

Forty years of USAID health cooperation in Bolivia. A lose–lose game?

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SUMMARY

The present article proposes an analysis of the USA–Bolivia relationships in the health sector between 1971 and 2010 based on a grey and scientific literature review and on interviews. We examined United States Agency for International Development (USAID) interventions, objectives, consistency with Bolivian needs, and impact on health system integration. USAID operational objectives—decentralization, fertility and disease control, and maternal and child health—may have worked against each other while competing for limited Ministry of Health resources. They largely contributed to the segmentation and fragmentation of the Bolivian health system. US cooperation in health did not significantly improve health status while the USAID failed to properly tackle anti-drugs, political, and economic US interests in Bolivia. Copyright © 2012 John Wiley & Sons, Ltd.

KEY WORDS: Latin America; Bolivia; USAID; health policy; health system strengthening

INTRODUCTION

In September 2008, the Bolivian president expelled the American ambassador, Philip Goldberg (McDermott, 2008), accusing him of interfering with internal political affairs while supporting the political opposition. Since then, Bolivian headlines often mention threats to evict the US cooperation agency (United States Agency for International Development, USAID). Besides political issues, this article explores possible technical factors to understand and explain this conflict and critically assesses the history of USAID cooperation in the Bolivian health sector.

History can be seen as an iceberg breaking away: external forces acting upon warming internal masses determine the erratic fracture line. In Bolivia, the USA was such a force: it aimed at shaping Bolivian policies and had the resources to do so. For instance, the 2001 USAID budget of \$7.9bn (USAID, 2010) was comparable with the entire Bolivian gross domestic product (GDP) (International Monetary

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Fund—Western Hemisphere Department, 2005). The USAID is sometimes viewed as always having been a mere tool for the US State Department (Chomsky and Herman, 1979; Carleton and Stohl, 1985; McCormick and Mitchell, 1988). But under the Bush presidency, more than ever, its programmes were put closely under State Department control (Bush, 2006; McMahan, 2006). Foreign policies were aimed at serving domestic interests, as did international aid (Tarnoff and Nowels, 2004). They still do: Secretary of State Hillary Clinton, in a Washington policy address, said that the Obama administration intends to put development and foreign aid on the same level as diplomacy and military power in US foreign policy (Gollust, 2010).

The US economic, security, and political interests in aiding low-income and middle-income countries are well known (McKinlay and Little, 1977; Maizels and Nissanke, 1984; Nelson, 1997; Meernik *et al.*, 1998; Alesina and Dollar, 2000; Adelman *et al.*, 2002; Easterly *et al.*, 2003; Barratt, 2004; Yuen, 2009) and often explicit (US Bureau of Public Affairs, 2008). They include opening/sustaining markets for American goods (e.g. medical technology and pharmaceutical products), services (e.g. healthcare) (Stocker *et al.*, 1999), and/or investments (e.g. health insurances and financing); securing the provision of strategic supplies (oil, gas, and tin); limiting taxes on the middle class of recipient countries to increase its buying power; minimizing threats against national security such as diseases with pandemic potential (National Intelligence Council, 2000; Leavitt, 2007; Fidler, 2008; The United States President's Emergency Plan for AIDS Relief, 2010), illicit drug traffic, illegal migration (Osborne, 2002), terrorism, and poor countries' demographic pressure; improving politically sensitive indicators such as infant and maternal mortality to please national altruistic feelings and strengthen popularity of allied governments and thus contribute to their political stability; and supporting the anti-communist fight and promoting democracy (US Department of State—Diplomacy in Action, 2010).

It is therefore not surprising that numerous publications suggested that the USA did not always provide assistance based on recipient needs (Avery and Forsythe, 1979; Carleton and Stohl, 1985; Clark, 1992; Alesina and Dollar, 2000; Chomsky, 2003). In Bolivia, the US interests were not much different from elsewhere, although, with the exception of combating illegal cocaine trafficking, they varied across time (USAID, 2010a).

In the health sector, because of the small size of the Bolivian economy, the USAID did not aim mainly at developing a health market but controlling HIV/AIDS, tuberculosis, and other infectious diseases and reducing fertility and maternal and child mortality. Meanwhile, Bolivia kept a 35 year-old sad record of the worst social and health indicators of Latin America (Table 1) and deepened the historical segmentation of its health system. Notice that a 1983 document (Ministerio de Salud y Previsión Social Bolivia, 1983) already characterized the Bolivian health system by a high degree of fragmentation and duplication of services, 'wasting scarce resources and with a heavy urban bias'.

The present evaluation aims at verifying whether the 1971–2010 US cooperation in health was a win–win game—that it served both donor and recipient interests. Assessment criteria include effects in quality of—and access to—healthcare and impact upon health management, planning, policy, and system. Because health status determinants

Table 1. Socio-economic and health indicators (selected countries)

Location	Bolivia	Ecuador	Guatemala	Guyana	Honduras	Nicaragua	Paraguay
Deaths due to tuberculosis among HIV-negative people (per 100 000 population), 2005	30.00	27.00	11.00	22.00	10.00	9.00	12.00
Incidence of tuberculosis (per 100 000 population per year), 2005	204.00	132.00	80.00	151.00	78.00	61.00	71.00
Deaths among children under 5 years of age due to malaria (%), 2000	0.70	0.50	0.40	0.70	0.40	0.40	0.30
Maternal mortality ratio, reported (per 100 000 lb)	229.00	90.20	148.80	112.50	108.00	76.50	127.30
Gross domestic product, per capita, international dollar (purchasing power parity adjusted)	4206.35	7449.14	4562.24	2782.42	3796.11	2569.55	4433.10
Highest 20%/lowest 20% income ratio	33.70	17.20	16.80	11.10	23.90	15.00	16.90
Proportion of population below the international poverty line (%)	19.60	4.70	11.70	7.70	18.20	15.80	6.50
Infant mortality rate (per 1000 lb; estimated less than 1 year)	42.60	19.70	27.10	40.80	26.90	20.20	30.70
A.7.2.0—total fertility rate (child/woman)	3.50	2.60	4.20	2.30	3.30	2.80	3.10
Physicians ratio (10 000 hab.)	4.90	15.40	9.90	3.80	9.00	16.40	6.00

can hardly be singled out, we did not use much cooperation impact upon health status to assess the cooperation effectiveness in the health sector.

Our hypothesis is that the USAID did not achieve much in terms of economic, national security, and political US objectives in the Bolivian health sector, while neglecting the country's health needs and deepening both the segmentation and fragmentation of its health system.

METHODS

This article aims at delineating the political economy of the bilateral US aid in health to Bolivia. To do so, we analysed the dialectic relationships of its actors with their environment (Bourdieu, 1977) between 1971 and 2010.

Along the timeline of contemporary Bolivian history, we reviewed the grey and scientific public health and political literature found through a PubMed and Google Scholar search, looking for documents addressing USA–Bolivia bilateral relations, US health cooperation policies, and Bolivian US-sponsored health projects. We read official Ministry of Health (MoH) and USAID documents made available by the interviewed officers, USAID representatives in Bolivia, and the USAID Development Experience Clearinghouse web page (USAID, 2010a). We interviewed 14 key actors of the USAID local health management team about their projects and Bolivian counterparts (five former project managers, three current USAID officers, and four USAID projects MoH counterparts).

A brief discussion of the lessons closes the unified story of each period.

On the US side, we examined the coherence of the USAID interventions in the Bolivian health sector with its mission to support the US public and private interests.

On the Bolivian side, we explored the following:

- (1) The stated and real objectives of USAID health programmes
- (2) The consistency of these objectives with Bolivian health needs, which mainly relate to tackling the determinants of ill health—illiteracy, water provision, etc.—and building a healthcare system that covers the whole population in an efficient manner and provides access to good family, community, and hospital healthcare
- (3) The impact of the USAID programmes on access to quality care, services, policy, and system
- (4) The impact of these programmes on *fragmentation* and *segmentation* of the Bolivian health system

Healthcare systems are said to be segmented when they host several co-existing subsystems with different modalities of financing, affiliation, and care delivery, each serving population strata with different incomes, ability to pay, and culture. In a segmented system, different socio-economic groups access distinct funding pools and providers—which limit or prevent income and risk cross-subsidization and thus solidarity.

Healthcare systems are said to be fragmented when health units are not vertically or horizontally coordinated and cannot share resources, know-how, and information.

Fragmentation strains care standardization, quality, and efficiency (because of lack of synergy and high transaction costs) (Levcovitz, 2007).

THE PATHWAY OF AMERICAN COOPERATION IN BOLIVIA

The anti-communist fight in Bolivia signed the decade of 1970. The military dictator, President Banzer (1971–1979), was closely affiliated to other regional dictators in the US-led Condor Plan. The USA strongly supported his government, three times more than for any other Latin American country in 1974, with military equipment, productive infrastructure loans, administration, and government grants. The USA provided an aid of \$92m during the first year of Banzer's period (Dunkerley, 1984; Cingranelli and Pasquarello, 1985).

Bolivia, in the 1970s, had a typical epidemiology of diarrhoea, measles, and respiratory infections causing 80% of infant mortality. Eighty five per cent of exposed households were infected with the Chagas disease vector. Hundreds of miners died of tuberculosis and silicosis every year (Pan American Health Organization, 1986). Infant mortality rate (IMR) was at 130/1000 newborn while 86% of the 2134 public services doctors were concentrated in cities (World Bank, 1977, 1979; United Nations, 1982). Cocaine production began to be an issue in the USA–Bolivia relationship in the mid-1970s (Iriarte, 1983).

In 1961, the Bolivian Political Constitution established health as a right. Nevertheless, no important initiatives were made by the US-supported Banzer government to improve health services. By 1981, the USA had invested in just two minor health projects: the technical support provided by the Centre for Disease Control to control haemorrhagic fever (until 1975) and the initial USAID support for the creation of a maternal and child health (MCH) direction in 1971 within the MoH. What could be seen today as a political blunder is understandable in the anti-communist ideological context of the 1970s, as social programmes were not yet seen as necessary social pacifiers.

The USAID also discarded all major health projects during the 1982–1985 left-wing government. Remembered for an out-of-control inflation, the government of President Siles Suazo managed to develop public health services across the country. He also set in motion the first primary healthcare programme in Bolivia with large community participation (Programa Integrado de Atención en Salud) in line with the Alma Ata declaration (Oakley, 1991). USAID activities were limited: provision of oral rehydration salts, poliomyelitis vaccines, and some services in the Chapare region (Organization of American States, 1984). By 1981, 62 non-governmental organization (NGOs) were already active in health (Mendizábal Lozano, 2002).

The USAID started seriously investing in health with the election of Paz Estensoro (1985) and the implementation of neoclassical economic reforms. During his government, a Structural Adjustment Programme (SAP) was implemented with the enthusiastic support of the World Bank and USAID. Social expenditure was dramatically cut down from 8% of the GDP in 1981 to 1.8% in 1986 (Loayza *et al.*, 1998) and up to 35 000 miners were fired (Antelo, 2000; Duran Chuquimia, 2005; Mercado and Oliver, 2010). At the time, the worldwide USAID priority was to support macroeconomic reforms, undermine socialist experiences even in defined sectors, and

open markets in all sectors (Meernik *et al.*, 1998). In Bolivia, rather than building up a health sector market, the USAID aimed at pre-empting political unrest on poor social achievements expected from the SAP implementation. Table 2 shows the impact of one USAID programme, the Food for Peace Public Law 480.

As in other countries exposed to SAP (Laurell, 2000), adverse consequences on the health status and system of this crucial phase of aid policy were critical in Bolivia (Morales, 1994; Thiele, 2001; Franco-Giraldo *et al.*, 2006). The SAP reduced social security coverage by increasing labour flexibility. It under-financed public services other than MCH and disease control, leaving the bulk of the MoH budget earmarked for salaries and restricting the MoH-subsidized interventions to transmissible disease control, immunizations, and MCH (Tejerina *et al.*, 2011). This way, the USAID tried to minimize the social consequences of healthcare.

In MoH services, the Community and Child Health (CCH) USAID project—\$24.3m in 1988–1993—aimed to improve some IMR determinants, such as control infectious diseases and improve contraception and immunization. Although it was implemented 4 years ahead, the CCH project shared several objectives with the health sector reform (promoted by the World Bank), for example, limiting the public sector activities to a minimal package encompassing MCH and disease control (Unger *et al.*, 2006) and testing devolution—a form of decentralization whereby state responsibilities are transferred to other institutions (Bardhan, 2002)—of local governance to municipalities associated with some health activities, such as immunization campaigns and oral rehydration (Sullivan *et al.*, 1998).

Unwittingly, CCH showed the limitations of a health-problem-specific strategy. Its activities, mainly used by children, did not speed up IMR reduction—from 14.6% to 11.2% in 1970–1980 and from 11.2% to 8.8% in 1980–1990 (UNICEF, 2010; UNICEF and UN Inter-agency Group for Child Mortality Estimation, 2010; You *et al.*, 2010)—although they were active in over half of the territory.

The USAID also tested the privatization of disease-specific and MCH activities. It financed some 50 NGOs (NGO JICA Japan Desk Bolivia, 2007), 24 of them being associated in Programa de Coordinación en Salud Integral (PROCOSI) since 1988 (PROCOSI, 1998). However, a USAID evaluation suggests that privatization of prioritized health activities did not yield convincing results (USAID Mission to Bolivia, 1994). Even knowing that the Bolivian health sector market had a very low

Table 2. A comparison of Ministry of Health and Food for Peace programme resources

Year	Budget in 1979 (million dollars)		
	Ministry of social security and public health	PL-480 project funds	%
1979	51.47	11.80	23.00
1980	70.60	17.10	24.00
1981	32.04		0.00
1982		9.70	
1983	21.36	31.80	149.00
1984	144.78	9.90	7.00

Sources: 1979–1983: Banco Central de Bolivia; 1984: Ministry of Finance.

development, the USAID had to strictly follow the US Congress' directives on market development.

In US development projects in Bolivia, the cocaine issue triggered an exceptional approach. The US assistance implemented several rural development projects in the Yungas and Chapare regions, the centres of the cocaine industry (Farthing, 2010), and lobbied for the approval of the Tariff Preferences for Drug Enforcement for Bolivian exports. From 1983 to 2006, the Bolivia USAID Mission invested over \$270m for the alternative development of the coca-producing regions, including health infrastructure and comprehensive services (USAID, 2005a).

In 1985, the PROSALUD health programme was initiated to meet the middle class' demand for accessing discretionary healthcare and to test the private non-profit provision of healthcare.

The PROSALUD project

Founded in 1985, this original project created a large nationwide NGO devoted to medical care delivery. It acquired features unusual by USAID standards because of its paradoxical constraints:

- It had to efficiently deliver multifunction healthcare to the urban middle class, while implementing all vertical programmes supported by USAID in Bolivia. In other words, the project had to make discretionary healthcare compatible with epidemiological interventions, which led to an interesting organizational model of health centre and programme integration—new in the Latin American context.
- It could not contribute to the development of public services. The (quasi)-self-financing criterion was high on the contract specifications, and a large array of care was used as a tool to attract clients.

In spite of receiving a large USAID fund to cover administration costs, the project was still not financially self-sustained in 2009 (PROSALUD, 2009). Unintentionally, it provided an opportunity to explore how public health centres could be organized to deliver comprehensive care in Bolivia.

With regard to the USAID's objectives, the PROSALUD project fed the ideology of discretionary care privatization. However, if healthcare systems are to be equitable, public services ought to target also the middle class because its political influence is crucial to maintaining overall service quality (Unger *et al.*, 2006; Gérvas, 2008). Either its household expenditure on health is directed to the private sector—for its own immediate benefit and that of the commercial stakeholders—or it is used for national solidarity through taxes and/or payments in public services (Freire Campo, 2010) as in Western Europe. The USAID clearly favoured the former and hampered any long-term equitable health system development.

In conclusion, between 1985 and 1989, the USAID strongly supported government policies to liberalize the economy. Reforming, privatizing, and deregulating the health sector (USAID, 1998) were its subordinated objectives along with the improvement of child mortality indicators.

A wavering state with a confused US cooperation characterized the decade of 1990. Three factors progressively made Bolivia ungovernable (Barr, 2005):

- In each of the elections held during 1989–2005, the parties that had an alliance with the USA (Movement of the Revolutionary Left, Nationalist Revolutionary Movement, and Nationalist Democratic Action Party) assumed power, but with no more than 30% of the votes each. Those governments lacked political legitimacy.
- Because of cocaine economics, corruption weakened governance (Transparency International, 1996; Gray-Molina *et al.*, 1999)
- The poorer 20% of the population received only 4% of the income, whereas the richer 20% received 64%. Exclusion of the majority from land tenure, income, political participation, and access to social services became rampant.

The USA often rescued these weak governments but with conditional aid support toward coca production control and deepening of pro-market reforms. The Paz Zamora presidency (1989–1993) was confronted with the worst crisis in terms of the Bolivia–USA relationship. The Bolivian international campaign ‘Coca is not Cocaine’ and its law reducing sentences for drug traffickers under voluntary surrender were countered by the USA by closing aid disbursements and threatening to withdraw political support. Ministers in the Bolivian government lost their US visas during this period. Bolivia reacted by convicting a high-level politician and extraditing the head of Bolivia’s Special Narcotics Forces and a former minister of the government. The law to privatize national industries was approved soon after.

During this period, the USAID and the MoH tried to standardize the MCH and contraception activities through the CCH project by writing strict guidelines and training the staff. It also established a national demographic, child survival, and contraceptive prevalence surveillance system and highly positioned reproductive health in the national agenda by developing a bilateral family planning programme (\$9.3m between 1990 and 1994). It also added Chagas disease and AIDS control to its portfolio with a \$1m grant.

On the other hand, the USAID also tried to privatize these activities through the NGO network PROCOSI with mixed results (USAID Mission to Bolivia, 1994; PROCOSI, 1998, 2001, 2006). The USAID also promoted community participation in the implementation of projects but limited it to task execution and cost recovery. PROSALUD created 14 new centres in La Paz and six in other cities in 1994.

In 1998, the MoH and the USAID began implementing the Integrated Health Project (PROSIN I) focused on immunization campaigns, integrated management of childhood illness, family planning, and HIV/AIDS control (USAID, 1998). This project also trained armed forces recruits and officers in disease control activities and set up a National Epidemiological Surveillance and Health Information System (USAID, 2000).

The Basic Health Insurance Programme was created to secure access to maternal and child care and treatment for tuberculosis, Chagas, and HIV, thereby reducing supply-side financing and increasing prioritization in public health expenditure. The USAID contributed technical assistance, training, and supplies. Of the \$29.24m, 47% was allocated for reproductive health objectives and supported this insurance programme.

Decentralization, as advocated and tested by the CCH project, was enforced in 1994 (Kohl, 2002). As a result, fragmentation became such that the MoH, the international aid, the region, and the municipality were all involved in the management of the same health centre and each organization was managing its portion of salaries, disease programmes, human resources, and drugs.

The government of Sanchez de Lozada (1993–1997) strengthened vertical programmes and deepened the devolution of the MoH facilities (hospitals and dispensaries) to municipalities with the People's Participation and Administrative Decentralization laws. The USAID supported these actions and provided almost 80% of donor assistance to the national family planning programme, as well as nearly all contraceptives.

The family programme was contracted out to a wealth of NGOs, for example, Project Concern International, Adventist Development and Relief Agency, Food for the Hungry International, and Caritas Boliviana by following the PROSALUD experience. This was a time of synergy between the US and Bolivian governments.

These reforms pleased the US-led donor community. In 1998, under the subsequent Banzer–Quiroga government, multilateral creditors condoned about \$440m of external debt through the Highly Indebted Poor Countries Arrangement.

During this period, the USAID clearly failed to understand the political instability. By trying to sustain the ideologically guided state reforms and avoiding the emergence of socialist alternatives, the USAID overlooked the possibility of stabilizing parties allied to the USA by, for instance, improving the population's quality of life and granting acceptable universal health services.

The first half of the 2000s was a time of social and political turmoil in Bolivia (Baer, 2008). Between 2000 and 2005, although Bolivia was the third largest recipient of US foreign assistance in Latin America (Veillette, 2005), the consequences of neoliberal reforms and corruption—Bolivia was ranked 105th by (Transparency International, 1996, 1997, 1998, 1999) Cites 18 to 21—had raised popular discontent.

Preoccupied by unrest and rapidly declining political stability, Bolivia implemented the Poverty Reduction Strategy Programme to increase citizens' support and trust for democratic institutions. However, the USAID continued with its focus on health vertical programmes. The infectious disease and reaffirmation of user rights in family planning initiatives were launched in 2002. This overlooked the people's demand for access to versatile healthcare in hospitals and dispensaries. However, the decay in government stewardship led the USA to support the government's capacity to strategically plan the public sector.

In 2003, street protests led President Sanchez de Lozada to resign (Orgaz, 2004). During the next 2 years, the USA tried to tackle the government's legitimacy crisis and the public distrust of national institutions. The USA feared that a civil war with social misery will form the ground for radical change. The indigenous poor majority was seen as being increasingly unwilling to accept the social and economic status quo (USAID, 2005b). And indeed, for the first time in 10 years, popular forces were voicing disillusion with democracy and free-market economics. However, the USAID's health activities and financing remained stable, although they aimed at improving quality and coverage of health networks and at strengthening the health system more than before.

In 2006, the 'socialist' government of Evo Morales was elected. Although it adopted a socialist terminology, its economic programme was rather of the 'Andean capitalism' type (CEDLA, 2006), with the state taking a lead in economic and industrial planning and regulation but with a clear role for Bolivian private and foreign investments and in particular for small businesses. Nevertheless, such a programme was at odds with the US Republican administration's orientation.

Taking a distance from the national government, the USAID now focused its aid at the municipal level and on empowering communities to diffuse social tensions, while it paradoxically scaled down its social programmes. For example, with the premature closing of PROSIN, funds formerly directed to the MoH were switched to privately managed projects on individual and community health and the delivery of services through the community and private health networks. The USAID promoted private sector partnerships in social marketing with the Global Development Alliance, which involved the pharmaceutical industry. It reduced the number of targeted municipalities, steering those vulnerable to conflict and/or with the lowest economic and health indicators. In 2007, the USAID trained 48 civil society organizations in advocacy and citizen participation to promote ‘corporate social responsibility, trade preferences, domestic markets, and exporting vision’. In the Santa Cruz region, leading the political opposition to the central government, the USAID developed a model for intra-departmental indigenous autonomy.

The same year, President Morales publicly criticized the (USAID, 1998) for its support of the political opposition. In 2008, the social organizations expelled the USAID-funded organizations from the Chapare region, and the government evicted the American ambassador, Central Intelligence Agency, and Drug Enforcement Agency from the country.

In 2008, the USAID continued to scale down its health activities, a trend initiated in 2005 with the election of Evo Morales. The proportion of health in the total USAID activities was reduced (Figure 1), while the same old package of MCH activities, sanitation, water supply, and disease control was financed in 40 rural municipalities. Meanwhile the USAID, with a low profile, focused on health aid in the private sector and in the regions governed by the opposition, probably trying to save what remained of its presence and influence.

Since the election of President Obama, the USA–Bolivia relationship and the questioning of the presence of the USAID in the country have improved. In 2009,

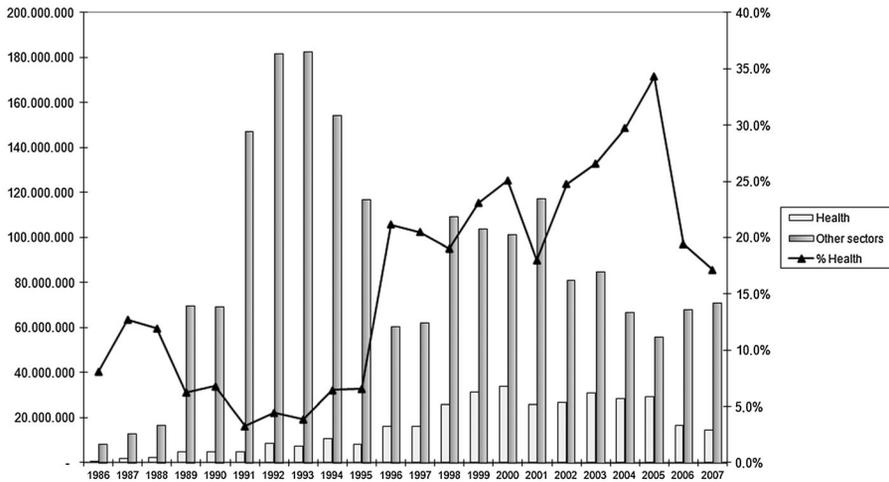


Figure 1. The evolution of US financial cooperation to Bolivia between 1986 and 2007 and the weight of the health sector on the aid. The relationship between Bolivian political events and the cooperation assigned to health and other sectors is commented in the Results section of the paper

the USAID (2010b) started a publicity project to communicate the health gains permitted by its programmes. In March 2012, a new Bolivia–USA diplomatic relationship framework was signed, and the USAID started financing two new health projects: strengthening of the health sector—FORTALESSA—with the Pan American Health Organization and United Nations Children’s Fund as subcontractors and the Community Health Project. In theory, these projects should follow the new Bolivian family and community intercultural health policy.

CONCLUSIONS

From scratch, a win–win situation resulting from 30 years of USA–Bolivia bilateral cooperation was unlikely because historically Bolivian (and many Latin American) governments had defined health as a right and health services as a public good, while US government and agencies’ philosophy of free trade and promotion of a market economy assumed that by expanding the private sector, economic conditions and thus overall health would improve with minimal government provision of healthcare (Waitzkin *et al.*, 2005; De Paepe *et al.*, 2007). The USAID has to strictly follow the US congress directives and has almost no margin to adapt its actions to local conditions and needs.

With a GDP about 800 times smaller than that of the USA, Bolivia remains a comparatively small market—hence, a low priority for American companies. Therefore, without being left completely aside, economic objectives did not score high on the US agenda, compared with political stability and cocaine control. The USAID thus limited itself to supporting the agenda of health system reform led by the World Bank.

However limited they were, the USAID failed to attain most of its health and general foreign policy objectives (controlling drug trafficking, illegal immigration, and demographic pressure and supporting the development of a health market) in 30 years of cooperation. It failed to do so in spite of having invested in the Bolivian health sector sufficient resources to support, at one stage, one quarter of the country’s public first-line health services (\$18.5m per year over the 1996–2008 period).

Unfortunately, the USAID in Bolivia proved incapable of timely adjustment to local requirements—even in the interest of the US government—as suggested by the two following examples:

- At the time of wavering governments (2002–2006), the USAID should have aimed at improving versatile polyvalent first-line health services, for the sake of social and political stabilization. It would not have been very costly as the infrastructure was in place, and it would not have hampered foreign investment. Perhaps the USAID staff lacked the managerial techniques, which are relatively specific. Another reason could be their interest on keeping the project structure strictly separated from public control to maintain their privileges.
- The USAID did not protect or strengthen the only local integrating structures, the district executive teams, which are so pivotal to the delivery of disease control and contraceptive interventions, as well as comprehensive primary care.

Although Bolivia remained among the first three providers of cocaine to the USA, the Drug Enforcement Agency was expelled in 2008. Governments that prompted the free-market economy were ousted in 2006. Hydrocarbons, telecommunications, and mining were nationalized.

Commoditization of healthcare is threatened by a new constitutional mandate to create a unified health system with universal coverage.

From a Bolivian viewpoint, the USAID never developed a consistent policy for its health system:

- The basic health packages for the poor were never properly delivered by the extensive network of NGOs upon which the USAID was relying.
- These adopted a large array of service models: integrated in towns and highly specialized elsewhere. Organization choices were driven by commercial consideration, not by the state of existing health services. PROSALUD however demonstrated how comprehensive services can be developed in public centres of health.
- Versatile healthcare was largely privatized. However, no effort was made to regulate this sector so as to secure basic conditions of fair competition and make the private sector also work for social objectives.
- Finally, the USAID operational objectives (fertility control, MCH, and disease control) may have worked against each other while competing for limited resources in poorly organized settings.

Acting as a donors' leader, the USAID largely contributed to the segmentation and fragmentation of the Bolivian health system. It used its influence to focus public services on the (almost) exclusive delivery of MCH and disease control care. It created and financed a myriad of (unsustainable) NGOs devoted exclusively to MCH and contraception activities. It developed a comprehensive service network to the benefit of the middle class only (PROSALUD).

Together with the World Bank, the USAID promoted the devolution of health facilities to municipalities in an environment where these had not the required intellectual and material resources and without due preparation (a worldwide problem) (Bardhan, 2002). Bolivia badly needed decentralization, but local governments had no capacity to regulate and control health services. De-concentration rather than devolution would have been an option. It would have capitalized on the existence of experienced executive teams at district level, which could have been enlarged to include NGOs and other organizations with a social mission. However, de-concentration was never seriously considered by the USAID in Bolivia.

It is thus not surprising that the health outcome of the US cooperation remained limited. Maternal mortality went down over time (from 416 in 1986 to 229/100 000 in 2003), but not in a way that reached the MDG5 (this would have required operating well-articulated systems) (Ronsmans and Graham, 2006). IMR dropped (from 89 to 54/1000 newborns in the same period) (Figure 2) but no more in USAID-aided regions than in the others and no more in Bolivia than in neighbouring countries (Figure 3). Maternal and infant mortality remained the worst in South America and its contraceptive prevalence (25.5%) the third worst after Saint Vincent and the Grenadines (20%) and Haiti (22.9%) (PAHO, 2010). The reduction of fertility rates across time was not impressive either (Table 3).

With regard to disease control, the USAID mainly addressed health problems seen as a threat to the USA (HIV and tuberculosis), whereas they overlooked malaria and Chagas disease in spite of them being key issues in Bolivia. Even HIV/AIDS and tuberculosis gains were inferior to the rest of Latin America (Table 4). These demographic and epidemiological gains were thus not worth the disarticulation of the health system.

As suggested by Lianne Urada (2005), US values and ideology could complicate the way that the USAID promotes American assistance around the world. However, political changes in Washington and conjectural changes in its foreign politics probably also prevented sector-specific assistance from adjusting. This is why it is difficult to foresee the direction this cooperation will take: supporting the Media Luna political agenda (representing the main opposition against the Morales government) or maintaining its traditional objectives.

The Bolivian record of the worst health indicators of Latin America is clearly underpinned by deficient access to care and a historically segmented health system. A 1983 document (Ministerio de Salud y Previsión Social Bolivia, 1983) characterized the Bolivian health system by a high degree of fragmentation and duplication of services. Fifteen separate social security funds worked in parallel with the MoH, 'wasting scarce resources and with a heavy urban bias'. Since then, the USAID activities have deepened this fragmentation and segmentation.

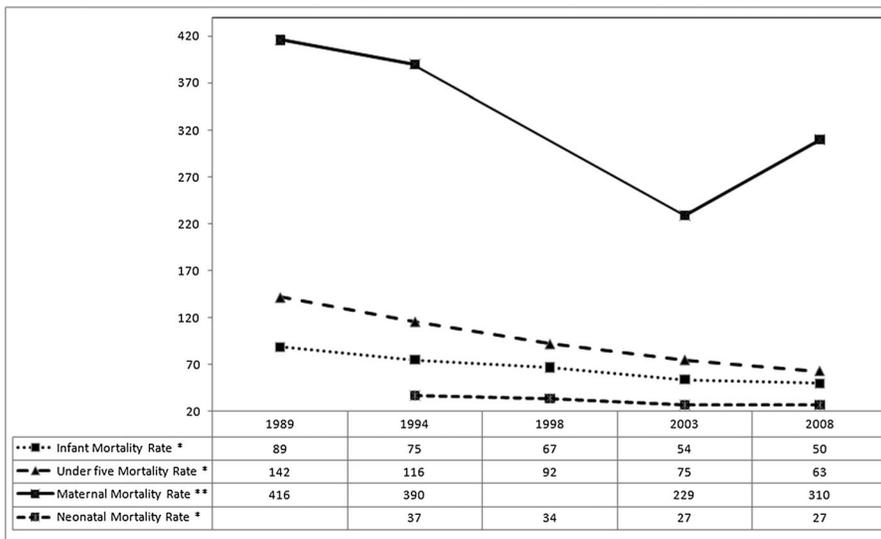


Figure 2. Mortality indicators from national surveys. Bolivia 1989–2003. It shows the decline of infant, maternal, under-fives and new-born mortality rates in Bolivia. The shortage of the indicators improvement is commented in the Results section of the paper. * - per 1,000 live births; ** - per 100,000 live births. Each survey covers the five preceding years. Source: Encuestas Nacionales de Demografía y Salud (ENDSA) 1989, 1994, 1998 and 2008. National Health Information System in: <http://www.sns.gov.bo/> and National Statistics Institute in <http://www.ine.gov.bo/>

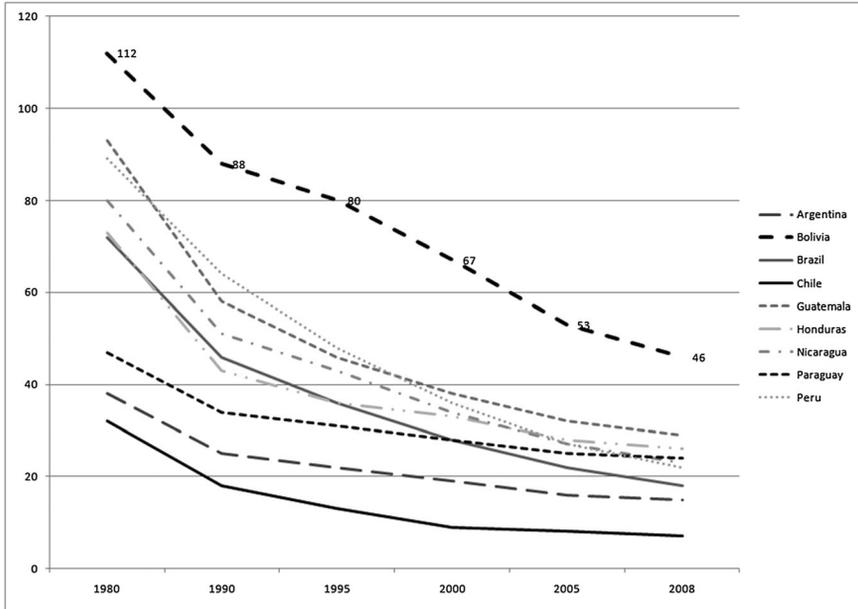


Figure 3. Infant mortality rate decline in selected countries, 1980–2008. It compares the evolution of the Bolivian infant mortality rate with other Latin American countries. The shortage of the indicator improvement to catch-up the region average is commented in the Results section of the paper

Table 3. Total fertility rate (births per woman) in selected countries, 1980–2000

Country	1980	1985	1990	1995	2000
Bolivia	5.52	5.13	4.91	4.58	4.14
Ecuador	5.06	4.34	3.67	3.23	2.95
Guatemala	6.18	5.91	5.58	5.24	4.80
Guyana	3.57	2.94	2.59	2.52	2.47
Haiti	6.06	6.03	5.43	4.89	4.30
Nicaragua	6.13	5.43	4.75	4.06	3.25
Paraguay	5.22	5.02	4.54	4.09	3.68

Source: The World Bank Group, World Data Bank, Health Nutrition and Population Statistics (<http://databank.worldbank.org/ddp/home>).

Table 4. HIV and tuberculosis indicators (Latin America average and Bolivia, 1990–2005)

Indicator		1990	1995	2000	2005
Prevalence of HIV total (% of population ages 15–49 years)	Latin America	0.29	0.47	0.52	0.53
	Bolivia		0.10	0.10	0.20
Tuberculosis prevalence rate (per 100 000 population WHO)	Latin America	123.63	81.37	62.75	45.88

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