The Politics of Affliction:
Crisis, the State, and the Coloniality of Maternal Death in Bolivia

Brian B. Johnson
ABSTRACT

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This dissertation examines the nature of personal suffering and the impact of a local crisis on a group of small Quechua speaking communities in rural Bolivia. I consider the ongoing processes of both sudden social ruptures and “permanent” crisis, inherent in the unique evolution of a (post)colonial state as it coexists in association with “traditional” Andean society. Of most significant interest to me is the manner in which relatively rare, extreme, “deviant” events may illuminate, as a kind of analytical lens, larger issues of social, political and cultural forces at work. Within this context, key determining natures are those of individual affliction and a wider structural violence, both of which are identified here as integral and pervasive components within society as a whole. I explore these as reflecting the transformations of social agency and cultural identity among indigenous groups in contemporary Bolivia, which pertain to their dramatically expanding role in overall civil society and state practices—yet which, nevertheless, remain in marked juxtaposition to deeply entrenched systems of power and state control over both the social and the personal bodies. Within a theoretical context of political economy and critical medical anthropology, I look at these dual subjects—the state and the indigenous citizen—in counterpoint with competing notions of birth, death, affliction, and the role of civil society, as perceived within a climate of unexpected crisis and renewal.

As its central ethnographic case study I focus on chronically elevated rates of maternal mortality in Bolivia, and in particular the local instance of an unexpected and dramatic surge in deaths. The multiple complexities of personal priorities and discourses circulating around these
events had at its center a crisis at once glaringly public and intensely personal—which was used to the actual advantage of some, while to the obvious disadvantage of others: what I refer to as the “quality of its imagining.” This personal tragedy of “death in birth” offers a unique perspective on the political uses and abuses of indigeneity and traditional culture, within a nation-state struggling amidst the often conflictive process of achieving the officially proposed objectives of interculturality and decolonization. Concurrent cultural manifestations may resist, or, conversely, adopt, assimilate, and accommodate the official tenets and trappings of modernity, while attempting to find viable solutions to seemingly intractable societal problems. Local reactions and understandings of this ultimate failure in the reproduction of society result in crisis as a social phenomenon of significant proportions: the ultimate issue concerns what is at stake for those involved at differing levels, ranging from the (extended) family unit, to the greater community, and ultimately to the political power structures at work.
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The debt that I and my family owe to the citizens of Puka Wayq’u is indescribable and beyond description. They accepted us into their midst without even a blink (a public one, at least), and have tolerated what must often have been our insufferable questions and participant observation-ish “hanging out,” and hanging around, over the years. We continue to return there on a regular basis, not just with “research” in mind, but because we want to. There are many, many to name, but I limit myself here to those who have become our closest confidantes: Don Alberto, Doña Tomasa and their family. And, I must also make a special mention of the staff at the health center. As they have rotated in and out of Puka Wayq’u (with a few steadfast lifers), they have allowed us to participate in their meetings and workshops, to access their databases, to interview them again and again, and to be a part of the salud scene of the municipality. I know that they are all so committed to the work that they do.
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Dedication

To my son, Natán, for being a kid back then,
and
para todos quienes ya de verdad son, pero siempre han sido,
llaqtamasis
A crisis occurs, sometimes lasting for decades. This exceptional duration means that incurable structural contradictions have revealed themselves…and that, despite this, the political forces which are struggling to conserve and defend the existing structure itself are making every effort to cure them, within certain limits, and to overcome them.

— Antonio Gramsci, Selections from the Prison Notebooks
Chapter 1

Introduction
Mortality and Its Discontents:
The Incomplete Quality of Social Transformation

“We want them to clarify how Doña Severina died,” Carolina Sotomayor said to me, with a tone of both anger and urgency in her voice. “We want to know why she died. That’s what we want to know.”

Carolina was a young mother of three little girls, originally from the valley community of Yomala. Since her husband, Félix, had been hired as a driver and assistant mechanic in the municipal administrative offices, the family had moved to the small town of Puka Wayq’u, the capital of the similarly named rural municipality and approximately an hour distant. The recent death of Severina Méndez Soto during the birth of her latest child—and while under the supervision of the local health facilities—had caused a profound impact not only in the victim’s native Yomala, but also in a number of other nearby communities including (most prominently) the town of Puka Wayq’u itself. In addition, the technical and political repercussions had spread much farther afield, to the regional health district headquarters, to the departmental capital health services directorship, and even to the national offices of the Bolivian Ministry of Health and Sports: this had been only the latest in an unprecedented series of maternal deaths in the Puka Wayq’u municipality, and the local population was increasingly on edge, ranging from the health authorities to the community at large.

“There are lots of pregnant women here, and we want everybody to know how this happened,” continued Carolina, emphatically glaring at me as if I were personally responsible. “Because the señoras are afraid to go to the health center, with all that they’re finding out now.”
This last comment also reminded me of something I had heard recently from Florencia Limachi, a single mother who lived with her children in Puka Wayq’u: “The señoras are afraid to get pregnant now; ‘maybe I’m going to die,’ they say. And the souls are wandering all about, people say. Of those women who have died.”

It wasn’t an easy topic to discuss: not only for myself, but also, primarily, for the women of Puka Wayq’u. Nevertheless, in recent weeks it had become openly and hotly debated as a result of the recurrent deaths and the very public emergency response from the regional health authorities, which had created an air of crisis that was rapidly seeping into varying aspects of both personal and public life in the municipality. What Carolina was expressing at this particular moment was what might be referred to as the social reaction to the unexpected situation, advocating for necessary action to be taken in order to rectify the growing state of public anxiety.

I asked her then about her private thoughts concerning what was happening in Puka Wayq’u: about the individual event itself, and its immediate and emotional impact at the most personal level. “Of course, any kind of death is difficult, and is difficult to talk about,” I began, “but…well, is a maternal death somehow different?”

Carolina paused for a long moment before replying, although the impression I had was that she already knew full well the words that she wished to say, and was but searching for the best manner with which to articulate them. “Yes, it’s different,” she finally answered, in a cautious voice, “and for me it’s the most painful kind, it’s the saddest kind of all deaths, because… To die with that kind of pain, and maybe not to see that the baby was born alright… I would never want to die like that; I wouldn’t die peacefully, without seeing my daughters again beforehand, without even saying goodbye. For me it would be a sad, painful death. Just like when Doña Severina died like that, so suddenly.” Carolina looked reflective, and said
thoughtfully, “But, you know, it’s...” Then she stopped, and glanced at me angrily again. “No, it isn’t. No, because it isn’t a death that God wants.”

“Do not fear death so much, but rather the inadequate life,” Brecht (1989) famously counseled us, within a different historical context but no less pertinently. The words would undoubtedly strike the señoras of Puka Wayq’u as being a sensible way to think, and to go about their daily business. Most, however, would almost certainly be hard pressed to accept that their own lives were in any way “inadequate,” as they were full and constantly occupied with one concern or another from dawn to dusk; without any desire for generalization, it is possible to say that women in Puka Wayq’u are just as happy or unhappy as anybody else with their lives. Undercompensated in their lives, perhaps; the bearers of unjust lives, probably more so. But inadequate would be an inappropriate way to describe things. The problem was that in recent weeks, and maybe even months, there had been a growing sense of concern in many of the communities, due to the disquieting number of recent pregnancy related deaths throughout the municipality. Everybody knew that this sort of thing happened sometimes, unfortunately, and probably most people around knew at least one story of a woman who had died in childbirth. But these were sporadic events, now and then, some years ago, in another community—again, unfortunate, “but such it is,” people would shrug, “these things happen.” However, the recent surge in maternal deaths was exceptional, and the population, women and men, were disconcertedly struggling for explanations. Among expectant women, all of a sudden there was an uneasy fear of death, which was out of the relative “norm.”

The most accepted reasoning overwhelmingly blamed the local health services. There were those who criticized the deceased mothers or their partners, for not taking better precautions; there were a few who whispered that they were “sinners,” or that someone had put a
curse on them—but those were very much the opinions of a small minority. On the whole, the condemnation was for the doctors and nurses at the Puka Wayq’u health center. For many women, it wasn’t a particularly difficult conclusion to come to: “They don’t treat us well at the center,” was one common complaint; “It isn’t fair how they try to take advantage of us sometimes” was another. Whether fairly or unfairly, the general consensus was usually that there existed an uneven and unequal relationship between the community and the health personnel. This was perhaps even more so for pregnancies and births; the great majority of women were not especially happy about the gynecological position atop an exam table, and the low statistics for births attended at the health center bore this out. Thus, the relationship between the overwhelmingly indigenous Quechua community members (and perhaps more so for women) and the predominantly mestizo or urbanized center staff was typically cordial, status quo, but unequal. I categorize this within a colonial framework, but of a specific kind. “Internal colonialism,” explained Mexican sociologist Pablo González Casanova, one of the first to define the phenomenon, “corresponds to a structure of social relations based on domination and exploitation among culturally heterogeneous, distinct groups…internal colonialism stands apart because cultural heterogeneity is historically different. It is the result of an encounter between two races, cultures or civilizations…the conquest or the concession is a fact which makes possible intensive racial and cultural discriminations, thus accentuating the ascriptive character of colonial society” (1965:33).

Doña Tomasa, owner of the house where my family and I lived with her, her husband Don Alberto, and their children, had herself nearly died during her last pregnancy. We were living in Puka Wayq’u at the time that this occurred, and due to the nature of its proximity in both a personal and an actual sense, it had been—at the risk of unpardonable understatement—a
distressing experience, aside from a potentially tragic one in the extreme. Both in the days immediately following and in the years afterwards, she was never inclined to discuss the matter in great detail. In regards to both her own case and to the other deaths that occurred during the same time period, she limited any comments or detailed condemnations to a shake of the head, and again the dismissive conclusion that, simply, “It was the doctors’ fault, they don’t provide good care.” Doña Tomasa remained conflicted by the biomedical admonitions of the local health services, drawn to them and yet rejecting them, at once despite the recent series of events and because of the fact of their occurrence. Although in great part it had been the questionable judgment of Dr. Javier Quispe, the Puka Wayq’u health center director at the time, that had brought her to the edge of her own personal crisis, she continued to consult with him in the months afterwards—but, she rarely followed his orders. “He says I need some sort of blood,” she dismissively told us once (a ferrous sulfate tonic, as it turned out, for her anemia), “but it was too expensive, so I left the prescription at the health center.” (And, as it bears mention, this cost had been requested of her in spite of the national law providing such medicines free of charge for pre- and postpartum women.)

During those same days, and in the midst of the social confusion around the deaths that had developed in the municipality, with Doña Tomasa and Don Alberto we sat once in the patio with handfuls of coca leaves and a glass or two of home-distilled singani brandy, as we had on countless occasions previously, and would on others yet to come. To one side of us was the small altar that the family maintained, on which were set small, smooth, ancient stones passed down through the generations, hand painted with faded, primitive, almost cartoon-like images: one of the Virgin of Guadalupe—the Mamita Gualala—patron of the city of Sucre, the departmental capital, and of the northern Quechua regions; another with a somber Our Lady of
Sorrows; and the last with Saint Peter, to bring good rains for the crops. All three were placed among a crowded and chaotic jumble of burnt-out candles, faded flowers, and tiny plastic cows, sheep, and horses, plus an incongruous elephant, dinosaur, and toy clown. Doña Tomasa related to us then that she would frequently see spirits. Once, it had been a man alone with a burro, who vanished on our street late one night in front of the house when she took a step to draw closer; at another time, she clearly heard the low and insistent murmurs of an entire crowd of people and animals passing by, human voices and non-human commotion blending together as one—but, when she looked out the door there was nothing there. Don Alberto shrugged, and denied that he had ever seen any of this himself. I mumbled something to show my interest in Doña Tomasa’s words, and thought again of all the other stories that we had heard of souls who roamed the darkened streets of Puka Wayq’u: of women in childbirth and otherwise, of some we had known, and of others we had not.

*   *   *

The purpose of this dissertation is to examine the nature of personal suffering and the impact of a local crisis on a group of small, Quechua speaking communities within a remote municipality in rural Bolivia. As part of this, I wish to consider the ongoing processes of both sudden social ruptures and “permanent” crisis, inherent in the unique evolution of a (post)colonial state as it coexists in association with “traditional” Andean society. Within this context, the determining natures of individual affliction and wider structural violence are integral and pervasive components within society as a whole: crucially, I see this as part of transformations in social agency and cultural identity among selected indigenous groups in contemporary Bolivia, which pertain to a dramatically expanding role in overall civil society and state processes. These considerations, however, at the same time remain in marked juxtaposition.
to, and ongoing conflict with, deeply entrenched official systems of power and state control over both the social and the personal bodies, and also of the individual human psyche. These are present in the often intangible manifestations of lingering historic colonial mechanisms of authority, ironically caught (since 2006) in the uncertain throes of an officially sanctioned *decolonization*, as coupled with the uniquely Bolivian conceptual formulation concerning the notion of “*interculturality*.” The result is a series of paradoxes which significantly impedes immediate progress. As observed within a theoretical context of political economy and critical medical anthropology, I hope to look at these dual subjects—the state and the indigenous citizen—in counterpoint with competing notions of birth, death, affliction, and the role of civil society, as perceived within a climate of unexpected crisis and renewal.

As its central case study, I focus on the topic of chronically elevated rates of maternal mortality in Bolivia—numbers which are historically and persistently among the highest in the western hemisphere—as the backdrop to these deeply entrenched social issues, and as one that both affects and is affected by them. I consider this within a framework of both prior and actual structural violence—which, during the core period of my research, was exacerbated by a deepening crisis of economic security, social upheavals, and daily questions of adequate subsistence and governmental legitimacy—and, in the following years, by the radicalized state counterattack to these threats. Thus, this all-too-common personal tragedy of “death in birth” offers a unique perspective on the political uses and abuses of ethnicity and traditional culture. As such, I adopt an approach similar to that of Janes and Chuluundorj (2004) in their own study of maternal mortality, who (after Krieger 1994) state that their intent is to observe “‘causal assemblages’…and models [to] assess how events, processes and factors occurring across the social scale ‘get into’ the body…we attempt to identify the ‘spider’ in the web of causation”
(2004:231). Here, then, my “spider” is how state control and the consolidation of national political and cultural sovereignty, combined with prevalent conflicts related to deeply entrenched racism and (inter)cultural differences, contributed to an increase in maternal deaths.

Additionally, I consider how, within a state structure amidst the painful process of “decolonization,” these may either resist or, conversely, adopt, assimilate, and accommodate the official tenets and trappings of modernity, while attempting to find viable solutions to seemingly intractable societal problems. Local reactions and understandings of this ultimate failure in the “reproduction” of society—that of an extreme failure in human sexual reproduction, ending in death—result in a crisis of significant proportions: the ultimate issue concerns what is at stake for those involved at differing levels, ranging from the (extended) family unit, to the greater community, to the very political power structures at work.

At the outset I must clarify that my project is one which attempts to concentrate primarily on the anthropology, and not the public health, of the topic of maternal mortality within the parameters of a specific episode. However, and at the risk of stating the obvious (from the medical and public health perspectives), it needs to be acknowledged that in effect direct maternal mortality mitigation is most often (although not always), at its bottom line, a clinical issue of appropriate emergency biomedical obstetric treatment and prevention—albeit frequently and firmly couched in a structural context of cultural conflicts, social dysfunctions, and health inequities. Simply put, there are, as a rule, basic intrusive biomedical procedures which must be performed quickly and effectively in an emergency situation, or else the death of either or both the mother and the infant are distinct possibilities, if not probabilities. I must decisively recognize and accept this clinical reality as my starting point, be sure not to lose sight of it, and then proceed from there in the analytical direction that I have selected. Therefore, it must be
acknowledged that this dissertation is not concerned in a direct sense with analyzing the causes of and the ways with which to prevent maternal mortality; nor is it precisely a study of non-western, indigenous, non-biomedical reproductive health practices, and their frequently very positive role in preventing maternal deaths (or, admittedly, sometimes exacerbating them); nor, perhaps, what can be termed as being an “anthropology of reproduction.” The research and literature on all of these subjects is detailed and extensive; I review the basic issues at stake in Chapter 3.

This being stated, whereas my original purpose for establishing myself in one specific rural municipality in Bolivia—which I (pseudonymously) call Puka Wayq’u (Quechua: “red gorge”)—was to focus almost exclusively on the cultural context of maternal death itself, this rapidly took on a previously unexpected dimension. I found myself in the midst of what was a veritable epidemic of deaths—at first, those that were on the official record over approximately the preceding six months; then, those that had gone unreported and undocumented in the local and regional health service registers, yet were known to people in the affected communities themselves; and finally (in quick succession), the deaths that occurred during my own time in the municipality. It was, needless to say, a disconcerting position, for any number of persistent and unavoidable moral and ethical reasons. Yet it was also a situation which brought me to recognize that something else was happening in Puka Wayq’u, something which also (I gradually came to realize, in growing hindsight) said a great deal about not only the individual human tragedy at the center, and, additionally, not only about the difficult reality of the local social context, its structural failures, and the resulting human suffering. It also, I maintain, said something critical about Bolivia in both a historical perspective, and as it still is today. The crisis situation which quickly developed was the Bolivian dilemma writ at once small, personal
and devastating; and also simultaneously large, public and with implications for society as a whole. The deaths that occurred, and the resulting aftermath, were emblematic of more than “just” the central, crucial, and undeniable individual and personal tragedy at its center.

What is thus of the most significant interest for me, in all that was to transpire in Puka Wayq’u and its communities during the years of 2003 - 2004—aside from the obvious considerations of how the tragedy of a wholly preventable maternal death may be adequately mitigated, and ultimately eliminated altogether in future pregnancies—is the manner in which relatively rare, extreme, “deviant” events may illuminate, as a kind of analytical lens, larger issues of social, political and cultural forces at work: a tangible illustration of Victor Turner’s observations (1957, 1974) of how society may be best understood through its ruptures and its breakdowns. Turner describes how the power of conflicts and crises (including the notion of “social dramas”), no matter how small and outwardly insignificant they may appear to be, serve to reveal the true nature of a society at its clearest, much more so than what may be perceived through all of the relative peace and good times. These are small conflicts, small paradoxes, some much bigger than others, but they reveal critical aspects about a culture. In the case of Puka Wayq’u and its own local crisis, these extend beyond the foreground—and very legitimate—concerns of medical attention and public health. Something is revealed about race, about indigeneity, and about the nature of being both the “colonizer” and the “colonized”; also critically revealed are matters of modernity, state control and international hegemony, and how one cultural model may incrementally supplant another.

Consequently, it is the multiple complexities of personal priorities and discourses circulating around this particular instance which has at its center a crisis at once glaringly public and intensely personal—and how it was used to the actual advantage of some, while to the (quite
obvious) disadvantage of others: what I might refer to as the “quality of its imagining.” These explanatory strands intertwine and converge to create a larger theoretical framework—strands that are, when all is said and done, little more than complementary characteristics of the same multifaceted issue. I view the often confusingly complex dilemma of maternal mortality in this context as a kind of metaphorical reflection comprising interlocking components of much larger social forces: the focal point in a study of crisis as a social phenomenon, and how this impacted upon one specific locality, and the society surrounding it. I wish to show the manner in which this particular crisis developed and unraveled in Puka Wayq’u, and thus how it was indicative and representative of an ongoing national social process swirling around it in Bolivia—and, how what happened in Puka Wayq’u ultimately reflected this broader reality.

Crisis of the State: 2000 - 2005, and Beyond

Throughout Bolivia, and in much of the Andean region, the transition to the “modern state” over the past half century has been accompanied by the burgeoning (and frequently militant) affirmation of cultural, political, civil and human rights among the indigenous populations. In Bolivia itself, the obvious affirmation of this is the unprecedented national sociopolitical changes underway since the “revolutionary cycle” of 2000 - 2005¹ (Hylton and Thomson 2007). The results of this have been increasingly consolidated since the 2006 elections and the rise to power of Evo Morales Ayma—“Bolivia’s first indigenous president,” as he is invariably portrayed in the international press—and his coca growers-originated social movement turned political party, the Movement Toward Socialism (Movimiento al Socialismo, MAS). This transformation, however, is undeniably still very much a work in progress—and

¹ This depiction is a direct reference to the “historical cycles or horizons” in Bolivia previously established by Silvia Rivera Cusicanqui (1990), all three of which she saw as still mutually co-existing in a contemporary fashion: the “colonial cycle,” the “liberal cycle,” and finally the “populist cycle.”
continues to exhibit a tendency, identified by some observers relatively early on in the administration, as one intimately tied to the “politics of identity” recurrent in Bolivian (and Latin American) statecraft. To date, however, an unprecedented series of structural innovations has indeed been implemented by the new government. These include a significant reformatting of the state bureaucratic apparatus, the quasi-nationalization of numerous industries, projected land reforms and possible future expropriations of large landholdings, the formalization of local and regional autonomies, and, most significantly, the approval by national referendum of a new and broadly reformist constitution (Nueva Constitución Política del Estado, NCPE), in 2009.

The 2005 elections were the culmination of an extremely active and tumultuous six year period of social and political ferment in Bolivia, beginning in the year 2000 (with the “Water War” in the city of Cochabamba, a revolt against the multinational control of local public services); and reaching a popular-based crescendo in 2003 (with the “Gas War” street mobilizations protesting the international siphoning off of natural resources, and which resulted in numerous deaths and the flight into exile of President Gonzalo Sánchez de Lozada). During this time, local and national social movements and the cause of indigenous revitalization attained unprecedented degrees of intensity and levels of practical success, even while taking into consideration the historically anything-but-tranquil nature of Bolivian society and politics in general. Within the overriding framework of cultural reforms that has been put into play since 2006, the process as a whole initially led many observers—Bolivian and foreign alike—to concur that a genuine revolutionary revival and national “refounding” was well under way in the new “Plurinational State of Bolivia.”

2 Previously a relative “niche” country in Latin American area studies, beginning in 2000 and then later exploding in 2006, Bolivia has become a virtual cottage industry for international analysts and pundits. The literature is now quite extensive. As an extremely limited sampling, and when taking into consideration the academic inquiry into the general historical and sociopolitical phenomena but only from the perspective of outside analysts: Hylton and
As a “pluri-ethnic, multicultural” subalternity that has asserted the right to be the subjects of its own history, these movements are historically descended within the Bolivian context from the recurring, and frequently violent, struggles and revolts throughout the preceding centuries involving indigenous resistance, accommodation, appropriation, and cooptation of imposed colonial models. Yet, and once it has reached a social breaking point, when confronted by this reality the popular tendency in Bolivia has traditionally been that of open rebellion, yet another version of crisis. For the present day circumstances, one manner of exemplifying this transformation from subtle resistance to overt violence might be through the so-called “five phases [to date, at least] of the Process of Change,” leading to revolution (García Linera 2011); this with a legacy of the confrontationally defined demands and societal “wars” of recent decades—peasant and indigenous struggles, Drug War, Water War, Gas War. (Among many, see for example Call 1991; CEDIB 1993; Hylton et al. 2003; Olivera 2004; Rivera Cusicanqui 1984). Indeed, and in supporting this model, at the global level an ongoing and negative overall climate of political, social and cultural oppression and repetitive low to middle-intensity social conflict has long been identified as bearing much more weight for the encouragement of a climate of peasant and / or proletarian opposition and resistance—both chronic and covert, sudden and overt—than do the more “mundane” albeit pressing questions of everyday subsistence and economic grievances (Skocpol 1982).

Thomson, in taking an historical perspective, proclaim that “the present is a revolutionary moment, the third great social revolution in the land called ‘Bolivia’” (2007:7); while Dunkerley 2007, for his part and equally historical, also somewhat cautiously initially refers to Evo Morales and the MAS as the “third Bolivian Revolution,” while later (2013) analyzing how the post-2006 process in reality owes much more to the ongoing legacy of the landmark 1952 National Revolution than the MAS administration would probably care to acknowledge. Goodale 2006 sees the events as the “second Bolivian Revolution,” in interpreting change from a determinedly cultural viewpoint. Albro 2006 looks in depth at the question of identity, and identity politics, around the figure of Morales. Deeply entrenched political instability and external neoliberal impositions are analyzed by Kohl and Farthing 2006; and also by Webber 2011, who critically refutes the assertion of significant and genuine economic or political change, in contrast decrying a “reconstituted neoliberalism.” Other aspects of the relevant literature, from both national and foreign observers, will be considered throughout as the specific cases warrant.
Throughout the “process of change” (*proceso de cambio*, as the MAS has officially designated the historical present), and as it has occurred to date, national policy and political discourse have very prominently and significantly (and perhaps only mildly surprisingly) revolved around the dual concepts of, first, decolonization; and, second, the linkage of this with the closely related idea of interculturality. Virtually overnight, these two key ideological pillars of the MAS government have moved beyond the previously rarefied worldview of small groups of national and international academics, intellectual social activists, and progressive development agencies to become the guiding doctrine of official state policy—mainstreamed, as it were, into the parameters of official policy platforms encompassing active laws and decrees. These are tenets widely and ubiquitously proclaimed as the preeminent and guiding principles of the “New Bolivia,” a nation-state now heavily identified (both in the national and international arenas) through its claims to indigeneity (however this is chosen to be defined), beginning with the president himself and ending with the great majority of the general population. In this manner, the peculiarly national brand of interculturality, and the accompanying domestic recognition of the need to “decolonize” the Bolivian state (however *that* may be defined), are recurrent themes in almost all government discourse: the concepts have, in effect, become institutionalized.

In Bolivia, many of the old political and economic structures are now being questioned, reformatted, and abolished. In an open, quite literal (in his view)—as opposed to symbolic—appropriation of ancient Andean cosmology, President Morales declares that Bolivia has entered the epoch of *Pachakuti*, a pre-Columbian cosmovision which constructs a time of radical change and the reordering of life as we know it. Consequently, in the official state discourse it is, precisely, supposed to be just that: a process and, significantly, a “time of change.” And yet it is also, however, a time of conflict. In the New Bolivia, arisen from a decades (if not centuries)
long cycle of historic tensions and crises, the pattern continues, and uncertainty remains the enduring and defining component.

Intercultural “Breakdowns”
and the Lens of Maternal Death in the Colonial

On the Road in Puka Wayq’u: Emergency Travels with the Doctores

The winding roads in the high altitude cordillera region of the municipality of Puka Wayq’u are rocky and narrow, and the driving is slow and arduous. Beyond the community of Molle K’asa, the scattered adobe houses disappear entirely, and the countryside becomes increasingly desolate: treeless, windswept, and bitterly cold. Thereafter, the narrow dirt road is a constant series of switchbacks around blind curves and through notches barely hacked out of the mountainsides, forever moving up and flanked by plunging gorges, with hazy views of rough mountains and hidden canyons flowing off into the distance. On this particular trip, I sat in the back of the Puka Wayq’u health center ambulance attempting in vain to maintain my equilibrium atop the hard bench seat, and also to maintain a conversation over the battered roar of the aged station wagon’s engine. Also in the ambulance were Dr. Javier Quispe, the health center medical director, who was driving; and Miriam Herrera, a medical student intern doing her required three months of rural training in Puka Wayq’u. I was along for the ride, so to speak.

We were travelling to the small community of Yana Huasi, about three hours distant from the town of Puka Wayq’u itself, where the central health center is located. Earlier in the afternoon, a call had come in from the sole telephone line in the cordillera—a satellite based community phone in the marginally larger community of El Rosal—to the single phone in the town of Puka Wayq’u, also a public line. The message had been directed to the health center:
there was a difficult birth of unspecified nature underway in nearby Yana Huasi, and the unidentified caller had requested that the ambulance come with a medical team. Puka Wayq’u was on high alert at that time: following the unprecedented spike in reported maternal deaths around the municipality since the preceding year, which had yanked the mortality ratio into alarming extremes—both epidemiologically and politically—the local health services had been besieged by the provincial and departmental (state) health authorities. Concerned not just for the general public health but also for their own public image, as reflected through the damning statistics reported monthly up successive administrative levels all the way to the Ministry of Health and Sports in the national capital of La Paz, the regional health officials and affiliated institutions had been engaged in a hurried series of meetings, workshops and planning sessions in Puka Wayq’u over the preceding months. The overall atmosphere—around the health center, at the isolated and far-flung health posts throughout the municipality, and among much of the local citizenry in general—had taken on a heightened quality of anxiety and discontent, of immediacy and urgency, and all amidst the sense that a sort of “hidden in plain sight” crisis had unexpectedly broken out around them. And, to add one further worrisome element to the already unsettling situation on this particular day, the community of Yana Huasi was precisely the site of one of the previous maternal deaths that had occurred the year before.

I happened to be at the health center when the call came in, and although it wasn’t typically in his nature to be especially inclusive Dr. Quispe had put up no objections to my accompanying the emergency trip to Yana Huasi. On later reflection, I reasoned that his openness was partly because he didn’t feel comfortable driving into the highlands, on a bad road, alone with Miriam; normally Pablito, the health center driver and mechanic, would have been behind the wheel, but he was unfortunately on vacation and out of town that week. Yet, I
conjectured, it was also possibly because he wanted me to witness his efforts, to pointedly show me something, in the midst of the critical epidemiological situation in which he was very, very much entangled—and, indeed, implicated. His intention was thus to demonstrate that he was “in control,” and that he was on the side of the pregnant women and mothers of Puka Wayq’u, with their best interests at heart—this in knowing full well of my own ample knowledge of his highly questionable, and questioned, role in the recent mortality incidents. These included, to his recent unspoken but always palpable discomfort in my presence, what had come perilously close to being yet another death: that of Doña Tomasa, in whose house my family and I lived.

Consequently, it was likely that Quispe saw my presence, in an emergency operation intimately related to what was precisely the outstanding local public health issue of the moment, as a means by which to both prove and to redeem himself, in at least one small way.

As it turned out, it was indeed a good thing for him that I was along on the trip. It was the late afternoon, getting colder, and the sun began to set lower on the horizon as we took the right-hand fork in the road, a few kilometers past Molle K’asa. Quispe had insisted on driving so far, which he did in an overly cautious and occasionally skittish manner, despite my offers to help out. For the entire journey he had kept up a constant stream of inane banter, which to me further revealed that he wasn’t entirely comfortable driving—he often seemed more than just a little nervous, which appeared to make Miriam nervous, and as a result I began to get somewhat nervous myself. On the increasingly steep and winding upgrades, the old ambulance ominously began to cough and lurch: something of a clunker to begin with—it wasn’t really a proper ambulance at all, just a large station wagon without any permanently installed medical equipment, or even a stretcher in back—it would rattle along leaving in reasonable doubt the functional existence of any shock absorbers whatsoever, and typically filling up inside with more
dust from the Puka Wayq’u roads than there was outside. Finally, it stalled completely. Quispe got it going after a moment, but then it broke down again, and again. While Miriam sat stoically in the front seat with a grim look on her face, I repeatedly placed large rocks behind the rear wheels, so that the ambulance wouldn’t roll backwards as we tried to restart. I asked Quispe why we hadn’t taken the new ambulance, which had arrived from the regional health department only two months before: it was too low, he said, and couldn’t make it over much of the local rocky roads. Kind of dumb, I commented; then what’s the point of having it around here at all? (I later learned that it was, rather, an issue of the new ambulance’s registration papers, which still weren’t in order: the vehicle was, in effect, an illegal importation with no paid customs duties—although it was never clear to me what actual practical difference that made when travelling the desolate Puka Wayq’u back roads.) There wasn’t a house or a living person for kilometers around, and it was highly unlikely that another vehicle would happen by if we truly needed assistance. I noticed that while there was a spare tire in the back, there was no jack or lug wrench. It was, I mused, definitely unfortunate that Pablito was on vacation: his skills would have been welcome, under the circumstances.

The setting sun was directly in our faces as we climbed higher, staggering from one breakdown to the next. With neither one of us possessing much in the way of mechanical skills, Quispe and I finally decided to take a look under the hood. “Huh, not working well, is it…” we contemplated, scratching our chins, “Nope, not at all…” As we stood next to the uncooperative ambulance, high on one of the bleak and lonely mountain passes as the sun slowly dropped increasingly lower, I began to feel increasingly uneasy. Quispe finally asked me to try driving, and I managed to keep the ambulance going for a while on a relatively level stretch of road. Perhaps to disguise his own nervousness—especially in front of the resolutely silent and perhaps
paralyzed by anxiety Miriam, his underling and subaltern (and a woman, to boot!)—Quispe kept up his empty chatter, which included frequent, and tiresome, admonitions to me uttered with a strained jocularity: “Don’t fall asleep, Brian! What’s going on, Brian! Brian, tell us a joke or two!” Through clenched teeth and my own strained emotions (driving clunky vehicle on hairpin dirt road with steep drops; frigid night rapidly settling in; Quispe’s irritating behavior), I made a few self-deprecating cracks (perhaps not exactly what he had had in mind) about the Three Stooges taking a trip: it got a laugh from Quispe and Miriam, but probably somewhat forcibly. It was almost completely dark by then; the headlights worked, albeit weakly. I asked about a flashlight: there wasn’t one.

Finally, a community appeared up ahead, a collection of adobe houses scattered over the slopes of a mountainside, which (to everyone’s relief) proved to be Yana Huasi. There was a group of men and children waiting in the road; the mother in question was in a house a little way above. Quispe started following them along a trail, while Miriam got out the medical kit—the latch of which then broke open, spilling the supplies out onto the road. We began picking up the gauze, alcohol, medications, syringes, etc., and putting it all back in order just as Quispe arrived with a small group of people, including the woman in labor, who was walking on her own. She lay down in the back seat of the ambulance, and Quispe asked Miriam for a fetal Doppler monitor; however, they had neglected to bring one along. He performed a revision nevertheless, illuminated by a hand-held flashlight from the community. An approximately 34-week gestation, during a third pregnancy; two other living children; she was bleeding moderately. Quispe diagnosed what was most likely a premature detachment of the placenta, with a possible infection. (This was later confirmed, back in Puka Wayq’u.) The mother moaned and complained that it hurt, but not unbearably so. All in all, the trip itself had proven to be justified:
it was, we all agreed, an accepted obstetric emergency, and one which might have had a much more serious outcome—certainly not by any means what anybody in Puka Wayq’u was hoping for at any time, but especially then.

The return trip to town and the health center—with the young mother and her father in the backseat, and the three of us crammed into the front, with Quispe driving—was mercifully uneventful, for the most part on flat ground and downgrades. (Although that didn’t precisely lower the anxiety level in regards to the possibility of more trouble, however; the ambulance was just as shaky and listing as ever, churning up clouds of dust that settled atop all of us inside, as we crashed along for hours through the dark night.) Quispe seemed content, even smugly self-satisfied: he had successfully retrieved a high-risk pregnancy, and thus averted yet another emergency situation; the patient (as it would later turn out) would prove to be alright; we had survived what initially appeared to be the imminent calamity of a mechanical breakdown on an isolated road; and he had accomplished it all under the wary eyes of the medical student and the gringo anthropologist. After what had initially appeared to be shaping up as a long afternoon into evening of logistical, technical, professional, personal, and community health network breakdowns, with potentially dire results for all concerned, this time, at least, the crisis had been defused.

* * *

*Acts of Mortality, Questions of Causality*

The maternal mortality rates in Puka Wayq’u, at the beginning of 2004, seemed to be sadly typical for Bolivia, with three registered deaths the preceding year. This was indisputably unacceptably high for its population base, but still not quite as distressing as other regions of the country where the rates were a number of fold greater (most significantly: northern sectors of
Local official services were limited to the one health center in the town of Puka Wayq’u, and a municipal system which at that time consisted of five far-flung health posts in different communities, each staffed by one nurse auxiliary. As I initially assessed the scene early on in my time in the municipality, traditional (ethnomedical) health resources—for my interests in particular, the local traditional healers (curanderos) and traditional birth attendants (TBAs; parteros)—seemed to be functioning as only relatively semi-active players, at least on the surface of things. For these reasons, among others (some theoretical, others practical, yet others personal), Puka Wayq’u interested me for the purposes of considering the effects of maternal deaths on local society: a more or less “average” rural Bolivian Andean town, heavily indigenous, and with the additional appeal of different internal ecological regions and cultural variations.

However, within only a few weeks of the arrival of my family and me, through informal conversations with a variety of people around town it became apparent that the unreported maternal deaths (those cases unknown to the health authorities, a frequently suspected “independent variable” in areas of high maternal mortality) were more significant than previously assumed. Shortly thereafter, in the span of slightly over a month, the pregnancy and birth related deaths of two women in different communities, Damiana and Severina, occurred; in addition, there were more than a few “near misses” which were unlikely to be formally reported as such. At differing health service levels—provincial (located in the town of Tarabuco), departmental (in the city of Sucre), and national (the administrative capital, La Paz)—Puka Wayq’u suddenly leapt onto the public health epidemiological risk map, anything but average, with unofficial mortality rates for its population equaling or surpassing by far the levels of any
other elevated threat zone of the country. A steady flow of health and political authorities and non-governmental organization (NGO) representatives began to make their way to the municipal capital, for one new meeting, workshop, or program initiative after another. And, as the dead mothers turned into hard and contentious numbers that were increasingly putting the department of Chuquisaca, where Puka Wayq’u is located—including the people responsible for monitoring and organizing its public health services—in a very poor light, the personal tragedies at the center of it all became more than just somewhat lost in the commotion. Although of course, these deaths were not, unfortunately, anything greatly out of the ordinary—not in Bolivia, and not in most countries throughout the developing world.

Perpetually weak in fulfilling its primary monthly goals of numbers of children vaccinated, tuberculosis patients identified and treatment monitored, pregnant women who received antenatal care, and births attended by state biomedical personnel, Puka Wayq’u in 2004 ranked second from the bottom of all the municipalities in Chuquisaca (although it did succeed in moving up a number of notches in the succeeding years). The Bolivian government had long been aware of similar problems at the national level, tangentially—at the very least, it had indeed been just that: the authorities were aware for many years prior, long before the current indigenous themed, socialist tinged administration of Evo Morales and the MAS came into power. Yet it had done relatively little to actually impact upon the situation, or even to recognize or acknowledge it in effective policy, although on paper much effort had been expended. In the early years of the decade, since new health service implementations in 2002 during the second Sánchez de Lozada administration, the most prominent innovation designed to attract more rural and low income families to the health services had been an economic one: free total coverage for all pregnant women, including a hospital birth, and total health care coverage for children up
to five years of age, as part of the Maternal and Infant Universal Health Insurance Law (Seguro Universal Materno-Infantil, SUMI). However, although this was certainly laudable progress, and attendance rates for health service attended births did indeed nominally increase, overall the health indicators themselves showed only limited improvement. In Bolivia as a whole, only moderately more than half (57%) of women were to seek out the available state biomedical services when it came time to give birth; in rural areas nationwide, it dropped to 30% (INE 2004).

Thus, the question remains as to whether the most adequate solution was, and is, in fact, most fundamentally one of physical infrastructure and sufficient finances: if it isn’t first and last the question of economics that keeps an already impoverished population from coming to the health services, then what is it? The conclusion, as numerous previous studies have attested, is that in the forefront are a variety of deeply ingrained dilemmas of cultural misunderstanding and lack of knowledge about official health programs; extremely deficient interpersonal provider-patient relationships, including disdainful and insulting treatment from the medical establishment; and thinly veiled racism. (In Bolivia, see for example: Arnold and Yapita 2002; Bastien 1992; Bradby and Murphy-Lawless 2002; Crandon-Malamud 1991; and Fernández Juárez 1999.) Puka Wayq’u was little different from this unfortunate national norm.

Methodological and Conceptual Junctures

This dissertation is based on fieldwork conducted during the entire year of 2004 and during several months of 2005, when I lived in the town of Puka Wayq’u with my wife, Karen (also conducting her own doctoral research project), and our son, Natán, who was 10 years old at the time. Over the succeeding years, we have returned to Puka Wayq’u minimally on a yearly
basis for visits and follow-up research; during 2007 - 2011, when I worked full-time in the city of La Paz, we were able to visit on a relatively more frequent basis (as vacation time would permit), often during festival days important to the town, such as Carnival and the Festival of the Virgin of Rosario. These later interludes in the municipality of Puka Wayq’u, both the town and its communities, have been brief and relatively intermittent, but important: in addition to the personal bonds which have been formed, they are for us a means to keep up on the course of events and the inevitable changes in the local scene as the months and years pass by, in a (perhaps vain) attempt to vanquish the creeping paralysis of “anthropological time” (Fabian 1983) settling in when it comes to the retrospective analysis of events. This has proved especially critical for me when taking into consideration that the events at the center of my research occurred some years previously, and in recognizing that the social, political and “cultural” reality of Bolivia has changed dramatically since the events in question occurred. Yet these changes in the national landscape, while frequently transcendental, are in my view still very much a work in progress—indeed, and to again adopt the terminology of the MAS government itself, it is an ongoing process: although this would go, I venture, much further beyond the official policy discourse involving a codified yet almost fanciful “process of change.” With this in mind, the events I choose to examine here continue to be relevant because they continue to occur: women in childbirth continue to die in Puka Wayq’u, as they do in Bolivia on the whole, although thankfully at what is seemingly an increasingly reduced, and much more sporadic, rate. Yet the conditions surrounding these deaths are virtually unchanged, and many of the health sector reforms are implemented in the letter of the new policy dictates but not the spirit: a colonial mindset never gives in easily, whether it’s among the colonizer or the colonized.
What was also remarkable concerning the series of events which took place over the course of 2003 and 2004—the “ruptures” in question, which precipitated a local crisis with regional impact—and much of which I was able to personally observe—is that these coincided with a time of incremental changes in the municipality, both intentional and unforeseen. It is partly my intent in these pages to discuss how this particular crisis situation, in whatever manner either perceptible or imperceptible at the actual time, may have in its own way lived up to the classic definition of the word itself, that of some sort of “turning point.” Consequently, our ongoing relationship with Puka Wayq’u and its citizens has served to reveal in hindsight what is undeniably a “before” and “after” lens with which to frame what occurred. I continue to be amazed by the amount of changes beyond whatever might be categorized as “expected”—new constructions, urban realignments, political policy, comings and goings of familiar faces, individual attitudes and outlooks of individual people—that for me may be identified as “post 2004.” These changes, both large and small at the local level, I increasingly came to realize, owe something important to what had happened that year. Thus, within a context of widespread mortality at both the local and national levels, and contrasted with the evolving social milieu in Bolivia—including such external variables made internal as the overall crisis of the state, mounting peasant and indigenous mobilization and protest over the perceived effects of multinational globalization economics at ground level, and an influx of non-governmental development projects—these seemingly isolated and unconnected deaths have taken on for me a significantly interrelated quality, illuminating the varied theoretical components that I wish to outline in the course of this dissertation.

For my specific research purposes, I utilized ethnographic methodologies including informal and semi-structured, in-depth qualitative interviews. I conducted direct interviews with
a total of 35 individuals, a number of whom were interviewed on several different occasions; these ranged from, in the majority, community members in the municipality of Puka Wayq’u, but there were also interviews undertaken with governmental health authorities in the provincial capital of Tarabuco, the departmental capital of Sucre, and the national capital of La Paz. For the most part (but not always) these lengthier interviews were recorded, and later transcribed for a closer and more detailed analysis. Fortunately for me, by far the great majority of those I requested permission to record put up no objections—and indeed, as often as not it was an actual incentive for many: the clear impression I was given was that it made the whole business seem more “important” for some, and that they were contributing to the analysis of a situation that was on the minds of many. Additionally, I took advantage of archival research and textual analysis of numerous municipal records and local publications that I was given access to—primarily from the local Puka Wayq’u health services, but also including regional documentation from the governmental authorities in the cities of Sucre and La Paz.

However, it was undoubtedly and overwhelmingly that most traditional and most definitive hallmark of ethnographic research, participant observation, which was the axis of my time in Puka Wayq’u. I came to understand full well that it was only through the classic methodological pillars of total immersion in the daily business of the municipality—gaining rapport through the famed studied and quasi-formalized variety of “hanging out,” incorporating such key components as language, awareness, memory and objectivity—that I would be able to have any sort of viable grasp on the delicate nature of what was going on around me. Perhaps Malinowski observed it best—if not first, perhaps, then plausibly the most transcendentally—when he affirmed that “there is a series of phenomena of great importance which cannot possibly be recorded by questioning or computing documents, but have to be observed in their full
actuality,” something that he termed as the “imponderabilia of actual life” (1984:18). I discovered early on that broaching the subject of maternal death was—rather unsurprisingly—not an easy one, and was actually quite an uncomfortable topic of discussion, especially with those who had been most affected. It was an issue best left to emerge organically and spontaneously in a conversation, and then to pursue it informally, yet systematically—although, as I must acknowledge, in the clear case of an “interview” as such (question prompts, notepad, recorder), the human subject sitting in front of me was certainly always fully aware of my central interests, and where we were heading. But it was only through the time-established methodology of simply “being there,” and being present to see, hear, converse, probe and stumble upon the casual utterance that defined a topic, that I was able to genuinely immerse myself in the unfolding sequence of events.

My original intention, as part of my stated research plan, was to learn about the cultural perceptions of maternal death among a rural indigenous population. We chose Puka Wayq’u as a study site because it suited a number of the respective criteria for both Karen and myself: first, a more or less “average” rural municipality, semi-remote and heavily indigenous, and with the appeal of different ecological regions and cultural variations within its borders. In addition, there was the presence of Emiliana, an old friend from our previous years living in the city of Cochabamba during the 1990s, who is a pioneering Quechua women’s social movement organizer since the 1980s; she and her husband had bought a piece of land in the past few years near the town of Puka Wayq’u, where they planned to retire. As one other incentive, their two sons were approximately the age of Natán. So, we could already count on established personal contacts right from the outset to help us become familiar with the local scene. Finally, and most importantly for my own purposes, and as I mention above, there was that seemingly “average”
nature of Puka Wayq’u specifically in regards to maternal mortality, according to the official records, which made it an “ideal” location—if such a word is even proper, considering the thematic context—in which to conduct fieldwork on the cultural perceptions of the topic.

However, my initial and dawning realizations that the local epidemiological situation was definitely not average became disturbingly apparent precisely as a result of my “alternative” status in the town: outside ethnographer, rather than inside health worker. I began to be told things that even the Puka Wayq’u health center personnel had no knowledge of, most particularly in regards to unreported maternal deaths. Then, in quick succession, there were the unexpected deaths of Damiana and Severina, and everything changed. My personal research topic suddenly became the topic of the community, from the civic authorities to the townspeople in general, and was soon having repercussions at wider provincial and regional levels. This was not only startling and somewhat unnerving for me; it also had the effect of reorienting my focus entirely. The unforeseen maternal mortality “crisis,” its nature and its local ramifications, suddenly became the prism through which I observed Puka Wayq’u. And, in the years which followed and in retrospect, I came to realize, the events were also a theoretical framework with which to reflect on what had concurrently been transpiring in Bolivia as a whole.

If not properly an actual transformation of my ethnographic approach in adapting to the occurrences in Puka Wayq’u, both in the moment itself and during the later process of eventually writing it all down, a notable “rebooting” of it has for me involved a pronounced orientation toward reflexivity. This applies both to how I have interpreted the events, and to how I portray them. In this, I take heed from thoughts offered by Geertz (1988), particularly in which he considers in a positive light the role of what he refers to as the “situated observer.” From his standpoint within the approach of interpretive anthropology, Geertz comments upon the
“experimental moment” in the discipline which led to the emphasis on postmodernity and the challenges to the very idea of true objectivity on the part of the anthropologist. If there is at least one thing about which to exalt concerning the paradigmatic shifts, he somewhat curmudgeonly concedes, then it is the reflexive ethnographer, who is able to stand back and turn a critical gaze upon the self.

In the course of my time in Puka Wayq’u, I came to realize that I couldn’t agree more. The topic of my research was too dark, too tragic, and ultimately too delicate in regards to human sensibilities to not leave some sort of effect on me. It was not, by any means, cheerful. In order to ward off any overly oppressive considerations of what I came to term as a possible “vulture” persona—waiting off-side for women to die, so that I could analytically observe others’ reactions—I found that by necessity I too had to turn that gaze upon myself, and then to fully reflect on the human condition in the town and communities and what my proper role there was, or should be. This was undoubtedly one of the principal reasons for the eventual shift in my research concentration, quite early on: the clouds of crisis began to develop very soon after our arrival in Puka Wayq’u, that is certain, and I quickly attempted to comprehend the complex dynamics of the evolving situation. It made sense to reorient my relative focus, from an ethnographic standpoint. However, and as I “reflexively” admitted to myself, it made sense from a number of other perspectives also.

So it goes. In what follows, and while both recognizing and taking into account the undeniably numerous overlaps and inherently porous borders, I outline below each of the central thematic focuses and overriding theoretical frameworks incorporated throughout the dissertation, and which I will expand upon in much greater detail in the following chapters.
Crisis, decolonization, and the state

The specific cases of mortality in Bolivia studied here—specifically, among indigenous Quechua communities—occurred within a charged and complex social, political and economic environment. Important components of this include: globalization and dominant free-market trade policies; an indigenous ethnic revival (which incorporates new variations on an historically radical brand of peasant politics); critical shifts in democratic reforms, including aspects of the electoral process; and a growing climate of violence, which takes into consideration an unusually wide spectrum—ranging from common crime and reactionary vigilantism; to the militant tactics used by many indigenous movements; occasionally to violently repressive police and military models used by the state; and to what at least appear to be rising levels of domestic violence, particularly against women.

Within this context, the concept of “crisis” that I utilize coincides in great part with that of the thesis of “social ruptures”: the idea that an understanding of any given society is perhaps at its clearest through an analysis of its conflicts and breakdowns, no matter how small and seemingly insignificant; inherent in this is to closely analyze how people try to comprehend and resolve those ruptures, and these crises. How does a group of people—the individual, the community, the state—identify, react to, analyze, and attempt to resolve an internal crisis, a process of breakdowns? What are the tools that they utilize—ritual, laws, the educational apparatus, health care and medicine, etc.? These, of course, may vary, depending upon the particular social actors involved, and the given context—political, economic, cultural. As I will later elaborate upon further, I take as relevant theoretical frameworks, notably, Turner (1957, 1974: the idea of social ruptures), and Obeyesekere (1990: “works of culture”—tradition, customs, rituals, etc.—which act as “containment devices” in order to keep a society intact),
among others. I thus consider the dilemma of high maternal mortality as an instrument with which to shed better light on diverse problematic facets of Bolivian society and culture (a number of which are unrelated directly to health status \textit{per se}), at a given moment in time. Many of these are also themes throughout current Latin America affairs in general: identity and indigeneity; “interculturality”; democracy, democratic institutions, and the state; cultural oppression and structural violence; tradition, modernity, and change.

There were two distinct, coeval, yet interrelated crises occurring, which are explored in the course of this dissertation: first, the individual, familial, personal crisis, that of the maternal death itself; and second, the ongoing crisis of the state, and its very legitimacy within the context of Bolivian indigeneity and social relations and a long history of apartheid-style colonial oppression. This is only now (post 2006) being seriously addressed by the nation-state, however inconsistently and at times superficially, as part of the key theoretical component of Bolivian restructuring, that of decolonization. Yet within this framework it is important to note that, whereas the elevated maternal mortality situation in Bolivia, historically and currently, is certainly endemic, what happened in the case of Puka Wayq’u, precisely in 2003 - 2004, and its aftermath—a sudden and startling upsurge in deaths—was a situation that fits quite neatly into at least one of the standard dictionary definitions of the very word “crisis”: “a stage in a sequence of events at which the trend of all future events, especially for better or for worse, is determined; a turning point.”

For both the state health services and political authorities, there also exists the simple question of professional image, in the face of an implicit failure to honor the social contract—a casualty of the nation-state’s desire to be considered as a legitimate member of the international community within the perceived boundaries of whatever it is that may be construed as
“modernity.” However, the health personnel I came into contact with frequently became squeamish at the mention of specific unpleasant realities in the local context (morbidity and mortality disparities), and resisted any serious self-examination while instead maintaining that maternal mortality (in this specific case) was not a problem in their districts. Related to this was the very nature of the governmental policy on maternal mortality reduction, as dictated in Bolivia by international financing bodies, often conditionally tied to debt relief—for example, successful attainment of local targets supporting the Millennium Development Goal No. 5, to reduce the world maternal mortality rate by three-quarters by 2015. (For Millennium Development Goals background and the most recent international progress report, see United Nations Secretariat 2013). The values inherent in these official decision-making processes, including the allocation of human and financial resources, are often much more reactive than proactive, “looking the other way” until issues of professional credibility become all too obvious. To this end, I also consider here whether the Bolivian state may actually in subtle ways have been increasing its power (politically and socially, something in the nature of a Foucauldian biopower) with relegated populations through negative health indicators: the provision or denial of services, and an insufficient progress in corrective measures. Is, then, mortality a tool of state sovereignty, by dint of its prerogative—albeit frequently under the dictates of international bodies—in determining formal policy and parameters, and subtly declaring who benefits from official resources, and who does not—thus, who is a “valid citizen,” and who is not?

These situations transpire within an environment of historic, ongoing and unequal dynamics between the state and indigenous groups, a relationship in which the health system, through its monopolization of a specific realm of knowledge and professionalization, acts as both a mediator and an agent of social control, of both internal colonialism and external hegemony.
These processes have been articulated either by means of tangible state apparatuses (health clinics, physician training), or through the implementation of externally designed development ideologies and programs (clinically based reproductive health, the Millennium Development Goals themselves). As such, the shifts currently taking place involving sociocultural and sociopolitical interactions are emblematically reflected in impacts on health-seeking beliefs, priorities and strategies associated with health services utilization, and the (theoretical) integration of ethnomedical (Andean) and biomedical (western, scientific) models. At issue here is the actual cultural process of mediation and transformation between these differing extremes, and how the struggle against the coloniality of health becomes an active component of the struggle against the continued coloniality of the state.

**Social suffering and structural violence**

The social suffering and anthropology of affliction framework, including the notion of structural violence, is a principal orientation in the analysis that I wish to make. It is critical, and complementary, to the theory of coloniality and crisis as outlined above, in that it focuses on the individual’s suffering, as a direct outcome of a complex situation, while regarding the social context (one replete with structural and actual violence) as emblematic of that suffering itself. Accordingly, there also exists the vitally important aspect of never losing sight of what’s “at stake” (cf. Kleinman 2006) for the actual human being in question, and both the personal and public portrayal of their individual affliction (Kleinman, Das, and Lock 1997). In a similar vein, I incorporate into the definition of social suffering that of “large-scale social forces…translated into personal distress and disease…embodied as individual experience,” all of which are part of “insidious assaults on dignity” (Farmer 1996:261-262)—and which concisely sums up the “death in birth” paradox that I will be dealing with here. An occurrence of maternal death is first and
foremost a *micro*, personal crisis, and a tragedy of individual human suffering; yet, it is then reflected within a *macro*, structural framework, and writ large socially into a moral fabric presenting a dilemma of affliction. Incorporating issues of profound social inequities (including health related) and structural injustices—as articulated here through the indisputable fact of an unequal distribution of mortality among certain segments of society—these deaths, and the circumstances surrounding them, also embody and reflect deeper predicaments within the Bolivia of today—a sociopolitical system that is in recent years under concerted attack, as previously discussed.

What is of paramount interest in this particular instance is the ethnographic construction and *imagining* of maternal death, how it is “made sense of,” and then dealt with: narratives of the problem as it is (or, perhaps, is not) conceived, and which external factors (social, political, economic) may eventually affect the internal cultural worldview of the individual. As such, the dilemma of maternal mortality may be seen as a lived manifestation of a moral dilemma: who lives, and who dies? Who is “more worthy”? Death is in itself always political, in one way or another, and a maternal death is especially politically charged: *something* went wrong, at some point throughout the long continuum of social relations, extending from society’s reaction to the crisis and how it is handled, to that of the nature of the personal relation between mother and child. In this manner, one of the most disturbing, and complex and paradoxical, aspects of the deaths considered here is precisely their association with the critical stages of pregnancy and birth, this in a rural culture with a worldview which has traditionally considered fertility in mystical terms, essential for the equilibrium of the natural order.

Consequently, and in taking all of this into consideration, I have tried to identify who, exactly, is my “micro” focus, within this social context of structural violence—and what for my
purposes I will refer to as reproductive violence—together with affliction, suffering, and crisis. Obviously, the immediate family members affected in the case of Puka Wayq’u are my immediate subjects: their personal histories, their thoughts and opinions, their processes of reconciliation. In addition, I try to never lose sight of the woman herself, who cannot be overlooked as the ultimate case of social suffering within the parameters considered. In a parallel manner, there are also the health providers who are intimately involved—if not sometimes directly implicated—in the deaths, and their own personal “at stakes.” And finally, there is the community as an entity unto itself. These are the personal stories that need to be told, the case studies with which to explain the wider context of affliction.

**Interculturality and intercultural health**

In a critical fashion, I also look at the events in Puka Wayq’u within the ongoing conflict of the biomedical / ethnomedical dichotomy. This is framed in Bolivia within the context of the increasingly debated, and increasingly important, movement to define “interculturality,” and its relation to health, curing, medicine, pregnancy, birth, and death— that is, “intercultural health.” One of the most widely utilized discourses in Bolivia today, the interculturality framework is most commonly used precisely in the fields of education and health. In terms of the latter, the supposed theoretical and practical objectives have their primary orientation in the promotion of both the ethno- and the biomedical systems as equally recognized and acknowledged as legitimate cultural apparatuses, each with its own respective worldview, and with its respective strengths and weaknesses—which are, it must be stated, often highly subjective, depending on the individual’s personal cultural reality.

Specifically, the model of intercultural health most typically applied is that of an idealized symbiotic fusion of two health belief systems, the biomedical and the ethnomedical—
yet in Bolivia this is, inevitably, still heavily weighted toward the ethical tenets of the western system, at the expense of the “traditional.” It is often used as a manufactured framework through which to view maternal mortality and the “institutionalization of birth” as a major justification for state control and (bio)power over indigenous / endogenous resources, and over a woman’s body itself. Whereas the theoretical proposal is that both systems should actively interact and function together, in an environment of mutual respect and tolerance, nevertheless in Bolivia there still exists the co-existence and constant conflict of a very unequal balance of powers between what might be called “pre-capitalist” (“indigenous”) and “modern” (“scientific”), and not just in regards to questions of medicine and health, but also in numerous other aspects. By extrapolation, supposedly the ultimate objective of the intercultural focus should be a mutually inclusive, equally based power arrangement; this ideal, however, still proves elusive.

In taking all of this into consideration, I reflect upon interculturality in theory and in practice as intimately tied in with the previous questions of decolonization, state sovereignty, and power. The question is how indigenous culture may hegemonically reassert itself within the social framework of the state (including health), as part of its attempt to (re)claim cultural, political and economic spaces of power. This is just as relevant when taking into account both the reality of the situation in Puka Wayq’u at the time of the mortality crisis, and also the current post 2006 climate in Bolivia of active popular mobilization and prominent “intercultural” reforms targeting the decolonization of the old statist model of government. These shifts involve sociocultural and sociopolitical interactions, ranging from the Bolivian nation-state itself to local gender and cultural power bases, and are emblematically reflected in the impacts on health seeking beliefs, priorities and strategies.
Final methodological points

The historical and current instances of crisis and ruptures, suffering and structural violence, interculturality and decolonization within the Bolivian context that I will be discussing here take into account a number of external models, which have been superimposed upon the indigenous reality and worldview of Bolivia. These frameworks may range precisely from colonialism to neocolonialism, and from neoliberalism to globalization. Important to the understanding of their functioning, however, is to consider how specific discourses and mechanisms—in this particular case, those of public health, health promotion, and the prevention of negative health outcomes—while here considering a concrete instance of elevated maternal mortality, may be either used or abused for purposes of social control by the dominant elites. These are, it must be remembered, long-term processes; in the words of Eric Wolf, they are “processes that transcend separable cases, moving through and beyond them and transforming them as they proceed” (Wolf 1982:17). Or rather, that an unchanging, ahistorical analysis must be categorically rejected as untenable: there is by nature an interconnectedness happening here, and hence what is most vital is the understanding of how that works, and how it still affects the course of events, with a very real present day impact.

This is, then, how I shall proceed: the events that I describe must be understood and respected, first and foremost, as an intimately wrought personal world of human tragedy sui generis. They are also undeniably connected to an ongoing series of historical tendencies, something much bigger than the events themselves, while they are both a product of it and a factor in its very transformation. Neither the micro nor the macro crisis is something isolated, or which originated spontaneously; the suffering of one individual is connected to the suffering of all: the word “intercultural” itself implies a kind of interconnectedness among different peoples,
beliefs, and historical trends. With this in mind, it is critical to remember that “everything changes,” and that any process is always dynamic—and then it is up to us, in doing our best, to try and figure out just exactly what it all means.

The dissertation is divided into a total of six chapters. Following this Introduction, in Chapter 2 I take a more detailed look at the dominant theories of coloniality, internal colonialism and decolonization, and interculturality within the Latin American context, particularly in regards to the question of indigeneity in the Andean region and Bolivia. This then leads into a more comprehensive discussion of how theories of interculturality and coloniality have later been applied specifically to the study of health and health care; that is, theories of the colonialism of health, and how those may apply to the Bolivian case. As the most central part of this analysis, I pay particular attention to the role of the rural physician as a key figure on the “continuum” of colonial relations in Bolivia. Following this more theoretical overview to one of the principal themes of the dissertation, I then provide an introduction to the municipality of Puka Wayq’u: its geography, people, key institutions, and relevant aspects of daily life. This section includes an extended presentation of key figures who brought me into the life of the town of Puka Wayq’u, together with my family, and who were instrumental in helping me to interpret the course of events as they occurred.

Chapter 3 provides a comprehensive discussion of the actual deaths which occurred in the municipality. This involves, first, a much closer consideration of the theoretical framework around anthropological reflections of personal affliction and greater social suffering among the general populace; and also of the wider societal contexts of structural and systemic violence, and how these are very much public health concerns. In order to establish the theoretical and technical background to the issue as a serious global challenge, I give a brief summary of the
dominant perspectives on maternal mortality, from both health and sociopolitical perspectives, including gender and human rights. I follow this with more detailed histories of the majority of maternal deaths which occurred in Puka Wayq’u over the time period in question; these are then further developed by a closer look at the surviving family members, particularly the husbands and partners, and including a discussion concerning the lasting impact of mortality cases such as these on the communities affected, with the perspective of their own thoughts and reflections.

After a consideration of local ways of remembrance involving death in Puka Wayq’u, I focus on a key case study: that of All Saint’s Day and the Day of the Dead. This is related as a critical manifestation and representation of personal and social, organized and shared, grief and suffering; it is analyzed as a cultural method of understanding, processing, mitigating and containing bereavement through communal (social) drama and spectacle.

A detailed exploration of the nature of crisis, and how this may be applied to the events in Puka Wayq’u, is undertaken in Chapter 4. Beginning with an overview of prominent crisis theory, and how this is manifested within the Bolivian framework, I then focus on one specific case of maternal death out of those that occurred, that of Severina, which was the incident that had by far the greatest impact both individually and publically within the municipality. This had numerous facets: among these, I explore most critically the institutional impact of the burgeoning crisis on the local and regional health services; how it affected the general community population; and how the mortality crisis was utilized politically, particularly from the perspectives of coloniality and governmentality. I also consider how the public health environment overall of Puka Wayq’u was altered, and suggest the possibility that health seeking behavior was influenced by subtle social resistance measures on the part of local women. The remaining, and substantial, sections of the chapter study in detail the local social impacts of the
crisis, specifically in regards to personal interpretations of blame and retribution: of the medical personnel, and specifically of one key family member in particular. I also focus especially closely on what I refer to as “crisis embodied”: the story of one “near miss” maternal death, and how this factored into the respective narratives concerning personal responsibility.

In Chapter 5, I look at the health care system reforms under the MAS government, post 2006. I consider the national policy overhauls and new directions given to health policy, which explicitly take into consideration two of my key theoretical pillars, those of interculturality and decolonization. While expressing concerns about what is effectively the “institutionalization of the discourses,” I detail the diverse components of the new health policy innovations, and in addition discuss the perceived opposition and threats. Throughout, I consider what the reforms have meant to the local health services in Puka Wayq’u in the interval following the maternal mortality crisis, and what they may mean in the future.

Chapter 6 is a brief look at the Puka Wayq’u and Bolivia of today, and what the major changes undertaken may signify for the “culture of crisis.” I conclude with final reflections on the nature of doing ethnographic research around a delicate and sensitive topic such as my chosen one, and how my own personal role as an observer may have impacted on the eventual course of the events themselves, and on the respective people involved.
Chapter 2

Questioning the Paradigm:
A Genealogy of the Andean Postcolonial

Historical Coordinates of a Culture of Crisis

*The Appropriation in Theory of Andean Decolonization and Interculturality*

By utilizing a discourse that situates Bolivia as an ongoing “colonial state” and referring to the majority indigenous population as “subalterns,” the MAS government and sympathetic intellectuals place the discussion squarely in the court of postcolonial and subaltern theory, and all that this implies. And, as numerous theorists have noted (for example, see Quijano and Wallerstein 1992, Mignolo 2001, and Young 2001), this categorization in itself requires a thoughtful reflection on the precise theoretical definitions and parameters in question: technically and historically speaking, after all, Bolivia—and the majority of other Latin American nations—have already been independent and “postcolonial” for close to 200 years, in contrast to the countries with more recent decolonization and independence movements which gave rise to postcolonialism as a theoretical discipline (in, for the most part, Asia, the Indian subcontinent, and the bulk of Africa).

Yet, Latin America frequently lives on in its own special postcolonial condition to this day, owing to the wide-ranging dependencies and disparities still so prevalent, and which are often regarded as in themselves qualifying the region as a place that continues to very much hold onto a colonial status with a minimum of “post.” According to Quijano and Wallerstein (1992) in particular,3 and as further elaborated specifically upon by Quijano (see for example Quijano--

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3 See Lander et al. 2000, for a posterior discussion and extended analysis of the themes advanced by Quijano and Wallerstein in this particular case.
2000), the history of the Latin American nations is representative of how *coloniality* and the *coloniality of power*—that is, the essential nature of “being colonial,” in the relationship between powerful and weak nations within the so-called “interstate system”—has intrinsic historical links to ethnicity, race and racism (since the 16th century and European expansion and colonization, which created the framework for merchant expansion, industrialization, and capitalism), and which does not disappear after formal independence. Rather, it transcends these, and “continues in the form of a social-cultural hierarchy of European and non-European” (ibid:550), which is manifested in political, economic, and most of all cultural realms. This manufactured structure of coloniality, subjugation and power, grounded in a racialized Eurocentrism, thus constitutes its own brand of modernity, and makes its own rules.

In the broader Latin American context, theories of “internal colonialism” hold a prominent position. Drawing on the work of early theorists including Fanon (1963; 1967), Memmi (1967), Stavenhagen (1965), González Casanova (1965, 1976), and Bonfil Batalla (1996), as well as more recent subaltern studies scholars such as Guha (1982), Spivak (1985), and Chatterjee (1993)—who in turn have been influenced by Gramsci, Foucault, and Said—and as reinterpreted by diverse Latin American intellectuals, the notion of internal colonialism is a form of socioeconomic-cultural domination based in capitalist hegemony and racism, and historically exercised by local and regional governing elites over subaltern groups. Internal colonialism, by incorporating an ideological assumption of the inherent superiority of one group in regards to another, shifts the emphasis from outside colonial powers to national power bases and their control apparatuses over relegated domestic populations, which in fact together frequently comprise the numerical majority (indigenous peoples, afro-Latinos, women, etc.).
These dominant institutions frequently have ties to external economic models, but power itself is manifested through local structures and dynamics.

**Legacies of the Bolivian Postcolonial**

In the Bolivian context, this body of theory has been incorporated along two predominant lines of thought: first, the ongoing nature of colonialism and coloniality as it is manifested through ongoing physical and institutional domination—i.e., imperialism, cultural or otherwise—by foreign entities. This would include the foreign states themselves (in the 19th century by Great Britain; in the 20th century by the United States); and also outside multinational political, economic and social bodies (i.e., the World Bank, International Monetary Fund, NGOs, etc.). The second interpretation is that of the phenomenon of internal colonialism, in which national institutions dominate and oppress other resident social groups, albeit frequently with the behind the scenes support of external entities.

One tangible result to either or both, in late 20th century Bolivia (although not identified as either a “colonial” or “postcolonial” reaction *per se*, until more recent years), was the shaping of a militant indigenous revitalization movement against what was characterized as a 150-year-old quasi-apartheid colonial state, dominated by a European and *criollo*-descended minority. Prominent among these currents, and whose thought was to prove highly influential until the present day, was Fausto Reinaga, whose texts concerning *indianismo* denounced historical social, economic, cultural, and racial divides, in both theory and practice, between the “two Bolivias…a mestiza-Europeanized and a *kolla*-autochthonous Bolivia” (1970:174). Reinaga advocated for an “Indian Revolution,” in which “the policy of the indian is a total struggle for the liberation of his people” (1971:143) and the overthrow of the criollo elite, including (in taking after Fanon) by violence if necessary. The militant community-organizing efforts done by the
katarista movement, primarily on the Aymara altiplano during the military dictatorships of the 1970s, drew on Reinaga’s work in calling for an end to the “colonial state,” and this has influenced indigenous political movements to the present day, including the MAS (Rivera Cusicanqui 1984, 2006). As further developed by the latest generation of Bolivian decolonization theorists (e.g., Mamani Ramírez 2007; Patzi Paco 2006; Quisbert Quispe 2007; Ticona 2005), internal colonialism takes on a more immediate aspect, containing a mixture of both defensiveness and aggressiveness, particularly in the wake of the MAS 2005 electoral triumph. On the one hand, the significant successes of the long-term social movements and the “indigenous government” itself are seen as under attack from retro and reactionary interests—which has primarily taken the form of the (now seriously weakened, if not nearly irrelevant) right-wing elites of the once so-called Media Luna (Half Moon) eastern lowland regions, with their calls for a highly racialized and economic self-interested political autonomy. On the other hand, Evo Morales and the MAS are frequently severely questioned and criticized by some die-hard radicals for not having proceeded far enough in attacking the entrenched colonial state as they perceive it, and are in turn accused (at least in part) as having been co-opted by it.

The scope of the (de)colonization continuum finally culminates in the highly personal and solitary phenomenon of the internalized colonialism paradigm, in which the given individual constructs an all-encompassing and fatalistic worldview, ultimately serving as a vehicle of his or her own oppression. Although the chain of colonialism may begin with foreign imperialism, in order that it remain latent within a country and a people it must identify minds and spirits conditioned to accept it. Through a process of devaluation, oppression, and violence, the person forcibly colonized by external forces, observes Fanon (1963), becomes dependent, alienated and affected by a lack of self-esteem, even arriving at a variety of self-hatred. As a result, one can
lose his or her own individuality and identity, and in this way actually be molded by the values and perspectives of the colonizer, even attaining a kind of psychological assimilation. In this manner, it is a diagnosis with echoes of the approach previously proposed by Nietzsche (1998), and his identification of the “slave” and “master” moralities; similarly, the oppressed person ends up by identifying with the oppressor, the former desiring to (re)create his own image in that of the latter. The effects of colonialism are, thus, for the most part psychological, and which tend to negatively affect the potential of the dominated person to, first, be able to recognize the very state of domination in itself; and, secondly, to prepare for an active struggle.

Again, for his part González Casanova (1965, 1976) in this respect sees the phenomenon of internal colonialism in a precise sense, which is about coexistence and “cultural shock” within a “dual or plural society” based on the economic domination and exploitation between heterogeneous cultural groups—and which is not simply capitalist-style class exploitation. Rather, in this analysis there are primarily deep traces of (among others) the relationship between feudalism and capitalism; racism and racial segregation; and the humiliation and dehumanization of the colonized. He also recognizes the purely psychological profile of internal colonialism between all those involved—thus, it becomes internalized. However, for González Casanova the condition is much more: most importantly, it is cultural; and, above all, an intrinsic problem of social organization. Hence, the notion of a society which is inherently defective—the quintessential “failed state,” at least in a social sense—and which brings prejudicial effects on various aspects of everyday life. (This also touches upon the notion of structural violence, as I will develop it later in regards to health disparities and discrepancies.)

The Bolivian scenario is, and always has been, extremely complex and contradictory: while resistance and struggle against oppression in the Andean world have been a constant
throughout Spanish colonial, republican, and modern history (among a vast body of work, see for example: Dunkerley 1984; Hylton and Thomson 2007; Mamani Ramírez 2004; Patzi Paco 1999; Rivera Cusicanqui 1984; Stern 1988; and Thomson 2002), thus revealing ideals deeply rooted in the consciousness of a subject well prepared to demonstrate his or her own agency to determine their future, simultaneously it is apparent that these roots lie in the midst of an equally fertile ground of both internal and internalized colonialism. Yet in Bolivia, the coloniality paradigm reality remains active and acute. The many years of free market economic “restructuring” inevitably left a marked social impact on a country that had, for many years of its history, already suffered the injustices of the world economy. Rivera Cusicanqui (1993) takes this theoretical argument into the Bolivian context (while circling back again to Fanon and also to Freire [1970]), in her identification of precise kinds of internalized colonialism and the subaltern nature of society (Rivera Cusicanqui and Barragán 1997), in which the subject (as discussed above) accepts his / her own domination and oppression as the natural order of things, and so remains mired in psychological, moral, social and economic stagnation, and not infrequently attempts to surpass the condition of oppressed by assuming the characteristics of the oppressor. In this, she also names racism as possibly the most insidious evil of them all, for the socially hegemonic effect it can have due to “the profound psychological power of racism (particularly in the veiled shapes of cultural racism) and its capacity to invalidate insurgent actions, neutralize and disqualify the subaltern population, and introduce into them a reproduction of the subjugating framework of the dominant culture” (Rivera Cusicanqui 2002). What had previously been a hidden reality becomes more and more blatantly visible and apparent, until finally the roots of colonialism reveal their kinship with the social crisis of today:
In contemporary Bolivia there operates, in an underlying form, a mode of domination sustained by... long-lasting colonial structures, thereby converting them into forms of internal colonialism that continue to be crucial for explaining the internal stratification of Bolivian society, its fundamental social contradictions, and the specific mechanisms of exclusion-segregation that characterize the state and political structure—which are the base of the deepest and most latent forms of structural violence (Rivera Cusicanqui 1993:30).\(^4\)

Crucially, within this highly charged social, political and cultural context of decolonization, state sovereignty, and power, there have been a number of policies and models both discussed and tentatively implemented in recent years, at differing levels, as means for combatting the theoretical and actual challenges amidst the volatile nature of Bolivian society. Perhaps the foremost of these is the discourse of “interculturality” (interculturalidad): an abstract and somewhat idealized goal of achieving truly integrated cultural relationships, between “traditional” and “modern” development models, in a wide range of social interventions (including health care). A simple and oft-quoted definition of the term identifies the integrated relationships between persons or social groups of diverse cultures or worldviews and, by extension, the attitudes of bearers of one culture toward the elemental norms of another. This is fundamentally a dialectical relation between two opposing poles—one’s own identity, and that of the “other”—that should optimally occur in an environment of respect, reciprocity, and honest exchanges of beliefs and practices, resulting in mutual growth, enrichment, and regeneration (Albó 2004). However, interculturality is not to be confused with *multiculturalism*, here perceived as the shared occupation of a common space by people of different cultures, and frequently limited to interrelationships on narrow terms and conditions and oriented more toward

\(^4\) In this respect, Rivera Cusicanqui again incorporates Fanon and his points of view on the violence, structural and overt, that is both inherent in colonialist race and racial relations, and yet which at the same time is necessary to eliminate colonialism. In the specific Bolivian context, Reinaga also figures importantly into her analysis (as previously discussed) in his dealing along similar lines as Fanon by looking at national questions of indigeneity and racism in his calls for a decisive (and violent) “Indian Revolution.”
assimilation than toward genuine mixing and integration—hence, potentially only a further propagation of a colonialist model (Albó 2004; Fernández Juárez 1999, 2004a, 2006; TARI 2003a). In Bolivia today, multiculturalism is simply a given; interculturality, in contrast, is an active process and dynamic of transformation. Adopted by intellectuals, by indigenous activists, and (at least on paper) by government bureaucrats alike, and expressly perceived as one approach for applying “Bolivian” solutions over foreign-conceived ones, the basic tenets of the model have found their way into documents ranging from radical manifestos, to NGO development projects, and to official state law and policy—generally (it must be noted) with a variety of political motives.

There are, however, dissenting views. Some hold that in Bolivia today an abstract interculturality becomes tangible only in the coexistence and constant conflict of a very unequal balance of power between the indigenous and non-indigenous. Viaña (2009) and Viaña, Claros, Estermann et al. (2009) argue that the true intercultural paradigm is virtually impossible to attain if inequality and a state of coloniality persist; and, that true decolonization is likewise impossible without an effective process of interculturality. They conclude that the unequal balance of power that continues in Bolivia—social, political, economic, gender, linguistic, cognitive—and despite any supposed post 2006 revolutionary change from the ancien régime—impedes any genuine “respect” or “dialogue” on the part of those in control: the structure itself remains intact and intolerant, and propitious only to a mono-cultural dialogue. Thus, the ultimate objective of the intercultural discourse should be to move beyond superficial platitudes about respect and tolerance, and open up channels of genuine exchange and power sharing (social, cultural, economic, political) between differing and competing, and yet complementary visions. Consequently, the conversation about “true” interculturality is synonymous with that of “true”
decolonization, whereas “multiculturalism” (in further developing the model described above) is primarily an essentialist discourse for concealing inequalities and neutralizing the decolonization process (Rivera Cusicanqui 2006:10).\footnote{In a similar vein, Rivera Cusicanqui also makes a pointed criticism of García Canclini (1992) and his concept of “hybridity”: in referring to it as a “neoliberal control mechanism,” she accuses García Canclini of relying heavily on the aforementioned negative connotations of “multiculturalism” in order to isolate people within individual “cultural boxes,” and hence control them more effectively. (Personal communication, November 2, 2006.)} At this point, the intercultural argument becomes increasingly controversial (and dangerous) in that it potentially threatens the entrenched interests of multiple power sectors.

Finally, the unspoken “intercultural question” here is that of the relationship between the supposedly opposing poles of the “Andean” (lo andino) and the “colonial” (lo colonial)—a dichotomy that many characterize as a rather blurry boundary of difference to begin with, and one which in reality probably fails to exist at all. After nearly 500 years of ethnic and cultural mixing—whether forced or voluntary—to speak of a “pure” Andean indigeneity may be naïve at best, and willfully separatist at worst. It is fraught with conceptual and essentialist danger to attempt a characterization of one, by denying its inseparable bond with the other. Social and cultural change is inevitable, emphasizes Thomas Abercrombie; the issue is to be careful not to fall prey to anthropological nostalgia…[that] could pretend to study beautifully hermetic ‘other cultural’ worlds, un tarnished by contact with the rapacious and polluting ‘Western culture’ or capitalism…[this does] not mean to suggest that colonialism did not ‘violate’ native societies, only that they were not pure and closed semiotic orders before the conquest, just as sixteenth century Spanish society was in no sense closed and unchanging. Both Andean social forms and Spanish ones were in the midst of rapid transformation at the time they were thrown together, and both were also transformed as a result of their confluence (1998:22).

Accordingly, this nature of transformation continues to the present day, and consequently “history” itself must necessarily be seen as an ongoing process, especially ethnographic history (cf. Fabian 1983). Both decolonization and interculturality are in themselves processes, working
together in tandem, and impossible to effectively bookend in time and space, or pigeonhole as applying only to one extreme or another, either “Andean” or “colonial.” I thus hope to show here how this played out in the municipality of Puka Wayq’u, under one specific set of circumstances, which revealed both the ongoing validity of the decolonization / interculturality duality and also the quality of, in practice, their very subversion.

_Trapped on the Continuum: Biomedicine, Ethnomedicine, and Coloniality in the State Health Services_

The situation in Puka Wayq’u was a paradigmatic reality of health status and available services not only in the municipality itself, but also that of so many other rural areas in both Chuquisaca and in Bolivia as a whole. And, it was starkly representative in its way of approaching the health dilemma of the indigenous population that it purported to serve, and which had long been a matter of both programmatic and theoretical debate. In order to partially address this, the project of decolonization that the MAS government has stated as its central overriding objective, in theory and in practice—key to the “refounding” of Bolivia—includes the health sector and the entire array of social, economic, political, and cultural apparatuses at work in the country. In itself, the very notion of coloniality as an undeniable component of the historic and lived Bolivian reality is expressly alluded to as part of the national development program, including health reforms, in the *National Development Plan: Bolivia Dignified, Sovereign, Productive and Democratic to Live Well* (Plan Nacional de Desarrollo: Bolivia digna, soberana, productiva y democrática para Vivir Bien, 2006). In regards to the health sector, through these governmental restructurings the intention is—as proposed by the post-2006 Bolivian state—to precisely address in a direct fashion what has been a centuries-old record of what may be
referred to as “medical colonialism,” as implemented by the official state health services.\(^6\) It is this reality which the Puka Wayq’u health services formed an integral part of, and which they replicated and sustained, throughout the period of these observations. Therefore, in order to properly contextualize the series of events as they occurred in the municipality, and their import as a representation of larger forces, there must then be recognition of the theoretical framework of colonialism and coloniality in Bolivia as it pertains to health and curing.

Even under the aegis of the MAS government—and definitively prior to it—there still exist a great number of gulfs between the varying strata of the Bolivian population: cultural, ethnic, economic, political, and gender-related. And while Bolivia continues to live its own peculiar variety of colonialism, both external and internal, and which forms the basis of the national decolonization project, the dilemma of health remains as one of the most persistent. Despite decades of efforts to improve the situation, through both national and international policies and programs, the great majority of the population—both “subaltern” and, to a significant degree, the population in general—is marginalized, condemned to suffer morbidity and mortality indicators which place the country near the bottom of Latin American socioeconomic rankings. Although the official statistics seem to show that there have been considerable successes in recent years, these are only infrequently apparent, and actually felt, among many strata of society: as statistics are wont to do, they reflect an overall “average” of the population, which in this case is heavily skewed by stronger, generally more positive, numbers for the urban areas.

In tracing the lines of coloniality throughout the health field in Bolivia, my focus of analysis here is primarily on the most common biomedical professionals at work in the rural and

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\(^6\) As to the relative success or not of these reforms to date, and the impact that they may or may not have had on the health sector since the events of 2003 - 2004—and again, much of this within the theoretical models of interculturality and decolonization, as officially conceptualized beginning in 2006—I will consider this in Chapter 5.
underserved areas: first, the physician; and, to a lesser degree, the registered nurse. These are the two positions which overwhelmingly dominate in local health services decision making, with their higher-level status and control, typically urban and more “cosmopolitan” associated, over more local positions such as nurse auxiliary and health promotor. It is the role that these individuals play as links in the chain of reproduction of the entrenched colonial hierarchy: in this case, as represented by the deplorable conditions of health, and of public health overall. Yet, they are also victims of it: figures located in the middle of a continuum, simultaneously dominating and dominated, between many other figures beginning, at one extreme, with the large bi-lateral and multilateral funding and planning organizations; passing through the national government itself, including departmental, regional, and municipal authorities; taking into account the lower-level health workers; and finally finishing, at the opposite end, with the sick, ill, or dying individual.

**Health and imperialism: the past and present hegemonic model**

The debate over the colonial nature of the health system must begin in the past, with the history of medicine not only in Bolivia, but also in Latin America overall, and in the Europe from which the colonizers arrived. As such, the genealogy of health colonialism in Bolivia—as a function and instrument of internal colonialism, as previously discussed—and in the same way as in many other Latin American countries, has much to do with external colonialism. That is, the new forces of sanitary order arriving from Europe in the 16th century were effectively imposed by force on the autochthonous medical system already in place. For all practical considerations, this stage continued to occur throughout the succeeding centuries, as a product of the Enlightenment and the transformation of “science,” including medical science, on the European continent. After the scientific revolutions of the 17th and 18th centuries, medicine in
Europe was transformed: from the native, the humors and the Galenic, the discoveries of the new science led to the creation of formal medical schools and the professionalization of the discipline, thereby establishing another class of elites, and thus further exclusion and social control. These norms were then exported to the colonies in Latin America. Over the centuries, western medicine established its hegemony over the colonized peoples, as another means through which power relations were exercised by the elites over the indigenous and the new mestizo and afro-Latino populations. Prior to the early 18th century, however, there had been a fragile truce between indigenous medicine and the western importations, perhaps due mainly to a colonial modus vivendi of mutual cultural exclusion. However, with the growing institutionalization of medicine as a formal profession, the suppression of domestic practices of self-healing were initiated, alongside of the open persecution of indigenous health practitioners by the colonial governments (Cueto 1996).

Successive decades throughout the 19th century saw a progressively strong increase in exclusionary measures related to health and health services. As the relative power of the new Latin American republics grew, so did the control that they exercised over their populations; one form of external colonization simply transformed itself into an equally repressive variant of internal colonialism, just as external Spanish colonization was transformed into internal repúblicano colonization (Medina 2000:53-54). In this particular instance, the vehicle for the colonial reproduction was through social structures such as the university, the medical school, and the local health personnel in direct contact with indigenous populations. In many ways, health care was simply another area of civilian life to appropriate; “sanitary legislation played a crucial role in expanding the powers of a nascent state bureaucracy that sought to deepen its involvement in society”—and thus an interest in health on the part of the state and local elites,
largely due to a desire to protect and increase the productivity of the workforce (Cueto 1996:19, 24). This process over the centuries, in turn, meant an increased consolidation of the hegemony of western medicine, the social control as practiced through it, and another way for local and regional elites to exert relations of power over the indigenous, mestizo and afro subaltern groups. The end result was that of a dehumanization of the body, and a colonization of both the individual and of local cultures. Medicine itself was transformed into a body of laws, coercion and repression; the human body became an object, and no longer a subject, in the hands of one prominent subsection of the new ruling classes, as were physicians. As yet another instrument of power based in imposed hierarchies, medicine was thus used to justify a supposed racial, ethnic and class superiority based on a privileged knowledge of the “truth,” and as such an unassailable domain by the uninitiated and the powerless (Foucault 1973).

Significantly, this elitist / quasi-mystic ethic was ingrained into the health system of Bolivia and other Latin American countries through its incorporation as a key tenet of biomedical training in itself. Throughout the 20th century and beyond, the trend toward medical specialization and the growing use of increasingly technological (and expensive) medical interventions is linked with the frequently weak (in an academic sense) professional training offered in Bolivian medical schools, utilizing courses based on foreign models (typically, European and American), but simultaneously lacking sufficient financial and technological resources. However, unfortunately, these same models frequently do not take into account the social, cultural and ecological environment and the direct well-being of the subject, and more typically have created a significant degree of alienation between both providers and indigenous patients. As part of this dynamic, they serve to reinforce the power of certain groups over others,
and the aforementioned “objectification” of the human body. Thus (and with the incorporation of a Marxist framework),

These models...reflect an engineering approach to the understanding of the body and its diseases and tend to ignore the understanding of the socioeconomic environment that brought about the diseases. The emphasis on hospital-based, technologically-oriented medicine and especially individual, acute-episodic care, typical of the medical education of Western, developed societies, is replicated in the developing societies...because the means of production and consumption in the health sector are controlled by the lumpen-bourgeoisie, which desires the same type of care...given to the people in developed lands (Navarro 1981:20, 27-28).

In this manner, a facet of external colonialism reproduces itself through social actors present in the same environment and the same subaltern culture. It is, rather, that the structures of knowledge replication in Bolivia and Latin America—in this case, universities and medical schools—are typically revealed to be no more than yet other structures of internal colonialism which still remain firm, and which serve to channel the interests and desires of the developed world. In Bolivia, as in almost any Latin American country, curriculum and medical training in great part have traditionally been tied into international development projects and have received financial support from international institutions and NGOs, often channeled through official programs of the national Ministry of Health and Sports (Ministerio de Salud y Deportes, MSyD) and a multitude of other governmental organizations. Together with this professional training went the capitalist and hegemonic ideology of scientific medicine; a real-world and “cultural” shock with local ethnomedical practices; and the habitus of the physician trained in western medicine, expensive healthcare, privilege, elitism, and social control. In effect, it is a reproduction of a contemporary capitalist model as applied to health services, and the result is a “crisis” in the biomedical field due to spiraling costs, ineffectiveness, and continuing inequities (Navarro 1986).
To speak properly of the health situation in Bolivia (as in a host of other underdeveloped countries), as it has been developed over decades and centuries, it is essential to also talk of the outside political and economic forces that continue to influence it in the most outstanding ways. In this respect, it can be affirmed that the tangible and acute deficiencies inherent in the Bolivian public health system, both qualitatively and quantitatively, have been due in large part simply to a poor distribution of resources: human, material, and economic. In addition to the historical elements already referred to, the deep background of this situation—without discounting the undeniable relationship to such internal factors as corruption and mismanagement within state offices—points to an historical source in the economic policies of the developed countries of the North, and its articulation through international organizations (multinationals, bi-laterals) that implement programs for the underdeveloped world (e.g., the World Bank, the International Monetary Fund, the United States Agency for International Development [USAID], affiliated NGOs, etc.). These global policies are designed not so much with the final objective of an improvement in the problematic social situations of developing countries, but rather with the subtle aim of perpetuating the economic systems of the donor countries themselves; the end result is then “the nature, subject, and control of economic and social investment leading to a pattern of production and consumption aimed at optimizing the benefits of the foreign and national controllers of capital, and not at stimulating the equitable distribution of health resources” (Navarro 1981:23). To recognize this as in essence a *fait accompli*, something that “was not only part of a phase of development, but also a recurrent feature of underdevelopment and dependence on foreign powers” (Cueto 1996:25), these exchanges between international and national interests are transformed into types of “dual economies.” With the process of economic inequality and underdevelopment that is encouraged through the incorporation of international
capital and foreign values, ultimately the distribution of health resources “follows an inverse relationship to the need for them” (Navarro 1981:26).

Finally, the abundance of services, goods and health products with prices which have historically been out of the reach of most has led to, again in Navarro’s words, a “pattern of consumption by type of [health] care, in both developing and developed countries, [that] is characterized by the broadening of choice for the few, and the narrowing of choice for the many” (ibid:28). This dichotomy can be summarized simply by pointing out that the greater distribution of resources is due much more to the greater economic power of the consumer (the developed countries), than to the relative power of the producer (the underdeveloped countries)—and, as such, the extension and deepening of the acute social crisis, including that of health, in the latter. It is thus the perpetuation of a hegemonic system with historic colonial origins, in which the core continues to benefit at the cost of the periphery and semi-periphery (cf. Wallerstein 1974), a consequence of which is reflected in the overall state of public health.

**Health and imperialism: internal(ized) colonialism and the medical metaphor**

Within the colonialism framework, health as a subject of focus is congruent with the concept of structural violence: that is, that of the basic right to good health, including the assertion that injustice and social inequality are *in themselves* essentially pathogenic, and direct causal agents of poor health (Farmer 1999). Thus, it is impossible to talk about eventual improvements in health status overall, without touching upon the topic of both external *and* internal hegemonic forces; the reality of health in this volatile environment, and the reality of health workers themselves play a critical role in the reproduction of the colonial state. In Bolivia, this chain is long and deeply rooted. It begins with the upper echelons of “international health”—the major professional bodies in the world of development (United Nations, World Bank, USAID, etc.); it then passes through national ministerial levels and the advisers and local
technocrats in residence; then on to the regional health directorships; later to the provincial health districts and municipal health centers, such as that of Puka Wayq’u; down to the peri-urban and rural health posts, and the local physicians, nurses, and nursing auxiliaries; and finally arrives at the patient: the person who must navigate this complicated system, if only at the lowest levels. This is, it should be emphasized, without taking into consideration the various alternative healing systems also present, of which the ethnomedical providers are the more widespread; in addition, it is also necessary to recognize other parallel biomedical resources utilized by the population—for example, in Bolivia the ubiquitous home-based, informal para-professional who gives injections and inserts intravenous medicines; or the employee of the local pharmacy who also prescribes medications as well as sells them. Each of these individuals is yet another link, each dependent upon the other, in a relationship which projects either toward above or toward below.

The rural medical doctor occupies a place situated approximately in the middle, or perhaps a little bit further down, in this sequence. Toward those above, the physician assumes a position of deference and respect to the immediate superiors in the regional and possibly municipal health districts; toward those below, he exercises an authority over the auxiliaries and perhaps community health promoters—and, of course, over the patients themselves, who are typically indigenous within a rural context such as that of Puka Wayq’u. Historically, this professional has usually (although not always) originally been from a large urban area; from the middle or upper classes; often enough without great proficiency in the native language of the region (such as Quechua in the case of most of northern Chuquisaca department); and, in one way or another, is located outside of the campesino or indigenous cultural context. However, and for better or for worse, this person is responsible for the “official” state duties of monitoring
the public welfare in regards to sanitary policy at the local level, in his or her role as one of several representatives of an abstract administrative entity and the powers of the elites which sustain it vis-à-vis the popular masses. Medicine and public health services thus serve as mechanisms within the asymmetrical dynamic of a low-level, community-based “war of position” between the dominant and subordinate classes (cf. Gramsci 1971), and are merely other components within a system of social coercion and control. Explicitly “sovereign power,” as exercised in the past by an openly colonial European state in the Americas, has been replaced by the “disciplinary authority” inherent in the functional mechanisms of the independent but neo-colonial state. In this case, biomedicine—here as articulated by the low ranking physician—does not consist of a centralized power, but rather one which is diffused and dispersed throughout society, and implemented according to the respective need and occasion (Foucault 1973). This vision and this power are instilled into the physician from the first day of professional training: the urban, third level hospital, with its “sexy” late model medical technology, is typically the ultimate career objective; while the rural areas, with their ill-equipped and poorly stocked health centers and health posts and chronically precarious health status, are the equivalent of an unfortunately obligatory (but hopefully temporary) purgatory.

In general, the disadvantaged populations intuitively recognize the nature of this power, and this awareness lives within both of the groups respectively involved: the dominant, and also the dominated. The latter makes use of biomedical health service resources (i.e., the local health posts) with an attitude of deference and submission—when confronted by what is often an ongoing process of cultural misunderstanding on the part of the medical personnel—and which clearly represents another manifestation of the historic and colonial patron / indian relationship that is constantly re-enacted,
by means of domination over discursive and normative production, and by the
discretionary use of powerful institutionalized (state) mechanisms of cultural discipline
toward the cholo-indio world. Through this monopoly, all other sectors are relegated to
the status of mere “subjects” of a foreign state (Rivera Cusicanqui 1993:111).

In this manner, it is possible to identify how the markedly colonialist relationship between doctor
and patient is embodied by means of the treatment imparted by the former onto the latter, and
how the latter defers to the former. The frequent patriarchal and chauvinistic attitude of the
health services personnel toward the indigenous campesino may even arrive at levels
approaching contempt, and a kind of moral condemnation—and this stance is not by any means,
regrettably, limited only to male physicians. On one occasion, for example, a female registered
nurse I knew who attended at one local health center where I had worked—and who was also a
Catholic nun—when she heard that a local woman known to her was pregnant again, commented
casually and dismissively that “these indians screw like rabbits.”

With this in mind, the chronic poor attendance at rural health services makes all too much
sense. Perhaps it is a strategy based on fear and caution: indeed, there are many in rural Bolivia
who still equate the official state health facilities in the same manner as their ancestors during the
colony and the post-independence republican era: a concept of the hospital as a wañusqa wasi
(“house of the dead”), where the sick entered, but never left alive. However, and when all is said
and done, it is more important to emphasize the question of the degree to which it might be
possible to imply a level of actual complicity among those same “subordinates,” and their
internalization of historic colonialism, without also recognizing possible modes of struggle. In
addition, how it is that externally imposed social and economic systems have been variously
resisted, assimilated, or co-opted by the indigenous populations. The marginalized classes in
Bolivia are well-documented for their adherence to a multitude of strategies of resistance. In
regards to health and the official health care services, the tactic of defiance that may be the most
prevalent is simply that of refusal: an abandonment, a non-use, a subtle rejection of the medical facilities, if it is not an emergency of absolutely last resort; a type of variant on the “weapons of the weak” premise (Scott 1985), and which I will examine closer in Chapter 4. I was reminded of this all-too plausible situation one day in conversation with a student intern at the health center, who frequently expressed to me her impatient anticipation of an imminent “return to the city, to work in the hospital with modern equipment and adequate medications,” and how she really felt that at any rate it was a waste of her time to even be out in the campo (countryside) in the first place: “Everybody here must be healthy anyway,” she shrugged, “because they hardly ever come to the health center.” When confronted by such an interpretation of reality, the potential status of the medical personnel as equally a victim stands out in even greater relief: a poverty of equipment and supplies, a poverty of academic and vocational training, a poverty of social and cross-cultural comprehension, a poverty of critical analysis, and a poverty of self-determination against the very model of a colonial scientific framework.

Yet it is the widespread—and often preferred—use of traditional medicine (ethnomedicine) which has proved most durable and most notable within the Andean (including Bolivian) context of illness and healing. The supposed theoretical and practical objectives maintain that both the ethnomedical and the biomedical systems should be equally recognized as cultural apparatuses, each with its own respective worldview, and with respective strengths and weaknesses—which are certainly often highly subjective, depending on the individual’s personal cultural reality. The ideal is that both systems actively interact and function together, in an environment of mutual respect and tolerance, for the benefit of the patient: this, again, is the intercultural paradigm. As a subject of study, in Bolivia ethnomedicine has traditionally been reviewed most comprehensively (although not solely) as part of a cultural framework emanating
from within the Andean (as opposed to the tropical lowlands, or the *oriente*) worldview (for example, and among many, Aguiló 1985; Alba and Tarifa 1993; Bastien 1985, 1992; Rösing 1990). As a potentially active *counterpart* to the dominant hegemonic biomedical system, and everything that this represents, in recent years there has been a series of sporadic experiences, experiments and studies, both formal and informal, advocating for the theoretical, philosophical and practical integration of both traditional and western health models within the Bolivian system, in distinctly intercultural modalities, in order to achieve a working synthesis of the two “medical cosmovisions”—a working version of intercultural health. This is frequently classified and documented in the literature as *chachawarmi* (Aymara: “man and woman, together,” in a still-living legacy of pre-Colonial Andean gender parity, albeit to a significantly lesser social degree): that is, a fusion between the competing and contrasting health care systems (e.g., Bastien 1992, Fernández Juárez 1999); or, as an active dialectic involving a “meeting of knowledge systems” (“*encuentro entre saberes*”) for mutual exchange and reciprocal benefit (Citarella and Zangari 2009). In counterpoint, however, some more recent critical interpretations of the intercultural health trend in Bolivia see it in a decidedly more unpromising, if not negative light. In this interpretation, the policy is little more than an imported, highly vertical, “stealth” concept designed only to gloss over the biomedical system with a kinder, gentler façade, the ultimate objective of which is to lure people into the state services and hence into biomedical hegemony (Loza 2008). Or, in a related fashion, it is a cheap economic and political strategy to dupe the indigenous and proletarian public into believing that the state is undergoing a transcendental health change to their benefit, when in actuality the central issue should not be intercultural fusions, but rather that of rectifying chronically deficient, understaffed, under equipped and poorly trained health services (Ramírez Hita 2011).
Finally, in specific respect to evaluating the choices made in negotiating biomedical obstetric care (emergency or otherwise), there have been efforts examining the legal and cultural background to interculturality, treaties and conventions which have had a bearing on programs, and specific matters applied to reproductive health (TARI 2003b); as well as the observed and stated primary impediments preventing indigenous Quechua and Aymara populations from seeking out the formal biomedical health services, even in times of obstetric crisis (Arnold et al. 2001; Bradby and Murphy-Lawless 2002).\(^7\) In addition, and within the complexity of these analyses of the intertwined social relationships between the indigenous populations, the state health services, and the private sector, a unique national context of medical pluralism must not be neglected for acknowledgement and recognition (see Crandon-Malamud 1991).\(^8\)

However, it often seems irrefutable that the difficulties in the actual realistic implementation—of what admittedly may ultimately be more of a romantic ideal, than a feasible potentiality—are primarily owing to a resistance and / or lack of seriousness, commitment, and in the end respect by the practitioners of western biomedicine, rather than that of the ethnomedical providers. The longstanding dichotomy of conflict and competition between the two models is evident in all relations concerning health care between those seeking attention—indigenous or non-indigenous, urban or rural; and also of the providers themselves—whether these are biomedically or ethnomedically oriented. Whereas in regards to actual curing

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\(^7\) Outside of Bolivia, the literature on health seeking behavior during pregnancy and birth is extensive. For one representative study of similar issues in Latin America, here specifically Guatemala, see Berry 2006. In this, women are seen not so much as consciously rejecting biomedical services, but rather that the state health model simply does not “make sense” within the already existing cultural paradigms concerning pregnancy and birth.

\(^8\) In her innovative and influential rethinking of medical pluralism within the Bolivian framework (in this case, through the ethnographic observation of a small Aymara town), Crandon-Malamud (1991) suggests that power relations are expressed through interpersonal medical discourse. An ill person’s medical choice of which provider he or she selects—biomedical or ethnomedical, both or neither—is a way with which to reaffirm identity, establish social status, and negotiate social power and positionality. As part of this model, medicine and medical dialogue are “primary resources,” while the “secondary resources”—the desired-for benefits—are economic improvement, social mobility, political influence, and cultural positioning itself.
outcomes, with results that are frequently unclassifiable—the empirical efficacy of the two models may be without conclusive answers; each case and each cure is fluid, and relative to the specific and particular relationship between patient and curer (Waldram 2000)—the divide is perhaps best felt in the very nature of the relationship.

In practice, this is frequently one of interconnectedness and interdependence, yet also one of undeniable biomedical hegemony: thus, it is very much a question of power (or, the lack of power), and highly unequal power relations within the sociopolitical and cultural context. These are heavily skewed toward the biomedical side—that of domination, control and the purported superiority of one system over the other, while couched within a mentality (both subtle and overt) of racism and cultural ignorance. For example, it is much more frequent the case of a curandero or other traditional healer who recognizes his or her limits in a specific situation, and knows to refer a patient to a biomedical provider; than one of these same western physicians also being able to recognize (or admit to) their own professional limits, when confronted by a patient subjectively within the realm of what might be termed an ethnomedical, metaphysical, or “cultural” illness (or, perhaps more pejoratively, “folk” illness), and refer them to the community curandero or to the yatiri (a quasi-local version of a shamanistic provider). “She does seem kind of bored here,” one of the local nurse auxiliaries observed to me, in reference to the discontented medical intern who had made the remark about the apparent lack of patients at the health center. He himself was from one of the nearby rural communities, perhaps around 50 or so years of age, and with several decades of work as a trained auxiliary; he also served as a translator into Spanish for some of the medical personnel, including this particular intern. “But they come to *me,*” he whispered in confidence, almost conspiratorially, with a faint smile, in regards to people
from the surrounding communities; “I know how to heal them, too. I also know other ways to heal, that the doctorita doesn’t know. Many times people prefer those instead; it depends.”

Of course, key in all of these considerations is the relative position of the patient, as a subject: which of the two alternatives is more appropriate for whatever the specific case may be, the ethnomedical practitioner or the biomedical? In many cases, the determining factor is simply an economic one, related to the costs of the respective service given; in others, it may very well be more related to questions of logistics and ease of access. But also of critical importance, more often than not, is the “cultural factor,” and the familiarity and comfort that the patient feels with the person who seeks to cure. However, the increasingly common paradox of this situation is that many times the campesino or indigenous person may decide not to go to the local ethnomedical personnel, precisely because the biomedical option is perceived as someone more “modern”: a belief that what is western and “official” must therefore by nature be better, precisely due to that practitioner’s knowledge of the city and perceived notions of whatever may be construed of as modernity, and of large, technology-filled hospitals and scientific medicine—that is, due to their elitist and mysterious process of acquiring learning and practice. One way in which this tendency manifests itself is the striking demand on the part of so many indigenous patients—if not those among the Bolivian “subaltern” populations overall—who do chose to opt for the biomedical alternative (antibiotics, injections, intravenous solutions), and many times when these particular interventions have no relationship at all with the respective disease from a purely biomedical perspective. Not so ironically, when dealing with an indigenous patient with this outlook the western physician finds his own position of dominance to be strongly refortified, through the validation of the potent myth surrounding the essential power of his medical “gaze” (Foucault 1973). Consequently, it is possible to identify in this attitude of respect—if not fear—
toward scientific medicine what Memmi, Fanon or Freire would see as the very same justification for what should, in all appearances, be the counterproductive reproduction of the (neo)colonial world of superiority, domination and power, as effected through the social relationship between the western physician and the poor and / or indigenous patient.

But in the end the figure of the Bolivian physician, and especially the rural physician, is certainly much more than just a metaphor. She / he is also both a tangible agent and victim of an ongoing colonialisit system, long-standing but still surviving in its own way. It is a figure which responds to the demands of a society that still classifies the nature of a “professional” in a very specific, yet skewed, manner—and frequently (with some marked exceptions) without considering the possibility that there just might possibly exist other debates, other realities. Furthermore, in order to personally advance within the society of the western world—the dominant world—the physician must conform to a framework of given, established social and cultural conditions and suppositions, or there will simply not be any discernible or quantifiable professional advancement. In addition, integral within this existential agenda is the recognition, the acceptation and the actual practice of the biomedical physician’s true position as a member of the social, cultural and political elite, one who occupies an elevated position above the sick indigent, campesino, and indigenous person. The fact that, on many occasions, this position is also relative to others yet more elevated than herself / himself on the continuum, does not change the relationship to those who are lower, to those who are of the subordinate classes: in fact and in actual practice, for these latter groups the tangible and qualitative difference between the lowly rural doctor and the person of the very same Minister of Health is most probably so insignificant, as to be nonexistent.
Critically, all of these social dynamics must necessarily now be perceived during the current time period in Bolivia—that since 2006—within the framework of contemporary social movements, which have effectively (albeit sometimes controversially) attained their own brand of social control and political power, if not hegemony. In a vibrant climate of ongoing transformations involving individual and collective agency, ethnic identity and cultural revalorization, all of this implies a much more active and profound insertion of the indigenous majority into political spaces (civil society, state processes) that were previously closed to them. Also implied are the previously latent discourses, but now exponentially exploding and increasingly influential at national policy levels, of multiculturalism (however limited as either a theoretical or functional template) and interculturality within the national context; the extent to which these may or may not be affecting the manner in which health and health care are conceived and actually implemented in practice; and their potential consequences among the indigenous public. (I will consider the possible nature and future of these marked, and ongoing, social and practical changes in the concluding chapter.)

**Puka Wayq’u: In the Reflection of Change**

The two-lane highway heading east from Sucre is paved as far as the provincial capital of Tarabuco, 64 kilometers distant, at which point it divides in two: the asphalt continues along with the main road, which winds on for a few hundred more kilometers through the high, dry and crevassed mountains, until eventually descending into the sparsely forested and often unbearably hot “green hell” of the Chaco plains. The other branch, however, slowly bounces through the narrow, cobbled streets of Tarabuco: past the cracked adobe walls and chipped terracotta tiled roofs of the Spanish colonial town, which has nevertheless long been the most important
indigenous Quechua center of the region. Immediately afterwards, it turns into a rutted and dusty dirt road (often impassably muddy, during the rainy season), partially graveled in only the past couple of years as part of an interminably stalled local highway improvement project. An hour’s driving time is then spent passing through dry river beds and small villages where monolingual Quechua speaking men and women, many of their heads still covered by the Spanish conquistador-inspired, helmet-styled stiff hats (monteras) which have been worn for the past 400 years, tend to cows, goats and sheep. In their own way, these are tableaus which give an illusory impression of timelessness following the classic anthropological mistake of “denying” or “circumventing” coevalness (Fabian 1983:25, 41), in failing to recognize and acknowledge the slippery nature of relative temporality and the many faces of an ever-changing “modernity.”

The road finally enters the municipality of Puka Wayq’u itself after crossing a dry gulley skirting the community of Huayra Cancha. A little way further on, it passes through Villa Rosario, which is the nucleus of the altura region of the municipality: one of the larger communities, it has a health post, a boarding school (internado), a person empowered as a local civil registry, a small Catholic church (but without a resident priest), an even larger structure which houses the only municipal evangelical sect, and a walled, sprawling, but crumbling and decrepit 19th century hacienda, which dominates one edge of the town. In tandem with a small, community-operated one-room museum on the opposite side of town—which exhibits numerous examples of the handmade weavings (axus) that the region is noted for; intricately composed depictions of village life in vibrant tones of purple, red, black and white, and which take many months each to finish—the hacienda and the museum represent the longstanding aspirations of the local population to attract the lucrative foreign tourism industry. In actuality, however, on a
monthly basis at best only a few handfuls of tourists ever appear in Villa Rosario, usually through tours organized directly from Sucre as an “off the beaten path” side trip following a visit to the more heavily transited regular Sunday artisans market in Tarabuco. Consequently, both the hacienda and the museum are more frequently closed and shuttered.

After leaving Villa Rosario, the narrow road twists on for several more kilometers, climbing higher into the rocky and nearly treeless mountains, through passes cut into the cliff sides, snaking around hairpin turns overlooking abrupt and slender gorges, and occasionally sighting a distant adobe dwelling. Regardless of whether it’s a traveler’s first trip on this sector of the road, or only the latest of many trips, it seems never-ending. Then, after what had initially appeared to be just another tight curve around the mountain face, suddenly and unexpectedly to the right a wide, immense canyon opens up before the eyes: bordered by sharp, high red dirt cliffs at the outset, which gradually spread aside and transform into gentle slopes farther ahead, a rolling, green valley floor stretches on for many kilometers toward the horizon, broken by low, pointed hills in the distance. A broad, semi-dry river can be seen winding through the valley floor, and by its side, far below the mountain pass, a small town: set amidst clumps of scrubby treetops and neatly outlined green fields, at this point all that is visible are tiny white-washed walls and red tile roofs, seemingly isolated and alone, an island of human habitation on the rumpled valley floor.

This is the town of Puka Wayq’u itself, the municipal capital, where I lived with my wife, Karen, and our son, Natán, for over a year, and to where we have frequently returned afterwards. From the first moment that I caught sight of it far down in the canyon, and each time that I have come back—after days, weeks, months, or years—it's condition of physical and geographic remoteness has struck me. When glimpsed off in the distance at the bottom of the valley, it
seems so far away, hidden, so “on the other side, beyond the mountains,” with a funny kind of Shangri-La mystique to it. For me—and despite what the quotidian reality of life among the local citizens may have actually been like, as I would learn soon enough—that first view of the town, before the road zigzags back and forth on its alarmingly precipitous descent of a few thousand feet and eventually passes the first house of the outlying communities, has always imparted it with what is almost a breathtaking, magical quality.

Although it was true, as I was soon to learn, this sentiment wasn’t necessarily taken by all in a positive sense of the word. I heard a story once about a new medical intern from Sucre who was arriving for the first time in the municipality, assigned by the regional health services to complete his required three-month rural training stint, in what could just as well have been any one of the random Chuquisaca communities. From the back of the local supply truck in which he was traveling, when it arrived at the point where the town first becomes visible far below he asked a companion if that was Puka Wayq’u. When told that it was, the intern banged his hand on the side of the truck, and called out for it to stop; he grabbed his backpack, climbed down, and walked wordlessly and determinedly back in the opposite direction toward Villa Rosario, never to be seen again. Whether this ever actually occurred, or was in reality something more of an apocryphal tale, I don’t know. At any rate, it was a pretty good story—and seemed to sum up for me a prevalent “native” sense of self that would periodically surface among the people of Puka Wayq’u: that of being relegated, semi-forgotten by the authorities, perpetually on the fringes, yet almost proudly (and perversely) simultaneously both combative and indifferent to that same fact. In reality, however, the municipality was only forgotten until occasional unexpected events would suddenly thrust it into the frame of reference of those very same provincial, regional and national authorities—and thus aggressively remind them of its existence.
The Municipality and Its Communities

Demographics and the division of space

The municipality of Puka Wayq’u is located in the department of Chuquisaca, in the approximate center of Bolivia, of which the city of Sucre is the capital. In 2004, the official government population figures for the municipality stood at a total of 9,241 inhabitants (INE 2002); the local health center’s own calculations, in contrast, maintained a figure of 10,173. The most recent official population projections at this date, for 2011, determine a municipal total of 10,990 (INE 2012); as such and following the governmental figures, the municipality shows an average annual population growth rate of 2.7 percent. A major discrepancy with all of these figures, it should be noted, is the population total obtained by the 2007 Puka Wayq’u communal census, undertaken under the auspices of the municipal government and a private consulting

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9 This is in addition to being the historic and constitutional capital of the nation as a whole, and where the Supreme Court is located (which, since the ascension of the MAS government to power and the new constitution of 2009, is now called the Supreme Tribunal of Justice [Tribunal Suprema de Justicia]). Hence, Sucre is the site of the judicial branch of government, whereas the executive and legislative branches are to be found in La Paz, which is thus the de facto and effective seat of government itself.

10 Based on personal observations, I would question these projections, particularly the average annual growth rate itself. Indeed, my own cautious analysis would be to speculate a relatively static rate, if not an overtly negative one, rather than the moderately positive calculation as estimated by the National Statistics Institute (Instituto Nacional de Estadística, INE). During the years in question, Puka Wayq’u suffered the same erratic weather that much of southern Bolivia was subject to, including both flooding and prolonged dry spells, which adversely affected the local economy. As a result, rural to urban migration kept relatively apace with the national (and international) trends of a gradual rural decrease, as many people gravitated toward Sucre, or perhaps to the large agrarian and industrial capital of Santa Cruz in lowland eastern Bolivia, in search of work under better conditions. Additionally, this period was precisely one of markedly high international migration movements in Bolivia, especially to Spain and Argentina and still to some degree to the United States, and Puka Wayq’u was no exception. In some cases, entire communities were virtually depopulated of young people between the ages of 18 and their mid-20s, as they sought better opportunities (albeit with typically undocumented immigration status) in what were at the time much stronger national economies than that of Bolivia. However, since the economic crises and downturns following 2008, and especially in the years since 2010, many Bolivians have returned home (particularly in reference to the considerable Bolivian laborer presence in Spain), to an economic situation which may not necessarily be all that much better than what they had previously migrated away from, but certainly could not be construed as all that much worse. At any rate, in the great majority of cases those migrants who returned to Bolivia from abroad remained in the urban areas in a permanent fashion, rather than relocating to their rural communities of origin if such was the case. (Among many publications on the subject, for an excellent study of Bolivian international migration and the economic, emotional and social positional impact that it has had on both those who left and those who stayed behind, see De la Torre Ávila 2006.) Following the eventual final release of the official (albeit somewhat contested) data from the census of November 2012, the overall population figures in general almost assuredly will show significant variations, in one way or the other.
firm: 11,806 inhabitants. There is, then, an appreciable range in the different population calculations, as based on their respective sources. On the lower end, it is necessary to take into consideration the unfortunate (albeit somewhat expected, within the local and national context) errors owing to common methodological issues when attempting to count individuals in hard to reach distant and isolated homes, which may also include people who prefer not to be counted in the first place. On the higher end, it bears remembering that the larger the population totals, the greater the probable government revenues received in return when the annual budget allocation planning rolls around—which includes both direct public works monies, and also the distribution of material and human resources to public services, such as local school and health systems.

An overwhelmingly rural municipality, the total population is divided among 32 small communities spread around the municipality; these population clusters may vary in size from the smallest with approximately 80 residents, to the largest with a total of approximately 850 inhabitants. The municipal capital and administrative center, the town of Puka Wayq’u itself, had an official total population of 460 inhabitants throughout 2004; lying in the valley headlands of the canyon, in the approximate geographic center of the municipality, all roads crossing to neighboring municipalities and provinces and to Sucre must at some point pass through the capital. Although over the years and to date these roads have been lightly transited and comprised predominantly of local traffic, there are persistent rumors that periodically resurface suggesting that the regional highway planners are considering a study of Puka Wayq’u as an alternative route to the south of the country—a project that would undeniably have a marked and lasting socioeconomic impact on the later development of the municipality as a whole.

The municipality of Puka Wayq’u comprises four distinct ecological levels, or tiers (pisos ecológicos), at varying altitudes. These include the following: the lowland, hot and humid semi-
tropical valley region (valle), bordering on the Río Pilcomayo, and ranging from approximately 1,900 to 2,200 meters in altitude; the drier and more temperate valley headlands (cabecera del valle), at around 2,200 to 2,900 meters; the “altitude” region (altura), extending from 2,900 to 3,300 meters, closely resembling the average highland landscape around Tarabuco and northern Chuquisaca in general; and finally the “mountain range” (cordillera), with expanses extending from roughly 3,000 to more than 4,000 meters, reminiscent of the frigid climate of the Bolivian altiplano of La Paz, Oruro and Potosí departments. These diverse zones may be considered close approximations of the well-known and oft-cited “vertical archipelago” model first suggested by John V. Murra (1972), a geographic and socioeconomic argument originally focused on historical interpretations of the Inca Empire and its “vertical control of a maximum of ecological levels,” as negotiated between both internal and external ethnic polities. In this, the socioeconomic environment is primarily dependent upon elevation, and each successive tier is notable for the different resources cultivated which are exchanged between communities and kin groups, often as part of a shared economic strategy incorporating diversity and the respective control of space and commodities. The four ecological levels in Puka Wayq’u still adhere to these same principles and practices, and in many ways this geography defines the municipality: that of a society greatly characterized by autochthonous versions of an economic system incorporating barter (trueque) and a form of either balanced or negative reciprocity (Quechua: ayni), and as determined by the relative social distance and routine contacts between the respective communities. In the local context, these involve the frequent transit and exchange of such products as, for example and among many others: fruit (particularly citric) and peanuts from the valle region; maize, wheat, apples, and grapes (this last more typically in the form of distilled singani brandy) from the cabecera del valle; quinoa and barley from the cordillera; many
different grains and vegetables from the altura; and multiple varieties of potatoes which are cultivated in all four regions.\textsuperscript{11}

The local economy is, in following, neatly divided among three distinct groups: in the majority by far is the subsistence based campesino economy, oriented around the aforementioned crops and small livestock. Alongside of this is the merchant economy of the townspeople who dedicate themselves to transporting agricultural goods to the city, and manufactured products back to the municipality; or, to selling goods in the small, local family owned shops (tienditas), and to attending the very few places in town where it is possible to get something to eat (pensiones), only two or three in the entire municipality. Finally, the predominantly “white collar” (within the local context) staffs of the municipal and departmental government offices (town hall, the school, the health center) and the locally operating NGO projects, all of which are almost entirely limited to the town of Puka Wayq’u itself; the sole exceptions are the small schools and health posts in outlying communities, the latter generally manned by nurse auxiliaries but at that time with two additional physicians who rotated among the communities. All of these employees—municipal office functionaries, school teachers, health personnel, NGO workers—are contracted or assigned from Sucre, and so for the most part comprise a reduced number of skilled service workers with little or no stable ties to the communities, and thus levels of long-term commitment to the local population which are uncertain at best.

According to the official statistics, the municipality of Puka Wayq’u is among the most economically disadvantaged municipalities in the country, at the bottom of the national rankings: the total population classified as “poor” is at 98.0%; a total 69.1% of this number is further

\textsuperscript{11} Notably, one mainstay of the typical Andean economy, the coca leaf, is not commonly incorporated within the internal barter economy of Puka Wayq’u. Coca, although its personal and communal use is just as ubiquitous and essential as anywhere else in the Andes for ritual, social and labor related consumption, is not grown at all. Leaves originating in either the Yungas region of La Paz department or the Chapare region of Cochabamba department are sold as part of the direct cash economy, imported through routine urban / rural market ties with Sucre.
characterized as “extreme poor” (INE 2002). At the same time, the overall population
significantly self-identifies as indigenous Quechua (“indígena,” or “pueblo originario,” original
peoples), a total of 95.4% (INE 2002), which places it at a level proportionally among the most
indigenous municipalities in the country as a whole. Similarly, the municipality overall is by far
predominantly Quechua speaking, at 98.4%, with a very high 61.5% classified as monolingual
Quechua (INE 2003). Whereas the 32 communities definitively share many cultural
characteristics between them, including language, each of the four ecological regions is also a
notably distinct micro-ethnic zone: this ranges from the Yampara, or Tarabuqueña, culture of
the altura region, to the fairer-skinned population of the valle, with the cabecera del valle and
cordillera regions somewhere in-between. The most prominent of the cultural differences
between the regions is in regards to local dress: with the exception of the altura zone, standard
clothing is much the same as in most rural regions of highland Bolivia (or lowland regions with
large highland migrant populations): western-style work clothes for men, and for women a
“chola” style (without any intentions of the pejorative sense of the word) dress for women—that
is, variants on the typical multi-layered pollera skirt, with genealogical lineage to both
indigenous culture and the influences of 18th century Spain. However, in the altura region,
geographically contingent with the municipality of Tarabuco and with only minor variations
ethnically, the use of traditional homespun axus and ponchos, together with the montera
headgear, still predominates. Throughout the municipality, the sociopolitical structural divisions
of community life remain constant: since the disappearance, in the early 20th century, of the
traditional ayllu (Quechua or Aymara kin group, or communal unit) in the Puka Wayq’u area, the
dominant political and cultural unit is the labor union (sindicato), a prevailing aspect of rural
Bolivian social and labor categories since approximately the 1940s. In each respective area,
there is a periodically elected (usually annually) echelon of sindicato officials (*dirigentes*), who are important leaders at the community level.

**The local scene / the quality of life**

Very early on in Puka Wayq’u, we were fortunate to find three rooms to rent in the home of Don Alberto Peña Espinoza, his wife Doña Tomasa Padilla Loayza, their five children, who at that time ranged in age from 6 to 16, and don Alberto’s elderly mother, Doña Evarista.12 Both Don Alberto and Doña Tomasa were in their mid-forties; born in the municipality and residents all their lives (except for a brief stint, many years before, looking for work among the vast low-skilled contract labor jobs for offer in the city of Santa Cruz); had studied as far as primary school; and spoke Quechua preferentially as their native language—although their spoken Spanish was also quite good, yet not as proficient as the children’s. Their house was directly off the small Puka Wayq’u plaza, a perfect central location, and yet was at the same time one of the most peaceful and “secluded” places in town: enclosed by a low adobe wall behind the two story house, the property that Don Alberto had inherited consisted of a sizable lot, extending down in the local equivalent of a half block, in which he cultivated a variety of crops that never ceased to amaze us. Maize, onions, cabbage, spinach, parsley, peaches, lemons, pomegranates, grapes, and many others, all planted in the midst of high *molle* trees (*Schinus molle* L., the Peruvian or American pepper tree), and scattered flowers—it was, in essence, a kind of symbiotic, sustainable agriculture, permaculture-like system, and although Don Alberto had never been formally “taught” anything to that effect it produced incredibly well. Regardless, the effect created was that of a small, verdant oasis in the middle of the town—embellished by the

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12 The names that I use throughout for all individuals are pseudonyms, with the exception of public figures at the departmental and national levels. All place names are also pseudonyms, at the municipal and community levels.
occasional visiting dog, chicken, cow, burro, or pig brought in for feeding—and which fronted a small interior stone courtyard that our rooms opened onto.

Don Alberto, Doña Tomasa and their extended family themselves didn’t live in the same house with us: rather, they slept, cooked and ate in much smaller rooms, which were partially in the open air, in a more reduced house directly in front of ours and across a ten-foot-wide rutted dirt pathway that carried the somewhat incongruous name of “street,” but at any rate did end at the corner of the plaza. Nevertheless, the entire family was constantly coming in and out of our patio: the main water source for everybody was found there (a small faucet); there was also another basin for washing clothes; maize, barley, and wheat would be spread about in the patio for drying; and the exigencies of tending to the multiple crops were a constant. Additionally, our house also consisted of four other rooms, which they rented out to a constantly rotating corps of local school teachers, NGO workers, and municipal employees, all of whom had come to Puka Wayq’u from the city for work purposes, and who upon occasion needed attending to. In addition, they owned another two small lots in town where they planted potatoes, and more habitually kept the cows, goats, chickens and pigs corralled. Thus, on the face of things, Don Alberto and Doña Tomasa seemed quite well off, and by local standards they indeed were—which was also the cause of more than just a small share of community sniping, in the spirit of what was one of the most frequently commented upon local characteristics by the townspeople themselves about themselves: that of envy (envidia).

However, economically speaking and in contrast to appearances, in actuality Don Alberto, Doña Tomasa and family were a classic example of resource rich, cash poor. On the one hand, they lived an ideally independent and semi-self-sufficient life, cultivating nearly all of their own consumption needs, and engaging in occasional bartering trips to the other ecological
zones of the municipality. There, in exchange for barley and other types of maize, they would bring potatoes and their home-produced singani. (As Don Alberto fabricated it—in his small, firewood-powered adobe backyard still, drop by drop in all-night marathons, using grapes that he had cultivated himself—it was of an extremely high proof and potent variety, which we were reluctantly but inevitably obliged to sample, and then diplomatically and stoically pass judgment upon, during our chilly early morning journeys to the outdoor toilet beyond the still.) However, it was simultaneously impossible for them to avoid the demands of the market based capitalist economy, which had been undeniably slowly encroaching upon them for years: besides the created needs for products that had become ostensibly indispensable for any rural family, and for which bartering at the local tienditas was obviously not the norm (cooking oil, rice, noodles, canned sardines, packaged cookies, toilet paper), there was also the growing economic bureaucracy of everyday life. An electric bill had to be paid, at least every few months or so when a collector from Tarabuco decided to make his rural rounds; a gas canister was more convenient than firewood for cooking (although Doña Tomasa did still make frequent use of kindling); Don Alberto frequently needed cement for his ongoing construction projects around the house; and there was always some sort of cost associated with the children, usually related to their schooling: new clothes, notebooks, pencils, monthly quotas paid to the local parents association. Consequently, actual cash on hand was needed, and the means that Don Alberto and Doña Tomasa had devised for acquiring this was through renting rooms to outsiders—a method which was also becoming increasingly common among many other people in Puka Wayq’u as the school and the health center steadily grew, the NGO presence notably expanded, and with all of this more and more short to mid-term workers from Sucre were brought in with their
respective housing needs. (And also including, of course, the occasional family of idle researchers.)

Despite their innately indigenous campesino nature and frequently expressed disdain for the aforementioned townspeople, Don Alberto and Doña Tomasa were also arguably in the “indigenous mestizo” mold described by Marisol de la Cadena (2000). Being proficient in Spanish although they definitely by far preferred Quechua as their native language, and possessing a gas stove and refrigerator although they rarely used them (as mentioned, preferring to cook outdoors with firewood), they lived in that gray zone between urban and rural. (Physically, in their case, a rural environment, as opposed to the urban one described by de la Cadena). In this, they adopted one superimposed and evolving set of “modern” norms, values and social constructions, while not fully discarding a more “traditional” ingrained and accustomed way of life. Their indigeneity itself became a virtual social construction, in that their “indian-ness” was enacted in the privacy of their home (including—interestingly?—in front of Karen and myself, when they would invite us to eat with them), yet their “mestizaje” was played out in public. De la Cadena describes how (in her case, for Peru) mestizaje became a sign of urbanity, education, and social status; a process of evolution from “primitive” indian to “civilized” (or “de-indianized”) mestizo. It was something that I couldn’t help but remember, whenever Doña Evarista, or one of the children, or even Doña Tomasa herself (but never Don Alberto, in my experience) casually let slip a stark insult about somebody or other by referring to them as “pigs” or “brutes”—or (disconcertedly), “indios”; or, a patronizing or denigrating comment about the “little indians” (indiocitos) up in the altura region, around the Villa Rosario communities. There was, of course, for the most part virtually no apparent cultural difference between them as a family, and the people living in the altura region: same language, (mostly)
same customs, (in general) same history. There was only one significant distinction between them, which was precisely, and inevitably, the answer that any of them would give me, in a mildly confused voice in reaction as to why I was even asking in the first place:  What makes the people up there in the altura an “indian”? “Those clothes they wear,” our family members would readily reply—those homemade, indian clothes. Thus, self-ascribed identity, through self-perceived modernity: what Hale (2002:524), in looking at Guatemala, terms as “mestizaje from below,” and what might possibly serve as an articulating principle between the dominant social constructs of what makes a “mestizo,” and an “acceptable” notion of what constitutes “indigenous” identity.

Don Alberto and Doña Tomasa had been together for many years, and had the five living children together; in addition, there had been another baby, who had died at age one—“from one day to the next,” as Doña Tomasa forthrightly yet wistfully put it—approximately some ten years before. From all indications based on how she described the event, it appeared to me to have been an instance of all-too-common diarrheal disease and dehydration. Although Doña Tomasa never spoke much of this child to us, it was clear that the death still weighed heavily upon her. With Don Alberto, on the other hand, it was difficult to ever fully gauge and understand his deepest emotions, on this or any other matter. His spoken thoughts were always disarmingly forthright, intriguing, and oftentimes opened new windows for us, but he typically would express a more profound opinion or sentiment only when it was pulled out of him—unless, that is, it was a critical or disparaging comment about somebody or other. In the end and despite his overall goodness, we had to admit, Don Alberto was something of a curmudgeon. It was easy to do a cheap pseudo-Freudian analysis of him: an only child, he had never met his father, and seemed to know virtually nothing about him at all—a mildly unique case in the rural communities, if not
in regards to the missing father (which was an all-too-common situation), then for the fact that his mother never had any other children after him.13 (“I’ve never been with a man,” Doña Evarista told us once with her typically irreverent attitude, early on in our relationship with her. “And Don Alberto,” we cautiously asked, “what about him?” “The wind,” she retorted, both derisively and with the faintest hint of a chuckle in her voice.) Indeed, one result of this was the life-long complicated relationship that Don Alberto had with his mother. (Something of a crank herself, Doña Evarista showed definite hypochondriac tendencies, winding up at the health center for self-diagnosed illnesses on countless occasions over the time we’ve known her.) “I hate her,” Don Alberto bluntly muttered to me once, and then continued with his oft-repeated sigh of self-pity by proclaiming that “I’m just going to go wander off and die.” Yet, he also doted on his mother, albeit in a simultaneously grumbling fashion, which only served to further exacerbate the intricacies of his relationship with Doña Tomasa, who both hated and was hated by her mother-in-law Doña Evarista. “He was never the man I wanted to marry,” Doña Tomasa confessed once about Don Alberto, in recalling what had essentially been something resembling an arranged marriage between two families, when she was still very young. Yet, they had long since reached a common ground in their relationship, and had grown together, albeit sometimes tenuously, in the bonds of a common modus operandi and the obvious instinctive closeness and affection that the passing of the years can bring.

13 In late 2007, Don Alberto suddenly and unexpectedly learned the details of his birth. Many years previously, his father had been an employee of the Chuquisaca health services epidemiological branch, and whose job it was to periodically go from one rural community to another in order to spray for mosquitos with the objective of malaria control. On one such trip to Puka Wayq’u and under poorly detailed circumstances, he had met Doña Evarista—and the result was Don Alberto. He also happened to be married and with a family in Sucre; the wife of this now deceased father had known about Don Alberto’s existence, but understandably had never wanted anything to do with him. However, and in a manner that was unclear to me, his six previously unfamiliar half-brothers and sisters in Sucre had tracked him down through some sort of urban connection, and they had all got together in the city. Don Alberto was visibly very excited when he told me the story—“They say I look just like their papá!” he exclaimed, and that now his newfound extended family (except for the mother) wanted to visit him in Puka Wayq’u. (For her part, Doña Evarista sulkily refused to offer any of her own thoughts on the matter.) Over the long run, however, I noticed that the revelation of his paternity and ready-made siblings did little to alter Don Alberto’s intrinsically moody nature.
Nonetheless, I often considered that these life circumstances in particular—lack of a father and siblings; initially fragile marriage bonds—were what made Don Alberto what he was: an inherently good, caring, and morally upright person, but also a critical, unforgiving and headstrong one as well. It would come out at random moments, such as his peevish demeanor directed toward many people in town; and, in one of the most manifest of ways, his personal attitude regarding sickness, illness, and healing. On one occasion, the entire family was sick with some sort of flu bug that they passed back and forth between them; a few of the kids went to the health center, and got an over the counter cough syrup. But Don Alberto had been vehemently opposed to anybody going to the center at all, and actually became verbally angry with them about it. As I interpreted the scene, in this particular instance it was not in fact any sort of outright rejection of biomedical cures, in relation to another supposedly more efficient traditional method. Rather—and aside from his overall antipathy to spending money in general—it was more that, to spend it on any sort of health remedy at all always struck him as a ridiculous waste not only of financial resources, but of time and effort as well. Don Alberto himself frequently claimed that he never got sick, and that if he did (such as on this particular occasion, with the flu), then he would simply keep on working in his fields until he felt better—“sweat it out,” so to speak, with a kind of “I’m tough, you’re not” mentality. Hence, for him to be sick at all was a form of weakness. This was also closely associated with his obvious constant need to patently demonstrate to everybody around—his family, the community at large, us—how much he could tirelessly accomplish without assistance, every day, from dawn to dusk (and sometimes through the night): constant farming and tree maintenance, frequent chasing after goats or pigs, singani production, ongoing home construction and improvement projects, elected General Secretary of the town water and irrigation committee, the occasional barter trips. This
obstinate pride of Don Alberto was revealed perhaps most tellingly, and potentially dangerously, during the course of later events when Doña Tomasa had her own personal, and life-threatening, crisis, as I will relate in greater detail (Chapter 4).

In early May of that year, we learned that Doña Tomasa was pregnant again. The news was surprising, and personally a less than welcome change of affairs for me. Considering how I was feeling about some of the discomfiting nuances of my project in general, being in fairly continual contact with a pregnant woman, and one who was rapidly becoming both an important informant and a close friend, was a situation which made me feel more than just a little bit ill at ease. When we had suddenly realized that she was looking suspiciously large, and asked her about it directly, she had already been to three prenatal check-ups at the health center. Nevertheless, the baby would eventually be born at home, Doña Tomasa informed us: the center staff was simply “bad,” in her opinion. All of her other children had been born at home, with only Don Alberto attending—the sole exception to this rule, the only baby who had been born at the health center, was the same one who later died. Not a good omen, she seemed to imply. When, in our uncertainty over the situation, we asked the perennially innocuous question about whether she would prefer a girl or a boy, she immediately, and dismissively, replied “boy”: “Men are for working, but girls are just for having more babies.”

Don Alberto and Doña Tomasa became the focal point for much of our time in Puka Wayq’u, our foremost key informants—consultants—and the fulcrum around which a good degree of our understanding of the town’s life circulated, the lens through which we were aided in our interpretation of many of the local social dynamics. They provided both a sounding board and often a voice of dissension—a sensible one, we usually thought—to the thoughts and actions of a great many of the individuals with whom we interrelated with, and the events that we both
heard of and actually witnessed. As such, together with their entire family they came to
“represent” Puka Wayq’u for us in an important way, indicative of much that we understood and
interpreted about the town. They were also to become our chief welcoming committee upon our
periodic arrivals over the years, and our central farewell party upon our inevitable departures.
And as I will discuss later, the fact that Doña Tomasa herself would eventually become a figure
entwined in the fragmented yet interconnected course of emergencies unexpectedly unfolding
throughout the municipality during that particular year has always seemed to me in reflection—
both in the moment, and in the intervals since—to be somehow at once simultaneously
astounding, infuriating, disturbing, and, yet, fitting.

* * *

Life in Puka Wayq’u, both the town administrative center and the surrounding
communities, was governed by a predictable routine punctuated by moments of scheduled
ceremonies and festivals on the one hand; and by random and unexpected events on the other.
Outside of the immediate boundaries (physical, as well as communal) of the Don Alberto and
Doña Tomasa household, our life in the town was oriented around the institutions associated
with our respective research projects, which frequently overlapped: the health center, the
schools, the municipal offices, the various (and sometimes competing) NGO projects. In
addition, of course, there were the individuals who came in and out of the picture as integral
components related to daily life—townspeople, friends, acquaintances—and of the transpiring
events that we became part of.

The official health services in the town of Puka Wayq’u itself were limited to one small
health center. In addition, during the period in question there were the five other distant health
posts in different communities—some relatively near to the town center, some as far as a day’s
journey by truck—each operated by the aforementioned nurse auxiliaries, in addition to the two occasional physicians. The central town health center throughout 2003 - 2005 was staffed by a total of nine employees: a medical director, an attending physician, two rotating medical student interns (doing temporary training), a head nurse, and assistant nurse, a dentist, a driver, and a cook / cleaning woman. With the exception of the last two employees mentioned, who were native to the municipality, all were originally from an urban center (Sucre, Potosí, Oruro), and had either been assigned to Puka Wayq’u, or had simply managed to find work there. The Puka Wayq’u health services themselves belong to Health District 2, which has as its administrative center the town of Tarabuco and which also oversees the health systems of six other municipalities; in addition, Tarabuco is where a second level reference hospital is located. The Tarabuco health district pertains to the Chuquisaca Departmental Health Services (Servicio Departamental de Salud, SEDES), and is one of a total of seven health districts in the department as a whole; each of the nine SEDES in Bolivia (one for each of the nine departments) in turn is under the authority of the national Ministry of Health and Sports. An assortment of traditional (ethnomedical) health resources—curanderos, herbalists (herbalistas), bone setters (hueseros), yatiris, parteros—were present in moderate amounts throughout the municipality, although also exhibiting signs of a notable decline in numbers and prestige—this owing to the steady encroachment of western biomedical practices, as I will consider further below.

The Puka Wayq’u school at that time arrived as far as the 12th grade. In fact, 2004 was the first year ever that the municipality had a high school graduating class (a total of 12 seniors), after many years of building up a student body. Many students of middle school to high school age were from nearby communities, and lived at an internado boarding school facility on the plaza administered by the Puka Wayq’u Catholic parish. There were plans at that time to build a
new school for the lower grades (which was finally completed in 2006), but for the time being the entire student body, from kindergarten to the secondary grades, attended classes in morning or afternoon shifts in the same increasingly decrepit old adobe building on the plaza, which dated back to the 1970s. It was in this structure that our son Natán attended the 5th grade, in a small room with 15 other children, many of whom would walk up to four hours a day from isolated surrounding homes. The classroom had adobe walls with creeping fissures; what had once been a cement floor, but was now more dirt than cement; a tattered burlap ceiling underneath a corrugated iron roof; and a broken window. The instructor, Doña Hortensia, was an elderly woman from Sucre (married to the school principal) who was unable to speak Quechua despite the near universal native Quechua speaking orientation of her class (the exception being Natán, who did eventually pick up a fair amount); who had apparently long since lost interest in both teaching and in children; and with whom Karen and I engaged in frequent sparring over pedagogical techniques and overall educational quality. In addition to Doña Hortensia and the 5th graders, the classroom was also populated by the occasional wandering dog; sightings now and then on the walls of the Chagas disease (American trypanosomiasis) “kissing bug” vector (in Bolivia, the species *Triatoma infestans*, known locally as the *vinchuca*); and more flies than one would imagine entomologically possible in a single room.

Much of the life of the town and the communities was oriented around the comings and goings of the truck traffic which tied the local economy to that of Sucre. In fact, however, numerically this was nothing extraordinary: one daily truck leaving the valle community of Yomala for Sucre, and one leaving Sucre for Yomala. Additionally, there were a few trucks which went to the cordillera region on Fridays, and returned to Sucre on Sundays. For many years, these were the only means of “mass transit” available for travelers to, from, and within the
municipality of Puka Wayq’u, until the long-overdue implementation of a (small and rickety) daily bus, in 2006, which at least made the nominal claim to maintaining a schedule. The trucks however had no such regularity, departing whenever their respective cargo (produce and animals on the way out; store bought goods on the way in) was on board, and the relative accommodations for passengers standing in the back was contingent upon the space available after the freight had been loaded. The typical truck trip to or from Sucre would last anywhere from four hours (rarely) to six hours (on the average), and on one occasion in our experience a lumbering all-night nine hours (due to a heavy cargo of several dozen bags of cement, plus two flat tires). (The bus trip now averages what continues to seem like an astoundingly speedy three hours.) For the casual traveler and the local ethnographer at that time, however, other than the sporadic (and very erratic) trucks the only means of journeying to various communities within the boundaries of the municipality was to hope for hitching a ride with a jeep or pickup truck working with one of the NGOs, or with the town hall; with Padre Antonio, the Puka Wayq’u parish priest at the time, and his own truck; or with the health center ambulance while on a vaccination trip or possibly in picking up an emergency patient.

When school was not in session, on weekends or during vacations, the internado was empty and the majority of children and young people stayed at home or in the fields of their respective communities. During these periods, the town of Puka Wayq’u would seem abandoned, virtually bereft of life except for small and relative (albeit reduced) hubs of activity: the health center, the town hall municipal offices, the tienditas, the Catholic church on the plaza during the daily evening mass, the juncture down by the river where the daily trucks stopped. The winds that would pick up in the late afternoons, particularly from July to September but which could occur at almost any time, churning up the earth of the unpaved streets (all streets in
Puka Wayq’u are unpaved, except for around the central plaza) into swirling dust clouds—with what always seemed to me as evocations of Innocent Eréndira and the wind of her misfortune\footnote{Gabriel García Márquez, \textit{La increíble y triste historia de la cándida Eréndira y su abuela desalmada} (Buenos Aires: Editorial Sudamericana, 1972).}—didn’t do much to alleviate the sense of solitude and melancholy in the waning part of the day, with so few people in view, as the evening darkness would increasingly spread. At times such as this, the alienating mood would most likely only be broken by some sort of sudden public gathering, a festival of one kind or another: and in Puka Wayq’u—as in so much of Bolivia—those would never be long in coming. Festivals are never lacking, for too extended a period of time. Carnival and Lent is by far the biggest, which in Puka Wayq’u is celebrated with four days of community dances following the actual formal calendar days, complete with singing, drinking and feasting around a towering, fruit and bread laden wooden structure, erected annually, typical of the Tarabuco region and which references the fertility of the earth \textit{(Pachamama, Mother Earth)}, called a \textit{pukara}. In the days after these festivities, a similarly fertility-themed cattle branding fiesta is then held. The Festival of the \textit{Virgen del Rosario}, the patron saint of Puka Wayq’u, is held on October 8; in the days leading up to this there is general merrymaking, a religious procession or two, and the festival centerpiece, a series of “bullfights”: these entail mostly young men attempting to tie handkerchiefs onto the horns of loose bulls in a field, which are usually not very cooperative. August 6 is Bolivian Independence Day, with some patriotic marching around the plaza by the school kids and municipal employees, and some random games on the soccer field and the athletics court beside the plaza. December 10 is the civic anniversary day of Puka Wayq’u, with local bands hired from Sucre, and typically with more politically themed festivities as the political party currently in power in the municipality takes advantage of the occasion. All Saints Day, November 1, and All Souls Day (Day of the
Dead), November 2, are just as essential, in their own local way, in Puka Wayq’u as they are in much of Bolivia and scattered parts of Latin America. (I will take a closer look at these in particular, in Chapter 3.) On and around all festival days, it bears note that the alcohol consumption is considerably more than what might be considered as “typical”—however that particular characterization might ultimately be defined and classified.

The most frequent and dependable festivity, however, was the weekly Friday night fair (feria) in the plaza, when the cordillera trucks (usually around three or four) arrived from Sucre, and parked for several hours before the long drive into the highlands. These were full of people returning to their homes after a time in the city, and a celebratory ambience would break out around the plaza in what seemed like a matter of minutes: several vendors would set up shop on the sidewalk; small tables would be placed where men could sit drinking beer or chicha (fermented maize beer); fried chicken and anticuchos (beef heart shish kabobs) stands appeared; groups would play table soccer (foosball); children would run amidst the plaza, and in the athletics court beside it organized teams would play either basketball or soccer (known as fulbito or futsal, when played on a small cement court); loud huaynos, cumbias, merengues and takiraris would blare from tinny-sounding stereo decks; and all of Puka Wayq’u would come out to buy items not on display on a daily basis (tools and implements, oranges, peanuts from the valle region that usually went straight to the city for sale). The feria would last late into the night, but not too late: it would grow cold, and the activities and the “revelers” (in all actuality, perhaps a bit too colorful of a word for them) would begin to disperse, drifting off and fading away into the scattered adobe homes or the backs of parked trucks for sleep, or perhaps some more drinking, in private. Don Alberto would finally arise from the large rock he sat upon for hours, on the corner of the plaza beside his house: this was a dark corner beyond the glare of one of the two plaza
streetlamps, and unfortunately people who had the need would frequently try to use it as a place to relieve themselves—but Don Alberto would be waiting, with a handful of stones to hurl, and send them scattering.\textsuperscript{15}

Overall, daily life in Puka Wayq’u was pretty much as it is in small towns anywhere: without incident, until suddenly and inevitably “incidents” do occur. Our routine was established early on with a focus around visits to the health center, concerns about school and the 5\textsuperscript{th} grade, and the gradually expanding network of social and research contacts throughout the town and the municipality in general. Initially, in the first months, I had little notion of what my geographically specific direction would come to be in the municipality—which communities I would eventually concentrate on—because the circumstances surrounding the current maternal mortality reality were as yet unknown to me—and as they seemed to likewise be so to the people back at the SEDES in Sucre. The available data were scarce; the local sources were poorly informed—or hesitant—to discuss the situation in what might possibly be too much detail. And,  

\textsuperscript{15} Sadly, as one of the overly eager, poorly thought out and ill-advised (at least, from an outside researcher’s point of view) “development projects” of a later municipal administration, in 2010 a new market structure meant to centralize the local vendors was inaugurated in Puka Wayq’u. Two floors, cement and brick, cavernous, appallingly out of style and disconnected in coordination with the Puka Wayq’u aesthetic and all local reality, it played a major role in effectively killing the Friday night feria. This was for a number of reasons: located far down the street from the plaza, the new market was not at all in the “center of the action”; previously, the only produce that had been sold in an organized fashion and with any consistency was precisely on Friday evenings, so typically during the rest of the week there were not even any local community vendors for the market to house inside; and, of critical importance, the town administration charged a rental fee for the interior stalls, whereas nobody charged anything at all to sell in the public plaza. As a consequence, and in light of the active enforcement of municipal ordinances (paradoxically; the enforcement of any on-the-book regulations was relatively rare)—that is, that products to be sold could only be sold “legally” in the new market—the overwhelming majority of previous vendors simply stopped selling at all. The cordillera trucks thus generally continued on their way up into the mountains but no longer pausing in Puka Wayq’u, until finally there was no longer an evening feria to speak of. Only one fried chicken seller remained, setting up shop in a previously unused kiosk on a corner of the plaza; and sometimes a lone woman or two would appear selling a forlorn pile of oranges brought from Sucre. This unforeseen development eventually combined with the increasing reality of more frequent transportation opportunities between Puka Wayq’u and Sucre for moving produce and goods around, plus the fact that with a special additional Friday afternoon bus most of the local schoolteachers took off back to the city at the end of the week, leaving even fewer people to participate in a feria even if there had been one. As for the new market itself, after two years it remained perpetually empty, devoid of any local vendors, and usually under lock and key; eventually, the upper floor was turned into a space of haphazard overflow for municipal offices in plywood cubicle style, and the lower floor became a municipal storage area for crates and supplies. It was, regrettably, yet another elefante blanco and a testament to misjudged planning and the poor use of municipal funds, gathering dust and steadily growing piles of peeling paint.
until the month of April, “nothing” had happened, nothing that would yet set my planned project onto what was an unexpected course. So these weeks at the outset were a time which I eventually came to identify as a sort of prologue to the primary focus as it later coalesced, due to the unforeseen events. It was, though, also a time in which the subtle beauty of Puka Wayq’u, its people and its rhythms, became increasingly appreciated by me. These were perhaps just as commonplace as they were in so many other rural towns in Bolivia, yet they could also be startlingly new and vividly distinctive: as vivid, for example, as the sudden and unexpected appearances in the sky of the bright green parakeets (*Myiopsitta monachus luchsi*, the Monk parakeet, unique to this part of the country), which would swoop down seemingly out of nowhere in flocks of several dozen and glide across the landscape chattering loudly, only to vanish again into the groves of trees lining the river, or perhaps over the horizon of the red bluffs that formed the canyon walls high above us.
There was a kid in the town of Puka Wayq’u named Mario, who was about the age of my son at the time, around 10. He had an older brother named Gualberto, who was then probably something like 15 or so. Neither one of them went to school, however, nor did they seem to participate very much in the “mainstream” of town life, in the sense of any sort of community groups, local soccer matches or other sports and games, Church related institutions, or most any other kind of formally or informally organized activities in general. Rather, for the most part the two of them simply idled about, lolling on the benches in the plaza, perhaps performing occasional manual labor type odd jobs for somebody who needed help in the fields or in some sort of construction work, bumming something to eat from one of the tienditas, or just doing nothing much at all. For the most part, they stayed out of trouble. Mario was always good natured and smiling, albeit in a manner which clued you in that he wasn’t really in his right mind: what was actually something of an imbecile grin without any discernible meaning; a playful goofiness that was a bit too fawning and ultimately annoying; and all of this without saying hardly a word, to the degree that for the first few months of our time in Puka Wayq’u we assumed (erroneously) that he was mute. (He seemed happiest during the days of Carnival, when virtually the entire town would act just as he always did: weird, with a moronic abandon.) Gualberto, however, was more “with it”; he would answer any questions in a relatively sensible way, but with an attitude bordering on the surly and always with a faint and vaguely suspicious smile, and it was known that he either drank cane alcohol or sniffed glue. The word was that, some years back, he had pulled a knife on a teacher, got himself expelled, and that was the end of
his local school career. Both of the boys could be characterized under the vague classification of “grubby,” with old and worn clothes much beyond any “typical” campesino garb, and it was obvious that they didn’t make much use of whatever water was available to them. Somewhat callously, I dubbed Mario the “Feral Kid.”

They didn’t have a mother, but their father was still around. He was a significantly older parent than what would be expected in the usual rural setting (in which childrearing typically begins early), considering the ages of his two children: probably in his late sixties when we first met him, even when taking into consideration the standard adage that looks (regarding age) can be deceiving among campesino populations. Like his sons, he didn’t have any apparent source of income, and seemed to live day by day and on handouts. He was perennially old and feeble, hunched over and walking without the use of a cane, yet would smile gamely in response to a greeting, and in turn reply with a few mumbling words of his own—but our conversations never progressed to any level of interest, or even of coherence. In one of those instances which seem curious in retrospect (and perhaps even uncomfortable) yet never occur to one during the actual lived moments, we never learned his name, nor did it even occur to us to ask. One time, during the town festivities for Independence Day on August 6, we saw him standing alone, far off on the fringes of the crowd gathered in the plaza to listen to the local politicians and their patriotic speechifying, as physically marginalized at that moment as he was socially within the community, tightly clutching a small Bolivian flag and standing as straight as he was able to, which wasn’t very much.

The mother, whose name had been Josefa, was from one of the nearby communities. Doña Tomasa and Don Alberto told us that she had burns and scars around her body, but they weren’t certain from what. They also characterized her as a “zonzita”: a dimwit, feebleminded,
although they couldn’t expand much upon that when pressed. She had been many, many years younger than Mario and Gualberto’s father, and was rumored (through the local community rumor mill) to have slept around a lot—although, in considering the “zonzita” label placed upon her by Doña Tomasa and Don Alberto, I can’t help but wonder if it hadn’t been so much the pejorative “sleeping around,” but rather a case of the local guys taking advantage of someone who didn’t have either the full cognizance or the ability to ward off unwanted advances. At any rate, the old man wasn’t Gualberto’s biological father (and I never found out who was), and there was a strong suspicion (at least among the townsfolk) that he wasn’t Mario’s either: rather, that Josefa had somehow “trapped” him, in a role of the supposed father. (In addition, there had been two other children born in the interval between the brothers, both of whom had died in infancy, father or fathers unnamed or unknown.) Then, in a later pregnancy (also of undetermined paternity) when Mario was about two years old, she had a “failure” (fracaso) at an advanced stage—which could have been either a miscarriage or a home induced abortion, the true nature of which probably only Josefa knew. Regardless, the story went that a week later Josefa tried to do something strenuous that she obviously shouldn’t have been attempting in her very recently post pregnant state and died suddenly, of what people defined as a heart failure, and what would, as based on the incomplete anecdotal evidence, most likely have been an obstetric death of “unspecified causes,” although it is obviously impossible to determine whether it was direct or indirect (following international guidelines, WHO 2010).

In subsequent years Padre Antonio tried to get Mario placed in an orphanage in Sucre, but for his own reasons the old father wouldn’t allow it. Some years following our initial contact with Puka Wayq’u, as late as 2012, the situation had not visibly changed much: Mario, now an adolescent, still maintained his status of local street urchin, while his alarmingly decrepit father
still plIED the town’s byways with a shuffle and no apparent destination. Gualberto, however, had long since taken off, reportedly joining the ranks of the homeless street dwellers in Sucre.

In one sense, Josefa was an all too common case: a maternal death which was somehow simply absorbed into the local history, and faded away with time. If anybody remembered to remember her, it was in a negative manner in regards to her mental state and supposed socially inappropriate behavior; similarly, I could find no administrative state record of her death as an officially registered maternal mortality event in the SEDES archives. In turn, the case of Mario, Gualberto and their father may be seen as but one extreme example of the familial consequences of maternal loss within the context of rural Bolivian society. “Extreme,” because the old father observed here was probably never really up to the demands of parenting, no matter what sort of tragic personal circumstances he, and the two boys, had been forced to confront after the death of Josefa. No matter what kind of person Josefa had actually been in life, she was still the mother, and her physical abandonment in death left the already disadvantaged Mario and Gualberto afloat, destined for poorly supervised and misguided childhoods, under the sole tutelage of an aged father who was undeniably unprepared and very probably unqualified for the task at hand.

Tellingly, the surviving children of a deceased mother are colloquially referred to as “orphans” within the local terminology, regardless of whether or not the father is still alive. “Of course they’re little orphans,” Doña Carmen Bautista, a longtime school teacher in the community of Yomala told me, “because they don’t have the mother’s help anymore. The mother is always there, she helps the children with more care, more warmth. The father leaves in the morning, and sometimes arrives in the evening, but the mother is permanently with them.” Although perhaps a somewhat idealized portrait of generic maternal relations, this still holds a strong truth, both in actual practice and in the firmly held imaginary of the community. Despite
the persistent, dominant and oppressing patriarchy of Latin American society overall—and Bolivia is certainly no exception—there is no argument that childrearing remains a predominantly matriarchal responsibility, for better or for worse, in Puka Wayq’u as it is in countless elsewhere. This is concurrent with how in itself the role of women often remains relegated and diminished in other respects, despite recent advances throughout the region which should also be recognized (and including the notable progress made in Bolivia in recent years, including a more protagonistic role for women in general).

Thus, ultimately the tragedy of maternal death most certainly goes beyond the actual death itself of the mother; the suffering and affliction of the surviving family members is ongoing, and typically much more so for the “little orphans.” Yet, it also must be recognized that the ongoing and prevailing coloniality of Bolivian society alone has played a significant role, through creating the structural context for the breakdown of this most intimate unit of the social structure—and in a way that is itself a form of (social) violence, in the sense of an unexpected, unintended, and unqualifiedly unjustifiable death.

*     *     *

This chapter explores the sociocultural construction and ramifications of maternal death among the population of Puka Wayq’u and its communities. Local actions and reactions to this ultimate failure in the “reproduction” of society, and what is at stake for those involved at differing levels, range from the (extended) family unit, to the greater community. (In Chapter 4, I will turn my attention to the greater political power structures at work.) Questions of indigeneity, gender, and (post)colonial influences play critical roles in the often conflicting dichotomy—in following Geertz (1973:18), regarding the “social discourse” inherent behind a given, concrete societal event. This includes the space between empirical medical claims of
“what actually happened” in any given death; as opposed to “what really happened,” in regards to individual and collective social discourses of how seemingly implicit cultural and biological patterns of fertility, birth, death and regeneration are juxtaposed, subverted and (re)interpreted as both private and public events.

What is undeniable is that something certainly happened, and the intimate, devastating aftermath of that fact must be acknowledged and respected. Thus, the imperative is to strive for an understanding of what is at stake for all concerned: the husband, the surviving children, other relatives, the health personnel (both ethno and bio), the community in general, and—again—society at large. What is on each person’s agenda, how were the events affected by their own personal history and make-up, which then in turn affects and is affecting their own interpretation of the “truth”? It matters little how much we might try (as well we should) to thickly describe and analyze the event and the context; to pick them up, turn them around, and review them from differing perspectives and interpretations, Rashomon style; and to consider how all of the actors played their roles in the drama, and how the events may illuminate a broader reality. In the end, there is still one undeniable fact: the woman is dead. In this manner, and against a backdrop of personal and communal affliction, tragedy and grief, this crisis of what I have termed reproductive violence is perceived by both the immediate survivors and by society as a whole through lived narrative imaginings of death, in this case maternal death in particular: cultural strategies for emotional survival and reconciliation to make sense of, and to come to terms with, sudden and unexpected loss.
“Ah, the Difunta Correa?” Doña Sebastiana, one of the more prosperous shopkeepers of Puka Wayq’u, laughed and looked at me with mild surprise. “She was a little saint (santita), who even though she was dead continued to nurse her wawita (baby), to keep him alive.” I had asked Doña Sebastiana about the intriguing shrine on the road outside of Tarabuco, on the way to Puka Wayq’u. Although she was familiar with the story, as were some others I asked in town (their respective versions, however, differed in key details here and there, as popular retellings of apocryphal tales are wont to do), there were likewise many others who had no idea what the small structure was all about, despite the fact that they had passed it on the road countless times during their travels and in their comings and goings. And, in actuality, it indeed was a vaguely curious thing to have placed alongside the winding dirt road in the Tarabuco countryside, considering that the dead mother it honored was in fact from Argentina.

As the legend has it, the Difunta Correa (difunta: “dead,” “deceased”) was a young woman named María Antonia Deolinda Correa, who had lived in San Juan Province of western Argentina. In 1835, during the civil wars following independence from Spain, she set out together with her infant son to find her husband who had been imprisoned by rival forces and “disappeared” (desaparecido—in an earlier incarnation of what was to become, in the late 20th century, an unfortunate phenomenon among many Latin American military regimes). But, lost in the desert and out of food and water, she eventually collapsed and died from thirst and exposure. A few days later, passing cattle drivers found the lifeless body, together with the still living baby suckling at a breast which miraculously continued to produce milk. By the late 19th century the Difunta Correa had become a folk saint, the center of a Christian cult which continues strong to the present day and is known for protecting travelers (with a special
predilection for truck drivers) who leave offerings—frequently, bottles of water—at the shrines which have appeared along the roadsides not only of Argentina, but also of Chile, Uruguay, and (albeit much less frequently) Bolivia. There are also studies, however, which affirm that the Difunta Correa is an example of an *indigenous* mythological tradition which remains essentially and stubbornly pagan, despite its outwardly Christian trappings and veneer, because “it could not be reinterpreted by the Catholic Church owing to the fact that there is no equivalent myth in western Christian culture…the structure of the myth is the survival of a child who nurses at the breast of a dead woman. To nurse from a corpse, to take life from death, does not structurally exist in western Christian mythology” (Moffatt 1984:92). Yet, if the Difunta Correa may thus be seen as essentially an indigenous figure, she is also at the same time undeniably *Christian*, and hence by nature “quintessentially maternal and, like the Virgin Mary, almost a deification of maternity…devotees repeatedly refer to her as ‘mother of those who suffer,’ ‘mother of those who cry,’ and ‘protector of the helpless who suffer and cry’ ” (Graziano 2007:174). Thus, and despite the grumblings of the official Catholic Church concerning the “unsanctioned” nature of the devotional following, in this manner the deceased María Antonia Deolinda has become a potent representation of salvation and regeneration among many “folk” elements of both the Southern Andes and the Southern Cone.

The lonely little shrine on the road to Puka Wayq’u—a lowly adobe construction, hardly larger than a variety of garden shed, with the words “Difunta Correa” stenciled above the halfway gated door, which reveals inside faded flowers and a few plastic bottles of long since evaporating water—is at one time far from home, yet also deep within its element. It remains unclear who erected it in the first place, how long ago, and why it is there at all, between Tarabuco and Puka Wayq’u, a site of reverence far from its principal body of worshippers and
unrecognized by many, on a precarious and only moderately travelled road distant from the main highways. But following many trips back and forth past the sanctuary, and within the context of the public health, and human, drama which was unfolding just down the road, what had initially been an object of idle curiosity began to take on new imagined meanings for me. Perhaps, I speculated, it had held a similar significance for those who had seen the importance in constructing it: possibly, the intended implication was not so much that of protecting passing travelers, but rather to remind them of the deep-rooted human tragedy still recurring in time-worn fashion within their midst, as played out between mother and child. For although it was not precisely the original intention or implication of the story and the popular veneration that it inspired, the figure of the Difunta Correa is most certainly an apt, and compelling, symbol of the local human condition in regards to but one tragic facet of its inescapable mortality. Not only the long-term medical records of the municipality of Tarabuco, where the shrine is located, but also the more recent upsurge in the neighboring municipality of Puka Wayq’u, both attest to this: a fabled instance of maternal death (regardless of whether it might have been obstetrically direct or indirect), leaving behind the suffering of yet another “little orphan,” who must then be kept alive—physically, spiritually—by “miraculous” means. As a tangible illustration of both maternal loss and also of historic relegation and endemic affliction among indigenous populations, it stands as the fanciful image of an individual, personal crisis and its tragic outcome rendered in magical tones both cultural and spiritual, reflecting both bereavement and redemption, and a local reality which is still all too persistent to this day.

* * *

When considering this case study of personal loss as I present it here regarding the events in Puka Wayq’u, and in critically observing the social and political context of Bolivia within this
respective discussion of maternal death, comprehensive insights are to be gained through a necessarily close analysis of the deeply felt *cultural* forces at work. The circumstances of maternal death are, as I again define them here, a concrete instance of structural inequities and abstract societal violence, yet dramatically and decisively reflected within a context of crisis, while challenged by the revitalization, and determined attempts at consolidation, of historic indigenous and social movements. The cultural representations of suffering within such a context, maintain Kleinman, Das, and Lock (1997), are important for their appropriation and use by both the popular culture and by social institutions with a political agenda, which at times may even result in a type of “commodification of victimhood” (1997:xii). Consequently, whereas the questions of subjectivity and agency must not be overlooked, it is also crucial to examine individual, personal narratives of suffering, in order to point out the ways in which these are “embedded in a social context,” and to identify the relationship between the concrete differentials of human suffering and the varieties of subjective experiences. Bourdieu (1999:4) talks about “positional suffering”: that from “inside the microcosm,” when in relation to the oppositional lack of empathetic understanding from “the point of view of the macrocosm”—although, in the case of maternal death itself, it is certainly not all that necessary to delve too deeply or too analytically into the *habitus* in order to externally perceive major affliction, relative to a great deal of other personal traumas. Again, it is an issue of what may be directly “at stake” in people’s lives, and how this may potentially affect their ultimate process of decision making.

What is of significant interest in the particular case of Puka Wayq’u—and the rural, “indigenous” context in which it sits—is the range of perceptions, accountings and discourses in regards to the “what happened” of maternal death by, first and foremost, the individuals who have been most impacted. Second, the actions of the official public entities as articulated
through both the state and non-governmental private sector health services (including internationally-based), which (intentionally or unintentionally) replicate and perpetuate an inherently flawed socioeconomic and cultural model. Such a framework is equally applicable to all of these social actors: the official Bolivian state and other non-governmental institutions, in their attempts to explain, rationalize, and rectify the shameful mortality situation (to international donors and political bodies); and the indigenous person (woman or man), who must try to comprehend a form of death which would seem to intrinsically undermine implicit cultural and biological patterns of fertility and birth, through this blatant failure of social reproduction. Thus, what must be addressed are the types of both social and (inter)cultural constructions and narratives formulated, applied and reproduced, in order to explain and make sense of a very specific form of political, economic, cultural and gender injustice.

Scheper-Hughes (1992), in her account of a neocolonial society defined by its own particular environment of structural violence, provides an agenda for understanding how death (in her particular case, child death) is constructed as part of the “natural order of things,” and the cultural uses of this for confronting grief and tragedy explicable only with a practical fatality, or as perceived within an externally (colonially) imposed ontology of sacrifice and redemption. Similarly, it may be possible to consider these as strategies for emotional survival and reconciliation in the case of mother death, among the immediate survivors who are left to carry on and come to terms with their loss. Within this context, it is crucial to also recall the deeply entrenched Catholic Marian iconography situated around the figure of the mother and her role of saintly servitude to the family, and how this maintains an equally powerful hold on populations throughout Latin America—undeniably also impacting on the perceived enormity of a maternal death. Finally, the onus falls on the role of the state, which is left to reflect (or not) on the nature
of its own responsibility and complicity, intended or otherwise, and the climate of crisis which has been created.

Within this methodological consideration of an “anthropology of affliction,” or as defined within the theoretical framework addressing the notion of social suffering, the persistent issues of health politics and structural violence come to play a fundamental, even decisive, role: the macro, structural framework on the one hand directly impacts upon a micro, personal felt reality on the other. The overriding and ongoing social context in Bolivia of inequality and covert violence (despite the small successes in mitigation of recent years), is a causal factor in regards to its high morbidity and mortality, including maternal. The (physiological) pain, and the (psychological and spiritual) affliction that result, in both the individual and the social body, become thus the objects of study. As discussed by Kleinman (1995), and by Kleinman, Das and Lock (1997) and Bourdieu (1999), individual personal suffering is the unfortunate outcome of unjust political and economic power systems and abuses, as these are variously manifested, inflicted and impacted upon society. This range extends from major (perhaps massive) and undisputed intrusive actions (starvation, torture, war, genocide); to an abstract structural injustice, which eventually leads into the distress of the individual (for example, heightened morbidity), and perhaps into the collective nature of society itself (Farmer 1996, 2004). Within this perspective, maternal death is an expression of suffering on a primarily individual scale, but which is multiplied many times over socially into a moral dilemma: first the actual mother; then perhaps the fetus; and finally the surviving members of the family (possibly including the child) and communal unit. (This latter category, that of the communal, must be considered of especially significant social and economic importance within the Bolivian, indigenous and other Amerindian, and overall Latin American contexts.) Maternal death is thus emblematic of social
suffering as it occurs throughout the social *body*, and takes into account that it is virtually impossible to divorce issues of health from those of politics, social transformation, and moral or ethical dilemmas.

An unjust death itself is, obviously, the final (physical) form of affliction; maternal death is perhaps one of the most poignant, in that it transpires during the process of the regeneration of life. The process of understanding the event is made much more difficult, more complex, and more paradoxical for those who are left behind, yet another manifestation of the context of coloniality and endemic crisis that I wish to consider here. Yet, and for this process of “containing” loss, the reactions and interpretations given by both the close survivors and by society itself may create understanding in the face of what is simultaneously both a *personal* and a *public* crisis.

*The Pervasive Nature of Systemic Violence*

In Puka Wayq’u and in Bolivia overall (and, it may be affirmed, in the “developing” world in general), the ways in which these official social, political and economic institutions in actuality foment an environment of structural violence is always a tenuous balancing act, often amounting to a subtle breakdown of the so-called social contract. Understanding just exactly what this is, in turn entails an understanding of how the tangible manifestations of an environment of abstract social and economic forces of inequality and injustice—those which are referred to as the “social determinants of health” (WHO 2008)—are made real in the forms of endemic hunger, racism and discrimination, environmental degradation, high morbidity and mortality from preventable diseases and health conditions, perhaps actual physical violence, and all of these playing out in deep-rooted health disparities. As previously discussed in Chapter 2,
this is intimately based in a detailed analysis of the nature of coloniality and failed colonialist systems, of both internal and internalized colonialism, and the hierarchies of subalternity—which in turn foment a social milieu of structural injustice, the propagation of which may be through either tangible or intangible violent acts. This is then inordinately weighted toward the economically and socially disadvantaged, causing an extremely lopsided differential in the production of human suffering; it is predominantly the poor who suffer the abuses and violations of human rights, and these groups are markedly delineated along the lines of class, gender, and ethnicity (Farmer 2003). In turn, by concentrating the discussion of structural violence and human rights specifically on health, the focus itself is shifted, as it is the sick and the poor (in the case of Bolivia, to a significant extent this may also be read as “indigenous”) who bear the brunt of this specific variety of violation. The historic reality of Bolivia is witness to this, in that its indigenous populations have historically, to this day (even while taking into consideration the current profound social and political processes of change currently at work), been those who have most endured the injustice of socioeconomic disparities and inequities, through poverty, racism, and social-cultural marginalization and exclusion.

For my purposes here, health disparities—and in this case in particular, maternal mortality—are tragically representative of the sociocultural and socioeconomic situation which still persists, even within the political context of recent years. They stress the vital necessity of honestly considering the imbalance of social and economic processes that are the true causes—the causes of the causes, in the language of social determinants—behind what might appear on the surface as “cultural” health differentials, while recognizing that economic growth does not necessarily equal social development. In perceiving how social and health disparities and inequities may be directly related to morbidity and mortality, it is most appropriate to analyze an
environment of endemic poverty, social and economic injustice, and structural violence within a framework of actual epidemiological \textit{causality}, rather than as a simple grouping of mere contextual factors (see for example Chen, Kleinman, and Ware 1994; Farmer 1996, 1999, 2003; Kim et al. 2000; Leon and Walt 2001; Parker 2002; Werner 1997; and Whiteford and Manderson 2000). In considering the case of maternal death—and despite the fact that as an epidemiological indicator of critical social disparities it is one of the most recognized and acknowledged, and while in Bolivia the MSyD engages in ongoing and aggressive campaigns to reduce the incidence of mortality—it remains stubbornly pervasive. Yet in regards to the death of a specific woman with a name and an identity, while it is routinely and duly registered (or \textit{not} registered, as in the case of Josefa), it is then inevitably forgotten in a statistical black hole. In borrowing the idea of what Scheper-Hughes (1996) refers to as “invisible genocides and small holocausts,” the maternal death becomes yet another instance of “unrecognized, gratuitous and useless social suffering,” unpardonably tucked among those “things that are hardest to perceive…[because they are] right before our eyes and therefore simply taken for granted” (in referencing Wittgenstein). That is, invisible to all but the deceased’s family which, as I shall try to demonstrate in the case of Puka Wayq’u, stoically and nearly unquestioningly—albeit not at all unfeelingly—continues on, fording ahead through its own personal small holocaust.

Accordingly, beyond the immediate etiological causes of maternal mortality in Bolivia lie numerous other, more profound, contributing considerations. These include chronic malnutrition among the population, especially women and children; poor physical and service infrastructure; inadequate human resource training; and a deeply ingrained racist and exclusionary mentality concerning indigenous peoples, as it was historically exercised by the state and its official services—and which the post 2006 state, nevertheless, strives to reverse. In addition, all may
ultimately be characterized as overt and flagrant affronts to *human rights*, particularly sexual and gender-based rights, as manifested in this case by the extreme event of the mother’s death (Cook and Galli Bevilacqua 2004; Freedman 2001; Germain 2004; Glasier et al. 2006; and Yamin and Maine 1999). Indeed, it is even what I propose to characterize as a metaphorical variety of “desaparecidas,”” to once again refer back to the grimly distinctive Latin American terminology: women who were “disappeared” owing to the indirect violence against their reproductive person and life, as perpetrated by the failings of their state and society.

These all-too-typical factors were readily apparent, in differing degrees, in each of the case studies that I will discuss here: insufficient or inexistent communications; poor highway infrastructure and extended travel time; inadequately trained and / or undervalued community health resources; poor judgment calls on the part of the local state health services; inadequate understandings and equally poor judgment by immediate family members, for whatever reasons, in regards to the full scope of what was occurring; and, most decidedly and unacceptably, occasional outright medical negligence or malpractice. Therefore, the historical and current framework of structural and reproductive violence as I examine them take into account a number of external models, which have been superimposed upon the indigenous reality and worldview of Bolivia: as also previously discussed in Chapter 2, these range from colonialism, to coloniality and neocolonialism, and to the national and international models of neoliberalism and globalization. Finally, critical to the understanding of their functioning is to consider how specific discourses and mechanisms—in this case, those of public health and disease and illness prevention—may be either used or abused for purposes of social control by the dominant social and economic elites.
For my purposes, a working definition of reproductive violence, then, must by nature take into account the concept of structural violence as I am discussing it within this context, and in particular as it pertains to gender relations. What occurs between the sexes in the familial and in the personal realms is framed as a direct byproduct of their relationship to the dominant power structures, and how these operate in both the abstract and, consequentially, on human lives. There exists a seemingly limitless quantity of inequitable social processes across human cultures, which may become reified at the individual level through “personal distress”: what needs to be comprehended in an ethnographic sense, then, is how the “political and economic forces have structured risk for forms of extreme suffering, from hunger to torture and rape” (Farmer 2003:18)—and this also includes a maternal death as yet another form of unjust violence. Farmer himself makes the connection, when he observes that “gender inequality and poverty—together, not apart—are the cause of almost all deaths during childbirth”; and, of course, “these deaths are registered almost exclusively among poor women” (2008:9).

The dimensions of structural violence are further expanded upon by Bourdieu (1992) into a framework which then explicitly incorporates the element of gender, as part of what he famously refers to as “symbolic violence.” The phenomenon of violence is not simply engendered by certain social structures, maintains Bourdieu; rather, it is inherent in any and all social structures to begin with—and consequently, in the Bolivian case, it is necessary for me to here emphasize the concurrent colonial nature. These are power relations of one over the other which are part of the very construction of “normal” social practice and social mechanisms, and are thus everywhere and in everything; yet, these qualities typically go unrecognized simply because of their familiar, commonplace nature—in this manner, they are “misrecognized.” This invisibility renders the oppressive collective structures which lead to either subtle, covert
violence or to blatant, overt violence as in themselves apparently integral components to the social edifice of society, and thus an essentially assumed given fact of life in its everyday functioning. In the specific instance of gender relations, then, these structures of violence promote an ongoing dynamic of domination and submission, of the patriarchal model as something “normal” and naturally intrinsic at all social levels. The innate aspects of this socialization may impede that women, first, recognize the subtle forms of male domination and oppression; and, second, it impedes that they ultimately question the uneven dichotomy which automatically places women in a lower social order than men, allegedly closer to irrational “nature” than to rational “culture” (cf. Ortner 1974). Or, as Bourdieu outlines it,

Male order is so deeply grounded as to need no justification: it imposes itself as self-evident, universal… It tends to be taken for granted by virtue of the quasi-perfect and immediate agreement which obtains between, on the one hand, social structures such as those expressed in the social organization of space and time and in the sexual division of labor and, on the other, cognitive structures inscribed in bodies and in minds. In effect, the dominated, that is, women, apply to every object of the (natural and social) world and in particular to the relation of domination in which they are ensnared, as well as to the persons through which this relation realizes itself, unthought schemata of thought which are the product of the embodiment of this relation of power in the form of paired couples…and which therefore lead them to construct this relation from the standpoint of the dominant, i.e., as natural (1992:171).

It is here important to also consider these same gender patterns within the historical context of colonial and pre-colonial Bolivian (or better, Andean) social trajectories. The continuing male / female roles enacted today in places such as Puka Wayq’u are the result of the selfsame processes of coloniality which define so many other social aspects, and have been inherited and passed down through the generations. Yet it was not always as it has been, the record shows: prior to the arrival of Europeans in the Andean realm, both genders were seen as parallel, neither more powerful than the other—which, while admittedly still existing in hierarchical forms favoring men, nevertheless maintained levels of parity which precluded either
violent domination or submission: and, it must be noted, this was a status later seen as dangerous by the colonial authorities (Silverblatt 1987). With the Spanish conquest and the centuries-long institutional framework of colonialism that ensued, then, all gender parity was lost, and through the historical process of mestizaje women were relegated to a dramatically lower social status (Rivera Cusicanqui 1997), a clear representational facet of the internal colonialism model. This reality, implanted in the colonial social hierarchy and passed down over the centuries—and still recognizable today—remains one of lasting gender domination, with women changed “into a commodity whose value hinged on her reproductive abilities as the primary resource for a new identity,” a value system transposed onto the conquered and which came to signify that for “Indian males the possession and control of the Indian woman acquired dramatic significance” (Choque Quispe 1998:12). Consequently, the society that resulted remained based in a coloniality mindset, arriving at a paradigmatic convergence with the social norms described above.

Finally, I then move this pattern further, back into the space of reproductive violence. As I wish to discuss by way of the events in Puka Wayq’u, the symbolic violence of deep-rooted patriarchy and gender domination was to lead, at best, to dangerous levels of overconfidence and “misrecognition” by the husbands and partners of the women in crisis. At worst, it was transformed into neglect, irresponsibility and hubris by some of these same men, in addition to some of those in the health services. Either way, the outcome was fatal. Added to both scenarios was the figuratively submissive person of the woman as “other,” captive to a decision-making process in which she had failed to exercise the full extent of her own rights and her own agency. In this, the maternal death that resulted may consequently be interpreted as a direct result of these normalized and underlying gender forces through their “inculcation” (in
Bourdieu’s words) into key private, traditional social modes: specifically, those which encompass the realms of sexual and reproductive health.

Death in Birth: Maternal Mortality in the Global and the Local

Politics, Public Health, and Development Paradigms

The perpetually precarious health status of most of the Bolivian population, and in particular that of its majority indigenous population, manifests itself most glaringly through the dilemma of excessive maternal mortality and its relation to obstetric safety in general. In this respect, Bolivia suffers the second highest indicators in the Western Hemisphere (after Haiti): a dismal 310 deaths per 100,000 live births, according to the most recent calculations (INE 2008); with an earlier, lower but still critical (and very controversial), officially recognized 229 /100,000 in the official Ministry of Health and Sports estimates (INE 2004). However, this global figure is undoubtedly misrepresentative, and misleading: it averages out the relatively lower estimates for the more developed urban areas, with their more readily available health services, with the unconfirmed but suspected rates of up to 500 deaths, and even perhaps 1,000 or more per 100,000, for selected (overwhelmingly indigenous) isolated rural areas. (At 1,100 per 100,000, Chad currently registers the highest rate in the world (WHO 2012). Even more seriously, the mortality figures, when controlled for just the majority indigenous population of Bolivia, were estimated (during the time period of study) to be as high as 496 per 100,000 live births (PAHO / WHO 2004). At any rate, and in the starkest of terms, sources still estimate that in the first years of the 21st century 620 women died for pregnancy related causes in Bolivia.

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By means of comparison, recent maternal mortality prevalence rates in most industrialized countries (Western Europe, Canada, United States, Japan, Australia, New Zealand, Singapore) generally vary between 3 - 10 maternal deaths per 100,000 live births (WHO 2012).
annually—although, and quite notably, for the year 2010 itself this figure had officially dropped to 510, for an average national rate of 190 deaths per 100,000 live births, albeit with an upper estimate of 290 (United Nations Secretariat 2011).

As in the great majority of countries, within the Bolivian context the most frequent direct etiological factors behind maternal death are well established: most typically, these consist of postpartum hemorrhage, retained placenta, hypertension (pre-eclampsia and eclampsia), sepsis from obstructed labor and an undelivered fetus, and other generalized infections (WHO / UNICEF / UNFPA 2000). Direct and indirect precipitating factors include chronic malnutrition (most significantly, serious iron deficiency anemia among women of childbearing age, a condition which in Bolivia is estimated at one out of three women); insufficient and / or inadequate prenatal care; unsafe and self-induced abortions; and inadequate or unavailable emergency care, the consequence of insufficiently trained personnel or a lack of needed equipment (ibid). The proposed practical solutions, as elsewhere on the globe, focus on such social determinants as improved nutrition, quality educational access, and overall living conditions; community participation and women’s empowerment; appropriate and accessible quality obstetric care, including emergency, when and where needed; acceptable living and hygiene conditions, including access to water and sanitation; and an overall improved physical infrastructure—for example, adequate road systems, available transport, and communications that work (Rauyajin and Yodumnern-Attig 1995; Rice 2000; Shen and Williamson 1999).\(^\text{17}\) In

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\(^{17}\) This institutional framework is best reflected in what has come to be known as the “three delays” model, and which is the most widely accepted measurement standard in public health circles for defining structural causality in cases of maternal mortality. The first delay is the failure to recognize and act upon an emergency obstetric situation by a woman, and (more importantly) those around her; the second delay involves potentially critical difficulties in arriving at adequate health services, once the emergency has been properly addressed, such as poor roads, communication, etc.; and the third delay refers to deficient or inadequate medical attention, once a health care facility has been reached. (Some experts prefer a classification incorporating four delays, in which the first is divided between the mother / family’s knowledge and recognition of danger; and then their subsequent decision to
addition, it is well documented that mortality rates rise when the overall social structure of a country is weak, due to budgetary issues, poorly focused “development” interventions, or misguided free market structural reforms, specifically those of the social services reduction “neoliberal” variety (Janes 2004).

However, despite the demonstrated effectiveness of these approaches for rectifying what is recognized to be a significant health issue, in many developing nations such as Bolivia they remain only haphazardly implemented, and despite marked improvements in the last decade the maternal mortality rates continue unacceptably high, as noted above. Large bureaucratic programs have been designed and implemented, with a weighted preponderance toward a biomedical solution; in the Bolivian case, principally that of the government’s establishment and institutionalization of what up until 2006 was known as Plan Vida, part of the global Safe Motherhood Initiative (Ministerio de Desarrollo Humano 1994). Prior to the ascension of the MAS government, there were also official (and positive) movements toward incorporating the principles and practices of intercultural health as they apply to pregnancy and birth, and as part of governmental norms (MSyD 2005); it would however still take some years for these to be at least formally and operationally adopted by the health services at the overall national level. At any rate, and although the official maternal mortality figures did continue to creep downwards, it was only at an achingly slow pace.

Currently, the reduction of maternal mortality remains one of the primary objectives in the MAS government’s national health plan—most prominently, the Ministry of Health and Sports promotes the National Strategic Plan to Improve Maternal, Perinatal and Neonatal Health in Bolivia, 2009 - 2015. Prior to the formal adoption of this, actions were implemented in

\footnote{take action.) Any one of these delays alone can result in the death of the mother. See Barnes-Josiah, Myntti and Augustin 1998; Thaddeus and Maine 1994.}
a working fashion between 2005 and 2007 by utilizing the intercultural guidelines as laid out in the 2005 norms, with the governmental project entitled “Application of the Intercultural Focus in Maternal Health Attention” (Zangari 2009). In succeeding years, this was transferred into specific operational programs which were part of the ongoing health policy reforms and the National Strategic Plan. (I will look more closely at these in Chapter 5.) Yet, in reality, it would be more accurate to recognize that it is still the case that any recognizable official progress is limited to technical and bureaucratic advances in the health field (third level facilities equipped with the latest technology in the urban centers; technocratic restructuring of the national and departmental health bureaucracy), while failing to achieve durable human advances for the most affected and critical populations. (That is, structural improvements and the incorporation of social determinants of health models, in order to achieve genuine quality of life improvements for the great majority of the impoverished population, rather than those endorsed by the oft-tinkered with statistics). Thus, it often remains a secondary treatment of the symptoms, rather than a concerted and honest contemplation of the structural causes—once again, the “causes of the causes”—for a death which, in the overwhelming majority of the cases, is wholly preventable.18

In the private and non-governmental sectors, the occasional more far-reaching and at least in theory holistic NGO development project or academic investigation has indeed been applied to the question of maternal mortality, yet with uneven results. For example, in Bolivia the MotherCare project, implemented in the 1990’s by the NGO Save the Children in a few select regions of the country, focused on identifying local perceptions of risk during birth, and in

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18 Nevertheless, due to recent reformulations of official health policy this could currently be seen as possibly a “debatable” affirmation, in a much more positive sense. As stated, I will later consider the MAS health reforms since 2006, and their inclusion of precisely the focus which I am analyzing here (or the lack of it)—especially in relation to the Family Community Intercultural Health model (Salud Familiar Comunitaria Intercultural, SAFCI), implemented beginning in 2007 - 2008.
training midwives (MotherCare 1993). More recently, the successful FEMME model, implemented first in francophone Africa and later in Peru, has been introduced to Bolivia, albeit with erratic and still undetermined results (CARE 2010). In general, the emphasis on imported Western risk models, and the marginalization of previously existing local human resources (traditional, ethnomedically oriented midwives—that is, parteros) has alienated many, and the follow-up since then has often been sporadic at best for many of the non-governmental programs.

Bradby and Murphy-Lawless (2002), and Arnold et al. (2001, 2002), as part of their extensive 1993-1996 obstetric risk and maternal mortality ethnographic study in Chuquisaca and Potosí departments, propose the intercultural integration of ethnomedical birth practices into biomedical settings, and vice-versa, but with a greater emphasis on the former. Along similar programmatic lines as those proposed by that particular research project, for the Bolivian health services the officially sanctioned means of increasing “institutionalized” births (either in a health facility, or attended at home by formally trained biomedical personnel) has become the promotion of what is called a “humanistic birth” (parto humanizado or parto humanístico). This implies the acceptance of labor positions other than the horizontal gynecological; allowing husbands and other family members to be present at the birth; and incorporating local concepts of foods and herbal remedies (mates) into the postpartum diet—for example, including the classic categorizations of hot and cold body humors (Arnold et al. 2001; Bradby and Murphy-Lawless 2002; Uriburu 2006). Although advanced during recent years among various NGOs and health activists in Bolivia as a means for increasing the respect of ethnomedical practices and promoting alternative viewpoints to the state health services, the MSyD would ultimately appear
to see the adoption of the parto humanístico simply as a means of attracting women to the state health posts, rather than as a path toward a genuine intercultural integration of the dual systems.

The problem of elevated maternal mortality in Bolivia, then, must necessarily be considered from multiple theoretical and practical vantage points. On the one hand, it arises from within the context of a structural crisis, much more so than that of a medical one, or even one which may be simply referred to as that of “public health”: a question of social injustice, as articulated through an unequal distribution of mortality. It is, consequently, identifiable within the Bolivian perspective—and to return to the previously discussed theoretical model—that of a charged and complex social, political and economic national environment: an issue of endemic social suffering. Also implicit within this schema is the nature of cultural racism and segregation, subjugation and control, as propagated in Bolivia by (neo)colonial manifestations of a dominant global and regional political system: the abolition of this is precisely what the post 2006 state claims as its principal mandate, yet which in multiple instances still translates at ground level into poverty and cultural and socioeconomic marginalization. With the case in point here, that of the tragedy of maternal death, there exists the aforementioned glaring fact that the mortality rates are invariably significantly higher among indigenous populations, be they urban or rural based.19 Thus, there are prevailing, overriding and unavoidable causal factors leading to this reality, and which must be observed, considered, discussed, and (most critically) acted upon. However, the problem of maternal mortality must also be seen in relation to the

19 For my purposes here in a merely statistical sense (as opposed to how I am generally discussing it), “indigeneity” is defined by utilizing the same (somewhat controversial) criteria as those adopted by the Bolivian National Statistics Institute (INE) following the most recent Bolivian National Census during the original period of this research, that of 2001: as that of individuals for whom Spanish is a second language, and / or is not the primary language used at home; and for those individuals who self-identify with a respective indigenous group (INE 2002, 2003). In the census of November 2012, the full results of which have not to date been released but which in partial form are already proving to be highly questioned and divisive, one of the specific issues in debate is the manner in which “indigenous” and “mestizo” were applied. Undoubtedly the eventual data will, yet again, redefine the definitions.
nature of its cultural construction as part of an indigenous (including historical) worldview (cosmovisión), as it emerges from within the confines of an environment of structural injustice—all of this as juxtaposed against the prevailing structures of the state and its respective institutions.

**Sudden Ruptures: The Events of 2003 - 2004**

The maternal death tally in the municipality of Puka Wayq’u at the end of 2003, as previously noted, counted three registered deaths for the year. This in itself was already statistically, epidemiologically, and morally a tremendous cause for concern. However, when those cases are compounded with the deaths which were to occur over the course of 2004, the combined total for the 2003 - 2004 calendar period (a chronological span of two years) was that of seven women from various rural communities in Puka Wayq’u who had died in pregnancy or childbirth. These were the cases which were (at least perfunctorily) investigated, registered and medically documented by the local health center (through actual health services participation and intervention, and / or family and community interviews and verbal autopsies), and later verified by the SEDES Chuquisaca. In addition to these identified cases, there were also two women in other communities of the municipality who died during the same period, yet whose deaths were not known to the official state health services,\(^{20}\) but yet which were recounted to me by

\(^{20}\) That is, not until I personally informed the responsible individuals at the respective health facilities. In regards to both unreported cases, the personnel at the Puka Wayq’u health center looked appropriately surprised and disturbed upon receiving the information. They were also visibly uncomfortable and disconcerted not only in regards to hearing about the events themselves—and the possibility of yet another stain on their professional public health and epidemiological records and personal job performance histories, which was understandably much to be feared—but also undoubtedly due to the fact that the outsider gringo anthropologist was the person who was doing the informing, utilizing data which they had not previously ascertained themselves. In neither instance was there any attempt at a follow up investigation from the Puka Wayq’u health center. In minor contrast, when I discussed the two anecdotal deaths with Dr. Fulvio Arteaga, the then Office of Maternal and Child Health Program Director for the SEDES Chuquisaca in Sucre, he appeared concerned and made note of the respective names of the two mothers, the communities involved, and the approximate dates of the deaths. He referred to the cases in succeeding
community residents and family members. Solely upon combining these data (and without knowledge of any other possible unreported deaths) into a total of nine cases for the years 2003 and 2004 together, an unofficial and informal calculation of the local maternal mortality in Puka Wayq’u for this time period (based both upon the municipal statistics available at the time, and on my own observations) is a staggering estimated ratio of 4,891 per 100,000 live births—a figure that far, far exceeds both the official estimations for Chuquisaca department and for Bolivia as a whole, and for that matter any medically, epidemiologically or ethically “acceptable” internationally known statistic in general.21

In addition to actual deaths, there were also two (known) cases of what I refer to as “near misses.” In both of these instances, the respective women involved were confronted with a situation in which, had it not been for fortuitous and perhaps even coincidental interventions, conversations with me over time, but despite my occasional questions it was never made clear to me whether the SEDES had sent out an investigative team from Sucre to verify these deaths and to collect further data, including verbal autopsies (as is required by institutional norms), or not. At the risk of assuming an overly pessimistic view of the situation, my own personal suspicion is that the SEDES did not ever do so.

21 9 reported and unreported maternal deaths / 184 recorded live births x 100,000, taking into consideration all communities in the municipality of Puka Wayq’u during the years 2003 - 2004 (24 months). The births include both those which were “institutional,” either occurring in a health facility itself, or at a minimum attended by an official (biomedical) health provider from the local services, at the mother’s home or other location; and those which were registered as “home births,” unattended by any official health services personnel (although perhaps by a traditional birth attendant), and notified postpartum as such to the respective health services, at some later date. Undeniably, there exists an extremely high probability of some underreporting of the births which occurred during this period, although this is unlikely to have exceeded a number consisting of approximately 30 - 40 additional home births unattended by any health services representative, based upon the trends of the years both prior to and following the period in question. In regards to the true number of maternal deaths, there obviously always exists the possibility of missed cases due to underreporting, thereby potentially increasing this estimated total even more—although that is, of course, certainly not what is to be hoped for. At any rate, a theoretical increase in the denominator value of unregistered live births over this chronological period, within the plausible range stipulated here, still results in a mortality ratio above 4,000—and obviously any additional unreported and undetected deaths which may still have been out there would only keep the resultant ratio at the same level, if not pushing it even higher. Again, as previously mentioned and as a measure of comparison in order to put things into perspective: in the year 2010 (for which the most recent WHO figures are currently available), the national maternal mortality ratio in Chad, the country with the highest ratio in the world, was 1,100 per 100,000 live births (WHO 2012).

It must also be acknowledged that due to the small numbers of births and deaths available in absolute terms, and to the geographically compact and limited size of the region in question, the quality of this (highly unofficial) calculation is ultimately contestable, if not unreliable, in a precise sense for purely statistical analysis. It is a figure indeed so far off the established radar for maternal mortality rates as to be effectively “too hot to handle” in a technical, operative or practical sense. However, for my purposes here it is an undeniably strong and indicative representation of the trend which was occurring in the municipality of Puka Wayq’u, and which was the catalyst for all that was to follow at various social levels.
both of them almost assuredly would not have survived the pregnancy related crises they were forced to endure. By “coincidental,” I mean that the initial intervening actions which “saved” both women were not originally on the part of the official health services themselves, although these did decisively step in later in a biomedical fashion. Rather, both women’s respective cases were detected and acted upon by vigilant townspeople and others, at times even in overt contradiction of the actions implemented by the local health personnel. One of these cases I had passing knowledge of when it occurred on March 16, 2004—as told to me by Pablito, the Puka Wayq’u health center ambulance driver and all-around maintenance man—but it was only briefly documented in the center’s medical records, and in an unusually sparse manner. This involved a woman referred to Sucre for more advanced care by the then center director, Dr. Ramiro Cárdenas, due to a “foreign body” which he had detected; later, and on greater examination in the city, this turned out to be a deceased fetus. I could never get a very clear idea of the circumstances in Puka Wayq’u, which always seemed to sink into murky avoidance among the resident personnel—however, a more complete story was eventually recounted to me by a medical intern who had completed his three-month rural rotation in Puka Wayq’u during this time period, and who was later an internist in Sucre when we spoke. It was a curious tale of a woman brought in to Puka Wayq’u from a relatively distant community by her neighbors, who following her referral turned out to be bleeding profusely upon arrival at the hospital in Sucre, then giving birth to a stillborn baby (gestational age unclear, at least at this recounting). The next day, although she should have continued to stay in repose at the hospital, she disappeared suddenly when her husband showed up—and with the body of the stillborn child, now somehow in her possession. She reappeared the next day sitting on a bench in the Tarabuco plaza, as seen
by the internist from Sucre, and holding the dead baby wrapped in a blanket, on her way back to her community. After that, the health services lost all trace of her.

The second “near miss” incident, however, was both directly and indirectly witnessed by me in a very personal fashion, as part of an emergency referral and transport to third level facilities in Sucre: “right under our noses,” so to speak. This particular episode occurred when Doña Tomasa suffered a sudden obstetric crisis at a late stage in her pregnancy, and survived, but lost the baby. I will discuss this particular case below, and in much greater detail, in Chapter 4.

My “ethnographic experience” with the specific four women whom I focus on in detail here is somewhat unique: these are women whom I never personally met, but only came to know indirectly through local medical reports, official actas signed by campesino leaders, interviews with community members and health personnel, and through my working relationship with their husbands, compañeros, and other surviving family members and friends. Accordingly, it would have been possible to give any of the nine mothers who had died equal consideration and weight, because all nine of them, after all, came to the same equalizing fate, the victims of the same social forces, both direct and indirect. However, it is these four women for whom there exists the most quantifiable data in the official record, whose direct family and friends I came to personally know and interview, and (in two of the cases) were deaths which occurred while I was present in Puka Wayq’u. As a result, I was able to observe the immediate aftermath, discuss the events with the communities and the health personnel, and observe as the process of “crisis generation” and “crisis control” unexpectedly and rapidly unfolded. Also, it must be recognized that these four women sadly represent quite accurately the Bolivian context in general: for, if in undeniable numbers at the national level the mortality statistics are significantly indigenous, then, similarly, in the specific local cases which follow here in Puka Wayq’u—Damiana,
Celestina, Benigna and Severina—all women had lived lives culturally and politically marginalized from the dominant political and economic coloniality of “mainstream” Bolivian society. Notably, all spoke Quechua as their first language (as did all of their husbands or partners), all were unable to communicate in anything more than rudimentary Spanish at best, and all were victims of both personal and societal forces generally beyond their immediate control—which translated into the sudden social ruptures revolving around them which were ultimately to prove fatal. And, being women, their deaths inextricably tied to their biology, what occurred in their individual cases thus also became concrete illustrations carried to the extreme of gender discrimination, subordination, subjugation, and rights denied (see for example, Des Forts 1996; Santow 1995; Sargent and Brettell 1996).

Yet these “social breakdowns” are also, first and foremost, individual human dramas which transpire in directly lived terms by actual human beings: this before it is possible to perceive of them as collective social dramas, reflecting the deeper cultural and political forces at play. Consequently, it is first necessary—prior to discussing the personal suffering and the public crisis—to describe in greater detail the actual events themselves: the stark “facts,” as based in eyewitness accounts, medical and community documents, and my own interviews and observations. I begin with the most chronologically recent case, and then work backwards in time. Again, these stories are the minutiae of the actual events themselves, the “ethnographically visible” which serve to hide “the webs of living power that enmesh witnessed misery” (Farmer 2004), a tangible exemplification of abstract forces in historical conflict—once again, the “what actually happened” in a concrete fashion, as opposed to the “what really happened” in regards to human lived experience. (My narrative exception for the moment is that of the complex tragedy surrounding the death of Severina, in the valle community of Yomala, and the role of her
husband, Héctor. Although the final mortality to occur in a chronological fashion, and the one which most impacted on both the local and departmental scene, Severina’s case will be addressed in detail in Chapter 4, and only mentioned tangentially at the present time.)

_Damiana_

On the night of April 19, 2004, Rosendo Durán, the local partero for the small altura community of San Marcos, decided that the delivery of Damiana Vela Sonabi’s placenta was taking far too long, and that the slowly increasing trickle of blood was becoming a cause of concern. (Rosendo was not actually a _traditional_ birth attendant _per se_, but rather a partero who had been trained by the state health services, in conjunction with the international non-governmental organization Plan International, which then provided technical, albeit only sporadic, supervision of him.) Damiana, 27, who had reached only the first grade in school, already had three children, from a total of three pregnancies—the first two, Wilfredo and Casiano, boys who were now ages 9 and 12, respectively, were from a previous union. The third was a girl, Prima, now one year and four months old, and born during her current common-law marriage with Prima’s father, Faustino Torres. All of these births had also been attended at home. This one, which was thus her fourth birth, followed a relatively eventless pregnancy, one which had been monitored through a total of four prenatal check-ups with Julia, the nurse auxiliary stationed at the health post in Villa Rosario, a half hour drive, or two-hour walk, distant. Initially, the labor had been attended at home only by Faustino and by his own mother, Isabelina, just as they had done previously with Prima’s birth. But after several hours the baby still wouldn’t come, and so they called for Rosendo.
At 7:00pm the birth had occurred without problem—a healthy baby girl who they named Erminda—but this was then followed by the retained placenta, the continual flow of blood, increasing pain, and the steadily fading consciousness of Damiana. Rosendo administered different medicinal plants and herbs to her in order to induce the expulsion of the placenta, but unsuccessfully. Eventually, from the sole phone in San Marcos (a public line), Rosendo and Faustino called to the sole phone in Puka Wayq’u (also a public line), at 9:00pm. At first, nobody answered; on the second attempt, approximately a half hour later, Anita (the ten-year-old girl responsible for attending the public phone and transmitting messages to the local population) picked it up, but for unclear reasons delayed up to another half hour in alerting the health center personnel that there was a birth requiring assistance in San Marcos, and without specifying (if she had understood it at all) that it was an emergency birth. The health center personnel stationed in Puka Wayq’u at that point in time consisted of Dr. Javier Quispe, the newly assigned health center medical director, who had arrived in town only the previous month, and who was on that particular day away at a training session in Sucre; Dr. Ramiro Cárdenas, the attending physician, who had been stationed there for two years previously as the center director but then demoted upon the arrival of Dr. Quispe, and yet who was at that moment the interim director in charge of the center during the absence of the latter; two registered nurses; two temporary medical student interns (three month shifts), and two temporary (also three month shifts) student nurse interns also doing their rural practice in Puka Wayq’u. The primary medical personnel present were off duty on that particular night, and the center was staffed only by the head nurse and one of the two student nurses in training. Awoken at home in bed, Dr. Cárdenas decided not to go to San Marcos himself—a decision highly questioned later—but instead sent the ambulance up with only Marta, the student nurse, and Pablito, the health center ambulance
driver. Dr. Cárdenas himself eventually walked over to the health center, in order to await their arrival with the patient.

The ambulance arrived in San Marcos at approximately 11:00pm in the midst of a driving thunderstorm, and on a pitch dark night with barely any public illumination at all; for a considerable time, Marta and Pablito could not find the correct location among the scattered adobe houses. After slowly circling the dirt streets and repeatedly honking the horn, someone finally pointed them in the correct direction; Pablito parked the ambulance, and the two of them climbed up a muddy hill to the indicated house. There they discovered a frighteningly pale Damiana unconscious in the bedroom, with neither a detectable pulse nor clearly discernible blood pressure, and lying splayed in an already very large and still steadily growing pool of blood. Pablito, Rosendo and Faustino carried the unresponsive and bleeding figure awkwardly down the muddy, slippery slope to the parked ambulance, still caught in a pounding downpour. (“She was heavy,” Pablito remembered, uncomfortably looking away from the memory.) On the winding and bumpy road back to Puka Wayq’u, a trip made even more arduous than usual due to the dark, the rain, and the slick road descending into the town, Pablito carefully drove the ambulance carrying the inert Damiana, accompanied by Marta, Faustino, his younger sister Benedicta, and in her arms the newly born and swaddled Ermiña. Marta later confessed to me that she herself was in a near state of shock at how to properly handle such a case, unprecedented for her. “It was horrible,” she said in limiting herself to any further comments, only telling me to “go read the doctor’s report.”

The ambulance arrived at the Puka Wayq’u health center at 12:10am, on the morning of April 20. Upon entry into the center, Damiana’s vital signs consisted of virtually non-existent pulse, arterial pressure, and heart sounds. The waiting Dr. Cárdenas gave her an intravenous
Ringer solution, although Faustino later complained that the doctor was far too relaxed and didn’t move quickly enough, and that it was more like he “just ambled about like he was resting.” However, after five minutes Damiana suffered cardiac arrest; after several minutes of attempts at cardiopulmonary resuscitation and the administration of an adrenalin dosage by Dr. Cárdenas, she died at 12:25am, as a result of hemorrhage from the retained placenta, hypovolemic shock, and cardio respiratory failure.

Celestina

Late the previous year, in the early morning of November 30, 2003, in the tiny community of Iskay Sach’as, also belonging to the altura region of Puka Wayq’u, an hour walk from San Marcos and three hours from Villa Rosario, Celestina Pachacopa Flores, age 44, was in difficult labor with her 13th pregnancy. Celestina had undergone a total of 12 vaginal births prior to the present one, all of them at home, attended only by her husband, Saturnino; of these, four children had died in infancy, leaving eight others who ranged in age from four to 22. This, her most recent pregnancy, had been as “normal” as a 13th pregnancy could be—by its very nature it was classified as “high risk,” due to the mother’s age and her elevated number of gestations. Julia, the nurse auxiliary from Villa Rosario, had made four prenatal visits to Iskay Sach’as over the course of the previous months, but at this point precisely when the projected date of birth was approaching, she had been away for several days at a training workshop in another municipality.

During the course of the day Celestina had gone into labor, and it was soon apparent that it was a complicated obstructed birth; however, she was at home alone with only four of her smaller children: since the previous day, November 29, Saturnino had been off celebrating his 46th birthday with friends, and had had a bit too much to drink. Once he found his way home,
however, close to midnight, Celestina continued to be suffering from the complications of the obstructed and prolonged labor process. Although intoxicated, Saturnino attempted to attend the birth alone in his home, without notifying a neighbor or anyone else; at any rate, there is no partero in Iskay Sach’as or within immediate walking distance (Rosendo Durán, the NGO trained partero, would have been the closest at an approximate distance of a two-hour walk), and the most accessible phone line is the one in San Marcos. Celestina began to hemorrhage at an undetermined hour during the night; Saturnino failed to seek out others at this point either, for assistance in moving her out of the community—at any rate, entry into and out of Iskay Sach’as is by foot, and the closest transportation would have been a truck or two down the road in San Marcos. The bleeding became increasingly profuse, and by approximately 1:00am both Celestina and the unborn fetus were dead; the first from the hemorrhaging and hypovolemic shock, the second from asphyxiation in the birth canal. Neither the health post in Villa Rosario nor the health center in Puka Wayq’u were informed of Celestina’s death, and the circumstances surrounding it, until late on the morning of December 1.

*Benigna*

Also in the same community of Iskay Sach’as, some months earlier on the night of March 30, Benigna Vela Quevedo, age 33, went into labor with her fifth pregnancy. Her first child had died at birth; the following three survived, and were now ages 10, 5 and 3, respectively. Her first two pregnancies (the neonatal mortality and the 10-year-old) were with a previous partner, while the following three—including the baby involved in the actual labor process—were with her current partner, Pedro, who was not at this moment present. Although Benigna was from Iskay Sach’as, and Pedro originated from somewhere in the neighboring department of Cochabamba,
they had both migrated to Monteagudo (in southern Chuquisaca department) a few years before, where he worked as a bricklayer. Her previous births had all occurred either at home in Iskay Sach’as or in Lajastambo (a barrio on the periphery of Sucre)—the latter being the only of her births to occur in a health facility—and in regards to the actual labor and birth of each child, all had been uneventful. In this latest pregnancy, and although all of her prenatal check-ups—a total of three, without any signs of possible difficulties identified—had been done in Monteagudo, for the actual birth Benigna chose to make the long trip home (2 - 3 days, by truck). She had arrived two weeks previously, first staying for nine days with relatives in San Marcos, and then moving home to Iskay Sach’as to be with her parents. Pedro, however, had stayed behind in Monteagudo.

When the birth seemed imminent, her parents brought Benigna up from the house where she had been staying—that of her brother, on the opposite side of a small gully—to the house where they (the parents) lived. This was so that she could be better attended by her mother, Agripina, who had personally attended all of her other births except for the one in Lajastambo. She went into labor three days later; the birth went relatively smoothly; and at 3:00am on the morning of March 31 Agripina helped deliver a healthy baby girl, who they later named Carmelita. Approximately an hour later, Benigna expelled what appeared to be an intact placenta; however, throughout the early morning what was originally a small trickle of blood turned into a strong hemorrhage, indicating that part of the placenta remained attached. The flow of blood suddenly became violently uncontrollable; Benigna became increasingly weaker and eventually lost consciousness; and—obviously seriously concerned—Agripina and her husband finally went for help from the nearest neighbors, an approximately ten-minute walk distant. But,
they didn’t make any attempts to send word to San Marcos or, even farther away, to Villa Rosario. By this point it was far too late, however, and Benigna died at 7:30am.

The community of Iskay Sach’as buried Benigna two days later in the small local cemetery, but without informing either the health post in Villa Rosario or the health center in Puka Wayq’u of her death, and also without alerting any civic authorities or the local campesino sindicato of Villa Rosario, to which it pertains. No news of what had occurred made it to the respective health authorities until April 27, nearly a month after the occurrence, during a routinely scheduled visit to the community by nurse auxiliary Julia, for maternal and child check-ups and prenatal revisions.

Additional Mortality Cases

As previously mentioned, there were also five other cases of maternal death during this same time period in the municipality of Puka Wayq’u. Due to fewer data (in the health center records themselves) and the lack of any direct personal contact with the involved individuals, the details of each case are difficult to clarify. Of these five deaths, three were documented, albeit sparingly, yet which together contributed to the disturbing tendency which was developing in the municipality.

Yana Huasi

From the health post located in Molle K’asa, the Puka Wayq’u health center received a radio message in which they were notified of a reported death in the remote community of Yana Huasi, in the high altitude cordillera region of the municipality. When the ambulance arrived with an official investigatory commission—comprised of the medical director of the time, Dr. Julián García (who had immediately preceded Dr. Cárdenas in the position); the nurse auxiliary
from Molle K’asa; the local police officer, René; and one of the Puka Wayq’u town
councilmen—they found the lifeless body of Petrona Chambi Garcés, age 37, with an
approximately seven-month gestation pregnancy, yet obviously no longer with any fetal life
sounds. From the testimonies of local community members, it was ascertained that Petrona had
had a violent argument with others during a sindicato meeting, returned home feeling ill, went
into premature labor, and then died suddenly on the afternoon of October 15, 2003. The health
center officially classified the death as cardio-respiratory failure, brought on by a suspicion of
Chagas disease (albeit unconfirmed by laboratory tests) and as exacerbated by the pregnancy.

**El Rosal**

In the community of El Rosal, also in the cordillera region, Sabina Copa Aguilar, age 22,
suffered from high blood pressure and severe eclampsia during her pregnancy. Notified too late
to be able to effectively do anything in the Puka Wayq’u health center, she was taken by
ambulance to the Dr. Jaime Sánchez P. Gynecological-Obstetric Hospital in Sucre (*Hospital
Góneo-Obstétrico Dr. Jaime Sánchez P.*), where she died on October 23, 2003. Although the
patient was from a Puka Wayq’u community, the actual death occurred in the city of Sucre, and
thus in the official records it was registered as a *Sucre* mortality, although in an “unofficial”
manner as expressed by the health personnel in Puka Wayq’u it was uneasily acknowledged to
be a local case.

**Huayra Cancha**

Teófila Paniagua Cruz, age 35 (approximate), from the altura community of Huayra
Cancha (located very close to the Villa Rosario health post), had had a difficult pregnancy, with
an intestinal blockage requiring colon surgery in Sucre, at a gestation of 24 weeks. She came
through that episode successfully, and had already given birth in early July of 2004, when in
early September she returned voluntarily to the Santa Barbara Hospital in Sucre for her scheduled follow-up surgery. However, upon arrival Teófila was diagnosed with severe malnutrition and anemia, and had not healed well from the first surgical intervention; she was diagnosed with a fistula in her colon which quickly developed into peritonitis; she then rapidly went into an advanced state of septic shock, and entered emergency intensive surgery. Nevertheless, on September 7 Teófila suffered sudden cardiac arrest, which together with the septic shock was classified as the cause of death. Although the actual death occurred at 60 days following the previous birth, and thus exceeding the 42-day postpartum period within the maternal death framework, under the official WHO terminology it remains classified as a “late maternal death” for up to one year, if owing to causes directly related to the previous pregnancy (in this particular case, pregnancy related malnutrition and anemia, which had exacerbated the ongoing intestinal difficulties and previous surgery). In this way, Teófila became the final registered maternal mortality case during this chronological period in the municipality of Puka Wayq’u.

In addition to these three registered cases, there were also two anecdotal reports, as told to me by family members or friends. Neither the health center in Puka Wayq’u, nor the SEDES in Sucre, had any prior knowledge of these particular deaths.

**Chimpa Mayu**

Severina, in Yomala, had a younger sister named Reina, who already had two young children; she lived across the river in the community of Chimpa Mayu, in what is the department of Potosí. In approximately early 2003, when she was almost 20 years old, Reina also died when in labor with her third child. Thus, there had been two maternal deaths in the same family.
Puente Orcko

In the community of Puente Orcko in the cordillera, on an undetermined date in 2003 an unnamed woman informally described as being an “opa” had died when pregnant. (“Opa” is a Quechua word usually used colloquially, and somewhat unkindly, to describe a person with one variety or another of mental deficiency or mental illness. In Bolivia, when characterized in this manner regarding those in distant rural regions, frequently enough it very probably turns out to be a case of cretinism due to iodine deficiency.) Nothing much else seemed to be known about her, including the precise circumstances surrounding the incident, other than the fact of her pregnancy, and of her death.

That Which Is Left Behind: Reflections on Mortality

These are stories all too typical of Bolivia, and of many other Bolivias throughout the world. While the details of the particularities and peculiarities are of course unique to each personal instance, the essential theme is the same: the social, moral and ethical injustice of an entirely preventable death, and the impact which that death may have upon its respective society. One of my interests here is to consider in greater depth, and beyond the immediate reality of the actual events themselves, the wider and long-range impact of what happened in Puka Wayq’u and the socio-historical framework that produced them—or, at the very least, aided and abetted them: the impact on the community, on the region, and on the nation as a whole. Yet still, and within the context of these considerations, it is necessary to reflect upon the circumstances themselves in terms of their importance as personal events at the epicenter of the “what really happened” within the context of entrenched socio-historical forces, conditions which are representative of the persistent dilemma as a whole. Among these, in regards to the cases from
Puka Wayq’u which I discuss and am able to identify as pertaining to the generalized contexts of structural and reproductive violence as overriding themes, preeminent is the question of *personal responsibility*, and “taking stock”—that of coming to terms with tragedy, and of strategies for moving on.

The role of the husbands / partners, in all four cases discussed here, was critical. Unfortunately, in none of them was it ultimately a *positive* intervention; in each, it is indisputable that the husband could have done more, and which would have very possibly saved the life of the mother. In this way, the question of personal responsibility is therefore prominent. Without resorting to a “blame the victim” approach, the deficiencies—and their socio-historical origins—need, nevertheless, to be recognized. At one extreme is the case of Benigna and Pedro: he was a completely absent partner, far away in the fields of Monteagudo, days away by truck; following the death of Benigna, Pedro returned to Iskay Sach’as only once: for the first All Saints’ Day and Day of the Dead celebration, at which Benigna would be the central figure. He never came again; two or three times he sent small sums of money to Agripina, to be spent on the care of Carmelita and the other children, but those dwindled out after the first year or two. It was rumored that he already had another wife and family in Monteagudo. I once asked Agripina about the quality of the relationship between Benigna and Pedro, and the bitterness in her reply was brutally evident: “He was a drunkard,” Agripina retorted, “How was I ever supposed to like him? I didn’t even *know* him.” In a sense, Pedro was already a non-person, implicitly not expected to show up for the second year’s All Saints’ Day (and indeed he didn’t, as it was to turn out). The “minor inconvenience” of the matter was that he was the father of Carmelita and two of the older children—an inconvenience which was rapidly slipping into the realm of a conveniently and dismissively negated history for the family.
The other three partners—Faustino, Héctor, Saturnino—were present at the difficult labor and births that their wives were suffering, but failed significantly in their reactions to the rapidly escalating emergencies, which then spiraled inexorably down into crises leading to death. Yet, was it their “fault” that they reacted poorly? In the case of Saturnino, perhaps, it must be recognized to a significant degree as yes: he was, after all, drunk at the time (yet another of the long succession of men I knew or had heard of who had “drinking problems,” as characterized by the respective communities), and although he attempted to get Celestina moved to safety once the direness of the situation had sunk into his clouded consciousness, by then it was far too late. During the emergency birth of Damiana (in addition to that of Severina and her husband Héctor, as will be discussed in Chapter 4), Faustino also suffered a serious lapse in judgment, not recognizing the true nature of the situation until it was, again, tragically very late—“first delay” missteps which were then fatally compounded by second delay difficulties (faulty communications networks, poor roads) and third delay miscalculations (errors in medical judgment, which probably bordered on, or crossed over into, verifiable negligence or even malpractice).

Yet it is ultimately difficult, if not impossible in a constricted ethical manner, to condemn any of these men for the crises and resultant tragedies that were to befall their families. In the first place, it is notable that all spoke halting Spanish at best, and were much more proficient in their native language of Quechua. Although their respective ties to market institutions and forces

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22 The particular case of Saturnino is additionally and rather seriously compromised, however, by the version of his married life with Celestina as recounted to me by a few of his neighbors. Most significantly and disturbingly, they frequently attested to me that Saturnino would often beat Celestina, typically when drunk. Without directly confronting Saturnino himself with these accusations—which I didn’t—it was obviously difficult to verify this version of their married life, although domestic violence in general and spousal violence in particular are, unfortunately, not at all uncommon in the campo (as they certainly also are in the barrios populares of the cities), especially after any notable amount of alcoholic intake has been taking place. Thus, any consideration of personal responsibility in Saturnino’s case is made even more complex, and increasingly murky, in a moral arena which involves complex (and all too common) issues of overt and blatant gender-based violence.
extending from the communities to the city of Sucre were obviously extant and viable, their lack of linguistic ties to the dominant (and colonial) culture meant that their ties to social forces were weak. Health education campaigns, deficient as they had been in the municipality, had not reached them; the local auxiliary nurses were apparently lacking in their coverage of the communities; thus, the men were not well aware of the danger signs in a problem birth, or when it was time to get their partners out—fast—for specialized help. (And when, as in the case of Faustino and the partero Rosendo, it was time to recognize that the situation had deteriorated to a much more serious level.) Was it, then, their “fault”? If it was certain that they had been effectively relegated by a state health care system which did not take them into serious account as active and protagonist partners in maintaining both family and community health, then how were they to properly react when the circumstances suddenly called for it?

“That’s just the way it is with people here,” I often heard the local health personnel comment, in reference to mothers’ choices to have their births at home with only their partners and perhaps a parent, “they prefer their own culture.” But whatever that “culture” may be perceived as being by the local governmental authorities, it merely ends up as being what Farmer (1996) refers to as “the conflation of structural violence with cultural difference.” Instead of addressing the policy and administrative (not to mention racial and political) issues which are behind insufficient if not erroneous responses and actions, the problem gets blamed on the “local culture,” as if in that way all culpability and recognition of formal state responsibility could be absolved, if not simply denied, and brushed aside. “Cultural difference is one of several forms of essentialism used to explain away assaults on dignity and suffering in general,” notes Farmer (1996:278)—and, consequently, the issues of “personal responsibility” become enmeshed and inextricably blurred by the structural variables surrounding them. Thus, the violence of the
social structure itself, abstract perhaps, is translated into the violence of the eventual tangible outcome, anything but abstract—that is, a woman slowly dying in a growing pool of blood.

But there is still a role for “culture,” however it may be defined. In the section following this one, I examine a clear example of how misfortune and tragic events may be better absorbed and “contained” by the very nature of ethos and tradition, which act as both mediators and mitigating agents—in this case, the celebration of All Saints’ Day and the Day of the Dead, as it is observed in Puka Wayq’u. Initially, however, I wish to comment briefly upon the process of loss and renewal undergone by both the respective families and by the communities. In adopting the notion of “the remaking of everyday life” (Das et al. 2001), in Puka Wayq’u it was possible to perceive the differing ways in which “communities ‘cope’ with—read, endure, work through, break apart under, transcend—both traumatic violence and other, more insidious forms of social suffering” (ibid:3). Among those with whom I shared time, perhaps the most crucial and the most basic strategy was the simple notion of family and communal solidarity. Saturnino, for example, commented to me once that “It’s very hard to take care of my children, I just can’t do it alone… At least [the older children] help me, because I cook alone, I wash the clothes for the little kids. That’s how we help each other in our lives.” Faustino, similarly, and in relation to the family unit comprised of his children and himself in addition to his mother and his sister, remarked that, “Since before, we’ve always lived together. We’ve never separated; we cook and do everything together.” In his particular case, his sister Benedicta assumed the almost total responsibility for the baby Erminda, carrying her around in a traditional weaving (aguayo) and sleeping with her at night. Faustino himself, however, was always visibly very attentive to the older daughter, the toddler Prima, with whom he shared a bed. These were common gestures within the Bolivian context in regards to children, and were to be expected—although, and in
direct contrast to these generous remarks made in reference to their particular families, all four husbands or caretakers (including Héctor in Yomala) scornfully dismissed their respective communities and sindicatos; all claimed that support and assistance, whether financial or just plain neighborly, had been virtually nonexistent.

Yet, there was also a subtle edge that I perceived, a tell-tale sign that this was not quite “business as usual,” even considering under the extreme circumstances, and which would crop up unexpectedly—although that qualification itself may be ingenuous on my part. For example, on more than one occasion, in what on the surface was a joking remark and said with a grin, both Benedicta (an aunt) and Agripina (a grandmother) “offered” us the respective children to take and care for as our own. A joke, said pseudo-seriously; or, a serious offer, said jokingly? It is often hard to be sure within contexts such as these, but the very possible moral sincerity of the remarks is not hard to understand: as much loved as they are, the children are another mouth to feed in an already tight family economy, and Karen and I would almost assuredly have been seen as a much better option for their respective futures.

All direct relatives remarked upon dreams that either they or the mother had had in the weeks or months prior to the deaths. Saturnino had dreamt about airplanes, which he considered a bad omen; Agripina had dreamt that Benigna was “deep inside somewhere, but I couldn’t see her. There were bats, a huge moth, they were all stuck together… They say that that means death and mourning, and I thought ‘Who is the mourning for?’ ” Later, after Benigna’s actual death had occurred, Agripina went to a yatiri—and, as shaman, these are both traditional healers and also key spiritual figures—who read in the coca leaves and the Tarot cards that Benigna had been bewitched, or cursed, which led to her death; there was, however, no firm indication offered of who might have been the guilty person responsible. Faustino, however, talked about Damiana
herself, and how she had suffered through many bad dreams: “She dreamt that her father had just died [although Damiana’s father was in fact already deceased, since many years before], and that he was making her dream now. A few weeks before it [her death] happened, she saw other ghosts in her dreams. If you dream something bad, well, you think that maybe something bad is going to happen.” All spoke of these dreams to me in a matter-of-fact manner and an accepting fashion, and in their commonly-held perceptions of them as visions acknowledging the truth that they had indeed ultimately held.

The respective partners all maintained the custom of wearing the black of mourning for a year after the death, except for Faustino, because he and Damiana had never been legally married in either the civil registrar or in the Church. Yet beyond that, the sorrow (phuti) that they felt marked them in such a way that they all commented upon the changes as a kind of personal transformation that they had undergone. Most representative, perhaps, were the words of Saturnino:

I’ve changed in my life. In the beginning I was sad, but this year I’m getting used to it—because, what else can I do? I’m already forgetting it all, through my work; in that way, I’ve changed. With my children [those who lived in the city], sometimes they come to visit, but when they leave, I get sad again. But, what else can I do? They go away because they have to, because they’re studying far away, and I want them to continue studying. They’re big now, and I can’t bring them here to live by force. And also, them, the little children here with me, without their mother, alone with their father—‘they can’t live like that,’ that’s what people say. People say that I need to look for another wife—but I don’t want that, because stepmothers hate the little kids they’re supposed to take on, and I don’t want that either.

In listening to words such as these, for a chronologically brief time I was there and part of their lives—temporarily, yes, but undeniably sharing their lives in a very real temporal sense, reliving their suffering albeit extraneously and at a “safe” distance, through their talks and their
memories. Consequently, I (and Karen and Natán, who were usually together with me on visits, most specifically with Faustino and his family), knew that it was critical, in particular, to extend the custom of reciprocity which is so essential in Andean communities, beyond the daily kind that we shared back in Puka Wayq’u with Don Alberto and Doña Tomasa. With these families of the women who had died, the very least that we could do—at the least—was to offer them small gifts: coca, food, and a little cash, in exchange for their time and their willingness to talk, and to share their thoughts. This developed the most extensively with Faustino. Over the course of many visits, we brought them fruit (hard to find in the altura communities), store bought cookies, cans of powdered milk for Erminda (the most requested item of all), coca (from the Yungas region of La Paz, especially prized and harder to come by in Puka Wayq’u than the more common variety from the Chapare of Cochabamba), toys for the little children, and school supplies for Wilfredo and Casiano, the older boys. In return, they gave us more food (eggs, potatoes, corn [mote], soup) than we could typically finish eating, a small room to sleep in, a live rooster (a gift of which to feel most especially honored, although it definitely was not an easy task carrying it in a burlap sack on the long walk back to Puka Wayq’u), and their time.

Finally, for all concerned but principally for Faustino and family, we found a way which seemed to serve as a proactive and significant mechanism to assist, just a little bit, in their process of coping and “coming to terms” that so interested me: taking photographs. Overall, people everywhere loved having their pictures taken, and we were much in demand as the unofficial photographers in the town and the communities; nobody owned a camera, and the occasional “professional” photographer who showed up on a festival day or two would charge a fee as a moneymaking business. We would always make copies of our recent pictures on trips

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23 And in this small way, again doing all that was “ethnographically possible” to avoid the trap of a “denial of coevalness,” as Fabian (1983) would have it.
back to Sucre, and later return these to the subjects free of charge, to which people’s gratitude seemed to know no end. So it was with the husbands also, especially with Faustino, and these small acts alone seemed to not only assure us a transitory entry into their lives, but also to somehow assuage the process they were part of. In this manner, with Faustino in particular, the preferred photo subjects by far were the two little girls, posed in an endless variety of manners, and with every last member of the extended family (including aunts, uncles, nieces, nephews, cousins, compadres, and friends). I was always to see these photos as a means for Faustino to preserve his daughters for his and for their own posterity, but most of all for that of Damiana’s.

Then there were the women of the families, who were also left contemplating the series of deaths and the social climate which arose out of them. These included not only surviving members of the immediate families themselves, of the respective mortality cases, but also the concerned thoughts of other women in the communities where these had occurred. For the most part, their reactions were focused on two overriding thematic focuses. First, there were the emotions brought forth in reaction to the events: how a maternal death was, somehow, different than other kinds of deaths; how the children especially were left alone to suffer; the feelings of sorrow that these women circling the deaths were experiencing themselves and how they, and the community, were (or should be) helping. “It’s so, so different,” Florencia Limachi in the town of Puka Wayq’u said to me, shaking her head,

People say, “Ay, she died giving birth; why did it happen like that? And now, who are the children going to be with? They’re going to suffer.” That’s what people say, and then they cry, too. Ah, but the little children suffer so much! It affects them so much. They also suffer and cry if their father dies, but there isn’t anybody who takes care of them like their mother.

This was, perhaps, the most common of sentiments, shared by all the women who gave their opinion, and was invariably the first thought on their minds: that of the children. “The
children’s life is such a tragedy then,” emphasized Bernarda Gallardo, a young mother in San Marcos, echoing the sentiments of Florencia. “They suffer. I get so sad when I see them left behind like that.” There again, as Doña Carmen Bautista in Yomala had previously expressed to me, was the identification of the children as “little orphans,” lost and abandoned without their mother. There were expressions of regret and sorrow over the dead mother, of course, but that always led back to the children. Several months later, Doña Miguelina de Arduz, who was from Yomala and had been a close friend of Severina, was visibly agitated in recalling for me the day that it had happened, and the repercussions: “The woman died in pain! In pain! And the wawita died also, and its mother…she died. It’s so sad. It’s so sad for those who are left behind. And she left so many, so many little children…”

For Agripina, in Iskay Sach’as, her initial thoughts were with her daughter Benigna, but these also soon moved onto her grandchildren. There was, yet, also a discernible note of self-pity, of anger and resentment—at what she felt was a lack of solidarity from her community, and at the fate itself which had befallen her:

If in the beginning something had been hurting her, or if she had got sick, then I would have tried to look after her somehow… But, she always called out to me from the house down there, “Mommy, I’m fine,” and I would call back “Does it hurt?” But if you had seen her feet when she first arrived here from Monteagudo, they were so swollen, really bad… But, she died. If it’s an old woman who dies, then there’s no problem. We say, “Ay, the old lady died, but she couldn’t even eat anymore, she had to walk with a cane.” So, we say that she’s free now. But if she’s younger and she dies, then there was still so much for her to do, and so we get sad. And if the wawita lives but the mother dies, then that’s even worse… Yes, that’s even sadder. And the children get sad. Here, they [Benigna’s surviving children] asked about her at first, but now they’ve already forgotten. Carmelita looks good though, doesn’t she? I didn’t think that she was going to survive… What am I going to do? I have to just keep taking care of these little children myself, cleaning up after them, cooking for them...

[Then, to the question of whether people in the community had been helping her.]

What difference does it all make to them? What, them help me?
This then, however, brings up the other prominent focus of local women’s reactions and thoughts, which had much to do with perceived mistreatment and injustices: from the Puka Wayq’u health center and its personnel on the one hand; and from the husbands and partners on the other. In this respect, the women were frequently concerned with what they saw as the manner in which the very context of the deceased mothers’ lives (as well as their own lives) had, in its fashion, both created the events which had occurred, and had also been reaffirmed by them. As one example of what was clearly their anger concerning the treatment they received from the health center and its staff, Carolina Sotomayor in the town of Puka Wayq’u was especially irate: “Women say, ‘I’m afraid to complain,’ because the center people yell at them. ‘Hey, just shut up!’ That’s how they yell at women. And Lic. Estela [one of the nurses] hates me, because I speak up. Women need to know their legal rights, we need some sort of training—in women’s rights, and how we can stick up for ourselves.”

In regards to the husbands and partners, I clearly noticed that a common theme that would often come up—either forthrightly or obliquely—addressed the issue of uncontestable physical, and gender, violence in regards to the men involved. It must be noted, in referring back to what I have previously discussed, that the very occurrence of the maternal death in the first place has an obviously discernible gender component. In these specific cases observed, the husbands / partners involved may be perceived as being frequently guilty of either a subtle or an egregious affront to their wives / partners’ dignity and to their safety, which in the end proved fatal. On the day that Celestina went into labor, Saturnino was drunk and effectively unfit to adequately assist her. Pedro was an absent partner, and in the end only returned once to Iskay Sach’as following Benigna’s death. (Again, an always visibly irate Agripina retorted, “He sent money once, but never again. I think he’s afraid of me, because he would never come over to
speak with me.”) Héctor also (and as I will look at more closely in the following chapter) was typically off somewhere else, and his behavior was much implicated in how it related to the events of the day that Severina died. (“Most men are hardly ever around the house,” shrugged Doña Miguelina de Arduz of Yomala, disdainfully; “men in general don’t usually take good care of their wives.”) Even the more conscientious Faustino was guilty of a serious lack of sound judgment at a critical moment—although, and in considering what was evidently for the most part a cautious and respectful behavior toward Damiana throughout their union together (based on how people in San Marcos spoke of Faustino, and on my own conversations with him), at this point it would be difficult to properly attribute the actual origin of this lapse in judgment. Rather, was it a careless, if not cavalier, attitude in regards to Damiana’s increasingly frightening labor process owing to a “patriarchal” mindset in itself; or, rather, was it owing to a socioeconomic structure which by its very nature left him at a distinct disadvantage when it came to exercising quick and responsible decision-making, as I have already implied above? In any regard, it remains without doubt that either way the social fault line had been deeply embedded, in what can only be identifiable as an indisputable gender divide.

Yet, it also goes beyond the immediate behavior of these men on the actual day of their partner’s individual crisis. As noted, two of them—Saturnino and Pedro—reportedly had histories of physical abuse of their partners, Celestina and Benigna, respectively. Similarly, Florencia Limachi told me her own sad personal narrative, involving the father of her four daughters—until he decided, one day, that he just had to go, never to be seen again. (Nor was any money or other help ever sent back to Puka Wayq’u, for her and the children.) But, while her partner was still around, it wasn’t much better: “He used to hit me a lot,” Florencia
recounted to me (in relation to one of her pregnancies), yet without showing much emotion at her own words,

He even beat me when I was pregnant with Marcelita. Maybe that’s why she was born all swollen up and green looking, because he really hit me hard. That must be why she couldn’t be born easily. I had to go to Tarabuco; it took two nights and two days. It was terrible, I suffered. I almost died! They gave me injections, they put in an IV. She was just barely born. I was really afraid—“Maybe I’m going to die,” I said to myself. I’ve never felt so much pain. I thought, “Maybe I’m really going to die…”

These are, of course, unfortunately enough all-too typical stories, as much in Bolivia as they are around the world. Florencia was certainly “lucky,” in an important way: she at least survived. Others do not. Levels of physical gender violence of this nature—for example, such as described by Florencia; or anecdotally in reference to Celestina and Benigna—are emblematic of an endemic disease of the collective structures of the social order, as it is manifested at the individual, personal level. In harking back to Bourdieu (1992), they are themselves representative and “symbolic” of the symbolic violence itself, reified instances of what are often only abstract conceptions of patriarchy, and of male domination and female submission. But with these particular examples, the violence is overt and unmistakable; it is not the variety that lends itself to “misrecognition” when casually (or not so casually) observing the framework of the social order. It is nevertheless an integral component of the flawed, coloniality imbued structure that played such a fundamental role in what occurred in the municipality of Puka Wayq’u, and the climate of pervasive tension and mourning that so settled over it during these months.

**A Tragedy in Common: The Sociality of Remembering**

As a key means for making peace with death throughout much of the popular classes of Latin America, the intimate—if possibly not more accurately the *comfortable*—relationship with
Death itself is frequently notable. Death in Bolivia is (no surprise here) a tragic event, not one to be desired, and certainly to be greatly mourned. As anywhere, it brings on great pain and suffering for friends and family members, and—frequently enough, in melodramatic Bolivian style—is observed with black mourning dress from head to toe (for weeks, months, or years) and copious alcoholic drink, initially accompanied by a sizable dose of strident wailings and other manifest histrionics. The loss and distress felt is undeniable, and extremely palpable and enduring. Yet in the campo with time—and, quite often, quite a short time—there is an almost imperceptible transition, and death is transformed into an old and familiar acquaintance who has come once again. The dead are remembered as they should be: as they were in life, as actual physical presences, with all of their frailties and joys, perhaps only occasionally and colloquially and tangentially, but still part of this world as long as they are remembered. For the survivors, there are always specific and designated moments propitious for that remembering: the regular masses for the dead, beginning at nine days after the death, and continuing on throughout the years at regular intervals; in November for All Saints’ Day and the Day of the Dead; and upon the occasion of another’s passing. At these times, there frequently exists a paradoxical yet easy and natural juxtaposition of deep sorrow at the deceased’s departure, with a joyful celebration of memories mingled with a delight in the fact that we at least are still here on this earth, and able to participate in all of its pleasures.

One afternoon we participated in the funeral rites for Sabino, a young man aged 35 who had died a few days before. He had gone to see Dr. Fernando Torricos, the dentist in the Puka Wayq’u health center, with a severe toothache; Torricos gave him some antibiotics and sent him home. That night Sabino got drunk (he too had had a longtime drinking problem, many remorsefully commented), unexpectedly his throat closed up and he had difficulty breathing, and
this was followed by what was apparently a sudden and fatal heart attack. Amidst a gathering of about 30 black-clad mourners in the Puka Wayq’u cemetery, located on a rocky and windswept hilltop overlooking the town and filled with small brick or adobe tombs scattered over the grounds, Sabino was brought up inside a black, homemade coffin of cheap wood. The body was accompanied by family members, including his ancient and stooped mother, totally covered from head to toe in a black shroud and topped by a wide brimmed black hat, and weeping inconsolably. By way of sad coincidence, it was May 27, Mother’s Day in Bolivia. In the simple chapel of the graveyard, Padre Antonio performed a quick and perfunctory mass in Spanish (including a religious hymn he sang to the tune of Blowin’ in the Wind), and during which he had to ask someone at his side what the deceased’s name had been. In Quechua, he proceeded to sternly admonish the assembled mourners first for not giving him enough notice in order to adequately prepare his service; and next for not paying him enough for the same. Then, once he had concluded the mass, he promptly left. Immediately after the ceremony’s conclusion, Sabino’s casket was taken outside, where a small knot of people, comprised

24 Although occasionally suspiciously implicated by some in a whispered fashion, Dr. Torricos was never openly or formally accused as having had any direct role in Sabino’s death. The dentist’s own version of the events, as he recounted them to me in what was unsurprisingly a somewhat defensive tone of voice, was that Sabino had undoubtedly died of septic shock, which may or may not have brought on the actual heart failure. He had had a pronounced tooth abscess, which had become seriously infected; Torricos theorized that the heavy alcohol intake had probably dilated his veins and caused a more rapid spread of the infection, despite the antibiotics. He denied that he had given Sabino anything else—an injection, for example—other than the oral antibiotics. As was typical with a case such as this out in a rural health post, there was no official follow-up or formal investigation in order to clarify any lingering doubts (let alone an autopsy, or some other equally unheard of procedure in Puka Wayq’u), and the actual cause of death quickly faded away into a non-issue. “He didn’t take care of himself,” Torricos shrugged, his rationale being that Sabino hadn’t come back for his scheduled follow-up visit. Not addressed very clearly by the dentist within this surmised diagnostic framework, however, was the question of what exactly had been his planned course of action for the days to come after the initial antibiotic treatment; nor the fact that Sabino had died on the night of the same day in which he had been to the health center—which was, it goes without saying, long before the date of his presumably scheduled follow-up appointment.

25 The allegation concerning the proper fee for the service was indignantly refuted to us afterwards by many of the participants, who stressed that Padre Antonio was unfairly demanding the city rate for a funeral, rather than the campo rate. Actually, the fact was that Padre Antonio was not always the most agreeable, or well-liked, of priests in the history of Puka Wayq’u; people would accuse him of being distant and somewhat arrogant. Don Alberto even denounced him to me once as being a chicken thief, claiming that the padre had snatched one of his hens and took it home for dinner, just out of spite. Despite his religious misgivings, for over a month after the alleged incident Don Alberto had refused to attend mass due to his disdain for Padre Antonio.
predominantly of the old women dressed completely in black mourning, set up a vigil loudly weeping, occasionally shrieking, wringing their hands, and singing chants in voices of high-pitched Quechua.

Meanwhile, some meters away a few men, including Sabino’s brothers, were digging the grave. The scene was distinctly different on this side of the cemetery, in contrast to that of the bereft and wailing female mourners: over here, and amidst a general atmosphere of joking camaraderie, the coca, home-rolled cigarettes, chicha and cane alcohol were energetically exchanged and offered to all. We were given our share also, and repeatedly taken by the hand by one person after another who wanted to show us the tomb of this or that loved one. Mario and Gualberto were there also, running and playing together with other kids; Mario latched onto us as he frequently did, and merrily took us over to show us Josefa’s grave. Amidst the increasingly drunken yet somehow always focused and structured liveliness, the gravediggers suddenly let out a whoop and began pulling bones out of the hole in the ground: two skulls and a big pile of femurs, ribs, vertebrae, etc.; plus, some old scraps of rotting clothes. We were told that one set of remains belonged to Sabino’s grandfather, for this was the “family plot,” which had reached the point of needing to be partially vacated in order to make room for the latest arrival. (Somewhat surprisingly enough but only mildly disturbingly so, it wasn’t at all clear among those present who the other skull and bones might have belonged to.) People crawled around, poking at the remains, laughing and making jokes and light banter; the most frequent and impressed comments by far were in regards to the impeccably well-preserved and complete set of teeth of the grandfather, and of the excellent condition of his leather sandals. Some people even casually, carelessly and unabashedly stepped on the scattered bones, apparently without paying much attention.
Eventually the coffin was carried over to the grave and lowered in. Then, in a gesture acknowledging an absent State (which must always be ceremoniously reified in one way or another, at formal occasions such as this), it was temporarily covered by a Bolivian flag, because Sabino had been an elected sindicato leader. (The Bolivian sindicato itself, ironically, exists parallel to the state, often in competition, yet also in an uneasy reflection of it.) The current sindicato officials said a few words and prayers of farewell, the flag was informally yet solemnly given to one of the family members, the coffin was lowered into the grave, and dirt and rocks and reeds were shoveled back on top of it, while the entire proceedings were accompanied by the mournful singing of the old women and the ongoing off-stage laughter of children and numerous moderately tipsy adults. At this point the activity at the center of the occasion wound down, and the assembled mourners gradually broke off into little groups to visit other graves, eventually slowly drifting away. As the sun set it grew quite cold, and more coca and cane alcohol were shared. Off to one side, two fellows unceremoniously reburied the pile of bones of Grandfather and the other Unnamed One together in an unmarked common grave located in a distant corner of the cemetery, placed a candle on a rock atop the mound of earth, lit it, and left.

“Yet in the midst of it all,” Kleinman observes, “we make a life” (2006:26). This undoubtedly applies equally to whatever kind of life we may be making, and however and wherever that may be. Sorrow and remembering go hand in hand, but it is not always essential that this be so, or at least not so for an overly extended period of time. Death was something to be dealt with in a variety of different manners, as was on display in the cemetery during the remembering of Sabino, and also as shall be described for the remembering of Damiana, detailed below. The family members who are left behind following unexpected crisis and tragedy, throughout the communities of Puka Wayq’u, felt sorrow, of course, and mourned in their own
ways. Their suffering was always present, yet it was mitigated and made manageable by the
very nature of the cultural mechanisms utilized in counterpoint to the structural injustices of the
social system that surrounded them: it was even celebrated, in its own way, and thereby
somehow transformed. Freud, in his much quoted essay *Mourning and Melancholia*, says that
there must be a healthy “respect for reality,” and “when the work of mourning is completed, the
ego becomes free and uninhibited again” (1957:244-245). This is the process that the survivors
were directly orchestrating for themselves, with the assistance of the symbolic use of certain time
honored conventions, and which returned them to the relative freedom of their lives—constricted
as they were within the constraints of their society, precisely through a respect for their own
reality as they knew it. In the following section, I consider one such extended example of this
process in Puka Wayk’u.

* * *

In taking into consideration the nature of the Andean world, of which Puka Wayq’u is as
good an example of as any, perhaps what stands out most prominently in both the literature and
in life is the communal focus that prevails throughout. Just as in its classic conceptualization—
that time itself is not *linear* in the indigenous Andean world, but rather *circular*; an ever-
repeating loop without any discernible beginning or end—likewise then the idea of space is
neither straight nor focused, in this sense on any single person. Thus, in the physical, occupied
community, it is not the individual who is at the center of society and existence, but rather the
community itself, in respect to those who comprise the social body. The cohesiveness of this
communal unit is expressed in a variety of different fashions: most vitally, perhaps, is that of
communal decision making, a process through which all members of a group have a supposed
say in the course taken by the community—*cabildos*, a kind of mass town meeting; or, in a
somewhat more political fashion, the agrarian sindicatos. In classic Andean society, there was, and is, the ayllu unit (although no longer culturally active in the particular case of Puka Wayq’u, however): kin groups extending across multiple communities, and over possibly extensive geographic areas. And then there are the specific occasions, tangible events physically occupying both time and space and with the active participation of most, if not all, the members of a community: the festivals, games, rituals, religious observations and group gatherings that both symbolize and embody the cultural profile. Each one of these occasions has its purpose and its reason for being, but what they typically all share is a kind of camaraderie, “group spirit,” a leveling experience—communitas, in Turner’s famed terminology (1969)—in which the individual fully realizes and exchanges with fellow group members whatever it is that the culture is trying to establish, and part of what makes it what it is.

During my time in Puka Wayq’u, I was able to witness an especially representative example of such a ritual communion / communitas / containment / event in order to redress and redeem the sudden private crises and suffering of mortality, and—highly important—to express, display, perform, and find expression for intense emotions, in order to achieve a kind of social equilibrium. This was the celebration and observances surrounding All Saints’ Day and the Day of the Dead. In order to put in context and analyze the activities which comprised these events, and a locally enacted representation of “what really happened,” I will adopt an interpretive contextual framework that is closely associated with the overriding macro framework utilized as a common lens throughout this dissertation: that of the social drama. In this specific case, I observe the culturally critical activities organized during the duration of these selected days as an example of performativity, and of the performance process. “Performance” is present in all walks of life, from the intimate and the micro, to the public and the macro. As defined by
Schechner (1988:281-283), with important nods to Goffman (1959), Geertz (1973), and Turner (1974, 1987), there are different levels of “performance magnitudes,” all of which are interrelated; in the case of Puka Wayq’u, I take into consideration the final three levels: scene, drama, and macrodrama. The first of these, scene, is a unit of interaction among individuals comprised of a number of bits of information and emotions, told sequentially. The second, drama, is a complex combination of many scenes, strung together (consciously or unconsciously) by the participants into a coherent system. The third, macrodrama, is a large-scale performance piece: Turner’s concept of the social drama, contextualizing the collective crisis of a community, how it is addressed, and the manner in which resolution is attained. At each of these performative levels, there is an equal interaction of the concepts of “theatricality” and “narrativity,” which inform and define the very nature of performativity itself.

In the following case study of All Saints’ Day and the Day of the Dead, it is the notion of a drama that I consider. In this illustration, a form of ritual is enacted which addresses and contains the personal crisis of a death—any death, but in this case specifically one which has also thrown the community as a whole into crisis. As with virtually any ritual process that has death at its center, a collective experience such as All Saints’ Day is also very much a social process, in this case in which both the deceased and the living participants find themselves ambling about together in a decidedly liminal stage—the classic “betwixt and between”—and during which the dead (who are not yet totally dead) are at last initiated into another stage following this life. It is enacted for the benefit of two distinct yet complementary audiences, both with their own respective positionality: the dead themselves, and the living.

As such, it is possible to divide the sequence of the chain of events I will describe here, over its duration, into what Schechner calls a “performance process as a time-space sequence”
In this, there are three distinct stages: proto-performance, performance, and aftermath; this taxonomy applies equally to a more social drama, as it does to an aesthetic drama, one involving the performing arts themselves, or to other forms of entertainment, or to sporting events. The first stage, that of proto-performance, precedes and readies the actual event; it is the preparatory stage, the “setting up.” The second stage, the performance itself, consists of different levels, but those which I incorporate for my purposes here are those of the “warm-up,” the public performance itself and its surrounding context; and the “cooldown” phase, following the event, in which the participants “wrap it up,” do a kind of debriefing, and go home. The third stage, aftermath, is the phase which consists of a “critical response” to the performance, as evidenced through ongoing discussion, analysis, and remembering; this may last only briefly, perhaps for a day, or it may extend for many years.

Within these parameters, however, it is also critically important to remember here what Rosaldo (1993) admonishes us to note: that an ethnography which touches upon the subject of death cannot consider the enacting of ritual alone as an explanation and means of understanding the mourning process; it is impossible to ignore the simple and essential quality of strong emotions as an intrinsic component in the observance of grief. A loved one dies, and the surviving friends and family members grieve, and suffer; deep sentiments and feelings are expressed, and this is also critically relevant in interpreting the extent of the suffering itself. By way of example, Rosaldo himself specifically comments upon the “agony of such unexpected early deaths as…a mother dying in childbirth,” and the danger of “mask[ing] the emotional force of bereavement by reducing funerary ritual to orderly routine,” and thereby leaving “concealed in such descriptions…the agonies of the survivors who muddle through shifting, powerful emotional states” (1993:13). In this way, the presence and display of strong emotions must be
recognized as key to understanding, and respecting, the felt weight of an individual’s suffering—in nearly any situation, and that applies even more so in considering the case studies presented here. (Later, in looking at certain specific tangible manifestations surrounding the Day of the Dead as it was enacted in Puka Wayq’u, I will further consider the question of powerful emotions.)

Perhaps the previously mentioned caveat must be trotted out again here, having to do with the self-questioning and unease that I touched upon in Chapter 1. We are, after all, dealing with something of an extremely delicate, and painful, nature. A person has died, and I feel compelled to reiterate the personal conviction—and while simultaneously acknowledging that every life is equally valuable in the Grand Scheme of Things, and must ultimately be weighed as such—that in this case I believe that the case in point is not, however, a “typical” death. (Whatever that might be—for it is precisely my intention in this chapter, through the accounts of the deaths in Puka Wayq’u, to recognize and attest to the fact that no death is at all “typical” for those who are forced to confront it, due to the innate human interconnectedness inherent within it. To cite, and to take the liberty of partially paraphrasing and adapting, John Donne’s oft-quoted words [Devotions, Meditation XVII]: “any [wo]man’s death diminishes me, because I am involved in [hu]mankind.”) In the cases I examine here, it involves a person intimately and exceedingly involved in the very process of the regeneration of life who has passed away; additionally, she is at the center of an ever-larger and intertwined network of concentric circles: beginning with the woman as a person herself, as an agency possessing individual; then proceeding to the inner circle of a mother of children, and all that it entails; later to a central figure within the family unit as a whole; following then to the community-wide matrix of citizens; and finally to that of a key element within the very social structure of the nation itself.
This is not a slight business. With such a death, the family, the community, and indeed society itself is thrown unexpectedly and haphazardly into a form of disarray, of upheaval, of chaos, of crisis: an incomprehensible negation and overtly *violent* rupture in “the way things should be.” And as such, by utilizing a determined (pre- or otherwise) conceptual, theoretical or heuristic framework to consider the nature of what occurred, and its later impact on the surrounding society, it is not by any means my intention to minimize the events which transpired in Puka Wayq’u, or to overlook or ignore the varying degrees of human suffering swirling around them. It is, rather, my intention to better interpret these events, to observe and to understand them in a universal sense, in order to help, I hope, in contributing something to the debate as to why such a thing happened at all in the first place, how it is understood by those closest to it, and how similar events might in the future be better mitigated or avoided outright—yet, without ever neglecting the *human* drama at their core. Without that, then the entire exercise loses its meaning and its reason for being; indeed, and as it is necessary to reaffirm, it would also lose its essential moral *right* for being.

*The Souls of the Departed Arrive at Noon: Culture as a Drama of Containment*

All Saints’ Day (*Día de Todos los Santos*)—or, alternatively, All Souls’ Day (*Día de Todas las Almas*)—on November 1, and Day of the Dead (*Día de los Difuntos*; alternatively, *Día de los Muertos*), on November 2, are indisputably two of the most important days of the annual festive calendar in a great many (although not all) Latin American countries, including Bolivia.26

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26 Across the differing regions of Bolivia, and which encompass specific Bolivian historical and contemporary manifestations, see for example Gutiérrez Garrido and Rivera Eid 2001; Jordán Arandia 2004; MUSEF 2004; Oporto and Fernández 1981; and Pórcel G. et al. 2003. Undoubtedly, however, the most well-known, well-documented and well-studied of all the Todos los Santos observations and cultural traditions in both Spain and Latin America is that of Mexico. For the respective social, cultural and political history and significance of the Mexican Todos los Santos and Día de los Muertos festivities, and the way in which they both shape and reflect the national
A syncretic fusion of Catholic liturgy with pre-Columbian indigenous traditions, the occasion is observed by virtually all segments of society, from rural to urban, from indigenous to mestizo and otherwise. Indeed, in the case of Andean Bolivia in general, and rural Quechua-speaking Chuquisaca department specifically, the occasion frequently extends into a third day (depending on the community, for this is certainly much more so a reality of celebrations in the countryside, rather than those within the urban context). There also may well be yet another related festivity following these two to three days, which can continue on for another indeterminate number of days, many times up to a week. Therefore, in the campo areas (in regards to Andean Bolivia, as opposed to the lowlands) and among some sectors of the indigenous and working class urban populations, Todos los Santos (typically shortened to simply Todos Santos) and the days (if not weeks) immediately preceding and following are major causes for observance and festivities. For the “typical” city dweller, however, the official holiday per se (in the sense of a legally sanctioned day off from work) is limited to November 1, and the other associated goings-on are less common and less frequented.

I focus here on the events surrounding Todos Santos and Día de los Difuntos in the community of San Marcos, together with the family of Damiana. Faustino had invited me to be part of the occasion, along with Karen and Natán, early on in our relationship some months previously. Whereas it was certainly something that I was interested in attending, his initiative in extending me the invitation on his own accord obviously both honored me and took the onus off of needing to screw up the courage to ask him myself due to the delicate nature of the day, the first Todos Santos following Damiana’s death. However, I soon realized that, in reality, it

identity—and which are also tangentially recognized as a certain kind of public performance—see for example Brandes 1997; Lomintz 2008; and Paz 1950 (this last being by far the most recognized and influential of the many analyses over the past decades). For the respective history of how the Day of the Dead has crossed borders and become more culturally integrated and “panoptic,” especially in the United States, see Marchi 2009.
wasn’t such a difficult issue to deal with, in terms of an active participation in the commemorations and festivity: indeed, I had been fooling only myself, because by the very nature of the occasion it is expected, assumed, that it will be heavily attended—the “honor” is felt by the surviving family members of the deceased (in this case, including a widower), for the participation of the community in remembrance. If anything, it was unique and special for us because we had not known Faustino for long, and of course had never known Damiana at all.

The so-called “cult of the dead” is at the heart of Todos Santos and Día de los Difuntos, although there is also much more to it in terms of its local cultural significance. In the spirit of communitas previously discussed, it is also a time for the community to come together and share, and to take stock of the past year’s departed souls. The dead of the *immediate* past year prior to a Todos Santos are those who are most feted. For them, a large, elaborate, no-expense-spared affair with ample food and drink (predominantly alcoholic) is organized, which can obviously considerably set back someone such as Faustino with scant resources. However, it is critically important that the recently deceased receive the proper respect of a fully organized recognition of their passing within this first year: on succeeding occasions, there will certainly always be a visit to the cemetery and a communing with those who have gone, but little or no fiesta. (On the second anniversary Todos Santos day the fiesta is however still moderately significant, but nothing approaching the first year.) This first occasion after the passing of the loved one to be honored, consequently, marks the final transitional and culminating moments of the liminality inherent in the event, by definitively sending the deceased on their way; prior to the first year’s ritual, the dead are still “betwixt and between” the two worlds, whereas following the celebration, and its nature of being the “central moment of separation” (Harris 2000:35), they now firmly inhabit another realm. Thus, this year Severina’s own Todos Santos in Yomala was
also lavishly feted (within the respective economic confines of the family), as was Celestina’s in Iskay Sach’as. Benigna, however, who had died over a year prior to this particular observance, would have received her full due at the previous year’s occasion, immediately following her death, and this time around only a very modest observance would be held for her in Iskay Sach’as; it would still be critically important to remember and acknowledge her in the graveyard, albeit in a more low-key manner and with significantly fewer participants (and perhaps not including anyone at all from outside of the immediate family).

So, over the successive months whenever I came to visit Faustino and family in San Marcos, prior to early November, I would always find them heavily involved with the preparations; as has been mentioned, these activities in themselves may be seen as a tangible means for the family to work through their grief, part of the process of “(re)ordering their world” (cf. Das et al. 2001). Within the performativity framework, these may be identified as part of the proto-performance stage: the “starting point” (Schechner 2002:191) that precedes the “central event.” Faustino and family stockpiled supplies for all of the food that would be prepared; over several weeks Benedicta wove a large aguayo on a rustic loom, all black, with one purple band throughout. The foremost activity among all was the construction of a new room out of adobe bricks adjacent to the family house, which effectively enclosed the small dirt patio beside the other three rooms in a “U” shape, forming an interior courtyard. This room was built by Faustino, with the help of his nephew, Hipólito, and in taking into consideration the functionality of the days surrounding Todos Santos and Día de los Difuntos: it would be where the festivities were centered, where the guests initially congregated, and where they would have their base throughout the three central days. For that purpose, Faustino moved a few essential pieces of furniture in—some wooden chairs, a few rickety tables—and eventually plastered the outside
adobe walls with a mud sealant. The floor, however, was to remain dirt. (After the holidays were over, it wasn’t long before Faustino moved a bed into the room, for him and Prima to sleep in — thereby moving out of the space that he had once shared as a bedroom with Damiana, and where she had spent her final night.)

The other important preparation that Faustino was involved in during the months preceding Todos Santos was in preparing the chicha, so ubiquitous in the countryside or in the barrios populares of any Bolivian city, both for festivities and on an everyday basis. For a large celebration, having a sufficient amount of chicha to pass around to the guests is crucial, and a singular responsibility of the host. Therefore, beginning in early September Faustino was already busy at work gathering together the necessary amount of corn from his field; in the first few days of October he had brought out four large, metal gasoline barrels and oil drums to eventually store the chicha in. By mid-October the piles of soaked maize that had been left in storage for the past two weeks had germinated, been dried in the sun, and ground into a flour known as *wiñapu*; over the following days, repeated cycles of mixing and boiling culminated in the nearly week long fermentation process (*poqochiy*), and the resulting chicha managed to completely fill the four barrels — hopefully, enough to cover three days-plus of heavy imbibing among the assembled guests.

Our decision to spend Todos Santos in the altura communities with Faustino (and Damiana) in San Marcos, and to be part of this particular festivity based in the Yampa region — as opposed to that of Saturnino (and Celestina), in Iskay Sach’as, also in the altura; or with the family of Héctor (and Severina) in the valle community of Yomala — was not based so much on any preference of one alternative over another. (They were, after all, very similar, albeit with key “cultural” variations, some more cosmetic and aesthetic than others.) Nor was it
based on giving more weight to the specificities surrounding the deaths of Damiana, Celestina or Severina. Rather, the decision was the simple result of expediency and practicality. We obviously had to opt for one or the other, and not even contemplate trying to spend time in two or more—the distance and travel time between the three communities outright precluded making such a plan anything of a viable alternative. (Aside from taking into account other significantly valid methodological and ethical considerations, regarding the propriety of skipping out on one intimate event to head off for another already in progress.) In the end, it was from Faustino that we had received an unequivocal invitation to be part of the family celebration, and thus the decision for us was a straightforward one.27

Day One, November 1 – Todos Santos

At home in Puka Wayq’u, we were awoken at 6:00am in the morning by Don Alberto and Doña Tomasa, who were sweeping inside and outside the patio, cleaning up for the souls of the departed (almas)28 who were to arrive at midday—and also for the family members and

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27 Additionally, it is necessary to acknowledge here that I was obliged to take into consideration an uneasy distance, “ethnographically speaking,” between Héctor and myself within the working confines of Yomala, and the definitive lack of anything approaching the convivial nature and rapport that I had been able to achieve in my relationship with Faustino. Also, the quality of the circumstances following these two particular deaths—Damiana and Severina—was markedly distinct: while in both cases there were similar questions of either medical irresponsibility or outright medical negligence, and involving the same health center personnel circling around the respective events, it was Severina’s death which was the more scrutinized, the more polemic, the one death which was still an open wound not only in Yomala but also in the municipality of Puka Wayq’u as a whole. Consequently, and especially at a potentially charged occasion such as Todos Santos, it was difficult to get too close to the context surrounding Severina without arousing prickly reactions from most anyone in the local communities. I will further discuss these complicating elements in Chapter 4.

28 The word “alma” itself in both the Quechua and Aymara conceptualizations typically refers specifically to the recognized figures of departed loved ones who inhabit otherworldly spaces, this being a legacy of Christian influence and literal Spanish translations. The linguistically correct utilization of the translation “alma” for the English “soul,” however, often causes confusion. In the traditional Andean world, the spiritual form of the physical human body—the soul—is divided into three distinct entities: ajayu (Aymara terminology), which is the principal underlying essence, and which totally sustains and defines the person as an individual; ánimo(a) (Spanish derivation, “vitality”), which gives energy and health, and may be summoned or “called” during illness in order to restore good health; and finally kuraji (“courage,” a transliteration from the Spanish coraje), more related to a singular personality. This triad plays a critical role in the emic categorization of health, illness and disease: it is the loss of either of the latter two manifestations which causes sickness, of differing severities; the loss of the first invariably causes death. (See for example Fernández Juárez 1999, 2004b.) In Puka Wayq’u, the more Christianized concept of alma as the “wandering soul”—perhaps, even, similar to those occasionally seen by Doña Tomasa on the streets
invited guests, who were due to arrive sometime later in the afternoon. Since the previous night, Doña Tomasa was wearing black: for her father, dead some many years at that time; and for the two lost babies—the one who had previously died of diarrheal disease and dehydration at age one; and for the baby lost at birth in June of this year, during her own “near miss” crisis. She gave us a plate of home-baked bread and cookies, made especially for the almas; later in the day, there would be t’anta wawas—“bread babies,” small people-shaped figures (usually children) made from an unsweetened dough mix, always prepared throughout Andean Bolivia for Todos Santos, to be placed on alters and other festive tables, in addition to other traditional baked goods.

With Karen and Natán, we wanted to be with Faustino’s family by noon, when the almas are said to arrive at the homes of the waiting loved ones—“they come from Heaven, they say that each year the almas arrive through the air,” was a typical, and simple, explanation of the event. At noon on the following day, November 2, Día de los Muertos, they leave once again, until the next year. However, in our own case and after the usual two hour walk to town we entered into San Marcos a little bit too late, just a few minutes past 12:00, and to the sounds of multiple firecrackers being set off in scattered locations around the community and up on the surrounding

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around her home—is the most predominant in the local imaginary, dictating the observation and enactment of occasions related to death and the afterlife, most importantly at a Todos Santos celebration.

29 In the pre-Columbian Andean cosmology, the Christian concepts of “Heaven” (or “Hell”) did not exist. Yet, in a fashion which was only coincidentally and superficially similar to Christianity, the Andean universe (here, in its Quechua manifestation) was divided into three realms: hanañpacha (or hanaq pacha), “the world of above”; kaypacha, “this world,” in which humans inhabit; and ukhupacha, “the world beneath.” As part of the process of European conquest and colonization and over the decades and centuries of the forced imposition of Christian religious belief systems, the Andean conception became fused with the European, yet another “intercultural hybrid,” and was altered in key respects. It is too facile and historically blurry to confuse these cosmic designations, however. For example, the pre-Columbian notion held that the underworld was the destination of all dead, in addition to some more dubious spirits and the gods of vanquished enemies; nevertheless (and together with the transformation of Andean gods such as Viracocha, Pachacamac and Illapa into Christian saints), it was a logical ecclesiastical step for proselytization purposes to modify and then equate this with the Christian Hell, populated by malevolent spirits and the Christian Devil. In a similar manner, hanañpacha and the sky above became the Christian Heaven, inhabited by angels, archangels, and the Christian God—and the place from which the blessed souls would return on Todos Santos. See for example Albó et al. 1989 and Gisbert 1999.
hills, to welcome the return of the departed. (“Hmm,” we commented to each other, “seems like the almas are a lot more punctual than we are…”) The entire town seemed deserted, as everybody was inside their homes together, making the same ritual observations.

At Faustino’s, we found some of the participants (consisting entirely of women cooking) gathered in the (appallingly smoke-filled) dirt-floored kitchen; and many others in the newly constructed room, where we were invited to sit down on short log benches, low on the floor. It was dark and the visibility was dim, due to only a couple of small, glassless windows; also, owing to the plumes of smoke arising from several recently rolled cigarettes. Faustino and Benedicta were friendly, and didn’t seem at all put out or surprised to see us actually showing up for Todos Santos. There were also many others gathered in the new room, the great majority of them being from Faustino’s side, rather than from Damiana’s: Paulino and his brother Horacio, other nephews of Faustino; some cousins; handfuls of old people (including one especially ancient couple, both of whom were missing an eye); numerous assorted townsfolk; and, presumably, the assembled (albeit unseen) almas of the family—most importantly Damiana, who was essentially the “guest of honor.” Most of those present sat talking in low voices and drinking chicha, some dressed in black ponchos used only once a year, but others were in their worn, everyday clothes. This part of the gathering can be identified as the so-called “warm-up” stage of Todos Santos: the moment when the participants were preparing themselves for the upcoming primary event at hand. It was “a liminal time…when performers prepare to make the leap from ‘readiness’ to ‘performance’…on one side of the void is ordinary-life, on the other, performance” (Schechner 2002:205).

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30 In addition, I saw this community participation support as being, in its manner, something of a contradiction to the general complaint (among all of the surviving families—Faustino, Saturnino, Héctor, Agripina) that the community had not supported or assisted them as they would have hoped. On the contrary, the presence of so many at the Todos Santos for Damiana seemed to negate that particular denunciation, at least for this given celebratory occasion,
At the front of the room, there were several chains made out of black, green, white and purple paper, hanging from the unfinished beams in the low ceiling. At the other side of the room, the “mesa” was set up: literally “table,” and in varying indigenous Andean rituals a site of veneration and magical communion with the dead, with spirits, and with powerful forces contacted for diverse intents and objectives, as following the occasion. In this instance for Todos Santos in San Marcos, the mesa itself—dedicated to Damiana—was covered with sprigs of chamomile and dill, and a small yet extremely busy altar arranged on top of that: this consisted of a bowl of chicha, a plastic bottle of pure cane liquor, piles of cigarettes, two large lit candles, and numerous small baked bread figures (turkas) placed everywhere: these are a variety of t’anta wawas, made from the same kind of dough, mostly crafted and decorated in the form of animals (cows, horses, dogs), and on this particular occasion also a total of four large and somewhat medieval appearing priests (tata curas, literally “father priests”). Atop the mesa, Horacio and Paulino were busy constructing, out of more black, purple and white paper links, what would be a “castle” (castillo), once finished.

We were given a half gourd (tutuma) of chicha mixed with panela, an (overly) sweet crumbly concoction of sugar, egg whites, cinnamon and other spices, made for special occasions; and three bowls of food: bread, a thick wheat soup (lagua), and pieces of dried beef (charqui). We tipped our tutumas in order to scatter a few drops on the ground, as is always done preceding drinking on nearly any occasion throughout the Andes: the ch’alla, a ritual, albeit frequently casual, offering of libations to the Pachamama. At this point, most people present were already mildly tipsy, but nobody was in any sort of extreme state as of yet. Taking turns at standing in front of the still under construction mesa, people would cross themselves, in honor of the

in its strong show of communitas-style participation—unless, of course, one wishes to adopt the cynical (albeit admittedly plausible) “grain of truth” angle, that they only came for the food, drink, coca, and the party in general.
Christian deity; do a ch’alla at the corners, in honor of the autochthonous Andean spirits; and mumble a whispered prayer, in an often syncretic fashion to both. I asked about the almas, and how and when they had arrived: “they’re already here,” was the only answer I received.

Faustino was in and out, mostly out, attending to whatever needed attending to. We offered to help Paulino and Horacio with the castillo, and they showed us how to put together the long reed poles, wrapped around with strips of the black, green, white and purple paper. We chatted among ourselves as we assembled the castillo together: I had the sensation that they were somehow suspicious, questioning of us still, although they were to gradually warm up to us; we had never really spoken much with either on previous occasions, only superficially at one or two of the sindicato meetings that I had attended. The conversation was, for the most part, unrelated to the matter at hand: we had some political talk, about the upcoming municipal elections in December, and the different candidates, which led into U.S. politics—and, as it commonly occurs, the topic of greatest interest was, precisely, us: the details of our stay in San Marcos; a curiosity for life in the United States. (Is Van Damme still alive? Where does he live? What about Rambo? And things of that nature.) At one point, as I tried to determine family connections, I asked Paulino and Horacio who their parents were: “I don’t have a mother,” Paulino replied, to which everybody laughed uproariously. We didn’t get the joke—but it somehow seemed somewhat inappropriate, in the immediate context; Wilfredo and Casiano laughed also, but to what degree? What, I wondered to myself, could possibly be funny for them about that kind of humor, under the present circumstances? For the most part, the two boys wandered about without saying much, and mostly sat quietly, doing little. At one point, as Wilfredo sat alone on the opposite side of the room, I saw that he cried softly, with his head turned away toward the wall.
Later, there were more little children ambling around, and Prima and Rosita made an appearance with Benedicta, holding the hand of the elder and with the wawa bundled to her back. I played off and on with one little girl of about a year and a half, making faces and bobbing my head; initially reticent, she began to laugh and hide her face in a peek-a-boo fashion. I was to learn shortly afterwards that she was Carmelita, the daughter of Benigna, born on the night of her mother’s death. I also began to clarify for myself certain family connections and relationship ties; two of the families of interest to me turned out to be related: Damiana’s in San Marcos and Benigna’s in Iskay Sach’as, and Agripina and Faustino turned out to be second cousins. It was not at all unusual for some of that family to be present here tonight, for as I was already aware of Todos Santos would not have been quite as big an affair for Benigna in Iskay Sach’as this year, due to the length of time since her final night.

Many more people had arrived, and were sitting on the dirt floor along the walls either eating or waiting to eat. More food was continuously served: another bowl of lagua; then papa wayk’u, a plate of unpeeled boiled potatoes with hard-boiled eggs, hot pepper sauce (llajua) and goat cheese (quesillo). It was a lot of food, and no matter how many times we had participated in different kinds of similar festivities in the campo in the past, with similar amounts of food offered, it’s always hard to get it all down. Indeed, the provision of ample food during a festivity such as Todos Santos is always a critically important element of rural celebrations—especially during Todos Santos, considering that the souls of departed loved ones are also present to feast, in addition to the living invited guests. As described by Olivia Harris (2000:37) in regards to the festivity in Northern Potosí department, the communal nature of feasting together among both the dead and the living is key; everybody must participate equally in consuming the variety of foods prepared, ranging from children to old people. (This collective concept also applies to the
non-food, not-for-children components, such as alcohol, local cigarettes and, to a degree, coca.) Spedding (1996:114), in discussing the Aymara of the Yungas in La Paz department, emphasizes the reciprocal aspect of the exchange of foods at Todos Santos: what comes back to the living, who have expended so much time, expense and effort to invite a large quantity of people—and who by consuming the invited foods have transmitted these directly to the alma at the very center of the celebration—is a kind of benevolence on the part of the “blessed soul” (alma bendita) who will then grant some sort of economic favor in the form of work, plentiful agricultural production, increased sale of goods, etc. At Faustino’s, this kind of attention was evident by the preoccupied bustling about of the entire family, from Faustino himself to his mother, sisters, cousins, and nephews, who were constantly assuring that the guests had all the food and drink that they desired. I noticed that we were the only ones who had been given (wooden) spoons; everybody else ate with their hands: we were either the “honored guests,” or perhaps simply the odd outsiders / Others, who required, by some ill-defined obligation, to be treated differently. Outside the door, there was a dead sheep lying on top of the shed by the side of the house, its eyes open and staring; it would later turn up as the next day’s lunch.

Around 6:00, there was a lull in the cooking and preparation activities, and a sudden push of people entered the room, sitting down on both sides, with the women congregating mostly on one side, toward the back corner. Strong, high nicotine, home-rolled cigarettes were still prevalent throughout the room. Coca—the absolutely indispensable element of absolutely any social gathering or ritual throughout the traditional Andean realm—was increasingly passed around among us, and we sat absorbed in our respective chewing (pijchay, or aculliy,

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31 As such, this variety of reciprocity in the Andean region is not the same as the aforementioned and much more commonly discussed balanced or negative systems (in the anthropological sense) of trueque and ayni, which refer to a direct and approximately equal exchange between individuals or communities of goods, labor, or services. See for example Guerrero 1998, Harris 2000, and Orlove 1974.
synonymous) as the quid-like balls of leaves grew larger and larger in our mouths. We were
given more to drink: now not only chicha, but rather more frequently (again, as is typical, as the
days and nights wear on) the harder stuff: in lieu of any available singani, it was the so-called
“trago” or “cóctel,” pure sugar cane alcohol (in this instance mixed with orange-flavored Yupi, a
local Kool-Aid equivalent). Invariably somewhat difficult to drink more than a few cups of (at
least for me), and as another round is continuously proffered by whoever is acting as host and
circles the room with a plastic jug which seemingly never runs dry (on this particular occasion,
this was the duty of Faustino, Paulino and Horacio), a large number of repeated ch’allas are
consequently in order, simply to diminish the overall quantity of drink that would otherwise have
been consumed.

As the evening wore on, Paulino and Horacio continued to work on the castillo, which
was taking on its true form. A large group of young children had gathered, and was engaged in
making even more of the paper chains, while laughing and playing. More and more chicha and
cóctel were going down, more ch’allas offered by both men and women sitting around the room,
and we were constantly given more handfuls of coca. Several people stood up and gave prayers,
standing in front of the mesa / altar, often performing ch’allas around its periphery. Most people
had notably acquired much more of a pained look on their faces—whether from emotion, the

32 At 96% (192 proof), Bolivian sugar cane liquor has the highest alcohol content of any (nominal) beverage in the
world. Sold nationally under three brands (Caimán, Ceibo, and San Aurelio), in either tins or plastic bottles, and
ostensibly for medicinal use, it is much more frequently ingested as a drink (a fact well-known to the respective
manufacturers). It is typically mixed with the likes of tea, water containing lemon, or the commercial sugar drink
powders. (At least, it is certainly to be hoped that it is indeed mixed with something.) Consumed almost exclusively
in the campo, or by the “popular” sectors and more indigent populations in the urban areas, it is often the drink of
choice based solely on economic factors due to its markedly lower cost than any other available alcoholic beverage.
When taking into account the pure alcohol content in question here, the long-term detrimental effects on one’s
personal health of drinking cócteles—on the liver or otherwise, and whether it’s in a “casual” drinker or a confirmed
alcoholic—are fairly straightforward and easy to imagine. I personally have not been able to find any actual
reference to a quantitative or clinical biomedical research project to this effect; however, one may very well be
warranted.
liquor, or both. An old woman cried unremittingly in a corner, sitting alone and moaning softly.

Outside, it had become quite cold, dark, and windy.

After a brief break—and more food—people began to thin out, off cleaning or cooking or getting their heads together, or some of them still sitting and drinking, by the light of a single dim and gloomy bulb. At this point Karen and Natán effectively checked out for the night, considering the increasingly alcoholic nature of the gathering, and returned to our small room down the hill. Additionally, by now it was only men present, about ten, all sitting along the walls, and all now dressed in black ponchos. I was given more coca and cóctel. The castillo was now completely finished: the reed poles at each corner, a crisscross at the back, the paper chain links hanging on the sides, cigarettes strung up in long dangling lines tied to different levels, a large black piece of material tacked up behind on the mud wall, and a variety of turkas spread at the base. In actuality, the chains were hung up all around, so that it was hardly possible to see the mesa itself, as it was so obscured by the extensive links of paper. It looked more like a large, black, green, white, and purple box; in its final form, it had an elaborate and intricate yet temporal beauty to it: the product of a full day of shared labor, which would later be totally dismantled and discarded, like a sand mandala, immediately following the conclusion of the festivities in another two days. With its tangible spiritual ties to a ritual constructed around the hybrid fusion of Christianity and pre-Columbian belief systems, the castillo artifice may be seen here as an example of a work of endogenous art which, in Kleinman’s words, “links the aesthetic tradition with religion as perhaps the most powerful means by which we build ethical meaning out of adversity and failure” (2006:11).

For the next couple of hours, there wasn’t much change. The scene was to sit, pijchar coca, drink, smoke, and talk. Interestingly, the conversations never really touched upon the
central issue at hand, around which the entire evening revolved—that of Damiana: the mumbled exchanges, low-key and not at all heated or animated, primarily dealt with the mundane questions of daily life—the harvest, the lack of sufficient public services (such as potable water) in the community, the upcoming municipal elections, necessary points of order for the next sindicato meeting. Only one or two tutumas of chicha were passed around; by this point, it was almost entirely cóctel, while the assembled participants (myself included) became increasingly deliberate and slow moving, yet soldiering on. But, at nearly 2:00am, there was suddenly a burst of hurried and concerted activity, as the small group began preparing to walk to the cemetery. Everybody in the family who had seemed to disappear earlier, reappeared from wherever they had been. Faustino observed that I would be cold, and fetched a poncho for me (dark brown, not black). We stood in the patio for a bit; Benedicta wasn’t going to accompany us, and was getting Prima and Rosita ready for bed—they had both been up until this point, albeit more than a bit dragged-out looking. Casiano and Wilfredo would be coming along, however. I asked what I could carry, and was given two five-liter plastic containers filled with cane alcohol, for more cocteles. We were approximately 15 people.

The walk to the cemetery, which was indeed cold, took about an hour, considerably longer than it would usually take; we arrived shortly past 3:00am. “It could sure use some trees, or something,” I thought to myself: barren, rocky, overlooking the valley far below where the town of Villa Rosario lies; nothing broke the harsh emptiness of the place except for several scattered above ground concrete tombs (tumbas), and scattered little wooden or metal crosses. Another small group of dark silhouettes was already there, gathered around a grave, a fire burning nearby, casting a dim orange glow. I later learned that it was the tomb of Don Rufino, an old guy who had died “of drink” a few months ago. (I had in fact been at the health post in
Villa Rosario on the afternoon when he was first brought in. In considering all of the drinking that goes on for Todos Santos—and most other—rituals and festivals, the irony in this case was not lost on me.)

We all gathered around the tomb of Damiana: an aboveground cement block, with a wooden cross planted into it, upon which the name “Damiana Sonavi” had been scratched when the cement was still wet, plus the date of death. (It was somewhat jarring for me, if perhaps for no-one else, the misspelling of her last name with the letter “v” instead of a “b,” a common phonetic mistake in Bolivia—nevertheless, an error that one would presumably hope to avoid for such a solemn and permanent venue.) Beside Damiana there was a larger tomb, with a metal cross, which was that of Paulino and Horacio’s brother, who had died in the year 2000, age 35, in a traffic accident in Santa Cruz. So, we all sat down around the tomb, where I took up a position on a small rock near the head, a bit back from the group. Some of the men began to set up what was to be the Todos Santos “tumba” itself: an elaborate composition of turkas and the blue, white and black colored paper, and placed atop the concrete grave. Their silhouettes moved wordlessly against the moonlight, atop the horizon overlooking the valley beyond, while the others sat silently watching. Each handful of shared coca was accompanied by another cigarette and by another freshening up of the single plastic cup for the cóctel that passed around among us, and we wordlessly and repeatedly performed the movements of the ch’alla. I identify this juncture—arrival at the cemetery, and the initiation of activities around Damiana’s grave—as being the beginning of the central part of the time-space performative sequence: the public performance itself. Each participant had their role and their place in the ritual moment, and this would continue throughout the length of the following day and into the succeeding night. In this case, it must also be noted that the “spectators” did not consist solely of each individual unto him
or herself, and of the community as a collective: a key spectator was of course Damiana, in her own role as the focal point of the activities in general, and of their reason for being; in this manner, Todos Santos was performed both for her, and with her.

Suddenly, and almost without my even noticing it, the tumba was done: covered in dozens and dozens of sprigs of chamomile and dill, as had been the castillo; dozens of turkas spread around; and many reed poles and multicolored paper chains, almost a mini castillo itself, arranged on top and with lit candles placed surrounding it. If the respective death has occurred in the past year since the previous Todos Santos, and thus the full treatment is in order, then the difunto warrants both the all-night presence of the participants and the elaborate castillo on the tomb: there had been two deaths in San Marcos this past year, Damiana and Rufino, and thus both of the families were present beside the graves, enacting this same ritual. If the death occurred in the last 2 - 3 years, then the family does a much simpler and quicker to construct graveside tumba / castillo, only starting on the early morning of the second day; if the death was even further in the past, then no big deal is set up, although the mourners will still visit the grave. My rock was uncomfortable to sit on, so I got up to walk around now and then, doing a circle around the grave and the group and in order to observe the tumba from all angles, while the others remained seated. Throughout the long cold night and into the even colder morning hours, hardly anything at all was said among us. Each member of the group sat silently, never putting aside their cóctel, coca, or cigarette, and gazed at the tumba with a calm, expressionless face, representing what I took to be a time of reflection, and of quietly remembering, and honoring, Damiana.
Day Two, November 2 – Día de los Difuntos

As the early morning light grew increasingly stronger, around 5:00am, more people began arriving from town and setting up around the graves of the respective deceased. Soon, there were many individuals and groups scattered about in the full morning light, the sun rapidly heating up the chilly air, the mourners spread amidst the graves in the small, barren and rocky cemetery. After the all-night vigil and as a continuation of it, the drinking was still intense and growing more so, and I thought to myself that it was a miracle that I could still keep going—the great majority of people were becoming truly, fully drunk, although for the most part in a “controlled” fashion, that is without becoming markedly out of control in any noticeable way. Máxima, one of Faustino’s aunts and probably around age 70, was a tough one to deal with, however: when she did the serving of the cóctel (or more properly as actually enacted and termed by the participants, the “inviting”), she would watch me carefully, to make sure that I was truly drinking it all, and not surreptitiously partially or wholly dumping it out when nobody was looking (as I indeed contemplated attempting, upon occasion…). Frequent prayers were said, in which people would stand over the grave, mumbling in deep concentration, and then more drink would be passed around. It was very egalitarian, with attention not concentrated solely on Faustino, but rather as a group experience. Paulino began to hand out turkas: whoever had said a prayer got one or more of those spread atop the tomb, but later it seemed like everybody got a couple of them regardless. The tumba was quickly cleared of all, but then a few minutes later Paulino and Horacio unloaded another bucketful, and spread them around, again completely covering the concrete surface.

Kids ran around playing, doing their own thing, and not really interacting much with the adults; I noticed Wilfredo and Casiano, somewhat incongruously (following an outsider’s
perspective, perhaps, rather than that of the spirit of the occasion as conceived of by the actual participants) also laughing and racing about, seemingly without a care in the world. Natán, who had arrived a short while before with Karen, warily studied them with quiet interest, but showing little inclination for joining them in their playing amidst such an admittedly “different” scene. At one point I mumbled, admittedly tiredly, something about my returning to town in order to have a brief rest. Faustino was not pleased, and looked me drunkenly yet fixedly in the eyes, admonishing me in a mixture of Quechua and Spanish: “Ya, ya, arí, pero kutimuy, kutimuy. Es mi mujer, es mi mujer!” (“Ya, ya, yes, but come back, come back. She’s my wife, she’s my wife!”) I stayed. The sun was high, it had grown hot in the high mountain air, and I removed the now heavy poncho.

The scene in the cemetery by that time had become increasingly vivid and worked up, a dramatic contrast to the studied and intense yet highly charged calmness of the previous night and the early morning. People were loudly sobbing, women were wailing, fists pounded the tombs. And most striking was indeed the transformation in a number of the women, primarily the older ones, most markedly Máxima, Isabelina, and a few others who were aunts or cousins: they were all, in their drunken state, loudly sobbing in the fashion that I have previously noted in regards to other gatherings of mourning, all of them shrieking and moaning, in as melodramatic a fashion as possible. They stood around Damiana’s grave, eyes closed, faces contorted and overdrawn, mouths wide open and bawling, screaming out in Quechua, crying distraught laments partly of her death, partly of supplications to God, partly of nothing particularly intelligible at all. Isabelina especially could barely stand, and at one point flopped onto Karen, grasping her tightly and in apparent desperation, sobbing loudly. Conversely, now and again the various women would suddenly enact their emotive and highly personal variety of a “take five”: seemingly just
fine, smiling and talking and gossiping for a number of minutes, perhaps drinking something alcoholic and munching on a plate of mote corn kernels, only to once again pick up where they had left off and begin weeping and howling anew. One woman, who I didn’t recognize, kept up a shrill yet low, unintelligible, repetitive chant, standing over the grave, eyes tightly closed, her face contorted. I asked a few people who she was, and the answers seemed to indicate (as dismissively commented upon by Paulino, for example) that she wasn’t a member of the actual family, or even a close friend or from a group of compadres; rather, she was something of a hanger-on type, almost a sort of Todos Santos groupie.

I have often been struck, after many years in Bolivia, with the extent and the quality of powerful emotions, in times of extreme stress, anguish, and grief. I’ve heard and seen the phenomenon many times before: the over-the-top melodramatics, the loud histrionics, the outright theatricality of grief and extreme emotion among the Quechua and Aymara—both men and women, but principally the women, by far. It was precisely the same scene that we had witnessed, for example, on the occasion of Sabino’s funeral, in the Puka Wayq’u cemetery. It can begin on a dime, accelerate to extreme hysteric within seconds, the person shrieking and crying, copious tears pouring down, the face red and contorted and the voice all but unintelligible in its high decibel lament of pain, sorrow, desperation, protestation or denunciation, fists clenched—and then just as suddenly cease, either rapidly fading away or abruptly cut off, as if a plug had been pulled, and with scarcely a trace of what has just transpired left on a now composed and placid countenance. These are scenes that are not at all unique in Bolivia—this sort of behavior in itself is in fact the norm, in virtually any situation involving intense feelings: death, injury, perceived injustice (road blockades, land invasions, persistent unemployment and loss of a job, labor rights, crime victims, etc.). Out of control emotions, yet also totally and
undeniably in control: again, it’s precisely the performative nature of it all that is so intriguing. Although this is indeed a phenomenon that I have long noted over my years in Bolivia, for me it came to the forefront during this central stage of Todos Santos in San Marcos. Although it was an overall constant, in varying degrees, during the entire three days of the Todos los Santos / Día de los Difuntos observations, it was at its most intense, its “high point,” during this core, central act of the entire experience, the night of November 1 until the day of November 2, the main “performance” itself, as spent in the cemetery beside Damiana’s grave. At these moments, sheer unbridled passions came into play, reaching their climax over the course of the day until approximately noon—when, again, I could nevertheless not help but be struck by the stark ritualistic force, even in moments of apparently informal “sociability.”

Where does this display of strong emotions come from? Why is it so deep, so passionate, so over-the-top; emotions which—while undeniably and irrefutably deep-felt, genuine, and painful—are also consistent with what can only be construed as distinct performative aspects, as I now argue them to be? In preface, here I must again recall the admonitions of Rosaldo (1993) previously discussed, regarding the vital importance of respecting the display of strong emotions as part of mourning, and the “emotional force of bereavement.” Yet for me, it is important to note that once more, and as it was in the San Marcos cemetery that day, it was principally the women who were so seemingly uncontrolled in their scenes of grief-stricken ardor. Perhaps something might be further illuminated by comments made by Das (1997) about other cultural settings—but specifically concerning grief and mourning—in regards to the concept of a “good death” and a “bad death,” as these are discussed in the work of anthropologist Nadia Serematakis concerning Greek mourning rituals. This is a similar case to what I observed in San Marcos, in that during intense periods of mourning it is precisely wailing women who are the designated
agents for the “interaction between acoustic, linguistic, and corporeal orientations [that give] a public definition to a ‘good death’ and distinguish it from a ‘bad death’ ” (1997:78). This invariably involves much explosive screaming and lamenting on the part of the women. “The silent death” (in the words of Serematakis, as recounted by Das), “is the asocial ‘bad death’ without kin support. Silence here connotes the absence of witness.” Das herself observes that “it is the special role of women to ‘witness’ death and to convert silence into speech” (ibid). She then relates this to her own work and experience in India, in which the role of women is very similar:

But since the mourning laments also have a dialogical element, soon other women begin to punctuate this by the counsel to get on with the work of living and by assurances to the most deeply affected mourners that the support of the community is with them. It is not that grief is seen as something that shall pass. Indeed, the representation of grief is that it is metonymically experienced as bodily pain and the female body as one that will carry this pain within forever (1997:80).

It is in these instances that women play a key part in the ritualistic drama of powerful emotions, involving mourning or otherwise, owing to a special and unique social relationship, a bond, with pain and suffering and their aftermath. “This is one path towards healing,” Das says, “women call such healing simply the power to endure” (1997:69).

In the Bolivian context, Harris takes note and describes a similar scene of choreographed distress such as in San Marcos at, precisely, a Todos Santos festivity among the Laymi of Northern Potosí, replete with participants who wail distraughtly and frantically embrace each other while they call out to the dead, part of a scene in which “the chaos was indescribable” (2000:37). However, in her case Harris fails to take the more profound quality of the frenzied actions on display much into consideration, nor even very seriously, and wastes no interpretive time on them; rather, Todos Santos with the Laymi rapidly disintegrates into one big,
carnivalesque, Rabelaisian drunk fest in which the celebrants drink, gorge themselves, sing and
dance, pilfer t’anta wawas from the alters for themselves, and overall subvert the very notion of
any possible shred of religious piety or respect for the departed—until finally and
“unceremoniously…the ghost was ritually dispatched.” A more contemplative study of the
nature of strong emotions, in this case amidst rural communities of the Cochabamba valley, is
described by Tapias (2006). She sees the expression of fervent outbursts, including rage and
sorrow, as “a principal etiological agent in the onset of numerous illnesses and symptoms in
men, women, and children” (2006:404), and which are a fundamental embodiment of how
women in particular perceive illness. Emotions such as these, Tapias believes, which are
conceived as actual fluids or other substances, must in a sense be purged from the body, before
they can bring on illness or cause other forms of real and actual physical damage. Her study
population consists specifically of mothers with small children, and how their manifest
sentiments are linked to the development of certain childhood illnesses; also, the social
significance that the emotions and the illnesses themselves may communicate to others within an
environment of hardship and injustice. For my purposes here, this provides an interesting
dimension to a multifaceted condition, although perhaps not entirely explaining the phenomenon
as I see it.

I once asked Pati, an old friend of many years in La Paz—now tragically departed
herself, at far too early an age—about this trait. “A Bolivian has to show strong emotions in
order to prove that he or she is vigente,” she told me—that is, “forceful,” “actual,” or “real”;
essentially, simply that he or she exists, and that everybody around should be well aware of that
fact. “They need to show the world their pain and suffering,” Pati explained, “they need to make
everybody understand. They can’t turn away from it; they need to feel it.” Hence: a vital
sensation that suffering is important for the self and for identity; that the public exhibition of passionate emotions is the vehicle for proclaiming this essential sadness; that the very self should essentially be removed and carried away, and in that abandon of reveling in personal pain and suffering there is proof that we are alive. In a manner quasi-echoing Nietzsche’s concept of being “hard” against suffering—“to live is to suffer, to survive is to find some meaning in the suffering,” etc.—the mourners / revelers in San Marcos that Todos Santos wanted to make loud and clear their pain and their sadness, and in such a way cathartically affirm it, welcome it, exalt it, and use it as a means to declare to the world their ultimate strength and the vitality of their existence. Thereby, and in their own way, it was to reify, and then ritualize that pain, making it tangible, manageable, bearable, and for all effects possessed by them in the manner of their own choosing. The louder and more unrestrained and melodramatic the exhibition of suffering, the greater the performance, then it is all the more apparent the strength obtained through the very process of suffering, and the more profound the catharsis and ultimate healing—thus, the more indisputable the social position as, precisely, a strong person who exists. To again cite Nietzsche (1998:117), who asserts: “Man, the bravest animal and the one most accustomed to suffering, does not negate suffering in itself: he wants it; he even seeks it out, provided one shows him a meaning for it, a to-this-end of suffering.” Yet, and in finally reflecting here on this undeniable tendency toward a sort of lingering, palpable sadness that permeates much of life in the Andean world (a colonial legacy?), it must also be recognized that this concurrently exists in a parallel,

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33 I do not intend that this characterization be misconstrued with the typically gloomy and highly controversial generalizations offered by Andean anthropology overly the past century, concerning the “taciturn” and “melancholy” Indian. As pointed out by Arnold (1997:43) in commenting upon the writings of many ethnologists of the early 20th century, “the unknown (for reasons of cultural difference, language, etc., or simply because of the brusque attitude of the anthropologist) is understood as ‘silent.’ For example, it was common to characterize the Andean Indian through racial stereotypes: ‘naturally submissive, sad and serious…silent and uncommunicative…melancholic, distrustful.’ ” On the contrary, both in Puka Wayq’u and outside of it in the Andean Bolivian realm, it is certainly impossible to be essentialist in this manner, and affirm a “stereotypical” indigenous character of this or any other nature. Nevertheless—and, again, I argue that it is for structural reasons—as in so many other countless
coeval fashion alongside of and in tandem with so much that is pleasurable, determinedly joyful, and oft celebrated in that same world.

Meanwhile, back in the San Marcos cemetery, most all adults present were by now completely, unabashedly, unashamedly rolling drunk. People stood unsteadily around the grave, shouting, loudly conversing, raucously laughing, and continuing to drink and drink and drink. At Damiana’s side, Hipólito wanted a picture of himself with a group of amigos, in front of the tomb, all smiling proudly. Paulino or someone-or-other asked me to say a prayer, and I solemnly mumbled and fumbled my way through an improvised invocation while standing over the grave. (And undoubtedly fooling no-one, even in their drunken condition.) More turkas were distributed; Natán got a few. (Natán in general was dealing with the scene remarkably well, sitting and watching in silence, stunned or otherwise.) One especially insistent fellow questioned me incessantly and insistently about my opinion of the wonders of “our customs, our culture” (nuestras costumbres, nuestra cultura)—a very common discourse, especially when addressing foreigners, and especially when alcohol is present; usually said with a kind of pride, yet also curiosity, almost requesting validation from the listener. After an extended (if somewhat one sided) exchange, to my surprise he turned out to be Damiana’s brother, who I had never met before: although he was not, unfortunately, in very good condition for coherent conversation, I asked him simply his opinion of why Damiana had died: his answer (also unfortunate for any ethnographic purposes) was intense, rambling, unfocused, and completely unintelligible.

I noticed that, except for our own group, by the early afternoon most people had left the cemetery except for a few stragglers here and there; even Rufino’s people had gone, and his tomb was quiet. The cocteles were still flowing (and some chicha also at this point), but at least
they were now watered-down and weaker, and easier to swallow. (I wondered: running low on the Caimán?) Then without preambles and quite suddenly and unceremoniously, Faustino, Paulino, Horacio and a few others began to dismantle the tumba. The paper chains and the reed structure came down, and all of the remaining turkas handed out to the attendees still hovering about; the chamomile and dill, however, were left atop the tomb. In a fairly cohesive group, at about 1:00 in the afternoon, everybody set out, drunkenly, to return to San Marcos. It had occurred to me at noon that, following tradition, at that time the almas were departing until next year—however, there had been no change in the rhythm of the proceedings, no perceptible observance of their parting. Indeed, due to the overall inebriation among the participants, there was very little observance of anything at all other than the immediate moment, and the intensity of each individual dialogue and encounter.

The walk back to San Marcos was an event in itself. One older man who was almost literally dead drunk was dragged along by a few others, collapsing on the ground every now and then. Natán and I managed to keep clear for a while going down, but then, concerned about Karen, we waited, and were overtaken by long caravans of drunken revelers—most of whom were no longer lamenting, but had entered a much merrier intoxicated state—and who repeatedly slapped us on the backs as they careened on by. Karen herself, however, was not as fortunate: she was glommed onto at first by a completely incoherent woman (we were never quite sure who she was), and then by both her and an unsteady Máxima. Isabelina was there too, in her own case still moaning and sobbing, grasping at Karen, hardly able to walk. The other two women genuinely could not walk very well and, one on each side, were gripped onto Karen as if their lives depended on it. She was pulled from one side to the other, jerked this way and that, and looked quite uncomfortable about it—it was, additionally, not at all an easy matter to maneuver
the walk down the rocky path. Eventually, Máxima and the first woman became involved in a heated argument of undetermined origin, until the latter tripped and fell down entirely, cut her lip badly, and was left behind, fate unknown. Now also free of Isabelina, Karen quickly took off ahead with Natán, and I was left alone to deal with Máxima—who was a very large, not too easily managed person. The final trek up the slope to the house was the most difficult, with the need to climb over little cliffs and crags, and cross over a crevasse via a narrow log. Karen and Natán (and all) watched in amusement, as I struggled to get Máxima into the house; we finally made it to the patio, where many not very sober guests were already seated in the new room, and the women who hadn’t gone to the cemetery were busy cooking and putting about (and all of whom were completely sober).

This recurrent issue of alcohol, and alcohol consumption, is, of course, highly relevant within the present discussion. As many authors have noted, drinking is frequently an integral, essential component of social and ritual life at virtually all Andean social functions, Bolivia included, by both men and women. Indeed, it begs the question as to whether on occasion some ritual-based social functions themselves may, in fact, merely be a pretext to drink. In this manner, it is also possible to identify here a definite social “problem” issue, in terms of the potentially negative ramifications of excessive levels of alcohol consumption on personal, family, social and professional life. It is also the case that there is a growing (albeit somewhat tardy, in my own opinion) recognition in everyday Bolivian society overall of alcoholism as a topic which warrants further study and attention, and not as something to simply write off to “our customs,” as is still frequently heard. In addition, the direct or indirect underlying reality of

\[34\text{ Among the wide-ranging literature addressing the issues and complexities related to the social, ritual and occasionally spiritual framework of alcohol consumption (excessive and otherwise) in Latin America, and within the context of Bolivia and the Andean region specifically, see for example Allen 1988, Butler 2006, Heath 1994, 2000, and Rasnake 1988.}\]
alcohol in the mortality cases that I examine here may also be identified as having been
tangentially significant in other associated ways, as in fact a commodity which played a key role
at certain critical moments: for example, Saturnino’s drunken state on his birthday in Iskay
Sach’as, as he attempted to attend to Celestina’s prolonged labor; or, the search undertaken by
Dr. Cárdenas for singani to buy in Yomala (to be discussed in the following chapter), which
delayed even more the emergency transport of the suffering Severina that he was ostensibly there
to alleviate. Finally, there is the uncomfortable question of what effect all of this drinking and
very pronounced drunkenness may have on the children present: first and foremost, the high
rates of domestic violence which are frequently associated with alcoholism; but also, simply the
psychological and indeed normative effects of frequently witnessing parents, grandparents,
aunts, uncles, and adults in general in a state of complete and unbridled, beyond control,
inebriation.

In the specific case of Todos Santos and the aspects here associated with grieving and
mourning, the significant alcohol intake may clearly be seen as a vital component of the cathartic
process, in order to “smooth” interpersonal and social relations, and to solidify and reaffirm
social networks as a whole at a time of lingering crisis. Spedding (1996:84-85) notes how,
during rituals and gatherings following a death in the Yungas region, the provision of alcoholic
beverages is important for maintaining an immediate and practical cohesion in the participating
social group: if there is any disgruntlement in regards to the amount of drink or the frequency of
it being served at an event such as a wake or funeral, then there exists the distinct danger that the
guest mourners may simply wander off and go home. This was quite obvious also in San Marcos,
as the alcohol was a constant presence at all moments during the course of the festival
observances, and it was very forcibly implied, if not insisted, that one was expected to drink, and
to drink heavily. In addition, it is notable that the occasion was unique because at a first Todos Santos—and at others celebrated during the succeeding years, albeit somewhat less so—it is socially permitted to drink until complete incoherent drunkenness; this is in contrast to other varieties of communal gatherings in the very first months following a death, when intoxication is frowned upon (also commented upon by Spedding 1996). As Faustino himself put it, during Todos Santos “it’s different, more joyful, because when someone first dies it’s so much sadder; people don’t drink very much then.”

At about 4:00 in the afternoon, there was a traditional lunch: mutton broth, plates of potatoes, rice, and boiled chicken. Among the nearly 30 participants present, the drinking steadily continued. The celebration—the final moments of which may still be characterized as part of the central public performance stage—slowly and leisurely continued throughout the cold and dark night. However, for the three of us—Karen, Natán, and myself—by nightfall we quietly and unobtrusively excused ourselves, much needing a bit of rest.

Day Three, November 3

The final morning, candles were still burning inside the castillo. This was the “cooldown” stage: the actual public performance was over, and “things return to ‘normal’…it is a bridge, an in-between phase, leading from the focused activity of the performance to the more open and diffuse experiences of everyday life” (Schechner 2002:211). Scattered guests, almost entirely men, were sitting on the floor on both sides of the room, and all remained dressed in black. One or another moved around among them with either a jug of cóctel with which to refill plastic cups, or with tutumas of chicha to pass from one to another. After two days of nearly solid drinking and little sleep, the participants were in amazingly good health, and nobody at all was passed out. They discussed the previous day’s activities to some degree, but limiting
themselves to vague and noncommittal expressions of approbation or criticism: this or that was good; this or that could have been better. Mostly, it was a time to simply sit, decompress, and continue with some of the same activities (drinking, smoking, pijcheos of coca), but with a much decreased rhythm and intensity. “Estamos costumbreándonos, no?” they said to me (literally, “we’re customing”; that is, enacting our culture). Many wanted photos taken of them, beside the castillo: later in the afternoon it would be disassembled and burnt, together with any other castillos from other families’ celebrations. The following day, in San Marcos and in many other communities in the region, there would then be the fiesta of larq’apichana, the cleaning of the irrigation canals and a ritual cleansing of the community as a whole, which always comes during the immediate days after a Todos Santos. With that celebration, and continuing on with a few more days of communal work, public and private gatherings, and drinking, the yearly observance comes to an end, and the dead are at last formally laid to rest—at least, until the following year.

What (Really) Happened, What’s Revealed, What’s at Stake?

Todos Santos and Día de los Difuntos is probably the most important occasion of the agricultural calendar in Bolivia. (Alongside of Carnival, which typically occurs at the time of the harvest.) It is representative of both the initiation of the sowing and planting season (i.e., fertility); and, of the critical transitional moment for the “liminal” dead to definitively pass on to the other world, where the souls of the departed must travel to—that is (and to return once more to the Quechua, albeit Christianized, characterization), that of hanampacha. Yet again, and even more so, as Spedding (1996:132-133) comments upon within the Bolivian context, it is a moment in which death is itself a motive for celebration: to get together with family and friends, to break from the work cycle, to eat and drink well. Accordingly, in this manner and quite
clearly, the entire festivity of Todos Santos and Día de los Difuntos is an important motive (indeed, what might perhaps even be called a pretext) “merely” for bringing people together in a social sense to eat, drink, celebrate, and share. Death brings about great suffering and sorrow for those who are left behind, and this was undeniably the case for Faustino and his family—during this Todos Santos specifically, and subsequently on any future festive remembrance for another’s passing, at which Damiana would also be at least remembered in spirit, albeit not in more than a few concrete gestures. The pain is significant, of course, and through performative gestures such as those that I have discussed, and of the extreme emotions on display and otherwise, this pain is reified anew, made real and palpable for all who are directly impacted and for any others who are present. Yet, it is also a time to actively welcome back the departed almas themselves, and to be together once again with them on earth—*kaypacha*—to share the same food and drink with them, and to remember.

Thus, for the process of grieving and mourning, the group dynamic within the Andean community is essential. Puka Wayq’u is but one instance, and the sense of communitas described here is intrinsic for the remembering and the catharsis that is so much a part of the healing process: that of “coming to terms” with what has happened. Each of the maternal deaths which occurred throughout the communities *needed* to be remembered, and the lives lost redeemed in some sort of way; in this manner, the communion is not only with the living, but also with the dead. Something such as this is most decisively achieved through ritual, and it is precisely by *performing* ritual that communitas is achieved. It is at such moments that “culture” (however it may be defined) is (re)affirmed, (re)established and (re)vitalized, in the service of making sense of events both good and bad—and, in the particular instance of Todos Santos,
tending more toward sorrow and suffering, perhaps, yet concurrently framed by celebratory, and liberating, release.

In what was enacted during the Todos Santos festivity in San Marcos, there was also a critical element of this dynamic which I have made reference to beforehand: that of community solidarity. This too is a form of ritualized behavior, and it is also through the process of its representation that culture is depicted and realized. Nonetheless, and as I have previously noted, all of the respective family members in these particular cases grumbled that they failed to receive the levels of community assistance that they would have hoped for, under the circumstances. To what degree these were objective and justifiable complaints, I of course cannot say, and I have no right to judge; yet, and whatever the situation might have been in actuality, these were the respective perceptions of “truth” and the subjective sentiments of the survivors. Yet, what I was personally witness to in San Marcos seemingly refuted their words, to some degree—words perhaps spoken out of deep sorrow and lingering remorse at their loss; perhaps out of irrational anger and unbridled bitterness that such a loss had befallen them, and not another. In this manner, however, the actions of the community of San Marcos nonetheless supported another apparent reality—at least for this critically important occasion—whatever its individually perceived backdrop may have been. In significant ways, Todos Santos—the actual event in itself, and the concurrent ritual realization of it—were both undoubtedly indispensable in creating this “coming together,” what can, again, only best be described as a sense of communitas, and of what “really happened.” Doña Carmen Bautista spoke to me of a similar organic cohesiveness in Yomala, prior to the commemoration that belonged to Severina, and what it all had to do with their innate and often verbally unarticulated consciousness of “culture”: 
For Todos Santos, a week beforehand lots of people were already helping to make chicha and t’anta wawitas. I mean, it’s the custom that people help out—so, when someone dies, people also cooperate, maybe with some food. But it’s more than just that: they bring potatoes, they bring wheat, they bring corn, they bring coca, they bring cigarettes, they bring something of everything. They make sure that everything gets brought to the house. So yes, there’s that kind of cooperation. Our culture helps us like that; the customs are part of the culture—it helps in everything.

Ritual and ritualized community solidarity, then, in being intrinsic components of any society, are examples of what Obeyesekere (1990) would define within the parameters of a “work of culture”: mechanisms formulated and nurtured within a given worldview as a means to “make sense of,” manage, and contain the potentially unpleasant, if not (as in this case) tragic, events that life has a habit of tossing out at us. The particular meanings which are ascribed to the explanations for such events are, Obeyesekere affirms, by nature “culture-bound,” determinate upon a mix of both quasi-Freudian personal psychology and the sociocultural context: “the process whereby symbolic forms existing on the cultural level [e.g., ritual] get created and recreated through the minds of people” (1990:xix). For example, in response to unfortunate events—breakdowns, ruptures in the personal and / or social fabric—and the potential that people suffer “a withdrawal from a painful mundane reality into a terrifying inner world…[yet they have] through the work of culture…recreated and moved into another level of reality that makes life not only bearable but transfigured and meaningful” (1990:68). Thus it is via the ritual repetition of given cultural benchmarks and signposts—for example, performative acts such as festive communal gatherings, shared food and drink of special symbolic import, or public expressions of extreme emotions—that the community together may comprehend and redress, within its own innate perceptions and respective positionality, the consequences of key critical events both personal and public.
Chapter 4

State of Emergency:
The Conflict and Convergence of Personal and Public Crises, Indigenous Subalternity, and Social Control

Late in the evening of Saturday, May 15, 2004, the birth of Severina Méndez Soto’s latest child began to get increasingly complicated. She had gone into active labor the previous morning of Friday 14, and had remained at her home in the valle community of Yomala since then, in the presence of her husband, Héctor, and five of their children (the eldest daughter studied high school in Sucre), who ranged in age from 4 to 16. Severina, 41, could neither read nor write, and like her husband spoke only Quechua. In order to supplement the income from the small plot of land that Héctor worked with maize and potatoes, she was the only person in the community who baked and sold bread. She had had a total of 12 pregnancies (including the current one), two miscarriages, nine vaginal births, and three children who had died within their first year of life (at least two of them reportedly from diarrheal disease), thus leaving her with a total of six living children on the day of May 15. Severina had never felt any necessity to utilize the health post when she had gone into her previous labors, and thus all of those children had been born at home with only Héctor attending, as was also to be the case with this one, her latest.

Over the previous months of her pregnancy, however, Severina had been a virtual model of officially sanctioned reproductive health-seeking behavior. The Yomala health post stands literally around the corner from the two-room house where she and her family lived, a two-minute walk, and which was staffed at that time by a single nurse auxiliary, Renato, who was thus also a neighbor. Severina previously had come to the Yomala health post for an impressive total of 10 prenatal check-up visits during the course of her pregnancy, significantly more than
the internationally recommended minimum of four, and obviously in some instances she had attended more than once a month. On two occasions, Renato had referred her to the health center in Puka Wayq’u for more comprehensive exams due to concerns about the size of the growing fetus, which seemed excessively large. For these same reasons, Severina had then been twice referred from Puka Wayq’u to Tarabuco, and then to Sucre, where at San Pedro Claver Hospital she had been given more advanced diagnostic exams than those available at the health center, including two ultrasound analyses. These showed cephalactic and genital edema in the fetus (a boy), in addition to being in a breech position, indicating what was certain to be a difficult birth. Severina was consequently scheduled for a Cesarean section at San Pedro Claver in the city, where she was instructed to check-in within a few days of the calculated due date. The then two-year-old national Maternal and Infant Universal Health Insurance Law (SUMI) would cover all medical, transportation, and boarding costs. In her near over adherence to the national health services’ systematic regimen of recommended prenatal check-ups, and with the addition of the advanced diagnostic exams undertaken in the city, Severina had thus been very much an exception—and an exemplary one at that—to the norm among both the rural communities of Puka Wayq’u and the majority of indigenous communities, rural and urban, in Bolivia as a whole.

Contrary to these indications, however, when the actual predicted due date for the birth drew near, Severina and Héctor opted to forego any further contact with the health services and, as mentioned, to attend to the birth in the same way that they had always done for their previous children: stay at home in Yomala. (“It was because of economic reasons that she didn’t go,” reasoned Doña Carmen Bautista, who had been a comadre35 of Severina, and despite the fact that

35 In Bolivia (comadre, feminine; compadre, masculine), a term used to denote a very intimate friend, someone close to an informal kinship network, typically bonded by way of a comradely “pledge” based on mutual ties of
the SUMI should have covered all of her costs—if, that is, Severina and Héctor were in fact even fully cognizant of their rights by law.) For his part, Héctor carried on his work routine as usual, and was off in the hills each day with his burros even after Severina’s contractions had begun. Yet, when after nearly two days of undergoing regular contractions, and as these continued with increasing strength but the baby had still not begun to descend into the birth canal, and with little apparent progress and considerable suffering on the part of Severina, she and Héctor had a reluctant change of heart based on the unforeseen circumstances and decided, at 10:30pm on Saturday evening, to make their way to the neighboring health post. When they showed up at Renato’s door, the amniotic sack had already broken (some in Yomala claimed to have knowledge that this had actually occurred a few days previously), and contractions were occurring at 10 to 15 minute intervals. Nevertheless, there was little or no dilation, and it was apparent that one of the difficulties was the nature of the fetus and the already diagnosed potential for an obstructed birth. Renato monitored Severina throughout the night, but was unable to call Puka Wayq’u by phone for assistance because the local Entel phone company public office was already closed (this was the only phone line in Yomala). In addition, the Puka Wayq’u health center’s short wave radio had already been turned off for the night.

Once Renato finally did make contact early on the morning of Sunday, May 16, Dr. Javier Quispe, the health center director (at this point, now on the job for only two months) decided not to go to Yomala himself, but rather sent the ambulance down without him. It arrived in approximately 45 minutes, with three people: Dr. Cárdenas, still the attending physician in Puka Wayq’u; Juan Carlos Padilla, one of the two medical students currently in training and doing his three-month internship at the health center; and Pablito, the ubiquitous ambulance respect, reciprocal social obligations, and patronage and clientage. A locally specialized concept of “fictive kin,” also used in other limited regions of Latin America.
driver. Upon arrival in Yomala, Dr. Cárdenas looked over Severina, gave his opinion that everything was proceeding normally, assured Héctor that he would be able to attend the birth there in the Yomala health post, and gave Severina an injection of the labor inducing drug oxytocin—yet, it is something of a mystery as to why he did this considering the present case of an obstructed birth, and in contradiction of established medical protocol. He then disappeared for over half an hour in search of, by different accounts, “his friends” and “something to drink”; many of those interviewed afterwards commented on the already present odor of singani on his breath. As Severina continued to complain and visibly worsen, and at the behest of the increasingly nervous Renato and Juan Carlos, Héctor sent his eldest son to find Cárdenas. Once the doctor eventually did return to the health post, the fetal heart rate was virtually nonexistent, the labor was still obstructed and with no change, and Severina’s vital signs were dropping rapidly. At that point, over an hour after first arriving in Yomala, Cárdenas decided to move her out of town and to the Puka Wayq’u health center, which meant an additional 45-minute journey in the ambulance. Unfortunately, the Puka Wayq’u team had neglected to bring a stretcher, requiring Severina to lie flat on a blanket in the back of the otherwise bare ambulance.

Accompanying her on the trip to Puka Wayq’u, in addition to the health services personnel (minus Renato, who stayed behind at his post), was her husband Héctor.

In Puka Wayq’u, the health team needed to refill the ambulance’s gasoline tank at the center, and to get Dr. Quispe’s authorization for transporting Severina out of Puka Wayq’u. However, they were unable to reach the gate and entry way to the health center itself: a pickup truck—as it turned out, belonging to Padre Antonio—was parked haphazardly in the street and, alongside the trench dug for the early stages of a municipal sewage line project, was blocking access to the center. Quispe came outside and confirmed the now total absence of a fetal heart
rate and Severina’s critical condition, while still standing in the street. The next step, supposedly, should have been to immediately send the ambulance on its way (Pablito had already filled the gas tank, within the first five minutes), with orders to stop very briefly at the secondary level hospital in the district capital of Tarabuco to check in, and where the attending personnel had already been alerted by radio from Puka Wayq’u that an emergency obstetric patient was arriving. Assumedly, the team would then receive immediate orders to continue on to Sucre, and to an advanced third level health facility (as standard protocol would dictate in such an emergency) for the assured Cesarean section. However, Quispe ordered that Severina be brought inside, so that he could make his own personal detailed assessment of the full extent of her condition. Due to the priest’s truck impeding the way, she had to be carried manually by Juan Carlos and Pablito into the health center, which entailed approximately a hundred meters and several additional minutes. Quispe called for an intravenous solution to be inserted into Severina’s arm, which she weakly protested, barely able to call out desperately to Héctor that she knew the baby was already dead, and to not let them “poke” (hurgar) at her anymore—and effectively, while performing his gynecological examination Quispe officially pronounced the fetus as deceased due to asphyxiation.

Then, something went even more dramatically wrong—what exactly transpired remains a source of considerable controversy—and there in the maternity room Severina suddenly erupted in an explosive vaginal hemorrhage. Amidst a rapidly spreading pool of blood, stunned shock and sudden commotion among the assembled personnel, and with a confused descent into blind “crisis mode,” Dr. Quispe, his white hospital gown now stained a damp and gleaming red from the chest down, gave a flustered and frantic order to immediately return Severina to the ambulance. While Lidia Toranzo, the head nurse, desperately applied whatever compress or
piece of material that she could find in a vain attempt to slow the bleeding, Severina was carried back again over the open trench and past the parked truck to the waiting ambulance, and the journey to Sucre was hastily resumed. Quispe remained behind in Puka Wayq’u, while Cárdenas, Juan Carlos, Pablito, and Héctor accompanied Severina, who at this point was bleeding out even more heavily and was by then barely respondent. There remained, however, one further—and still grossly inexplicable—stop at Doña Sebastiana’s tiendita on the way out of town, where Cárdenas hurried inside. After what seemed like a very long and increasingly unnerving five minutes, Pablito began to repeatedly honk the ambulance horn, at which point the doctor ran back outside, eating an ear of corn.

During the winding trip up from the valley floor to the altura, Juan Carlos repeatedly tried to insert an intravenous line into Severina’s right arm, but due to the massive loss of blood was unable to locate a viable vein. Severina proceeded to lose consciousness completely on the trip, and shortly over half an hour later, precisely when crossing the dry gulley upon entering the community of Villa Rosario, she went into sudden cardiac arrest. The ambulance hurriedly stopped at the Villa Rosario health post, where both Cárdenas and Juan Carlos attempted emergency cardiopulmonary resuscitation but to no avail, and Severina died of hypovolemic shock and heart failure at 12:50pm on the afternoon of Sunday, May 16.

With the initial objective of the emergency trip to Sucre now made tragically irrelevant, the health center team at first attempted to contact the Puka Wayq’u facility on the short wave radio, but nobody answered. The ambulance and its occupants then turned around in Villa Rosario and began the slow, winding journey back down into the canyon with the body of Severina and her obviously distraught husband. They stopped at the Puka Wayq’u health center, where Quispe grimly removed the deceased “product”: a full-term fetus which, as was apparent,
had already begun to show signs of severe infection. This was done despite the strong objections of Héctor, who demanded that the extraction be undertaken in Yomala; at Quispe’s refusal (for what must be recognized were undeniable technical issues related to the available medical facilities) an argument broke out between the two men, and ultimately Héctor was forced to leave the room. Once Quispe finished the procedure he ordered that Severina be taken to the ambulance, and returned to Yomala.

Without the company of Dr. Cárdenas this time on the final leg of the journey, Juan Carlos, Héctor and Pablito continued on with the bodies of Severina, wrapped in a woven blanket (fullu), and that of the dead fetus, in a cardboard box, to the lower valley and into Yomala. They arrived in the center of the community at nearly 3:00 that afternoon. It was only a matter of minutes before the word spread, and a crowd quickly gathered around the ambulance, the commotion becoming increasingly loud and desperate, as Severina’s children and the community as a whole conveyed their shock and disbelief by wailing and crying out “just like little baby chicks,” as our friend Emiliana from Puka Wayq’u (coincidentally in Yomala that afternoon) later described the scene. The body of Severina, still covered by the fullu, was removed from the ambulance and carried inside the family home, with much of the crowd pressing in after it; also taken inside was the box containing the baby’s body. Many other people, however, remained outside, and the climate turned decidedly tense and hostile, with unspoken accusations palpably directed toward the health center personnel. Juan Carlos and Pablito, after only a few more perfunctory minutes, returned to the ambulance and rapidly drove away in the direction of Puka Wayq’u. Many of those present that afternoon were to later comment on the large amount of blood stains visible inside the ambulance.
If the atmosphere in the town of Puka Wayq’u and its surrounding communities, in both the local health services and among the population as a whole, had been somewhat edgy yet quiet following Damiana’s death the previous month (and while simultaneously taking into account that specific event together with the other maternal deaths which had preceded it, from late in 2003), in the wake of what occurred with Severina it erupted into an open and full-blown crisis. In the following weeks, the series of deaths was repeatedly and pointedly raised in their totality as a pressing local issue demanding immediate attention, this on the part of many people at previously scheduled town gatherings and health promotion activities throughout the municipality, and at which the local authorities were often and quite directly confronted and questioned. Almost overnight, the words “maternal mortality” became common usage among the community—while simultaneously attaining the status of a virtual mantra among the health services personnel themselves, infusing and coloring all regularly scheduled administrative and technical meetings with staff at the Puka Wayq’u health center and in the community health posts. After what had initially been a formal and essentially protocolar response from the authorities in Sucre in order to address the confusion as a result of the Damiana death (albeit a very indicative one, in regards to the local social and institutional climate, and which I consider in greater detail below), following the Severina incident the Puka Wayq’u health center, the district headquarters in Tarabuco, and the SEDES Chuquisaca in Sucre increasingly and rapidly went first on the defensive and then on the offensive. Within a week after Severina’s death, the town was visited first by health officials from Tarabuco, and then by SEDES authorities from Sucre. Two weeks later, the Puka Wayq’u “situation” had grown even more significantly in prominence during administrative and technical discussions at the SEDES in Sucre; it was attracting national attention from the Ministry of Health and Sports in La Paz; and, as I will
discuss, the health center and the mayor’s office began to coordinate the organization of large-scale community meetings to address the issue. Maternal mortality was suddenly at the top of the formal political agenda in the municipality. Reflecting the heightened tensions, only days after Severina and the precarious immediacy of the contextual social demands surrounding her death burst onto the local and regional public health and political consciousness, the SEDES Chuquisaca officially declared the municipality of Puka Wayq’u a “Red Zone”—ostensibly in regards to both the immediate situation of medical emergency and the chronic situation of maternal mortality, yet, and as it would later become apparent, more so in response to corresponding political and societal anxieties.

*   *   *

The following chapter examines in detail the not-so-systematic “damage control” inside and outside of Puka Wayq’u amidst a growing crisis of political and social legitimacy, for both the local and departmental government authorities and institutions—and, beyond these, for the Bolivian state itself, vis-à-vis the community (and predominantly indigenous) populations that it purported to serve. In addition, I consider the community and popular reactions to the uncertain situation, and the ways in which accountability and “blame” were attributed and allocated, further exacerbating local anxieties. As I have previously discussed, endemic maternal mortality had certainly existed in Puka Wayq’u as a matter requiring immediate and concerted public health attention for some time already (most recently, at the very least since the previous year), yet had been relegated to that of a background problem of perennial neglect and only occasional official notification, let alone determined action. However, and as a result of its sudden overt nature and undeniable critical immediacy within the realm of municipal and overall public affairs, the mortality dilemma was suddenly transformed into something else: incidents
emblematic of deep-rooted issues of indigeneity, coloniality and subalternity, state sovereignty, the manipulations of social power, and coercion for state advancement. Thus, the local and regional response to the unforeseen crisis—or, as perhaps defined more accurately yet with a very fine line, the *foretold yet unanticipated* crisis—and the sudden rupture of the established order was, I argue, to increasingly reveal much more about the overall complexity of the Bolivian state as a whole.

*The Nature of Crisis in Context*

The official dictionary definition of the word “crisis” indicates Greek etymological origins in the noun *krisis*: literally, decision, choice, or judgment. The various meanings include the following:

A time of intense difficulty or danger;

A stage in a sequence of events at which the trend of all future events, especially for better or for worse, is determined, as in a turning point;

An unstable or crucial time or condition, as in social, economic, political, or international affairs, in which a decisive change is impending;

An emotionally significant event or radical change of status in a person’s life;

And (*in a medical context*), the turning point in the course of a serious disease at which a decisive change occurs, leading either to recovery or to death.

The concept of “crisis” that I utilize here coincides in great part with that of the “social ruptures” argument as conceived by Turner, as I have previously mentioned. That is, the notion that an understanding of society is perhaps at its clearest through an analysis of its breakdowns, rather than through its condition of everyday “normalcy.” In further developing a theoretical
framework for examining crisis, however, I also take into account and outline as follows a number of diverse approaches.

German historian Reinhart Koselleck (1988), for his part, takes on a political and “philosophy of history” perspective, one of “unpredictable change”:

It is in the nature of crises that problems crying out for solution go unresolved. And it is also in the nature of crises that the solution, that which the future holds in store, is not predictable. The uncertainty of a critical situation contains one certainty only—its end. The only unknown quantity is when and how. The eventual solution is uncertain, but the end of the crisis, a change in the existing situation—threatening, feared and eagerly anticipated—is not. The question of the historical future is inherent in the crisis (1988:127).

Within the context of the Enlightenment and into the 19th century (with a particular emphasis on Rousseau and his thought), Koselleck thus frames crisis as the inevitable precursor to state upheaval and revolution. In this argument, the historical view of the “state of crisis” and “crisis of the state” is something anti-progress, and not at all “rational,” being instead of a cyclical nature; “the concept of the circularity of history made it easier to conceive of a turning point” (ibid:162). 36 Historian Randolph Starn (1971), however, examines the concept in a more dismissive (if not cynical) vein, decrying something of an “overuse” in considering “crisis” as key within the parameters of historicity, although there is also something of a parallel with the Turner viewpoint concerning ruptures in Starn’s observation that “what the historian defines as a crisis situation does not necessarily change anything at all so much as reveal the fibre of its subject” (1971:16). A more “exulting” esteem (as Starn terms it) was professed by 19th century cultural historian Jacob Burckhardt:

36 What is interesting to note here is the concept of “circular history” (in following both Rousseau and Koselleck): as previously mentioned, it has long been acknowledged the indigenous Andean notion of a cyclical, non-linear dimension of time. The question in this case is whether this “traditional,” autochthonous perception, rather than a more “modern,” occidental one, prevailed during the crisis that was to occur in Puka Wayq’u.
The crisis itself is an expedient of nature, like a fever, and the fanaticisms are signs that there still exist for men things they prize more than life and property… The crisis is to be regarded as a new nexus of growth. Crises clear the ground, firstly of a host of institutions from which life has long since departed and which, given their historical privilege, could not have been swept away in any other fashion (quoted in Starn 1971:8).

Historical perspectives in general oftentimes have a tendency to dwell upon, yet without necessarily resolving, Marx’s historical view of crisis theory: a presupposition for systemic change stemming from capitalist economic crises of the production and overproduction of both commodities and capital. However, Habermas (1975) adopts a more philosophical direction, but equally Marxist, in what he refers to as a “social-scientific concept of crisis,” and which includes both economic theory and historiography itself: the basic premise is that of “an objective force that deprives a subject of some part of his normal sovereignty. To conceive of a process as a crisis is tacitly to give it a normative meaning—the resolution of the crisis effects a liberation of the subject caught up in it” (1975:1). Gramsci (1971) also takes the political vantage point of Marxism, focusing on the concepts of what he calls the “crisis of hegemony” (“crisis of authority,” “crisis of the state,” also the “war of position”): this occurs once the ruling classes within society lose the consent of the masses; or, when there is a mobilization of large subordinate (subaltern) classes (i.e., the peasantry or intellectual petit bourgeoisie) against the ruling classes. At this point, says Gramsci, anything can theoretically happen, with violent solutions to the crisis not only possible, but expressly seen as a positive force. When the ruling classes then inevitably attempt to reassert and reinforce their social control, the crisis is perpetuated, eventually reaching some sort of breaking point in favor of one side or another.

One of the earliest anthropological considerations of crisis (Bidney 1946), in the specific context of cultural crisis, sees it as either a moment of transition—perhaps a constructive one, but just as equally perhaps a destructive process—from a previous to an actual form of cultural
life, and as brought on by either internal or external change. This latter dichotomy between the
“internal” and the “external” forms the overall framing of the argument, in a clearly materialist
analysis, with its distinction between “Western and native peoples”: with the former, crisis
erupts as a result of modern society itself, with all of its vicissitudes extending from within and
outwards to other competing societies. In the latter case, crisis is owing to an ongoing and
eternal struggle with the unpredictable forces of the geographical environment, or through
sudden contact and juxtaposition with a new and alien culture. The end results are perpetual
“survival or axiological crises” (ibid:542) of either forced acculturation or deculturation, which
may also apply to “modern” societies in a sense of larger public upheaval and transformation.

While acknowledging these interpretations of crisis, for my purposes here, however, I
will base much of my own argument around ideas as outlined by Vigh (2008). Vigh defines the
reality of crisis for much of the world’s societies not as sporadic or episodic events, or inherently
as “aberrant moments of chaos and decisive change,” and taken out of context. Rather, in his
analysis crisis is endemic, not in context but rather as context, and a “terrain of action and
meaning.” As understood, crisis is therefore not considered in a retrospective, “post” fashion,
not historically contextualized, and hence is not seen as an interruption of so-called “normal”
daily life. To do so, maintains Vigh, obscures the fact that countless people are caught up in a
prolonged situation of crisis, and are not necessarily moving out of it at any notable pace. Crisis,
then, is a slow, persistent, durable condition; a difficult process of negative change, “it is
fragmentation; a state of somatic, social or existential incoherence” (2008:9). There is, it must
be noted, much to be found here which invokes the oft-cited crisis related observations of Walter
Benjamin (1968), inherent in what he refers to as the “state of emergency”: “The tradition of the
oppressed teaches us that the ‘state of emergency’ in which we live is not the exception but the
rule” (257). In a similar vein, Kleinman remarks that “dangers and irregularities are not anomalies; rather, they’re an inescapable dimension of life” (2006:1). Regardless, in this respect what is important is to observe and interpret how social agents act in the crisis, rather than through it: with crisis as context, subjects are habituated to a kind of normalization and routinization, in which they develop heightened abilities of “social reflexivity” (ibid:19) with which to become aware of, interpret, and navigate the social terrain. In companion responses to Vigh, Scheper-Hughes (2008) and Reynolds Whyte (2008) re-emphasize the model of crisis as something that discriminates and differentiates, and which thus allows greater possibility for ethnographic opportunities to explore and illuminate critical human qualities—not as an acute state, but rather as a chronic one. This chronicity then helps in painting a more accurate portrait of oppression—and, as I would add, of coloniality—and especially of the means with which people “re-frame” and cope with crisis, in what Scherper-Hughes describes as a process of “transcendence” as based in a learned resilience (2008:50).

It must be clarified that for my own consideration of the events in Puka Wayq’u, I make one key theoretical discrepancy with the otherwise useful model as outlined by Vigh: specifically, what is essentially his disavowal of the possible recognition per se of the notion of sudden ruptures, within the crisis as context framework. While adopting the argument of chronic crisis as a valid one, I do not hold that the “isolated” events which, together and as they repeatedly occur, are not worthy of our exceptional attention. Despite the coping mechanisms which people may adopt in order to make sense of and manage their chaotic and afflicted lives in an everyday, if not endemic, fashion, this should not in any way negate the immediate, lived and

37 And to which Carl Schmitt (2005:15) might have again retorted his memorable, and previously espoused, assertion: “The exception is more interesting than the rule. The rule proves nothing; the exception proves everything.”
felt impact of a sudden traumatic event—and which is not always possible to handily categorize as merely one interlocking thread of a wider fabric, and there it all ends. That lived reality is—and again, to use Kleinman’s (2006) words—“what really matters,” because it is what the individual subject personally knows, and experiences. In this respect, I recognize the events described here as indeed “ruptures,” because that is how they were closely perceived by those most intimately involved with regards to the people they lost, and to the lives they were living.

**The quality of crisis in Bolivia**

Building specifically upon these models of “permanent crisis,” “chronic crisis” and “crisis as context,” then, at heart is my proposal that Bolivian society is, and has historically been, a more or less permanent “culture of crisis,” in its own unique way. That is, the essential qualities of instability, danger, radical change and a never-ending series of turning points are inherent in the very sociocultural fabric of everyday life: ranging from the small-time “normalcies” of daily human interactions; to the large-scale transitions at the national level. (Of which the events beginning in the year 2000 and extending into the present have been particularly noteworthy examples.) For years various analysts (among others, see for example Calderón and Dandler 1984; Dunkerley 1984; Klein 2003; and Mesa et al. 2008) have long recognized, taken note of, and analyzed the deep-rooted divided nature of Bolivia: geographically, between the highlands and the lowlands; historically, between the native peoples and the dominant colonizing elites of European descent (although it is certainly possible to extend that even further back in time, and to the divisions between the Inca Empire elites and the many smaller Andean polities and cultures—the indigenous señoríos—which they conquered and colonized); and socioeconomically, between the extreme ranges of affluent and indigent classes extant today. Expanding upon these parameters, another key point of analysis as it
relates to what often appear as levels of constant conflict associated with social relations and
governability unique to the region may reside partly, albeit more specifically, in the highly
stratified and unequal exercise of power, precisely in terms of the aforementioned internal
sociopolitical divisions (Crabtree 2009:12).

Hence, consequently and by extrapolation in exploring the specific nature of this endemic
nature of national crisis, there existed both of two interrelated processes at work within the Puka
Wayq’u context: initially, the individual crisis of the individual death itself, and its impact upon
the respective surviving family; this has been discussed in detail within the social suffering
framework in Chapter 3. Yet in a parallel fashion there was also the crisis of the state which was
occurring at the same time, including that of its very legitimacy vis-à-vis the context of Bolivian
indigeneity and a history of coloniality and oppression. Thus, the “culture of crisis” suddenly
manifested itself in different, very dramatic ways: at the “micro” level, as a marked increase in
the incidence of maternal deaths (but, notably, not of other deaths, with the glaring exception of
infant mortality); and, at the “macro” level, as an intense generalized social violence and the near
collapse of the state (in late 2003, and again in mid-2005), which was then reborn—“refounded,”
in the current official discourse—with the ascension of the MAS and the organic social
movements to political power. This has by no means, however, signified the end of tensions,
conflict, and perpetually bubbling ruptures, and so the crisis continues.

In this manner, what I propose is that there is a variety of correlation between the two
phenomena (although not, to be sure, causality). In some senses, it is a direct, empirical
manifestation: most prominently, through an ingrained inter-ethnic conflict—i.e., “racism”—
which results in deficient, inappropriate, hostile and what are frequently outright detrimental
health services (specifically for my purposes here, within the public health context). But, more
profoundly, it is in a *representative* or *symbolic* sense—a subjective sense—when considering that the deaths I consider in the case of Puka Wayq’u occurred due to a crisis of confidence and legitimacy at the personal and communal levels (as articulated through reproductive health practices and beliefs, by both the community beneficiaries and the state providers). Intriguingly, this occurs just as the Bolivian state itself was undergoing its own organic crisis, complete with violent deaths in the streets and “martyrs,” for exactly the same reasons, and much of it very significantly having to do with questions of race and ethnicity.

The dynamic and its impact have previously been acknowledged within the Bolivian context. Most critically as developed by René Zavaleta Mercado, probably the most influential sociologist and political philosopher of 20th century Bolivia, the idea of “crisis” as a fundamental social element is definitive in his understanding of the complex dynamics and discourses prevalent in the contemporary society that he was familiar with. Especially in *Las masas en noviembre* (1983), addressing what he termed the “national-popular” classes in Bolivia, Zavaleta, in analyzing the interrelationships and even the interdependence between popular insurrectionary movements and the state,38 affirms that “crisis is the classic form of revelation or knowledge of every kind of social reality…[it is] the phenomenon and the outward appearance of society which do not have the possibility of an empirical, comparable cognitive revelation, of societies that require a synthetic ascension of knowledge” (1983:17). Crisis, for Zavaleta, reveals the deepest contradictions in society, and, most significantly, in a *subjective* rather than an *objective*

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38 Zavaleta’s historical focus was predominantly on the social movements and insurrectionary politics of the urban working and middle classes, the mining sector (indisputably one of the central driving forces behind Bolivian protest movements and sociopolitical change, from the 1940s until the mid-1980s), and also urban student movements, all for the most part between the 1950s and the 1970s. Notably, he did not significantly take into consideration the “indigenist” (*indigenista*) and “indianist” (*indianista*) movements, nor for that matter indigenous peoples and social movements themselves, which importantly began to gather force in Bolivia precisely during the 1970s. (See for example, in regards to the militant and highly influential *katarista* movement, the discussions in Rivera Cusicanqui 1983, 1984 and Albó 1987.) This omission may possibly be interpreted as a potential weakness of Zavaleta’s overall historical analysis, yet at the same time without negating the innovations and essential insights inherent in his argument; see Hylton and Thomson 2007.
manner: the crisis \textit{per se} fails to effectively resolve anything in itself; rather, it is through one’s purported experiential and empirical knowledge of what is occurring in his / her own lived reality—rather than through the playing out of that reality itself—that each respective individual is eventually able to subjectively resolve the crisis to its respective end. This is most noteworthy in a complex and conflictive society such as that of Bolivia, the restless diversity of which Zavaleta famously characterized as “motley” (abigarrada).

A more recent view, building upon Zavaleta and also from a class-based Marxist perspective, holds that Bolivia is a product of perpetual and ongoing state crises owing to its “multisocietal” composition; that is, not based so much around \textit{cultural} aspects (languages, beliefs, traditions) as it is around \textit{economic} and \textit{political} differences, including the structural and coeval reality of three socioeconomic modes of production in the country: agrarian, modern, and nomad (Moldiz 2008:13). In this view, since the early years of the Bolivian nation-state until the present (and following Tapia 2002, 2006), it has not been possible to “forge a solid national unity and identity,” or for the state to successfully “synthesize” national society (ibid:14). The result is permanent crisis, owing to an unequal entity which disenfranchises and marginalizes the popular masses (primarily indigenous), and propagates a weak, capitalist “apparent” or “superficial” state (\textit{estado aparente})—this being a Zavaleta concept in itself, in which what goes by the name of “the state” is only an elitist faction detached from the \textit{true} state, the essence of which remains submerged in civil society (Zavaleta 1990).

Another position incorporating this, and also with an overriding Gramscian perspective, is held by (autodidactic) sociologist and prominent political analyst (and also, not at all coincidentally, since 2006 the sitting Vice President of Bolivia) Álvaro García Linera in numerous works (see for example, García Linera 2010, 2011). According to his interpretations,
the “crisis of hegemony” (a concept now enshrined in the modern Bolivian sociological and political science literature under the label of empate catastrófico—“catastrophic deadlock,” or “catastrophic stalemate”) began in the year 2000 with the initiation of the current cycle of protest and rebellion (as previously discussed in Chapter 1). In this model, at the particular historical moment in question an overt frontal confrontation between diverse social movements and projects incorporating ethnic, class-based and regional popular groups on the one hand, and the long-established traditional sociopolitical power elites on the other, generated unprecedented instability and uncertainty at both the local and national levels. This precarious impasse only began to be relieved (argues García Linera) by the elections of 2005, in which the MAS came to power.39 The events in Puka Wayq’u took place at the height of this unrest.

A similar but also somewhat divergent “culturalist” perspective examining the question of race and ethnicity is later emphasized in a reminiscent and relevant manner for my purposes by Arnold (2009a, 2009b), who sustains that the historic insistence on distinctive racial identities, which is delineated by the propagation of the “political construction of identities” in Bolivia—including during the MAS administration, and if not actually exacerbated by it—is perhaps the key factor generating conflict in the country. Within the context of a decolonization oriented analysis, Arnold maintains that by focusing so persistently on the notion of “culture,” this results in the promotion of a notion of racialized identity “differentiation and stratification” between the various native peoples of the country, oriented around an essentialist “schizophrenic clash of civilizations language” concerning “Andean” and “western”—a false dichotomy which

39 Bolivian artist and poet René Antezana Juárez, in following his own personal Gramscian inspired line of thought as adapted to the national scene, characterizes the Bolivian national body as a “stalemate culture” (cultura del empate): intrinsic and entrenched opposing social forces are forever correlated and equal, one never surpassing the other—although, indeed, one of the two may also be manipulating the situation, at the possible expense of, and thus to the detriment of, the other—and the conflictive players are thus locked in a perpetual draw and an eternal state of crisis (personal communication, June 2010).
is then itself a root of conflict and crisis (2009a:5). In contrast, she proposes a “different but equal” style model based in a micro level self-identification, frequently associated with local realities involving modes of production (agricultural or otherwise), and which avoids artificial (and conflictive) identity politics.

Both the local maternal deaths and the national state “ruptures” arise organically out of this socio-historical context, and consequently there are then similar issues of concern. Most prominently: the respective local, departmental and national reactions and responses to crisis; who suffers from and who benefits from the time of danger and change; questions of hierarchy, in that either previously existing or newly coalescing divisions are brought to the fore; and whether the “crisis” is even one as such, or rather was exaggerated, misrepresented, manipulated, or perhaps outright fabricated, in that it was always an extant reality owing to the deeply ensconced social divisions, yet seldom recognized or openly acknowledged by those in power until the danger had become too close and too personal. In this way, I propose that the maternal death crisis in Puka Wayq’u serves as a kind of metaphor for the national crisis in Bolivia: both productive and (re)productive violence, which also incorporates matters of gender; interracial and interethnic conflicts erupting and resulting in tragedy; one of the most eternally vulnerable population groups caught in the center; the fracturing of and then the (re)consolidation of power; and finally, a “turning point,” for better or for worse.

The social ruptures that I will examine here, and which in tandem created a unique variety of crisis in Puka Wayq’u, were many. There existed a lethal combination of various critical factors: to begin with, the typically insufficient health infrastructure, including physical facilities, medical supplies, and human resources; this together with the professional limitations, incompetence and / or outright negligence and malpractice of the local health services personnel.
(With all of these being integral to the accepted “three delays” model.) In addition, and perhaps most distinctively, all of this came into play together with the element of “phased out” (or, at the very least, in scarce supply) local traditional providers and birth attendants, concurrent with a clear lack of trust and cultural comfort with the biomedical providers on the part of the rural population. In what might be identified as a kind of forced transition from “traditional” to “modernity,” and the imposition of an essentially alien cultural worldview, the end result was that the community then fell into the social and medical cracks. And again, it bears recalling that behind these most immediate dynamics was the presence of an enduring colonial state structure that naturally sought to increase and further entrench its power—social, cultural, political, racial, and ethnic—over a majority rural and indigenous population. Accordingly, the crisis in maternal mortality in Puka Wayq’u was initially a crisis of the state’s ability to “protect” the citizenry, and thus maintain its own legitimacy in the eyes of both the internal (the provincial Bolivian community) and the external (the international community, especially in regards to economic assistance in grants and loans—with the Millennium Goals “contract” in the balance).

Nevertheless, once the official health system did eventually mobilize (and as will be discussed in greater detail later), the exaggerated political uses of mortality came to the fore. In addition, together with this came the distinctly unpleasant concept of the “state taking power from the dead” (Taussig 1997:21) as it increased the reach of its cultural vision and model, its authority, and its sovereignty for the consolidation and stabilization of local social hierarchies, somewhat beyond the pale of the “typical” governmentality model. Consequently, the mortality “crisis,” and the apparent breakdown in the social structure, eventually served to feed into the (post?) colonial power structures still handily at work in Bolivia, at least throughout 2004—and, the debate goes, to whatever degree these may still persist, even in the post-2006 MAS state. In
this, there are notable parallels with the respective situations, each equally crisis-ridden, as described in Briggs and Mantini’s portrayal of a cholera epidemic among an indigenous population in Venezuela (1997, 2003), Farmer’s HIV/AIDS in Haiti or tuberculosis in Peru (1999, 2003), and Schepers-Hughes’s hunger and complicit infanticide in Brazil (1992): all are instances of the political amplification, embellishment and use of suffering and disease—or, in the present study, of excess mortality—by a government with the ultimate aims of population control and the stabilization of widely differing social hierarchies. Within this framework, the Puka Wayq’u scenario also conforms to the model of what Klein (2007) has notably christened as the “shock doctrine,” and which she aptly encapsulates—for her purposes, and also for my own—with a quotation courtesy of an historical personage admittedly somewhat antithetical to the theoretical bent of this dissertation, Milton Friedman: “Only a crisis—actual or perceived—produces real change. When that crisis occurs, the actions that are taken depend on the ideas that are lying around” (quoted in Klein 2007:140). And in Bolivia, these particular circumstances occurred on the virtual eve of a significant (albeit still polemical) social paradigm shift, which was just barely yet to come.

**Red Zone: The Construction of a Local Crisis with National Impact**

In this theoretical context as I characterize it, what to make of the state reaction to the mortality crisis in Puka Wayq’u? It is possible to identify three distinct stages in the official response: first, an established statistical “normalcy” and relative administrative inaction prior to the initial upswing in the incidence of deaths (up until late 2003), and despite the strong suspicions of a persistent “low level” endemic mortality throughout the municipality over the years. Later, the essentially protoclar reaction of the departmental and local health services
appearing on the scene (albeit with legitimate concern) following the Damiana incident—that is, once the deaths were suddenly and unexpectedly deviating from the conventional “norm”—as part of the first official response. And finally, an intensive and hurried rush of frenzied mobilization and “crisis control” in the wake of Severina’s death, when an unanticipated and alarming “situation” was suddenly perceived by the authorities—and which was, by that point, also an *acutely* perceived, if only *obliquely* acknowledged, breakdown of the established order, sanitary and otherwise.

*Crisis Management: Institutional Response and Mobilization, from Puka Wayq’u to La Paz*

**First responses**

Damiana had died on April 19. On May 5, the SEDES Chuquisaca convened a large meeting together with the Puka Wayq’u health center, in conjunction with the regularly scheduled quarterly meeting of the Local Health Directory (*Directorio Local de Salud, DILOS*). A typical DILOS meeting, similar to those elsewhere in the country, would typically be held in the town of Puka Wayq’u (as the municipal capital and nexus) and consist of only the mayor, the health center director, the president of the local Civic Community (*Comité Cívico*), and perhaps one or more of the town council members. Its mandate is to review and assess the current status

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40 At the national level, the Comité Cívico as a municipal institution began in the mid-1990s with the 1994 Law of Popular Participation (*Ley de Participación Popular, LPP*). The LPP was ostensibly designed to decentralize the nation-state, and did indeed grant previously unheard of powers to municipal and local governments—but has also received much criticism for being a type of stealth mechanism to undermine popular and social organizations. (See for example Kohl and Farthing 2006 and Postero 2007, for analyses of the LPP history, impact on national and local governments, and legacy within community and indigenous organizations.) However, since approximately 2009 it has been the intention of the MAS government—initially in a quasi-subtle fashion, now very overtly—to phase the Comité Cívico out of existence as another vestige of the “neoliberal state” (i.e., the “colonial state”) established following the free market reforms of 1985, and consolidated during the 1993 - 1997 Sánchez de Lozada administration. Their replacement will be municipal entities set up under the 2010 Law of Autonomies and Decentralization (*Ley Marco de Autonomías y Descentralización “Andrés Ibáñez”*), which officially and effectively replaced the LPP. It is as yet unclear what the eventual effect will be on how the DILOS will function, and how local health administration will be impacted. (This presumes, however, that the DILOS themselves will not be reorganized also, or otherwise made obsolete—something which is still a significant unknown.)
of municipal public health and service provision, and to discuss and formulate administrative recommendations and budgetary guidelines for later town council approval. However, on this occasion and owing to the special agenda, together with the participation of the authorities from Sucre, it was a large, open communal gathering held in the public meeting room of the Villa Rosario health post, in its quality as the convergence point for health services activity in the altura region and to which both the San Marcos and Iskay Sach’as populations gravitated. At that time, the post was a somewhat shabby construction, built in the 1980s, with dusty chairs, faded health education posters, and more than a few broken windows; it was replaced in 2005 with a newer, more modernized building.

In addition to the usual participants for a DILOS meeting, and the SEDES authorities, a large number of local authorities from the surrounding population centers corresponding to the Villa Rosario health sector (a total of eight communities) were also in attendance. These consisted of dirigentes from the local agrarian sindicatos; all members of the municipal Civic Committee; mothers’ club representatives; the nurse auxiliaries from all of the municipal health posts, some of the staff of the Puka Wayq’u health center; a couple of NGO representatives (from Plan International); and finally a significant number of ordinary local community members (with numerous babies): no large and noteworthy meeting in Bolivia is ever truly “closed” to the general attendance of all interested parties. All told, there were approximately 30 community representatives present. The joint meeting’s nominal moderators were Javier Quispe, in his quality as the Puka Wayq’u health center director (and still only a few weeks on the job); and Gabriel Saavedra, the mayor of Puka Wayq’u. They were joined by two high-ranking officials from Sucre, both nurses, in presiding over the gathering: one of the licenciadas,⁴¹ Amalia

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⁴¹ The title in Latin America of licenciado(a) (abbreviated as “Lic.”) corresponds to someone who has completed an undergraduate university education, in a given profession; that is, a B.A. or a B.S. degree. Similarly, in still colonial
Delgadillo, represented the SEDES Chuquisaca as the technical coordinator for women’s health, part of the Office of Maternal and Child Health; the other, Marina Quiroga, was in charge of the Chuquisaca office of PROSIN, a USAID-financed and administered NGO, which included a central focus on reproductive health. It soon became apparent that these two women were to essentially conduct the day’s agenda, and to direct the meeting as a whole.

Before long, I understood that the primary objective of the gathering was to begin adopting the second stage approach, as described above: that of implementing a standardized protocol for better putting previously established emergency measures into effect. At the outset of the meeting, the local and departmental health officials laid out the worrisome panorama to the assembled communal delegates, as they saw it: the official version of the recent deaths—as presented in a lengthy, overly didactic and borderline paternalistic manner, partially in Quechua, partially in Spanish—was framed as a direct consequence of two seemingly contradictory arguments (although these were not overtly acknowledged as such). First, that the governmental health services had not penetrated far enough into the municipality: the official facilities were too few, and another health post (probably in San Marcos itself, it was strongly suggested) might be

and hierarchically conscious Bolivia (post-2006 MAS ascension notwithstanding, it bears repeating), it is invariably used frequently, and often enough somewhat obsequiously, as an obligatory honorific when referring to the respective person at hand who has achieved the recognized degree—for example, “as the licenciado has already expressed”; or, “Lic. Marina, I’d like to ask you the following question…”

42 The Integral Health Project (Proyecto de Salud Integral, PROSIN) was a nationwide program initiated in 1998, through a bilateral agreement between the Bolivian government (i.e., the Ministry of Health and Sports) and USAID. As described in a later United States government final audit report, it was “the project through which USAID/Bolivia provides financial resources, technical assistance, training and other support to the public health care system. The project promotes women’s empowerment by helping women identify and prioritize household health needs, overcoming barriers to the use of quality health services, and encourages local health service providers to provide more client-oriented services” (USAID 2007). Somewhat beyond and exceeding this stated mandate and scope of work, however, PROSIN since the year 2000 had as an institution attained significant influence at the national governmental level in Bolivia, reflecting the decades old financial and political power of, and dependency on, USAID. Consequently, it maintained a not so covert, and anything but subtle, role of actual state policy formulation and direct decision-making control in the Ministry. In 2006, as part of its sweeping overhaul of the governmental health care system at all levels and in the name of “decolonization” and “national sovereignty,” the new MAS government ordered the total closure of PROSIN, effectively the first effort at dismantling the national health policy authority of the United States in Bolivia, as exercised via USAID. (See Johnson 2010.)
a good idea. Second (and at any rate), the local communities were undeniably guilty of an endemic non-attendance at the already existing services and facilities, and of a generalized non-compliance with overall official health recommendations and guidelines as outlined in government posters, brochures and organized community educational meetings—specifically, as these pertained to maternal health issues. “Why don’t mothers come in for their prenatal check-ups?” was the repeated question to the assembled listeners, actually more of a demand, by Quispe, Amalia and Marina; “Why don’t they come to the health center for their births?” They also incorporated a more tragic, guilt-laced appeal: “There are now three widowers and 24 orphans in the San Marcos communities,” intoned Marina gravely, “this trend cannot continue,” to which the assembled delegates said nothing. Increasingly, it seemed to me that the community was becoming set up in what was beginning to look suspiciously like a “blame the victim” framework: admonished for not abiding by the officially established rules of the game, and for not allowing the state to play its sanctioned (biopolitical) role, that of the chief (if not sole) agent and arbitrator of the community’s health, in this case through its self-affirmed hegemonic prerogative for maternal care through “institutional births.”

Thus, having transgressed by not following the officially established course of action, the communities were now paying the price through the recent string of deaths. The approach adopted by the representatives of the health services was, therefore, a variant of the stern “Okay, let’s not let this happen again” discourse. Or, as imparted through a lens with a disciplinary pedagogical focus that verged fairly unambiguously along the lines of something like Scheper-Hughes’s remarks (in reflecting and expanding upon critical meditations made by Foucault) concerning a “hostile gaze, the punitive net of surveillance cast by the state and its disciplinary and biomedical technicians over the sick and deviant majority” (1992:272). (Which, in her case
in considering the Brazilian reality, was more of an *averted* gaze by the authorities, one of neither seeing nor caring.) Notably, at this and subsequent meetings, I discerned the vague contours coming together of what might even be called a subtle “cover-up”: by overtly incriminating the community for its non-cooperation with the official health care model as the central rationale for the slowly developing crisis (and which was soon to be a rapidly escalating one, following Severina’s untimely death), attention was deflected from a concurrent internal shake-up which was brewing—an implicit acknowledgment of significant medical culpability—and which was to eventually come to virtually dominate the health discourse in the municipality.

Although the initial message emphasized by the health services representatives was one of displeasure and reproach, almost a scolding of the community, it later turned in a more explanatory, if not conciliatory, direction. Amalia outlined the three delays model, the obstetric risk factors, and the need to accept the local nurse auxiliaries as completely trusted members of the community. Marina advocated for an active collaboration with the local parteros—which applied for the most part solely to Rosendo Durán, who had attended Damiana’s labor and was the only identifiable community birth attendant currently active in the altura region. However (and as previously mentioned), he was not originally an organic, empirical partero, but rather one who had been delegated to receive training under government and NGO sponsorship. (Rosendo himself, sitting quietly in the back of the room, failed to speak up at all during the course of the Villa Rosario meeting.) Quispe, for his own part, adopted an unambiguously collaborative tone that was impressive in its authority and in its comprehensiveness, with a number of positive goals—and yet what was for him to be, at this still extremely early juncture in his tenure as the Puka Wayq’u health center director (and as I will discuss in greater detail below), an
unfortunately short-lived embrace of the inclusive “we want to learn from you, because you have
the solutions” doctrine:

The solution is in the community; we all need to work together. I’m young, I’m new
here, and I bring new ideas. We can do a lot together, by working as a team. We, as the
health services, need to think about and analyze what you’re telling us here today, and
about what we’re going to do. This is our strategy: first, a mobile medical brigade
[brigada móvil] will be doing a tour throughout the communities. Second, the medical
interns from the Puka Wayq’u health center will focus more on the communities,
especially San Marcos, for at-risk pregnancies. Third, we’ll begin an intense vigilance
for pregnancies, new mothers, and sick babies—the compañera Celia [the local Plan
International representative] and her community health worker mothers [madres
vigilantes] will help us with that. Fourth, we’ll implement partos humanísticos: family
members can be present during the birth, which will be in whatever position the mother
prefers, with a partero if she prefers, but a doctor will always be there in case of any
problems. Fifth, better coordination with the parteros; we need to identify more parteros,
they need to help also. Sixth, we’ll try to get a phone line installed for the San Marcos
health post, if it gets built. Seventh, the problems with transportation: there’s a new
ambulance that’s going to arrive in Puka Wayq’u, and we need to station it here right
away; also, we need to put the three motorcycles that are idle in the municipal garage into
service, as they should be—and, we need collaboration from the town hall, for gas and
maintenance.

All well and good, and Quispe’s speech was very positively received by those present;
the “humanized birth” pledge especially provoked the most interest, including a flurry of
whispered exchanges, poking and muffled giggles among several women. Yet, in all its apparent
sincerity and sensible practicality (if not time-tested in multiple experiences, both national and
international), and which gave the impression that Quispe had read up on and supported the latest
publications by academics and activists who advocated “alternative” birthing practices, it was
nevertheless very much yet another expression of the on-again, off-again officially sanctioned
state line in rural obstetric care of community involvement and collaboration, and very much in
line with the non-committal nods to primary health care which had been prevalent over the
preceding decades in Bolivia. In addition, and as later confirmed to me by both Quispe and the
Amalia / Marina team, it had been a completely spontaneous speech, not previously planned by
Quispe in order to outline new policy strategies, but rather what he had deemed, off-the-cuff and in the moment, to be the most appropriate thing to say to the assembly. (In addition, Mayor Saavedra was to later grumble that the pledge about providing gas and maintenance for the health center vehicles, while indeed being somewhat assumed and something of a given in the usual course of municipal administrative and technical responsibilities, was not yet formally incorporated into the current Annual Operation Plan [Plan Operativo Anual, POA], and consequently Quispe’s promise could cause the municipality some unplanned financial inconvenience.)

For their part, both the dirigentes at the meeting and the assembled community members in general maintained that the core issue was that of insufficient and deficient medical personnel. Marina and Amalia conducted a participatory exercise in which they listed (in Spanish), on large sheets of paper taped to the wall, the opinions called out (in Quechua) by those present, under the title of “Health Problems in Villa Rosario, of Pregnant Women.” The remarks expressed were not so much the problems themselves, but rather the causes of the problems, and were overwhelmingly both an implicit and overt condemnation of the health services. With frequent repetition and redundancy among those present, the primary reasons voiced in synthesis were:

The health attention given in the health post isn’t any good;
They make us wait a long time in the health post;
The auxiliary nurse isn’t around often, and when he goes away, nobody attends to us;
For a long time, there wasn’t anybody at all in the health post [following the departure of the previous nurse auxiliary, Julia];
The health personnel don’t visit all of the communities at all frequently;
There’s no ambulance.
Although one person offered that the community should meet more frequently to discuss the local health problems, and another noted simply that the geographic distances between the widely dispersed communities were in themselves a limiting factor for adequate attention, only one person out of the several present made the observation that women only infrequently, if ever, went to their scheduled prenatal controls. Although, and when considering the negative opinions generally voiced in respect to the perceived quality of the available health services, it should be recognized that a relative non-attendance and non-compliance with the health services norms and regulations seemed quite understandable and logical.

Yet, and despite the general line as expressed above, the debate increasingly turned to one of actual infrastructure, and that a new health post (in San Marcos) would indeed solve the sudden maternal health dilemma. This was somewhat paradoxical, in that the question of actual community usage of such a proposed facility was thus sidestepped, both in light of the opinions previously expressed and without discussing the undeniable fact (based on monthly records of prenatal check-ups and births attended by state personnel, dating back years) that the use of the already existing health services for pregnancy and birth was indeed highly minimal. In the particular case of the dirigentes and local authorities, one interpretation is that the issue was more that of establishing and maintaining a claim to “citizenship” within the existing state structures, for what they saw as possible routes to a perceived variant of “modernization” (through increasing the official biomedical services) and social and political ascension—and especially as it was then being expressed, in the company of the high-ranking municipal and departmental authorities. In this analysis, there are parallels with the observations previously noted of Crandon-Malamud (1991), concerning health choices and health services utilization within an environment of health pluralism on the Bolivian altiplano. Following this model, in determining
how and why people make the choices that they do in seeking (or not seeking) medical attention from the different health care providers available, the decision-making process concerning health and efficacy is not so much a biomedical issue, but rather one of cultural relations, economics, and perceived sociopolitical opportunity—thus, it extends outward into the community at large, adapting itself to the specific cure and healer as the respective situation requires.

Along these lines and under the circumstances present in Puka Wayq’u, the choices made (or at least advocated) by the local authorities as to what the most recommendable course of action should be closely paralleled the official direction typically promoted by the governmental authorities themselves, including those at this particular gathering (notwithstanding Dr. Quispe’s impromptu ode to the spirit of obstetric interculturality): that of state-sponsored biomedicine, at the expense of more pluralistic, intercultural options. However, I suspect that this perspective held more sway with the actual dirigentes than with the overall community members in general; one example pertaining to this (as commented upon by numerous mothers) was the existence in the Villa Rosario altura communities of a reported sindicato decree, which imposed an economic fine (five pesos bolivianos) for not using the health post. This was, it seemed to me, a rather curious attempt to determine people’s health choices for them, and to coerce them into acquiescing to what was considered “better,” if not simply more “politically advantageous”; in a way, a kind of both perceived and enforced modernity. At any rate, the sindicato decree seemed to be wholly ignored by the general populace and in actual practice wholly unimplemented by the dirigentes themselves, who—when on a few different occasions I persisted in asking various individuals directly about the fine—would only reluctantly and uncomfortably acknowledge to me, in an oblique fashion, that it even existed.
Throughout the afternoon, and regardless of the specific topic at hand, a commonplace gender divide was apparent among the participants. Despite this being, at least on the immediate surface of things, a “woman’s issue,” nearly all of the women actually present sat at the back of the room in a group; in contrast, the men lined up along benches toward the front. Most of the talking and opinions expressed were by men, and as a group a number of them were bored and fidgety. Although the women were on the whole much more attentive, only one or two among them spoke up at all during the meeting; for the most part, they repeated the previously voiced complaints about there not being enough health personnel on duty at the Villa Rosario post. The only exception to this overall lack of participation was Doña Santusa Claros, one of the Puka Wayq’u municipal councilmembers present, who frequently spoke up with questions and comments. Indeed, she was one of the most outspoken people present, and the only person to take on the issue from a “woman’s point of view”: mothers don’t want to have medical and gynecological check-ups with men, she pointed out, because they’re embarrassed, it isn’t part of “our culture”—a fact that was hardly a revelation to anybody in the room, the health personnel included, but nobody else was speaking up in order to articulate the obvious. Besides that, Doña Santusa continued, women have a right to have access to contraceptives, but “we can’t get any in Puka Wayq’u, there isn’t anything at all in the health posts.” Despite these lone exceptions, however, the community voices at the meeting were overwhelmingly dominated and controlled by men.43

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43 Doña Santusa herself was a troubled figure, throughout our years in Puka Wayq’u. Elected as a town councilmember in the previous elections on the same political ticket with Mayor Gabriel Saavedra, that of the Free Bolivia Movement party (Movimiento Bolivia Libre, MBL; now defunct), Doña Santusa and her other female colleague on the Town Council, Doña Silveria, both Quechua campesinas, were essentially political puppets, recruited in order to comply with national Electoral College regulations that all party campaigns for public office include women as at least 30% of the presented candidates on the ticket. Although both women held their own during their time on the Town Council, and on some issues were quite vocal, they were certainly far from being power brokers, and Doña Santusa suffered much in terms of her own political legitimacy and viability due to her personal life. A married woman with three small children, she became involved in a romantic affair with the driver
This last point as raised by Doña Santusa, in regards to local contraceptive availability, was especially divisive in addition to being politically sensitive—and also in addition to its obvious relevance to the maternal health issue at the forefront of the debate. It was a frequent underlying yet unspoken current in sexual and reproductive health care not only in Puka Wayq’u, but also in the other six municipalities that were part of Health District 2: effectively, in the entire district there was an actual prohibition on any form of artificial birth control. Since 1978, the health district and the health services of its municipalities had been administered from Sucre by a program affiliated with the Catholic Church, the Cardinal Maurer Health Project (Proyecto de Salud Cardenal Maurer, PROSCAM). As a formally constituted Church – State contract for implementing a specific program (the only administrative arrangement of this kind in the entire country), PROSCAM had direct budgetary and hiring power within the governmental health services, in the respective municipalities included in the project. Although ostensibly solely an administrative arrangement, and still officially under the political control of the national Ministry of Health and Sports in conjunction with the SEDES Chuquisaca, in the institutional flow chart of the Chuquisaca prefecture PROSCAM was actually placed hierarchically above Health District 2 (albeit still not technically part of the ministerial structure), and exercised an almost total command there in planning and setting overall health policy. As managed by its long term and elderly director, Lic. Ruth Sensano, a registered nurse, PROSCAM’s original and still
ostensibly primary focus was on Chagas disease control in the district. However, its long arm was felt in all aspects of the health care system, especially in its hiring and firing veto power over health center personnel and in the decision making influence on annual budgets firmly held by “Señorita Ruth.” (Sensano, although not actually a formally ordained member of any Catholic order, was colloquially referred to by most in Sucre as “la monjita,” the little nun, or “la hermanita,” the little sister—although these were not used with her directly, as they were typically employed in terms which were not particularly flattering. “Señorita” was the more common title employed in her actual presence, which while presumably more respectful, was not without a certain sideways irony). In effect, most all programmatic decisions in the district ultimately had to pass through PROSCAM, whether at regularly scheduled planning meetings, or at technical evaluations.

The administrative and technical arrangement with PROSCAM went back several years, and was never seriously questioned or challenged in the seven affected municipalities—until

44 I personally ran afoul of Señorita Ruth, in the course of formal research. At the initial introductory meetings I requested and held with her early on at the PROSCAM offices, located downtown in the Archdiocese of Sucre, she was very open and cordial, expressing an interest in my project and pledging the support of both PROSCAM as an institution and of herself. As I had already become aware of the technical control and the political weight of PROSCAM on health issues in Puka Wayq’u, I certainly understood the importance of establishing and maintaining good relations with her. However, at our third meeting, after I had been in Puka Wayq’u for several months, I made the mistake of asking her about the growing division between PROSCAM and the municipality, precisely in regards to the lack of access to contraceptive methods and the possible relationship of this to the recent maternal mortality cases. Denying that there were any conflicts with Mayor Saavedra or the Puka Wayq’u Town Hall, she told me that she didn’t like “political” questions. “We’re not a dictatorship, we’re a democracy,” Señorita Ruth informed me, her voice rising. “Women are free to do whatever they want. But we don’t do family planning. We know what the health situation is like; we’ve worked in Puka Wayq’u for 25 years. And you, how long have you been there?” “Well,” I commented, unsuccessfully trying to calm her down and get her back on track, “it’s just that there may be some association between this and the problem we’ve seen with maternal deaths recently…” “There is no problem with maternal deaths,” Señorita Ruth retorted, perhaps realizing that if she were to acknowledge that there was indeed a problem, then the 25 years of PROSCAM involvement in Puka Wayq’u were not put into a very positive retrospective light. “Those were isolated cases. Do you want me to talk badly about my institution? Do you talk badly about your wife? I’m not liking this very much, Mr. Anthropologist. I know what anthropology is, and this is not anthropology.” Recognizing that her position had turned perhaps irreparably defensive and hostile, I cut short the interview in as polite and diplomatic a fashion as possible, under the circumstances. This was to be the last time I had any personal contact with Señorita Ruth. However, I was to feel her now confirmed animosity soon enough, near the end of the year, when I was alerted by a few of the Puka Wayq’u health center personnel, in whispered confidentiality, that she had issued a thinly veiled warning against further collaboration with me—which was, fortunately for my sake, for the most part unobserved, or at the most only superficially and ineffectually so.
now, in Puka Wayq’u, and with the looming maternal death crisis at its center, and as couched in the debate over contraceptive availability. Being a project directly affiliated with the Church, and as conducted for decades by Señorita Ruth, all forms of artificial birth control were strictly prohibited in the municipalities under PROSCAM control, whether in state facilities or as part of an NGO project. This dictum applied not only to the official state health services, but also to private pharmacies: although there were none in the town of Puka Wayq’u, at the geographically closest pharmacy—located in Tarabuco—it was indeed impossible to openly purchase any form of artificial birth control. An interested individual had to know how to navigate the unofficial system. In the case of Tarabuco, condoms at the least were available literally “under the counter” at the local stationary and school supplies store; in Puka Wayq’u itself, Don Roberto’s tiendita on the plaza had condoms for sale.45

Moreover, and up until as late as 2003, it was also prohibited by PROSCAM for the health services to even (openly) discuss birth control with the populace—although all acknowledged that it certainly happened behind closed health center doors, and without any notation in official patient medical files. This meant that, for anything other than clandestine condoms, a woman and / or man had to make the trip to Sucre in order to have access to such

45 In the case of Puka Wayq’u this was a discovery that I made some months after first arriving in town, in true outsider participant observer fashion. Someone or other eventually felt comfortable enough to confide in me that I was mistaken about the complete local unavailability of birth control methods: “Actually, that’s not entirely the case, Don Brian; you can get condoms in Puka Wayq’u. Go to Don Roberto’s.” When I hurried over to the tiendita to confirm this, Don Roberto’s assistant, a teenager nicknamed “Billete” (money, dollar bill), cheerfully exclaimed with an unquestioning openness, almost as if he were surprised that I’d never asked before, “Sure, Don Brian, we have condoms! Right over there in that box, underneath the other box.” “Wow,” I mused, “and people buy them?” Billete enthusiastically assured me that the condoms sold quite well. “People from the communities buy them?” I insisted. “Oh no, no,” he corrected, “people in the communities don’t want those, they don’t know anything about them. They don’t buy condoms.” So…? “People from the institutions buy them,” Billete explained. “Municipal employees, from Town Hall, and the health center, or the NGO people. For the fiestas.” This was a stunning revelation for me. Additionally, I found it necessary to recognize that the previously unforeseen implications for further analyzing yet another facet of local social relations—between the indigenous / campesino population, and the white collar workers contracted from the city to staff the municipal offices and the ubiquitous NGO projects—implications which could include a theoretical spectrum ranging from gender to patriarchy to subalternity to economic capacities to knowledge and power differentials—seemed endless…
methods as, for example, oral contraceptives, intrauterine devices, or Depo-Provera injections. Although not by any means an immense and prohibitive journey, it was nevertheless potentially problematic for many people in a number of practical ways (economic, work responsibilities, ongoing medical follow-up), and was at the very least an unnecessary personal imposition. Minimally and as a matter of simple legalities, in this manner the PROSCAM program stance directly conflicted with the official Bolivian sexual and reproductive health rights policy guidelines, norms and laws which had been in a steady and sequential process of development and consolidation since the early 1990s starting with Plan Vida (Ministerio de Desarrollo Humano 1994); and, in 2004, culminating most prominently (at that point in time) with the National Sexual and Reproductive Health Program and the National Contraception Plan (MSyD 2004). In the case of Health District 2, this was also simultaneously implemented through USAID and the PROSIN program, and their promotion of the official government policies in regards to sexual and reproductive health (although not including the actual provision of any contraceptive methods). When faced off against these other parallel structures, the reasons for the undisputed endurance of the overriding PROSCAM authority as a quasi-independent health policy in seven municipalities, and despite the frequent sotto voce off the record grumblings I would hear—which ranged from the personnel at rural health posts in the likes of Puka Wayq’u, to the offices of the SEDES in Sucre—had everything to do with the obvious: it was the Catholic Church, and that was reason enough for not causing trouble. Yet, the theoretical connections between the draconian and theocratic regulations in the PROSCAM municipalities and Señorita Ruth’s autocratic influence; women’s sexual and reproductive health in general; and the recent maternal deaths among women who had had multiple pregnancies in particular, were all but undeniable—and, indeed, acknowledged and confirmed by both maternal health theory
and experience in general, and by the restive local health personnel in particular. Consequently, and even when recognizing the PROSIN influence at both the national and departmental levels, the PROSCAM authority was yet another ironic layer of external political control parallel to the Bolivian state, within one individual municipal micro region. Not too surprisingly, relations between the two institutions were poor, as Señorita Ruth herself had made clear enough to me through a number of disparaging remarks during the course of our first meeting.  

At the DILOS meeting in Villa Rosario, and following Doña Santusa’s denunciation regarding the availability of contraceptives, the key municipal and departmental individuals managing the discussion quickly and not so subtly latched onto the issue in order to advance specific personal and professional agendas. And, despite the unquestioned institutional power of PROSCAM at the local level, and the political power of the Church that stood behind it, it was evident that it was precisely PROSCAM itself which was increasingly becoming the pointed   

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46 I often pressured Dr. Fulvio Arteaga, of the SEDES Chuquisaca Office of Maternal and Child Health, about the origins of the PROSCAM / SEDES relationship, and why it persisted—that is, once we were reasonably able to get past the overall questions of historic Catholic Church power and influence. He himself was uncertain about it, and could not cite any concrete laws or papers that “legitimized” the arrangement, aside from the fabled Church – State contract itself—which was, however, nowhere to be found in Sucre and which nobody, apparently, had ever actually seen. “Maybe at the Ministry in La Paz there’s some sort of documentation,” he suggested on one occasion, with a shrug and a smile that I interpreted as a task he was assigning to me, something that for him was not “politically” possible.  

And so, on my next visit to La Paz, I did just that. At the Ministry of Health and Sports, on the always hectic and traffic clogged Plaza del Estudiante, I located the cramped and dusty official archives room on the bottom floor. There, with the help of the sole records employee on duty and after only a mildly time consuming search, we found the yellowed and bound pages of the original document. A Church – State contract (again, the only one of its kind in Bolivia), granting technical and significant administrative control of Health District 2 in Chuquisaca to PROSCAM, it was signed on June 5, 1978, by Cardinal Clemente Maurer himself, representing the Archdiocese of Sucre; and Lieutenant Colonel Guido Vildoso Calderón, the titular authority of what was then known as the Ministry of Social Security and Public Health. The intriguing point, as I realized at that moment, was its genealogy: a Church – State contract signed during one of the most turbulent periods in recent Bolivian history, between 1964 and 1982, when military regimes and nominally elected civilian governments alternated back and forth, representative manifestations of the ongoing crises of weak parliamentary democracies and the bloody military coups d’etat that inevitably truncated them. The PROSCAM contract was signed precisely during one of these de facto military governments, in the final days of the infamous General Hugo Banzer Suárez regime. Once back in Sucre, I excitedly informed Dr. Arteaga of my discovery: “It was Banzer! An illegitimate de facto government! Fulvio, the whole PROSCAM thing is illegitimate! Can’t the SEDES just break the contract, just walk away from it?” However, that was as far as it was to go with my particular line of reasoning, as Dr. Arteaga ironically shook his head, bringing me out of my temporary self-induced delusional naiveté and back to reality, by reminding me again of what was, for the government health services, the glaringly obvious issues of realpolitik: it was the Church we were dealing with, and so we were to proceed with business as usual.
target of choice for other respective power interests, albeit restrained in an overtly public manner. For Marina and Amalia, the aforementioned ongoing conflict with the institution over reproductive health, and who had the final word on actually determining recognized and effective official policy, was the preeminent issue. PROSCAM was yet another contender in the crowded field of political actors who claimed significant levels of decision-making authority over sexual and reproductive health, yet which would frequently contradict the opposing institutions and ultimately cancel each other out. In representing the SEDES—and thus the Ministry of Health and Sports, and beyond that the Bolivian state itself—Amalia would have appeared to have been the highest ranking health services person present, and with the most at stake; theoretically, no-one else in Puka Wayq’u should have been officially articulating national health protocol, especially in the context of the current mortality situation. Thus, and when taking into consideration its egregiously biased local policy as based on religious precepts, PROSCAM was an easy target, albeit a risky one.

“Their family planning position is terrible, horrible,” Amalia complained to me after the Villa Rosario meeting, “it causes so much damage. They have to change. Hopefully, within a couple of years.” However, it was apparent to me that for her, besides the glaringly evident institutional questions of sovereignty—a Church-based entity which held what discomfortingly amounted to the “final word” in reproductive health matters, within a significant part of the national territory under SEDES Chuquisaca jurisdiction—it was also something personal for Amalia. Stripped bare, it was a power struggle with Señorita Ruth and PROSCAM, over who legitimately articulated and implemented state policy for maternal health—not only in Health District 2, but also by extrapolation in Chuquisaca as a whole. In the particular case of Amalia, however, there was on the one hand the debilitating factor of her own professional instability,
within the frequently shifting environment of personnel shuffles among government employees (hirings, firings), as based on ever-fluctuating Bolivian political realities, and as contrasted with the firmly entrenched and seemingly eternal presence of Señorita Ruth. And, on the other hand, there was the inherent irony of this politically “righteous” stand for institutional sovereignty on the part of the state health authority when concurrently, at Amalia’s side and as her most prominent ally in the conflict, was Marina in representation of PROSIN: yet another institution that, while apparently functioning most visibly as technical support for the MSyD and the SEDES, was in actuality another variety of shadow government that unequivocally influenced the direction and implementation of national health policy.

In the particular case of Marina, similar issues were at play. For her, both the maternal death crisis itself, and the related issue of contraceptive availability which came prominently to the forefront during the Villa Rosario meeting, were personal and professional challenges. A licensed nurse, Marina had worked for many years and under differing political administrations with programs addressing the persistent dilemma of maternal mortality, and it had become for her almost a personal crusade. At one point she had shared with me long reminiscences about her close participation as a researcher and interviewer with the previously mentioned 1993 - 1996 obstetric risk and maternal mortality ethnographic study, in Chuquisaca and Potosí departments—research that had produced significant data (Arnold et al. 2001, Arnold and Yapita et al. 2002, Bradby and Murphy-Lawless 2002), yet only limited health services recognition and with virtually no lasting results at the official policy levels. The question of unequal and inequitatable levels of preventable deaths among the indigenous populations where she had long worked (Chuquisaca, Potosí, Oruro), and in particular considering the current upsurge in Puka Wayq’u, obviously weighed heavily upon her. Besides the elevated maternal mortality rates
which had so occupied her professionally for years, also troubling were the (controversial) findings, a semi-independent offshoot of the Bradby and Murphy-Lawless team study, about supposed widespread infanticide among rural Quechua communities in northern Potosí, and what was the apparent (albeit still formally unconfirmed by other researchers) complicity of mothers themselves in what were, allegedly, effectively the induced and hastened deaths of their children (in relation, see Platt 2001).47 “Only the fit survive,” Marina ruefully commented to me, shaking

47 The apparent similarities and parallels between the Platt study and the situation in Brazil as discussed by Scheper-Hughes (1992) are obvious. However, there are key differences in the findings as analyzed by the respective authors. In Scheper-Hughes’s analysis of the Brazilian urban shantytown poverty context, the mothers adopt a “wait and see” attitude toward their children for the first year or more of life, in order to determine whether these are “fighters,” and so will survive; or, if they are in fact “angel babies,” mistakenly sent to earth and unavoidably ordained to perish. This belief system is shaped by the daily grinding structural violence reality of the women’s lives, most prominently the persistent lack of sufficient food and a subsequent low-level yet endemic starvation; the result is a chronic “madness of hunger” which breeds, says Scheper-Hughes, “nervous sickness” and a fatal indifference to the possibility of child death. (I myself learned of a similar case in the town of Puka Wayq’u, yet which however more approximated a case of outright hostile negligence. A young mother from one of the altura communities had arrived in town, where her husband was working as a laborer, and had given birth in the home where she was temporarily staying. She refused to breastfeed the newborn at all, and showed no perceptible interest in its welfare—even indifferently and forthrightly declaring “Let it die.” Before anyone had alerted the health center to the situation, the mother disappeared from town with the infant; some weeks later word filtered down from the altura that the child had indeed eventually perished.)

In contrast, in the Platt study of heavily Quechua rural northern Potosí department, specifically the municipality of Macha, the identified cultural belief patterns focus on a supposed “mytho-historic psychodrama” of social relations waged between the mother and the fetus in the womb, and then with the child after birth. In what might even be characterized as a kind of internal, “gestational” form of conflict and crisis, the fetus is a dangerous, aggressive entity, associated with a pre-Christian demon figure, a player in what is defined as an open “combat” and which must be forcibly expelled at great risk to the mother. As an event revolving around the dual and complementary processes of both birth and death, the newborn baby will then represent, in its early stages, the mythic origins of pre-Conquest society in a struggle between the emically perceived notions of “Andean” and “colonial.” The infant is seen as continuing to harbor a pagan soul which must be “domesticated”—most prominently, through the Christian baptism—and which must be forcibly “separated” from and later “reconciliated” with the mother via different rituals, in order to fortify it for survival in the Andean-Christian world. Therefore, once born the baby must confront a battery of psychological, emotional and physiological lessons of nutritional and physical deprivation, and subsequently learn to “control” its hunger and discomfort; this is perceived as a “conciliation between the voracity of pagan ancestors and the alimentary discipline of Andean-Christian society” (2001:674-675). As concrete aspects of this “acclimatization” process, urine is the first liquid given to the newborn, and no breast milk (and thus colostrum) is allowed for three days; also (not directly discussed as such in the Platt article itself, but addressed to me personally by Marina), the baby is left to sleep alone in inhospitable corners of the home, and often no adequate clothing is employed for up to three months. Infant deaths are, unsurprisingly, not uncommon. Not considered by Platt, however, is the degree to which this parenting approach may be just as much socioeconomically based, as it is psycho-ethnologically—for example, how the chronic scarcity of available food and amenities throughout the rural Potosí communities may subtly yet implicitly influence maternal behavior. This, of course, would bring us back around in partial, yet significant, convergence with the conclusions of Scheper-Hughes, in her own respective research and setting.

Although not precisely part of my own research agenda, I was intrigued to hear some of my informants express an opinion that seemed to echo the Platt study (albeit within the Puka Wayq’u context, in Chuquisaca) in
her head in reference to both the mothers and the children who still seemed condemned to die prematurely. Yet simultaneously, the rivalry with PROSCAM was palpable in how Marina characterized the current critical situation, almost as a kind of impasse. First, there was the religious facet of the controversy: “If it isn’t part of the Church, then it’s heresy,” she ironically grumbled in reference to the ideological course imperviously laid out by Señorita Ruth and PROSCAM. Alongside of this, there was, as discussed, the undeclared yet subtly clear posturing of PROSIN for institutional political hegemony in the health district, ostensibly in a consultancy relationship yet, in actual practice, over state institutions such as the SEDES (although this was always implicit, and never explicit). This was just as it had been similarly conveyed in a parallel fashion (to me, by Señorita Ruth herself), and in opposing counterpoint, by those at PROSCAM in regards to their own respective ideological and political interests.

Along these same lines, there were other personal and political interests present at the DILOS meeting, with their own unique perspectives on the unfolding developments. Celia Ramírez, the nurse who represented Plan International in their local maternal-child health project in Puka Wayq’u, with a regional base in Tarabuco, also made her own periodic, sideline and somewhat denigrating intromissions regarding PROSCAM, within the subtle power politics evident during the DILOS meeting. A member of one of the many evangelical Christian

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respect to a supposed fearful “mytho-historic” component of pregnancy, and the expediency of swiftly and safely expelling the fetus. Demetrio Arancibia, the local dirigente in Yomala, in the course of conversation began to explain to me the supernatural dangers inherent (for the child itself) in the death of an unbaptized infant, whether inside or outside of the mother’s womb: “They say that if it isn’t baptized, then its soul goes straight to Hell.” (I later heard similar versions of such a possible fate from others in both Yomala and Puka Wayq’u, yet who claimed that the unbaptized dead infant was transformed into a devil or a duende—a malicious elf, or goblin.) “They say that the devils take it down, and then they make it hail. So, if the child isn’t baptized and it dies, there can be a disaster in the community. There could be a terrible hailstorm, or a terrible wind, or there could also be a flood. They can also make it flood, no?" (All of these extreme weather events are potentially catastrophic in rural areas; in the case of severe hail, the possibility of significant crop destruction, and consequent economic disaster, is dangerously high.) As to my question of whether, with such a consideration, a divinely condemned unborn baby could cause any peril to the mother herself during pregnancy (beyond the standard issues of obstetric risk), Demetrio replied, “Of course. There can be those lightning bolts and thunder they say, no? The pregnant woman needs to be very careful of that, because it comes in through her head and it kills her, they say, just as if she had fallen from a tree. It tears her right apart, just like that.”
denominations that claim adherents in Sucre, Celia’s personal religious faith would regularly pop up in conversation over the years I knew her, and she seldom overlooked the opportunity to utter an off-handedly negative comment about the Catholic PROSCAM. On this particular occasion with Amalia and Marina, she chimed in with the informal chorus of denunciations with the vaguely sneering remark that “I bet the Church even actually hides maternal mortality cases, because they’re so implicated in them.”

Conversely and for his part, however, Dr. Quispe throughout the day’s proceedings increasingly maintained a low profile, and following his early morning pledge of community collaboration he said little of any technical or programmatic importance (in regards to either the PROSCAM debate or anything else), leaving the overall conduction of the meeting to Marina and Amalia. This, something of a tempering of his initial bravura (despite his position as the chief medical official in the municipality), was undoubtedly due to his status as a still relative new-comer to Puka Wayq’u and its affairs, and his own uncertainty and hesitancy in the face of what was obviously a very undesirable mortality event within his jurisdiction so early in his mandate. It was also most likely related to a clear disinclination to express any opinions at all concerning PROSCAM—after all, his hiring had been personally approved by Señorita Ruth. However, the very next day he unleashed a weary tirade to me in private, grumbling that the Puka Wayq’u health system “doesn’t work from top to bottom, it’s all vertical and demagogical, I can’t get a damn thing done,” while accusing the local population in general as being totally dependent on government services, and unable to see beyond the health infrastructure and personnel issues. Refusing to comment in any significant fashion on the role of Señorita Ruth and PROSCAM, Quispe instead focused on Mayor Saavedra and the Puka Wayq’u municipal administration: he complained that there were no decent budget allocations for the health center
and community posts, nor adequate money for any additional staffing; and, that in addition there
was an openly hostile attitude from the mayor, who had supposedly recently referred to the entire
local staff of the health center as a “bunch of clowns” (*payasada*).

Saavedra, for his part, took advantage of the occasion to work the room with the more
long-term objectives of his well-known, but not yet officially declared, re-election campaign for
the upcoming municipal elections in December of 2004. His open agenda was the promotion of
what would eventually turn out to be the most serious challenge to the PROSCAM hegemony in
Puka Wayq’u to date: that of a sexual and reproductive health care project that had recently
begun operating in the municipality. Initiated in late 2003 by a small NGO which only operated
in southern Bolivia, called the Center for Regional Development - Tarija (*Centro de Desarrollo
Regional - Tarija, CEDERTA*), as run through its Chuquisaca satellite office it was financed by
USAID, which had effectively become Saavedra’s funding agency of choice. This in itself was
indicative, in that it essentially meant overlapping U.S. government health projects (together
with PROSIN) in Puka Wayq’u, significantly “calling the shots” on municipal health policy in
what the mayor proclaimed had been designated as a USAID “pilot municipality.”

The CEDERTA project, which would continue until the end of 2004, extended its operations
to all 32 of the Puka Wayq’u communities, and consisted of a four person team of physicians that gave
educational talks on sexual and reproductive health, sexually transmitted diseases, and family

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48 In reality, the situation was even more extensive than it appeared. On March 16, the USAID Bolivia-financed and
directly staffed and administered national organization Partners in Health (*Socios en Salud;* no relation to the more
well-known international development and relief agency of the same name) had held a community-wide workshop
in Puka Wayq’u. The objective had been that of undertaking a municipal-wide diagnostic study, for establishing the
baseline information of what was to be the next Municipal Development Plan (*Plan de Desarrollo Municipal, PDM*)
with a 5 - 10-year projection. Although the workshop had gathered together most of the municipal employees and
campesino leaders for the day, and had drawn up an extensive blueprint for undertaking the actual study, over the
following weeks it gradually fizzled out and never came to fruition—very possibly a partial consequence of the
notably altered political environment following the maternal deaths. *Socios en Salud*, however—and by extension
USAID—managed to maintain its direct presence in the municipality as part of the technical advisory team on the
CEDERTA project, in addition to its more regional role with PROSIN.
planning methods. For the population of Puka Wayq’u as a whole, and for many of the isolated communities in particular, it was definitely something radically new to have participatory meetings with such detailed, open, and even explicit discussions and visual materials pertaining to sexual health, all presented in Quechua. By the end of the year, the project was a major success, markedly raising awareness of sexuality matters among community members who had previously had little if any clear understanding of such topics as birth control—and all of this to the obvious dismay of PROSCAM, which found itself unable to control or veto the (purely educational) CEDERTA activities, due to the project’s affiliation with an outside NGO and USAID, and which had managed to gain entry to the municipality. However, the ban on any actual availability of contraceptive methods in Puka Wayq’u held throughout the year, and successively into nearly the following three years; in the immediate sense, this translated into the situation of an unexpectedly heightened public demand for birth control, yet without any concurrent creation of a local supply. As a result, the off-the-record grumbling about family planning restrictions was brought to new heights significantly not just among the health personnel, but also among the general population.

The presentation of the CEDERTA project was also, importantly, couched within what turned out to be the initiation of a significant party politics build-up, orchestration, and eventual fall-out. At the Villa Rosario DILOS meeting, Saavedra in effect unofficially—or rather, symbolically—presented the CEDERTA project as one of his “big guns” for the confrontation against PROSCAM’s continued influence in the municipality—undeclared at first, but increasingly open in later months—that he was only then making his first substantial moves on. This was done with aims and objectives both “moral” and political: on the one hand Saavedra, with a nod to the acknowledged public health concerns and in what was his typical flowery
oratorical style, made much of how CEDERTA would provide necessary education for both men and women to make informed decisions about their own sexuality options; how they had been denied this for far too long (at this point, still without naming any names); and that this was indeed directly related to the question of maternal mortality currently under discussion. On the other hand, and as previously mentioned, however, Saavedra also had a blatantly political intent, which was evident in retrospect, although not as clearly so at that particular moment: that of a prominent health component in his soon to be declared re-election campaign. By taking on PROSCAM, he meant to, first, further consolidate the pseudo-“maverick,” “tough guy,” “can-do” image he often cultivated, by attacking what was indeed by all accounts a high-risk target; and second, to again emphasize his much-avowed strength at attaining financing for the municipality, most prominently through NGO projects associated with the likes of well-known and powerful Big Spenders such as USAID. What was notable at this particular juncture was how, unforeseeably but fortuitously for the mayor, his ultimate political interests had actually been facilitated by the sudden context of maternal mortality swirling around Damiana’s death. For example, on this date he had a ready-made forum in the assembled presence of many community dirigentes and representatives from a geographic region of Puka Wayq’u that Saavedra knew would be, for him, one of the more difficult sectors (the altura) in which to later win votes—and with the symbolic and substantial backing and actual presence of an important contingent of both municipal and departmental government authorities.

This embedding of Saavedra’s personal political agenda into what was part of a “just” campaign against the longtime undue influence of PROSCAM, in the interests of women’s health, was only to deepen yet more in a very brief period of time, as the mortality emergency later progressed. Yet ironically, ultimately the eventual political beneficiary of CEDERTA’s
work was not to be Saavedra at all. Instead, and as it was to become apparent later in the year, the entire project had had a covert political agenda unto itself, and indeed an electoral one, albeit not in Saavedra’s favor. (Although the degree to which USAID, as the financer, might have been aware of this backstory is unknown.) It transpired that the local coordinator of the project, Julio Taboada (not a physician himself, but an agronomist who had served as a town councilman in a previous administration), was himself planning on running for mayor of Puka Wayq’u in December of that year. And as it turned out, he was by far the best known candidate due to his personal involvement with CEDERTA in every one of the municipality’s communities: thus, the project had effectively served as his own extended and comprehensive—and conveniently well-funded—mayoral campaign. Taboada later unexpectedly defeated Saavedra in the local elections, in a contested process that was demonstrably marred by numerous electoral irregularities and questionable voter tally outcomes, in numerous communities. Afterwards, all of the CEDERTA medical team members were to find themselves contracted for relatively comfortable jobs, in both Town Hall and the local health services.

Finally, significantly and in reference to all of these sexual and reproductive health controversies which were both public health and politically motivated, there was not one representative from PROSCAM itself present throughout the day. Although Dr. Daniel Rivas, the health coordinator for the institution, was on the list of official invitees, he failed to appear. The suspicions which circulated afterwards—as voiced by Marina, Amalia, and Saavedra—were that PROSCAM, and by extension Señorita Ruth & Co., had been afraid to show up, because they knew that they might become a potential target. And, in effect this had indeed certainly been the case. Yet, and amazingly enough, Saavedra’s war was later to be actually won: in late 2007, PROSCAM initiated a sullen and bitter withdrawal from Puka Wayq’u—and only from
Puka Wayq’u, but not from the other six municipalities of Health District 2. Saavedra himself, however, was no longer around at that point to savor the results. The final blow to the long institutional history of PROSCAM was struck by his successor as mayor, Julio Taboada, who also came to realize the political expediency of challenging the program, despite the potential risks related to its Catholic Church affiliation, and aggressively questioned the lack of significant community health results despite over 25 years of work in the municipality. (I will make further reference to the PROSCAM exodus in Chapter 6.)

Thus throughout the day—this first salvo of what was to become a greatly intensified model of “crisis management”—a number of unresolved conflicts and power struggles, both old and new, were exploited for personal and institutional interests. Although topics of physical infrastructure and adequate coverage by existing health personnel in the municipality were superficially the primary concerns for most of those present, there were also questions of communal responsibility and culpability, personal political interests, and more specific policy debates around reproductive health and choice which were the actual themes of relevance.

Damiana’s death was thus the first “rupture” to have an impact on the local social and political fabric of Puka Wayq’u, the first openly acknowledged recognition of the wider long-term issues prevalent for years in the municipality, and was indicative of further changes yet to come in local community relations.

**Second responses**

The conclusions and proposals from the DILOS meeting on May 5 had barely been typed up, and the debate among the town council concerning how to actually implement the recommendations had certainly not yet been initiated in any meaningful kind of way. Then, without warning and completely unexpectedly, the death of Severina on May 16 plunged
everything and everyone into a sudden state of stunned disbelief and apprehensive paralysis. Initially, on the actual day of the emergency incident and following the dramatic events of the afternoon, into the night there was what amounted to a silent and determined adherence to routine among the Puka Wayq’u health center staff, and a busy occupation with any other medical cases which presented themselves. Among the locals in town the news of what had occurred down in Yomala spread quickly, amid what was at first surprise and what would later grow into a sense of muted yet intense outrage.

A day later, I made my first visit to the health center. Dr. Quispe himself was not around, and for the next couple of days he was virtually impossible to corner, as it were: he seemed to be constantly running off to one community or another, on what were purported to be previously scheduled monitoring visits and health post personnel evaluations. On May 18, there was an unscheduled community meeting in Yomala: Quispe had gone down with a few other municipal employees for a planned technical inspection of the health post and to confer with Renato, somewhat curiously when considering the now charged backdrop to what was supposed to be a “routine” visit. They soon found themselves obliged to discuss what had happened with a handful of dirigentes who had become aware of their presence. The dirigentes’ analysis of the events was essentially focused on concerns for logistical solutions, which were certainly legitimate and practical, albeit narrowly focused: communications issues and the need for an additional phone line at the health facilities; better medical equipment; bad roads. As I learned later, the overall assessment of the dirigentes had apparently been a fatalistic one of “what

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49 I myself was unaware of the trip down to Yomala until it was already underway, and was informed of the details only afterwards by Alejo, an administrative municipal employee in the town hall, who accompanied the group from the health center in order to record the number and status of medical supplies. Obviously, I would have hoped to have been present also at this particular meeting, but the lack of confidence and collaboration on the part of Quispe at that point, resulting in his attempted secrecy, was admittedly understandable within the unfolding context—despite his full knowledge of my research focus in Puka Wayq’u.
happened, happened,” and, remarkably, at this time there was no confrontation over how the emergency had been handled by the health personnel, either in Yomala or in Puka Wayq’u. For my part, I waited around the health center for Quispe’s return from Yomala. However, no sooner had I caught sight of him upon his arrival, he only waved quickly and perfunctorily in my general direction and immediately departed with Don Seferino, the president of the municipal Civic Committee, and Pablito on another scheduled health post supervision in the cordillera region, where he was for the remainder of the day.

On the morning of May 19, Quispe and Cárdenas were behind closed doors at the health center—until receiving an emergency call from the Villa Rosario health post, where several people had been brought in with poisoning symptoms. (It would later turn out that a local woman had used a large jug, which unknowingly already contained pesticide to be used in crop spraying, for mixing up a powdered drink mix; consumed by several people at lunch, two later died and six were hospitalized in Tarabuco.) Quispe immediately took off for Villa Rosario, with yet another opportunity (albeit highly necessary) to avoid dealing with the Yomala situation, and without addressing the issue at all with me; “We’ll talk some other day,” he said hurriedly in parting, leaving me outside with Dr. Cárdenas.

Cárdenas looked at me with a tired face, and vaguely shrugged. He began to speak offhandedly about inconsequential issues, yet soon began to address Yomala, without any probing from me. His version of the events coincided with much of what I already knew, but there were also contradictions, inconsistencies, and omissions—most critically, that Severina had not suffered any kind of major hemorrhage during Quispe’s exam, and there had only been a little bit of blood; and certainly nothing about his own (Cárdenas’s) wanderings about in Yomala, or the stop to eat an ear of corn with a patient in a critically urgent state stretched out in
the back of the ambulance. (Indeed, he claimed that there had been no delays at all in bringing Severina to the Puka Wayq’u health center, or on the road out of town—a version of the events contradicted by multiple participants and witnesses.) Severina had died, he said, essentially because her uterus was “worn out,” and she hadn’t been able to withstand the rigors of such a difficult birth process—which she and Héctor had been duly advised about at the prenatal controls in Sucre, Cárdenas pointedly remarked. Thus, the implication was that the blame for the death was primarily (if not wholly) on Severina and Héctor, for their lack of caution and forethought. The impression he gave me was also that of hewing close to what was a possibly pre-established “official” version of the events together with Quispe, perhaps in anticipation of trouble to come: Cárdenas had his own questionable actions to defend (the delays in patient transport from Yomala; plus, with this compounded by the uncomfortable complications of his lapses in judgment involving the response to Damiana’s emergency only the previous month, when he had sent only a nursing student to San Marcos).\(^50\) Quispe, meanwhile, had his own curious delays and impositions, and the soon-to-be damming vaginal examination to contend with. Hence, it was a probable instance of the two trying to “keep their stories straight,” in a spirit of mutual protection. Cárdenas ended his comments to me with the rueful acknowledgment that it had been a “pretty bad situation” in Yomala that day, and that people had been “furious” with him and Renato. “It all kind of takes away my desire to keep going,” he sighed, shaking his head, “I just want to get out of here.”

Yet it was evident that what I later came to refer to as a “climate of concealment”—essentially, a cover-up—was inexorably settling in at the health center. With the very prominent

\(^50\) In addition, this is without taking into consideration another personal “crisis” episode involving Cárdenas in mid-2003, when he veered off the road to Villa Rosario while driving the health center’s previous ambulance, crash landing and effectively sending the wrecked vehicle back to Sucre and the junkyard. Fortunately without suffering any serious personal injury, Cárdenas was later found at the scene of the accident weeping alongside of the mangled ambulance, and with the smell of alcohol on his breath.
exception of one particular assignment of blame (which will be discussed later), it became increasingly difficult to learn anything new from the health personnel. Again, it seemed apparent to me that it was perhaps again a case of how my presence, and my spectacularly inconvenient research focus, was making people uneasy under the circumstances. One day, I overheard Cárdenas speaking with Renato on the radio using the words “written reports” and “blame,” but the conversation ended when I entered the room. Quispe himself especially closed off to me, offered little information, and did his best to avoid me—a significant turn-around from what had been his previously welcoming persona. He would typically give me an initially friendly, even chipper, greeting, but would immediately go on the defensive—wary, like a rabbit caught in the headlights—and then would slip away. At first, what I did learn about “official” events and forces came from other sources—friends at town hall, Julio Taboada of the CEDERTA project, Padre Antonio—all who were usually more than eager to discuss the topic, albeit in a hush-hush, off the record kind of way.

And yet, as the crisis environment slowly increased, these institutional forces began to coalesce into a semblance of analysis and planning, albeit informal. The health center, town hall, the NGOs, Health District 2, the SEDES itself, all discussed one possible project proposal after another, to look for potential funding. As I reflected on my original hypothesis in Puka Wayq’u, I needed to ask myself: if it was actually the case that maternal deaths were historically much more endemic than suspected—undoubtedly due to the usual underreporting, whether at the community level, or that of the health services themselves—then, why all the frantic commotion at the moment? The only “logical” answer was that which I came to accept as my basic understanding of the argument: there had been an unusually high amount of maternal deaths, a spike that was even higher than what was “permissible.” Or, at the very least (and somewhat
more cynically): previously, endemic deaths had possibly been known only to the communities, and possibly to the local health personnel; this time, it was anything but unreported, and was very much public knowledge. Thus, the services needed to scramble, because suddenly their reputation and credibility were very definitely and very publicly on the line; in this manner, it could be perceived as more of a stopgap effort, without seriously evaluating the fundamental root causes of the “unforeseen” crisis. Thus, was the ultimate interest of the health authorities not so much in the actual population at risk, but rather in themselves, in the bureaucracy?

On June 4, the “Crisis” (with a capital “C”) was officially declared as such, verbally and in municipal documents, at the inauguration of what was referred to as the “Inter-Institutional Meeting in Puka Wayq’u.” In addition to the local health personnel, also present were representatives of Health District 2 headquarters in Tarabuco; the SEDES Chuquisaca; PROSIN; the sindicatos; and numerous other community members. (Still no one from PROSCAM, however.) It was at this gathering that the designation of Puka Wayq’u as a “red zone” was much debated. Throughout the day, four different groups worked independently on specific topics, with the goal of “establishing a plan” for mitigating the current emergency, and for avoiding future similar situations. (I was placed, for whatever reason, in the “community” group. I would have preferred the “health services” group; this was suspiciously—I thought—already “full.”) However, at the end of a long round of meetings, until the late afternoon, the results (I thought) were remarkably few and depressingly routine. This had all been said previously, at numberless governmental workshops and planning sessions: do a diagnostic study of health indicators; identify the local parteros (if there still were any); increase the training levels of the nurse auxiliaries in emergency birth attendance and the knowledge of Integrated Management of Childhood Illness (IMCI) norms; draw up risk maps of the communities
throughout the municipality; create a list of all varieties of community human resources; form a Municipal Vigilance Committee, specifically dedicated to monitoring local maternal health and projected births. It was all very legitimate and worthy, pages taken from the usually overlooked (or more probably ignored) book of “intercultural health” practices, written by the World Health Organization or UNICEF, or at a local or national level within Bolivia. However, there was amazingly not much that had not been said before; it was the stuff of that proposed at any one of the SEDES or health districts throughout Bolivia (and the world) during another moment of sudden “problems.” In short: nothing new was accomplished; it was business as usual. Marina Quiroga and Amalia Delgadillo seemed even more distressed and disgruntled than usual; meanwhile, Mayor Saavedra palpably exulted at his newest project proposal options, and at the enhanced opportunities for close contact with the Chuquisaca departmental authorities.

The following day was to be the first in which the new, “official guidelines” were to be formally implemented at the local level: the monthly statistical and epidemiological gathering at the health center, the municipal Information Analysis Committee meeting (Comité de Análisis de Información, CAI; other CAIs are held at communal, district wide, and departmental levels). Thus, all of the community nurse auxiliaries remained in Puka Wayq’u for the day’s analysis. Whereas the previous day’s Inter-Institutional Meeting was certainly the main topic at hand, it was oddly not actually discussed or analyzed in any significant detail. Rather, Dr. Quispe only alluded to it briefly at the outset and, before getting down to the standard readings of each rural health post’s monthly report, he gave a pep talk referring to the public health situation that was obviously on everybody’s mind, clearly influenced by the on-going movement and overall climate that was weighing so heavily on the municipality. Standing in front of the silently seated
auxiliaries—with his typically assumed “doctor” look of white medical coat, clean-cut hair, glasses, and notebook—he delivered his speech:

I want to tell you all about what’s going on. Since I arrived in Puka Wayq’u, I’ve been trying to work well. Then, we had the maternal mortality cases happen, and it’s been like a bomb. A bomb. District 2 is watching us closely. We’re up and we’re down, but it’s getting better; we need to work hard. We’re in a crisis—but, we’re being helped by institutions like Esperanza Bolivia, PLAN, by CEDERTA. We need to carry on, to forge ahead. Yesterday, we started to take charge of the situation, and again, we’re being helped by the institutions. Numbers are boring, but they’re important indicators. We’re going to do a diagnostic investigation of the health situation, and then we’ll strengthen all of the local services. Little by little, but you need to help, too. We’re not about to die with all of this, right? Hey, I’m getting excited just seeing you all here! Okay, compañeros? Renato? Fidelia? Braulio? With all of this commitment I see here, let’s get going! It’s not just me, not just the health center director: we all have to take it on, and follow it through. Okay, let’s get going!

After Quispe finished, nobody said a word. There were no questions, no comments, no suggestions. “Yes, doctor,” was the most that anybody uttered. The CAI proper then began, without further ado, and without much of anything else said about the maternal mortality situation. In the coming months, some, but not all, of the planned implementations from the Inter-Institutional Meeting were tentatively begun, and sometimes put into action. However, they were undertaken with the same degree of efficiency as they ever had been on previous occasions, despite the continued environment of uncertainty and tension in the municipality, and the rapidly disintegrating situation at the health services themselves. In the end, what had most struck me during Quispe’s address to the staff, perhaps, was a sense that what really mattered to him at that moment had been a strong desire to make clear his role as the health center director, as the person in charge, and to keep everything and everybody under control. Yet, it also seemed clear that he was desperately trying to be everybody’s friend, while manifesting a vague air of discomfort that things were not under his control, that people were increasingly griping about him behind his back, and that the discontent was steadily growing.
In the following days and weeks, and on into months, the sense of outrage and repudiation among the communities of Puka Wayq’u and Yomala steadily intensified. This was echoed in other communities within the municipality as a whole, in which people had heard of the incidents and commented openly upon them, expressing a concern that similar misfortunes might occur within their populations. In San Marcos, there was what might almost be referred to as a studied familiarity with the story of Severina, as if she were but a tragic continuation of the already established sequence of events that they had all been part of, expanded out from their immediately local altura environment and into the valle region. The resulting generalized atmosphere of uncertainty and confusion in the municipality was increasingly unsettling: one which was not precisely something out in the open, actively discussed and analyzed; but, rather was a force that permeated and informed many other actions, at both the governmental and community levels. For example, the specific issue of “maternal mortality” might be brought up yet again as an illustration of one of the numerous pressing health issues that should be addressed, perhaps at a health center evaluation meeting, or at a municipal strategic planning session; or, the name of Severina might be mentioned in passing in regards to the upsetting and persistent troubles so prevalent in the daily fabric of communal life; or, ironic black humor quips along the lines of “nobody (i.e., state authorities) gives a damn about us” and “life is cheap” would increasingly surface with a notable and atypical nonchalance in everyday conversations.

Accordingly, the pervasive yet almost entirely unspoken impression was more and more that of a reluctant, and grim, recognition among the community at large that something unsought after and unwanted, yet also somehow something unsurprising and almost assumed, had occurred in their midst: that there had been a social breakdown of sorts, and things were suddenly and
distressingly changed, but in such a way that it was all part of what was now to be expected, almost as a matter of course. In this respect, if the sudden mortality events around the municipality were indeed a rupture leading to a steady process of slow-motion crisis, they were also reflective of something enduring and subterranean about a distinct and ever-present social reality, tacitly recognized yet determinedly unacknowledged, which had unfortunately been brought into a sudden, harsh, and distressing light.


The events of 2004 occurred not only within the context of the dual actualities of an historic coloniality and a conflictive interculturality, as previously discussed, but also one of a nation-state caught on the murky border between the frequently ill-defined (and controversial) notions of “traditional” and “modern.” The crisis of the Bolivian state, as seen through the sights of the Puka Wayq’u microcosm, played out within the confines of a given set of previously instituted norms, modalities and conditions. Supposedly, the modern day nation-state has as one of its fundamental obligations the task of alleviating (if not altogether preventing, in as much as it is possible) the suffering of its respective population. Within this overall framework, the nature and role of the state, and of state power, is critical—particularly as it concerns the relationship with the competing power bids of a diverse range of social actors.

This is especially true as it concerns a “developing” country such as Bolivia, with its interconnected ties between the “modern” colonial state and the “traditional” indigenous subject, which for my purposes here as they are articulated through the official health services. However, these same health services may also be an acknowledged arena of power and social control: state
interests have long been instrumental in the formation of the modern health system, with its proprietary command of medical knowledge and practice. This may refer to the previously discussed (Chapter 2) notion of “health imperialism” (cf. Navarro 1981), in which economic interests are achieved through the manipulation of both health services and the underlying socioeconomic determinants of illness, disease, and affliction—by either the respective state itself, or by an external power, or perhaps by both, in an unequally functioning dyad. Internally, in a “pluri-multi” cultural context such as Bolivia, the predominantly urban, Spanish speaking and dominant biomedical health care system may serve as a discourse of coercive social domination, and as both a mediator and a potential agent of state cultural oppression, through its monopolization of a specific realm of knowledge and professionalization, more so than as merely one other option among many within the rarified environment of medical pluralism, Bolivian style. In the case of the mortality events in Puka Wayq’u, official actions ultimately served to separate the mitigation of mortality from the agency of the populace itself—a process which frequently assumed the form of assimilation and appropriation of indigenous, or endogenous, beliefs and practices, as I will argue below.

In itself and for my purposes of definition, the very notion of “the state” may be conceived of here as essentially a quasi-sacred structure, a superstructural entity that holds (at least in theory) a forceful and enigmatic authority, brought about through reified and hidden power relations (Abrams 1977). Moving yet further beyond such a delineation, it is an abstract concept designed to establish a kind of “magical” framework, comprised of a sovereignty directed at social control mechanisms, which themselves both originate and support an environment of ongoing social and cultural crises among the population. Its intrinsic power is, in ways both tangible and intangible, in itself a product derived from its very secrecy and
mysteriousness, and indeed the very “mysteriousness of its mysteriousness” (Taussig 1997). Other analytic trends discuss how the state reproduces itself and exerts its power over the public, not necessarily through actual physical state apparatuses, but rather through social programs: in the Foucauldian approach of governmentality and biopolitics (Burchell et al. 1991; Dean 1999), conceptual social policy objectives and power configurations are articulated and reproduced through specific structures and programs of the formal state apparatus. The key in this case is the official administration of the populace’s life necessities and living conditions as indirect forms of social control: municipal functioning, elections, vital services, education, and, most important in this instance, public health institutions and programs. Conversely, the notion of biopolitics also allows for the idea of either the subtle or the overt creation of a kind of counter-hegemonic politics, in that the public may formulate its own unique demands on the state and hence an opposition to official policy, and to its increasingly far reach—essentially, an attempted reversal of established power relations, possibly even coalescing into an active resistance to the dominant socioeconomic and political system at work—in this case, with a focus on healthcare and healthcare options.

In as much as both the historical and present day climate in Bolivia of social and political ferment and unrest—if not even, it might be said, the traditional climate—is symptomatic of clashing power relations, eventual strong opposition to the actual national health model and its structural confines would also seem to be a distinct possibility, along with current indicators defining the “Bolivian way of death,” maternal or otherwise. However, and as it was demonstrated in the weeks and months following the initial crisis moments in Puka Wayq’u, the official health services themselves may also represent a critical example of this paradigm of the “rationality” and the “art” of governmental practice: who governs, and who is governed. This
power has been instrumental in the formation of the modern healthcare system throughout the developing countries of the world (including Bolivia), with its proprietary control of medical knowledge and its intimate relation to power and control (Foucault 1973, 1977; Taussig 1980) through the twin phenomena of the aforementioned and further developed (Chapter 2) notion of “health imperialism” (Navarro 1981) and that of “health colonialism” (Marks 1997). Thus, and in regards to a variety of questions pertaining to the public’s health (precisely, for example, such as the reasons for and the respective means of dealing with maternal death), the historical tendency of the Bolivian state has been to mystify both morbidity and mortality, with the resulting potential to effectively remove the power and control of either its prevention or its alleviation from the hands (that is, the agency) of the community.

It was within these national parameters that the events in question were played out, in a number of conflicting manners which both reflected the pervading climate of crisis, and also appropriated it. The question of who exactly was in control of the situation, and who would “benefit” from it, increasingly took on an importance which might have been misconstrued if it had not been for the lingering impact of the generalized climate of inconvenient and uncomfortable mortality. However, eventually in Puka Wayq’u the maternal death emergency was even further appropriated and taken advantage of in an overtly political manner, making it quite clear just who the potential beneficiaries were. Most importantly, in December, during the nationwide electoral campaigns for municipal authorities (mayors and town council members), health became a prominent issue, with subtle and oftentimes open references to maternal safety frequently used as an example of concern to voters: for nearly all of the mayoral candidates (five out of six), the proposed solution was to dramatically increase the health infrastructure and
personnel, both at the Puka Wayq’u health center and at the community health posts. The deaths had, effectively, entered the political discourse.

Assimilation, Accommodation, and the Cooptation of Medical Discourse

**Governmentality in (partial) practice: “institutionalized births,” shifting modernities, and the stabilization of social hierarchies**

When it comes to issues potentially critical for the outcome of pregnancy and birth, the reality witnessed among the Puka Wayq’u population—that is, the minimal use of (admittedly scant) official services, even at potentially critical moments of life or death—was typical for many other areas in Bolivia which suffer from similar dilemmas. In her study of health seeking behaviors in the “urban campesino” city of El Alto, for example, Loza (2008) outlines a “labyrinth of healing” in which the ill seek out care based on criteria more often related to issues of expediency and mistrust of the biomedical services, than to those having to do with economics or social ascendancy. Ramírez Hita (2005), in a study of illness and health in the barrios populares of the city of Potosí, implicates the “classic” dilemmas of cultural misunderstanding and poor communication, as viewed through the lens of ethnicity and an unsympathetic biomedical service force; this in addition to both autochthonous and evangelical Christian infused beliefs which influence emic disease taxonomies. At the core of many of these questions, whatever the specific region, is precisely how the Bolivian state actually perceives the genuine incorporation of its citizens into the reproductive health model that it wishes to promote, including the very nature of the body itself, and whose property it really is—and, how those citizens themselves perceive of it. As I have suggested, one crucial means of (biopolitically) achieving this is through such social services as education and health—a development occurring only after the mid-20th century in Bolivia, in contrast to previous decades, when official efforts to
racially, socially, politically and culturally isolate indigenous groups, partly through matters of
hygiene and the restrictive regulation of health services, put a selective limit on the accepted
definitions of “citizenship”: who was, and who was not (Zulawski 2007). In the particular case I
describe here, amidst all of the theoretical and policy maneuvering and posturing of the various
governmental authorities around national and local obstetric practices, the “institutionalization”
of births—as it is officially referred to by the state health services, which refers to a birth either
attended in a state health facility itself, or at a minimum at home by state-trained biomedical
personnel—is the clearly stated objective of the national health services and the international
programs and financing behind them.

Although comprised by motives both concerned and altruistic (at least on the surface),
and also undeniably professional along international guidelines, as admitted to me (even by the
Puka Wayq’u health center personnel) the strategies implemented had just as much to do with
the public image presented through statistics to the superiors in Sucre and La Paz—and thereafter
to the predominant international aid financers, including the World Bank, the Inter-American
Development Bank, and USAID—as it did for the sake of trying to save lives. However, this
institutionalization of both the woman, her body, and the resulting “product”—as the baby itself
is characterized in the accepted medical terminology—was also little more than yet another
means by which to incorporate the family unit into the dominant citizenship model of the state,
one which subtly encouraged a gradual distancing from the assimilation of a “traditional” set of
Bolivian-style “ways and customs” (usos y costumbres, as it is widely referred to within both the
social and legal contexts, and which is in itself a concept that intrinsically denotes the status of
“indigeneity”), 51 and a wider embrace of the norms of the official control apparatus. This occurs,

51 The 2004 Bolivian Law of Citizen Groups and Indigenous Peoples (Ley de Agrupaciones Ciudadanas y Pueblos
Indígenas, No. 2771), defines original peoples populations themselves as “organizations with their own legal and
however, while the government health services simultaneously present evidence of a seeming
willingness for cultural brokering—for example, the promotion of incorporating parteros into the
health system, but as what ultimately amounts to little more than a reference agent for the state
services of imminent births—and which thus turns out to be little more than a façade for another
form of cultural cooptation.

To what degree, if any, might it be said that the state may have actually increased its
social control as a result of the series of maternal deaths, and in particular the death of Severina,
a near-monolingual indigenous woman who was unable to communicate fluidly in the dominant
language of the state? In the long run, the official health services themselves would indeed seem
to have gained: Severina’s death, coming so soon on the heels of Damiana’s own demise, plus
the other deaths in the previous years (always known about and commented on in the *vox populi,*
if not in the circles of the health services), effectively spooked people, and the number of
“institutionalized” births increased—not tremendously, but they increased. As such, the health

judicial status recognized by the State, whose organization and functioning are in accordance with ancestral *usos y
costumbres.*” In contrast, Peruvian jurist and anthropologist Raquel Yrigoyen Fajardo (1999:6), who has published
extensively on the history Latin American indigenous legal systems, “community law,” and the current state of
indigenous rights amidst international conventions, affirms that the term “*usos y costumbres*” is itself of colonial
origin, and reflects an engrained framework of discrimination and coloniality. In this analysis, in the Americas most
native populations already had their own functioning legal structures in place prior to the arrival of the Spanish,
which then became subordinated (if not erased) under colonial rule. In assuming and adopting an ideology of the
“natural inferiority of the Indian,” who in turn must be colonized and Christianized, indigenous judicial pluralism
was made subservient to the imported European legal models, which in turn were characterized as “divine and
natural law.” Thus, the already established native American systems, perceived as alien and which must not be
allowed to conflict with the prevailing European legal norms, were reduced (similar to the common European
colonial notion of “customary law”) simply to an unthreatening, lowly and prosaic (and anthropomorphized) “ways
and customs,” which thereby effectively legitimized colonial law. In this manner, the concept is implicitly one of an
inferior status, in that it refers to “indigenous or popular norms” unrelated to an officially recognized civic or human
right, or to a recognized and sanctioned judicial system. In a complimentary historical fashion for the context
examined here, Thomson (2002) discusses the case of the southern Andes under Spanish colonial government and
limited and restricted native self-rule. Indigenous communities were typically allowed to maintain their traditional
communal structure in tightly contained units on the periphery of Spanish and criollo towns, in which they were
permitted to continue administering their own autochthonous local government—including actual legal structures
and “usos y costumbres”—as long as these remained strictly relegated only to the confines of the respective
immediate native communal population, had no bearing on colonial social and political structures, and always while
recognizing their ultimate subordination to the dictates of the Spanish crown.
services had effectively defined the parameters, and had widened its brand of state sovereignty, through extending its protection to “citizens” who were at last presenting themselves for counting. The situations observed in Puka Wayq’u validate this argument. The “humanístico” approach—and it was frequently invoked by Dr. Quispe, as the health center director—did seem to have an impact: it must be recognized that in the wake of the sudden spike in maternal deaths, and amidst the ominously prevailing climate of urgency and crisis, there was a relatively noteworthy increase in prenatal check-ups in addition to the institutionalized births, albeit still in fairly modest numbers. One explanation for this, however, was simple anxiety and fear on the part of pregnant women and their families, a reaction based in the clear recognition of an existing threat in the municipality that was hitting them all too close to home: the far greater quantity of maternal deaths than the tenuously acknowledged “norm” which was occurring among their peers, and the desire to avoid a similar fate.

At the end of 2004, when visiting one afternoon in Yomala, I saw an example of this for myself at the health post: Doña Lucia (who also happened to be the wife of Don Lorenzo Callejas, one of two semi-retired local parteros in Yomala) had just given birth to her tenth child. Interestingly enough when taking into consideration Don Lorenzo’s partero background, and besides the fact that they chose the health post, her husband was present, but not actively participating in the birth. This had, however, occurred in a traditional squatting position on the floor, attended by nurse auxiliary Renato and Dr. Cristina Porcel, the recently arrived staff physician at the newly renovated Yomala health post (inaugurated in late October 2004). In addition to Doña Lucia’s immediate family—Don Lorenzo, and four or five of their older children—several other friends and neighbors were also present. All were in an extreme emotional state, indeed what was an intensely celebratory mood: crying, laughing, daubing their
eyes, arms interlocked in embrace. However, it was quite apparent—and was confirmed to me by the low murmurs of a few of those present—that this was a different kind of happiness, and was not so much in direct relation to the arrival of yet another member of the family. There existed a palpably charged state of exhaustion, relief and catharsis that was present obviously, and critically, simply because Doña Lucia had survived the experience, and had not become yet another grim statistic contributing to the tense atmosphere of which all were so acutely aware concerning local births, and what Puka Wayq’u had so unfortunately become known for over the preceding months. Thus, it was a happy reversal of sorts, and one which in this particular case at least augured something positive for the local health services, and for their ongoing reputation.

However, the prevailing modus operandi of the Puka Wayq’u health center had yet to wholly fulfill its pledges of a more profound cultural make-over, those made by holding out the offer of better treatment through the much proclaimed and transformational practice of the “parto humanístico,” which would later fall more squarely into the rubric of “intercultural health.” Births in traditional positions, such as in the case of Doña Lucia, were at least permitted if requested, albeit somewhat grudgingly so, and were not exactly encouraged, so as to not overly deviate from what was indisputably the “most comfortable position for the doctor.” (This was as Quispe himself described it to me, following one birth at the health center that he had attended in the gynecological position, and during which the allegedly “uncommunicative” mother did not request any changes in the established biomedical norm for the birth. But I can’t help but wonder: how well had she spoken or understood Spanish? Had Quispe at least made the attempt, in his rudimentary Quechua? Yet by the doctor’s own admission, no other options had even been offered to the mother—and, accordingly, the established power dynamic was confirmed.) Indeed, of all the births in the health center that I had knowledge of during my time
in Puka Wayq’u during this period of both institutional and communal tensions, by far the great majority were still in the gynecological position, despite what the official policy might have been, and recalling the (oft-repeated) fatalistic comment from numerous mothers of “that’s just the way he was born” (“así no más ha nacido”) in reference to her baby’s birth—spoken not so much with resignation or anger, but rather with the recognition that this was simply the way things were at the center. However, with my follow-up question of what the respective mother would have preferred, the invariable reply was that a more “traditional” position—squatting, kneeling—would have been better, and much more to her liking.

The question thus remains as to how genuinely and seriously the so-called interculturality model was being applied to the health services at the time, not only in Puka Wayq’u but also at the departmental and national levels—a time prior to the dramatic health system overhaul, post-MAS ascension (further discussed in Chapter 5). Nevertheless, it must be acknowledged that it was still a quasi-official policy in the process of supposed implementation; the question was rather to what degree community ethnomedical beliefs and practitioners were actually and realistically incorporated into the dominant biomedical system at the local level.

The role of the community partero is critical in this. In the town of Puka Wayq’u itself the only resident partero, Don Filiberto Cuellar, stopped attending births with women who sought him out in approximately the year 2000—he did, however, continue to perform what was apparently his own personal version of a prenatal check-up. Specifically, he was known to have the ability to determine pregnancy status and fetal conditions by gauging the nature of the mother’s pulse, after which he would “call,” or bring forth, her “ánima” (as mentioned in Chapter 3 [Footnote 28], a spiritual manifestation best characterized as one of the three facets of her “soul”). Also, he reputedly continued to perform occasional manteos, a traditional technique
in which a pregnant woman is rolled about and tossed in a blanket or large weaving (manta), held by others, in order to re-adjust a poorly situated fetus into the correct heads-down position. As such, Don Filiberto continued to receive frequent clients, and “referred” women after a fashion to the health center when he knew that they required more specialized attention. But in the case of the several different communities that include Iskay Sach’as and San Marcos in the altura region, and others within a walking distance radius of a few hours around each, there was only the one practicing partero: the NGO-trained Rosendo Durán. In Yomala, there were two active traditional practitioners, Lorenzo Callejas and Justo Sotomayor, yet both (and who were also older men, similar to Filiberto and Rosendo) claimed to be “tired,” and tended to refer women directly to the health post, although not exclusively so. In all appearances, the business of being a partero in Puka Wayq’u had either been co-opted or was in the process of being phased out entirely, although it hardly seemed to be due to an overall preference on the part of the public for the state health services, which remained relatively yet consistently low in their overall quantity of institutionalized births. Although home births attended only by (most typically) the husband, mother, mother-in-law, or another family member have always been

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52 At one point early on, and then again some months later in the year, I asked Dr. Quispe, the two members of the current nursing staff, and also Dr. Luisa Velázquez, the medical coordinator of the CEDERTA project (and who would in later years become the health center director), about collaboration in the town of Puka Wayq’u between the governmental health personnel and any local parteros. In a similar fashion, all replied that whereas there were still parteros scattered around here and there in the rural communities, in the town itself there was no longer anybody who did anything at all with pregnancies, except for the official health personnel themselves, and there hadn’t been for “several years”—which was a time frame invariably affirmed in a vague, hesitant kind of way. On each occasion, when I would then politely ask them about Don Filiberto (who I had previously interviewed) and whether he had ever had any direct or indirect assistance role with the health center, either previously or currently, I was consistently met with a blank stare accompanied by either an outright “no,” or an uncertain reply to the effect that they were unfamiliar with him at all. The truth of the matter, however—as I would typically later inform them, as respectfully and with as little irony as possible—was that for many decades Don Filiberto had lived in the same house, approximately a block and a half away from the health center, where he continued to perform his own brand of prenatal care. (By 2010, with the strong promotion by the MAS government of the intercultural health model—including the incorporation of parteros and other traditional medicine providers—Dr. Velázquez, in her then capacity as health center director, asserted that she frequently requested Don Filiberto’s presence at officially attended births, usually to help adjust the fetus into a more optimal position, if so requested by the mother. However, this was apparently undertaken without the use of the manteo, a technique which was definitely frowned upon by the biomedical health establishment.)
practiced, with the deepening lack of ethnomedical personnel in the area the potential for an “intermediary” to help bridge the differences between ethnomedical and biomedical beliefs and practices was also substantially reduced. One unwanted and unintended consequence was that, in absolute numbers, many fewer births may actually have been attended by any variety of capable human health resource who might at least have recognized early enough the need to seek outside assistance, thus leaving open the possibility of greater risk to the mother. This can even be identified as, I might argue, one aspect of a discomfiting failure of the local ethnomedical services, to monitor their own target populations.

These were additionally, in might be said, the implicit perils of a forced modernity. In the case of Puka Wayq’u, the modern, biomedical health services were still not fully accepted by many sectors of the population. Yet, at the same time local ethnomedical resources and back-ups were discouraged, and eventually eliminated; there was for example the “manufactured” dependence on biomedical services through the dirigente-ordained fine in the altura area (despite how generally unobserved it may have been). Then, the trust that the health center tried to instill in people may actually have ended up undermining and debilitating that very trust; it was something forced, or obligated. And, through a supposedly renovated and enlightened intercultural approach (the lure of the “parto humanístico”), the official services may only have been repeating and reproducing the same patterns as before, increasing the exercise of a type of control over bodies and behaviors. The apparent consequence of this was that maternal health did not improve, but rather declined: an abrupt jump in maternal mortality that had everyone up in arms, as part of a slow transition to whatever “modernity” might have been construed as—yet, what in the end turned out to be more deadly than evolutionary. In the long run, while it was certainly to be hoped that the general health status of the population improved in a quantitative
sense, there was still the concern about what might be occurring in a *qualitative* sense: the age-old concern of the impact on local culture and cultural patterns, as these are discarded in favor of the new things that society and the state have to offer.

The ultimate seriousness of the issue cannot be glossed over; nor can it be denied that probably the only way in which to save the life of a woman in the midst of an obstetric emergency is through biomedical means, usually referred to as “essential obstetric care” (antibiotics, blood banks, the ability to perform Cesarean sections). These are interventions unavailable to typical traditional health practitioners, and indeed to biomedical practitioners far from an appropriate care facility. Thus, what is ultimately at stake here is a very blunt and unassailable outcome, that of the life or death of the mother. However, what is also at stake in the bigger picture, vis-à-vis the dilemma of potential affliction and human suffering (cf. Kleinman 1995), is that of both the cultural identity of the mother, and the personal story of what is gained and what is lost by the dint of the choices made. The issue may frequently boil down to whether by making one decision—because it seems to be the one that holds out the safest outcome in stark terms of life and death—the sacrifice then demanded is to turn away from “traditional” beliefs which are integral to personal and cultural worldviews, yet which are often narrowly framed as dangerous, for the sake of the promise of a “safer” modernity.

However, the eventual strengthening of the state can in no way be categorized as an “*intentionality*” of the state—certainly, nobody actually maliciously desired the deaths, and the health care reforms were implemented in a genuine spirit of the public welfare. Yet the interventions which kicked in afterwards were the direct result of a kind of “*unintentionality,*” which worked toward its own driven interests of what is right and necessary for effective governance and control—what Abrams (1977), as previously discussed, identified as the reified
manifestations of hidden power relations comprising the normalized day-to-day workings of what is characterized as the superstructural entity of the state. There was an unexpected local health and social crisis, which was an identifiable deviancy from the “norm”; then, a series of perceived external pressures (institutional and bureaucratic concerns related to statistical profiles; related international financing threats and uncertainties; pesky on-site anthropologist) provoked an official response. In the end, there were indeed unintended, unexpected benefits accrued from the deaths, in that they set the stage for a greater state intrusion into daily life, through an incremental biomedicalization and cooption of local ethnomedical beliefs—prominently, in this case, by means of the increasingly fashionable interculturality discourse. Here, the local apparatuses of the state moved in, reaffirmed authority, and took charge in Puka Wayq’u. Consequently, the local culture (as represented by both official and community reproductive health practices) was inextricably altered: this occurred while the institution of the state itself was (apparently) nudged a bit farther along the decolonization road leading from the neoliberal ancien régime to the fabled Pachakuti.

**Gestures of Protest and Resistance?**

I wish here to figuratively and parenthetically backtrack for a moment, in order to briefly consider elements which may be interpreted as not only relevant, but also critical, to the eventual unraveling in Puka Wayq’u. These have to do with the aspects of maternal and reproductive health previously discussed in Chapter 3, and also with some of the points made in Chapter 2, concerning biomedicine and coloniality. When taking into consideration the specific social and public health environment of the moment, just how was it—in a direct medical and maternal health framework—that the mortality situation in the municipality even arrived at the edge of such an extreme in the first place? There were the foreground “second and third delay”
questions of communication, transportation, infrastructure, professionalism, negligence: these are indisputable. Yet, what about the background “first delay” questions? In this particular local context, why was the level of participation of pregnant women in “institutional” births so low to begin with—which was, it must be admitted, also so typical for Bolivia as a whole? Both the stories of Damiana and Severina especially—and also those of Celestina and Benigna, although these were in a more abstract fashion at this primary level—reveal numerous fatal missteps in judgment between both partners in each couple, and also including other nearby family members; I have discussed this point previously. But in considering the municipal-wide reality, the history begins before the actual moment of the birth even arrives, in the characteristic attitudes of the women of the communities in regards to their maternal health practices.

In my review of past Puka Wayq’u health center records over a period of approximately ten years prior to the events studied here, it was glaringly apparent that the attendance of pregnant women at the health facilities throughout the municipality was sparing at best. As previously mentioned, while the number of prenatal check-ups was moderately acceptable (at best) for the purposes of municipal and departmental statistical records purposes, in contrast only a bare minimum of women chose to go either to the Puka Wayq’u health center, or to the closest corresponding community health post, or at the very least to alert the local nurse auxiliary, of an imminent birth or one in progress. I have also previously touched upon issues of women’s (and men’s) preferences in this regard, and these are well documented world-wide—factors such as prohibitive cost (although this supposedly would not have been the case in Puka Wayq’u, considering the nationwide SUMI coverage53), convenience, comfort, culture, gender relations:

53 The SUMI has had a spotted history of implementation, however. In numerous anecdotal instances throughout the country—and including my own personal observation in Puka Wayq’u—health care providers have frequently been unaware of (or perhaps turned a blind eye to) the myriad conditions and medications unarguably covered at no cost whatsoever under the program—which is indeed the absolute majority of potential interventions—and have
all of these play prominent roles. A telling remark in this respect, most specifically in regards to questions of culture and gender, and indicative of many others heard from numerous women, was uttered by Carolina Sotomayor of Yomala, living at that time in the town of Puka Wayq’u. It reflected a sentiment still widespread throughout the municipality—if not throughout Bolivia, and perhaps in numerous other countries as well—and was similar to what Doña Santusa had pointed out at the DILOS meeting in Villa Rosario: “You know why so many pregnant women don’t want to go to the health posts or to the health center to give birth, even though they try to make us go? Because they’re afraid to be seen by the doctors. ‘Let my baby be born here in my house,’ they say. And what are they afraid of? They know that the doctors will make them get up on the examination table, that the doctors will make them spread their legs, and then they’ll look. That’s why they don’t want to go. And they can’t make us go.”

Yet, I wish to suggest another rationale, a companion to what I acknowledge above were influences on the women, in addition to their felt needs, in either obstetric care seeking or in the avoidance of it. This involves the proposition of yet another key dynamic in the process, and which is also traditionally one of the most “Bolivian” of all organized activities: active social resistance to unpopular authority, in itself a form of opposition to an intrinsically perceived climate of lasting and durable coloniality.

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In her own particular case, however, Carolina was one of the few “renegade” mothers in Puka Wayq’u, such as I have described previously. I always saw this as undoubtedly having much to do with the fact that her father, Don Justo Sotomayor, had been one of the last practicing curanderos and parteros in Yomala—but who, as mentioned, no longer played an active role specifically as a birth attendant. As a result, prior to her own pregnancies Carolina had long been exposed to issues surrounding pregnancy and birth. Although she ultimately decided to have her last baby (born only a few months beforehand) in the health center, she refused to be intimidated by the medical personnel: “I told Dr. Javier that I wasn’t going to get up on the examination table, that I was going to have my daughter on the floor. He said, ‘Señora, you have to get up there.’ ‘If that’s the way it is,’ I told him, ‘then I’m going home.’ But he backed down, and he didn’t make me get up on the table, and I didn’t. So I had my baby on the floor, and he watched.”
As I have noted, throughout Bolivia and in much of the Andean region the transition to the modern state over the past half century has been accompanied by the burgeoning (and frequently militant) affirmation of cultural, political, civil and human rights among the indigenous populations. Within this dynamic, the role of health and health care is a crucial component. In these changing parameters of sociocultural and sociopolitical interactions, encompassing diverse actors from local gender and cultural power bases to the Bolivian state itself, there exists a great potential that these may be transposed onto beliefs and practices related to health-seeking priorities and strategies, as they relate to the active utilization of the available services. Although political participation and representation in local health management have increased significantly among the indigenous populations in recent years, however (and have even further intensified since the current health reforms began in 2006), it was not until as late as approximately 2011 in the case of Puka Wayq’u that this was translated into actual increased co-participation with the governmental health services, and only moderately improved levels of local empowerment in health decision-making regarding policy implementation. This was despite the presence in health planning meetings of local community organizations—most importantly through the DILOS, which, it must be remembered, includes the participation of the

55 I discuss the MAS national healthcare system reforms in greater detail in Chapter 5. As part of this overhaul, and most importantly when taking into account the Family Community Intercultural Health model (SAFCI), which is official policy since 2008, a community and municipal level network of local health co-management is still under ongoing implementation nationwide. In the case of the Puka Wayq’u communities, the SAFCI system of community participation was not initiated until late 2010; however, at that point it was essentially an active policy in name only, as part of the community organizing work of a Chuquisaca-based, Danish-financed NGO, the Community Development Program (Programa de Desarrollo Comunitario, PRODECO), which incorporated a strong central focus on intercultural health and traditional medicine. It was, then, not until almost mid-2011 that the new health administrative structure was consolidated at the municipal level, and the recently elected SAFCI oriented dirigentes began to actively participate in the local decision-making process, alongside of the governmental health center personnel. However, as late as 2012 the community social structure as organized remained weak and relatively ineffective: as the director of the health center, Dr. Luisa Velásquez, commented with a shake of her head, “It isn’t working. Nobody here even really understands how this is supposed to work.” This last remark I interpreted (as based on her own particular history, within my personal experience), as being one in a series of her typically world-weary observations concerning the overall state of affairs in the municipality—and in which she also included herself, just as much as the rest of the health center staff, in regards to SAFCI-related confusion.
president of the Comité Cívico as a community-based regulatory body. Unfortunately, this was a relatively ineffective local institution for the formulation of concrete municipal health policy, as I personally saw at ground level in Puka Wayq’u.

In actual practice, the more significant challenge to the historic deficit in adequate health and healthcare in Bolivia is, as always, bottom up rather than top-down—ministry level or otherwise. The conceptual framework of governmentality and biopolitics discussed above would seem to lend itself to this reasoning, with its plebian challenge to official power models and state hegemony. In as much as the current climate of both official and extra-governmental social and political mobilization and consolidation in the “pluri-multi,” intercultural, and (albeit slowly) decolonizing Bolivia is symptomatic of this reasoning, an historic, subtle, and latent opposition to the actual national healthcare model and its structural confines was always a distinct possibility. In Puka Wayq’u during the years leading up to the specific maternal mortality emergency, it is this resistance to the officially imposed model—and to a forced assimilation into certain aspects of western culture which themselves created resistance—that I define as an illustration of indigenous culture counter-hegemonically reasserting itself, here within a healthcare framework, as part of its attempt to (re)claim cultural, political and economic spaces of power. Thus, health and healing as cultural constructs provide an opposition and counter-point to historic and institutionalized colonialist discourse, while experimenting with the manners in which alternative healing and (maternal) health systems may themselves contain subtle forms of resistance to sustain the (at least figurative) independence of the oppressed (cf. Taussig 1987). In this manner, “traditional” cultural identities (cf. Mamdani 1996), in this case concerning health (i.e., ethnomedical practices)—the realm of the internalized private sphere—ultimately have proved to be instrumental in the assertion of both social and political legitimacy,
and the demand for collective (civil and human) health rights from the state-structured public sphere.

One of the forms that this resistance took, I suggest and as alluded to previously, was through a silent and conscious non-participation in the official health model, whether through the strategy of passive non-compliance and the controversial notion of “everyday forms of resistance” (Scott 1985); or, as an “in between” resistance to state models (Fox and Starn 1997), which are neither covertly passive nor overtly rebellious. In regards to pregnancy and childbirth, as I assert Puka Wayq’u is typical of most of rural Chuquisaca, and for Bolivia as a whole (in addition to many of the populous urban areas): nationally, the (indigenous) population prefers to give birth at home—78.6% (INE 2003). In subtle ways, when considering the more “intimate” health related behaviors observed in this respect—that is, the impact of culturally-based rejection, especially to what may be identified as a “sexualized” backdrop to pregnancy and birth,56 rather than the more neutral or “mundane” considerations of common illnesses, infectious diseases, injuries, etc.—personal health care seeking choices are, again, the demarcation and the affirmation of the (individual) private sphere, in opposition to the domination of the (state) public sphere. This is exercised, then, simply through the act of choosing not to utilize the available governmental health services. Consequently, in Puka Wayq’u as elsewhere, there is still an uncommon and atypical use of the health services for the actual birth itself, except under extreme duress—as exemplified by Damiana, Celestina, Benigna and Severina and their respective partners, none of whom made any moves (if at all) to contact the local services until

56 Bradby (1998) discusses the reactions of women from the campo and the barrios populares interviewed in the city of Sucre, in regards to the typical obstetric care received from biomedical personnel in the hospitals, health centers, and private clinics. For both prenatal care and actual birth, many respondents focus especially on what they perceived to be a “sexualization” of pregnancy and childbirth by the male physicians and interns. Similar to the comments of Carolina Sotomayor cited above, Bradby documents a strong dislike and violent opposition to the manner in which the medical personnel employ a literal “gaze,” as part of their overt staring in what is for the women usually the very unaccustomed gynecological position; and in frequently derogatory remarks which can properly only be characterized as sexual harassment.
the childbirth process was already well underway, the perceptions of undeniably unmanageable life-threatening complications were a reality, and it was tragically far too late. In this way, it is not only the preference for the home birth itself, with the comfort of family and within familiar surroundings; it is the outright rejection of the alternative—a rejection that originates in fear, shame and incomprehension of an imposed, foreign (bio)cultural model.

This is where the line is drawn: in the denial of the state’s hegemonic entry into the very private realm of the body, during intensely personal moments of both the biological and the cultural (re)production of society; it is a resistance against the most intrusive practices of assimilation into the mestizo citizen model. Perhaps one of the most eloquent and profound manifestations of this powerful sentiment, taken to the extreme, was what would appear to be Severina’s fundamental reason for refusing to go to the city for the strongly recommended (indeed, biomedically ordered) Cesarean section. This was one which was much more powerful than the economic rationale assumed afterwards by both Doña Carmen Bautista in Yomala, and by some in the Puka Wayq’u health center (and at any rate, again, Severina would have been covered by the national SUMI policy); or the “cultural” rationale of Dr. Quispe, in his casual and denigrating dismissal of her behavior by saying “they don’t know the value of their own health.” Rather, not long before she went into active labor Severina had come home from one of her two prenatal check-ups in Sucre, where she had been reminded (admonished?) again at San Pedro Claver Hospital to return soon for the actual birth and the scheduled Cesarean. Clearly anxious about her prospects, she had gone to a neighboring señora in Yomala for a manteo. The señora had said “no” to Severina in regards to the manteo, however, because her appearance was extremely sickly (“really yellow”), and simply because she looked so strikingly, worrisomely, bad. In a state of desperation about the proposed alternative, Severina told this particular
neighboring the fundamental reason that she would stubbornly resist going to the hospital in Sucre: she refused—frankly, unconditionally, fearfully, but quite logically and rationally as based upon her own personal experience (of previously uneventful home births), and all that she had heard from other women she knew (in reference to the murky mysteries and uncertainties of biomedical hospitalization, especially in regards to a Cesarean section)—“to be cut.” Yet the fatal downside to her fears, of course, was a tragic miscomprehension and underestimation of the dangers that she potentially faced, in her previously identified (biomedically or otherwise) high-risk pregnancy.

This also recalls the question (discussed in Chapter 3, regarding Damiana) of whether the death could feasibly be characterized as the actual “fault” of those most intimately involved, as reflected in their apparent lack of initiative when confronted by an obvious emergency situation. This becomes very paradoxical, and problematic, in the case of Severina and Héctor, in their decision to reject the state-sponsored health services. Specifically, they were not treated as active protagonists by these services; rather, they were effectively marginalized in any sort of way resembling an active “agency” in the pregnancy, and were instead instructed to behave in a certain manner without an adequate explanation of the rationale for doing so, and in regards to the full extent of the potential consequences otherwise. As a result, neither Severina nor Héctor themselves, nor the health services, perceived them as actual partners in their own personal drama—and Severina and Héctor’s seemingly paradoxical behavior was the end result. After all, she had had a total of 10 prenatal check-ups, and had been diagnosed in the city with two ultrasound examinations as clearly being an “at risk” pregnancy. Yet, when the critical moment arrived, the couple opted for what they were most familiar and comfortable with: a home birth, to be attended again only by Héctor, as with the previous children. Despite Severina’s terror of a
Cesarean birth at the hospital, the entrenched forces of custom, habit, and mistrust of the biomedical health services fatally converged, and were further exacerbated by the disastrous performance during the crisis of those very same biomedical services—beginning with the uncomfortably hesitant and determinedly tardy reactions of the Yomala auxiliary nurse Renato, and continuing through to the highly questionable decisions and actions made by Drs. Cárdenas and Quispe. Yet, in the end and more than any inherent rejection by the interested parties of “the system” per se, however, it had been more of a failure of that same system to live up to its definitive responsibility to ensure the reproductive safety and success of the population.

In the case of Puka Wayq’u, then, the unfortunate consequences of consciously resisting western notions and norms of female health care was the sudden rise in the levels of maternal mortality, as defined by the series of individual deaths. Thus, and with such a tragic outcome, this may even be seen as an example of a failed resistance, in an immediate, lived sense. Such a designation of maternal death as a secondary by-product of both social suffering and social struggle in this case would classify it along the lines of the argument postulated by Scheper-Hughes: an instance of how “dominated people sometimes play the role of their own executioners” (1995:419)—a logic which might, it should be noted, appear to obliquely bolster the rationale exemplified by the internalized colonialism approach. Still, this is also, it might seem, a characterization which possibly comes perilously close to that of a “blaming the victim” paradigm, and is thrown into a harshly suspect light. The resolution of the problem is still ultimately just as complex, debatable and “in process” as is the outcome of the social, political and cultural transformations that Bolivia is experimenting since the original “revolutionary cycle,” now extended (as some would have it) into a decade-long phenomenon. The answers, however, lie not so much in the deaths of the women who have gone before, but in the lives of
those who are exploring the ways in which “intercultural” models may ultimately prove to be the most powerful form of resistance to deeply entrenched and unjust social structures.

**Interpreting Crisis: Professional and Community Actions, Reactions, and Imaginings**

*Blood on His Hands: Severina’s Death, Power Grabs, and the Assignment of Blame*

On that first afternoon after the death of Severina when I went to the health center, I had found nobody at all around with the exception of Lic. Lidia Toranzo, the head nurse, who was counting over a hundred bags of macaroni for distribution to the pregnant mothers on record in the municipality. Usually friendly but moderately reserved with me, on this occasion she smiled but only perfunctorily addressed me directly, and continued silently with her tallying. In an adjoining room, I studied the wall with a posted schedule detailing monthly community visits for the health center teams, while considering my most appropriate move with Lidia under the circumstances. At first I felt that she was acting distant, but then I saw that she was simply busy—and, I suddenly realized, seriously perturbed and increasingly flustered. After a few minutes more she came in and abruptly told me to sit down, and it was obvious that she wanted to talk.

“You know,” Lidia began, leaning on the table as she looked at me, “during the afternoon after it happened, I couldn’t eat, I couldn’t sleep, I couldn’t do anything at all. I just went home. I can barely work right now, I’m so upset. I’m angry.” She emphasized the level of her emotion, concerning what was obviously the topic being discussed although it had gone unnamed, by staring intently at me for what was an uncomfortably long interval, and saying nothing.
“What happened?” I finally asked her. “Or rather, why did this happen?”

Lidia looked increasingly distressed, and waited several moments before replying. “Dr. Javier wanted to do his own inspection, evaluation, I don’t know what, of the señora, and so he had her brought into the center. He did a vaginal examination, he put his hand up, deep [showing me her arm]; maybe it was to try to adjust the baby. I really don’t know. But suddenly, there was something like a loud sound—plash!—and blood spurted out, making a big puddle all over the floor. The doctor’s clothes were covered with blood. I felt so much anger, rage, I wanted to scream! But… I tried to control myself, I had to, because the husband was also there in the room.”

“Why did Javier want to do the exam?” I asked Lidia, the implications of her words slowly dawning on me.

“He shouldn’t have done it!” she exclaimed, looking even more agitated. “It was stupid; he should have just sent her directly on to Tarabuco. He had no right to bring her in. Why did he question Dr. Ramiro’s judgment? It was an authority thing, to show that he’s the boss. You know, there wasn’t even one drop of blood when the señora came in. He did something, Dr. Javier brought on the hemorrhaging. You know what this is? This is medical malpractice.”

It was the first time I was to hear what would become a familiar refrain in Puka Wayq’u over the coming months, and throughout the coming year: the accusation that Dr. Javier Quispe was directly responsible for the death of Severina. Usually uttered in a secretive or confidential manner—although occasionally quite openly—it was the commonly accepted vox populi by virtually all in town—and also down in Yomala itself—and tacitly accepted as unequivocal truth. The origins of the story were clearly in whatever it was that had been observed by those present in the maternity room at the health center on the afternoon of May 16, which was soon reported
by a few, and later repeated by many. And as it turned out, the witnesses to what had happened in the Puka Wayq’u health center were in themselves numerous—in fact, it had been a disconcertedly large group crowded into the maternity room: besides Severina herself and Dr. Quispe, those present also included Lidia, Dr. Cárdenas, medical student interns Juan Carlos and Miriam, Severina’s husband Héctor, Pablito, and Florencia, who was at that time working as the health center’s cleaning woman. Not including Severina, a total of eight persons. (And as if it were not already in itself a questionably sizeable group to accompany such a private and delicate moment—not to mention one charged with implicit danger—and this without even addressing the obvious issues of provider / patient confidentiality and medical ethics—the odd presence of Pablito and Florencia was never adequately explained or justified to me.) In regards to who later “talked,” it was very evident that all had publicly given their opinions at one moment or another—with the probable exceptions of Juan Carlos and Miriam, undoubtedly for precautionary reasons owing to their relative “subaltern” and tenuous student status at the health center. As it later transpired, the most openly vocal among them had apparently been Lidia and Florencia; however, it was also apparent that, again, all who had been in the maternity room that afternoon were either protecting themselves, or looking for a way to attack Quispe, or both.

In this regard, and most specifically in the case of Lidia, her direct denunciations to me (a relative outsider) of Quispe—the center director and her superior—concerning a work-related conflict were notable; openly “airing the dirty laundry” in my presence, so to speak. What was later to become clear over the succeeding months was that a serious internal conflict was intensifying in the health center, with Javier Quispe at its center—already simmering, but tipped into a critical stage with the death of Severina—and which would result in a power struggle among virtually every staff person present. Lidia had already been off to a rocky start with
Quispe almost immediately after his arrival on the scene two months previously, frequently squabbling over different points of authority and questions of “turf,” and it seemed obvious to me that she was drawing battle lines and trying to establish alliances during the days immediately following the Severina incident, with questions of culpability clearly in her mind. Significantly, these attempts at coalition building included, first, her apparent confidences in the local gringo anthropologist who must have had connections (albeit unclear and unconfirmed) to individuals who must undoubtedly be somebody of weight back in Sucre. Also concerning Lidia’s comments to me, her defense of Ramiro Cárdenas (“Why did he question Dr. Ramiro’s judgment?”) was unusual. Cárdenas, although affable and well-enough liked as a person among the center staff, was also typically the target of much whispered sniping because of his drinking problem, which was additionally related to a generalized (though usually unspoken) sense that he really shouldn’t still have been an active duty medical personnel—let alone assigned to the interim managerial position he had held, prior to Quispe’s appointment in Puka Wayq’u. And, as if to only further consolidate and exacerbate these underlying and disparaging opinions, Cárdenas’s behavior that day (disappearing in Yomala for a prolonged period of time in order to find “something to drink,” while Severina was agonizing in the midst of what was obviously a dangerous emergency birth; the ear of corn on the way out of Puka Wayq’u) was well-known by all, and very early on was already embarrassedly (although, it must also be recognized, typically not indignantly) commented upon, albeit in a hushed up kind of way. He was, though, also one of Lidia’s superiors, and also obviously not at all on good terms with Quispe, and therefore the figurative “enemy” of who had unfortunately suddenly become Lidia’s own “enemy”—and, therefore, he was her potential “friend.”
Following her initial outburst against Quispe that afternoon, together with other related words expressed with outrage, Lidia gradually calmed herself, even becoming reflective.

“What’s happening in Puka Wayq’u?” she wondered aloud. “There are five maternal death cases now, just since last year. This never happened, before last year—that we know of, at least. It’s so confusing. And what’s going to happen to Dr. Javier now? He’s already got two maternal deaths on his record, in such a brief time. He really is at fault, but we’re also all at fault. Things are bad here. The town government doesn’t help with health, they don’t do their part. There’s a transportation problem; the old ambulance is a real piece of junk. We need a phone line here at the health center, urgently. And…” Her voice trailed off, but then she looked at me again with an indignant expression. “I know that we’re kind of a Church project,” she said, “but this all has to change. You hear stories about women with 16 kids; now look at this maternal mortality case. And the other one, from just last month. This can’t go on. The Church doesn’t want family planning, but then it doesn’t matter to them all of the poverty, the abandoned kids, women’s health. At least for the last two years we’ve been sort of permitted to tell the señoras how to get different methods, but that doesn’t always work, because those aren’t available in Puka Wayq’u, and the señoras can’t always get to Sucre. So, what can we do?” Lidia didn’t seem to have an answer to her question, and slumped back in the chair, an increasingly distant look on her face.

At this extremely early stage of the tragically unfolding situation, it seemed confusing, uncertain, volatile. What transpired over the following days, weeks, and months, however, was that Quispe effectively became the central, even essential, figure at the core of the painful and messy events in Puka Wayq’u. This refers to a conflicted dynamic from opposing directions: on the one side, Quispe gradually—but perhaps inexorably—became the focus of official attention in Sucre, as the SEDES searched for an acceptable explanation to account for the series of
unacceptable mortality events in the municipality, and for a viable solution. In addition to the specific measures proposed at the inter-institutional meetings, this would soon take the somewhat facile (and ethically dubious) form of identifying a single individual—a “fall guy”—to absorb most of what might be ultimately construed as a more collective body of responsibility for all that had not been done preventively in the past, at both community and higher official levels. For his own part in the events, the other health center key actor, Dr. Cárdenas, was an easy target: his misconduct had been blatant, egregious, and very public, and he would quickly pay the consequences (as I will discuss below). Yet Quispe represented something more organic, more systemic, in that he was at that time the “official face” of the national health care structure in Puka Wayq’u. He was young, newly appointed (vetted by Señorita Ruth herself), and was supposed to have brought the municipal epidemiological statistics up—and not, conversely, to have played a direct supervisory role in a plunge into even lower depths.

**Affliction and crisis embodied: Doña Tomasa**

Probably the most glaring—and potentially tragic—indication of Dr. Quispe’s failing grasp on both the immediate reality of the public health crisis roiling around him, and on his own handling of it, came at the end of June. It was, additionally, an event which directly involved myself and my family in ways completely unforeseen, undesired, and disconcertedly ironic. This was the “near miss” episode involving Doña Tomasa that I have previously alluded to, in which her late-term pregnancy (32 weeks) arrived at a critical juncture: one in which she could have easily died; and, in which her baby did indeed die, at birth. The circumstances surrounding the incident were sudden, frantic, and confusing, but Quispe’s decisive role in it was undeniable to all—that is, with the possible exception of himself.
At Doña Tomasa’s last prenatal control, two days before, Quispe had repeated a previous recommendation—from two weeks earlier—that she go to the local secondary level reference hospital in Tarabuco, in order to take blood and urine tests and an ultrasound exam. On that occasion, he had diagnosed her as being overly anemic, and noted that the fetus was experiencing serious bradycardia. For whatever reasons, Doña Tomasa had not yet heeded his directive—perhaps her personal rationale in delaying had something to do with the long-ago lost baby, so associated with the hospital services—yet, neither had Quispe followed-up on the case, or instructed any of the health center staff to do so either, let alone had he made a proactive move to get her to a more advanced medical facility. But now she was experiencing significant pain in her back and abdomen, complained of a “dirty water” discharge, and had felt no fetal movements since the day before. Although she hadn’t spoken with anybody about it except for Don Alberto, she was by now growing increasingly anxious.

However, this crucial, and by any standards highly worrisome, situation came to light not in a meeting between Doña Tomasa and Dr. Quispe, but rather in conversation between her and Karen. In what was little more than a momentary encounter and part of the daily routine, Doña Tomasa told her, almost casually, that she was preparing to go to the hospital in Tarabuco—having finally felt compelled to make the move—on that afternoon’s truck. At Karen’s questioning of what the problem was, Doña Tomasa detailed the situation and confessed that she hadn’t spoken with Quispe again since the other day, or with anybody else in the health center, out of a fear that he would get angry and yell at her (renegar) because she hadn’t gone to the hospital weeks before, when he had first told her to do so. She was still reluctant to do so now, but was seriously worried about how ill she felt, and the lack of fetal movements, and believed that she had no alternative but to act. Karen was startled, and indignant that Quispe had not kept
closer track of her pregnancy status, and also very concerned about the prospect of Doña Tomasa—in her advanced condition and with an undetermined obstetric difficulty that was obviously not to be taken lightly—sitting in the back of a truck for two or three hours on a bumpy road, crowded in with other travelers and their sacks of potatoes, barley, chickens, and what have you. Yet when Karen hurried over to the health center and complained to Quispe, expressing her opinion of the urgency of the situation and how Doña Tomasa should be taken to Tarabuco immediately in the ambulance, he was more taken aback that the non-physician gringa researcher was, as Karen put it, “telling him how to do his job,” and balked. He entered into a heated discussion with her, at first claiming that he didn’t know where Doña Tomasa lived (which was just across the plaza from the health center), and then strongly criticized her (Doña Tomasa), insisting that she should have gone to Tarabuco days ago: that is, any problem now was wholly Doña Tomasa’s own responsibility.

Only after a lengthy argument with Karen did Quispe grudgingly relent to go to the house and examine Doña Tomasa; once there, he confirmed that not only was there a heavy discharge, but also that the fetus was indeed without any discernible movement. At that point, he consented to send her in the ambulance—in the older, more decrepit of the two, with the questionable excuse that “Pablito has the day off, and he took the keys to the new ambulance.” Still, this was only after Quispe had indeed lectured and reprimanded Doña Tomasa, in front of a group consisting of Don Alberto, student intern Miriam, and Karen, for not having gone sooner to Tarabuco on her own. To this, she could only dolefully apologize. Accompanied by Miriam—who sat up front, obliging Doña Tomasa, along with Don Alberto, to sit on the hard back seat (there was no stretcher in the old ambulance)—they left for Tarabuco. I was in Villa Rosario at the health post that afternoon, and saw the ambulance speed past, in a cloud of dust, with unclear
figures seated in the back. “Hey,” I wondered aloud to Francisco, the local nurse auxiliary, “what’s going on in Puka Wayq’u?”

What transpired later we learned from the hospital staff in Sucre, Don Alberto, and from Doña Tomasa herself. In Tarabuco, the hospital gynecologist examined her with what was apparently great alarm and determined that she was in an extremely precarious condition, and beyond the scope of their technical abilities and available infrastructure. Doña Tomasa was sent immediately to Sucre (in the regional hospital’s ambulance), and to the SEDES third level facility, the Dr. Jaime Sánchez P. Gynecological-Obstetric Hospital. The fetal heartbeat was 60 per minute upon arrival at the hospital, instead of an ideal 120 - 130. An ultrasound and an emergency Cesarean section were performed; the baby, a boy, was born alive but died after only a few minutes. Much to everybody’s taken aback surprise, the baby suffered from grave and multiple deformities which had not been previously diagnosed (as no previous ultrasound had ever been performed on Doña Tomasa): a severe cleft lip extended up to eye level; the intestines were partly exposed; toes were missing; and there were no lower arms, while fingerless hands protruded from the shoulder stubs. In describing the unsettling scene in the operating theater to us later in Sucre, Dr. Esteban Tellería (coincidentally, someone we already knew, for he had been one of the residents at the Puka Wayq’u health center earlier in the year, when we had first arrived in town) was visibly disturbed, describing his feeling of shock when he had seen the severity and unusual nature of the deformities. The attending physicians had all quizzed Doña Tomasa and Don Alberto afterwards on possible exposure to toxic chemicals, and on any medications that she may have taken during pregnancy; however, no confirmed cause of the fetal defects was ever unequivocally established.
Dr. Tellería’s overall professional opinion of the situation, based on what he knew: Doña Tomasa was a high-risk case, and should have been identified as such during the course of her pregnancy; she probably should have been moved out of Puka Wayq’u at least two weeks previously, following her prenatal visit with Quispe at that time and when the fetal bradycardia had been first identified. At the later prenatal visit two days prior, Tellería believed that she indisputably must have already had a severely distended and overly large abdomen—an indication of excessive build-up of amniotic fluid, and a frequent tip-off to birth defects—and that the vaginal discharge must have already been quite noticeable. All of those signs and symptoms were more than enough of a justification for an immediate emergency referral to Tarabuco, he maintained, if not directly to Sucre. When he heard that Doña Tomasa had been on the verge of journeying to the city with the daily truck, Tellería looked startled: “She very possibly wouldn’t have survived the trip. That was an extremely delicate situation. Her uterus was probably like a water balloon, filled up way too much, overextended and stressed, and could easily have ruptured. That in turn could have caused the placenta to rupture, which would have caused uncontrollable bleeding, critical and difficult to control even in a hospital setting—let alone bouncing around in the back of a truck on the road to Tarabuco.”

Neither Doña Tomasa nor Don Alberto ever saw the deceased baby, or had wanted to. They simply had no desire to deal with it—a nurse at the hospital said that she would take care of the body, and get a baby coffin for it. Later, back in Puka Wayq’u, Don Alberto couldn’t stop praising the nurse, and how helpful she had been—yet his effusiveness seemed curiously overeager, almost agitated, and also somehow mystified. It was simultaneously seemingly unconcerned, and even a little put upon: a distraction from his weightier and more profound concerns; how he had lost so much time tending to his cows, for example. In what we perceived
as a kind of warping of his confusion, grief and remorse, he focused the attention on himself:

“Why do these things always happen to me?” he asked plaintively; and again his old familiar, pitiable line: “I just want to go away from here, go away and die...” When he had returned to Puka Wayq’u from the city, Don Alberto brought the casket with him (and I had desperately hoped that neither he, nor any of their children, had dared to open it and look inside), for burial in the windy and lonely cemetery on the hill. Meanwhile, Doña Tomasa continued to convalesce for another week at the hospital in Sucre. She had had a tubal ligation after the Cesarean section, by her own choice.

Thus: was what happened to Doña Tomasa a “near miss”? Was Dr. Quispe seriously guilty of (another?) flagrant case of negligence, one which might have resulted in yet another grim statistic for Puka Wayq’u? What probably draws the greatest attention, of course, is that the Doña Tomasa incident occurred precisely during the height of the Puka Wayq’u emergency situation, when the local health personnel were supposedly on high alert and vigilant exactly for a case such as this one—beginning with Quispe himself, as the health center director. On a later date, in discussing what had happened in regards to his interaction with Doña Tomasa, and that of the health services in general, Quispe commented to me—somewhat ingenuously, as if I were unaware of all the details—that “it was critical for her to get out fast, because each birth nowadays is a risky birth; we’re in a zone of high risk for maternal mortality.” Following the official state line, it was a notion, a discourse, which he had openly adopted and embraced. Nevertheless, his words were paradoxical, and obviously contradictory to what his demonstrable actions had been—and, if it had not been for the concerned and obstinate pressure exerted on him by external forces originating from outside of the health center proper (namely, Karen),
Doña Tomasa very well might not have survived until the end of the day—which was something that Quispe, at least in my experience, was never to openly concede.

I must also recognize and acknowledge that this was an instance of the ethnographic subjects being directly impacted by the ethnographic researchers, in an overtly tangible manner. The conscious and decisive intromission of Karen, and later myself, into the very heart of the Doña Tomasa drama undeniably altered its outcome in ways difficult to conclusively establish, but equally difficult to deny. Or, for that matter, to reasonably question in respect to its very legitimacy. The pursuit and the observance of straightforward anthropological “professionalism” and “purity” through a steadfast dogma of theoretical distance and separation between “researcher” and “subject” may very well need to be reconsidered—as all fieldworkers typically discover at one time or another—on a wide continuum ranging from complete inactivity, to subtle collaboration, to aggressive intervention, and all points in-between. This was an instance demanding the latter. For, in this case, the hypothetical alternative was of such a frighteningly tragic nature, that to have acted otherwise under the circumstances would have been not only unthinkingly insensitive and inexcusably unethical, but above all it would also have been antithetical to the stubbornly human quality of the anthropological endeavor itself—an ethical role focusing on praxis which Scheper-Hughes (1995) defines as “witnessing.” Indeed, in this particular instance it would have additionally been a violation and a lack of respect for the very ubiquitous and pervasive nature of compadrazco—that quintessentially Bolivian quality of mutual respect and reciprocal social contracts—which had, albeit in a somewhat nebulous fashion, become so vital for us as fellow citizens (however temporal that may have been, in an “anthropological time” sense) and confidants in the town of Puka Wayq’u.
In the end, and other than simply yet more issues of medical negligence and/or malpractice, the episode involving Doña Tomasa (and Dr. Quispe’s role in it) was indicative of something wider, which opens up the questions of affliction and crisis beyond the suffering of an actual maternal death as the focal point. In itself, it is noteworthy that Doña Tomasa was a very potential death, but escaped becoming one. Hence, her very real suffering—her dismissive treatment by the health center personnel, the physical ordeal, the deformed and dead baby, her own narrow avoidance of a very conceivable fatal obstetric disaster, the undeniable emotional aftermath—reveals, I think, something structural, organic, latent, what may be termed as something pervasively subterranean in society that was occurring at that time, which manifested itself through her, and which must be accordingly considered: something that connotes suffering and underlying crisis in both a manifested and an abstract form, even if in this case an actual death (fortunately) failed to ensue. In a numbingly symmetrical fashion, Doña Tomasa’s own personal obstetric crucible, which brought her close to the border of her own mortality, thus reflected and reenacted the wider conflicts and crises which were then swirling about and inside of Puka Wayq’u. These, as I am arguing it here, concerned questions of the misuse and abuse of knowledge and power, indigenous and gender positionality, and the limitations of what was still very much a colonially descended health care system in theory and in practice.

**Hubris and paranoia**

Eventually, both the internal and the external pressures from the Severina episode began to wear on Dr. Quispe in what were strikingly public and disturbing manners. He was well aware that he was blamed by much of the center staff for her death; and that the community at large, in both the towns of Puka Wayq’u and Yomala, also not-so-subtly harbored the same opinion. In addition, there was the written documentation that he was repeatedly required to file
with the SEDES while it underwent a lengthy review of the Puka Wayq’u organizational structure, which had obviously been precipitated by the Severina incident; and then there were also the guidelines laid down in the inter-institutional meetings (as poorly implemented as they were). Perhaps it was the rising levels of this tension, being at the center of the debate over “what went wrong” in Puka Wayq’u, that brought him to such contradictory and paradoxical lapses in judgment and basic good sense—including, by way of prominent example, that of the incident involving Doña Tomasa.

Around the middle of the year, Lidia instituted a legal process against Quispe for malpractice in the death of Severina. With this open challenge not just to his authority as the health center director, but also to his very competency as a medical professional, and ultimately to his professional reputation and integrity as a member of the community, it was effectively the “beginning of the end” for Quispe. Lidia amassed an impressive amount of documentation related to the events in Yomala and later in Puka Wayq’u, including medical reports, hospital evaluations, and (most importantly) personal testimonies. These latter accounts not only directly accused and implicated both Quispe and Cárdenas in the death—the greater part specifically revolving around what had transpired in the Puka Wayq’u maternity room, and the sudden hemorrhaging—but were also personal affirmations of support for Lidia herself, in what was the developing institutional struggle between her and Quispe. There were signed statements from local dirigentes, community members, some of the (braver) nurse auxiliaries from the health posts, and from Severina’s husband Héctor: all of these backed up Lidia’s version of the events. (In the case of the reclusive Héctor, however, I couldn’t help but wonder how much she might have “coached” him in the matter, despite what would certainly have been a justifiable interest on his part: the two-page handwritten document in Spanish with his signature at the bottom
obviously had not been written by Héctor himself, who was known to be both illiterate and essentially monolingual in Quechua.) And, with me personally, anyone who was willing to openly speak about the subject invariably took Lidia’s side in the ongoing dispute.

As the maternal and child health indicators in the municipality remained more or less static at poor levels, month after month—fortunately without any further deaths, at least—the situation was not improved by Quispe’s increasingly autocratic, if not erratic, behavior. Initially, his offensive was mounted solely against Lidia: counter-legal challenges at the departmental level; derogatory quarterly personnel evaluations about her to the health district; and an almost daily chilly dismissal and denigration of her around the workplace. However, and as the latent and subtle tensions grew in regards to the other center staff also, and then to scattered incidents in the community at large, he began to reach beyond Lidia herself, and to counter-attack by targeting those at the health center who were clearly speaking out against him, albeit in an “off the record” fashion. In this manner, Quispe struck out in what could only be construed as a form of both defense and retaliation for being on the “wrong side” of the confrontation. An obvious concern for him was in regards to those who had been present in the maternity room during Severina’s crisis moment—that is, the employee witnesses to what had occurred. By this time, Cárdenas was already gone (as I shall further discuss, below); Juan Carlos and Miriam could have had their intern rotations extended, but Quispe denied them that (although for their part, they showed little interest in continuing in Puka Wayq’u), and both returned to Sucre. Pablito, for his part, obviously considered keeping his job to be the most important thing, generally steered clear of the matter and usually avoided any comments when asked, and never became a “threat.” That left Florencia, who had clearly voiced her opinion of what had happened at
specific moments—and she would pay the consequences for this, when Quispe later terminated
her long-term contract as the health center cleaning woman.

Eventually, Quispe began to pressure some of the nurse auxiliaries who were beginning
to make critical comments, while the others kept their silence in obvious fear of their own
positions. He then attempted to phase out Sonia, the health center administrator who, together
with her fiancé Alejo (who worked in the municipal government), were the principal co-litigants
on Lidia’s legal claim, in the quality of both character witnesses and “concerned citizens.” This
growing tension culminated later in the year, with the spontaneous uprising of approximately
half the health center staff, when Quispe tried to conclusively terminate Sonia’s contract. During
an afternoon of angry denunciations and accusations, and much shouting and weeping by a
few—a meeting at which almost all of the center staff were present, and which was mediated by
a somewhat ill at ease Padre Antonio, but without the presence of Dr. Quispe—a petition for the
health district in Tarabuco was circulated requesting the director’s immediate dismissal. Still,
not everybody felt comfortable in signing. Very soon afterwards, close to the end of the year,
and for whatever legal or political reasons, Lidia’s case against Quispe was dismissed by the
attending court in Sucre. She was then immediately and permanently transferred by Health
District 2 out of Puka Wayq’u to another rural Chuquisaca municipality, effectively out of the
picture altogether and thereby no longer a “risk.”

Throughout the growing rift in Quispe’s frustrated relations with the health center staff,
evident virtually from the outset of his tenure and certainly before the maternal deaths began to
throw things so off-course, and finally when it reached the extremes that I detail here, Quispe
came to appear increasingly damaging and ultimately “expendable” in the official eyes of the
SEDES. However, it would presumably have been too open an acknowledgement of official
state and institutional negligence and culpability to have taken a strongly proactive stance very early on—especially before the health services themselves were subjected to a more prolonged process of evaluation and analysis. While he was still in power, some commented that Quispe was able to hold on because of his personal friendship with Dr. Freddy Zamora, the then administrative director of Health District 2, and who was Quispe’s immediate superior. This was definitely a probability, but the more likely scenario—and as I was able to intimate from the SEDES authorities in Sucre—was more fundamentally that at the departmental levels they were trying to, in effect, “ride out” the unexpected crisis and inconvenient controversy, without drawing any more public attention than was necessary. Apparently, the hope was that Quispe would eventually pull things together himself; or, that the other health center staff would be able to bring things under control, at least until they (the SEDES) could find the right moment to act decisively.

So, it wasn’t until the first month of 2005, and following what had finally come to official attention in Sucre as the catastrophic levels of low morale and infighting around the health center, that the SEDES terminated Quispe’s assignment and removed him from Puka Wayq’u. As expressed to me (typically “off the record,” and in markedly uneasy terms) by different SEDES authorities, the direct rationale for his firing was indeed the inexorably mounting impact (communal, departmental, ministerial) of his seriously questioned role in the back-to-back maternal deaths of that year, and most particularly in regards to Severina—at the least, almost certainly medical negligence, and indeed very possibly bordering on malpractice. This was in addition to the historically compounded factors of Quispe’s already recognized inefficient managerial style, and his abysmally poor relations with the health center staff members—although both of these factors were being perceived as virtual by-products of the mortality
episodes and their fallout. Consequently, and in the official SEDES estimation, the unexpected deaths succeeded in pushing Quispe’s shaky institutional status beyond one of mere professional mediocrity and monthly statistical reports filled with stagnant childhood illness indicators. These were transformed into the embodiment of an irrefutably moribund and flailing municipal health system, beset by crises ranging from an intensity both chronic and low grade, to acute and dangerous, and which were negatively impacting outward appearances extending from the epidemiological profiles of Health District 2 and the SEDES Chuquisaca, to the ministerial and public reputation overall.

Ironically, Dr. Quispe’s eventual discharge occurred only a few short months after Lidia’s own removal. However, in his case, the procedure was not that of simply being rotated out of his current administrative position, and then re-assigned far away from the scene of his downfall, as would be the typical SEDES response. With Quispe, his contract was definitively cancelled, thereby ending his tenure with the state health services. This was, undoubtedly, a dismissal that was very much a long overdue partial “sacrifice” on the part of the health authorities, in order to best and finally wash their hands of the Puka Wayq’u mess. Over the course of the following years I completely lost track of him, and nobody I knew—in Puka Wayq’u, in the SEDES, in Sucre overall—had any knowledge as to Quispe’s whereabouts. (“Only God knows,” Celia Ramírez, of Plan International, tersely replied to me when I asked her at one point in 2006; “nobody else wants to know.”) Eventually, early in 2008, I heard a story that he had opened a private medical practice in the city of Potosí—but, I was never able to confirm this.

Quispe’s trajectory in the directorship of the Puka Wayq’u health center was a downhill slide which, if it had not been for the maternal death crisis, very probably would have settled into
an uneasy and unhappy routine of staff discontent on the one hand, and the medical director’s own personal ambitions on the other. Early on, his authoritarian demeanor had served to significantly alienate him from most of his co-workers; the highly vertical system that he implemented in the health center (even when considering the frequently rigid hierarchies typically incorporated into Bolivian state bureaucratic apparatuses) was definitively disliked and sullenly commented upon by much of the staff almost from the start. Thus, and even without the unexpected mortality incidents, he had already set himself onto somewhat tenuous ground, a status which was unfortunately fashioned and consolidated by his own approach to managing the Puka Wayq’u health center, and then his later aggressive behavior. In the end, for me Quispe’s tenure was a sad cautionary tale, ultimately a classic case of megalomania and personal ambition gone wrong, and how that may spiral out into not only individual destruction, but also into conflict and tragedy for those around him—what was very much a descent into uncontrolled paranoia, bringing down some with him, and yet others around him nearly so. (I was later to exert way too much energy in attempting to adequately determine the best “literary” analogy for Quispe’s character, none of which were especially flattering or uplifting: Macbeth? Ahab? Michael Corleone? Kurtz in his heart of darkness?) It was a professional (self) immolation and personal forced disappearance, through the lens of governmental emergency control; a community crisis wrought individual, resulting in decisive suffering of one kind or another for all concerned—ranging from the medical director himself; then to his staff at the health facility; the long line of patients (mothers giving birth, or otherwise); a “near miss” fatality such as Doña Tomasa; and, finally, to the extreme reach of the definitively dead mothers at the center of it all.

“I believe that now, during this year, like never before,” Quispe had said to me on an earlier occasion, “Puka Wayq’u is closely watched by everybody, precisely because of the
maternal deaths since last year.” We were sitting in a café in Sucre, where we had coincided on our respective week of “time off” in the city: I from fieldwork, and he from the daily grind of what was increasingly becoming a complicated and tense situation at the health center. (Although his formal reason for being in Sucre at that particular time was still work related, for informational workshops at the SEDES.) We were meeting after the Severina incident had occurred and once the crisis wheels were well set in motion, including the inter-institutional meetings, but before the mounting backlash against him personally had been fully established and the scene around the Puka Wayq’u health center had irrevocably disintegrated. He and I were still on relatively good terms. (Although we were never truly on actual bad terms; in later months, it was more of what could better be termed as a vaguely distant, sometimes strained relationship.) On this occasion, it had been Quispe who sought me out, rather than the other way around, back in Puka Wayq’u when he learned that we would both be in the city at the same time; he had enthusiastically suggested that we meet for a beer. Soon on, it became apparent to me that he was seeking someone to open up to, to confide in, someone he felt was “at his level” and safe in these times of stress—in essence, it was a friend he was looking for, and he increasingly had fewer and fewer of those in Puka Wayq’u.

“And, precisely because the personnel at the health center weren’t committed to the work at hand,” Quispe continued, “all of the eyes are pointed at Puka Wayq’u: not just because of the maternal deaths themselves, but because of the problems with all of the local medical and public health programs.” His ruminations about the nature of the critical mortality state of affairs, thus, shifted to a not-so-veiled condemnation of the health center staff—a “problem,” in his eyes, of professional competence and discipline that he was there to fix, by attacking it at the roots. I saw at that moment that Quispe perceived of himself as the answer to the developing crisis, rather
than—just perhaps—as one of the causes of it. He elaborated on this yet further: “We’re still at risk. And even more, you know, it’s really that the entire Yampara culture has a predisposition for its own socioeconomic condition, for its malnutrition, for its idiosyncrasies, because they always go to the health services last when they have a problem.” Hence, in his view Quispe conceived that the blame was also on the very “culture” itself: it was predisposed, preordained, preternaturally fashioned to bring ruin upon itself and, furthermore, it was his own special mission to put the house in order—a task that was his sad yet inexorable duty to perform, and one approaching that of near moral obligation. (“This whole act’s immutably decreed,” Ahab declares at one point during the second day of the chase, when the going was getting pretty tough, in defense of his obsessive but unquestionable rightness, for whatever the reason and whichever the circumstances. “I am the Fates’ lieutenant; I act under orders.”)

It was an all too common quality not only in Dr. Quispe but, and as I have discussed here, also in a more generalized sense among the health services as an institution. The notion of a coloniality of power in health was specifically contingent upon an unequal balance of power between provider and beneficiary; this imbalance, in turn, depended upon an entrenched, intrinsic and intransigent moral belief system in order to sustain it. The pervasive environment of both internal and internalized colonialism consequently served as an underlying common denominator: as an element in the actual chain of factors which precipitated the fatal events; and later as a subsequent framing for Quispe’s own interpretation of these same events—and, ultimately, of his reactions to them. This included how the individuals surrounding him were dealt with, in an increasingly defensive, and then preemptive manner, seeking an advantage for himself personally—as was the approach also of the state and nongovernmental institutions in Puka Wayq’u and Chuquisaca, maneuvering for greater power in the wake of a crisis which had
been, in many ways, foretold. All of them, Quispe included, were thus both creators and products of the series of events. In the end, I also couldn’t help but acknowledge that Quispe had come out of the tragedy something of a victim himself, who had lost most of what he had had, and much of that due to his own mistaken mishandling of the situation.

A final note in this vein, qualifying and cautionary, which must yet be recognized and acknowledged. Despite all of the above, Dr. Quispe, and the other physicians and nurses in Puka Wayq’u at the time of the crisis, were not necessarily bad people, not at all malicious or malignant—albeit occasionally misguided and sometimes even paranoid, perhaps. I believe that they usually considered themselves to be doing the “right thing” in their respective caregiving. But, nevertheless, in the Bolivia of then—and still in the Bolivia of today, even while taking into account the undeniably transcendental changes since 2006—they exist in, and are part and product of, the historic colonial state apparatus that I have invoked throughout as my central argument, and which has very clear, albeit not always precisely defined as such, social and cultural objectives concerning power and control along racial and ethnic lines. This historic apparatus as constructed, in a sense, actually thrives on crisis, and actively strengthens itself from the ruptures that may, in fact, indeed be an organic aspect of its social framework.

Guilty Until Perceived Innocent: Community Narratives of Responsibility and Retribution

The health personnel: allegations and denunciations

Early one frigid morning in mid-June, as I waited on the corner for the truck from the cordillera going to Sucre, with plans to get off in Villa Rosario, René, the local police officer at the time, appeared up the street. (There was only one officer at a time assigned to Puka Wayq’u, who was nominally in charge of whatever laws needed enforcing throughout the entire
municipality; they were rotated in and out of Sucre on a year-long shift basis.) He was wearing his olive green uniform, singing incoherently in a moderately loud voice, and it was obvious that he was more than just a little bit tipsy. In fact, René was yet another local known to have something of a drinking problem (occasionally mitigated for the purposes of general public approval by his guitar playing, which was actually quite good), and his wife, Juana, constantly had to fetch him from wherever he had last ended up after a binge. “Hum,” I said to myself, when I caught sight of him, “long night.” René saw me and walked up, addressing me forcibly in an intense, although not aggressive, drunken kind of way, which nevertheless needed to be managed diplomatically. His eyes were red and watery. I humored him in meaningless conversation for several minutes, all the time wondering about the truck and wishing that it would finally arrive.

Suddenly, René stopped short and stared at me with an angry face. Seemingly out of nowhere and with no apparent relation to whatever his previous line of dialogue had been, he forcibly leaned in toward me. “That maternal death, Don Brian,” he demanded, “you know?”

I was caught off-guard, and cautiously asked, “Yomala?”

René nodded vigorously. “He killed her!” he exclaimed, his voice rising into a shout. “Goddamit, he killed her, that doctor killed her!”

I tried to determine whether he was referring to the “old” doctor—Ramiro Cárdenas—or to the “new” one—Javier Quispe.

“The new one. You know, right? Javier. And if he were here right now, I’d tell him so!” René began to sob with rage, his face turning as red as his bloodshot eyes. “Asshole. It was his fault. You don’t stick your hand up like this, dammit,” he cried, holding up a fist and indicating a depth reaching to his elbow, “up to here, all inside!” Then he showed me two pointed fingers,
held together. “It’s just like this.” René looked spent, pained. “I feel so sorry for Ramiro,” he said with a long sigh. Then he furiously straightened up and implored me, “Why did she die? She shouldn’t have died!” He began to weep again, messily. From his drunken and melodramatic entreaties, uttered while uncomfortably poised only inches in front of my face, it wasn’t quite clear whether he was demanding a direct explanation from me, personally; or, whether it was René’s own version of a metaphorical and existential cry of anguish for the sake of Severina and her lost soul, and for the souls of all the other nameless women also so sadly and needlessly sacrificed in the depths of the Bolivia profunda.

At that point, René’s ten-year-old daughter Catalina materialized at his side, tired, disheveled and shivering in the early morning hours, and in an increasingly desperate manner tried to get him to move away with her. A moment later Juana appeared. “Let’s go, René,” she said in a weary tone of voice, and obviously embarrassed that she was forced to enact their little ritual yet again, this time in front of me. René continued staring into my eyes, a confused look on his face. I told him to go home, to get some rest, and that we would talk later. He finally shambled off without saying another word, visibly exhausted, guided and held upright by the two women.

Even while taking into account his altered state at the time, it was nevertheless quite obvious that René firmly believed in the widely circulating version of the events, and of Quispe’s culpability in the death of Severina. Whatever the “truth” might have been in the matter, the important point was that in the case of René and so many others in Puka Wayq’u and Yomala, this was indeed the truth for him: that Dr. Quispe had killed Severina. Some did implicate Ramiro Cárdenas also (not unsurprisingly, mostly people in Yomala), but that was almost a tangential issue, or one semi-overlooked, even discounted—in what was (for me) often a
disquieting kind of way, owing to Cárdenas’s own recognized weakness with liquor.  

Undoubtedly, this had much to do with the fact that he was generally so well-liked as a person, and as a kind of local staple around town. It was, then, notable René’s pity here for Ramiro—presumably, for the latter’s having become so unfortunately and inextricably enmeshed in not one, but two local back-to-back maternal death dramas, despite being such a “nice guy”—and virtually in the same breath and on a par with the anger and distress that René exhibited over Severina’s death, and Quispe’s assumed role in it.

Yet, where did this personal suffering assumed in Severina’s name come from, alcohol-fueled or otherwise? René hadn’t known Severina personally, and he certainly bore no individual responsibility for her death—in fact, his overall personal involvement in the incident had been very minimal, and he hadn’t even been called to Yomala to accompany the required health center verbal autopsy investigation, as he had been previously in the case of Damiana in San Marcos. In fact, in this lack of actual personal ties to the death, René and I shared something in common: we were both essentially “outsiders” to Puka Wayq’u society, present in town and in the municipality in general for only a relatively brief amount of time. In René’s case, of course, it was a job that he was assigned to. But we had both become caught up, in our own respective ways, in the confusing little tragedy with big implications that was unfolding in Puka Wayq’u. And, in a similar fashion, we both seemed to be trying to figure the whole thing out, and what it all meant. In René’s case, he was seeking not only an explanation, but also blame, a scapegoat, that “fall guy” to pin the whole thing on, which would make it all so much easier to comprehend in any profound sort of way. Otherwise, and in perhaps finding it necessary to broaden the explanatory scope out from a simple “whodunit,” René and everybody else would have been forced to openly acknowledge, to themselves and to others, their unsettling and
unspoken ill at ease that something deeper had gone wrong in town, that something else had broken, had ruptured, that was emblematic of the system itself.

Perhaps I myself didn’t feel that intangible and unarticulated apprehension at the time, due to my own position of “detached observer” (although I would feel it later, as the circumstances and the spoken words of the community and the distant urban authorities inexorably accumulated): after all, what did I ultimately have to lose? Despite my long-term relationship, and sense of commitment, with Bolivia (and, as it was to turn out, with Puka Wayq’u itself, counting a minimum of one to two return visits per year since 2004 - 2005), I could obviously still simply walk away from town and everybody in it without anything tangible to actually hold me back. René would eventually walk away also—for him, it was “only a job,” and his would indeed be a total disappearance from town, never to be seen again, at the end of 2004 and his temporary police assignment. Conversely, of course, such an exit was not at all a simple feat for those actually from Puka Wayq’u. However, and whereas both René and I had become personally enmeshed in the fabric of the community, albeit briefly and fleetingly, my sense was always that he somehow recognized deep down that Puka Wayq’u was the same as all of the other little towns that he had previously been stationed in, and would be sent to later on, in work details yet to come. That is, these pueblitos weren’t in any way islands, and both their interconnectedness and their “involvement with [hu]mankind” signified something dismaying about the inherent nature of the society that they were a part of. Severina’s death had put that into stark relief—and that had to be disquieting for René, as it likewise was sure to be for many others, in unforeseen ways.

It was also intriguing in this particular instance with René to see the same gesture that Lidia had made to me once or twice in the past—including on that first afternoon after the
original incident—and which was to rapidly attain a virtually iconic status in its common mimetic repetition among almost all those who recounted Severina’s fate. I refer here to the raised arm, and the outraged admonition that Quispe had inserted his own hand and arm “up to here” during the vaginal examination. (And, in my also commenting on it in what is perhaps an unfairly ironic fashion, another unanswered question on this occasion was René’s claim of an amazing and previously unknown gynecological expertise in reference to his subsequent demonstration of how a proper exam should have been performed on Severina.) It was a procedure roundly and universally condemned throughout town as unwarranted—and, it was rumored, ultimately constituted the cause of her death. This was what I later came to denote simply (and vaguely irreverently, I must admit) as “the hand story,” and which was what best exemplified the generalized popular opinion concerning the perceived accountability of Dr. Quispe. René’s version of the events was of course a recounting of the stories told by others; but, the precise number of generations in the telling between the actual physical observers in the maternity room, and that of he himself, was very much open to debate—indeed, it was not always clear what precisely the original story might actually have been, or again just what the “truth” really was (cf. Geertz 1973:7-9). My suspicion at the time was that René’s own understanding of the incident came from Cárdenas himself, with whom he was frequently a kind of drinking buddy in their mutual tendency toward pastimes involving alcoholic beverages. In this respect, however, there was obviously also the element of self-preservation to keep in mind, in that Cárdenas certainly had his own accusations of accountability in the episode that he needed to stay alert with, in his own defense.

In any case, the hand story, and the related allegations of blame concerning Javier Quispe, persisted. I eventually concluded that the recurring and damming motif among those in
the town of Puka Wayq’u had most probably originated with either Florencia or Pablito, both of
whom who had been (curiously and inappropriately?) present in the maternity room that
afternoon, and were already known to have “talked,” most especially Florencia; or, possibly, it
might have been Lidia herself. Or, it very well could have been all of them. On one particular
occasion, for example, as I sat in the health center jotting down notes, I heard Pablito in the next
room whispering with Dr. Torricos, the dentist, about “that day in the maternity ward,” and how
“he was still inside.” Carolina Sotomayor from Yomala assured me that in the health center
“they [presumably the support staff who had been present, including non-medical] say that Dr.
Javier put his hand in up to here” [showing me her elbow], “he wanted to pull the baby out, but
he couldn’t…and when he took his hand out, there was lots of blood. They say that everything
was stained with blood.” “Everybody talks about it, everybody in town,” municipal
administrative employees Alejo and Sonia assured me; “everybody knows that it was Javier’s
fault. He stuck his hand into her way up—up to here [at which Alejo, in his own demonstration,
energetically pounded his upper arm]. All the nurses say so; even Florencia says so.” Finally,
on one occasion some months later in conversation with Florencia herself, she began to cry softly
about how Dr. Quispe was still trying to force her out of the health center, without actually
resorting to firing her. (Which he eventually did.) I asked her why; she hesitated for several
moments, but then nervously and furtively replied,

I know what I saw, I know, I know what I’ve seen. I’m not going to lie. And they all
saw it, too: Lic. Lidia, Pablito. When they brought the señora from Yomala, she was bad,
but not really bad. They brought her into the center, even though Dr. Ramiro wanted to
take her straight to Tarabuco. But Dr. Javier didn’t want to, he made us bring her in, he
forced us to. He wanted to make the baby get born quickly, so he stuck his hand up, he
wanted to pull the baby out, and he made her bleed really bad! He stuck his hand in up to here! [And in this particular case, Florencia indicated a height all the way up to her
shoulder.]
Quickly, the condemnatory tale also circulated in Yomala itself, and here it apparently had Severina’s husband Héctor as its primary source. I first heard it from Demetrio Arancibia, the Yomala dirigente:

According to Don Héctor, they arrived in Puka Wayq’u, and stopped in the street. Then they brought her in; ‘give her an IV!’ they shouted, and they hooked her up, he says. Then the doctor stuck his hand up into her [demonstrating by jerking his arm up], and then he pulled his hand out, and blood came out with it. Like an arrow, Don Héctor says, the doctor stuck his hand up. Right there, according to Don Héctor, it was like they broke something—‘because so much blood poured out, in that moment the blood gushed out,’ he says.

In 2007, and then again as late as 2011, I was still hearing it; both of those specific instances involved Doña Tomasa. When the subject of the health center came up once with her (in 2007), and of its previous (by then no longer present) personnel, including Quispe, she immediately focused not on her own personal crisis drama as experienced with him, but rather on “the señora in Yomala,” and how Quispe had “killed her, but then tried to blame Dr. Ramiro. It was because he stuck his hand up inside of her so far.”

It was, then, a performance that had become standardized, codified, mythologized, albeit with interpretations of varying intensity. It was almost as if they were physically and tangibly reenacting what was widely perceived to be the fatal maneuver as executed by Quispe, with the accompaniment of the representational gesture itself in what was undeniably an integrally mimetic fashion (cf. Benjamin 1986, Taussig 1993). Individuals were blurring the perceived moral divide between themselves and the doctor through using their own arms, paradoxically, in order to represent his; thus, figuratively condemning him in a very public manner, and at the same time reaffirming his guilt both to themselves and to the judgment of an imagined body politic. (Or, at the very least affirming his guilt to me, in what I interpreted to be the tentative hope that I would then repeat the inflammatory charges to those in power back in Sucre.) It was,
most certainly, a not-so veiled condemnation of what was widely perceived as a violent act, a form of violation in that moment of the prostate and hyper-vulnerable Severina. And through its visual witnessing as a site of physical violation, it was thus subtly yet vividly interpreted and re-interpreted by its tellers and re-tellers as an analogous image of the violation of women in general—of reproductive violence—and, perhaps, of the community as a whole.

It was also an instance of “unconfirmed fact” which soon took on a life of its own, defining both the unfolding story and the actors within it. This was a common element throughout the series of events in Puka Wayq’u. It was, precisely, the position of hearsay, of gossip and rumor, of both the verified and the unverified repeated recounting of “I heard that…,” and “they say that…” Veena Das points out that “Rumor occupies a region of language with the potential to make us experience events, not simply by pointing to them as to something external, but rather by producing them in the very act of telling…in the deployment of rumors is the perlocutionary force of words, their capacity to do something by saying something, through which words come to be transformed from being a medium of communication to becoming bearers of force” (Das 2007:108-119). This then was the power that the pervasive hand story was assuming, that of bringing the death of Severina alive for both the tellers and the hearers in the community, and thus of making all feel the communal pain and outrage. The repeated words and the mimetic gesture were meant to both bear witness and to demand retribution: whether through legal means perhaps; or, simply through the more powerful tool of a latent yet damning community condemnation. In this it is also, once more, that inconvenient and annoying matter of the “truth,” and whatever it may in actuality be, which persistently arises. After a time in Puka Wayq’u, however, I came to question whether any of this—“the truth,” that is—was really of any lasting importance to what was actually going on. Rather, it was what people believed to be true
that had a genuine lasting import, and which in actuality itself said something valid about the situation. And of course, again, something actually happened—or, didn’t happen, perhaps.

Concerning whether Dr. Quispe had indeed somehow inadvertently brought on Severina’s death with his impromptu vaginal examination in Puka Wayq’u, there would never be a conclusive answer. Obviously, no autopsy was ever performed in order to resolve any doubts, whether immediate or lingering; after Severina was brought back to Yomala on the same afternoon of her death, a few days later both she and the stillborn infant were buried in the local cemetery (just a short distance behind the health post), and no legal or forensic demand was ever formally filed by either the family or anyone else. I once asked Dr. Fulvio Arteaga, of the SEDES in Sucre, his own opinion on the issue. It was readily apparent that he didn’t feel particularly comfortable in discussing the matter with me, and he was visibly cautious—not wanting to compromise himself in regards to either his medical expertise, or to the muddled institutional controversy that was causing so much tension in both Puka Wayq’u and Sucre. His own personal, very tentative and very unconfirmed, “most likely scenario” assessment was the same as what Quispe himself had said to me at an earlier date (and which, clearly, had been in his own self-defense). In effect, that there had probably already been critical internal bleeding occurring in Severina, but which was blocked by the jammed fetus in the birth canal; then, when Quispe had conducted his manual examination and attempted to adjust the poorly positioned baby, the pent-up flow of blood had suddenly and uncontrollably been released. In considering the validity of this hypothetical explanation, it must then be recognized that Quispe had not precisely caused the fatal hemorrhaging, certainly not in any sort of intentional way. Yet, this was a question that pertained to only one (admittedly crucial) specific aspect of the death, and which uneasily circumvents the issue of his overall judgment and conduct involving the manner
in which Severina’s emergency case was handled in the first place, upon her arrival in Puka Wayq’u. Thus, in the end the question of “guilt” remained unresolved in any sort of conclusive way from a clinical perspective—although this was not at all, however, the generally accepted perception in the eyes of the communities and the citizens who were directly involved.

* * *

In reference to the specific fate of Dr. Ramiro Cárdenas, this was particularly notable in the ongoing fallout of Severina’s death. As previously noted above, among the population of Yomala itself Cárdenas received a significant proportion of the blame for what had happened. An indignant Doña Carmen Bautista summed it up for many: “They took their time. They arrived in Yomala around 9:00 in the morning, but didn’t leave until noon—three hours! [This was, it must be recognized, something of an exaggeration of the time frame actually involved.] They had plenty of time to get to Tarabuco or Sucre, but they blew it.” In Yomala, this was also concurrent with a comparable degree of anger against the subsequent role of Dr. Quispe at the Puka Wayq’u health center, where his actions in the maternity room were equally commented upon and condemned. In the town of Puka Wayq’u itself, however, the brunt of the guilt was placed squarely on the person of Quispe, by far. Initially, this always seemed somewhat incongruous to me, in considering that it was so starkly undeniable that Cárdenas’s judgment and conduct during the sequence of events had been highly questionable: the rambling about in Yomala; the unwarranted delays in leaving both there and Puka Wayq’u with Severina in the ambulance, as angrily denounced not only by Doña Carmen but by many others as well. Yet, nary an ill word was heard about his behavior among those in Puka Wayq’u—with the marked exception of Dr. Javier Quispe himself, who on more than one occasion muttered to me what amounted to “off the record” asides concerning the ultimate responsibility of Cárdenas—and, in
this case, the rationale for his personal opinions were certainly obvious. But in regards to the local townspeople, it was quite the opposite; indeed, there were even those who openly defended him (such as the police officer René), almost as if it had in fact been Cárdenas’s tragedy. It would have been expected and assumed that similar stories about the events in question would have circulated, in both communities—gossip, truths and untruths, travel quickly—so, why the contrasts?

I came to understand it as a reality of lived experiences, which in their own ways affected different people’s versions of “what really happened” in this particular case—in a sense, it was a question of positionality. However, this was not only the lived experiences of the actual event—that is, Severina’s death—and the respectively questioned roles of the health services’ protagonists (Cárdenas’s wanderings; Quispe and the hand story). Rather, it was also the lived communal experiences of the entire historical trajectory of the two doctors. Both of them were much more daily, perceived, felt, shared presences in the town of Puka Wayq’u itself: accordingly, it became a more widely witnessed and generalized opinion among people that Quispe generally behaved in an arrogant and contentious manner with both staff and patients; and, he was also was a person who dedicated himself wholly to his work, and rarely shared in community life. Cárdenas, however, was typically convivial and good-humored, enjoyed taking an active part in local social events, and had successfully integrated himself into the community overall during his more than a year on the job—although this frequently and regrettably went beyond simply having a drink with the guys, and crossed over into a markedly inconvenient alcohol problem. But in Yomala, in contrast, those prior perceptions of Cárdenas were much less widespread, and consequently there was little to interfere with the public observation of his actions related to Severina as the principal way in which they “knew” him within the present
context, and thus the resulting generalized condemnation of his person as integral to the fallout from the events.

As part of the overall aftermath, the ultimate consequences for Cárdenas were not remarkably swift, nor were they always especially commonsensical, but neither were they particularly surprising in the end: it was, rather, something of a destiny foretold. Although there was a low-level, albeit markedly growing, consternation at the SEDES in Sucre over the whole sequence of events, and despite the fact that the developing consensus at the higher levels was that whereas both physicians were significantly to blame, the performance of Cárdenas in Yomala had been especially egregious. (Or, at the very least, it had been unfortunately and uncomfortably witnessed by large numbers of the general community.) Somehow, however, it took the SEDES over a month to definitively remove him from Puka Wayq’u: or rather, as it was more tactfully explained to me by Dr. Fulvio Arteaga, he was “invited to resign.” The word on the street—typically spoken with satisfaction in Yomala, often enough with a degree of pity in Puka Wayq’u, and matter-of-factly without much related commentary of any sort at the SEDES in Sucre—was that his career was effectively over. At that point, Cárdenas somehow managed to make himself disappear from public view for over a year.

In July of 2005, I heard the surprising report that he had somehow succeeded in being reassigned by the SEDES to another post; then only a few weeks later, I bumped into Cárdenas himself on the street in Sucre. He seemed a little surprised—if not taken aback—to see me, but nevertheless greeted me amiably enough, and confirmed that as of two months beforehand he was the new medical director in a municipality some hours distant of Sucre, in the opposite direction of Puka Wayq’u. He appeared content—and with very little desire to discuss his days in Puka Wayq’u, as evidenced by his hesitating, polite and protocolar-tinged question to me
regarding how things were going there. In response to my vague, unspecific, somewhat platitudinal descriptions of the current scene—understandably spoken with a degree of uncertain discomfort, considering his past history—Cárdenas suddenly launched into a fervent, and unprovoked, self-defense. “They all want to blame me for that death in Yomala,” he exclaimed, “they say that I killed her. But I’m here to save lives! It was like a chain of different people who were at fault—the husband, the nurse auxiliary, the institution itself. They even want to blame me for those other deaths, in San Marcos!” Obviously, he was looking for someone to “unload” to, and he apparently saw me as someone both familiar with the situation first-hand and sympathetic to his cause—or, conversely, as possibly yet another person who included him among those primarily responsible for the series of events in Puka Wayq’u which had indelibly darkened his professional career. “They’re looking for a scapegoat,” was all that I non-committedly replied to him, to which Cárdenas nodded his head in eager, yet sad, agreement. I didn’t feel that there was much else that we could discuss, and that his responses to whatever else I might ask would all be woefully predictable: a suspicion made yet more real for me by his seeming inability to ever make direct eye contact.

As we parted, with firm handshakes and a pledge to keep in touch that was never fulfilled, I couldn’t help but wonder to myself how Cárdenas had managed to redeem himself at the SEDES, and what strings he had needed to pull in order to be assigned to his current directorial job. (Despite the status associated with being a municipal medical director, however, this was in a small, remote, and somewhat peripheral locality even within the Chuquisaca context, and certainly no more consequential in a career advancement sense than Puka Wayq’u had been.) Then, only a year later, I heard at the SEDES that before much time had passed at his new post Cárdenas had been dismissed from that administrative position also, due to his chronic
drinking. After that, in the succeeding years, I definitively lost all track of him, despite my occasional casual inquiries of friends and contacts at the SEDES. It was, in its way, not surprising, and somehow seemed like the logical progression of his ill-fated tenure in the Puka Wayq’u health services, and beyond—and also seemed to bear more than just a passing resemblance to Javier Quispe’s fate. In the end, they were both key figures in the confusing institutional crisis with very real individual human faces, leading to ignominious downward spirals enacted out in painful slow motion, into professional disgrace and enforced oblivion.

**The surviving family: veiled accusations**

It was only after some months following the actual event when I began to understand that one of the most contentious figures in the death of Severina was neither Javier Quispe, nor Ramiro Cárdenas. Both of them were, of course, undeniably in the center of the social and political maelstrom surrounding what had occurred: both were perceived as not having acted opportune or adequately under the circumstances, and the not-so-subtle charges of outright medical negligence and / or malpractice against them were to become common knowledge and embedded in the popular perception of the tragedy. However, as critically voiced by many community members in Yomala the entire obstetric crisis in itself very probably would never have even begun, if it had not been for what was commonly seen as highly irresponsible behavior on the part of Severina’s husband, Héctor. As the oft-heard opinion went, in what was becoming a burgeoning case of community discord, Héctor was almost contemptuously guilty of not supporting Severina enough at a critical moment. Rather than assuaging any fears that she herself may have felt concerning her previously identified high risk condition—in this case a strongly recommended Cesarean hospital birth, and subsequent spousal support for what many in Yomala indeed thought to have been the safest option—he instead (in the judgment of his critics)
emitted a metaphorical shrug and opted to stay at home, as they had for all of the preceding (albeit lower risk) births.

“It was his fault, Don Héctor’s, because he didn’t take her when he should have,” Demetrio Arancibia told me, in a disgusted tone of voice. “Because he’s a jackass he didn’t take her. Everybody says so. He’s irresponsible [dejado]; people had even argued with him about it beforehand, saying that she was really weak, that because she had had so many kids before, that it’s dangerous. But, ‘Why should we go to the hospital?’ he had griped.” Echoing Demetrio, “irresponsible” was the word most often used by those in Yomala in reference to Héctor, even by Doña Carmen, his comadre. For her part, Carolina Sotomayor griped that Héctor (who, I was surprised to discover, turned out to be Carolina’s uncle) “at first wasn’t even around that day, he was with his burros out in the bush. He only came back on Saturday. After it happened, people were saying, ‘he should sure know why she died!’ ” It wasn’t difficult to discern the social context from which this generalized sentiment originated: with time, I came to understand that Héctor wasn’t always held in the highest of esteem by the population of Yomala, under any circumstances. He was, for example, denigrated as being an “uneducated burro driver,” and an all-too-common local observation obliquely referred to how often he spent a sizeable portion of the family income on his own personal needs, especially his alcohol consumption. “If his stomach is full and okay, then he’s okay,” Demetrio pronounced once, in a sneering tone of voice. Overall, he was perceived as something of a difficult person, a quasi-antisocial on the blurry representational limits of the community’s social periphery: or, in the blunt inferences of more than just one citizen, something of a bum.

Interestingly enough as a potentially significant factor in considering this very issue, my initial curiosity in regards to Hector’s supposedly monolingual Quechua capabilities was to
eventually be confirmed through numerous individuals. Several of those in Yomala whom I pointedly asked, at one time or another (Doña Carmen Bautista, Carolina Sotomayor, Demetrio Arancibia, Don Zenón Arduz and Doña Miguelina de Arduz, among others) were all to tell me that, effectively, Héctor actually spoke very little, if any, Spanish; in addition, his functional understanding of it apparently wasn’t much better. In itself, even in the Bolivia of today, this is not anything to be particularly surprised at: according to what are still the most recent official census data (INE 2003), 23.4% of the total national indigenous population (49.9% overall) remains monolingual in one or another of the 36 officially recognized native languages. In specific reference to monolingual Quechua speakers in Chuquisaca department, this was determined to be 34.9% of the total indigenous population (INE 2003), and in the specific case of Puka Wayq’u (as previously indicated), monolingual speakers stood at 61.5% (INE 2002).57

However, what is notable in this particular case is that Yomala, and the surrounding smaller communities of the Puka Wayq’u valle region, while undeniably maintaining their culturally firm “Quechuista” status in both language and worldview (but also simultaneously taking into consideration the micro-regional differences noted in Chapter 2; in regards to dress, for example), is markedly and arguably the least “traditional” sector of the municipality. This is in contrast especially to the altura and cordillera regions, both of which are comparably more geographically remote, relatively more physically isolated from the municipal mainstream, and which maintain more outwardly “traditional” cultural denominations. (Aside from clothing, this might also include, for example, traditional agricultural modes of production; artistic expression,

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57 Effectively, and as would be expected in any sociopolitical scenario of rapid capitalist expansion, accelerating rural / urban migration, uncontrolled urbanization in general, and an eager process of “modernization,” the estimated numbers of monolingual speakers of an indigenous language has been consistently and significantly diminishing, as the Spanish language arrives at a near total linguistic hegemony. Once the official data from the November 2012 census are made available, the monolingual Quechua speaker figures from 2001 (in addition to other native languages) will presumably and almost certainly have dropped to even lower levels.
such as the woven axus; and culturally specific festivals.) But, and in the case of Yomala, the reality has everything to do with the strong market ties between the valle region and Sucre, and with those beyond in the national commercial centers (La Paz, Cochabamba, Santa Cruz) as a whole. Again and as previously discussed (Chapter 2), by far the most (if not only) products emanating from Puka Wayq’u with anything approaching an important urban commercial exchange value (“cash crops”) for the municipality are handicrafts (traditional weavings), potatoes, peanuts, carrots, and lemons: these last three are grown for sale almost exclusively in the valle region and, significantly so, mostly from the communities around Yomala.

Accordingly, there is a frequent and fluid connection between the valle communities and the urban areas (on average, 1 - 2 local trucks a day to Sucre, one of which originates precisely in Yomala), and most local residents earn at least part of their spendable income from some sort of informal market economy role as small-time merchants and tradespeople (comerciantes). As a result, whereas all valle residents are native first language Quechua speakers, by far the great majority are also bilingual in Spanish, owing especially to these market ties. (With the notable exceptions of some of the considerably more aged men and women, specifically those who had never gone through any of the local primary school system.)

Héctor, however, seemed to be a decided social anomaly: male, relatively young (early 40s), born and raised in the market-oriented Yomala area, and equally tied into that market—yet, he was monolingual Quechua. Doña Carmen Bautista, as Héctor’s comadre, theorized (and I found it interesting from her bemused and thoughtful reaction, when I asked her about it, that apparently she had never really put much thought into the matter) that it had to do with the fact that he also had never gone to school (like Severina), and so was functionally illiterate in both
Spanish and Quechua. In addition, when considering that he supported the family equally between subsistence farming and working with his burros as hired labor, and the sale of his crops (predominantly peanuts) to the city, it was important to recognize that these transactions were undertaken for the most part via middlemen, with the actual business part done at truck side in Yomala; according to Doña Carmen, Héctor himself would typically only venture to Sucre 3 - 4 times per year. In this manner, and similar to both Faustino in San Marcos and Saturnino in Iskay Sach’as, Héctor remained relatively yet significantly disconnected from the wider dominant market economy, at both departmental and national levels—commercially, politically, socially, linguistically, and culturally.

As a result, and to whatever degree it might have been possible (because it is of course impossible to speak in categorical, essentialist terms; for centuries in Bolivia and Latin America as a whole, the hegemonic state capitalist influence is undeniable in multiple socioeconomic spheres), all three men were not fully integrated into the overriding national “modern colonial” society project. This social condition was to later play an indisputable role in the tragic fates of their three respective wives and partners, through their lives lived on the figurative edges of the ostensible economic “mainstream” of early 21st century Bolivia, and the undeniable penetration of this into the still-marginal rural regions of the country. And, most importantly, through the choices that they had opted for at their own moments of personal crisis—both potential and confirmed—involving medical decision-making and personal responsibility—in relation to their wives, their families, and ultimately to themselves. Yet in Héctor’s own case, this relative

58 However, it is important to note that in practice very few native speakers anywhere, in the countryside or in the city, are genuinely and prolifically literate in the Quechua language. This is recognized in the historic (over the preceding centuries) lack of consensus between formal linguists and educators, from Bolivia to Peru to Ecuador, in regards to establishing a standardized alphabet and writing system for what is a previously unwritten language. (And this despite the numerous, albeit typically unobserved, international congresses and signed agreements over the decades, attempting to determine practical, consensual and functional norms and regulations for transcribing Quechua.)
cultural marginalization was distinct from the other two men discussed here, who lived and functioned in communities which were geographically more isolated, and with a considerably more reduced flow of communication and information available to them. (Although both Faustino and Saturnino did speak rudimentary Spanish.) Héctor’s identity as a monolingual Quechua male, who rarely participated in the explicit cultural infrastructure of the prevailing national society, set among a predominantly bilingual Quechua male population which held almost constant daily economic ties to that same society, set him apart. Despite his furtive contacts during Severina’s pregnancy (the prenatal exams and ultrasounds in Sucre), the choices he had made were, by nature, in contrast to any “intercultural” sensibility; these were assumed within the context of an inherently and decidedly monocultural worldview, that in the end informed and dictated his eventual behavior.

Nevertheless, it cannot be claimed that Héctor was explicitly ostracized in any sort of way, or effectively marginalized (including self-marginalized) from the community as a whole—for example, he was an actively participating and voting member (afiliado) of the Yomala sindicato. Despite all of the off-side sniping about him prevalent around town, he was locally respected in a functional “daily business” sort of way, for his status as the father of children who were wholly integrated into the educational and social environment, and if not solely for the obviously high regard in which the community had held Severina. (“She worked hard,” reminisced Demetrio, voicing a commonly heard sentiment, “more than her husband. She baked bread to sell every day, she made chicha—what didn’t she make, the poor woman.”) Doña Carmen Bautista, who for her notable standing as Héctor’s comadre generally tended to express a more tolerant attitude toward him (albeit in a somewhat removed kind of way), nevertheless always gave me the impression that the relationship was based more around Severina, than with
Héctor himself. Yet, I could also recognize that she was not alone in her expressions of sympathy for him—albeit perhaps more grudgingly so, among the wider populace; part of a completely understandable communal sense of pity, despite the whispered and cynical running commentaries. It was an emotional response which indeed may be seen as critically important for intra-community relations, considering the circumstances—and indeed which would seem to ratify the perspective previously discussed concerning the spontaneous cohesion of the social group. In effect, this even represents a sadly elicited sense of what may be identified here as an instance of communitas—in the face of sudden loss and personal crisis, echoed as social crisis.

“He’s really trying,” commented Doña Carmen to me once about Héctor, “and he’s changing. I see him sometimes down by the river; he goes now to wash clothes with his children. One Sunday I saw him combing Carlita’s hair, washing her, bathing her. I’ve even seen him combing Carlita’s hair before she goes to school. So, that’s the mother’s role. He’s changing.” It was, then, a notable transformation in Héctor, and one that made me recall the similar “awakenings” expressed to me previously by Faustino and Saturnino, under the same sad circumstances (Chapter 3). Even Carolina Sotomayor, despite her previous angry denunciations concerning Héctor’s generally unsupportive behavior over the years, and especially about how he hadn’t been around when Severina was just about to need him the most, also recognized that most people had eventually stopped commenting so poorly about him—at least in such an open fashion. “Because he simply doesn’t have anybody to help him, to talk with him,” she commented, shaking her head. “He doesn’t have money to get around. So, everybody has kind of just shut up about him.”

In the first few months following the death of Severina, I would hear periodic whispered updates in both Yomala and Puka Wayq’u that Héctor had initiated legal action in the district
capital of Tarabuco: against the Puka Wayq’u health center in general, and against Drs. Quispe and Cárdenas in particular. Or rather, it was Héctor’s brother who had apparently taken it on to hire a lawyer, initiate the paperwork for a potential lawsuit, and look for eyewitnesses willing to testify. (This was tied to unconfirmed gossip about vague political interests involving both the brother’s and the lawyer’s party affiliation with the then opposition MAS, and some sort of scheme to smear the government services before the upcoming municipal elections.) “One of the nurses,” I was told, had made a legal deposition in relation to the case—undoubtedly Lidia, I assumed, and this was later confirmed to me by Lidia herself. In turn, and in order to defend himself, Quispe was then obligated to make his own deposition, a fact which was officially unacknowledged by the health services, but confirmed to me, quietly but somewhat triumphantly, again by Lidia. (“What a waste of time,” exclaimed Don Zenón Arduz in Yomala when the subject arose in conversation, “what are they going to be able to do? Are they going to give Héctor back another woman, are they going to take care of his children? It’s already a loss, a loss of family.”) After some time, however, the whole thing seemed to fade away, and nobody heard anything else about it. “I don’t know why, probably because he doesn’t have the money to go there [to Tarabuco, and later to Sucre], so he just dropped it,” was Doña Carmen’s opinion.

Yet, the more persistent rumors that began circulating had a decidedly more “conspiracy theory” aspect to them. “They say…,” “I’ve heard…,” as the common qualifying refrains would put it, that Héctor had quietly accepted an unknown sum in order to drop the legal action, and not press any sort of charges—essentially, to not make an issue out of the whole thing, and to just quiet down. When asked specifically about who had supposedly paid off Héctor, the invariable assertion I heard from many people was that it was either Quispe himself; or possibly Dr. Freddy Zamora, his superior in Tarabuco. The rationale attributed to the state health services’
hypothetical counter-maneuverings was obvious: the maternal death upsurge was bad enough to deal with as it was, without the additional stain of official medical negligence—if not actual fatal malpractice—in court and further complicating the perceptions of the local health district in the respective view of the SEDES in Sucre, the Ministry of Health and Sports in La Paz, and the overall public at large. The accusation of having “sold out” was, again, yet another “unconfirmed fact”—as also manifested in the hand story, and as seen here in the account of Héctor and his pivotal role in the local drama—and which was to attain its own force and internal logic.

Finally, amidst the tortured Héctor narrative, there is an additional, more personal (in regards to myself) and potentially more troublesome quality, which must also be addressed within the ethnographic context. This has to do with my uneasy recognition that I never succeeded in establishing a true rapport with Héctor, and indeed most of what I learned about him, and what had happened immediately surrounding Severina’s death and its aftermath, didn’t come directly from Héctor, from time spent with him and from detailed interviews: rather, it came almost entirely from the words and actions expressed by “secondary” informant sources in the community. As I have recurrently contemplated this, both in the moment and in the time since that has passed since then, the reasons were multiple. To begin with, there was the difficult nature of Héctor the person, as discussed above: his quasi-antisocial nature, and his relative distancing not only from the community at large, but also from myself personally. His was a studied non-cooperation with my research project: not stated, not overtly—on the contrary, at our first meeting he had expressed an openness (albeit somewhat tepidly) to further interviews, and we had agreed on the details of financial compensation. Rather, his lack of participation was manifested through his constant unavailability to ever engage in a true dialogue: whether in the
day or at night, he was always either “just on the way out” to someplace else; or (and more frequently) he wasn’t to be found at all, already “being” someplace else, as explained to me by one or more of his children. (On one occasion, after the oldest son told me that Héctor was off in his fields, as I turned to go I caught sight of who I was positive was Héctor himself, hurriedly and furtively ducking behind the window shutter inside their house.) It didn’t take me long to figure out that Héctor didn’t really want to have anything to do with me, to deal with me at all, and pretty much did his best to avoid me, despite any previous promises or monetary incentives.

Why? Perhaps it was just the kind of person he was, not especially eager for excessive human contact—and I certainly had to be honest with myself that it was not particularly surprising that Héctor (or anybody in a similar situation) would be hesitant to readily discuss the issues around my stated focus of interest. It goes without saying that talking about Severina could potentially be a delicate, distressing and upsetting subject. However, when I eventually made these concerns known to others in the community—that is, Héctor’s apparent desire to steer clear of me—the rationalization that people voiced had a distinctly more condemning, unforgiving tone. As it was that so many laid a large part of the blame for his wife’s death on Héctor, they would derisively theorize that he was very probably well aware within himself that he bore significant responsibility (in the public eye, at least), and was thus in fact “hiding” something from me, out of a feeling of doomed complicity and guilt. Within this frame of reasoning, the topic was certainly the last thing that he wished to discuss, with me or with anybody else.

Nevertheless, alongside of these considerations I still need to turn the ultimate responsibility back onto myself, the ethnographer. I realized that one of the main reasons that I never got much data out of Héctor was simply because I was uncomfortable with him, and so I
made a conscious decision to lay off, to not press him too much, when faced with his obvious avoidance of me—which then became *my avoidance of him*. This discomfort was based in, first, and in considering his not-so-subtle attitude, a reluctance to openly confront a sensitive situation and history, and quite possibly a nasty and volatile one at that. The “vulture” analogy that I already wrestled with (as mentioned in Chapter 1), the self-construed and pseudo-existential burden in which I imagined myself hovering over the landscape of Puka Wayq’u waiting for women to die, didn’t help much. “Who am I to pry?” I would rationalize. Yet, beyond that there was a perennial discomfort that I felt with the entire Héctor family: whereas the children, in their case, didn’t openly try to avoid me, they were nonetheless always an equally discomfiting group, and not very forthcoming.

I have no illusions as to this: the psychological trauma that the family was undergoing was undeniable, and beyond my scope of understanding. I never attempted to invoke the subject of their mother with the children, for obvious ethical reasons—and there was no indication that they would even have been amendable to do so, with an outsider such as myself. Nevertheless, the five surviving children who still lived at home in Yomala, ranging in age from 4 to 16 at that time, were difficult for me to understand, or to determine a “status quo” with, both then and into the succeeding years. During the first year, perpetually dressed in increasingly frayed black mourning clothes (which Héctor, curiously, eschewed; reportedly simply because he had never had the money to acquire anything), their faces were typically unfriendly and even surly, despite the wan and forced smiles they would present to me. The aura about them was dark, distant, disquieting, impenetrable, odd. I would try to avoid them, to walk quickly past their house, which was inconveniently located in the very center of the community. Sometimes we would come into direct contact in the street, and the kids would gaze at me as they always did: an
inquisitive, suspicious, defensive, vaguely hostile, definitely sad and wounded kind of look, all with the air of abandoned children—as they of course were, in a very significant kind of way. The littlest girl, Carlita (4 years old when I first met her), I never once saw smile. The second eldest boy, Máximo (14 at first meeting), I was always able to remember mostly through his handshake, rather than his name or face (owing to his strong physical resemblance to his younger brother): he would grasp my hand firmly, and I would then invariably have a difficult time extricating myself; he would hold on and not let go, fixedly smiling at me and never dropping his eye contact, until I would finally have to forcibly pull myself free. “This must be the same kid.” I would sigh to myself. But in the end, could any of this really be considered as starkly unusual, considering the situation? Yet the contrast with Faustino and family in San Marcos, with whom I had established a friendly, relaxed, reciprocal relationship despite a similarly tragic situation—albeit without the same darker shades of possible spousal culpability—was striking.

After 2005, Héctor disappeared to me, and I never saw him again. I would hear of him often, and talk of him with Doña Carmen Bautista or with Demetrio Arancibia or with others, but he was never around Yomala whenever I was in town—or so it seemed. (“He manages to keep himself free of me,” I would ironically admit to myself.) But I would still run into one or another of his children over the years, and hear about them from others: little Carlita, for example, as I was told at the school, frequently came to class without eating, and had been hospitalized once or twice for severe anemia. Then, in late 2006, after several months away from Puka Wayq’u and its communities, I was given a piece of startling, disturbing information by Dr. Jorge Zelaya, on his first assignment out of medical school as the new resident physician (following the departure of Dr. Cristina Porcel), in the expanded Yomala health post (which now included both doctor and nurse auxiliary positions). “How’s Héctor doing?” I asked Zelaya
during one conversation, to which he replied, “He’s fine, I guess. He keeps to himself.” Then he shook his head grimly. “But you know about Fátima, don’t you?” he asked. Fátima was Severina and Héctor’s second daughter. As Zelaya recounted it, late in 2005, when he had been on the job in Yomala for only a few weeks, he became aware that Fátima (at that time 13 years old) was pregnant, as it turned out by seven months. The father, it transpired, was her older brother, Rafael (age 16 at the time), and the eldest of the children. Zelaya called it “rape”—the same word that I later heard used by others—and that Rafael had “escaped” afterwards, supposedly to the sprawling urban anonymity of Santa Cruz. Nobody knew anything else of his whereabouts. Zelaya had convinced Héctor to send Fátima to Sucre, in order to receive adequate prenatal care and counseling, and to give birth. She had returned to Yomala three months later, bringing with her a dead baby in a plywood baby coffin. Dr. Zelaya’s opinion was that she had let the baby die, which presumably couldn’t have been older than one month upon its death. My melancholy reaction upon first hearing the story, and as it remains so to this day, was that this turn of events somehow epitomized Héctor and his children, that there was something supremely tragic about the family, something which was deeply troubling, something that struck me as downright Gothic. At its center was Severina. However, and I was reluctantly compelled to recognize, for various reasons I was never able to adequately draw myself into the full width and breadth of this particular tragedy and this world, through those who were the closest to it.

Be all of this as it may: for my own purposes, my “lack of success” with Héctor is something of a hole in my research—an ethnographic weak spot, it might be termed. To this end, when speaking of the subjective impact within these particular circumstances I must consequently fall back on what may be only a shaky pretext of “ethnographic authority” (Clifford 1983), as based on my own subjectivity and the personal closeness I held over the years
to the figures surrounding Severina and her death. This must unfortunately, however, ultimately be somewhat qualified in respect to Héctor himself, and to his family.

* * *

At a point much later, many months later, a paragraph that I had somehow previously overlooked stood out for me from my fieldnotes and recordings, and brought me pause. During a conversation with Doña Carmen Bautista, long after the death of Severina, she began to talk again about Héctor, and how he was holding up. “He’s doing okay now, at least he’s working, in one way or another,” she said. “He hires himself out as a laborer (peón), doing odd jobs,” while also tending to his burros and taking care of the family’s small plot of land. Then she commented on how Héctor had been gravely affected by flooding in early 2005, when after several days of heavy rains the river swelled over such as it hadn’t for many years within memory, and the turbulent waters inundated the adjoining agricultural properties of many local campesino residents before subsiding after a few days. Fortunately, no lives were lost. But Héctor’s small and somewhat scraggly parcel of land was especially hard hit. “The river took his entire peanut crop,” Doña Carmen told me, “he lost it all. Nothing was left. Nothing.” This was, it goes without saying, a catastrophic turn of events for Héctor and the family’s economy. I asked Doña Carmen, in all seriousness, if she thought that perhaps someone had “cursed” him, considering all of the tragic misfortune to which he had recently been subjected to. “I really don’t know,” she had replied thoughtfully, “who knows…?”

It was following this conversation with Doña Carmen, on another occasion some months later, that Demetrio Arancibia told me about the local beliefs in regards to possible unfortunate consequences after the death of an unbaptized infant (this chapter, Footnote 47). These had included potentially disastrous events brought on by supernatural causes, such as hailstorms and
floods. Severina’s full term child, of course, had not been baptized before (or after) its death during her prolonged obstructed labor. In accordance with community practices, before its burial beside Severina the baby was nevertheless hastily given a name (which few seemed to recall)—this being understood as a cautionary and indispensable practice at a minimum; “of course, if we even give little names to children’s dolls, don’t we?” Doña Miguelina de Arduz explained to me on another occasion, about the same topic involving Severina. But there had been no priest available for at least a hurried postmortem baptism, no appearance of Padre Antonio in the days preceding the interment. At the time when Demetrio told me of these local beliefs, I committed the regrettable oversight of not in my mind making the intriguing connection, and thus neglecting to pursue his own possible thoughts on the matter. Nevertheless, the potential relationship in the popular imagination between the hypothetically condemned fate of Severina’s stillborn infant in the Afterlife, and the great misfortune to Héctor’s land and crops less than a year later, would undoubtedly be a subject of some interest. This is, of course, aside from any serious contemplation (within the realm of “local reality”) of a potentially genuine and verifiable phenomenon of cause and effect.
Chapter 5

Institutionalizing the Discourses: The 2005 Elections and Their Ongoing Impact on Morbidity and Mortality

In this chapter, I discuss the structural implementations of Evo Morales and the new MAS government as they specifically apply to health policy, and how these have played out in Puka Wayq’u as one case in point. Concurrent with these are distinct paradoxes at play in the proposed and actual radical project of government restructuring, in regards to what I have wished to discuss in previous chapters as historically one of the most “colonial” of Bolivian state apparatuses: the health sector. For my purposes here, by “paradox” I understand this to mean the inherent contradictions in the design and implementation of what is still, at this stage, a semi-embryonic formal state policy under development—and, beyond that, the resultant exacerbation of the conflicts and tensions that have been historically present in Bolivia for generations, indeed for centuries. These longstanding tensions are now further illuminated by the current policy reforms—occurring in places ranging from the dusty streets of Puka Wayq’u and other rural outposts of the Bolivia profunda, to the busy urban offices of the Ministry of Health and Sports in La Paz—and as a result self-interests are at stake, deeply ingrained prejudices are brought to the fore, and offense is often taken. What is perhaps at heart is a struggle between cultural and political factions within the ranks of both the government’s public health national directorship, and the personnel entrusted with actually implementing health policy at ground level. The frequent conflicts and seemingly never-ending crises (at levels from low to high) are part of the uncertain melding, and clashing, of a juxtaposition of factors: newly formulated state policy
objectives, the abstract guidelines of postcolonial and (inter)cultural theory, and the sheer blunt force of Bolivian reality.

This uncertain climate of ongoing challenges and risks within the rapidly evolving health sector, which at this stage has yet to be definitively resolved and assimilated (if it ever truly will be) is again emblematic within the Bolivian context of what I have described as the power of conflicts, breakdowns, and crises—those “social dramas,” as Turner would have them—to reveal the “true” nature of a society at its clearest. Thus, the paradoxes and the potential pitfalls of this (re)envisioning of health, health policy and health services—a policy area on the frontline of the debate over the process of decolonization in Bolivia today, both theoretical and practical—may be seen as revealing something indicative of the current Bolivian experiment, and the experience of the would-be indigenous nation as a whole. For my purposes, these are as they apply to the “state” of health as described here, including critical scenarios such as the maternal mortality crisis in Puka Wayq’u.

**The National Development Plan**

Six months after taking power, and as mentioned previously, the Bolivian government publicly issued their official social development strategy, the National Development Plan: “Bolivia Dignified, Sovereign, Productive and Democratic to Live Well” (*Plan Nacional de Desarrollo: Bolivia digna, soberana, productiva y democrática para Vivir Bien*). The Plan declares at the outset that “the history of Bolivia…has been marked by colonialism and neoliberalism,” and that the country (especially since the mid-1980s, considering the structural adjustment policies implemented at the time) has been dominated by “transnationals and international organizations of the powerful nations,” while “external colonialism grew…and the
‘national bourgeoisie’ listened only to the orders of foreign countries” (MPD 2006:21). Because of the dependency, inequality, diminished human and civil rights, and poverty that resulted, it continues, the government “has initiated the process of dismantling colonialism and neoliberalism and, at the same time, initiates the construction of a new society of a plurinational and communitarian state.” Specific national strategies include the following areas: economic, “socio-communitarian,” international relations, and “social power;” all with the stated objective of “the transformation of the national production matrix, the dismantling of neoliberal coloniality, the decolonization of the State and the construction of the new Bolivian identity, based in multinational institutionalism with a communitarian focus” (ibid:1).

At the very core of the National Development Plan is the paradigm known as “Para Vivir Bien” (To Live Well), also frequently and colloquially referred to, as the cultural context demands, in Aymara (suma qamaña), Quechua (sumaj kawsay), or Guaraní (ñande reko).59 Adopted as a theoretical guiding standard for most governmental policy and programs, To Live Well exemplifies the MAS’s use of an indigenous discourse to promote state ideology—in itself, perhaps, a unique form of interculturality. Simply expressed, the notion is that of living comfortably and with dignity within one’s means, without excess. As described by Javier Medina, one of the most prolific intellectual proponents of the concept (2006, 2008),

“Quality of life” is a deeper reflection upon the “human condition.” It considers that cultural identity, the physical, mental and spiritual ties to one’s llacta [people], one’s land, is of equal importance to the raw materials of life. The loss of common values, the disintegration of communal structures, and the alienation from the spiritual world can affect the individual more than the lack of physical items… The struggle against poverty is more than just improving the economic base and access to public services (2008:10).

59 In the past few years there have been other experiences, most particularly in Ecuador—where the focus is known simply as “Buen Vivir”—which have also incorporated a similar philosophy into governmental planning models. In Chile, a key component of the worldview of the indigenous Mapuche people is known as kiüme felen—precisely, “buen vivir”—which is now finding its way into developmental discourse, although usually communally and not as yet at the official governmental level.
Similarly, in the official strategic plan of the Ministry of Health and Sports, “To Live Well” is “a demand for the humanization of development, so that it is transformed into one of collective decision making and action from a society that is an active subject, and not a passive receiver of vertical initiatives,” and is based on a “cosmocentric vision that transcends the typical ethnocentric development contents” and postulates “progress as beginning with mutual discovery and horizontal contributions and not imposition and authoritarianism” (MSyD 2009b:5).

Although innovative, this somewhat esoteric concept translates, in practice, into what has become a ubiquitous slogan for governmental programs, particularly for health. It is used as a backdrop in the media promotion of most official projects and serves as the link between the modernity of the MAS government’s social and economic programs, and the imagined indigenous pre-colonial past that is held up as an ideal for national identity. In this way, To Live Well may be seen as a contrasting model evoking the pre-MAS state—which was, it goes without saying, in the current official conceptualization the colonial state—in order to emphasize the fact that the nation most certainly did not live well in the pre-MAS past.

**State institutionalization**

In March 2009, Bolivia took a concrete (or, at the very least, bureaucratic) step toward formalizing (or, institutionalizing) the complementary discourses by creating the Vice Ministry of Interculturality and the Vice Ministry of Decolonization, both under the aegis of the Ministry of Culture. For interculturality, the stated functions of the Vice Ministry are, among other activities, to “foment an intercultural dialogue between the various nations and indigenous peoples” and “promote interculturality as an instrument of development” (VMI 2009). For decolonization, the functions of the office are to “coordinate the implementation of decolonization programs and projects,” “foment the participation of the indigenous original
campesino nations and peoples, intercultural communities, and Afro-Bolivians in the public management of the Plurinational State,” and “develop policies for the prevention and eradication of racism and cultural intolerance,” all as part of “the struggle against intellectual, social and economic colonization, which continues to live on in some parts of the nation” (VMD 2009). However, both offices are poorly funded and staffed and lack firm proposals for long range implementation; as such, they remain relative theoretical showpieces, with a limited focus on isolated activities and events, although formally and in practice at least their stated projects are proliferating in numbers.

The (Postcolonial) Transformation of the Bolivian Health Care System

In numerous municipalities and individual communities in Bolivia, for years both the local populations and the state healthcare services themselves had recognized that the system was operating at a loss. The 2004 maternal mortality crisis in Puka Wayq’u was but one more indication, a small symptom, that despite all of the ongoing interventions over the decades, things just weren’t working as they should have been. The chronically poor national health status, especially in rural and high density urban areas, and most notably among the vast poor and indigenous population, required more than the introduction of yet another imported high-tech program application, which would unlikely ever reach the ostensible target populations. Or, and as was even more typical, the persistently indulgent and hypocritical platitudes from the political sphere concerning their commitment to the most underserved groups, incorporating the principles and methodologies of supposed “community health” approaches (which all too often only barely resembled primary health care itself), and that in reality were only infrequently acted upon while the emphasis continued to be on costly and impersonal third level attention and
interventions. Within this context, perhaps the only feasible attempts at change were to necessarily be dependent upon a renovated political environment, rather than a purely sanitary and public health one. With this in mind, I wish to turn my focus now precisely to the health systems reforms undertaken by the Bolivian government since 2006, in order to address chronic national deficiencies and failings.

Health Policy and Development Strategies

In late 2005, prior to the national elections that would bring Evo Morales to power, the MAS undertook their own independent diagnostic of the health situation in Bolivia. Following their ascension into the government, the results of this study would eventually form part of the National Development Plan of 2006, in which the health sector is one of many social structures explicitly framed as a vestige of national historical coloniality. Among other theoretical arguments, the Plan asserts that

The state has a social debt concerning health with the Bolivian population accumulated since the colonial past [and] aggravated in the past 20 years by neoliberal health policies that have resulted in the privatization of the health sector, the mercantilization of services, and the establishment of an individualistic health culture… The health system has not responded to the needs and demands of the Bolivian population; on the contrary, it has reproduced the inequalities and inequities of the economic structure (MSyD 2006: 37).

The Plan goes on to identify a number of prevalent structural problems: pathological and epidemiological differentials among the population, based in socioeconomic determinants related to poverty and unequal access to health services; an inefficient health service that fails to take into account cultural and ethnic differences; poor management of the national health service network, with little or no cooperation between social sectors and an overdependence upon international financial aid that carries ties and conditions; and a lack of satisfaction in general
with the services on the part of an unmotivated, alienated, and disempowered population (MPD 2006:37-38).

As a way out of this situation, which is specifically directed at “the promotion and constitution of a space of organization and socio-communitarian mobilization in order To Live Well,” the Plan proposes that the state guarantee equitable access to healthcare services and an active participation of the population in the process. This is to be achieved by (1) dismantling colonial structures and developing an intrinsically sovereign national health system, that includes the incorporation of traditional medicine; and (2) eliminating the market-driven (neoliberal) economic apparatus, replacing it with a communitarian and intercultural plan based on social participation and coordination between social sectors. Five specific policies make up the overall strategy: a single intercultural, communitarian health system; state proprietorship and sovereignty over the health system through the consolidation of financial, judicial, and human resources (while allowing the right to private healthcare services); social mobilization; health promotion, to be implemented through coordination among social sectors; and solidarity, focusing on the causes and outcomes of extreme poverty, especially malnutrition and domestic violence (MPD 2006:40-42). These programmatic lines are echoed in the MSyD’s (2009b) Institutional Strategic Plan, and complemented by strategies for disaster relief and climate change. The desired outcomes of both documents are thus a restoration of state responsibility for maintaining integral health and the quality of life, and a revalorization of health as a priority of the population at large.

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

The state …will protect the right to health, promoting public policy oriented toward improving the quality of life, the collective welfare, and free access to services by the population (Article 35).

The state has the undeniable obligation to guarantee and support the right to health… Priority will be given to health promotion and disease prevention (Article 37).

The state will guarantee public and private health services; it will regulate and monitor the quality of attention by means of sustainable medical audits that evaluate personnel performance, infrastructure, and equipment (Article 39) (REPAC 2008).

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

As the key player, the MSyD has been reconfigured into three vice ministries. The Vice Ministry of Health is primarily occupied with the core public health work of the MSyD and the nine respective SEDES that implement policy at the regional level, including epidemiology and statistics, immunizations, nutrition (the most celebrated being the Zero Malnutrition plan [Desnutrición Cero], with the objective of eradicating child malnutrition by 2015), infectious diseases, maternal, child, and reproductive health interventions, etc. The Vice Ministry of Traditional Medicine and Interculturality is of particular interest here, and will be discussed below. The Vice Ministry of Sports, physically located in offices distant from the central MSyD buildings, is largely ignored in a programmatic sense by the central administration, and upon occasion there even appears to be serious consideration for its reorganization into another ministry entirely. All three vice ministries, however, operate under the same guiding norms and principles of the MSyD as a whole.
**Family Community Intercultural Health (SAFCI)**

The cornerstone of the restructured healthcare system is the Family Community Intercultural Health model (*Salud Familiar Comunitaria Intercultural*, SAFCI). Under development and gradual implementation since 2006, SAFCI was formally adopted by Supreme Decree No. 29601 and signed by President Morales in 2008. This establishes it as the “official health policy of the MSyD, with the objective of improving the health of the individual, the family, and the community,” with the ultimate objective of a Bolivia “mobilized for the right to health and life—To Live Well” (MSyD 2009c). In theory, the policy should eventually be applied at all levels of the countrywide health system—from the national (ministerial), to the departmental (SEDES), to the regional (district), and finally at the municipal and community levels. It is based on four guiding principles, closely drawn from the National Development Plan: social participation; inter-sectorial cooperation (between education, housing, agriculture, justice, etc.); interculturality; and the idea that health is integral to all other aspects of family and community life.

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

SAFCI, implemented through strategic alliances between communities, social organizations, and institutional actors (local governments, health services), incorporating social mobilization and shared communication and education, has two foci—participatory management and medical attention. Participatory management involves community and municipal based organizational structures. At the community level, organically chosen and elected Local Health Authorities (one per community) act as advocates for local health needs, rotating annually; groups of these representatives together comprise Local Health Committees, directly affiliated with particular health posts or clinics. The committees are charged, together with local district

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

61 Participatory management is also pointedly referred to in the new constitution: “The state will guarantee the organized participation of the population in decision-making and in the administration of the entire public health system” (Article 40).
health personnel, with the planning, execution, administration, monitoring, and evaluation of all health-related activities in the community or urban barrio. As an echo of the traditional Bolivian sindicato system of elected dirigentes, in theory they have a significant degree of decision-making power and control over the local governmental health services, including budget and performance evaluations; in actual practice, however, nationally the committees have been put into place in a relatively delayed fashion, and when they have been formally established there are frequently subtle degrees of non-cooperation from the established health services. In the specific case of Puka Wayq’u, at all municipal levels the SAFCI structure was relatively late in its implementation and remained very weak, for years existing virtually only on paper. (See Chapter 4, Footnote 55.)

The second SAFCI focus, biomedical and clinical health attention, involves the actual government health services themselves, and both interculturality and decolonization are key in this regard: the reforms are directly related to the perceived necessity of an overall transformation in the outlook and behavior on the part of medical personnel, and the quality of attention provided. Rudeness and disrespect for clients, and misunderstanding and rejection by physicians of traditional medicine and the cultural beliefs of the population, have been long identified as the most frequent obstacles to a fluid physician-patient dialogue (e.g., Arnold and Yapita et al. 2002; Crandon-Malamud 1991; Dibbits and de Boer 2002). SAFCI calls for recognition of the strengths and limitations of both biomedicine and traditional medicine as part of an “exchange of knowledge and practices…between two medical cultures…in order to achieve articulation and complementarity between these actors, equally sharing the solution of problems and ensuring quality attention” (MSyD 2007:39). It goes without saying that this requires a significant ideological shift on the part of those with deeply ingrained beliefs and
prejudices on both sides of the medical divide; to this end, the MSyD proposes a sort of “cultural-sensitivity” workshop approach, which has yet to produce tangible results. The consensus, even within the MSyD and as expressed to me by a high-ranking official in 2010, is that the medical and clinical attention component is a slow starter and calls for much more concerted, and indeed more political, efforts.

Two central government programs have been established to “reorient” physicians and change attitudes within the medical establishment. The first is the formation of mobile teams (Equipos Móviles SAFCI), made up of a physician, a nurse auxiliary, a dentist, a sociologist or social worker, and a driver, each team based permanently in a municipality and rotating among its rural health posts. (In many ways, these teams are improved versions, with a community empowerment component added, of an earlier MSyD experiment, the Extensa BRISAS health brigades, which would spend a few days in a given municipality and report directly—and competitively—to a somewhat parallel MSyD structure, financed by the World Bank. These brigades did not, however, include a sociologist or social worker.) In the new mobile team structure, the sociologist-styled employee is designed to function as a kind of (intercultural) broker between the biomedical personnel and the community, including any local traditional medicine providers, to assist in grassroots organizing (for example, with the Local Health Committees), and to conduct relevant applied research whenever appropriate. Initially, the mobile teams were implemented almost exclusively in the geographic regions of the country which were generally more sympathetic to the MAS (for the most part, the highlands); this programmatic concentration added a distinct element of political difference and conflict, identified by many state actors as one of the most noteworthy limitations to achieving more comprehensive coverage. As the MAS has consolidated its political control and within the
context of shifting coalitions and municipal partisanships, however, since approximately 2011 there has been a more widespread diffusion of the mobile teams throughout the country, including the previously oppositional lowland regions.

The other key SAFCI program is a specialized medical residency (Residencia Médica SAFCI). This involves a three-year commitment by new physicians to work in a rural or peri-urban health post under the logistical and clinical supervision of a regional second-level hospital: in addition to the standard medical curriculum imparted (with a specialized focus on family and community health and primary health care), it involves training in ethnographic techniques (qualitative interviews, participant observation), the history and cultures of indigenous peoples, the precepts of traditional medicine, the keeping of detailed family health history files, and proactive assistance in the co-organization of community participatory-management structures. An additional unique facet of the physician training program is the nature of the historical and theoretical background included in the curriculum: alongside of modules focusing on medical anthropology and international health models (including ethnographies concerning Andean and Bolivian health practices, and authors such as influential Argentinian medical anthropologist Eduardo L. Menéndez) and the sociopolitical context of health, disease and illness (including, for example, various historical readings by and about Rudolph Virchow), there is a marked poststructural, postcolonial and subaltern orientation to the coursework (authors listed in the various syllabi include Fanon, Quijano, Barthes, and Mignolo). Together with an affiliated postgraduate certificate program in intercultural health at the central state university in La Paz.

Financial difficulties have, however, often hampered personal commitment and professional implementation of the residency program. At various points since its inception, the medical residents have voiced their complaints about how the program is handled administratively—for example in 2009, after not having received their salaries for over six months, SAFCI residents were on the verge of walking out on strike until they received an input of monies channeled from international development assistance, courtesy of the French embassy.
Universidad Mayor de San Andrés, UMSA), this program thus aims at changing the overall outlook, approach and behavior of the “typical” Bolivian physician.63

Social and “socialized” medicine

A central current running throughout the MSyD reforms, and to which the SAFCI model is strongly related, is that of “socialized” medicine. An explicit official goal is to eventually create a state-run single-payer healthcare service, guaranteeing attention free of charge to the entire population; while not yet actually implemented for both financial and political reasons, and likely to confront numerous political obstacles, a tentative foundation has already been laid. As a complement to the previously existing programs of universal maternal and infant health insurance which provides free care to all women beginning with their pregnancy and covers both mother and child until the latter is 5 years old (the SUMI coverage); and that of universal coverage for those over age 65 (both of these programs dating to the Sánchez de Lozada administrations, 1993 - 1997 and 2002 - 2003), the MAS government has initiated a state insurance program that proposes to cover all citizens up to age 25 for essentials and a wide range of elective care. Natural gas revenues will supposedly support eventual complete universal coverage of the entire population—but, they have not yet proved sufficient to do so.

An additional key component of a more comprehensive system, aimed at salaried workers, is the planned merging of the various and competing institutional health insurance programs known as cajas—to which a beneficiary belongs through employment and for which a percentage is deducted from the monthly paycheck—into a single super caja that would include everyone who is formally employed (approximately 30 percent of the labor force). The not-so-veiled intention, however, seems to be to phase out the caja system entirely, once the

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63 An additional, fundamental and complementary objective of the MSyD is to revamp the basic curriculum of the national medical schools, but resistance from entrenched faculty members has to date proved daunting.
hypothetical universal health care system is in place. At any rate, all attempts to date have been stalled by considerable opposition from the unions representing both insurers and affiliated physicians, who fear a loss of revenue and institutional autonomy, if not a significant degree of political control. Non-binding agreements have been made between the government and some physicians’ professional associations, which may in fact effectively doom any future integration of these, and the *cajas*, into the proposed single-payer plan.

Other related government programs offer monetary bonuses (*bonos*) to select populations. In 2009 the government established the Bono Juana Azurduy, which pays women directly for prenatal checkups during pregnancy, delivery in a state medical facility, and infant medical checkups until age 2. If a woman completes the entire schedule, she can receive up to approximately (as of 2011) the equivalent of US$261. The US$25 million cost of this bonus for the first few years comes from natural gas revenues and a credit from the World Bank; however, because of the declining income from gas sales and higher than expected enrollment among pregnant women, there have been doubts about the ultimate solvency of the program. Although there may certainly be justification for the cash bonus in terms of the promotion of maternal and child health, and the program has achieved international recognition,\(^6^4\) it has predictably been sharply criticized as blatant populism by the political opposition, especially during the electoral year of 2009. (Also under opposition scrutiny are other high profile actions, such as the 719 ambulances donated as part of Spanish and Venezuelan cooperation to all 327 municipalities throughout the country in 2008—nearly 600 of which, however, were not actually delivered until as late as 2010.) The bonus has also received *not* so predictable criticism from some progressive health care and development workers: as told to me by one MSyD physician with a typical

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\(^{64}\) By the Organization of American States, and the United Nations affiliated International Center for the Training of Authorities and Leaders.
tendency toward both appropriately radical indigenous rights and feminist leanings, there are those who see the bonus as a step backward toward mercantilism and dependency, from long-standing efforts by social movements and progressive NGOs to raise awareness and empower women with regard to health knowledge and health-seeking behavior. Nevertheless, MSyD officials directly credit the payments as the principal cause of the reduction in the maternal mortality rate reported in 2010 (as I have discussed), to 190 deaths per 100,000 live births (United Nations Secretariat 2011): according to public announcements from the MSyD, this is primarily due to the estimated totals of 700,000 children and 500,000 women who have received benefits from the Bono Juana Azurduy program, which translated into a 30% increase in the percentage of institutional births attended by health services personnel since 2005, to 75% (La Razón 2012).

Integral to the implementation of the health care system’s goals of universal free coverage is the participation—in “socialist solidarity”—of Cuban medical personnel. By mid-2009, an estimated 900 physicians and 800 paramedics were working in 243 of the country’s 327 municipalities (MSyD 2008). Part of a worldwide program run by the Cuban government, for the island itself it has various objectives for both political reasons (garnering international recognition for the acclaimed national health system) and also financial (a safety valve for an overcrowded Cuban professional pool). The Bolivian effort has proved both popular and controversial. Usually placed for two-year rotations in remote regions or crowded barrios, with their nominal salaries paid by the Venezuelan government, they have earned predictable ire from their local counterparts. Ostensibly based in complaints from the Bolivian College of Physicians about allegedly uncertified and unqualified Cuban personnel, and periodic flare-ups of politically

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65 Over approximately the past decade, there have been numerous historical and policy analyses of the Cuban medical brigades around the world; see for example Kirk 2009.
interested accusations of Cuban and Venezuelan “involvement in Bolivian internal affairs” and even “espionage,” this opposition has much more to do with simple professional competition: the Cubans provide typically quality medical attention free of charge, and unemployment remains high among Bolivian physicians. In general, however, the Cuban doctors have earned themselves an overall positive reputation among the population at large, based in great part on the success of “Operation Miracle” (*Operación Milagro*), the provision of free operations for cataract blindness, which by early 2009 had reportedly restored functional vision to approximately 319,000 persons (MSyD 2009a). In addition, the Cuban bi-lateral cooperation donates medical supplies, finances hospital and health post construction (nationally, 42 second-level hospitals), and provides scholarships for low-income (primarily indigenous) Bolivians to study medicine in Cuba.

**Traditional medicine and intercultural health**

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

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66 At one point in 2006, the College of Physicians went on an extended strike in protest of the Cuban presence in the country, demanding their immediate suspension and expulsion. There was, however, no official reaction whatsoever, and the Cubans stayed at their posts, while the Bolivians soon quietly and unceremoniously ended their actions, if not their objections, and returned to work.
a cultural resource and heritage codified in law (MSyD 2006:6-7). Internal coordination problems, inadequate funding, and the frequent turnover of (limited) personnel have, however, made the tangible implementation of programs and concrete results few, and qualitatively weakened the Vice Ministry’s advocacy power.

Nevertheless, the emphasis in the MSyD on the importance of recognizing and incorporating Bolivian traditional medicine on equal terms are integral aspects of the SAFCI model, and thus are present (at least theoretically) in most government programs. The most frequently stated means for actually achieving the fusion of traditional medicine and biomedicine involve the use of local medicinal plants, including their pharmaceutical industrialization and commercialization; the aggressive promotion of nutritious indigenous crops that have fallen out of widespread popular consumption (for example, grains such as quinoa, tarhui, and amaranth); mutual cross-referrals between physicians and traditional medicine providers (curanderos and parteros), as appropriate; and the active incorporation of traditional practices into common biomedical interventions. This last strategy includes, for example, the “calling of souls (almas)” prior to direct medical intervention; and—very relevant in recalling the previous tentative emphasis on “humanistic births,” in Puka Wayq’u and elsewhere—the unrestricted promotion of non-gynecological positions during childbirth, if the mother so desires (MSyD 2006:9-11).

The most notable practical and quantifiable experiences to date regarding this proposed articulation have been at the local and regional levels (either SEDES or health district based), rather than nationwide. In the department of Oruro, for example, a participatory planning program symbolically based upon the ancient Andean chakana symbol; and in Potosí department, both a postgraduate degree in intercultural health and a certification program for
traditional healers through the central hospital.\(^6^7\) It is also at the regional SEDES level that the most tangible progress in regulating and accrediting traditional medicine providers is seen, in lieu of more concerted and concrete efforts by the Vice Ministry of Traditional Medicine and Interculturality; local validation programs have been established to set standards, in addition to national, ministerial level, accreditations.

Then again, however, what need to be closely examined are precisely the supposed theoretical and practical objectives underlying the Vice Ministry itself. Specifically, this applies to the central precept that both the ethnomedical and biomedical systems that exist in Bolivia should be recognized as equal cultural apparatuses, each with its own respective worldview, and with their respective strengths and weaknesses—which are certainly often highly subjective, depending on the individual’s personal cultural reality. The idea, then, is that both health systems actively interact and function together, in (at the very least) an environment of equal articulation, and (intercultural) mutual respect and tolerance. However, in the Bolivian Real World (at least, as it still is at this point in time) things don’t always work out as planned in actual practice, due to the indisputable fact of a continued and deeply ingrained dominant biomedical hegemony, as I have tried to emphasize throughout. Thus, it is still very much a question of power (or, on the contrary, the lack of power), within the respective sociopolitical and cultural contexts. Whereas the Bolivian College of Physicians, for example, and in

\(^6^7\) The Potosí programs may be seen as an early, limited, semiofficial effort to “standardize” and accredit ethnomedical interventions in order to regulate traditional medicine providers (see Campos Navarro 2004), but questions remain concerning their impact and efficacy, both practically and ideologically. For example, some traditional medicine providers who had previously worked alongside physicians found themselves relegated to hospital janitorial staffs following program termination; it was also a reflection of poor sustainability issues, once Italian financing was discontinued. The Oruro program, however, continued functioning smoothly for some years. Its premise (directly correlated with the “To Live Well” paradigm) was a methodological fusion between revitalized Andean cultural and communitarian visions, with that of development models predominant in the individualistically oriented Westernized context. The chakana cross figure (from the pre-Incaic Tiwanaku culture) was used as a model on the basis of its symbolic and mythological representation in Andean cosmology of parallel and ordered dualities (heaven/earth; masculine/feminine) and its four dimensions, which may be interpreted for present purposes as energy/spirituality, political organization, economic production, and art/technology (see UNDP 2007; UNICEF 2007).
following its public declarations, is not overtly opposed to the official intercultural bent to incorporate local community healers and midwives and the like in any sort of outright fashion, the functional commitment it shows is minimal: an outward policy of smiles and nods yet while later looking the other way, without any true appropriation of the new official health policy principles and dictums. Or, it may be seen as something of a one-way street in the eyes of most of the “rank and file” physicians and nurses. That is (and in recalling what I have previously discussed in Chapter 2), for the indigenous community healers to cross the metaphorical line and learn some non-threatening (to the physicians, in a professional sense) basic biomedical techniques, and thus to better understand his or her biomedical colleague, is generally seen as acceptable, indeed to be actively encouraged. There have in fact been numerous community traditional healers and herbalists who have participated in government training programs, in order to become health promoters or nurse auxiliaries. Yet, simultaneously there have to date been relatively few instances—despite the much touted creation of the Vice Ministry of Traditional Medicine and Interculturality, and all of its official state project promotions—of MDs who have recognized and accepted the perspectives of traditional health workers as true equals, in a debate over the best course of action for a particular patient’s case.

By way of a real-world example: back in Puka Wayq’u—already a few years into the implementation of the new MAS intercultural health guidelines—I was sitting in one day at the monthly CAI, the team meeting at the health center during which the nurse auxiliaries from the surrounding community health posts deliver their latest statistical reports. In general, and as noted for the previous CAI discussed (in Chapter 4), these are meetings characterized by the endless recitation of statistics concerning monthly totals: number of children under five years of age vaccinated; number of babies weighed and measured; number of acute diarrhea cases and
acute respiratory infections treated; number of new tuberculosis patients identified and previous ones dosed with their monthly medicines; number of family planning talks given and contraceptive methods dispensed (in the post-PROSCAM era of Puka Wayq’u, in itself something quite noteworthy); number of prenatal visits accomplished; number of births attended by the health services personnel. The discussion turned at one point to this last subject: institutionalized births, preferably attended at either the health center in the town of Puka Wayq’u or in one of the community health posts, but at the very least in the family’s home by the local health services biomedical personnel. Ever since the 2003-2004 crisis of maternal deaths, officially attended births had been a top priority for all personnel and planning goals. There has been a steady succession of health center medical directors following the ignominious departure of Dr. Javier Quispe in early 2005: a total of five in the years since, as one after another either could no longer handle the remoteness of Puka Wayq’u and resigned, or was fired for varying reasons of incompetence—until finally arriving at the unprecedented stability of Dr. Luisa Velázquez, who has maintained the position since 2009. Uniformly, each has held up the “institutionalized births” statistical indicator as their gold standard. A maternal emergency—and, God forbid, a death—is one of the most serious setbacks imaginable that can potentially arise for the municipality: not simply for the obvious and essential human element at its core, nor for the damning effect that this has on any health facility’s performance record, but also owing to the notoriety of the past Puka Wayq’u mortality experience in the annals of the SEDES Chuquisaca.

At this particular CAI meeting, much was made, again, of the ongoing minimal quantities of attended births in the local health facilities, or by state personnel: for the previous month in question, slightly more than half had been attended by either a community partero (those few still
practicing) or by a family member. The greater part of the discussion among the health center physicians, nurses and nurse auxiliaries present involved how to capture those women, and those births, for the health services: how to, essentially, definitively phase out the parteros and home births entirely. “This isn’t good,” the assembled staff members asserted, in reference to the high percentage of births attended by community members. As I listened, I had in my mind a recent trip I had made to the Ministry of Health and Sports in La Paz. On that occasion, I had spoken with several officials about the current status of the government intercultural health strategies, including the active articulation of the biomedical and ethnomedical health workers—and also, interestingly enough when considering the recent “intellectual” climate of some Bolivian bureaucracy, we had touched upon the theoretical background and context for governmental policy. In this strategy, and as I have previously discussed, traditional community health workers, including parteros, are a high priority. The “official” intercultural guideline on the books is that they be incorporated into the system as equals; that they share and apply their traditional knowledge with government personnel in order that both maintain with dignity the key aspects of their identity as health workers, indigenous or western; and, finally, that both camps become more familiar with and skilled in each other’s respective “discipline.”

As specific theoretical support of relevant directions along these lines, and in following the writings of the Bolivian “intercultural theorists” previously surveyed (Chapter 2), Ticona (2006:63-64), for example, maintains that to this end “true” decolonization will only be achieved when the white man or mestizo is able to first erase from his mind the racially charged and racist image of the indio as someone savage and defective, as an “object” or even as a “subject without reason,” and that he be able to accept the knowledge, science and technology of this indigenous “other”—something that he at the present time finds unbearably difficult to accomplish, because
that would mean acknowledging as equal an alien science from a world perceived as little more than “brute.” In turn, Quisbert Quispe (2007) emphasizes repeatedly that just as much as there is a necessity to “make” the criollo more “like” the indígena for there to be any real progress, it is equally vital to also change the mind of the indígena (in yet another echo of both Fanon and Freire): this in order to free and open his mind in a more expansive fashion; to accept himself as he is and to be receptive to the arduous demands of decolonizing not only his oppressor, but also himself. Indisputably a difficult process to make, we are reminded, for either the colonizer or for the colonized.

At this point in the discussion at the CAI, when the topic of implicitly and explicitly “dealing with” the parteros and home births arose, I spoke up, and asked how many of the remaining local parteros were currently actively collaborating with the Puka Wayq’u health services. The question was met by blank stares; after some whispered consulting, I received the answer that in each community throughout the municipality there was a partero who was theoretically supposed to collaborate with the health center or the nearest health post. However, this didn’t sound right to me, although I didn’t say so at the time: it was a stock answer, the proper one, the one they thought that I wanted to hear, and the one that they wanted me to believe. As I have already discussed (Chapter 4), I knew for a fact that, to a significant degree, the parteros of the Puka Wayq’u communities had already been effectively phased out, and that there were many fewer than there had previously been due to pressures over the years from the health center and other locally operating NGOs. The idea of a partero in every community, let alone a partero collaborating with the official health services—it struck me as very farfetched,

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68 This statement is reminiscent of the famous admonition (threat?) of radical Aymara theorist, dirigente and politician Felipe (“El Mallku”) Quispe Huanca: “We need to indianize the q’ara” (“Tenemos que indíanizar al q’ara [white man, of European decent]”). This was in effect his own declaration of militant resistance to any generalized and watered-down concept of mestizaje in Bolivia (Quispe Huanca 2000).
and was an assertion that I seriously doubted. I asked specifically about Don Filiberto Cuellar, the old partero who lived up the street from the Puka Wayq’u health center, and yet who had been unknown to Dr. Quispe (Chapter 4, Footnote 52), because at this point in time his was (still) a case of someone who *was* active and who indeed *had* collaborated with the health center in the past—by referring tough cases, and by alerting the services when a woman was close to being due. However, during the CAI it was at first apparent that nobody was even recognizing the name; then, somewhat contradictorily, I was told that Don Filiberto was “unarticulated” with the health services. I asked whether people were aware yet that the official ministerial policy currently out of La Paz was now that all state health services were supposed to incorporate local parteros into the system on an equal footing, as part of the stepped up intercultural orientation for reproductive health. Those present at the CAI were unaware of the policy, it seemed: their enthusiasm for further discussing the issue at that moment was palpably low, and the subject was unceremoniously changed a minute or two later, without ever providing a concrete response.

As I have previously mentioned (Chapter 4, Footnote 52), a year or so later after this particular CAI meeting Dr. Velázquez assured me that she had actively incorporated Don Filiberto into health center institutionalized births as a kind of ethnomedical back-up, if the mother so requested. On hearing this, on the one hand I felt encouraged, and thought that this was a positive indication of Puka Wayq’u at last integrating itself into the “process of change.” Yet, at the same time I couldn’t help but remember Don Filiberto’s own previous words to me, to the effect that for a number of years he had preferred to no longer take part in the actual birth process itself—due to a tacit, if not overt, marginalization by the health center personnel—and consequently he clearly limited himself only to prenatal pulse measurements, referring all other cases to the health center. And, as I must also confess, Dr. Velázquez’s reply to my query about
Don Filiberto’s active participation and collaboration had seemed to me at the time to be, perhaps, just a little bit too hasty and too glib (“Of course! We take advantage of his expertise all the time!”). It was almost as if it were an affirmation that she knew she was supposed to proclaim, as part of the new official MSyD guidelines—and also what she believed that I myself was hoping to hear from her.69

Yet, again, and as I have already protested, for the most part these are good, decent people at the Puka Wayq’u health center. They believe in their work, most of them genuinely want to help the local population, and they generally work hard. But, to what degree were they at that moment unintentionally reflecting the truth in the notion of Quijano’s “coloniality of power,” in their negative attitudes and dismissal of merely discussing, let alone embracing, a hypothetical exchange with the remaining partero “subalters” in Puka Wayq’u? Here once more was the truth in the critiques voiced by the interculturality doubters, Cassandras and naysayers (cf. Viaña 2009; and Viaña, Claros, Estermann et al. 2009): in this case and like so many others, to honestly introduce full and genuine interculturality into the realm of the health services would indeed be in itself a form of decolonization—and it is to be expected that this would bring tension and conflict. And, again (in recalling Turner), through the manifestation of this conflict certain “hidden” truths were revealed, which in this given instance said a great deal

69 In another instance worthy of note, Rosendo Durán, the partero for the communities surrounding San Marcos, was formally hired by the Puka Wayq’u health center in 2009—yet not in his capacity as a partero, but rather as a kind of combined janitor and night watchman. Although Dr. Velázquez frequently maintained the official line that one of Durán’s functions was also to help in attending births if so required—precisely as part of the mandate from the Vice Ministry of Traditional Medicine and Interculturality, as well as that of the MSyD in general as implemented through the Directory of Health Promotion, to incorporate local ethnomedical human resources—this was not his principal role at all, as it was affirmed by Rosendo Durán himself. Rather he had been hired, simply and as designated on the administrative payroll at the health center, as, again, a custodian and night watchman. (Although he did also acknowledge participating in the occasional birth.) In addition, and in a strikingly significant statement of cultural assimilation and accommodation within the stratified context of the diverse Puka Wayq’u ecological levels and their respective social particularities, Durán had stopped wearing the distinctive multicolored poncho and homemade woven pants typical of the Yampara culture in the altura region, and was now dressed in cheap western shirts and trousers typically purchased at market stalls in Tarabuco or Sucre. It was, therefore, a distinct reflection of his new role as a salaried employee within the official state bureaucracy.
about gender, race, ethnicity and power in both Puka Wayq’u and Bolivia as they intrinsically remain, with or without the implementation of officially mandated intercultural and decolonization projects.

Challenges, Contradictions, and Paradoxes

Institutional opposition

The official efforts of the MSyD to achieve the proposed decolonization of the Bolivian health field are still very much “in process,” just like so much else post-2006. Despite the discourse and emphasis on interculturality and decolonization from external and internal power structures, biomedicine continues to maintain an indisputable dominance in the practical operation of the state health system, relegating traditional medicine to its historic minimized status. A few professional institutions—for example, the national College of Physicians, and the College of Licensed Nurses branch in the department of Oruro—on some occasions have openly condemned the SAFCI model as threatening undue operational control over their activities, presumably from community and barrio representatives who would (theoretically) have an active say in how the health services should be administered. Thus, it is still very much a question of power (or rather, the lack of power), within the respective sociopolitical and cultural context. These confrontational attitudes are somewhat mitigated by public assertions (e.g., again, by the national College of Physicians) of, for example, a stated openness to working with traditional medicine practitioners, but the actual demonstrative appropriation and professional commitment in practice remains minimal, as I allude to above. This is a fundamental divide that often manifests itself as rejection and opposition by many physicians to all related official health
policies as promoted by the MSyD, on the grounds that they threaten the integrity of the very biomedical profession itself.

**Political opposition, domestic and international**

For the first few years, most of the overt and clear-cut opposition to the government health reforms, especially SAFCI, came from the political rivals of the MAS, particularly in the “Media Luna” departments of Santa Cruz, Tarija, and Beni. In these areas the departmental governors, both subtly and overtly, discouraged any local cooperation with official policy not on public health grounds, but because it was perceived as “MAS politics.” In the extreme case of Santa Cruz, in the SEDES there was an open rejection of the policy and quasi-unofficial orders not to cooperate with the SAFCI medical residents or mobile teams working in the department. The residents did not, unfortunately, help their own case much by maintaining a nearly parallel organizational structure: receiving their paychecks directly from the MSyD in La Paz, rather than from the SEDES and local health districts; reporting their statistical data only to the ministerial epidemiology offices in La Paz; and due to the discouraging fact that, because of the fewer numbers of physicians from the lowlands who apply for the residency, those eventually assigned to these regions were very frequently from the highlands, and as a result had somewhat greater personal troubles integrating into the local communities—indeed, there may be the possibility that in composition and training, the SAFCI residency is overly “highlands-centric,” in regards to Aymara and Quechua culture. In the case of the southern department of Tarija, however, the opposition was initially more adaptable: with the operational structures tenuously in place, its various components were given alternative names—“Local Health Caretakers,” for example, instead of the official “Local Health Authorities”—as if to deny any ultimate authority of the “MAS institutions.” Similarly, in many parts of other eastern departments, in rural health
districts where the model (specifically, the participatory management component) is recognized as potentially positive for community planning and health center functioning, the essential elements were cautiously implemented, provided that the actual name “SAFCI” was not used and no contradictory political sensibilities were offended. Nonetheless, the situation began to noticeably change once the MAS began to overcome the political obstacles to the respective geographic and operational implementation of the policy reforms. Either through legal maneuvers with which to remove rival mayors and governors from office (typically, corruption charges which must then be interminably fought in the courts by the accused), or increasingly through winning elections, the political landscape has significantly opened up more in what were formerly opposition regions, and hence program implementation such as SAFCI has been markedly facilitated.

Although a number of international cooperation agencies (most prominently WHO, and those of France, Japan, Denmark and Spain) assist and frequently fund parts of the differing MSyD and SAFCI components, USAID was initially another source of politically oriented opposition. The United States had been for decades a major financer of the Bolivian health services, annually supplying it with financial assistance and supplies ranging from vaccines to paper and pencils. Following the forced closure by the MAS government of the USAID-operated PROSIN project (see Chapter 4, Footnote 42), and the subsequent loss of active and direct political influence on health policymaking, USAID’s relations with the MSyD slid downhill into unilateral planning and less-than-subtle resistance to the new health model and programs. In early 2007, USAID ordered a pull-out of all its directly financed and administered health projects in the highland (predominantly MAS) departments and a relocation to the lowland (at that time, predominantly opposition) departments; strongly discouraged any
involvement with MAS-controlled municipalities; and prohibited any contact, let alone coordination, with “foreign personnel” (i.e., Cuban physicians). In addition, rival programs were established, among them a postgraduate degree for physicians called the “Family and Community Health Master’s Degree,” paid for with USAID scholarships and coordinated with the (frequently cantankerously oppositional) national College of Physicians. Transparently a political attempt at competition with the SAFCI residency, virtually all of the scholarship recipients were located in the then political opposition dominated lowland departments; originally planned as a two-year program, it was abruptly closed down after only a year because of strong pressure from the central government, most prominently the MSyD.

From 2007 into 2008, USAID maintained a somewhat sullen silence and studied ignorance of the new health reforms and structures that were gradually being implemented, in differing degrees, throughout the country. Once the SAFCI Supreme Decree was signed in June of 2008, however, making the model unavoidable—a development that occurred, coincidently enough, at the same time that Washington-La Paz relations were deteriorating from bad to worse, resulting in the Bolivian government’s forced closure of politically questioned U.S. programs in general (USAID coca-related alternative development, Drug Enforcement Agency presence, the “democracy initiative”), and culminating in the expulsion of then-Ambassador Philip Goldberg—it became apparent to a suddenly more enlightened USAID that to avoid being thrown out of Bolivia entirely, it would be best to coordinate with the government whenever possible. The result was increased USAID financing for programs ostensibly supporting MSyD goals and a sudden and markedly semi-enthusiastic jump onto the SAFCI bandwagon, involving encouragement of the incorporation of local health-management norms into USAID-financed projects, and smoother relations with the MSyD at the technical (if not always political) level.
Much of this cooperation, it must be recognized, was not-so-transparently based on financial agreements which channeled USAID monies directly through the MSyD—an unparalleled arrangement, showing the degree to which the U.S. had wished to maintain at least a minimal foothold in Bolivia, for whatever reasons of political pragmatism. However, this very tenuous and charged relationship finally collapsed entirely on May 1, 2013 when President Morales, for reasons of political expediency vis-à-vis the official governmental relationship with his social movements base, formally and definitively expelled USAID from Bolivia.

**Bureaucracy and rivalries**

The new MSyD policies in general have also suffered from bureaucracy and internal politics. The most visible consequences of this are the frequent turnovers of key ministerial personnel, generally due to internal political favoritism, which has seriously affected institutional continuity and clarity. For example, since 2006 there have been five Ministers of Health, three Vice Ministers of Health, eight Directors of Health Promotion, five Directors of Epidemiology, and five Chiefs of Community Health and Social Mobilization (the office which directly oversees the SAFCI program). The most debilitating situation, however, has been at the Vice Ministry of Traditional Medicine and Interculturality. Following the untimely death of Jaime Zalles, the first Vice Minister and a nationally renowned ethnobotanist, after only a year and a half in office, the succeeding Vice Minister was soon dismissed for incompetence (and alcoholism). His replacement was also forced to resign because of legal questions concerning embezzlement and false identity; the succeeding Vice Minister also resigned; and it was only with the following appointment that the Vice Ministry achieved a modicum of stability. In addition, the formal process of appointing functionaries has proved to be vaguely mysterious: supposedly, all of them were established traditional medicine practitioners, yet all except Zalles
were judged illegitimate (in terms of experience and practice) by the very social or professional organizations that represented them (e.g., the Bolivian Society for Traditional Medicine). Thus, the appointments seemed to owe more to old-style partisan politics.\(^70\) The unfortunate result has been a nearly moribund Vice Ministry, with a reduced staff, few results to show, and no clear functional operational ties to obvious allies in the parallel Vice Ministries of Interculturality and that of Decolonization (both affiliated with the Ministry of Cultures). Overall, it has been a lackluster performance of what is supposedly one of the showpieces of the intercultural and decolonized MSyD.

**Internal contradictions and paradoxes**

Aside from these difficulties and challenges, other contradictions in the implementation of the health reform programs persist. Among them is the enduring centralization of the MSyD in La Paz and of the departmental SEDES, while the new health model by nature calls for a significant shift to the municipal and local levels. How this apparent inconsistency will play out remains to be seen—for example, how much real control the grassroots Local Health Committees will have, especially when confronted by entrenched and possibly uncooperative local health post bureaucracies. Another question is a practical one: both communities and municipalities need concerted theoretical, methodological and technical “nuts and bolts” assistance in order to actually implement the SAFCI model—electing local authorities, forming committees, the variety of respective responsibilities, etc.—and, simply, in understanding how the policy is supposed to work, and how it should fit into municipal program and budgetary planning. Yet many state and regional governments have neither sufficient finances nor personnel to adequately operate at these levels, and some are plainly uninterested in, or opposed

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\(^70\) Zalles himself was, however, questioned by the stricter “culturalist” factions during his tenure: not for professional reasons, but rather because of his non-indigenous roots, Western education, and Catholic seminarian background.
to, doing so for political reasons. The end result is that the functional responsibility falls on the various NGOs operating in Bolivia, if they are so inclined to adopt SAFCI-style policies and actions. (And, increasingly, many are: in the end, this is a practical realization of how the game is now played in Bolivia.) It is thus paradoxical that the Bolivian state, in its desire to “de-neoliberalize” and decolonize, finds itself relying on internationally based institutions or those with international financing, many of which have played leading roles in the selfsame neoliberal history of international development, in order to implement one of its leading decolonization policies.

The possible actual and future contradictions between the socialized and the intercultural health models are more profound. It is here that the potential divergences between “cultural” and “political” interests become most apparent. As one MSyD insider official grumbled to me in 2010, at one extreme and pushing for greater influence within the ministry there is a minority “culturalist” (predominantly Aymara) faction of the MAS, that adheres to a hardline, quasi-autarkical view advocating the supremacy of pre-colonial indigenous practices and political structures, including health care, and the exclusion of all q’ara individuals and precepts from political power. This tendency, combined with the parallel latent distaste for an intercultural system among much of the Bolivian biomedical establishment to begin with, could very well doom the ideological component in the long run. In the face of an entrenched medical system, decolonized or not, interculturality itself could slowly and inexorably become institutionalized, controlled, and defanged, a mere discourse accepted on the terms of those (the biomedical

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71 For example, in regards to the health field: the Declaration of Alma-Ata, although signed by all U.N. members, was actually implemented by only a few. Once its potentially “subversive” nature (i.e., community empowerment) was fully understood, ostensibly similar alternative strategies such as “Child Survival” programs were increasingly adopted by national governments. Instead of taking a wide-ranging, holistic approach to health as did Alma-Ata, incorporating social determinants and recognizing local social, cultural, political and economic contexts, these models narrowly focused on specific health issues in “safe” isolation, and primarily in terms of technological solutions (see for example Werner 1997).
physicians) with the most to lose and also the most to gain, in regards to their power and influence.

The Cuban physician program has proved to be an interesting, and key, intercultural case study, worth looking at in greater detail and one representative of additional potential paradoxes and contradictions in the programmatic implementation of the overall intercultural discourse itself. At the Puka Wayq’u health center, there was a succession of rotating pairs of physicians (on an annual basis), a total of four different pairs in all, until eventually they were no longer assigned to the municipality. The first two-person team of Cuban doctors stationed in Puka Wayq’u, in 2006—one man, one woman, as is the standard composition of all the physicians fanned out among Bolivian rural municipalities—had managed to successfully integrate themselves into the local community scene—at least, that scene pertaining to public health and curative medical issues—with relative speed and ease. Willing to hike long hours through the campo to isolated communities, and jovial and outgoing in their Caribbean infused spontaneity and familiarity—behavior which differed significantly from the all-too typically glum faces and distant demeanors of the usual rural Bolivian physicians who the townspeople were accustomed to encountering—their manners vaguely bordered on the inappropriate by local standards, yet they were also a source of quick endearment. (“Loco” being a frequent, albeit affectionate, word used to describe the couple.)

However, while on the one hand expressing contentment at their posting in Puka Wayq’u, even referring to it as a “paradise,” and conveying a great fondness for the local population, the Cubans’ attitudes in regards to all matters “intercultural” did not exactly conform to expected, or accepted, “correct” viewpoints or practice. “The ‘indios’ need to learn more, and to progress,” Yordani, the male doctor, remarked to me one day, “They lack culture.” “They have narrow
minds,” his female partner, Mayelin, added. Although for the most part this presumably had to do with a specific issue that we were discussing at the moment, concerning how long ill people in the Puka Wayq’u communities usually delayed before they finally decided to seek medical attention, I couldn’t help but be taken aback by their statements; questions of race and ethnicity seemed to weigh just as heavily with them, as with the “typical” Bolivian. (Additionally, and notably, Yordani was Afro-Cuban.) Regardless, the two Cubans had become accepted at the health post and, again, were well liked. In all appearances, however, this certainly had nothing to do with their lack of any “politically correct” opinions regarding the local population, especially within the context of the new indigenous, intercultural and decolonized state. Rather, it had all to do with simple yet critical factors regarding certain basic norms of physician-patient interactions: namely, respect, genuine human interest in the patient as a person, and good humor. (In a similar vein: “If you want to talk about interculturality,” an MSyD official in La Paz said to me on another occasion, “then interculturality is in second place in relation to the patient-provider relation. There’s a ferocious mistreatment of the indigenous population by Bolivian doctors.”)

It bears noting here that the later pairs of Cuban physicians to be stationed in Puka Wayq’u were not near as popular or well-integrated into the community as the first couple, Yordani and Mayelin, had been. For the most part, these were comprised of unexpectedly and disagreeably serious and dour medical workers, as unfortunately distant from the easy-going island stereotype as it was possible to be, and who exhibited little inclination to trapse through the mountainous countryside in search of isolated dwellings on their primary health care mission. As a result, and despite whatever their professional skills might have been, in the end international (and intercultural) solidarity seemed to be failing to make much of a local impact.
Due to a combination of budgetary restraints (the current mayor wanted to reallocate the municipal funds spent on paying the Cubans’ rent), and Dr. Velázquez’s subtle personal pressure to the health district (in what she saw as the better interests of local staff / community relations, negatively impacted by the ongoing issues of poor integration with the foreign teams), the Cuban medical presence in Puka Wayq’u was discontinued altogether in 2011.

Ultimately, then, there would appear to be the potential for an internal ideological contradiction and practical conflict involving the Cuban physicians at various levels, from the local to the national, which may or may not pose a danger to the very idea of an intercultural model. This conflict has to do with the nature of the interculturality paradigm itself, together with certain implementations of the decolonization process that involve the cost-free and widespread medical attention given by the Cubans, in “socialist solidarity.” In many respects, it would indeed seem that the MSyD is moving toward the gradual adoption of the “socialist” health model, based on both public health concerns and political affinity: e.g., specialized family doctors on every street corner, well-versed in public health measures and prevention—at least, this is their stated public position, although in actual practice the ideological and concrete impediments remain strong.72 Most prominently, perhaps, is that whereas it is well recognized that Cuba has done wonders with health indicators on the island in the last 50 years, and while maybe a similar system could work in Bolivia, there is one prominent impediment: the Cuban model is hardly intercultural, at least in the Bolivian sense of the word. Rather, it is a thoroughly

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72 However, there are also pockets of subtle resistance to the Cubans in the Cuban model. As one MSyD official in La Paz commented to me, although the many MAS physicians in government are generally pro–Cuban (and pro–Chávez Venezuelan Bolivarian revolution), they are not all emphatically “pro” on the Cuban doctors in Bolivia. This is unrelated to the more common issues of professional jealousy over work availability, earnings, or popular sentiment, as previously discussed. Rather, in this instance it has to do with how the Bolivian officials view the recent Venezuelan experience with Cuban public health influence, primarily with Misión Barrio Adentro. There, in this perception, the Cubans were absorbed so thoroughly into the Venezuelan system that they began to shape it to their own style, rhythm, and norms; that is, to their own medical culture. In the end, continues the interpretation, the Venezuelans grew to depend exceedingly upon the Cubans and their expertise, and their own local cultural sanitary history was lost. “We want our own Bolivian revolution,” the MSyD official in La Paz told me.
biomedical, physician-based, vertical structure, albeit with certain levels of popular participation and the limited, almost token, incorporation of some traditional plant-based natural medicine cures. In the end, the convergence of the two medical systems, the Cuban model and the Bolivian public health environment in which it functions, may very well prove to be more contradictory than complementary—and that convergence will most certainly prove elusive.

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For Bolivia today, then, the intercultural state is key to the concept of the decolonized state, and vice-versa. “Intercultural health” requires the recognition, acceptance, and articulation of the two health models, the biomedical and the ethnomedical. As follows the official rationality of interculturality, neither model is superior to the other; both hold an equal status, albeit relative: many illnesses (e.g., cancer, AIDS) are deemed appropriate for the “scientific” doctor at the health post or hospital; and others (e.g., soul loss) are not. Both the biomedical and the ethnomedical provider (this latter who looks more toward the social and community body to diagnose illness) must recognize their limitations. Although this ideal has yet to be fully achieved, the theoretical and practical coming together of both realities is a crucial part of the official intercultural experiment, haltingly applied in Bolivia as it is today by the respective state services, and they will be even more prominent in the near future if state policies are maintained as they currently are. And there is indisputable evidence that they will be, with inevitable tinkering and refining, with success and failures, and with a further branching out into previously tangential areas of public policy which have become central to the MAS vision of the “re-founding” of Bolivia.
Chapter 6

Epilogue
The Aporia of Pachakuti:
Radical Change, or the Evolution of Crisis?

When I returned to Puka Wayq’u in mid-2007, on a more or less regular visit and after a period of only six months away since my previous trip, what first struck me on that particular instance was a sudden, and wholly unexpected, building boom which was going on. For the previous three years, the non-governmental organization Esperanza Bolivia had been involved with their project (financed by USAID) to renovate the typical adobe and tile roof houses of both Puka Wayq’u and the surrounding communities, with the objective of bug proofing them against the Chagas disease vinchuca vector. Indeed, Esperanza had established the preliminary groundwork for the project in early 2004, almost simultaneous with our own initial arrival in the municipality. Since its inception, the presence of the NGO workers had already sparked a minor wave of modest home makeovers among the inhabitants of the selected target communities (including the town of Puka Wayq’u itself), aside from the specific Chagas improvements per se.

That is, in addition to tile replacements, wall plastering, enclosed toilets and kitchens and the like, many local families readily took advantage of the available cement, roofing materials and generous credit plans to add on other components to their homes which were not precisely related to infectious disease control. It must also be recognized that there were more than a few who built entirely new rooms or even houses, with the intention of later renting these out to the white collar hires from the city brought to work in the town hall, school or health center. Not that it would have been possible, or even proper, to “supervise” the uses to which some of the
donated building materials were actually put—however, these instances were definitely not in either the original spirit or the original intent of the project.

Yet, what confronted me now upon this most recent personal arrival was of significantly greater proportions. Suddenly awash in funds from sources that included, in addition to Esperanza, other locally active NGOs and bi-lateral assistance (courtesy of, ironically, the politically diametrically opposed governments of Venezuela and the United States), there was a virtual onslaught of municipal construction projects under implementation. In varying stages of progress, although at that point in 2007 none of them were more than a month or two along in actual on-the-ground work, these were concentrated in the town of Puka Wayq’u itself, and more specifically in the immediate environs of the plaza. The undertakings included the reconstruction of the now demolished school on the plaza itself (where Natán had maneuvered through 5th grade), and which was now being designed solely as a secondary school; an entirely new primary school, located two blocks away in a previously unused large field; the appallingly inappropriate two story communal market (that which, in significant part, would eventually cause what had been the once lively Friday night feria to die a sad death); a ten-meter high corrugated iron dome over the combined basketball court and fulbito soccer field, next to the plaza; the paving of the previously dirt streets surrounding the plaza itself; a planned new detour for entering the town (which would eventually plow through numerous farming parcels, despite the futile opposition of their respective owners), and also including the projected construction of a new bridge to replace the collapsed one on the old section of the road; the rebuilding of the filtration tanks for the miserably botched local sewage system project, which had been inaugurated only two years before (after eighteen months of achingly slow and increasingly disruptive labor—including the ditch which had impeded the arrival of Severina at the health
center—much of it involving copious amounts of dynamite to blast through the hard bedrock of the Puka Wayq’u streets); and, last but not least, a new hospital.

It was this future hospital—eventually inaugurated in 2010—that most surprised me. To be located on a large lot adjoining the old health center, the latest medical director (in 2007) confidently told me that it would be built as “full service.” A two stories high structure, he assured me, staffed by specialists in pediatrics, obstetrics, and gynecology—and here the director explicitly mentioned the events of 2003-2004 as a contextual reference point and justification—thereby warranting a classification of secondary level by the SEDES Chuquisaca authorities. At the time I tended to doubt that assessment as being overly optimistic—partly because one of the town councilmen, who had previously worked as the town administrator, told me outright that the hospital as planned was only budgeted to be a limited service facility, and would still be ranked as primary level. In addition, due to the town of Puka Wayq’u’s relative remoteness it was not very centrally located for many of the surrounding communities (primarily Villa Rosario and the altura region), in relation to the already existing secondary level hospital in Tarabuco. Nevertheless, the demand for a bigger and better health facility was an old, much lobbied and highly politicized issue in Puka Wayq’u—yet, and whereas anything would seem to be possible, I doubted that something as ambitious as what was described to me by the then director would eventually materialize. It was however still apparent that the new hospital, of whatever size, would definitely be a vast change from the old one. (The final product, while indeed impressive by municipal standards, turned out to be relatively modest and certainly nothing approaching the exalted image conjured up by that particular previous—and now long since departed—medical director.) In this respect, and whatever the eventual outcome of any current or future projects
might be, it was nevertheless still without argument that there was little direction in which the state health services of Puka Wayq’u could move, but up.

To all effects, the defining discourse of the “historical moment”—in Puka Wayq’u, and in Bolivia as a whole, both then and now—is without a doubt change. It is inherent in the very way in which the MAS government characterizes all official state policy: everything is a critical component of the self-styled national “proceso de cambio,” which itself is a more tangible facet of the much wider, much touted, and much more intangible quasi-cosmic nature of the “Pachakuti” itself. Yet the question remains precisely how these transformations actually play out at ground level—in the myriad Puka Wayq’us of the country—and what their ultimate outcomes will be. Obviously, at this point in time it is still way, way too early to properly and legitimately identify and analyze anything truly conclusive—although the process in and of itself has indeed provided more than enough material for multiple analyses, and from diverse perspectives.

But again: to what degree, then, is this supposedly ongoing revolutionary process truly perceived and assimilated by the actual actors and agents of it? In Puka Wayq’u, that remains somewhat in doubt. At the political level, the municipal government became entirely MAS (mayor, town council members) in the 2010 elections: ergo, proceso de cambio, as the government argument would have it. As I indicate, that has certainly been evident in terms of physical infrastructure, to cite but one palpable aspect. Also, and as but one example also previously discussed involving official policy and programmatic developments, the health center is tepidly in the hesitant and halting throes of SAFCI and the new sanitary reforms. But among the population at large, the man or woman on the Puka Wayq’u street, there is so far only limited
discussion: the typical and mundane workings and responsibilities of daily life more than occupy the average citizen’s time and concerns.

Don Alberto and Doña Tomasa are but one isolated case, but they are my chosen one. For them, the overriding changes which dictate their lives are, simply, familial and economic. The children grow up, as they’re wont to do, and move out; three are now studying at the university in the city, with at least one more soon to follow. This costs money—again, resource rich, but cash poor. The school expenses that previously constricted Don Alberto and Doña Tomasa (notebooks, pencils, the modest uniforms demanded by the Puka Wayq’u school) now seem minor when compared with what replaced them: university matriculation (however relatively inexpensive that may be in the Bolivian public system); the never-ending photocopying of textbooks; room rents in the city; food costs; and specialty expenses such as the cost of constructing models and mock-ups incurred by Ricardo, their eldest son, in the architecture department. Now, they must work harder; sell more produce on the urban market-bound circuit; build more rooms to rent to temporary municipal employees from Sucre; Doña Tomasa worked for a time as the high school janitor and now sells egg sandwiches in the plaza. Nevertheless, over three years they incrementally built a small, three-room adobe house a block up the street, on one of their properties, as time and finances permitted for buying cement to finish floors and wood for doors and window frames. Their stated intention is to eventually move into that, the two of them: then, I suspect, there will be more rooms to rent in the old house. In addition, however, there are always other factors which also impact upon their domestic situation: the lack of decent rains for two years and the poor grape crop (hence, less singani produced for sale or barter); the interminable (psychological?) illnesses of Doña Evarista, and the subsequent purchase of medicines; and the goat that didn’t return home from the hills last
night with the herd and was probably nabbed by a puma. All of this, as around them Puka Wayq’u is incrementally, in piecemeal fashion, “urbanized” through the ongoing construction projects; and as their children themselves are also urbanized, the oldest ones returning home from the city with less and less frequency.

These then are their concerns. And despite their undeniable intelligence and at least middling interest in national current affairs, over the course of our curious, discreet and respectful questioning of them periodically (every year or so), Don Alberto and Doña Tomasa still can’t quite figure out how to reply when we ask them about “interculturality” and “decolonization,” and what those terms might mean to them personally. So far, through the trudge of their daily exertions just to stay in the same place, for them those theoretical concepts haven’t yet become sufficiently recognizable or reified in a practical sense, in order to adequately resolve any of the problems that matter to them in ways that they find meaningful. These problems of theirs may be endemic and ongoing, or they may flare up suddenly, unexpectedly and dangerously—just like a distended abdomen about to burst.

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This dissertation has sought to explore how a very local and very personal crisis affected and impacted upon one specific locality, and how this was a reflection of a deeply rooted and seemingly never-ending sociocultural climate of crisis in Bolivia. In adopting the individual tragedy of maternal death as the given case study, it has been my aim to demonstrate how this distinct “rupture” in the social fabric of society—sudden, unexpected, and devastating to all concerned, both the dead and the living—is representative of the manner in which anthropology may look at isolated extreme events as a lens onto a broader and more profound sociocultural reality. If the nature of this particular reality cannot quite properly be defined as, say, “typical”
or “mundane,” it must at any rate be recognized as, again, both endemic and ongoing, the pervasive quality of which both shades and characterizes the overall evolution of a society in the midst of its own reflexive decolonization process, and which is in itself intrinsically linked to persistent questions of historical indigeneity. And, it also reveals not just the “why,” but also the “how” of both the community and the state reactions to unexpected and disturbing events: the ways in which the Bolivian state hierarchy benefited, grew stronger, gained power, and used the unfortunate local incidents to its own advantage, as part of the nation-building enterprise of what was still at that point in time very much a colonial structure.

Perhaps it was René Zavaleta who described it best, in characterizing Bolivia as a sociedad abigarrada, a “motley” society. A chaotic mixture of parallel, heterogeneous, clashing, conflictive, intercultural societies, including the indigenous, the creole, the European, the Afro, all co-existing simultaneously and overlapping and co-dependent, but only truly articulating during times of recurrent and inevitable crisis. To apply it in an even more “autochthonous” sense, I believe that there is also in this the concept of the tinku: the word itself, from the Quechua, literally means “encounter,” “meeting,” or “reunion”; the noun forms of the related verbs to encounter, to meet, to join or to tie together. But tinku also has another meaning, and one which is just as readily recognized within the Bolivian historical and cultural context. It is most familiar through the much studied ritualized festival occasions periodically enacted in rural areas of Northern Potosí department, violent and often brutal physical fights of hand-to-hand combat between two persons (man or woman) from different communities, a stylized struggle—a symbolic representation of, precisely, the centuries old colonial encounter—through a kind of contentious encounter, an inter-communal conflict which needs to be resolved through a head-on confrontation before the assembled public. Blood is shed; sometimes, there
are deaths. In essence, the tinku is public crisis enacted at the individual level, Bolivian style, and a crisis which is simultaneously resolved in a metaphorical (albeit violent) fashion. I have argued here that one way in which the always latent and often active national crisis is manifested is through state institutions: in this particular instance, the national health services. Through this constant conflict of beliefs and practices—traditional, modern; indigenous, European and the undeniable product of both transformed together after five centuries into a unique hybrid—there have been irrefutable benefits for the public health (for example, the “intercultural” potential for healing). Yet there have also been, and there continue to be, moments of rupture when the friction—the combat—proves too great, and things break. As I have suggested, one clear instance of this occurred in the case of Puka Wayq’u, with a troubling outbreak of unexpected and unpardonable maternal deaths.

The paradigm of change currently sets the actual agenda for Bolivian politics and society, in a formal, official, politicized and institutionalized manner. In this, I echo some thoughts of García Linera (2011) who maintains that previously the country was in its own variety of a deep-rooted and long-term (many decades old) generalized unrest, which led to a precarious descent into the “systemic transition” of stagnating conflict and instability, marked most prominently by the state control of knowledge. This then resulted—as analyzed by the sitting vice president with a theoretical nod to Gramsci, and an undeniably partisan political expediency—in a “hegemonic transition,” eventually culminating in the current political and social reality of the “refounded” Bolivian state, courtesy (in the official governmental discourse, at least) of the social movements in alliance with the MAS, as their political instrument.

Such it was also in Puka Wayq’u on a lesser scale, as I have discussed: a historic situation of inherent crisis, albeit low-key and semi-subterranean, of the colonial state. Then, a
sudden pronounced rupture of the established “norm,” and a descent into confusion and full-blown public, civil society emergency. One prominent result: the official health services were able to take advantage of the situation to further implement, strengthen and consolidate certain models and policies, and the established power system, the order of things, was subtly altered.

But one other example: after decades of the option not even being on the table or even remotely plausible, unexpectedly a “window of opportunity” opened and created the political maneuvering (admittedly, still somewhat surprisingly) that ended with the departure (voluntarily, but recognizably subtly—if not pointedly—encouraged by the municipal authorities) of the previously untouchable Catholic Church program PROSCAM, thereby leaving a public health power vacuum in the municipality. This was then promptly filled by the municipal and state governments themselves, and as frequently implemented by partner NGOs, especially later on with the “intercultural, decolonized” health sector reforms. On this particular occasion it was a positive set of events, it must be recognized, for the reproductive health of the women of Puka Wayq’u. It was also, however, both locally and nationally, a paradigm shift. Indeed, the inherent concept of paradigm in itself dictates that things must necessarily and inexorably change during times of crisis; it is the same as transformation, as radical change. As such, crisis and confrontation may certainly combine to be a positive phenomenon: it can impart strength; it can serve to renew and to restore.

I have also argued that the stories related here of personal affliction, within a wider framework of public social suffering and structural and systemic violence, through a close consideration of what is truly “at stake,” offer a unique view on how this affliction may be muddled through and eventually contained, both culturally and psychically. Shared grief is nothing more than individual grief multiplied and processed mutually, as a pathway to,
somehow, comprehending; and, ultimately, to moving on. This is, in turn, not so much an *intercultural* endeavor, but rather an *intra* cultural one: within the fluid confines of the Puka Wayq’u boundaries, the incomprehensible deaths were all-too-tangible manifestations of a deeply ingrained colonial process, and the true struggle against that must necessarily come from within, before it may come from without.

In many ways, the progress at this point in time appears uncertain on the decolonization front in Bolivia, in regards to health or otherwise. What once (to many) seemed like an overall positive change process following the 2005 elections has not proved as transformative and transcendental as previously hoped for. (By some—e.g., Dunkerley 2013, Regalsky 2010, Webber 2011—but certainly not by any means by all, García Linera himself being the most obvious case in point.) There still remain numerous “unresolved tensions,” and “the experience of the MAS…suggests that closing the gaps could be more difficult than many had initially predicted” (Crabtree 2009:12). Much continues as it has always been, or perhaps even deeper so: the exacerbation of class divisions and wealth disparities (for example, as exemplified by land tenancy and land reform); a continued erratic distribution of relative power levels; and, above all, the pervasive manifestations of varying racisms and the competing, conflicting models of a desire for the just affirmation of rights for the majority of the many, and the protection of an entrenched “way of life” for a minority of the few. There are indeed innovative and often radical policy implementations, many of them quite positive, but the overall situation is far from resolved: old hegemonic and counter revolutionary political and economic forces remain strong; civil unrest is still a daily occurrence (strikes, marches, road blockades, etc.). At times, the MAS government itself also seems to contradict and subvert its own much vaunted ideological tenets. Most prominently and polemically, from 2011 through 2013 there was the forceful government
promotion of highway construction and natural resource extraction in fragile and protected ecological regions, especially the Isiboro Sécure Indigenous Territory and National Park (*Territorio Indígena Parque Nacional Isiboro Sécure*, TIPNIS)—a misguided endeavor which has been perhaps the most potentially damaging over the long term for the MAS government to date, ranging from the political to the social to the ecological. (See for example, and as part of a growing literature of critique on this topic: Bautista et al. 2012; Laing 2012; and Mayorga 2012.) As a result, in the state attempting to establish (in many cases), and/or to then solidify its control and its influence over the general population, its “citizens” and “subjects,” perhaps then the entire notion of “crisis” has itself virtually become institutionalized—ironically, what might be termed an *intercultural* crisis, and a series of *intercultural* conflicts.

Where, indeed, then, is that progress, and where is that change? There is indisputably the desire for it fermenting in the central offices of the Ministry of Health and Sports in La Paz, as articulated by battle-weary socialist physicians from the mines of Potosí, or by earnest young academics who can cite Bourdieu and Foucault, comprising a variety of individual technical and policy teams in cluttered cubbyhole offices, all of them ready for action: the Vice Ministry of Traditional Medicine and Interculturality, the Directory of Health Promotion, the Office of Community Health and Social Mobilization, the SAFCI Medical Residency, and so on. (In this last, the office of “los SAFCIs,” and on one occasion in my experience, the politically radical *indianista* physicians rummaged about for their coca leaves and proudly proclaimed themselves to be the “most revolutionary” department in the entire Ministry—so revolutionary, they conspiratorially inferred, that they had in fact succeeded in making somebody higher up uncomfortable, because now their electricity had been mysteriously cut off for days...) Yet, this is in La Paz, in the halls of government, in the capital city: these initiatives do not always
translate well, or filter down to the local levels where they may be needed the most. Out in the Puka Wayq’us of Bolivia, they may not even be heard of at all; and, if they are, then it may be quite a while before any change is actually accepted and assimilated, and genuinely occurs.

Historically, the Bolivian health system has been designed and constructed as a vertical and colonial apparatus, and in many ways it remains so despite the efforts toward decolonization and the stubbornly resolute discourse of a “process of change.” To transform the system requires an additional overhaul of the mentality of those who work within it. To erase from the mind those long-held convictions about “unenlightened” (indigenous) “subjects without reason” (Ticona 2006) can take quite a long time—even when the “rational” mind clamors that, when all is said and done, it is, simply, wrong. I have a friend, a middle class mestiza who lives in La Paz, who is of the political left and supports the social movements now in government. Yet, in the midst of one of the ubiquitous protest marches in the city during the months prior to the MAS victory (for whatever the reason may have been on that particular instance, although I must admit that in this particular case it definitely was an impressively large multitude), she wrote an open email to her friends in which she expressed something very close to unbridled fear about the thousands of indigenous marchers who had descended from El Alto on the heights of the altiplano, and occupied the downtown center of La Paz. With an instinctive yet unrecognized dread inherited down the generations since 1781 and the Great Insurrection (Gran Rebelión) of the organized indigenous polities against Spanish rule (which included the siege of La Paz), and although she neglected to actually use the term “indian hordes,” it was nevertheless there between the lines. Where was all of her social consciousness at that moment? Where also, for that matter, was the “intercultural” sense of acceptance and cooperation on the part of the Puka Wayq’u health workers toward the local ethnomedical providers, on so many occasions? These
are little conflicts, little paradoxes, little crises, some bigger than others; but again, they reveal something to us about the essence of the society and the culture we here reflect on. In this given case, something is revealed to us about race, about indigeneity, and about the nature of being both the colonizer and the colonized—and, sometimes, about all of these concurrently.

A Final Word: The Dilemma of Personal Ethnography

In closing, I wish to briefly mention—in a decidedly reflexive vein—my own perceived personal impact on the events that transpired in Puka Wayq’u, in recognition of the influence that the mere fact of the ethnographer’s presence may have on the behavior of the local social and political actors. I have alluded to this at different moments throughout this dissertation, and I wish to close with it also, due to the particular import that I believe it held in my own personal case. There is, it has long been acknowledged, little if any probability of fieldwork so wholly neutral and antiseptically objective as to negate the incalculable effect of the researcher on the people under observation. In this it might be helpful to consider the notion of what has been called “radical empiricism” (Jackson 1989), in which ethnography in itself is “lived experience,” and is “first and foremost ‘a philosophy of the experience of objects and actions in which the subject itself is a participant’ ” (1989:3). That is—and in opposition to traditional empiricism—one in which the actual interplay “between observer and observed, between method and object” becomes “the focus of its interest.” The anthropologist interacts with the culture being studied, and is consequently a determinant upon it, and therefor (perilously?) an independent variable of the first order in regards to the final results.

In my own personal experience, the actions and reactions of the state health services were significantly, perhaps even profoundly, affected by the nature of both my research project itself,
and by myself as an individual—although it admittedly took a number of months for me to fully comprehend what, in retrospect, has seemed a somewhat obvious dynamic. I had certainly previously discussed the study objectives with the state, regional and local health authorities; they were wholly aware that I was researching the topic of maternal mortality in Puka Wayq’u; they were in complete, if not enthusiastic, support of the project, in what they perhaps perceived of as a somewhat academic exercise, yet which nevertheless might contribute some useful data. However, when actual deaths unexpectedly and disturbingly began to transpire during my on-site time in the municipality, the presence of a gringo anthropologist hanging around and witnessing all of the commotion, while closely observing the local health services and asking frequently uncomfortable questions, was not exactly the situation that the authorities would have preferred. Indeed, over a year later, both Dr. Lilián Calderón—a gynecologist and at that time also a political figure, as one of the senators who represented the department of Chuquisaca at the national level in Parliament, in La Paz—together with Dr. Fulvio Arteaga of the SEDES, similarly confided in me that the mere fact of my physical presence in town had strongly encouraged the energetic official response in regards to the situation in Puka Wayq’u. In effect, that the respective health authorities had consequently “woken up” and mobilized their forces with greater intensity and dedication—the reaction, perhaps, of a state which had become, in a sense, an accidental and inadvertent “accessory” to my own ethnographic project. Yet it was also, it needs to be emphasized and as I have attempted to maintain in these pages, a distinct opportunity for the state to take advantage of, in its own interests.

In developing the argument even more (and as I have previously hinted at), does that mean that the maternal mortality crisis in Puka Wayq’u might have been, perhaps, just a little bit “manufactured”? If so, just what would that precisely mean; to what ends, and to whose benefit?
This is to some extent unstable ground, certainly, but in small part, at least, an argument which must be recognized, permitted, and debated. Or, perhaps more accurately, the crisis (or rather, the local *manifestation* of the broader, systemic national crisis) was thus recognized and *acknowledged* and *enacted* with a more significant degree of seriousness and concern by the authorities, owing to the presence of the ethnographer. That concern, nevertheless, was undeniably based just as much on the “cleaning up” of a local, national and perhaps even international image, as it was on rectifying an unpardonable human dilemma of mortality, public health, human rights and human dignity. And for me, this then brings up the issue of another “inter”: that of “intersubjectivity.” Just how much was I a subject myself, in my own research? To what degree were my own personal relations with the topic, with the actual subjects, and among them? For that matter, and as I have noted, to what extent was Karen her own subject, and mine also, during the episode with Doña Tomasa? (Albeit in an extremely timely and beneficial manner, in what was a *human* sense, it must again be acknowledged.) In my case, it isn’t only an issue of some sort of hypothetical and unintentional impact on the health authorities’ programmatic responses (at the local, regional and national levels) owing to my physical presence, but also of the degree to which I did become a kind of co-worker, an unofficial “member of the team” in the Puka Wayq’u health center—albeit with their protocollar limitations, and with my own ethical borders drawn. It is then ultimately a question vaguely circling around, once again, the nature of my personal “ethnographic authority” (Clifford 1983), and how I have consequently represented both my subjects, and myself.

Ultimately, and as discussed at an earlier point in reflecting particularly upon the words of Farmer (2004), Das (1997) and Schepet-Hughes (1995), what is brought to the forefront here is the matter of *witnessing*, and that of *bearing* witness. In an important sense, in observing the
unfolding of a local tragedy and a local crisis in real-time, I found myself compelled to “ally” myself with the circumstances, to take part (to a modest degree) in ways that were not, perhaps, as “ethnographically neutral” as the “rules of the game” (whatever those might be) would have had it. Indeed, might it not then have been that to do otherwise—that is, to do nothing, to avoid all potential personal impact, to remain silent—would have been not only unethical in a rudimentarily human sense, but might also be construed in itself as derivative of a colonial mentality and its corresponding code of conduct? Thus in the end, I do find myself significantly deliberating this so-called (and ongoing) intersubjectivity with Puka Wayq’u as a community, and with the research topic itself. It is, very probably, simply the nature of fieldwork as defined. But these are fine lines, and I repeatedly return to questioning myself along them. This too is a variety of change, it must be recognized, and it remains for the ethnographer—for me—to be left in contemplation of the delineations, both clear and blurred, of my own ultimate ethical responsibility.
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