represent their ideas. In this way, these forms of policy were
already involved in interpreting what counts as part of its existence.

One of these guides, the didactic version of policy, also created and circulated by the
Ministry of Health, and the material version I was given and saw in circulation the most often
during my fieldwork, is a seventy-six page document divided into sections that lay out the key
premises of policy through questions and answers, pictures, drawings, and charts. Often during
interviews, when a person would explain the premises policy to me, this is the version they
would show me, either in hard copy or PDF. I look here at the 2009 Didactic Version of Salud
Familiar Comunitaria Intercultural: Documento técnico—estratégico, which explicitly states
who the “user” of the document might be: “This document aims to inform health personnel, local
health directories (DILOS), social leaders, and others about Salud Familiar Comunitaria
Intercultural.” In order to examine this version, I look at three graphic images from the guide in
order to explore some of the aesthetics of this form of policy, and the types of stabilities and
mutations it creates.

The first image, below, appears above the first full page of text of the document. It poses
the question “What is salud familiar comunitaria intercultural?”
The images of the Bolivians’ faces that appear next provides a representation of plurinationality and difference by showing a multitude of indigenous people. This image also suggests a certain perspective, from those who circulate the document, about who the recipients and users of policy should be. These users are those who make up the “revived” Bolivia. Their cultural difference is portrayed through the clothing they wear and the differences in their faces. Age and gender difference are also represented in the image, suggesting the “family” and “community” premises of policy. This version of policy incorporates these types of images to represent different indigenous groups in Bolivia throughout the pages, interpellating audiences who associate with the politics of indigeneity in Bolivia. Just as the origins of policy aimed to represent a spectrum of Bolivia’s cultural diversity, so too has this vision been incorporated, graphically, into some forms of policy. However, if the intention is to aesthetically represent the political vision in this form of policy, then image must be privileged, as these versions were all circulated in Spanish; I never saw a single version of policy written in the language of the different indigenous groups of plurinational Bolivia. Rather, visual representation and graphic diversity seem to be the solution to “speaking” to everyone, to interpellating diversity. At the same time, then, that this imagery interpellates a specific kind of user, it also cuts this user off, as the text of the document makes certain assumptions about literacy, the ability to access these documents, and the ability to see oneself in the image.

Images in these documents also stabilize certain concepts that I have already discussed, such as “family,” “community,” and “person.” The diagram below represents these stabilities, which also were inscribed in Dr. Tamayo’s journals, as well as in Jaime’s talks. The person, as an individual, is represented even though the idea of the individual in healthcare was critiqued by the Ministry of Health team. It is not surprising at “the person” is represented with a western doctor, “the family” is represented with indigenous clothing, and the community has a mixture of both.
The final image, below, defining “interculturalism,” separates traditional medicine from western medicine, which is actually very distinct from the articulation of the two medicines that policymakers discussed as they defined interculturalism. The image continues to maintain these in bounded spheres, rather than representing interaction. It separates traditional medicine from western medicine, which is actually very distinct from the articulation of the two medicines that policymakers discussed as they defined interculturalism. The image continues to maintain these in bounded spheres, rather than representing interaction.
All of the material documents I have discussed so far have one thing in common: I was presented these materials during interviews, I saw these guides scattered around bureaucratic offices, NGO headquarters, and handed out at conferences. However, I rarely saw the document being used by people implementing health care provision, or in discussions with the doctors, nurses, midwives, or community members involved in practicing some of the models that these documents expressed. Rather, the most common communication of concepts having to do with policy in practice involved the use of voice, a “form” of policy that had its own aesthetic features. Sometimes these vocal performances were near-exact replications of the words and ideas contained in the documentary forms, while other times they involved a other tools, including storytelling, creating examples, using captivating intonations, or religious-like call-and-response speech-making.

I was curious about this irony in the proliferation of documents and the uneven use of these forms. I spoke with a doctor from Santa Cruz about this issue. He told me, “SAFCI is a necessity. While many of these programs existed before in my area, the ones that were implemented did not have the legal framework (marco legal). Now they have the legal backing as a mandate to implement the care required through the policy. However, it has been difficult to implement. When we read the documents from the Ministry of Health, the translation of these documents into practice is not well defined, and they don’t always correspond with what we are doing. Instead we have workshops to clarify things, because the local health authorities,
municipal coordinating directors, and the Ministry all have different interpretations of the concepts.”

Conclusion

The co-existence of all of these forms of policy, circulating some of the ideas of policy, demonstrated an aspect of the mutability and iterability of policy, and the attempts to make policy intelligible as it circulated through and manifested in a number of different channels within Bolivia. A certain story was told about policy by all of the different forms, and by the channels through which they circulated the most fluidly, and those where they got held up or their movement was blocked. The utopian vision of the originary process that there is a Sistema Único de Salud, but it is also a reparation of the past, where beauty is in the reparations of the past. This creates a discordance for the circulation of policy, as it was made more intelligible and usable for some, rather than others. The language of beauty, of reparations was used by policymakers, and they believe in this language, even though it is not possible the way that policy circulates, with the failures built into it. What does it mean that the form can circulate this beauty, but the content does not exist in the same ways in the same places, or allow for the same interactions? There is still something to be learned from understanding the appeal of the form. The policymakers and Bolivians and NGOs and international communities know it is unequal and not upholding these standard that they wrote but everyone still feels like it is really important to spend time and energy on. Part of the exercise behind analyzing the forms that emerged around and out of the conception of policy developed in Bolivia is thus to see and understand the audiences generated by certain ideas, and the forms that gave them shape and tangibility and why they exist in such a way.

Further, as distinct as these forms of policy were, within all of the policy forms that circulated, certain aspects of policy were stabilized that were seen as required for policy’s implementation, while simultaneously trying to represent flexibility. These stabilities and mutabilities were some of the features that policymakers had built into the policy, and represent that tension between authoritative structures and adaptability. Some of these stabilized entities included framings of the community, the individual, the family, and indigeneity. These stabilities were produced in a variety of ways. I looked here at some of the stabilities produced through policy’s form: the ways certain units are defined and represented as the foundation for the healthcare system, the framing of indigeneity and difference through images. In many ways this seemed to be quite a linear, top-down way of implementing policy, through these documents that stabilize. There was a vitality in the fact that it needed to get its life-force from so many different approaches and forms, that it was infused with liveliness because of where it was able to travel and how, its aesthetics, and its audience. The multiplicity of versions, representations, and forms that policy was represented through in is important for reception and the “vitality” of policy—these keep it alive for some, and replicate the vitality that the policymakers infused into the document for those that the reparations were aimed at.

While paper policy Documents can seem enchanting to us, and there are specific reasons why they were produced, there is something lost if we only stay with a document of policy. There is no policy just in a document. Throughout this dissertation references to a number of ways of communicating policy have circulated: documents, texts, voices, PowerPoint presentations, journals, flash drives. What is really most constitutive of the structures that made them are the oral/presented forms of policy, not the documents- they do not speak unless they are
spoken, even though the policymakers claim that they are written, they can be touched, and there is a proliferation in an attempt to make them circulate as documents which are standard bureaucratic forms. But the making of policy was one that was generative of the verbal, the story, the memory. In the same way, even as they attempt to put this multiplicity into documentary form, they require the personalities to express them - through two forms in particular, PowerPoint and Oral presentation. That is how they came alive. Through Tamayo’s pages too, policy emerges in a written form, just a jumble of notes, but the audience is made in the stories around them. Some of the stories produce the bureaucratic categories of the document, and reflect the document—such as the making of indigeneity, community, mother, etc. This is thus not about what documents do, but about what they cannot do when the policy itself emerged from so many different forms. Successful policy was when policy was constructing a notion of policy itself in practice, where policy was constantly being made as part of the manifestation of its form. Reproducing the policy, then, becomes part of this process of constructing policy and making it recognizable, understandable, and usable as policy.

Conclusion: Expanding the Scope of the Anthropological Study of Policy

Policy as a Vital Form

My study of the making and circulation of health policy in Bolivia was full of stories of great sorrows and discrimination, stories of loss, as well as the sharing of treasured memories, playfulness, collaboration, and beautiful visions. All of these became part of a concept of “policy” in Bolivia. The idea of a “beautiful policy” in particular was tied to ideas about reparations. A “beautiful policy” was an attempt to address the violence and suffering of the past. Health policy was seen by some to offer a way forward, a way out of this past into a future framed by a revolutionary approach to a paradigm shift in health and healthcare. To write of the affective, memorial, personal lives of policy and policymakers requires taking seriously the language people used to write and talk about policy, and how these were infused into policy and its circulation. Drawing attention to words and forms that circulate, in this case a multiplicity of forms, and notions of revival, rescue, living well, utopia, and difference, was central to this project. These ways of understanding and studying policy and policymaking expand the ways we might think about what policy is, how it is made, and what it can do. A study of Bolivia’s health reform policy in particular provided a significant site through which to study the expanding scope of health policy and policymaking. Here I was able to study policy at its limits, which also means grasping its limitations.

However, I want to suggest in this conclusion that a study of policy and policymaking in Bolivia, and, in fact, the creation of a cultural biography of policy itself, can contribute more broadly to anthropological and public health approaches to the study of health policy. The anthropology of public policy has become an important focus in anthropology, and it is an area to which medical anthropologists have contributed substantively. Focusing on the authority and expertise of policymaking to govern local populations (Fassin 2007; Briggs & Mantini Briggs 2003; Greenhalgh 2005; 2008) or on the impacts of the implementation of policy (Biehl 2004; 2006; Horton & Lamphere 2006; Lamphere 2005), scholars have generally viewed the making and implementation of health policies as distinct phases that are organized in a linear fashion. I have built on this work, and am indebted to the scholars who laid out these foundations for recognizing the importance of critical analyses of policymaking processes and policy
implementation. Through my research I aimed to build on the work of these scholars, as well as to work to significantly advance anthropological understanding of one of the major policy issues of our day, health and health care reform. My research itself built on calls for genuinely ethnographic approaches to policy study by looking both “upstream” at the making of policies as well as “downstream,” to adopt current spatiotemporal metaphors, at the circulation of their logics, how they are implemented, and their effects on health care and health conditions.

Reflecting now on what strikes me as most significant, I identify two interventions. Firstly, I have contested the notion that policies are abstract, boring, mechanistic, and static, suggesting that it is not only through implementation that they gain social embodiment, but also through their “making.” The social lives of policies begin long before they are even formulated and formed as policy, in the histories, memories, debates, experts, and theories that lead to their design and production in the first place. These origins have fundamental impacts on policy’s circulation. Furthermore, I have argued that we cannot so clearly delimit the boundaries of policy “making” and policy “implementation,” as policies have no singular origin, and are constantly being remade and iterated in different ways as they encounter difference, mutating at times, and hitting up against the authoritative structures that impose understandings of policy at other times. Through this work, I have disrupted the oft-reified boundedness between “phases” of policymaking and policy-implementation, suggesting that these are perhaps more an imposition of policy analysis and the ideological framings of what policy is understood to do and who is understood to be able to work with it than about what happens in everyday processes and practices surrounding policymaking. What if we see these as processes that begin long before the formal writing and enactment of policies and that continue to unfold throughout the social life of a policy in practice? As such, I have examined the origins and mutations of policy as a way to propose and theoretically frame these new analytics for the study of policy. But what do these analytics actually do for us, when thinking about the study of policy, more broadly? My examination of the collaborative making, revision, and implementation of policy in different sectors of the health care system has demonstrated that these areas are intricately enmeshed. Policymaking is not just about producing Documents but also about managing its multiple forms of representation, its discursive reproduction, and its adaptive implementation, for example, through trainings, workshops, and pilot studies. Revisions and new understandings of policy were produced based on the gathering of measures of success that never even refer to statistics or economic modeling. This approach continually aimed to not take policy itself as a given, but rather looked at the contingent relationships and dynamics that exist between a focus on a policy’s production, the actors involved, and the unevenness that emerges when health policies circulate.

Policy, in the way that I propose anthropologists might study it, can be understood as a vital form. It does not just emerge from a series of linear, mechanistic, depersonalized steps and scientific or economic justifications, but rather, from what is projected as the life-force of a nation and a nation-building project. In Bolivia this vitality was folded into the poetics of the policy, through the notion of vivir bien and a discourse of life and living well. Yet, health and healing everywhere are about life and living, living well or living as best we can. Deleuze discusses vitality as opposed to mechanistic approaches to creating. He writes, “Creating isn't communicating but resisting. There's a profound link between signs, events, life, and vitalism: the power of nonorganic life that can be found in a line that's drawn, a line of writing, a line of music. It's organisms that die, not life. Any work of art points a way through for life, finds a way through the cracks” (Deleuze 1995: 143). Might we see policy in this way? As a work of art that
must be understood as something designed with particular ideas in mind, through particular personalities, and able to create particular channels and interactions through its circulation? Policies everywhere, are, in some way or other, about addressing the past, and offering a way out, or at least a new or different way forward into the future. In Bolivia this was done through the manifestation of a utopian vision as a departure from the past, and an attempt to create the impossible through everyday practices. Policy in this theorization is a living form, alive with stories, histories, memories, and alive in that it is meant to create. Furthermore, I have argued that policy does not have predetermined boundaries or sites where it must be enacted, debated, circulated, or discussed. In creating a cultural biography of policy, I reject the boundary between an abstract and decontextualized “policy” as a set of principles or institutionalized terms against “implementation,” where policy gains embodiment and shape and form. I rather suggest that we need to expand the scope of how to study policy, where policymaking takes place, who policymakers are, and what policy itself is.

Other Places, Other Policies: The Affordable Care Act

I am also interested in larger questions about policy, about how things get to be called policies, and how that impacts their social and political lives. I have already undertaken the task in relationship to the SAFCI policy in Bolivia. Here I want to suggest that the way I am proposing that how anthropologists study policy can be useful for understanding other policies in other places. This exercise can help us see aspects of other policy debates that otherwise would not be readily visible, such as where we might identify attention to aesthetics, affect, and identity, and what happens when these elements get left out of policy processes and debates. Further, this exercise can tell us something new about policy that builds on the work I have already done in examining the SAFCI policy in Bolivia, for example, in regards to how competing or oppositional parties both understand “the State” to be made in particular ways through policy. The way I analyzed SAFCI might allow us to see how policies are made so that we can understand better why they take the form they do, what actors are involved, and how they are shaped as they circulate.

The United States, for example, has its own recent stories to tell about health reform policy. I bring in a discussion here of the Affordable Care Act (ACA) not as a benchmark against which to measure the Bolivian healthcare reform and health policy, but rather as another example. The United States health reform and the ACA policy emerged from a government discourse about issues surrounding healthcare exclusion and affordability. Coupled with rising healthcare costs and expenditures, these issues prompted health reform efforts and the designing of the United States health reform policy. I suggest that the analytics that I have proposed to expand the scope of the study of policy might illuminate some of the debates, tensions, and circulation approaches of this and other policies, as well as help us to understand practices and approaches surrounding policy’s iterations and implementations. In thinking through the ACA, I was also particularly struck by the words that a conference participant in Bolivia once spoke to me. During an informal conversation, we were discussing the similarities and differences between the United States and Bolivia in regards to health reform efforts. He suggested that the United States would do better to look to Bolivia as a model for healthcare reform, as, in his words, its national populations are “multicultural and diverse like Bolivia.” He told me that the United States would benefit from paying more attention when dealing with health reform efforts to issues of class, race, and history that the Bolivian health reform policy incorporated. This
approach would be helpful in order to account for the variety of health and healthcare needs, the multiplicity of ways of thinking about and understanding health, the different languages spoken, as well as issues surrounding access to healthcare. This comment complicates racialized geopolitics that tend to frame “the North” as a model that should be adopted by “the South,” reifying problematic ways of thinking about knowledge flow. There is a parallel in this geopolitical construction of how knowledge might travel to models of health coming out of Latin American Social Medicine and critical epidemiology. These approaches provide models that emphasize new ways of thinking about health disparities in general. While work by Howard Waitzkin (2011), for example, does bring Latin American approaches to health and healthcare in the United States, much of the scholarly work on healthcare outside of Latin America does not incorporate these perspectives.

Indeed health disparities in the United States can be connected with long struggles with issues around healthcare provision: a large uninsured population, long histories of racism, immigration debates, minority and low-income populations that have differing and uneven access to healthcare services, and monumental disparities in quality of care and access to care between the public healthcare system and the employer-supported and private sectors. The standard story, one that emerged from the bureaucrats and policy scholars involved in designing the ACA tells us that, for example, based on US Census Bureau reports, the uninsured population in the United States at the time that this law came into effect was 47 million (Krueger & Kuziemko 2011). Further, this uninsured population is not static or homogenous, with studies showing that there are both chronically and transitionally uninsured people in North America. The uninsured are less likely to have access to quality care, and are less likely to elect to seek medical care, whether for preventive services, or for chronic or acute illnesses, and are more likely to have serious health implications due to their insurance status (Hoffman & Paradise 2008; Dow et al. 2013; Rowland et al. 2008; Ayanian et al 2000; Carrasquillo et al. 2004). The uninsured population puts pressure on the healthcare safety net, their primary source of medical care, and has led to rising costs in the health care system. While these statistics and public health accounts provide important information about why health policy reform was necessary, there are stories, histories, and particular constructions of “policy” itself that also comprise the origins of this particular health reform policy in the United States.

Making policy always involves making pasts, presents, and futures, and I have suggested that health policies typically involve plans to replace or revise existing systems, whether through new approaches to health care coverage, health care access, or health care payment. In formal policy analysis, these visions are often framed around economic analyses, policy modeling, and projections. These projections question whether policy will be effective in implementation, in other words, projecting the social life of a policy as involving a linear transition from two opposing states. But what other visions are part of policy’s founding premises? For example, Title 1 of the ACA, the United States health policy, is entitled, “Quality, Affordable Health Care for All Americans.” It reads:

This Act puts individuals, families and small business owners in control of their health care. It reduces premium costs for millions of working families and small businesses by providing hundreds of billions of dollars in tax relief—the largest middle class tax cut for health care in history. It also reduces what families will have to pay for health care by capping out-of-pocket expenses and requiring preventive care to be fully covered without any out-of-pocket expenses. For Americans with insurance coverage who like what they
have, they can keep it. Nothing in this act or anywhere in the bill forces anyone to change the insurance they have, period.

Embedded in this statement are ideas about the type of society envisioned: people will have control of their health care, reduced costs, freedoms to choose their health providers. From Bolivia to the United States, and anywhere else engaged in healthcare reform, anthropologists and others must question what happens when health policy institutionalizes certain notions of health and healthcare, and the frameworks and structures through which these might circulate, take new form, and be understood and implemented. I have argued for the importance of not taking for granted certain forms of policy or certain ideas about what policy is, how it works and moves, or how it can be analyzed; rather I have looked at policy and policymaking through the analytics of temporality, utopias, aesthetics, mutations, and beauty.

The ACA, with its own political and social biography, is notorious for its complexities, and for its excessive Documentary form weighing in at 1,200 pages. As this number of pages was constantly recirculated by critics, it seemed to negate the notion that the ACA could ever be characterized by an aesthetics of policy. It is also known for the many debates surrounding its making and implementation that continue today. When the policy was designed, the Obama administration maintained an approach to policymaking that relied only on experts, rather than incorporating public participation. The “befores” to policy that they shared focused on healthcare exclusions, affordability, and cost-savings. The areas of policy that I explored in relation to the Bolivian SAFCI policy included aesthetics, affect, and identity. Yet, these areas were not part of the discussion or process of policymaking surrounding the ACA; the focus was rather on issues of how to deliver quality care to the most people at the least cost. This approach was based on economic modeling and a market-based approach to healthcare delivery. Yet, there were many debates surrounding the policy that have created a politically volatile space around health policy itself as a form. These debates in particular have emerged from the Tea Party’s participatory movement against government health policy, who viewed the ACA as the imposition of big government regulation, and another battle to be won against the left-wing, which demanded a single-payer system. The federal administration and bureaucratic actors that helped design the policy had not anticipated these reactions, as their understanding of policy itself was limited to creating the Document, not what would happen to the policy and the concepts it carried with it as it circulated. Yet, my work on the aesthetics of policy suggest that processes of implementation actually define policy, rather than just an abstract text.

Thinking about the ACA in this way raises questions about how making policy also makes certain notions of “the State” (Gupta 2012). The kind of state that politicians like Obama aimed to create through the concept of policy represented through the ACA was of a care-giving state that could rationally address issues of social welfare. Yet, the same discussion was framed by oppositional actors, who used the healthcare policy to frame the state as one that was using its strength and size to control the population. These two competing forces came from very different perspectives, yet both offered ways to think about how “the State” was made through the ACA both saw health policy as a site where the state might be constructed. When considering the ways that “the State” was conflated with the expertise involved in health policymaking, the ACA debates thus also raise questions about the circulation of policy and of who is authorized to weigh in on the debates.

Briggs and Hallin (2007) explore this issue in their discussion of “biocommunicability.” They suggest that communicability allows scholars to understand “How effects of power emerge from everyday ideological constructions of how information is purportedly produced, circulated, and received, how individuals and institutions participate in
this process, and how statements are infused with authority and value” (Briggs & Hallin 2007: 45). When circulation occurs in relationship to issues of health, it is called “biocommunicability.” Particularly, these terms are useful in looking at the role of communication in how power works. The way that policy was communicated from the Obama administration suggested that it was a debate relegated to bureaucratic policy circles, not to the citizens of the United States. It was only meant to reach the population through its dissemination, or a concept of “implementation” that the government was working with that assumed that the ACA as a supposedly fully-formed “object” could be implemented without having impact on the concept of policy itself. Yet, resistance parties to the ACA argued that the debates should not solely be left to the policy experts, but rather should allow citizens to participate. This approach made policy experts out to be part of “big government,” pitted against the “public.” Biocommunicable models as much as the specifics of healthcare policies were subject to debate.

A Return To Bolivia: Continuities and Change

I must end with an obvious confession: these stories of policy, as beautiful or full of vitality as they may be, do not always go as planned, representing the continual ways that differently situated actors, new mutations, and new iterations are always at work in constructing notions of policy. In Bolivia, as things go, new Ministers of Health have replaced the old, and the priorities of the Ministry of Health have changed. Specifically, following two ministerial overhauls since my fieldwork (one due to a corruption case), Salud Familiar Comunitaria Intercultural is no longer the central focus of the entire Ministry of Health, and it has been relegated to one department of the Ministry, while others are taking different approaches to healthcare provision. Updates I receive from friends, a research assistant, and through a proliferation of social media suggest that there has been a return to a focus on more linear, curative approaches to healthcare provision: vaccination campaigns, improving health statistics, purchasing ambulances, and curing illness are all approaches that are circulating now on the Bolivian national political and representational stage.

Those currently working in the health sector in Bolivia have suggested that the SAFCI policy has struggled to circulate as widely as hoped due to lack of continuity in the Ministry of Health, and the differing priorities of new Ministers. Resource constraints also continue to be an issue in the implementation of the health policy. USAID provided 40% of expenses in health in Bolivia, but after USAID left this had to be covered by the Bolivian government, which was unable to fully assume this expense. However, I am also told that certain elements of the policy are still being actively pursued: sixty residents received Masters degrees in SAFCI in 2011 through the Juan Misael Saracho University in Tarija, a public university; the carpeta familiar, or medical records, of populations in rural communities is expanding to new sites and in continual use; and more rural communities are actively participating in the health sector by taking part in meetings and decision-making processes. The current national coordinator of Médicos del Mundo in Bolivia, in particular, focused on the successes manifested through the production of new documents, suggesting that a study based on four years of work between the NGO and the Ministry of Health has been validated as an “operational tool of SAFCI” by the Ministry of Health. This document is called “To the Articulation and Complementarity between Traditional Medicine and Academic Medicine within the Principles of Interculturalism of SAFCI” This document, he explained, is important because it will guide the health workers in other regions of Bolivia to continue working on the premises of SAFCI despite what happens in the Ministry of Health. My account of policy suggests that even with these changes, which seem
to have conventionalized this exceptional policy biography, there are still reverberations in the immaterialities of policy’s foundations. It still lives in the minds and work of many of the people involved, and it still circulates because its origins were never bound to any law or document, but rather preceded policy’s materialized form.

All of these elements of policy—its continuities, changes, and troubles— all become part of a concept of “policy,” and are all, I suggest, in need of anthropological study. Anthropological study of health policy allows us to ask important questions: How might we begin to think of health policies beyond a one-size-fits-all model? What conglomeration of actors are involved in producing policy and how does that impact its design and circulation? How might underserved people be recognized and incorporated into health policies to make healthcare more equitable? What measures of success might we use that go beyond statistics and modeling? What do stories of policymaking and implementation tell us about policy as a modern form? An anthropological study of policy expands the scope of policy by requiring us to look at its material and immaterial social lives, its mutations and boundaries, its iterability, and its multiplicity. Policy has a vitality, affect, and aesthetics expressed through this mutability, whether it is thriving or struggling, continuous, or not. Policies are, and should be studied as inextricably in relationship with and connected to particular people, places, histories, memories, practices, and affect.
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