“No Saldrá Eva de la Costilla de Evo”¹:
An Analysis of Gender and Health in Evo Morales’ Bolivia

Alli DeJong
March 23, 2015

ABSTRACT

The election of Evo Morales in 2006 signified an era of radical social politics in Bolivia. Morales’ decolonial rhetoric suggests that by empowering indigenous identity, all other groups previously excluded from adequate health care by the colonial state will also be empowered, leading to the restructuring of the health system in a more inclusive, culturally sensitive, and efficient way. Race and gender converge in Bolivia to place indigenous women at the intersection of Morales’ promise of gender and racial equity. But the health of indigenous women has not improved, and the promises of Morales remain unfulfilled. Through an analysis of Bolivia’s historical legacies and current policy, this paper concludes that Morales’ decolonial paradigm misspecifies the root of gender inequality. Rather, gender inequality has more essentialist and dynamic roots that must be addressed in their own terms.
Upon his election in 2006, Bolivia’s first indigenous president Evo Morales ushered in a wave of radical indigenous politics in Bolivia. The most unequal country in Latin America, Morales and his party, *El Movimiento al Socialismo* (MAS), which began as a movement to defend the interests of indigenous coca-growers, sought equality for Bolivia’s most marginalized. Specifically, MAS granted indigenous communities and women rights to universal, intercultural health reform based on indigenous values and conceptions of well-being, as codified in the 2009 constitution. In doing so, Morales has embraced a decolonial framework, which suggests that by empowering indigenous identity all other groups previously excluded will also be empowered, leading to the restructuring of the health system in a more inclusive, culturally sensitive, and efficient way.

Race and gender converge in Bolivia to place indigenous women at the intersection of Morales’ promise of gender and racial equity. For example, the preamble to the constitution states that from the indigenous movement, Bolivia will “construct a new state in the memory of our martyrs respect and equality for all, on principles of sovereignty, dignity, interdependence, solidarity, harmony, and equity.” Specifically, the constitution establishes that women have the right to a safe maternity, with inter-cultural practice and vision (Article 45) and the exercise of sexual and reproductive rights (Article 66).

However, despite health sector reform, these promises remain unfulfilled. The implementation of Morales’ health policies has produced unequal results. Though health indicators have improved as a whole, the health of women and particularly indigenous women remains extremely poor. Despite a 61 percent reduction in maternal mortality from 1990 to the early 2000s, maternal mortality rates have increased gradually since 2003 and are three to four times higher in the most indigenous municipalities. Indigenous women continue to face the highest levels of infectious disease, malnutrition, and have the lowest
access to reproductive health services than any other population in Bolivia (DHS 2008; Amnesty International 2011, USAID 2012).

This paper explores why indigenous women, who sit at the intersection of Morales’ big promises, have been left behind in Bolivia’s new development model. By applying an intersectional lens to Bolivia’s health reform, it becomes apparent that Morales’ decolonial paradigm does not account for the way that multiple forms of identity converge to make one individual’s (i.e. indigenous women’s) marginalization qualitatively different from another’s, even of the same race (i.e. indigenous men) or gender (i.e. non-indigenous women). I argue that MAS has misspecified the root of gender inequality—by applying the lens of colonialism, problems have been misdiagnosed and state responses inadequate. Ultimately, gender issues necessitate greater differentiation that can’t be watered down or encompassed by the amalgam of indigenous politics. Rather, gender inequality has more essentialist and dynamic roots that must be addressed in their own terms.

Identity Politics

By conceptualizing gender through a decolonial framework, MAS brings into stark contrast liberal ideals of individual rights and cosmopolitanism, most often associated with gender equity and feminism, and communitarian values promoted by indigenous worldviews and the Bolivian state. Most importantly, this comparison illustrates that the two frameworks utilize drastically different interpretations of the root cause of gender inequality. Liberal feminism argues that patriarchy, independent of time and geography, is the root of gender inequality. Decolonialism, as the name implies, sees colonialism as the root of gender inequality in traditional culture. This seemingly small theoretical distinction has profound implications for the policies that they produce.

Liberal feminist scholars urge that instead of grounding ourselves in specific
communities or contexts like culture, we must recognize a universal standard of rights and justice that is not dependent on political or cultural boundaries. To achieve this ubiquitous standard, the state must promote global citizenship rather than cultural citizenship (Okin 1999; Widmark 2007; Sen 2006; Appiah 2006). In one of the most well-cited, yet controversial, iterations of this view, Okin (1999) argues that the promotion of culture in state society inherently harms the well being of women because traditional cultures are the origin of patriarchy. While Okin’s view represents the most condemning interpretation of traditional culture, liberal feminists largely agree that the root of gender inequality is patriarchy, which has existed universally, in every culture, since the beginning of society, preceding colonialism and the formation of the modern state (Okin 1999; Widmark 2007; Sen 2006; Appiah 2006). Therefore, while colonialism certainly did introduce its own version of gender hierarchy, each culture is uniquely patriarchal. Thus, according to the process depicted in Figure 1, which shows the linear progression of patriarchy through time, removing colonialism only disrupts one input into gender inequality, but doesn’t disrupt the causal chain as the link between patriarchy and culture remains undisturbed.

By contrast, decolonialism sees the promotion of traditional culture as a useful tool for extending rights to all marginalized groups in society (Madrid 2008). According to MAS’s rhetoric, by empowering indigenous identity, all non-colonial identities (including women) are also empowered. “Internal colonialism” in Bolivia refers to the socioeconomic and cultural domination and racism historically exercised by criollo or white governing elite that relied on the assumption of European superiority. Decolonization, thus, suggests the dismantling of “internal colonialism” and the overthrow of the elite in order to promote indigenous ideas of well being and to free marginalized groups from hegemonic rule (Johnson 2010).
The rhetoric of decolonization, thus, suggests that patriarchy is a symptom of the
colonial state—the only reason that there is a gendered hierarchy in Bolivia is because
colonial elite introduced it. According to this view, removing colonial power disrupts the
causal chain depicted in Figure 1, dissipating the foundation of patriarchy and removing all
inputs into gender inequity. As one Indianista-Katarista activist and mail yatiri (shaman)
explained in an interview with Burman (2011):

   It’s because of the machistas. It has come from the Spaniard: Men have to be leaders,
   women have to be inferior… This is not ours, it’s Western; of course they brought it
   here. Now the whole world works like this (Burman 2011, 74).

In accordance with this viewpoint, empowering indigenous groups (the ultimate target of
colonialism in Bolivia) will also repair the inequality inherent in a patriarchal system (Figure
1).

Canessa (2010) asserts that the assumption that politics of indigenous liberation
could automatically emancipate women ignores the gendered nature of colonial domination
(Canessa 2010, 178). Many scholars contend that the colonial and post-colonial subjugation
of indigenous cultures was driven by the ideological feminization of Indians (Canessa 2010;
Zuwalski 2007; Postero 2010), therefore, it is impossible to separate a process of indigenous
liberation from its gendered roots. Frameworks that attempt to do so, will engage in an
inherently masculinizing liberation process, and rather than remedy gender inequality, will be
predicated on the increased marginalization of indigenous women (Canessa 2010).

Viewing patriarchy as progressing linearly from its “origin”—however that is
defined—to its present day form necessarily overlooks the ways that cultures interact and
exchange values through political, economic, and social means. According to Song (2007)
minority cultures inevitably incorporate some aspects of majority norms as they are brought
into and governed by the state. Isolating patriarchy to a single origin, therefore, “overlooks
the polyvocal nature of all cultures and the ways in which gender practices in both minority and majority cultures have evolved through cross-cultural interactions” (Song 2007, 78).

The dynamic nature of culture and identity that Song (2007) begins to illustrate is best captured through the concept of intersectionality. An intersectional approach to identity asserts that social differences are not reducible to a single axis, but instead intersect to create a dynamic and interlocking cultural system, which organizes and gives meaning to one’s place within the social and political hierarchy (Ewig 2010; Htun and Ossa 2013; Paulson and Calla 2010). In contrast to homogenizing and competing notions of gender and ethnicity, intersectionality sees ethnicity and gender, along with class, age and sexual orientation, as overlapping elements in the construction and negotiation of identity and power within society (Paulson and Calla 2010). Thus, intersectionality refers to the ways in which social positions overlap, making the experiences and needs of an indigenous women qualitatively different from a white women or and indigenous man (Ewig 2010). In particular, intersectionality reveals the gendered nature of race and the racial nature of gender.

Identity as a Political Platform

Yashar (2005) offers a useful framework through which to view MAS’s institutionalization of indigenous identity and the implications it has on state policy. According to Yashar, states play an active role in the formation of identity categories by privileging certain political identities through citizenship regimes: states decide “who has political membership, which rights they possess, and how interest intermediation with the state is structured” (Yashar 2005, 6). Thus, it is the state that fundamentally defines the official terms of identity, a definition that may or may not reflect the actual nature of that community or their associated political and social needs.
Albro (2010) refers to the process of institutionalizing identity as a process of making identities “legible.” By this, he means the state’s use of legal language and political distinctions in order to formalize identity for the creation of policy. This process has largely occurred in Bolivia through the process of constitutional ratification in 2009 in which certain indigenous traditions, worldviews, and ways of living were codified, and where many scholars argue an Aymara-centric—the highland indigenous groups where MAS originated—version of indigeneity was institutionalized (Postero 2009; Albro 2010; Grisaffi 2010; Canessa 2012). Indigenous identity has also been formalized through the promotion of a national culture, evident in the institutionalization of certain indigenous celebrations or ceremonies, which usually only represent a small subset of indigenous cultures (Postero 2009). Canessa (2012) labels this as the “invention of tradition” by Morales and MAS. This is to say, that indigenous identity as employed by the Bolivian state, is far from primordial, but rather a constructed, politicized, and generalized version of the numerous diverse and differing indigenous cultures of Bolivia.

By asserting that all native peoples share similar cultural values, Postero (2010) argues the state engages in a process of essentializing what are actually complex and ever-changing ethnic formulations, a process that produces what Song (2007) identifies as the “problem of internal minorities.” Making an identity politically legible exaggerates the degree of consensus and solidarity within a group. Vulnerable subgroups within minority groups (including religious dissenters, sexual minorities, women and children) are often overlooked and ignored in the state’s policy formation (Song 2007). Furthermore, prizing one version of indigeneity over another (i.e. highland culture over lowland culture, or rural indigenous women over urban cholos) creates a hierarchy of representation in which one group’s cultural values are prioritized at the expense of another’s. So, while this policy is
suited to address inequality between cultural groups, it also has the potential to exacerbate the inequalities within minority groups by not addressing existing cultural norms or communal systems that lead to the subjugation of vulnerable subgroups (Canessa 2012; Song 2007). Thus, policy suited to dismantle the colonial state and promote indigenous identity is not the same policy that can adequately address gender inequality.

However, recognizing the hierarchies within culture can require a critical stance towards values and traditions held by that culture. When faced with the conflict between interculturalism and a critical analysis of gender relations (or any aspect of indigenous culture) a common response among government authorities, indigenous representatives, and some scholars has been to prioritize respect for indigenous traditions, at the cost of addressing issues of gender (Burman 2011; Lukyx 157). An assumption associated with this view is that interculturality (and a respect for culture more broadly) necessitates the unconditional acceptance of all that culture entails, thus making critical analyses of gender relations unnecessary and even contradictory to the empowerment of indigenous culture. Instead, Burman (2011) asserts that to understand the cultural and political dynamics at work in the subjugation of indigenous women in Bolivia, one must move beyond preconceived notions of “western patriarchy” or “indigenous complementarity” and simply try to “address and take seriously social and political processes as they are experienced, lived through, resisted, catalyzed and explained by women and men” (Burman 2011, 89).

In order to demonstrate the gendered implications of Bolivia’s new model of governance, this paper will conduct a longitudinal study that focuses on the process of change and what is left unchanged by Morales’ healthcare reforms. It will utilize Christina Ewig’s policy legacy approach that recognizes the historical roots of the intersection between gender, race, and class and the policies that have reinforced them (Ewig 2010). A policy
legacy approach assumes that prior policies and their corresponding interests create politics that feedback into and necessarily constrain contemporary social policy reform (Ewig 2010, 9). Understanding these legacies as defending a particular class, gender, or race interests help to reveal the broader interests that are at stake in policy reform periods—these are not just struggles over particular policy choices, but struggles over power and privilege. Looking at current policies through a historical lens is especially important because of the decolonial project of the state—we cannot understand a project that is aimed specifically at deconstructing historical patterns of dominance without looking at what those historical patterns were.

Using this framework, this paper will first examine the historical roots of indigenous and women’s health and health services in critical moments of Bolivian history. It will reflect on the degree to which the reform process reshaped prior legacies and may have created its own political legacy. Applying a gender-based analysis of health and health policy, necessitate an analysis of men and women’s distinct social roles, the balances of power between them, and how these affect their physical and mental health profiles (PAHO 2004, 2). A gender analysis of indigenous women’s health, therefore, explores the ways that indigenous women and men’s traditional roles and relationships, as well as the relationship between indigenous women and non-indigenous groups, impacts their ability to attain good health. It highlights the cultural, economic, social and political causes behind indigenous women’s consistently high rates of morbidity and mortality (PAHO 2004).

**Indigenous Women and Access to Health**

Indigenous women are triply disadvantaged in Bolivian society due to (1) ethnicity (2) sex and (3) predominately rural residency patterns (PAHO 2014). They also hold the triple burden or reproductive, domestic, and productive labor. In general, women require
more health services and incur higher health costs because of their reproductive function.

While estimates vary widely, the DHS survey (2008), Amnesty International (2011) and the World Bank (2013) all agree that while maternal mortality (MMR) decreased significantly between 1990 and 2003 (almost 61 percent), it has begun to climb again—since 2003, MMR has increase from 230 deaths per 100,000 births to 310 deaths per 100,000 births in 2011. Furthermore, indigenous women have four times greater probability of pregnancy and birth-related deaths than non-indigenous women who live in urban areas (64.3 percent vs. 15.3 percent). Although 53 percent of maternal deaths happen at home, 37 percent occur in health centers that should be able to provide skilled delivery and postpartum care—70 percent of hospital deaths occur during labor or immediately postpartum (USAID 2012).

Contraceptive prevalence in Bolivia is the lowest in the LAC region, and decreased nationally between 2003 and 2008 (35 percent to 33 percent), especially in rural areas (25.2 percent). Unintended pregnancies among adolescent girls rose from 14 percent in 1998 to 18 percent in 2008 (USAID 2012). Beyond reproductive health disparities, indigenous women experience disproportionately high rates of infectious diseases, malnutrition, and cervical cancer (PAHO 2014).

As outlined in Table 1, these adverse health profiles result from low levels of service access, education and employment, high levels of poverty, low levels of infrastructure, and discrimination and cultural misunderstanding in the provision of care (de la Vega 2008). Furthermore, because indigenous women are most often employed in the informal sector or not employed at all, they have lower access to private health insurance schemes that would help cover the cost of care not covered by the state. Moreover, the silencing of women, particularly of indigenous women, in public and political contexts (many times through violence), has lead to the underrepresentation of their viewpoints in the policy formation and
resource allocation of the health sector (Burman, 2011; PAHO 2004; UN 2014).

**Legacies of Health and Identity**

The relationship between decolonization and the “depatriarchalization” of Bolivian society depends on an understanding of the reach of colonialism and the hegemonic attitudes that have persisted. Starting with Spanish colonization, the way that health and health services were thought about and constructed in Bolivia helped stratify the racial and ethnic hierarchy of society. Specifically, the interests of foreign elite, medical doctors, and the Bolivian state interacted to create Bolivia’s foundational health policies. In the process, these groups have actively constructed notions of race and gender, which relegated indigenous and feminine identity to a marginalized space.

Throughout Bolivian history, the provision of health care for both groups was thought of as a means of control and domination, rather than a state-mandated social service. This section is interested in (1) state sanctioned social norms of indigeneity (2) the construction of femininity in the modern state (3) how these two identities intersected in the provision of healthcare. It highlights three important eras of health care formation—the colonial era, the years leading up to and following the Chaco War (1932), and the neoliberal era—to demonstrate the durability of the social and political understandings developed during these critical periods and illustrate the ways that they have influenced the fundamental nature of Bolivia’s political and social trajectory.

**Colonial-Constructed Identities**

During the colonial period, Stephenson (1999) argues that indigenous groups were seen as a “fiscal category” and Zulawski (2007) debates over indigenous populations were at the core of the elite’s contradictory social and economic situation. On one hand, starting as early as 1557, the economic exploitation of indigenous groups was necessary for Bolivia’s
role in the international market as an exporter of raw materials. Revenue from private silver exports, mined by indigenous laborers financed the lifestyle of the *criollo* elite and represented much of the Spanish empire’s wealth. On the other hand, elites believed that the “uncivilized” indigenous population was an obstacle to Bolivia’s acceptance from other “civilized and progressive” countries, sparking efforts for assimilation and religious conversion (Zuwalski 2007).

Between the 16th and 18th century indigenous groups fell victim to European diseases in large numbers, resulting in the rapid decline of indigenous populations. At the time, the treatment of these diseases was largely framed through fears of contamination of the elite. The “unhygienic” Indian that could infect the higher sectors of society with his “unknown” and “dangerous” diseases represented a threat to the racial hierarchy and could potentially undermine elite control of society’s lowest order. Concerns over racial difference were increasingly cast in positivist terms of “pathological illness” throughout the early 1900’s, and many feared that Bolivia’s progress toward modernity would be cut short by the “festering disorder” of it’s indigenous population (Stephenson 1999, 4).

The fears of the colonial elite were largely expressed through the feminization of the indigenous culture. For example, indigenous masculinity was defined by it “impotence” both physically and politically. There were even contentious policy debates during the early 1900’s about the indigenous man’s capacity to reproduce given his “dangerously low libido” (Canessa 2010, 181). The feminization of indigenous culture particularly targeted the racialized bodies of indigenous women, as the markers of culture and tradition, which, in the eyes of the elite reflected so badly on Bolivia in the world arena, were most visibly marked on women, through traditional dress, hairstyles, language choices, and reproductive role (Stephenson 1999; Zulawski 2007).
Images of womanhood, which were cast largely in terms of “motherhood,” and the related features of domesticity, hygiene, and reproduction were seized and shaped by nationalist discourse to serve upper-class interests of political, economic, and racial assimilation. Rural indigenous females were not only labeled as “mothers” but also as “bad and unfit mothers” and seen as the root cause of the “uncivilized” and “embarrassing” race in the Bolivian state (Zulawski 2007). Indigenous women (cholas) who migrated to or worked in cities and who wore traditional dress (pollera) in the “modernized” urban centers, were especially linked to racialized images of pollution and disease, which could only be “cured” or “cleansed” once they exchanged their traditional garb for a modern skirt (Stephenson 1999, 5). In a more violent form of cleansing, the colonial mentality supported sexual violence against indigenous women. According to Choque-Quispe (1998) colonialism introduced the belief that white skin was the only requirement for holding a higher position in society. Thus, society could be elevated through the production mixed-race, or mestizo, children: “whitening” the “dark skinned” race.

Early-State Health Policy

The health sector represents the paradox of this problem, as it played an important role in the process of colonial domination as well as represented efforts to “improve” and “civilize” indigenous populations. The colonial state saw the provision of health services as a means of gaining control over geographically isolated areas, improving the nation’s “human stock” for economic and political ends, and avoiding contamination of the elite (Ewig 2010). Medical discourse of the time identified “culture” as the root of the Indian's susceptibility to disease, and in turn, the elites ability to fight disease as what made them “civilized” and “modern” (Zulawski 2000, 120) The cultural explanation was a embraced by elite society, as
it allowed them to accept the sharing of certain phenotypic characteristics without admitting to the same genetic defects (Zulawski 2000 119).

Bolivian doctors were well aware of Bolivia’s poor health and published profusely on the hygienic problems of the indigenous race. Today, many of the health hazards they pointed to would be classified as the results of underdevelopment. For example, Revista Médica in 1902 stated that out of 3,337 babies born in the city of La Paz in 1900, 1,298 (39 percent) died before their third birthdays, and 19% died in the first year of life. These deaths were traced to intestinal infections due to impure drinking water (Zulawski 2000, 117; Stephenson 1999). According to Birn (2002), soaring rates of infant mortality gave rise to a movement of “mother-feminists” made up of elite, catholic women who played upon the cultural predisposition of protecting mothers to promote maternal and child health practices of the state (Brinn 2002).

However, this movement met limited success due to the rapid spread of epidemic diseases, the most rampant killer in both urban and rural Bolivia. With recent advances in parasitology and bacteriology, the state decided that infrastructural health measures (providing potable water, rural health care, or maternal care) were too monetarily and time intensive, and opted for a state health plan based purely on vaccination. In 1902 the state passed a law to make vaccination mandatory, which had to be repromulgated in 1909 in the face of huge epidemics (Zulawski 2000, 113).

War and Revolution

Between 1932 and 1952, Bolivia experienced a number of destabilizing events—namely the Chaco War (1932) and the National Revolution (1952)—that radically altered the structure of the state. During these years, a growing recognition of the state’s role in health
care and increasing political activity of indigenous and women’s groups clashed with lasting cultural notions of femininity.

The war signified a moment of profound cultural exchange as indigenous men were conscripted to the army to fight against Paraguay. By extending rights of citizenship through military conscription, Gill (1997) argues that the Bolivian state subjected the majority indigenous armed forces to hegemonic definitions of masculinity. Basic training, according to Gill, was a gendered process that set the parameters of appropriate male behavior, prizing aggressivity, male camaraderie, discipline, autonomy, and obedience of authority. The feminization of indigenous males was particularly evident in this process, as indigenous men who did not conform to hegemonic notions of masculinity were forced to don pollera and perform domestic tasks in front of their military units.

The Revolutionary Nationalist Movement (MNR) emerged in the 1952 national revolution, implementing sweeping land reform, promoting rural education, and nationalizing the country’s largest mines. While these policies benefited the fiscal well being of indigenous groups, MNR reshaped the debates as a class, rather than ethnic, issue: “The term Indian, now considered pejorative, was replaced by the more neutral peasant, and the class-based militancy of organized workers overshadowed question of cultural identity” (Zulawski 2000, 126). This more inclusive political category recast hegemonic notions of culture as purely economic notions of class, ignoring a large portion of indigenous group’s core interests and needs.

According to Stephenson, the figure of the “woman-mother” took on critical significance in the years leading up to the Chaco War, and became a vital symbol of economic development and emerging modernity in Bolivia. After the Chaco role, emerging women’s movements references the “woman-mother” ideal as suggesting a duty to promote
national peace, drawing a parallel between the national and domestic sphere that had never existed before (Stephenson 1999). Women’s movements, however, developed within their own racial and socioeconomic spheres, and alliances between indigenous/peasant movements and white women of the upper-class movements were exceedingly rare. Indigenous women were most often still labeled as threats to the state, as they were often seen as deviating the most from women’s motherly domestic role. According to one popular writer of the time, “The [indigenous] women get drunk and carry the children on their backs in their revels. They feed them meat and fruit and chichi (alcoholic beverage brewed from corn) and chili at an early age. They take them out in the elements and hit them cruelly” (Zuwalski 2007, 45).

At the same time, white upper-class women’s organizations consolidated they’re socially superior positions over the indigenous women and cholas. Thus, according to Stephenson, the prevailing ideologies of womanhood reconstructed hierarchies, not only of gender, but also on racial and class lines, which defined womanhood in terms that indigenous women and cholas did not fit (Stephenson 1999). Some, particularly religious, men protested emerging women’s organizations claiming that they were too disruptive to the elite social order. Surprisingly, this led them to praise the cholas for their femininity, seeing their loyalty to culture as a means of subduing the upper class women’s feminist “rebellion,” which utilized more radical discourse that was seen at odds with tradition (Stephenson 1999, 23).

Health Policy

The Chaco War represented a major juncture in the development of state health policy. The war, which lasted from 1932 until 1935, was the bloodiest 20th century war in Latin America. Yet, during the same three years, more lives were taken in Bolivia by disease and starvation than actual warfare (Zulawski 2007). The state’s inability to adequately care for its citizens, especially the rural indigenous population, which comprised the front lines in
the war against Paraguay, was brought to the forefront. Thus, by the middle of the 20th century, intellectuals, doctors, and politicians began to the provision of health as a responsibility of the state.

As doctors entered into the political sphere, there was an increasingly targeted effort to assert biomedical superiority over traditional medical practices, which were still regarded as largely more successful than the vaccination campaigns implemented by the state. Because of this, there was a special urgency to doctor’s efforts to both relegate and “improve” the “abysmal” indigenous race. Doctors both criticized traditional curing practices as “ineffective,” “barbarous,” and “trickery,” as well as characterized indigenous lifestyles as unhygienic and repulsive. According to Zulawski, doctor’s particularly harsh criticism of indigenous women was because biomedical doctors faced their stiffest competition from traditional medicine in areas related to women’s and children’s health (Zulawski 2007). According to one doctor of the time, “indigenous midwives were ‘unhygienic’ hacks who made women give birth in the “praying position,” which cause hemorrhages and uterine inversions” (Zulawski 2007, 45).

Upon the recommendation of most doctors, large-scale vaccination campaigns continued to be a central strategy of the state, especially after the outbreak of yellow fever during the Chaco war. However, due to the urgency of the epidemic and its propensity to spread to neighboring countries through warfare, the Rockefeller Foundation entered as the first international aid agency in Bolivia to implement the yellow fever vaccination campaign.

International aid organizations brought similar hegemonic notions of race and gender to their provision of care, buying into state discourse of “dirty and backward” Indians (Zulawski 2007).
Hygiene was emphasized as an important tenet of health. Hygiene was a fundamental component of rural school curriculum in 1940. According to Stephenson, the Consejo Nacional de Educación argued that the educational strategy, primarily among the campesinos (read: indigenous), had to be first and foremost a matter of exterminating “lice and filth” (Stephenson 1999, 112). Dirt and pollution were racialized symbols of disorder employed by hegemonic discourse to designate indigenous and cholo people as “other”. For example, in 1935 urban elite organized a “hygiene campaign” to keep cholos off of the streetcars:

> It is categorically forbidden to allow any large bundles or packages on the cars that might come into contact with other passengers; the same goes for people who are visibly dirty or whose clothing smells or might contaminate passengers. Any passenger has the right to demand that the conductor get these people off the streetcar. (Stephenson 1999,142).

Laws like this legitimated this category of the racialized and polluted “other” in state policy. At the same time the “Hygiene Police,” began to mandate indigenous women who worked in upper-class homes be routinely subjected to medical examinations. They were stripped naked in front of police who looked their bodies over for any sign of “infection.”

Post 1952 revolution, hygiene took the form of modernization discourse. Public policy distinguished the modern body (white elite) from the premodern body (indigenous) by its state of cleanliness. Many indicators of poor health among women were seen as threats to the future of the country, particularly infant mortality, abortion, prostitution, and venereal disease, as they suggested women were not fulfilling their preconstructed identities as mothers.

Neoliberal Reform

Military junta overthrew the MNR in 1964, beginning 10 years of political instability and military rule. A deep financial crisis in the early 1980’s opened the way for the implementation of new economic and social policies in line with the Washington Consensus.
Between 1981 and 1986, social expenditure was cut from 8 percent to 1.8 percent of GDP. The World Bank (WB) and International Monetary Fund (IMF) played formative roles in the construction of new health policies, which were seen as a means of mitigating the negative effects of Bolivia’s structural adjustment program (SAP) on the delivery of social services and subduing the resulting social unrest.

The elimination of the public service sector demanded a substantial increase in the productive and reproductive burden of women. A dramatic increase in household expenditures for health and social services required women to enter the market economy as producers, while at the same time facing an increased burden as mothers and caretakers at home, as all social service responsibilities previously held by the government were transferred onto the household. Many indigenous women report having to enter the “productive” economy, often commuting long distances to cities to sell goods at urban markets, while also feeling an increased responsibility to care for children and the elderly at home (Cannessa 2012).

During this same period, the left discounted gender specific issues, arguing that patriarchy was a product of capitalism and therefore would disappear when the working class revolution triumphed. According to one liberal leader of the time:

“by fighting between men and women, we are pleasing those capitalists who are the ones that created chauvinism.... In this way they are dividing us so that we can’t fight together, united. For this reason too, the capitalists have created feminism: in other words, so that women might fight against men” (Stephenson 1999).

Therefore, women were discouraged to participate politically. For example, when some women became politically active through hunger strikes and protests in mining centers, their husbands lost their jobs, and therefore women’s political participation was framed as a threat to economic and familial stability.

*Neoliberal Health Policy*
The World Bank became actively involved in Bolivia’s health policy in 1990, and because they provided over 50 percent of the funding for Bolivia’s social service sector at the time, they had almost uncontested control over the formation of the new health system. The WB’s main initiative was the Proyecto Integrado de Servicios de Salud (PROISS). Under PROISS, the state implemented selective primary health care (SPHC) to restrict the public delivery system to a basic package of services targeted at the poor and to delegate the allocation of discretionary care to private providers. The adoption of SPHC was predicated upon “cost effective” discourse, which lead to critical decisions between “necessary” and “unnecessary” care.

SAP reduced social security coverage by increasing labor flexibility, lifting the employer’s obligation to co-finance their employee’s insurance. This created more demand for private practitioners, who concentrated on cheap general practice among lower middle class and highly specialized care and expensive tests only available to the wealthy. As the private sector grew, the state cut all public health services other than a severely limited mother and child health (MCH) program and disease control programs, usually funded by external aid agencies. As a result, women’s—especially poor and indigenous women’s—access to primary healthcare was practically eliminated and targeted maternal care was concentrated in urban centers, excluding most rural indigenous women (Zulawski 2007; Paulson and Bailey 2003).

During this period, a widely held assumption by international aid agencies and the Bolivian government held that poor health indices of indigenous women were almost exclusively due to cultural barriers, which hindered access to modern health services, and not the weakness of the health system or inequity of the social structure itself (Aizenburg 2011).
Morales’ Health Reform

In many ways, MAS’s rise to power inverted the hegemonic power structure so consistent throughout Bolivian history, representing a dramatic break from colonial and neoliberal policies that asserted white, elite and biomedical authority. However, an intersectional examination of current policy, political rhetoric, and the actual implementation of health care demonstrates that the intersection between the political and societal legacies of indigeneity and gender, which we saw established during critical moments in Bolivian history, remains relevant to policy making today. Despite MAS’s decolonial goals, the legacies of hegemonic health policy have actively constrained the state’s role in ameliorating gendered health disparities for largely two reasons: (1) the misspecification of the origin and perpetuation of patriarchy (2) a politically constructed version of indigenous identity that doesn’t account for indigenous women as vulnerable sub-groups.

Populism and the Divided Women’s Movement

It is important to recognize that the legal and theoretical framework espoused in the constitution and the NPD rest on the populist appeal of the president that backs them. In his ascendance from the leader of a coca union to the presidency, Morales became a heroic figure for the marginalized. However, his electoral success, continued popularity, and ability to diverge so far from the political status quo, were largely due to this ability to appeal to a wide cross-section of the Bolivian population through his broad populist appeal (Madrid 2006; Rousseau 2010). Morales used this “cult of personality” to promote the centrality of indigenous identity in the state, presenting himself as the “indigenous godfather of the nation,” integrating traditional fabrics into expensive western suits; performing and celebrating large scale, highly publicized, cultural ceremonies and traditions, and emphasizing his plebian roots (Postero 2010).
Morales’s position as the charismatic head of state as well as the national and international figurehead for indigenous movements suggests that his rhetoric drives much of the conversation surrounding gender norms and women’s place in indigenous politics. However, a closer look at his political rhetoric and public persona suggests that a separate, and somewhat dichotomous characteristic of his popular appeal relies on the perpetuation of hegemonic ideals of masculinity. In public speeches and interviews Morales has been known to build upon public conceptions of his masculinity, perpetuating rumors about seducing women and his many sexual exploits, even using his many relationships with non-indigenous women to prove that he “relates to all sectors of society” (Canessa 2008). Furthermore, in a speech on International Women’s Day, Morales perfectly demonstrated the cultural durability of gender norms: “To see a woman is always to see a symbol of affection and honesty… To talk about women is always to talk about family unity. Personally, when I see a woman, I see my mother” (Rousseau 2010; Morales 2006). Morales’s rhetorical depiction of women relies upon the “mother-women” ideal, and even as he promotes women to positions of political power, he maintains that their most important role is in the family unit. This public machismo combined with the rejection of an individual rights framework has led to a growing rift between Morales and the feminist movements of Bolivia, as well as between feminist and indigenous women’s groups.

During the tumultuous post-neoliberal era, indigenous and non-indigenous women’s organizations played a particularly prominent role in Bolivian political conflict, and many times, fought alongside MAS for the same cause (Rousseau 2010). Despite their history, Morales has seemingly excluded the more liberal feminist organizations like Mujeres Creando from participating in political decision making, while purposefully including other social movements, including Bartolina Sissa the Indigenous women’s organization, in political
forums (Monasterios 2007). In turn, many women’s organizations have spoken out against Morales, claiming that he is allowing indigenous conceptions of gender complementarity, which according to many feminists manifest in passive and demeaning ways, to completely crowd-out liberal conceptions of gender equality in state discourse (Monasterios 2007; Galindo 2006).

Legal and Theoretical Frameworks of Health

In 2005, the Ministry of Health and Sports (MSD) conducted a report to identify the major weaknesses of the Bolivian health system and provide a framework for health reform (MSD 2006). This report later formed part of the National Development Plan of 2006 (NPD) and represents the ideological and empirical foundation of MAS’s health reform. As detailed in Table 2, the MSD cites five main problems of the Bolivian health system including, an inefficient and ineffective structure and a focus on biomedical medicine and western health norms. The report calls for the promotion of intercultural medicine, the adoption of a social determinates of health (SDH) framework, and the recognition of health as a community right, emphasizing its departure from liberal modes of thinking of health as an individual right. The NPD emphasizes the feminization of poverty and the states role in removing any form of discrimination in the provision of health. The main goal of the health strategy in the NPD is to establish a single, universal, intercultural health system. Both documents reflect the political will of MAS to treat health as a political priority and recognize the state’s fundamental role in combating discrimination in health.

The indigenous concepts of buen vivir and chachawarmi are central to state policy and are particularly relevant to this analysis. First, the indigenous concept of “Buen Vivir” was adopted as the theoretical guide for all social policy in the National Development Plan (2006) and exemplifies the indigenous lens through which MAS constructs state policy. Buen
**vivir** suggests that quality of life requires more than material and physical well being, but also a deeper connection to “one’s spiritual ties, one’s people and one’s land” (Medina 2008). Inversely, the root of biological and social illness lies in the loss of a common value system, the disintegration of a communal structure, and alienation from the spiritual world (Johnson 2010; Medina 2008).

*Chachawarmi* is a parallel theoretical tool guides MAS’s conception of gender. An Aymara concept that literally translates to “man” (*chacha*) and “woman” (*warmi*), *chachawarmi* represents the indigenous notion of gender complementarity. It suggests the opposite and equalizing nature of man and woman leading to a cooperative and codependent understanding of gender. In fact, according to *Chachawarmi*, individuals cannot be considered a complete social person before marriage; therefore traditionally, unmarried individuals cannot hold positions of political, social, or religious authority (Burman 2011; Mclean 2014). Gender is largely defined through a predetermined set of roles—to be “female,” for example, is to be reproductive, the bearer of tradition, to harvest the crops, and to care for the family, to be “male” is to participate politically, till the land, and exchange in commerce (Burman 2011). Though a western lens would cite role distinction as a form of gender inequality, indigenous conceptions of gender assert that because both sets are equally vital to the community, they are inherently of equal value. However, although generally held to represent more equitable gender relations, a number of cultural anthropologists suggest that the lived realities of *chachawarmi* demonstrate that the roles of women and men are not actually perceived on such equal terms, but rather represent a culturally unique gender hierarchy (Canessa 2010; Burman 2011; Mclean 2014).

Guided by this theoretical framework, Bolivia’s public health sector consists of the *Salud Familiar Comunitaria Intercultural* (SAFCI) primary care program and two targeted maternal...
care programs. SAFCI represents MAS’s main health policy innovation and the foundation of public health care—it attempts to create a universal, intercultural, community based delivery model in order to bring health infrastructure into rural areas and adapt the provision of health the needs of indigenous communities. While SAFCI is supposed to create a comprehensive primary care model and fulfill the goals of a universal system espoused by the constitution and NPD, it has only been implemented sporadically and has not led to significant increases in rural health care access nor the development of primary care infrastructure (Ledo et al. 2011). Therefore, a majority of the public sector’s actual implementation is represented by SUS and CCT programs, both of which are targeted-maternal health programs.

State health policy relies on a social determinates of health (SDH) framework, which theoretically, views health in the broader context of the conditions in which an individual grows, lives, works, and ages, which is shaped by the distribution of money, power, and resources (MSD 2006; WHO 2014). However, in practice, Bolivia’s SDH framework has become what some scholars have deemed a “cultural adaption framework” (Aizenburg 2011). In contrast to the broad scope of the traditional SDH framework, Bolivia’s has consistently prized cultural barriers to health as the most important determinant of indigenous people’s poor health profiles. For example, the incorporation of traditional medicine has garnered the most state attention since the implementation of SAFCI—one MSD presentation describes it as the main strategy to improve rural health:

Health policy in Bolivia, because of its strong Biomedical vision creates a large gap, and a socio/cultural approach is needed in order to develop a new model of health, grounded in mutual respect, which permits the incorporation of the knowledge and ways of knowing of traditional indigenous medicine …a focus on intercultural health should improve the health of rural communities (MSD 2006).
MAS’s culturally-skewed SDH framework is consistent with decolonial logic—if the root of gendered health inequities is colonialism, then restoring what colonialism attempted to destroy (culture) is the most important first step towards restoring equity. However, while cultural barriers are certainly an impediment to care, Bolivia’s tendency to give them higher explanatory power than resource and access based determinates overlooks the practical implications of poverty, poor infrastructure, geographic and economic isolation, and gender hierarchies (within the community and the health center), which are lived realities in most indigenous communities (PAHO; ECLAC-IDB; Gonzales et al. 2005; Camacho et al. 2003). De Loge (2011) warns that while restoring cultural knowledge through traditional medicine is an important step towards empowering indigenous communities, it can also be—inadvertently or purposefully—used as a strategy to circumvent the costly infrastructural, economic, and biomedical solutions to poor health, harkening back to the cost-effective solutions of colonial vaccination campaigns and neoliberal SPH programs. PAHO (2014) suggest that without first building the necessary health infrastructure in rural areas, goals of incorporating indigenous medicine and therapies into national health systems can only amount to symbolic policies.

*Intersections of Cultural Adaption and Policy*

Two recent policies illustrate the way that the amalgam of indigenous politics has failed to adequately address the unique health disparities of indigenous women. First, the Comprehensive Law Ensuring Bolivian Women a Life Free from Violence (2012) attempts to address the epidemic proportions of gender based violence (GBV) effecting women in Bolivia. Over 67 percent of women of reproductive age report having experienced GBV at least once, while only 14 percent of women received adequate health after for GBV-related injuries. Rates of political violence against indigenous women are also particularly high in
Bolivia (USAID 2013). GBV has profound health impacts on the individual’s that it affects. Health consequences associated with GBV include traumatic brain injury, depression, addiction, unwanted pregnancy, STI’s, HIV, and chronic pain (WHO 2014). There is a strong and significant negative relationship between GBV and the future use of fertility planning and reproductive health services, and an even more significant negative relationship with indigenous women (USAID 2008).

The severity of GBV in Bolivia has received increasing national and international attention and mounting political pressure led to the Comprehensive Violence Law, which recognized the catastrophic costs of such high levels of GBV and implemented more severe criminal punishments on perpetrators of sexual violence. This law was seen as a groundbreaking step supporting the safety of women in Bolivia, however, socio-cultural norms of gender and enduring legacies of the “mother-women” in Bolivian society have severely handicapped its implementation. Evidence from 2013-2014 demonstrates that healthcare providers, police and the judiciary, continue to value the integrity and union of the family above the rights of GBV victims (USAID 2013; Sieder et al. 2010). This is especially problematic in indigenous communities where complimentary gender norms increase the cost of leaving an abusive relationship. In 2013, less than half of reported GBV cases were ever fully adjudicated (USAID 2013).

In an effort to recognize indigenous sovereignty and reduce cultural barriers to justice, many rural indigenous cases are relegated to autonomous regional indigenous courts. This has led to the uneven, unpredictable, and culturally dependent prosecution of GBV. One report finds that in the Pucarani community in the department of La Paz, community authorities considered cases of rape as “matters of honor” and repairs and sanctions came in the form of cattle and land. In another community, fathers had to acknowledge paternity in
order for cases of pregnancy by rape to be prosecuted (Coordinadora de la Mujer 2014; Sieder et al. 2010). However, in an ayllu in the department of Potosí, communal indigenous authorities reported that a repeated rape offense could be sentenced to death (Calla et al. 2005). The strict familial structure present in some interpretations of chachawarmi—which sees a union between man and women the only way to become a social and political unit—has lead to the promotion of familial structure over the prosecution of intimate partner violence (IPV).6

Abortion rates are closely linked to rates of GBV and contraceptive use, both of which are extremely poor in Bolivia. However, like many countries in Latin America, abortion in Bolivia is highly criminalized and only legal as a life saving measure. Despite this, there are more than 80,000 induced abortions in Bolivia every year, with the highest rates of clandestine abortions take place in indigenous communities. Cultural norms associated with abortion are severe, in one report, 42 out of 50 women interviewed, reported having been rebuked or verbally abused by hospital staff when seeking care for health complications due to induced abortion (Thorston 2012). A quarter of all maternal deaths in Bolivia are a result of abortion (Thorston 2013).

The high criminalization of abortion in Bolivia is largely thought to be a token of the Catholicism brought by Spanish colonists. Therefore, with the secularization of the Bolivian state (Article 4) and the assertion of universal rights to reproductive and sexual health (Article 66), many women’s groups, female politicians, and aid organizations believed that criminalization would be overturned. For this reason, indigenous MAS deputy Patricia Mancill challenged the criminalization of abortion in the Bolivian Plurinational Constitutional Tribunal (TCP). However, after two years of deliberation, in 2014 the TPC rejected that Bolivia’s new constitution conflicted with the 1972 criminalization law. While
the ruling did nullify an existing rule that required judicial approval of life-saving abortions, no other aspect of the criminal code was altered.

What is most notable about this ruling is the rhetoric used defend it—in defense of their limited interpretation of the Article 66, the TPC replaced the catholic pro-life rhetoric that was formerly used to justify criminalization, with rhetoric that explicitly drew upon Andean cultural norms, seeing human life as part of a cosmic cycle, without beginning and without end, and which must be constitutionally protected (LMW 2014; Achtenburg 2014).

Structural Legacies and Maternal Health Programs

Bolivia’s insistence on improving women’s wellbeing by targeting maternal indicators not only betrays the SDH framework that the new health policy prizes, but also illustrates the way in which the medicalization of the mother-woman has persisted in Bolivian conceptions of health. Furthermore, only addressing women’s health through targeted maternal health programs addresses only one small aspect of a women’s overall health and only benefits women of reproductive age.

Because they are targeted programs, SUS and CCT programs do not build infrastructural capacity in their own right, but rely on the foundation of SAFCI and the health infrastructure that preceded it. SAFCI, and therefore SUS and CCT, were implemented on top of the same vertical health system espoused by the neoliberal state—health serves are structured into three levels based on the complexity of care provided: (1) entry level with basic facilities and nurse assistant or rotating doctor (93 percent of all facilities in Bolivia and almost all of the rural facilities) (2) basic hospitals with four specialties: pediatrics, gynecology, general surgery and traumatology (5 percent of care facilities in primarily urban areas) (3) general and specialized hospitals operated by doctors, nurses and specialists equipped to handle specialized and critical care (1.9 percent of care
facilities, only in Department capitals) (MSD 2014; Jonson 2010). Disease and problem-focused programs are not as effective at targeting vulnerable groups than universal programs, and even more ineffective when not supported by comprehensive and responsive health infrastructure (Tejerina et al. 2009; PAHO 2014).

However, SUS and CCT are exactly that, and despite bearing striking resemblance to the SPH model implemented by the neoliberal state, there are no plans to embed existing vertical programs into horizontal services. For example, combating domestic violence is seen as a vertical and separate program from the maternal and child health program, just as malnutrition control is a completely separate vertical program from sanitation programs. While all are seen as social determinates of health, none of these programs have been integrated into a horizontal structure nor are their clinical interventions seen as integrated (Tejerina et al. 2009). For an indigenous woman, who is often victim to many negative social determinates at once, the lack of horizontal coordination is particularly detrimental.

Between 1996 and 2010, Bolivian governments implemented four different insurance plans meant to improve maternal health. While Morales renamed his plan “SUS,” it is the same plan implemented in 2003 (SUMI) with only slightly more decentralization. However, as Figure 2 illustrates, after a gradual decline in maternal mortality rates between 1989 and 2003 under National Maternal and Child Insurance (SNMN) and Basic Health Insurance (SBS) programs (a non-targeted primary health care package), the implementation of Universal Maternal and Child Insurance (SUMI) in 2003 coincided with an upward trend in maternal mortality.

An important difference between SNMN and SBS plans and SUS/SUMI was that while the former two provide care mainly at first level facilities, SUS/SUMI provides advanced care mainly in third-level facilities absent from rural areas. The SBS plan, which included
sexual reproductive health and family planning services for all women of childbearing age as well as treatment and prevention of endemic diseases for the entire population, was the most effective insurance plan. It had a significant effect in reducing maternal mortality, even in rural areas and among the indigenous population. Notably, less effective SNMN and SUS/SUMI programs were restricted to pregnant women and children under five. SUS/SUMI removed coverage for endemic diseases as well as reproductive health and family planning services for non-pregnant women (Silva et al. 2009).

Health indicators worsened after the implementation of SUMI, particularly in rural areas. Inequity in health outcomes also grew because the third-level, highly complex services that SUMI made available in urban areas, never reached the rural population (Silva et al. 2009). In 2004, the coverage of pregnant women under SUMI showed a clear gap between urban and rural areas. In rural areas, neonatal coverage through SUMI was only 6 percent, while it was close to 95 percent in urban areas.

Despite its weaknesses, reestablishing SUS/SUMI was not an easy feat for the Morales administration and was the source of a factional debate that spanned from 2009 to 2012. The primary antagonists of healthcare reform are sector-based interests (i.e. doctors and medical workers) whose positions are threatened by a decomposition of the private sector and a reduction in biomedical services in favor of traditional services, and who fear reduced autonomy from the state apparatus. Sector-based resistance to MSD policies has taken the form strikes, marches and blockades. Thus, despite an indigenous party at the helm of the Bolivian state, elite interests continue to play a key role in the policy choices that are available and not available to decision makers in the arena of health reform (Siren 2011).

In contrast, Bono Juana Azurduy, was passed through what many deem “blatant populism” during the pre-2009 election cycle. The CCT program was developed through a
top-down approach, without consulting government personnel working on gender issues, and was implemented quickly without a pilot program and with funding from the World Bank. The program provides up to US $260 per household, with separate cash payments for up to four prenatal medical visits, giving birth with a trained attendant, acquiring a birth certificate for the baby, a week of post-partum medical monitoring, and for taking the baby up to twelve checkups. However, expectant and new mothers who are covered by another insurance program, whose youngest child is below the age of two, whose most recently born child died before the age of two, whose last pregnancy ended in an abortion, or who have given birth within the past three years, are ineligible (McGuire 2013). These restrictions exclude a large proportion of indigenous women, as they generally have the highest birth rates, highest infant mortality rates, and highest rates of abortion due to inadequate care in other arenas.

In a 2012 report on the effectiveness of Bono Juana Azurduy, it was noted that coverage was particularly low in the department of Beni, one of Bolivia’s most vulnerable and indigenous regions. Visiting a health facility in Beni involved a long walk in cold temperature followed by an average 7-hour wait (McGuire 2013). The original goal of CCT programs was to incentivize rural, poor, indigenous women to utilize maternal and perinatal health care, but in reality, the majority of women who have received the benefits of this program, have been middle class urban women who are more inclined to use perinatal care anyways (McGuire 2013). The biggest impediment to rural success has been infrastructural weaknesses. In 2009, the government recruited 794 doctors to handle the expected influx of women to health centers, but in 2012, seven of the nine departments were still without a program coordinator, were understaffed with doctors, and coverage was far below the target in the four majority rural, indigenous departments (McGuire 2013). A rise in patient demand
facilitated by cash transfers is ineffective if the state does not first address the historically weak administrative capacity, build the infrastructure to allow for rural access, and integrate vertical programs into a horizontal framework.

Conclusion

Discourses of indigeneity have powerful liberatory potential for marginalized peoples who otherwise would not have the same access to political capital or claims to justice in national and international contexts. Morales utilized this discourse to break away from legacies of political exclusion perpetuated by white elite and lead the majority indigenous population to political power. However, as expressed by Canessa (2012) “[While] there can be surely no issue celebrating the taking of power from the white elite by a government which represents an indigenous majority, the problem arises when the concept of indigeneity obscures internal differentiation” (24).

Specifically, the discourse of indigeneity and the associated decolonial paradigm have obscured the gendered differentiation within Bolivian society. By framing women’s interests through the lens of indigenous politics, problems unique to the their gendered identities are not properly addressed. In the context of health, indigenous women do not receive adequate health care when their interests are politicized through the lens of their ethnicity, rather than addressed through the lexicon of gender. Furthermore, it is clear that the mother-woman binomial is not a sufficient means of addressing women’s health, illustrating that when patriarchal legacies are left intact, decolonial strategies can do little to improve the health of women. Ultimately, politics of indigeneity divorced from the intersecting issues of patriarchy, are not an adequate tool too address politics of gender. According to Bolivian feminist María Gallino (2006),

The dignity that Evo claimed to the world is not the dignity of women, it is the dignity of indigenous peoples and the two are not equivalent. Although in theory the
two should be parallel dignities, analogous dignities, sister dignities, in political practice it is today again demonstrated that through patriarchy it is possible to claim one and deny the other.

It is important to note, however, that there is nothing unique about indigenous politics in this right. Rather, it represents a familiar sin—opting for a more inclusive definition of identity in order to expand the scope of liberation. Reminiscent of MNR’s recategorization of indigenous interests through class rhetoric, we see that when particular interests are represented through the amalgam of another’s marginalization, the multidimensional nature of marginalization and deprivation is flattened and hollowed, significantly reducing the emancipatory potential of the politics that come out of them.

A trade off between progressive politics and the amelioration of gender discrepancies is not necessary, and represents a false dichotomy present throughout Bolivian history—we see it framed as a threat to modernization in the colonial era, workers revolutions under neoliberalism, and finally, through the politics of indigenous representation under Morales. Reconceptualizing the decolonial framework to include the particular interests of all women, and particularly the ways that axis of marginalization interact with gender, holds emancipatory potential for the Bolivian state. However, as the continuity and durability of gendered legacies illustrate, it will require more than addressing colonial origins of ethnic marginalization, but rather, a concerted deconstruction of particularly patriarchal cultural, societal, and political structures in all sectors of Bolivian society.
"Eve Doesn’t Come From the Rib of Evo.” Statement taken from blog post by Bolivian Feminist Maria Gallino reflecting on her disappointment with Morales’ gender politics.

For example, “indigenous” is most often modified by the adjectives “rural” or “originario” suggesting that the form of indigeneity being made legible by the Bolivian constitution is rural and traditional indigenous groups, as opposed to urban indigenous populations (Grisaffi 2010). Furthermore, while article 4 declares freedom of religion, Article 8 promotes a specifically Aymara moral code, suma quemana, an Aymara ideal of the good life, enshrining specific cultural values (Postero 2010).

Bolivia is the most indigenous country of all of Latin America—about 60% of Bolivian society self identifies as one of the 37 distinct indigenous cultures, with an additional 30% identifying as mestizo. The largest cultural groups are Aymara and Quechua from the highland regions, which together make up 88% of Bolivia’s indigenous groups. All 36 indigenous languages are considered official languages of the state, including some that have become completely extinct.

The fundamental structure of the Bolivian health care system is based on the public sector, social security, and private sector. The public sector programs focus on mothers, children, and the elderly but is significantly limited in its capacity and resources. Social security, which is offered to those employed in the formal sector, provides coverage for diseases, pre-and neonatal care, childhood care and occupational risks. The private sector is comprised of clinics administered by churches, non-profit organizations, foreign aid and for-profit facilities. Interestingly, traditional medicine is located in the private sector.

It even received the UN Women’s Council, honorable mention for “Visionary Policy” in 2013. Later, However the UN put together a report expressing the extreme limitations of its implementation.

The deleterious effects of such a strict duality is evident in a number of startling anecdotes suggesting in cases where a woman has been abandoned by their partner, mothers collude in the sexual abuse of their daughters in order to secure a male head of the household (USAID 2010).

Notably, only six abortions had ever been judicially approved as a life-saving measures in the 40 years since the 1967 criminalization law was passed.
Tables and Figures

Figure 1. The root of gender inequality according to Liberal and Decolonial frameworks.

![Diagram](image)

Table 1. Social determinates of Health and their consequences for Bolivian Indigenous Women. Adapted from PAHO (2014).

<table>
<thead>
<tr>
<th>SOCIAL CAUSES</th>
<th>HEALTH CONSEQUENCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being Indigenous &amp; a woman</td>
<td>Acute respiratory infections</td>
</tr>
<tr>
<td>Triple Burden of Labor</td>
<td>Infectious and parasitic diseases</td>
</tr>
<tr>
<td>Absence of sufficient, culturally appropriate health services</td>
<td>Genital-urinary system infections and diseases</td>
</tr>
<tr>
<td>Socioeconomic Conditions</td>
<td>Malnutrition</td>
</tr>
<tr>
<td>Social Instability</td>
<td>Cervical Cancer</td>
</tr>
<tr>
<td>Informal Sector Employment</td>
<td>Vaginal Infections</td>
</tr>
<tr>
<td>Silencing in Public and Political Sphere</td>
<td>Mental Health</td>
</tr>
<tr>
<td></td>
<td>Maternal Mortality</td>
</tr>
</tbody>
</table>
Table 2. Problems of Bolivian National Health System identified by MAS (2006):

<table>
<thead>
<tr>
<th>Problem 1</th>
<th>High socio-biological deprivation in a majority of populations (Social and political determinates unfavorable for quality of life and health)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem 2</td>
<td>Focused on welfare system and biological approach</td>
</tr>
<tr>
<td>Problem 3</td>
<td>Inequitable system that ignores the ethnic cultural diversity of the country, with insufficient response capacity of health facilities at all levels.</td>
</tr>
<tr>
<td>Problem 4</td>
<td>National health system that is targeted and fragmented, with weak management and ineffective and inefficient management.</td>
</tr>
<tr>
<td>Problem 5</td>
<td>Dissatisfaction of users of National Health System</td>
</tr>
</tbody>
</table>

Figure 2. Maternal mortality by public insurance plan. (Silva et al. 2009).
Works Cited


