



Liberating the people from their “loathsome practices:” public health and “silent racism” in post-revolutionary Bolivia

Como libertar as pessoas de “práticas abomináveis”: saúde pública e “racismo silencioso” na Bolívia pós-revolucionária

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Abstract

After the Movimiento Nacionalista Revolucionario (MNR) took power in the 1952 National Revolution, the party expanded rural public health programs to address what early twentieth-century elites called the “Indian problem:” the idea that indigenous culture was an impediment to Bolivia’s modernization. After 1952, the MNR used public health as a project of cultural assimilation, and state-sponsored health programs sought to culturally whiten the population by transforming personal habits. This essay analyzes the language with which health workers discussed the indigenous population to show that despite the regime’s intention to move away from defining the rural population on racial terms, medical and political elites continued to define indigenous customs as an obstacle to progress and a remnant of an antiquated past.

Keywords: Bolivia; *mestizaje*; Movimiento Nacionalista Revolucionario; public health; race/ethnicity.

Resumo

Quando o Movimento Nacionalista Revolucionário (MNR) assumiu o poder em 1952, programas de saúde pública rural foram usados para tratar do que as elites chamavam de “problema dos índios”: a ideia de que a cultura indígena dificultaria a modernização da Bolívia. Após 1952, o MNR usou a saúde pública como projeto de assimilação cultural, e programas de saúde patrocinados pelo Estado queriam embranquecer culturalmente a população, transformando seus hábitos. Este estudo analisa a linguagem dos médicos quando falam dos indígenas para mostrar que, apesar de o regime tentar não definir a população rural em termos raciais, as elites médicas e políticas ainda enxergam os costumes indígenas como um obstáculo ao progresso e um resquício de passado antiquado.

Palavras-chave: Bolívia; mestiçagem; Movimento Nacionalista Revolucionário; saúde pública; raça/etnia.

In April 1952, Bolivia experienced a social revolution that brought the Movimiento Nacionalista Revolucionario (Nationalist Revolutionary Movement, MNR) to power. Over a period of 12 years, until the MNR was ousted by a military coup in 1964, the party attempted to modernize Bolivia and overcome centuries of political exclusion and economic dependency. During a “period of initial radicalism” (Whitehead, 2003, p.29) lasting from 1952 to 1956, the MNR worked to address these conditions via their three main political and economic reforms, which have been the benchmarks for understanding the revolution’s successes and shortcomings. Universal suffrage, implemented in July 1952, gave women and indigenous Bolivians the right to vote for the first time in the country’s history. Nationalization of Bolivia’s three largest tin mining companies, which began in October 1952, tried to break the country’s economic dependence on tin exports. Finally, agrarian reform, decreed in August 1953, broke up large estates where a few wealthy owners monopolized most of the arable land, and redistributed this land to the peasants. This period of state-driven economic and political change was a response to popular pressure on the part of miners, peasants, and other radicalized sectors, although the MNR attempted to control the tempo and scope of these reforms (Alexander, 1958; Malloy, 1970; Dunkerley, 1984).

A less-explored aspect of the MNR’s modernization agenda was its attempted cultural and social incorporation of the indigenous population. In 1952, Bolivia’s population was between two-thirds and three-fourths indigenous, including over 100 different indigenous nationalities, the largest being the Aymara and Quechua. The country’s population was also about two-thirds rural, including people living in radically different landscapes and climates: the high-altitude Andean plateau, known as the Altiplano, which makes up most of Bolivia’s western area; the central Andean peaks and valleys; and the vast *Oriente*, or tropical lowlands, covering the northern and eastern regions. Additionally, prior to 1952, most Bolivians were illiterate and did not have the right to vote (Albó, 1980). As President Víctor Paz Estenssoro, who assumed the presidency following the 1952 National Revolution, asserted in a 1956 speech to the MNR’s annual convention,

in grand historical perspective, when human beings have disappeared, when our struggles will be seen in their just dimension, the only thing that will register with universal valor will be the incorporation of the Indians, of the servants, of those that were oppressed for centuries, into civilized life, into human life (Paz Estenssoro, 1956, p.9).

In Paz’s estimation, the annals of history would record the liberation of the indigenous population from servitude and their incorporation into the nation as the MNR’s proudest accomplishment.

My research shows that public health was essential to the MNR’s intended transformation of the Bolivian nation. After 1952, the MNR expanded rural public health programs as one pathway for the political and economic inclusion of Bolivia’s indigenous population. MNR officials believed that the indigenous population could be transformed by changing their personal habits and everyday practices. Ultimately, the MNR looked to solve what early twentieth-century governing elites and the medical profession called the country’s “Indian problem” (Zulawski, 2007, p.21), which defined indigenous culture and traditions as inherently backward and an impediment to Bolivia’s transition into a modern nation. A fundamental

component of the MNR’s plan to transform Bolivian society was to erase historical racial and ethnic divisions that legitimated exclusionary political rule. This process took the form of cultural *mestizaje* (miscegenation), through which Indians would be transformed into citizens through Spanish language education and incorporated into the nation’s political and economic structures (Rivera Cusicanqui, 1987; Albó, 1987; Choque Canqui, Quisbert Quispe, 2006; Lucero, 2008).

In pursuit of these objectives, MNR officials, including the Minister of Public Health, Julio Manual Aramayo, used new revolutionary terminology – such as the term “*campesino*” (peasant farmer) in place of the derogatory term “Indian” – to refer to the nation’s indigenous population. “Indian” itself was never a stable ethnic category in Bolivia, and its meaning changed over time, from being an economic category during the colonial period to taking on political and cultural significance during the national period (Harris, 1995; Larson, 1995; Stephenson, 1999). This goal of transforming Indians into *campesinos* was designed to undercut traditional landowning elites, change social organization in the countryside, and create a politicized peasantry loyal to the MNR government. Additionally, it denoted a more modern, class-based society rather than one divided by race and ethnicity. Furthermore, it was supposed to reconcile a “clash of two cultures in the Bolivian Andes” (Hahn, 1991, p.IX) or the idea that rural and urban Bolivia were “two worlds in which values, perceptions, and social organization [we]re radically different” (p.3). Although the term “*campesino*” existed in Bolivia prior to 1952, it was never systematically used to describe a large sector of the population the way it was in the 1950s. After 1952, “*campesino* became an ethnic designation as much as, if not more than, a designation of occupation” that elites used “with the intention of dignifying the ethnic category of Indian” (Hahn, 1991, p.4). As *campesinos* and citizens rhetorically replaced Indians, this lexical sleight-of-hand was a way to bridge the “two Bolivias” (Dunkerley, 2007) and create an imagined modern nation that was economically productive, politically united, and culturally Hispanic. Robert Alexander (1958, p.95), a US diplomat visiting Bolivia in the 1950s, described unification of the “two Bolivias” as the Bolivian Revolution’s most significant objective.

In this essay, I analyze the language that doctors and public health workers used to describe Bolivia’s indigenous population in the 1950s and 1960s. Using examples from Health Ministry and other official public health publications, MNR leaders’ public speeches, and newspapers, I show that for all the language of inclusivity and the regime’s intention to move away from discussing the rural population in racial terms, political and medical elites typically defined indigenous customs and healing practices as an obstacle to progress and remnants of an antiquated past. I do not intend to give a thorough assessment of all the rhetoric used by government and health officials to speak about rural populations. Instead, my objective is to provide an overview of how the early-twentieth-century idea of the “Indian problem” was replicated in official MNR rhetoric in the 1950s and 1960s, and demonstrate that this language is generalizable across Bolivia’s public health institutions. For all the rhetoric of change and transformation generated by the MNR government, health workers’ language obscured the racialized assumptions on which public health programs were based.

As many scholars have shown, race and ethnicity have always been at the center of Latin American nation-building projects. After independence in the nineteenth century,

Latin American elites charged with building modern nations out of former colonies debated the role of race in national identity. Leaders wondered whether nations could be forged from diverse populations, or if racial homogeneity was the key to stability and prosperity. Indeed, whereas some nation-building projects focused on “civilizing” or assimilating the indigenous populations and other non-white groups (such as in Mexico and Ecuador), others, such as Argentina, embarked on projects of outright exclusion or extermination. By the late nineteenth century, elites largely accepted their nations’ racial diversity while also arguing that their populations could be improved through “soft” eugenic programs, such as medicalized childbirth, infant care, hygiene campaigns, and urban sanitation programs. The late nineteenth and early twentieth centuries saw the rise of more inclusive national projects, where discourses about “racelessness” in Cuba, “*mestizaje*” in Mexico, and “*indigenismo*” in Peru began to embrace these countries’ diverse populations, even while they continued to denigrate indigenous attributes and favor criollo or mestizo characteristics. By the 1950s, elites largely rejected biologically deterministic ideas about race. Though these individuals often replicated previous eras’ discourses, they tended to couch them in new cultural terminology about ethnicity or modernization (Appelbaum, Macpherson, Roseblatt, 2003; Gotkowitz, 2011). As Florencia Mallon (2011, p.321, 334) argues, race is a “postcolonial palimpsest” for nation-state formation in Latin America, where elites reemployed and rebranded previous racial struggles in new historical moments for political purposes as a tool for consolidating power, unifying communities, and deflecting challenges to the established order.

Medicine and public health were also integral components of nineteenth- and twentieth-century nation building in Latin America. Discourses about health, disease, and race were intertwined, and the practice of medicine was always laden with racialized stereotypes and prejudices (Stepan, 1991; Rodríguez, 2006; Zulawski, 2007; Soto Leaveaga, 2013; Cueto, Palmer, 2015). Diseases often symbolized broader national economic or political concerns, became an integral part of state-building processes, and framed questions of political inclusion and exclusion. Definitions of illness were flexible in many Latin American nations, and metaphors linking diseases to questions of national inclusion and identity permeated popular and print culture, shaped social perceptions, and infused political and economic debates (Armus, 2003). Yet, what it means to be healthy or diseased is contested and contextually specific (Rosenberg, 1992). Likewise, hygiene itself is not a neutral term; it is laden with assumptions about geography, racial and ethnic demographics, and notions of morality that elites historically used to characterize people as part of a civilized modernity or barbaric past (Turshen, 1989, p.11). In Bolivia, as Libbet Crandon-Malamud (1991, p.11, 139) has shown, health and medicine acted as a “metaphor for the nature of ethnic boundaries;” illness and healing practices allowed individuals to negotiate their social position vis-à-vis people of different races or classes in a medically plural environment. As health and disease represented metaphors for both national divisions and national unity, state-sponsored public health programs sought a cultural whitening of the population by transforming personal habits and everyday practices.

To develop a “*mestizo* hegemony” (Mallon, 1992, p.47), the MNR embarked on a project of cultural *mestizaje* through health and medicine that is distinguishable from earlier discourses about race and national identity. In the first half of the twentieth century, “*indigenismo*”

was an influential political philosophy in the Andes and Mexico that put Indians at the center of discussions about national identity, political rights, and social policy, often with an assimilationist intent. *Indigenista* writers tended to romanticize the Inca past while criticizing the indigenous population's current state of being, either due to their marginalization and exploitation within the nation-state or as a product of their own inherent backwardness. According to Ann Zulawski (2007, p.28-29), a "particularly Bolivian version of indigenismo" with a "specific antimestizo bias" distinguished Bolivian indigenismo from the Mexican and Peruvian variants. While Bolivian indigenistas believed that modern Indians had lost most of the civilized characteristics of their ancestors, they also castigated mestizos for having "all the defects of both Spaniards and Indians" (Zulawski, 2007, p.30). In reality, blurred boundaries always existed between indigenous and mestizos, and an oppositional binary between mestizos and Indians was never an accurate characterization of Bolivian cultural politics (Bigheno, 2006). For these reasons, *indigenismo* never became the basis of a major political or intellectual movement in Bolivia the way that it did in Peru and Mexico (Zulawski, 2007; Coronado, 2009; Gotkowitz, 2011).

Indigenista authors like Alcides Arguedas, one of the most well-known critics of Bolivia's indigenous and mixed-race heritage, were particularly scathing in their attacks on the country's racial composition. He invoked the metaphor of the "sick nation" in his famous 1909 book, *Pueblo enfermo* (reprinted in 1936), to argue that Bolivia's ethnic makeup was the source of its political and social problems. Although he spared no ire for Bolivian mestizos, he specifically identified the indigenous population as diseased, and thereby inferior. For instance, Arguedas argued that a population's hygienic habits directly correlated with its "ethnic element" and "barometric altitude:" the more indigenous a community, defined either by ethnicity or elevation, the less hygienic it was (p.240). Arguedas conflated race and disease, and located the source of pathology within the ethnic category "Indian." The idea that Indians needed to be reformed for the nation's benefit formed the basis of elites' earlier attempts to solve the country's "Indian problem" and meant that the ideology of *mestizaje* did not gain traction in Bolivia until the 1950s.

In contrast to the first half of the twentieth century, in the 1950s race was coded in cultural and medical terms rather than explicitly racial ones. A shift from biological determinism (popularized in the nineteenth century) to more cultural ways of framing race and ethnic differences by mid-century was common across Latin American countries (Stepan, 1991; Borges, 1993; Peard, 1999). In the 1940s, the MNR party rejected the earlier generation's biologically deterministic rhetoric and embraced *mestizaje* as an artifact of historical struggle and a pathway to Bolivian modernity (Gotkowitz, 2007, p.171-172). However, the MNR government in the 1950s did not advocate *mestizaje* through racial mixing or eugenic ideas of better breeding – there was no desire for a kind of "cosmic race," as defined by José Vasconcelos, who celebrated Mexico's mixed heritage as the foundation of a prosperous society, nor a program to physically eradicate the indigenous population, as happened in other parts of Latin America. However, Peter Wade (2003) argues that there is not always a stark difference between biological and cultural racism. While *mestizaje* as a discourse tended to promote ideas of homogeneity and inclusion, its practical application made clear an inherent tension between inclusion/exclusion and homogeneity/difference.

Coding race in medical terms allowed the MNR and its public health officials to practice a form of what Marisol de la Cadena calls “silent racism.” As de la Cadena (1998, p.143), whose research looks at how education shapes race and racism in Peru, notes, “conceptually, the struggle [to classify race] entailed a dispute over whether race was to be defined by external appearances (mainly phenotype), or through such ‘internal’ qualities as morality, intelligence, and education.” She defines “silent racism” as “the practice of ‘legitimate’ exclusions, based on education and intelligence, while overtly condemning biological determinisms” (de la Cadena, 1998, p.143-144). In Bolivia, when health officials and MNR leaders used public health discourse to side-step biologically deterministic ideas of race, they nevertheless reinforced the social hierarchy that placed urban, white, and mestizo Bolivians above rural, indigenous Bolivians. Rather than overtly degrade indigenous Bolivians based on their race, as earlier generations of elites had done by consistently calling indigenous populations barbaric, backward, and uncivilized (Zulawski, 2007; Gotkowitz, 2007; Larson, 2011), during the MNR’s tenure, descriptions of rural populations focused on their clothing, their diseases, their malnutrition, and their unsanitary living conditions (Stephenson, 1999). In Bolivia, “legitimate exclusions” were based on cleanliness, personal hygiene, and willingness to utilize professional medical services over unlicensed indigenous healers. In other words, after 1952 Bolivia no longer had an obvious “Indian problem” – instead, it had a public health problem with underlying racial tones and a similar civilizing message.

This analysis shows, to use Laura Gotkowitz’s (2011, p.6) words, “the work that race does to create and reproduce social hierarchies, domination, and violence” in Latin America. A continuity of marginalization, social stratification, and structural violence existed in Bolivia from the colonial period, through the nineteenth century, and into the post-1952 period, even if the mechanisms of exclusion changed with each era (Rivera Cusicanqui, 2010). Echoes of colonialism continued into the second half of the twentieth century, especially in attempts to eradicate indigenous culture and traditions (Mamani Condori, 1992). Moreover, the existence of “silent racism” does not mean that overt racism did not exist in Bolivia after 1952. Indeed, some MNR officials, including the Minister of Peasant Affairs, Ñuflo Chávez, made public statements calling indigenous Bolivians “ignorant” or childlike (Young, 2017, p.50). Racism certainly continued to exist after 1952 even if many public officials subverted it under a new lexicon.

Silent racism in MNR rhetoric and public health institutions

After coming to power in 1952, the MNR enacted a series of reforms in an attempt to improve the country’s economy, unite its disparate populations, and change its social structure. In addition to universal suffrage, mining nationalization, and agrarian reform, the MNR government looked to expand public health programs into the country’s rural regions in order to enhance people’s quality of life and foster loyalty to the MNR regime through paternalistic politics. MNR objectives for improved rural health centered on increasing public health infrastructure in the form of hospitals, clinics, and mobile units, as well as training doctors and other practitioners (nurses, sanitary inspectors, and midwives) to staff these physical structures. Programs targeted the most pressing illnesses in each geographical region:

tuberculosis and silicosis in mining communities, typhus in the Altiplano, and malaria and other tropical diseases in the lowlands and Andean valleys. Some disease control measures and vaccination campaigns were also national in scope.

The MNR allotted an average of about 30 percent of its national budget to social programs between 1952 and 1964, which included health, education, housing, and social security (Wilkie, 1969, p.15, 21). However, the Bolivian government’s relatively meager resources and an economic crisis during the 1950s meant that Health Minister Aramayo frequently complained that the budget was insufficient for accomplishing their goals (for example, Aramayo, 27 Feb. 1953). For this reason, the MNR government relied heavily on funding from external organizations, including the World Health Organization and Pan-American Health Organization, as well as the US government. The US government provided funding for health initiatives through a number of programs, most notably the Servicio Cooperativo Interamericano de Salud Pública (Inter-American Cooperative Public Health Service, SCISP) – a bilateral health service jointly funded by the US and Bolivian governments that was supervised by North American officials but run on a day-to-day basis by Bolivian doctors and health auxiliaries. Due to this arrangement, US officials did have influence over Bolivian public health policy; however, they were reliant on their Bolivian colleagues’ cultural and geographical knowledge to make the programs successful. Therefore, Bolivian doctors and technicians played a central role in shaping post-revolutionary public health policy. Furthermore, the “silent racism” of public health doctrine was a Bolivian creation, as US officials working in Bolivia tended to be more overtly racist than their Bolivian counterparts, including denigrating Bolivian doctors (Pacino, 2017b).

Overall, the MNR wanted to enhance what MNR leaders and Health Ministry officials frequently called the country’s “human capital” (Navarro, 1953, p.1, “Presupuesto de higiene y salubridad;” Paz Estenssoro, 1956) – the idea that healthy citizens make productive workers that can contribute to national economic development – by increasing the availability and quality of rural health services. Due to this emphasis on human capital, public health was intimately tied to the MNR’s universal suffrage and agrarian reform decrees, which were supposed to prepare Indians to exercise their political rights as citizens and contribute to the national economy (Alexander, 1958, p.80-82, 92-93). As Hubert Navarro, Director of the Biostatistics Department, wrote, “the sanitary problem is above all an economic problem” (Navarro, 1953, p.7, “Presupuesto de higiene y salubridad”). Agrarian reform and public health efforts frequently worked in tandem, as both were attempts to restructure rural society, and the success of some of the MNR’s agrarian initiatives hinged on sanitation and public health campaigns. For example, the MNR wanted to turn the *Oriente* region into an agricultural zone to spur economic growth and increase food production. In pursuit of this goal, they encouraged internal migration from the western Andes and Altiplano, where the majority of the population lived, to the sparsely populated eastern lowlands (Zondag, 1966, p.160-161), meaning they also had to address endemic and epidemic tropical diseases in that region, like malaria.

Yet rural public health also provided a way to push the urban political elites’ hygiene norms and ideas about health and wellness onto Bolivia’s indigenous population. The goal was to replace healing customs and traditions these elites viewed as backward and uncivilized

with ones considered more modern and professional. In alignment with the quote from President Paz cited earlier, the MNR leaders saw rural public health as a means of cultural assimilation through which indigenous Bolivians would be transformed into modern citizens. Paz's successor, Hernán Siles Zuazo (president from 1956 to 1960), frequently reiterated these claims that the MNR's rural health program was a transformative force in the countryside. In a speech to Congress in August 1960, Siles Zuazo (6 Aug. 1960, p.78) claimed that "for generations, the Indo-mestiza race's drive was stopped in the extensive regions where endemic diseases did not permit the path of civilization." He thereby equated the presence of disease in the country's large rural expanses with indigenous and mestizo Bolivians' lack of progress. However, he continued, "with the revolution ... an intensive campaign is taking effect to eradicate endemic diseases that decimate the small population centers in the Altiplano and the tropics, especially malaria and smallpox" (p.78). Siles argued that the MNR's disease eradication efforts would eliminate the obstacles that prevented the development of these populations, who would subsequently be able to join the "civilized life" and "human life" that Paz claimed in 1956 awaited indigenous Bolivians.

Public health institutions and prominent health officials echoed these general sentiments about the redemptive potential of Bolivia's indigenous population and public health programs. For instance, the Bolivian Health Ministry frequently described its desire to expand rural public health programs as a process of cultural transformation, but one that required overcoming rural, indigenous Bolivians' lack of knowledge of hygiene and hostility towards health workers. As a September 1953 article in the Health Ministry's bulletin explained, rural inhabitants' general "inhospitableness and lack of culture and cooperation due to their limited knowledge in sanitary education" made work that seemed "easy in the theoretical planning stages, difficult without a doubt." As the bulletin continued, "one unquestionable factor that damages the development of public health work is the problem of social order consistent with the rural population's preponderant poverty and illiteracy." Only through raising these populations' standard of living and educational level, the Ministry argued, would the MNR government "be able to ensure that these groups enjoy the legitimate right to better health through improved sanitary organization" (Bolivia, 17 Sep. 1953, p.2). In this bulletin, the author positioned health workers as the nation's saviors and indigenous people as fighting against inevitable progress.

Nowhere in the article were the words "indigenous" or "Indian" used. Instead, the author talked specifically about "rural populations," whose poverty, illiteracy, and lack of education the author identified as the principle obstacles to the success of rural public health work. This focus on poverty, illiteracy, and limited education allowed the Health Ministry to implicitly discuss Bolivia's indigenous population, or what previous generations of elites had called the "Indian problem," without naming it explicitly. For instance, when the Health Ministry bulletin referenced rural inhabitants' poverty, it conjured images of poor Indians in torn clothing living in dilapidated shacks that needed to be rescued from their misery by government benevolence and patriotic health workers. Indeed, Bolivia was one of the poorest countries in the Western hemisphere in the 1950s, and poverty indicators improved little over the course of the twentieth century, especially in rural areas (Klein, 2003, p.236, 251-255). Yet, when public health officials pointed to poverty and illiteracy as the most

significant obstacles to improved rural health, they sidestepped the fact that poverty was not just a rural problem. In doing so, they ignored the prevalence of poverty (as well as illiteracy) in Bolivia's mining centers and urban and semi-urban spaces (Gill, 1994; Zulawski, 2010), due in part to inadequate access to arable land, which caused frequent seasonal migrations to La Paz and other regional cities (Hahn, 1991, p.90-91).

This article also invoked "illiteracy" and "educational level," described as obstacles to expanding rural health care, as a way to differentiate rural and urban populations. Literacy programs had a long association with elite-driven "civilizing" missions that aimed to assimilate Bolivia's indigenous populations into urban, Hispanic culture (Luykx, 1999; Choque Canqui, Quisbert Quispe, 2006; Irurozqui, 2014). According to the 1950 census, only 31 percent of the total population over the age of 15 were literate (Klein, 2003, p.248). In the early twentieth century, elites advocated for an increase in rural schools to be staffed by teachers trained in new Escuelas Normales, who would become civilizing agents of the state. Ideally, a two-year preparatory program would prepare non-Spanish speaking students for entrance into regular primary school programs (Larson, 2011). When educational initiatives did prioritize literacy, it came in the form of Spanish-language-only education, which often maligned ethnic differences and marginalized indigenous history in favor of a unified, nationalist narrative (Alexander, 1958, p.85; Luykx, 1999, p.44-48). However, political leaders also recognized indigenous Bolivians as a massive rural labor force and a potentially significant political base. For this reason, there was a strong emphasis on creating a "separate, segregated system of rural education geared to [Indians'] 'racial aptitudes' and 'natural habitat'" (Larson, 2003, p.187-189). To achieve this goal, elites advocated educational initiatives that they considered appropriate for rural dwellers, which meant promoting vocational education to train indigenous Bolivians for agricultural work instead of literacy programs (Larson, 2003; Gotkowitz, 2007, p.63; Larson, 2011). Indigenous communities often used assimilationist educational programs to gain access to and understanding of criollo laws in order to achieve their own goals, such as communal land rights or the legal pursuit of justice and equality (Choque Canqui, Quisbert Quispe, 2006, p.49; Irurozqui, 2014). However, many rural education programs were geared towards developing patronage networks and fostering electoral clientelism rather than improving indigenous literacy rates or knowledge of the law.

Educational policy during the 1950s diverged little from these earlier initiatives. According to Roberto Choque, post-1952 educational reforms actually deepened social inequality. The MNR passed an Education Code in 1955 that distinguished between rural and urban education, but mostly replicated earlier discourses that cast the rural population as an obstacle to national progress and positioned them as merely agricultural workers (Choque Canqui, Quisbert Quispe, 2006, p.23, 186). An Education Ministry publication from 1956, cited by Manuel Contreras (2003, p.263), indicated that rural education should seek to "develop in the peasant good habits of life in relation to his nutrition, hygiene, health, living quarters, clothing and social and personal conduct" and "teach him to be a good agricultural worker through practical training in the use of up-to-date systems of cultivation and animal rearing." Thus, Contreras concludes, "the code sought to 'civilize' the Indians and convert them into 'peasant' farmers" and had limited effect on quality of or access to education in the countryside. Additionally, the MNR focused on Spanish-only education because, as Minister

of Peasant Affairs Chávez explained to *El Diario* (a La Paz-based daily newspaper) in January 1956, “Quechua and Aymara are not a means of liberation for the masses” (El Doctor..., 14 Jan. 1956). Even though as late as 1976 over one-fifth of the population spoke only an indigenous language and no Spanish (Albó, 1980), educational initiatives remained focused on providing vocational and Spanish-language education in rural areas and inculcating good, hygienic habits in their inhabitants.

Health officials also suggested that the rural population was only capable of understanding simplified messages presented in straightforward ways. For rural health campaigns to be successful, officials insinuated that rural inhabitants needed access to what *La Nación*, a La Paz-based daily newspaper closely associated with the MNR government, termed “education they can understand” (Medicina..., 1955). To reach indigenous Bolivians through easily accessible educational media, health workers distributed easy-to-read pamphlets on diseases and social vices like alcoholism. They also created comics advocating sanitary practices and enlisted off-road vehicles armed with projectors and speakers to show hygiene-related films on everything from the merits of washing one’s hands and brushing one’s teeth to providing a basic understanding of common diseases such as smallpox, yellow fever, and tuberculosis.

Examples from official public health publications show the presumed benefits, from the health workers’ perspective, of using audiovisual means to promote public health messages. A December 1954 article from the Servicio Cooperativo Interamericano de Salud Pública’s (SCISP) monthly bulletin explained the importance of audiovisual aids:

An audio-visual service includes all of the elements used for awakening public curiosity... Readings and drawings have to be exactly measured and available to the masses ... especially those that have managed to come out of the darkness of ignorance. And only a good audio-visual service can provide this to them by eliminating everything that causes confusion and emphasizing comprehension (SCISP, Dec. 1954, p.3).

The SCISP publication replicated the Health Ministry bulletin’s basic assumption that uneducated rural populations were the biggest obstacle to improved public health. In a separate SCISP bulletin, Dr. German Hoyos Torres, the director of the San Ignacio de Velasco health center, called movies a “powerful assistant for spreading healthy habits” (SCISP, Sep. 1955, p.8). These articles reinforced *La Nación*’s idea that rural inhabitants needed “education they can understand” and that audiovisual services presented simplified messages accessible to simple minds. While mention of the “masses” and people that had emerged from “the darkness of ignorance” constituted a clear reference to rural inhabitants, it avoided any explicit mention of the indigenous population. Likewise, by assuming that written or complex ideas were too complicated for these populations to follow, the articles referenced long-standing tropes of the rural, indigenous masses as uneducated and backward. This language created the “legitimate exclusions” that de la Cadena identified as part of “silent racism:” the rhetoric was not biologically deterministic or overtly racist, but nevertheless indicated that the rural masses were not as intelligent or civilized as their urban compatriots.

A 1961 Health Ministry report echoed these sentiments in a statement about the need to “establish a definite plan for the sanitary attention of the campesino population.” The report’s introduction stated that to “incorporate campesino communities into the nation’s active

life" it was necessary to "convince them that constantly maintaining private and collective hygienic norms was an important part of civilized life" (Bolivia, July 1961, p.3). As with the Health Ministry bulletins, this report argued that public health was a process of cultural acculturation. To be "civilized," in the report's own words, *campesinos* needed to embrace personal and collective hygiene practices as advocated by the medical profession. Even though the report used the word "*campesino*" (again with no explicit reference to an indigenous population) in place of the word "rural," which was preferred in the 1953 Health Ministry bulletin, it nevertheless replicated some of the fundamental ideas of the "Indian problem:" that *campesinos* (as a stand-in for indigenous Bolivians) were dirty and unhygienic, and therefore uncivilized. The report also argued that *campesinos* needed "convincing" about the benefits of hygiene and modern medicine, suggesting that they had to be tricked or coerced into acting in a civilized manner because they did not inherently understand the intrinsic value of these modern practices. This rhetoric mirrored the bulletin's ideas that indigenous people were uneducated, and therefore a danger to society, but that they were also easily manipulated for the benefit of the greater good through "education they can understand." It also reinforced the idea that state public health officials were especially suited to redeem the ignorant, backward, and down-trodden masses.

In addition to talking about rural populations, their attributes, and their abilities, these official public health reports and publications used the term "*campesino*" as a replacement for the disgraced term "Indian." For example, a 1953 report sent to the Health Ministry from Navarro at the Biostatistics Department detailed what he called "the reality of our sanitary situation" (Navarro, 1953, p.1). Navarro tackled a great many subjects in this report, including general morbidity and mortality rates and overall causes of death, but he was especially concerned about the state of the country's "rural population centers" (Navarro, 1953, p.8, "Población"). In explaining his concerns about these rural communities, he described the majority of housing in these areas as "unhealthy, and mostly of a primitive type" (Navarro, 1953, p.2, "Presupuesto de higiene y salubridad"), again conjuring images of impoverished Indians in need of government intervention and assistance. When discussing general mortality, he singled out indigenous mothers, whom he claimed put their families and the nation at risk with their poor nutrition, deplorable hygiene, and use of "ignorant, dirty and superstitious" midwives whose "dangerous practices" created "bad birth conditions" (Navarro, 1953, p.8, "Mortalidad general e infantil").

Consider the words Navarro chose to present this information. Each word formed part of a coded language used by the medical profession and ruling elites to refer to characteristics historically associated with Bolivia's indigenous population. "Ignorant" meant uneducated. "Dirty" signified a lack of understanding of modern concepts of hygiene and sanitation. "Superstitious," or what Navarro also called the "mystical indigenous mentality" (Navarro, 1953, p.3, "Profesionales en medicina"), indicated a reliance on traditional methods of health and healing based on Andean cosmology instead of modern ideas of scientific medicine. In other words, peasants were mystical, not rational. "Dangerous" was a synonym for unhygienic, while "bad birth conditions" conjured images of dirt floors, dirty sheets and towels, and babies born by unwashed hands rather than sanitized metal instruments like forceps. Last but not least, he linked these concepts to "*comadronas*," a term for midwives

referring to indigenous women who cared for the mother during pregnancy, childbirth, and the postpartum period but had limited or no medical training.

The references to housing, education, hygiene, ignorance, and hostility used by these reports historically referred to Bolivia's supposedly "backward" and uncivilized indigenous population. These official pronouncements and reports placed the blame on rural inhabitants, but not explicitly on their race or ethnicity. By linking these issues to Bolivia's rural areas, rather than the indigenous population specifically, MNR leaders and public health officials were addressing the "Indian problem" without naming it directly. Instead, they gave the "Indian problem" a new, less biologically deterministic definition whose legitimate exclusions were rooted in elite concerns about rural masses' health and hygiene. In doing so, these officials created implicit racial hierarchies through which they reified the rural/urban divide and invoked all of the images, representations, and prejudices that went along with that division.

Doctors and silent racism in practice

Doctors associated with the MNR government and its health institutions, including the Health Ministry and SCISP, replicated much of the rhetoric that replaced outright denigration of indigenous Bolivians, their culture, and their healing practices with medical and health terminology. Around the country, doctors put this silent racism into practice in health clinics, hospitals, and mobile units. When they reported on their endeavors in official publications, doctors and other health practitioners used the same coded language found in official MNR discourse and public health publications and avoided directly addressing the "Indian problem."

One prominent Bolivian doctor, Dr. Juan Manuel Balcázar, who was Health Minister on three separate occasions (1942, 1949, and 1950) and held a series of important public health appointments during the 1930s and 1940s (Mendizábal Lozano, 2002, p.167-168), advanced these ideas in his seminal work, *Historia de la medicina en Bolivia*, published in 1956. After arguing that "neither personal nor public hygiene has varied much in comparison to the previous century," he went on to differentiate between different classes' hygienic sensibilities. He claimed that "there is a better conception of the benefits of personal hygiene in the cultured classes, but it takes a long time for the habits that have predominated among the popular classes, especially the indigenous, to disappear." And he continued, "the[se] unhygienic habits continue producing elevated percentages of morbidity and mortality, and the majority of the sick belong to the popular classes" (Balcázar, 1956, p.553). While these claims were not necessarily representative of doctors' sentiments, his longevity and prominence as a health official gives some indication that these ideas were influential and had not disappeared by the 1950s.

In Balcázar's coded language, he differentiated between the "cultured classes" and the "popular classes," and thereby divided the Bolivian population along ethnic, class, and geographical lines. "Cultured" referred to the urban, educated, white and mestizo population, while "popular" encompassed everyone else. He singled out the indigenous population as especially problematic, indicating that their hygienic sensibilities were the worst of all the popular groups. Even among the "popular classes," in his estimation, some people were

more sanitary than others. Finally, he invoked the idea of progress by suggesting that over time, these unhygienic habits would disappear, even if it took longer for the indigenous than for other groups. In doing so, his rhetoric reinforced the ideas put forward by the MNR government and its health institutions that health programs and state intervention could improve rural populations.

Where Balcázar referred to the cultured and popular classes, other health publications spoke of “clans” or “tribes” – which were alternative references to indigenous communities – whose “backwardness maintain fear, selfishness, and mistrust” and where the people “do not know service, only servitude” (SCISP, Aug. 1954b, p.8). Like Balcázar, this SCISP publication blamed rural populations for their own lack of progress. Similar to the 1953 Health Ministry bulletin discussed earlier, this article claimed that rural populations’ own hostility and mistrust were the cause of their backwardness. Like President Paz’s 1956 statement, the SCISP report suggested that this rural population was in need of liberation from their own ignorance so that they could be assimilated into modern, civilized life. This same article also invoked the common trope that rural populations lacked education, explaining that “when a man or a woman is uneducated, they have less concern for doing things well” (SCISP, Aug. 1954b, p.8). As discussed earlier, health workers frequently commented on rural inhabitants’ lack of education and the need to form their hygienic sensibilities through education presented in a manner that they could understand.

Another example comes from a report published in 1954 in a SCISP bulletin documenting the work of a mobile health unit in the Andean province of Potosí. The report’s author was not identified, but nurses, sanitary inspectors, or other medical auxiliaries typically operated mobile units. The report claimed that health officials had started an “all-out war” against *curanderos* (traditional healers) because they practiced “certain extravagant rituals, used herbs, and demanded alcoholic beverages, cords of black wool, chickens, and coca in place of money.” These *curanderos*, according to the report, acted in direct contradiction to the health workers’ mandates and told locals “not to practice personal hygiene or sweep the floor because, according to them, the Devil would become enraged and spread disease.” The report argued that waging war against local healers was necessary to counter the “loathsome practices that cause the *campesinos*’ degeneration” (SCISP, Oct. 1954, p.11).

The language used by this medical professional to talk about indigenous healers is telling. The report’s author described the *curandero* as unsophisticated and lacking in medical knowledge, relying on mystical (such as the Devil spreading illness) rather than medical explanations for the causes of disease. The author also denigrated the superstitions and traditions that underlay *curanderos*’ healing practices, referring to “extravagant rituals” and the use of herbs to delegitimize them. Furthermore, the author alleged that *curanderos* extorted local populations by demanding the exchange of goods instead of monetary payment. Finally, the report positioned *curanderos* as an obstacle to the good “civilizing” work being done by trained technicians in these areas. By indicating that the *curanderos* contradicted the directions that health workers gave rural populations on how to sanitize their homes and prevent disease, the author insinuated that indigenous healers undercut the medical professionals’ authority. Like in other SCISP bulletins, the author again identified indigenous

Bolivians as obstacles to medical progress, although in this particular case the object of the professional's ire was the healer rather than the patient.

This report also connected local healers' influence to the idea of degeneration. Throughout the nineteenth and early twentieth centuries, degeneration was a euphemism for national decline. While North American and European geneticists linked degeneration to biological determinism and saw tropical populations as racially inferior and backward, many Latin American elites believed their populations could be improved through eugenic social programs and *mestizaje* (Stepan, 1991; Borges, 1993). Suggesting that "waging war" against the *curanderos* was necessary to overcome their "loathsome practices" and prevent the indigenous population's degeneration invoked earlier discourses that Latin Americans could be improved through personal practices. It also evoked previous generations' concerns about the "Indian problem." Yet, the health professional in this case modernized the rhetoric by talking about practices that affected the *campesino* population rather than focusing on the indigenous population's backward traits, as previous elites had done. By claiming that reliance on traditional healers and healing practices caused their degeneration, health workers insinuated that *campesinos* could be redeemed and modernized through state policies.

In contrast to the previous example, an article about a mobile unit from Tarija published in the SCISP bulletin presented a story of redeemed *campesinos*. The mobile unit's workers, who were attending in the town of Junacas, reported that the local inhabitants "find themselves enjoying the courteous and delicate attention of a doctor and nurses." One day each week, the report noted, the mobile unit came to town and the residents "congregate and gladly accept immunizations." According to the author, thanks to the mobile unit's work, Junacas residents "have the desire to conserve and improve their health," and "this community of few but good *campesinos* have seen quick and invaluable benefits for everyone" (SCISP, Aug. 1954a, p.7). Juxtaposed against the "extravagant rituals" of the *curandero* in the last example, the health workers here provided "courteous and delicate attention" that won the Junacas residents' loyalty and appreciation. These workers' careful attention had converted this rural community into believers in modern medicine. In comparison to the previous example, the Junacas *campesinos* were "good" *campesinos* because they cooperated with the professional health workers and valued the work that they did in their community. These good *campesinos* were redeemed Indians, grateful for government intervention and understanding of the value of modern medicine.

This story of redeemed *campesinos* as willing recipients of government health care provides a glimpse into rural reactions to these programs from the medical profession's perspective. In reality, rural communities had a multitude of reactions. People in these communities did embrace government health services for the real material benefits they provided, but they also manipulated state rhetoric to position themselves as worthy of government funding. Rather than overtly critiquing the MNR's silent racism, petitions and letters from rural communities often employed this language, identifying themselves as poor, isolated, and needy communities that were ardent supporters of the MNR government. However, they did not necessarily adopt the MNR's rhetoric about *curanderos* and indigenous healing practices, indicating they saw indigenous medicine and biomedicine as complementary rather than mutually exclusive (Pacino, 2017a). In much the same way that they manipulated

assimilationist educational programs for their own benefit (Choque Canqui, Quisbert Quispe, 2006; Irurozqui, 2014), rural communities adopted and adapted the MNR rhetoric to gain access to government health services, which were often being made available for the first time.

Doctors and other health workers frequently reiterated much of the coded language supplied by MNR officials and the Health Ministry in their reports about their labor in rural communities. These medical professionals repeated the idea that rural communities’ lack of education and occasional hostility to public health work were obstacles to progress and modernization. In addition to *campesinos* and rural dwellers, they also saw *curanderos* as a problem to be overcome. Indigenous people, either as patients or healers, could be roadblocks to progress. However, as the last example illustrates, *campesinos* were also redeemable. Once obstacles like lack of education and rogue indigenous healers were removed and rural communities embraced doctors’ directives, they came one step closer to being full citizens of the modern nation.

Final considerations

The way MNR officials and medical professionals talked about public health in the countryside formed part of a coded language. Theirs was a project of cultural integration, looking to surpass characteristics of an indigenous past marked as unmodern and undesirable. However, they did not use the same terminology employed by an earlier generation of Bolivian intellectuals that targeted indigenous culture, identity, and practices as problematic and an impediment to building a modern nation. Instead, the MNR’s project was expressed in new, non-racialized language that allowed them to talk about the “Indian problem” without naming it explicitly. In this way, health officials practiced a form of what Marisol de la Cadena has called “silent racism” that drew on familiar racialized ideas about the indigenous population but expressed them in a new language. Illiteracy, poverty, lack of education, disease, hygiene, and sanitation all became “legitimate exclusions,” showing the continued existence of racist ideas about indigenous Bolivians’ ability and potential (de la Cadena, 1998).

Through their work in rural areas, doctors and other health practitioners put this “silent racism” into practice in their reports on their interactions with indigenous communities and healers. These medical agents of the MNR state actively defined the behaviors that would operate as legitimate exclusions. Doctors cast certain practices and attitudes as either bad, which justified continued state intervention in rural communities, or good, meaning the “*campesinos*” were redeemed and assimilated. Doctors’ repeated use of the coded language adopted by MNR officials and the Health Ministry to classify rural actions and attitudes demonstrates the pervasiveness of silent racism in the MNR’s rural health program. As with educational programs (de la Cadena, 1998; Irurozqui, 2014), actors at all levels – from the national government, the Health Ministry and other health organizations, to individual health providers – played a role in replacing the “Indian problem” with more culturally-oriented means of excluding the indigenous population from full citizenship.

In this way, the MNR and their public health officials reproduced pre-revolutionary discourses that the countryside was the principle obstacle to national progress and modernization, but employed a new rhetorical strategy that obscured the racist assumptions

at these programs' core. Their assimilationist project looked to modernize the country and produce a culturally mestizo population. Using the concept of "silent racism" to analyze this project shows a disjuncture between rhetoric and reality: for all the rhetoric of change generated by the MNR government, its leaders, its public health officials, and its medical professionals tended to reiterate earlier tropes about the countryside and its indigenous population while packaging them in a new lexicon. The intended liberation of so-called Indians and their transformation into *campesinos* actually served to maintain existing social hierarchies and created new mechanisms of exclusion. From the perspectives of the political and medical elites, Indians were not inherently hygienic, sanitary, or educated, and therefore needed to be made into citizens rather than being accepted as full citizens on their own terms.

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