GOVERNING RURAL HEALTH

Making Manageable Citizens in Colca Valley, Peru

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Thesis submitted in partial fulfilment of Master's degree
Department of Social Anthropology
UNIVERSITY OF BERGEN
Spring 2017

Contents

List of illustrations

Acknowledgements

Cecilie Vindal Ødegaard, my excellent supervisor, I thank you for your patient support, constructive comments and inspiring guidance in the production of this thesis. I feel lucky for your time and effort.

I am grateful to all my interlocutors, friends and *familiares* in Colca Valley for receiving me with open hearts and teaching me so much about everyday life in the Andes and Peru in general. Unfortunately, I cannot name you, but I hope you feel recognised by my writings and that my interpretations of your everyday lives can be justified.

I would like to thank everyone who have supported me through this long and winding road, it has been a challenge and I could not have done it without all the backup. A big thank you to everyone at Chr. Michelsen's Institute; to Siri Lange for inspiring conversations, to Camila Gianella for enlightening conversations and comments on my chapters, the Gender and Rights cluster and Catalina Vallejo for thorough and constructive comments on my paper. Thank you to the Department of Social Anthropology at the University of Bergen, especially Hilde Ellefsen for nice conversations and administrative help. Thanks to the Signe Howell foundation, Norsk antropologisk forening and the Meltzer foundation for economic support. Thank you also to NorLarNet for arranging master courses every year, it was unbelievably helpful for aligning a chaotic mind.

I also want to thank my fellow students at UiB and CMI, thank you for your company, laughs and refreshing social moments. I am immensely grateful to Isabelle, Marte, Oda, Karoline, Anna and Veronika for reading and commenting on my chapters. Your advice and encouragement have been incredibly valuable to me in the process of writing. To my amazing friends in *Superantropologane*: the collective interest in Anthropology, life and society keeps on inspiring me. You are the best! Karoline, my dear friend—thank you for great company and motivation through the years as study-buddies. To my family, who always provide care and support. I keep you all in special places in my heart. Finally, I wish to thank Osmund for your love and patience. For reminding me that my life and self should not be defined by work. Thank you for entering my life.

Takk. Thank you. Gracias. Uspalay.

Abbreviations

ACS	*Agentes Comunitarias de Salud* (Community Health Agents, sometimes referred to as Community Agents, or just Agents)
CMI	Critical Medical Anthropology
CPVC	*Centro de Promoción y Vigilancia Comunal del Cuidado Integral de la Madre y del Niño* (Centre for Community Promotion and Supervision of General Mother and Child Care)
DNI	*Documento Nacional de Identidad* (ID card)
ESSALUD	*Seguro Social de Salud* (Social Health-Insurance)
IMF	International Monetary Fund
MDG	Millennium Development Goals
MIMP	*Minesterio de la Mujer y Poblaciones Vulnerables* (Ministry of Women and Vulnerable Populations)
MINSA	*Minesterio de Salud* (Ministry of Health)
PAHO	Pan American Health Organisation
PES	*Programa de Emergencia Social* (The Emergency Social Programme)
PRONAA	*Programa Nacional de Asistencia Alimentaria* (National Programme for Alimentary Assistance)
SIS	*Seguro Integral de Salud* (Total Health-Insurance)

A Note on Abbreviations

In Peru, names of institutions and programmes tend to change, which also applies to the institutions mentioned in this thesis. The abbreviations and names used in this thesis is according to what they were during time of research and literature review in 2015–2016.

Glossary

(from Spanish/Quechua to English)

agente comunitaria de salud	community health agent, sometimes referred to as a community agent, or just agent
andino/a	a person, object or trait from the Andes
anticucho	animal heart (mainly alpaca or beef) on a skewer
ayllu	kinship corporations
campesino	farmer
capacitación	lit. 'training'; educational sessions arranged by state institutions
capacitadores	instructors at *capacitación*
centro de salud	health-centre
chacra	agricultural field
chuño	freeze-dried potato (qu. *ch'uñu*)
comedores populares	community kitchens
criollo	lit. 'creole'. Refers to a person with Hispanic origins
cuaderno	notebook (here: checklist-books)
faena	qu. community labour tax
feria	market
indio	lit. 'indian'. Refers to a person with indigenous origins
lliqlla	qu. women's shawl used to carry things on the back
matecito	lit. 'small tea'. Herbal tea or remedy
mestizaje	mixture of indigenous and Hispanic cultural and racial qualities, or the process of cultural accommodation and assimilation where the indigenous becomes *mestizo*.
mestizo	lit. 'mixed race', referring to a person with both Hispanic and indigenous origins
perezoso	lazy
posta de salud	health-post
presidenta	female president/leader of an organisation
pueblos jovenes	urban squatter communities

sumaq llaqta	qu. ‘beautiful village’
vulnerable	vulnerable, weak, defenceless
wawa wasi	qu. lit. ‘children’s house’

A Note on Language

Whenever I use Spanish or Quechua expressions or quotes in the thesis, I *italicise* them and translate them in parenthesis. Spanish and Quechua is used for concepts and things I perceive as central in the ethnography. Through using original phrases, I seek to emphasise the importance of certain concepts for both interlocutors and context. In some cases, original quotes are used to remind the reader that the ethnographic statements have been translated, opening for a transparency in the interpretations.

A Note on Names

According to ethical standards in Anthropology, all names of interlocutors and friends are anonymised in the thesis. Exceptions are made to government institutions and geographically relevant names.

A Note on Footnotes

The text contains many footnotes, which function to clarify certain terminologies, such as references to other literature and sometimes as commentary. These notes should help an interested reader to complement information given in the text.

A Note on Text Typography

As required by the Harvard Reference Standard, all direct quotes longer than three lines are formatted as block quotes. Block quote formatting is additionally used on ethnographic descriptions to facilitate the readers experience and understanding of ethnographic descriptions.

Map of Peru

Map of Peru, indicating the Arequipa region in the south, in which the Colca Valley and the region of Colca is located[I]

[I] The map is public domain. Source: https://commons.wikimedia.org/w/index.php?curid=390636

CHAPTER ONE

Introduction

> It is early daybreak in the Colca highlands of southern Peru and the dark blue sky is lit up by shimmering stars. Outside a small adobe house, Imasumaq[2] squats besides a big tub filled with dirty clothes on the earth-paved patio. Her knuckles are chapped from the cold water and the acidic soap, yet it does not bother her. She hurries to finish the laundry before waking up the children and get them ready for school, knowing that the day is often too short to complete every task, errand and voluntary community work obligation required. Imasumaq is an unemployed mother of three who spends most of her time on motherly responsibilities for the children and the *cuidado* (care) of house and husband. In addition to her daily job as a mother and house-wife, she works regularly as an *agente comunitaria de salud* (community health agent). At the local *metacentro* in her village, she registers health-information about her village neighbours. Occasionally she also assists the village's *comedor popular* (community kitchen) and *wawa wasi* ('children's house'), a public kindergarten option for low-income families.

This thesis is about public healthcare in the Andes and how women in the Colca Valley, an area located in the southern region of Arequipa, are made subjects by health-development projects managed by the Peruvian State. The thesis also explores how these women manage and negotiate their positioning. Imasumaq is one of the targeted women for a set of development and poverty related programmes and projects. She is concerned with how women like her can get a better future by following state-managed programmes. Imasumaq and my other interlocutors in Sumaq Llaqta (pseudonym),[3] a village located in Colca Valley, were preoccupied with what they saw as community efforts to secure health for themselves and their families. To understand how health-development programmes are comprehended by voluntary workers engaged from the community, I use Foucault's (1979; 2002 [1972]) theories of power related to governmentality, discipline, and discourse. This theoretical framework facilitates my

[2] Pseudonym.

[3] 'Beautiful village' in Quechua.

analysis of relations between the state and citizen in a context of poverty, development and public healthcare. Additionally, I focus on racial categories and cultural racism, illustrated by de la Cadena (2000:4) as cultural constructions taking part in dominant discriminatory practices, deriving from a 'belief in the unquestionable intellectual and moral superiority of one group of Peruvians over the rest'. This way of thinking, called 'new racism' or 'racism without race', does not resort to racial terminology but tends to define race referring to culture as a marker of difference (de la Cadena, 2000:2-4).

Before I elaborate on the theoretical framework of the thesis, I will introduce the site of fieldwork, present research questions, summarise some critiques of public healthcare in Peru, provide a relevant context for understanding the ethnographic material presented in this thesis. Then, elaborate on the methodological approach before and during and after fieldwork, and present my interlocutors.

Entering the Field

Situated between 2000 and 4000 metres above sea level, the landscape of Colca Valley is characterised by surrounding cactus-hills, herding sheep and alpacas, and tall volcanic mountain-summits that can be seen from a distance. The Colca Valley holds one of the deepest canyons in the world, Peru's second after Cotahuasi. Within the villages, there is a mix of adobe and stone houses with tin roofs. Stray-dogs and other animals pass daily through the streets where the *mayores* (elderly) sometimes sit and chat. During tourism-seasons and festivals, the streets are filled with Peruvian and international travellers dressed in mountain-gear taking pictures of people, architecture and the breath-taking landscape. Around the *feria* (market-place) in the town of Chivay, there are street-vendors selling jelly in plastic-cups, *anticuchos* (alpaca-hearts) on skewers and warm *matecitos* (herbal tea) from trolleys. Chivay, the municipal city of the province of Caylloma, is a busy town. The *Plaza de Armas* (main square) is always full of people working; bus-drivers and guides waiting for tourists taking pictures of the colonial white church, moto-taxies tooting or waiting for passengers, children playing in the streets while their mothers work at the *feria*. The air smells paved earth and gasoline, while sunbeams warm and burn the skin of incautious visitors.

In contrast to Chivay, Sumaq Llaqta is a village that does not give the impression of hectic everyday-lives. The dusty streets are often empty, although youth and kids occupy the *Plaza* (main square) after school. At night, the silence is only occasionally interrupted by stray-

dog barking. The village is a short bus ride from Chivay, and many of the villagers in Sumaq Llaqta work either in *chacras* (farmlands) or in Chivay during daytime. They travel by *combi*, a small bus passing the village several times a day.

When I entered the field, I had the ambition to reach both users of public health-services and health-personnel working in public and private health-sectors. I started by contacting the municipality to acquire information about community organisations in the Colca Valley. After a while I got to know Imasumaq, who became my gatekeeper into the field. She brought me into her village Sumaq Llaqta and introduced me to its *comedor popular* (community kitchen) and *metacentro* (centre for health-registration and community vigilance). Since I lived in Chivay, I had to commute between the two villages, just as many others did regularly. In Chivay, I also got to know professional health-personnel working in public and private sectors, teachers, politicians and pharmacists. Some of them were born and raised in Colca villages, and had because of economic access to education. Few would say they spoke Quechua, but several of them could understand words and phrases. Most of these 'professionals' were, however, not from Colca, but had moved there from cities like Arequipa and Lima to work. Through emerging friendships, I enjoyed following my interlocutors through the outstretched landscape of the Valley, in which some of these experienced have been synthesised into a Master's thesis. The core thematic focus of this thesis is presented in the following section.

Research Inquiries

Women in the Andes, especially those who are targeted in health-development programmes, are understood in certain ways by state-actors according to their ethnic identity. They are targeted by development programmes due to their socioeconomic status, but also because of their placement (by outsiders) in racial and class-related categories. The reason for the focus on women in this context is because it is *women* who were central subjects of health-development programmes in the Colca Valley. Later, in chapter two, I will come back to *why* women are so central to development. Introducing the research inquiries for the thesis, I will explore discourses of health, hygiene and poverty, especially with regards to how these discourses actualise and reproduce certain notions of gender, race and class in the Peruvian context. In particular, I will explore the following questions:

- How do women experience and negotiate health-development programmes, and how are such programmes actualised within pre-existing relations of power and inequality?
- In what ways are *capacitación* (training) and documenting practices made particularly central in health-development programmes, and how do documents materialise power-dynamics between the state and citizen?

To discuss these questions, I will draw upon various theoretical and analytical terms. Before presenting these I will provide a brief overview over central critiques towards Public Healthcare in the Peruvian highlands, followed by a short description of how health is conceived and practiced in Andean regions.

Critiques of Public Healthcare in the Andes

In literature about health in the rural Andes, critique frequently address a lack of cultural sensitivity among health-personnel, who are often born and educated in the cities and said to be unwilling to adapt to and understand the sociocultural context and economic conditions in which they are working (Ewig, 2010; 2006; Blaisdell & Ødegaard, 2014; Figallo, 1994). This, despite the requirement of doing a year or two of practice in rural areas before they get entitled *doctor* in Bolivia and Peru. Doctors are nonetheless often reported to make little effort to speak native languages or to understand the culture of their Andean patients (Bastien, 2003:176–177). To Ewig (2010:7), a typical encounter between an indigenous Peruvian woman and a doctor at a health-centre would be enacted as follows:

> The woman would face a white or *mestizo* doctor born and educated on the urban coast who would not comprehend her language or her customs. He would likely call her *mamacita* (little mama) rather than by her name. Indigenous health concepts like *pacha* (sickness from the earth) would bewilder him, which in turn would frustrate her. These factors would affect her access to healthcare, as well as the quality of care she received.

Ewig's illustration of a common situation for patient-consultations at a health-centre underlines frequently reported issues of racism and presumptions of identity. The argument is that the doctor's stereotypical ideas of who is sitting in front of him/her affect how he/she meets his/her patients. Additionally, if the doctor has no or little knowledge of how his/her patient

conceptualises health this reduces the quality of the provided healthcare. Indigenous *women* are particularly exposed because of a gender divide in mastering the Spanish language. Women in the Andes are more likely to speak only their indigenous tongue, while most rural indigenous men speak Spanish as well as their native Quechua, Aymara or other indigenous language (Ewig, 2010:3). This ability gives men access to vital information, as Spanish is the language of the government and the professional class. Quechua is one of three official languages in Peru, yet it is not much used by the state to provide information. Urban residents from professional classes often consider rural Quechua speakers 'illiterate' (Piedra, 2006:402). Powerful discourses about the 'illiterate' and the 'educated' assist in legitimising lack of focus on Quechua and bilingual attention in healthcare.

Since the 1990s, public healthcare has been increasingly addressed by the Peruvian government, after major reductions in healthcare spending (more on this in chapter two). Yet, projects and programmes initiated or expanded by the Peruvian State have been heavily criticised for being top-down population management-programmes that do not consider nor acknowledge citizen rights, needs, or local knowledge. One of the most well-known and severe cases is the Fujimori governments' sterilisation campaign incorporated in an economic strategy of family planning (Lerner, 2011:327). This strategy envisioned that population reduction would contribute to economic growth. Health-personnel and health-clinics of the state were rewarded for the number of tubal ligations (permanent sterilisation of a woman) they carried out, as the Fujimori-government used the number of sterilised women as an indicator of successful poverty alleviation (Ewig, 2010:151). During the two years of the campaign in the 1990s, many rural Peruvian women were subjected to state-provided tubal litigations at poorly supplied health-posts (ibid., 2010:148). Among those who only spoke Quechua, there were misunderstandings and lack of information and consent for the operations. The health-workers crossed several ethical guidelines while they were subjected to a fierce governmental pressure to meet strict quotas (Blaisdell & Ødegaard, 2014:3). This campaign is yet an item on a long list of events and actions that have created a great distrust in health-clinics. Other issues entail threats of prosecution if people die in their own homes without medical treatments, and general experience of bad and disgraceful patient treatments (ibid., 2014:3).

In critiques of public healthcare in Peru, there is a general focus on developmentalist effort to develop the Peruvian Nation-State, for instance through population-management and planning. As we shall see in the following section, conceptions of development in Peru tend to be expressed through notions of modernity and progress.

Notions of Modernity and Progress

Terms like 'modernity' and 'progress' have been heavily criticised within the 'anti-development' literature (see for example Escobar, 2005; Coronil, 1997; Watts & Peet, 2004). Nonetheless, despite the political incorrectness associated with these terms, and their empirical and analytical inaccuracy, it is relevant to examine the ideas related to these notions (Ferguson, 1999; Ødegaard, 2010:15). The strategic effect of these ideas can be explored by asking not simply 'What does this concept *mean*; what does it really refer to?'; but, 'How and to what effect is this concept being deployed; what does it *do*?'(Ferguson, 1999:205). Inspired by Foucault, Ferguson (1999:205) argues that exploring the term modernity can help us understand how the idea of the *modern* has been implicated in larger structures of power and resistance that have shaped recent history. According to Ødegaard (2010:15), Ferguson's insistence on exploring the term 'modernity' is grounded in an analytical interest of 'dismantling linear teleologies of emergence and development' and to explore debates on modernism and postmodernism in the light of distinct regional experiences. This means examining how 'the modern' is conceived by both scholars and popular masses. Modernisation and urbanisation have, in Ferguson's ethnographic accounts from Zambia, come to be understood as a linear movement toward a certain end, portrayed as a 'Western-style industrial modernity'. The notions of modernity and 'progress' have in this sense been related to exaggerated dualisms such as the rural–urban, and traditional–modern.

In Peru, the notion of *progreso* (progress) in official discourses has historically been connected to the ideology of *mestizaje*, which is the perceived 'mixture' of racial and cultural features of the indigenous and the Hispanic or cultural assimilation of indigenous populations (Ødegaard, 2010:5). In contemporary Andean contexts, notions of progress tend to concentrate on social mobility in relation to a hierarchisation of places. To seek mobility in a process of *progreso*, an individual might move from a rural to an urban context, seeking better life-condition through an urban way of living (ibid., 2010:8). Lund Skar (1994:181) has argued that the populist political tradition in Peru have influenced the central values of self-help that liberates the state from the responsibility of providing basic services to the population. Following up on this, Ødegaard (2010:42–43) highlights how many Peruvian governments have encouraged local organisation of projects to construct or develop communities in order to *progresar, avanzar,* or *adelantarse* (progress, develop or move forward).

The term 'progress' is used by both state and NGO agencies involved in projects in urban neighbourhoods and rural communities, often in relation to the improvement of

infrastructure and conditions of living (Ødegaard, 2010:16). In development discourse, which I will come back to in chapter two, the belief in technology is equalised to progress, development and civilisation. This, in the sense that technology is believed to amplify material production and thus economic income (Escobar, 1995:36). It has long been thought that 'new "scientific" social sciences' and technology can provide a needed detailed knowledge that would help to realise economic and human potentials (ibid., 1995:37).

'Progress' is even part of the Peruvian State's slogan '*Peru, progreso para todos*' (Peru, progress for everyone).[4] The notion of 'progress' is often connected to the change of self and identity. How people conceive the term concerns also their attempts to change themselves in order to climb a social ladder represented in a modern discourse (Ødegaard, 2010:15–16). Thus, it is important to explore these notions in relation to what meanings and importance that are implied to them in social life, instead of presupposing normative and political dimensions of these terms (ibid., 2010:15–16).

Andean Understandings of Health

As a backdrop for the thesis, it is relevant to present how health is understood in the Andes by looking at how cosmological aspects of Andean life encompass health, culture, politics and socioeconomics. Even though Peru is largely a Catholic country, animistic beliefs continue to be important to conceptions of social life and human health in the highlands. The feminine earth-being known as *Pachamama* (Mother Earth), is for instance one of the most central spiritual beings in the Andean regions of Peru. She is viewed as the creator of the world and protector of life, and is synonymous with landscape and cycles of reproduction in agriculture and business (Blaisdell & Ødegaard, 2014:1). Between humans and spirit-beings there is a reciprocal bond that require appreciation from humans through ritual gifts (such as alcohol, fat and sweets), which is repaid with generosity and protection. If not properly appreciated, *Pachamama* can in anger cause conditions that are believed to cause illness, such as rapid temperature changes, cold winds, or loud noises (ibid., 2014:2). A central perception of health in the Andes is that it depends on corporal homeostasis, defined as an internal equilibrium that is achieved if the body's vital substances are in balance and the body organs are arranged in their proper places (McKee, 2003:136). A brief summary of how health is understood in the

[4] (La República, 2012)

Andes is: 'ties of reciprocity to nature, society, and cosmos are critical to healing rituals which restore balance to body and soul' (Miles & Leatherman, 2003:8). Health and illness are often connected to the importance of body equilibrium and the belief that the body fluids and substances should be in balance (Stensrud, 2015:82). Environmental impacts or intake of food may upset the body and make it sick, thus health-conceptions are deeply related to food and drink. More on this in chapter three, now I will move on to a brief account on medical pluralism.

Medical Pluralism

The mixed use of medical systems in the Andes is not in the direct attention in this thesis, since my fieldwork turned out to focus more specific on public healthcare. Rather, it forms a contextual backdrop, for as we shall see in the theoretical framework, my approach in medical anthropology is more about the relationship between various institutional levels of health and healthcare. Although I will not use these terms actively in my analysis, I will present two of the medical systems used to categorise medical practice, namely that of *biomedicine* and *ethnomedicine*.[5] Biomedicine is a medical system that sees the cause of disease as traceable to unique physical origins inside the body, such as microorganisms causing infection, malignant cells growing within the body, or the failure of an organ (Medical Anthropology Wiki, 2013). Biomedicine is practised and recognised as legitimate medicine throughout the world by governments and international NGOs and is often perceived as 'true medicine' in opposition to other medical systems, for instance ethnomedicine (also called folk-medicine). In ethnomedical practices in the Andes, healing techniques and the conceptions of illness are incorporated in an encompassing and holistic animistic belief system. A widely-used model developed by Chrisman and Kleinman describes three overlapping sectors in pluralistic healthcare systems (cited in Baer, 2003:43). The first is the popular sector, which refers to healthcare provided by the sick persons themselves, their families, social networks and communities. The second is the folk sector, in which healthcare is provided by what is often referred to as traditional healers, including herbalists, bonesetters, midwives, mediums, and magicians. The third and last is the professional sector, being healthcare provided by practitioners and institutions in biomedicine and professionalised heterodox medical systems such as Chinese, Ayurvedic and

[5] These terms are broadly discussed within Medical Anthropology. See for instance Singer (2012:18).

Unani medicine. Here, I refer to the popular and folk sector through the term *ethnomedicine*, and the professional sector through the terms *biomedicine* and *formal* or *public healthcare*.

The existence of multiple healing systems within the same society is generally known as *medical pluralism*. In early medical anthropological studies, the choice of medical system was perceived as interconnected with ethnic belonging and identity (Crandon, 2003 [1989]:28). Ethnomedicine was related to indigenous groups, while biomedicine was related to Western ('modern') societies. However, Crandon-Malamud (1991) has suggested that the divide between the use of ethnomedicine or biomedicine is an artificial divide set up by researchers to facilitate analysis. Additionally, ethnic boundaries and class relations that have been linked to the choice of one medical system over another are constantly shifting (Crandon, 2003 [1989]:28). Crandon stresses that it is important not to reduce a person's choice of medical system to that of ethnicity. Such a focus can mask class-relations and even justify the domination of *mestizo* identities over indigenous (ibid., 2003 [1989]:28). The topic of racial categories and class will be discussed later in this chapter, after a brief description of the general focus on health-issues in academic literature on the Andes. Before this, however, I will explain the methodological approach to the realisation of ethnographic fieldwork providing the database for this thesis.

Methodological Approach

> '*Mira, Señorita Kaya, un turista desnudo!*'[6] Imasumaq exclaimed as we walked down the mountain-side. She and her little sister giggled at the sight of a muscular bare-chested young man walking up the mountain with his fashionable Arequipeño guide, who wore sunglasses and a black cap. The outburst surprised me, but I quickly realised what kind of 'nakedness' she referred to. The sun was a dangerous natural element, and 'tanning' by uncovering parts of the body was not something a normal person would do in the Colca Valley. I had myself been encouraged to use a hat several times, an advice that would have saved me from several sunburns in the face and on the head. At the time of this mountain-trip, I was approximately half-way through my fieldwork, and Imasumaq had invited me to visit her extended family in her childhood-village. Imasumaq was an active community worker, and became a great door-opener to

[6] 'Look, miss Kaja, a naked tourist!'

> various arenas of community work, in addition to providing me with a kind of legitimacy and familiarity in the community.

When initiating the fieldwork in January 2015, my goal was to gain access to people who were living steadily in the Colca Valley, who perhaps identified as 'villagers' in contrast to Peruvians living in Arequipa, while working in tourism in Chivay. My initial research focus revolved around how people conceptualise and practice health in Colca. I initially contacted state and community based organisations that engaged mostly female community workers. Imasumaq was one of the first who invited me into her life.

One of the most important issues while conducting fieldwork is to find a balance between overt and covert research (O'Reilly, 2012:63). Potential interlocutors were informed of my intentions of participating and learning about their lives. To protect the privacy of the people involved, I have changed the names of the people and some institutions. However, I agree with Hopkins (1996:127) in that protecting anonymity must balance the utility of the data. Consequently, along with the responsibility of protecting interlocutors follows the 'responsibility to portray cultures in the richest possible detail' (Hopkins, 1996:128). Therefore, it makes no sense to anonymise the regional information of Colca Valley, because o portray the region and its peoples in a rich way requires a description of the historical and political context. In the thesis, there is a mixture of verbatim conversations obtained from fieldnotes, and conversations reconstructed from memory. To create a more cohesive narrative, I have shuffled time lines and made some occurrences more compact.

I found that generalisation and categorisation creates a great ethical challenge in providing analysis and rich descriptions. In order to highlight hegemonic discourses and narratives about certain groups of people, I use simplifying concepts as 'poor', 'indian', 'indigenous' and 'rural women' to refer to generalised groups. Especially if taken out of context, the disadvantage of using such concepts is that they may serve to reproduce negative stereotypes and inappropriate categorisation. The advantage, however, is that using generalising social labels facilitates discussions and analysis of these. It helps to illuminate dominating and stigmatising ideas that are taken for granted in public discourse (such as poverty and development discourse).

Method

The anthropological fieldwork for this thesis was conducted in the two villages Chivay and Sumaq Llaqta in the Colca Valley. The main methodology was participant observation, including informal conversations as research method. I put myself in the position as a humble student in order to gain the trust of my interlocutors. Thus, interlocutors saw me eating, knitting, chatting, laughing and playing, and after a while I got requests to participate in activities at the *Metacentro* in Sumaq Llaqta, which became my most central space for doing fieldwork.

In Chivay, I mainly did observations in the waiting area of the health-centre, although on some occasions I conducted informal interviews. It was never in my interest to get too close with the professional health-workers and bureaucrats, as I suspected this would have had negative consequences for how people in Sumaq Llaqta would see me as 'their anthropologist'. My goal from the beginning was to conduct an anthropological fieldwork where I would live in a way that would give me insight to the lives of non-professionals, adapting the best I could to the everyday habits and norms of those I wished to learn about.

Additionally, I spent a lot of time at a pharmacy in Chivay. There, I normally sat on a plastic stool, intensely writing observations or conversations in my journal. I visited the pharmacy once a week for a couple of months, and was fortunate enough to get to know doctors, nurses and pharmacists who sometimes had down-time to spare for longer conversations. Observations at the pharmacy led to my most detailed accounts of conversations between patients/customers and health-personnel. Health-personnel also turned out to be interesting interlocutors on intricate matters such as personal health, health in poor rural areas, women's health, reproduction and other matters that were often difficult to address directly with my interlocutors in Sumaq Llaqta. Additionally, the contact with health-personnel gave me insight to the hegemonic discourses they were involved in. In retrospect, I see that I could have got different and more data from the community of Sumaq Llaqta if I had not spent so much time in Chivay at the pharmacy and the health-centre. Nonetheless, the combined insight from all locations provided a holistic lens for understanding different aspects of health in Colca Valley.

Introducing the Interlocutors

The personas presented in the thesis are based on individuals from my fieldwork. In the thesis, these personas are collages based on shuffled histories and facts from many individuals. I have changed names, family and personal details and sometimes even occupation. This is to secure the anonymity of my interlocutors, so that even they themselves would have difficulties connecting statements to a specific individual.

The two institutions I address in Sumaq Llaqta are the *Comedor Popular*, where the reader meets Paulina, a young *socia* (volunteer), and the *Metacentro*, where you get to know three *Agentes Comunitarias de Salud* (Community Health Agents); Imasumaq, Ximena and Rosmery. These women are adult mothers in their mid-twenties to late thirties without formally paid jobs. These interlocutors have different life-stories, but share some of the same preoccupation about health and education for their children. Their interactions with health-personnel and other kinds of professional workers and authorities offer interesting perspectives on the state's development work in the Andes, and how the targeted populations negotiate the discourses, disciplinary techniques and social relations connected to these spheres.

Interlocutors working in Chivay include the already mentioned health-personnel and authorities, which are presented in the thesis as anonymised personas with shuffled stories, statements and personal information. In the thesis I present doctors, a midwife, a nurse, social workers and pharmacists. To protect their anonymity, I have altered identifiable traits such as gender, occupation and workplace. All in all, I find my measures ensuring the best protection of anonymity for individual interlocutors.

Challenges in the Field

Before, during and after my fieldwork in the Colca Valley, the list of challenges, both personal and practical, was long and kept on growing as time passed. What particularly stood out for me during fieldwork were the challenges of reflexivity and sensitivity. Upon entering the field, I thought I had prepared myself sufficiently. However, to fully predict what might happen is not possible. On a personal level, challenges connected to physical health were stirred up with that of being in an unfamiliar situation of fieldwork. On beforehand I knew little of what behaviour would be 'right' or 'wrong' for this fieldwork.

Practical challenges were related to for instance being a highly visible participant, something that amused some villagers and provoked others. It was not always convenient or possible to inform people about the reason for my presence. Yet, I tried to use myself as a tool while risking embarrassment and blunders for the sake of being able to comprehend how people thought about the things I were interested in. Initially, I strived to establish myself as a trustworthy individual that had a lot in common with my interlocutors. After a while, this process became quite exhausting and I realised I had to put away worries about how people perceived me and my own biases. Consequently, I started paying more attention to paradoxes and questions relevant for developing macro and micro perspectives on public healthcare in Colca Valley.

Bleek (1987:319) discovered in his survey-based research on health in Ghana in the 1970s that 'embarrassing questions (…) produce unreliable answers'. In his case, the female interlocutors had lied to escape embarrassment. In my case, when I tried to ask delicate questions (and questions my interlocutors were not necessarily interested in), my interlocutors in Sumaq Llaqta did not answer at all, but completely ignored my question as if I never asked. This was a challenge I had to confront from the beginning. It was not until I started relaxing and stopped asking direct questions that people started opening up to me and letting me in on conversations in Spanish that they initially mostly conducted in Quechua. However, as I present in the following, language provide many kinds of challenges.

Language Barriers and Translation

Language flexibility became a central practical element during my stay in Chivay and Sumaq Llaqta. Most of my interlocutors and friends spoke mainly Spanish, although several of them were active users of Quechua on some occasions. Norwegian, my mother tongue, became a natural and strategic choice of language in my fieldnotes. However, a downside with the flexibility of operating in several languages simultaneously is that it might reduce the accuracy of verbal data. Especially when reconstructing whole conversations, I have learned to acknowledge the transformations the data go through. It might happen a lot in the interpretation of the initial phrase when translating from Spanish to Norwegian in fieldnotes and later translating them into English in a thesis. Therefore, I am fully aware that the accuracy of the phrases might have been reduced. Language is not a perfect tool for communicating, even for native speakers, but communication is also about body language, gesticulation, and other

gestures depending on context, time and the relation between the narrator and the listener (Jenkins, 1994:433). Fortunately, using a lot of time studying the para and body-language of people helped me integrate it. This embodiment of language is an advantage for my conceptions of people's statements and expressions, and for the continuous process of blending in.

Writing fieldnotes provided several challenges. Practically, it was not always possible to take notes while having informal conversations. Although taking notes was generally accepted in conversations when they were working, such as doctors and pharmacists, it felt very unnatural doing this among people in Sumaq Llaqta. While talking about certain topics, such as food recipes, herbs, healing techniques and the Quechua language, I would write down details about the topic of conversation, body language, and contextual elements. Yet, this was not possible when listening in on and participating in other informal conversations. In such situations, I relied much on what Frøystad (2005:59) refers to as 'head-notes'. Sometimes I could only jot key-words on my smart phone, or wait until I left the situation, making it important to concentrate hard on memorising the rest until I was alone to write field-notes in my journal or laptop.

Frøystad (2005:59) stresses that when working like this, it is crucial to develop a technique of memorisation. This is mentally exhausting because it forces you to be constantly alert and observant throughout the day, but it also gives a more active relationship to your own observations and experiences (ibid., 2005:59). Although the quoted conversations might not be completely accurate word-by-word, I feel confident that I have been strict and thorough when imparting meaning, associational shifts, examples and significant local concepts. One of the strengths of this study is that it contains an ethnography from people with different roles. Since I on the one side got to know villagers targeted by health-development programmes and projects, and a variety of people working as 'developers' in these programmes (health-personnel, bureaucrats, social workers, and other middle-class professionals) on the other, I have had access to different and sometimes contrasting perspectives on health and development. This access has facilitated a holistic interpretation of people's practices, ways of communication and how they understand health and healthcare. My motivation for conducting this type of explorative field-work was that such methodologies provides ethnographical data for a thesis that lets the ethnography lead the way for analysis, that is, a grounded theory approach. Having synthesised the methodology behind this thesis, I will now present the theoretical framework.

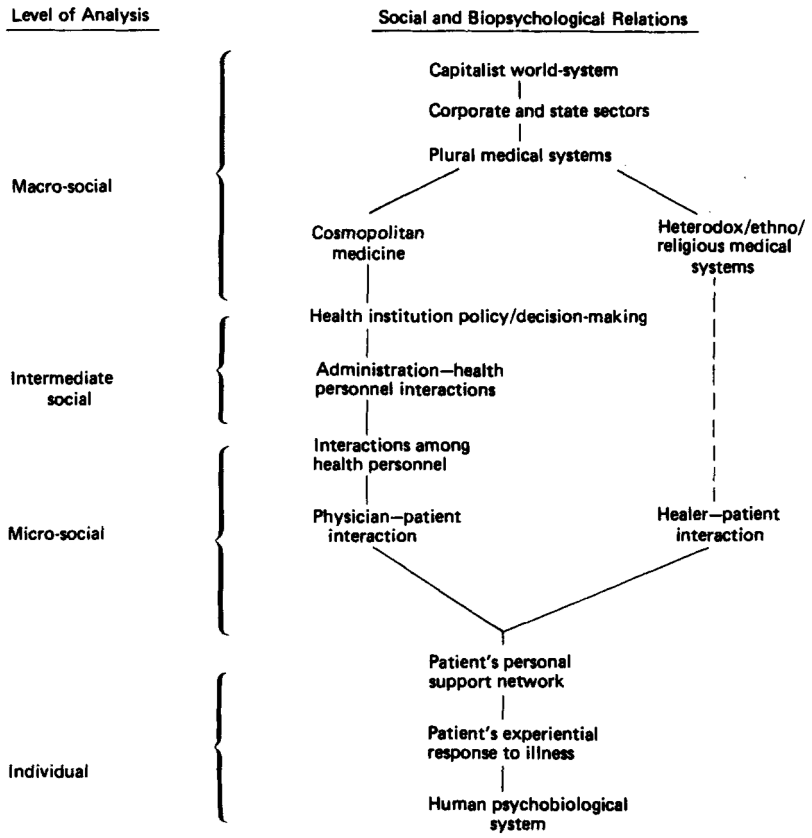
Theoretical Framework and Analytical Terms

The thesis contributes to the scholarly tradition of Critical Medical Anthropology (CMI), which is a field of study that goes beyond locally focused, ground level analyses by widening the focus and including the larger political and economic structures that take part in and shape how people deal with and understand health and illness. CMI incorporates political and economic levels of analysis and can be defined as a:

> Theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the *interaction* between the macrolevel of political economy, the national level of political and class structure, the institutional level of the healthcare system, the community level of popular and folk beliefs and actions, the microlevel of illness experience, behaviour, and meaning, human physiology, and environmental factors (Singer, 1995:81).

Baer et al. (1986:95) argue that the 'dominant ideological and social patterns in medical care are intimately related to hegemonic ideologies and patterns outside medicine'. The focus on power structures and biomedicine is essential in CMI. Within this academic tradition, it is argued that research on social relationships and small communities should be conducted 'with the recognition that disease, illness, and treatment occur within the context of the capitalist world system' (ibid., 1986:95). According to Baer et al., questions that need to be posed are: who has the power to control how biomedicine is structured? how is this power delegated within the system? and how do these power structures become visible? These questions touch the various levels of analysis that a Critical Medical Anthropology needs to approach: the macro-social, the intermediate social, the micro-social and the individual level. These are analytical levels separated to help illustrating their interdependent connections (Barth, 2001 [1994]:844). Baer et al. (1986:96; 2003:39) use the following diagram to illustrate the macro-social, the intermediate social, the micro-social and the individual levels:

Levels of healthcare systems



The macro-social level includes the most extensive power structures in our individual lives. Unicef, World Health Organisation and the World Bank are often mentioned as big actors operating on these power structures. The latter is for instance the biggest provider of loans in healthcare projects, being a 'key player in establishing health policies and providing financial loans to healthcare endeavours' (Baer et al., 2003:40). On this level, one would for instance look at how aid-donors and loan-providers hold great decision-making power in how health is organised. It is interesting to investigate how institutions such as the World Bank have strong influence on health-policy. Through country-specific health-sector analyses it recommends health-reforms compatible to an economy regulated by the market (ibid., 2003:40). Critiques of the World Bank often include that priorities within the economy comes first, while health is subordinated: 'Bank staff [appear to be] more driven by pressure to lend than a desire for successful implementation' (Walt, 1994:157 cited in Baer et al., 2003:40).

The intermediate social level is used to analyse how rules and laws are developed, and how health is administrated. In analysis of this level questions of the dominance of the biomedical system in certain societies are often posed, looking at how health-institutions are

being increasingly integrated in the capitalistic system. For instance, there are large quantities of private hospitals in the United States. Economic profit is criticised for being prioritised over what is necessarily the best for the patient. Doctors are seen as 'bosses' in economically oriented businesses. However, Baer et al. (1986:97) underline that the doctors themselves are also *secondary actors* in front of hospital bureaucracy. Above the doctors there are directors with an economical administrative background that form clear hierarchic structures within these institutions: 'the growing array of other health-workers causes the medical hierarchy to replicate in detail the class structure' (Baer et al., 1986:97).

At the micro-social level, one tends to look at the relationship between the physician and the patient. On this level, one may for instance look at the power of the physician and how it is implemented on his/her most important task, that is, to take care of the patient. Analytical perspectives on a micro-social level might highlight how the physicians' diagnostic task is affected by the social factors in contexts outside the examining room and locate this relationship 'in a broader political and economic framework' (Baer et al., 1986:97). At least formally, physicians control the patient's access to certain benefits, such as specific treatment and some welfare benefits. Mol (2002:57) argues that it is the sick person's obligation to seek medical assistance. In this, doctors play a role in maintaining the social system, as they exercise the power of providing a sick note or send the patient back to work. Additionally, the relationship between the physician and the patient is influenced by the patient's power of language and knowledge, meaning that a patient able to express him-/herself are more likely to achieve his/her goals inside the consultation room.

The physician also plays a role in medicalising social distress, 'due to reductionist model of disease in which physicians assign the source of disease to pathogenic or related factors' and secludes social distress from 'the potentially disruptive political arena and secured within the safer medical world of individualised treatment' (Baer et al., 1986:97)

Discourse

Discourse refers to 'practices that systematically form the objects of which they speak' (Foucault, 2002 [1972]:49). Discourse is more than the act of speech, but consists of numerous oral and textual statements that derive from the same system of creation (Schaanning, 1997:189–190). These statements are not autonomous entities, but must be examined in relation to something else, such as agents, actions, tools and institutions. To Foucault, it is

important to investigate the network of these elements, which make certain communicative elements valid (Schaanning, 1997:184). A statement enters a network of pre-existing statements, which have been formed through a set of practices, tools and institutions. Collectively, they constitute the *conditions of possibility* for what is understood as truth or not (Law, 2004:35–36). Foucault traces the present 'conditions' (within what he called *the modern episteme*) to the eighteenth century. He argues that these are still, in the twenty-first century, producing knowledge of realities. Latour, however, suggests that the limits of scientific knowledge and reality is provided by *inscription devices* (Law, 2004:20). These are defined as a 'system (often including, though not reducible to, a machine) for producing inscriptions, or traces, out of materials that take other forms' (ibid., 2004:20).

Like Foucault, Latour is critical of those who interpret discourse as something detached from nature and society, as an autonomous field (Schaanning, 1997:206–207). Although Latour has not established any theory of discourse, the connection to Foucault is obvious through his fundamental point of view that scientific statements should be analysed as 'knots' in a horizontal network and not as primarily representations of things or subjects of the society. Both Foucault and Latour are interested in how knowledge is managed so that it appears as convincing and true (Schaanning, 1997:211). The network of statements, institutions and tools that statements are attached to are simply the materials used to provide the power of persuasion to the statement. According to Latour and Woolgar, there are no realities without inscription devices, and it is impossible to separate the production of certain realities from statements about these realities, or the inscription devices that produce these realities and statements (Law, 2004:31). Rather, as I shall come back to in chapter five, they are all produced together. In this, Latour shows how the scientific world exists attached to the social world in its numerous activities in networks of social relations, inscription devices and statements. Yet, because the social relations and inscription devices are *hidden* after a 'fact' is established, science can appear as independent and definite, although it is not.

This way of understanding how scientific truths are established is also applicable in analyses of the society (Schaanning, 1997:217–219). Just as nature (science) is not something existing 'out there' in order to be 'discovered', society is constructed through the discourses that keeps it as an object. Society is a final product of historical and political processes and is thus a paradoxical entity. Comparing society and nature to the hidden God, Latour explains the three as entities created in our effort to understand. An additional paradox according to Latour is that 'modernity', in the form of producing new, independent knowledges, does not exist. The

'realities' and knowledges produced are all 'hybrids' of nature and culture, the human and non-human, by politics and science. It is the 'blind spot' of modernity, something that we persistently refuse to realise (Schaanning, 1997:217-219). Schaanning remarks that Latour's focus on science in network theory is not a clarification of Foucault's discourse theory. What Latour argues, rather constitutes a *shift* of Foucauldian ideas of discourse. However, the 'creators of knowledge' that Latour illuminates can be viewed as entities that functions to secure the discourse, in order for it to be maintained (Schaanning, 1997:224).

Power and the Art of Governing

Notions of *body* and *power* is important for the analytical framework in this thesis. These notions are interconnected in what Foucault (1981 [1978]:140) calls *biopower*, which are mechanisms employed to subjugate bodies and control populations. To Foucault (1984), power is always present, inducing knowledge and understandings of the world. Power is strategy, tension, relational and something that is exercised rather than possessed (Foucault, 1979). In Foucauldian thinking, power is not something that 'exists' a priori. Rather, it emerges in relations, in the very meeting between people (Schrift, 2013:145). In his later works, Foucault analysed three modalities of power: dominance, strategy and governmentality (Lie, 2008:124). The first modality, dominance, refers to direct power relations between those who governs and those who generate resistance. Strategy on the other hand, refers to a game between wills, were the winner is not determined on beforehand, but becomes an empirical question. Finally, governmentality refers to the conduct of conduct, or more precisely, how the subject governs itself (ibid., 2008:124).

Foucault saw governmentality as an effect of the eighteenth century's formation of modern state Europe (Lie, 2015:724). It has been said to be a new form of government, which 'ensures the survival of and defines the limits of the state' (Ball, 2013:60). The concept of governmentality encompasses the strategies, techniques and procedures of the liberal state as they 'act upon the human body and social behaviours through many and varied capillaries of power' (ibid., 2013:60). Foucault's idea was that the state's goal is to produce 'normal' and 'docile' bodies for the state (Scheper-Hughes & Lock, 1987:26). This refers to that institutions have particular ways of speaking about and dealing with bodies, which serve to create and reinforce hegemonic ideas of the modern individual.

The modern individual is required to conform to the norm, that is, to be 'normalised' (Schrift, 2013:145). Normalisation is achieved through the exercise of discipline, which 'trains' the varieties of bodies and forces them into a 'multiplicity of individual elements' (Foucault, 1979:170). Individuals are 'made' by discipline, which is a 'specific technique of power that regards individuals both as objects and as instruments of its exercise' (ibid., 1979:170). In a way, normalisation 'individualises by making it possible to measure gaps, to determine levels' and thus 'the norm introduces, as a useful imperative and as a result of measurement, all the shading of individual differences' (Foucault, 1979:184). Normalisation of human bodies implies that healthcare is important for maintaining social order (Mol, 2002:57-58). Doctors set the standards of what is normal, and they actively intervene to bring about normal states. Yet, Mol (2002:57-58) says, doctors do not punish, for normality is not a law that one is required to live up to. However, those who do not meet the standards of normality, are nonetheless marginalised to the peripheries of society, being situated in undesirable places. Through mechanisms of governmentality, people themselves desire to stay within the borders of 'normality'. Thus, medicine as a science is vital to society as a quite specific social power (ibid., 2002:57-58). The state makes use of the power of science to 'govern'.

The embodied experience of 'the art of governing' makes possible the creation of 'docile bodies', which may be used in modern economic and political institutions (Foucault, 1979:136–138). This happens for instance through writing of *documents*. To Foucault (1979), *documentary techniques* are essential mechanisms of discipline. Through written documents, such as a patient journal, the individual turns into a 'case': 'The turning of real lives into writing is (…) a procedure of objectification and subjection' (ibid., 1979:191–192). One of Foucault's major arguments is that today's notions of the individual became this way through the practical work and writing of *institutions* (Farquhar & Lock, 2007:7–8). Gastaldo (1997) shows this through her examination of political dimensions of health-education in arenas of health and health-promotion. By following Foucault, she argues that bodies are constructed as objects of knowledge through the communication methods of health-education. She argues that education contributes to the norms of healthy behaviours in its promotion of discipline to achieve good health (Gastaldo, 1997:113).

Biopower and the Anthropology of the Body

Now, coming back to the previously introduced concept of *biopower*. Through *biopower*, Foucault refers to how biological life is political, as economic processes integrate population, reproduction and disease as subjects of control (Foucault, 1981 [1978]:141; Gastaldo, 1997:113). Biopower is thus a concept referring to how institutions regulate populations, sexuality, gender and reproduction through the hegemonic power of science, in the relation between the body and the body politic (Scheper-Hughes & Lock, 1987:27). Within the concept of biopower, there are two basic forms of power, the 'bio-politics of the population' and the 'anatomo-politics of the human body' (Gastaldo, 1997:115–116). The *bio-politics* refer to the regulatory control and interventions meant to manage the population, such as the invisible power-techniques of expanding health-systems in order to collect information and establish the 'normal' and 'pathological'. The *anatomo-politics* refer to the mechanisms of integrating the body into economic and social life, through techniques of discipline and individuality to create docile and useful bodies. The political space constituted by health-care and health-policies is thus important spaces for exercising disciplinary power (Gastaldo, 1997). In this, biomedicine has often served the state in its interest of controlling female population, in terms of women's role in reproduction and as caretakers (Scheper-Hughes & Lock, 1987:28). However, this does not mean that biopower guarantee the state's control of citizens. It is rather a 'subtle, constant and ubiquitous power over life' (Gastaldo, 1997:115).

Within a phenomenological approach, the body can be defined as an 'embodiment of consciousness and the site where intention, meaning and all practice originate' (Farquhar & Lock, 2007:6). Thus, consciousness exists as it is mediated through experienced embodiment. It is essential to note that the body should not be reduced to dualisms of material bodies versus subjective experienced. To capture the life of bodies it is important to embrace the complexities of the body and to study 'cultural, natural and historical variation in whole worlds' (ibid., 2007:11). Scheper-Hughes and Lock (1987) examine three analytical perspectives of the body in order to deconstruct concepts of it. The first, the *body-self*, refers to the ways that the individual body is received and experienced, through its constituent parts of mind, matter, psyche, soul, self, etcetera (Scheper-Hughes & Lock, 1987:7). The second, the *body social*, refers to how the body symbolically is used to think about culture, society and nature. The *body politic*, the third perspective, refers to the regulation, surveillance and control over bodies (individual and social) and is tightly connected to Foucault's notion of biopower. Through the

perspective of body politic, they show that the relationships of the individual and the social body are also about power and control (Scheper-Hughes & Lock, 1987:23).

Foucault's theories and the use of them in post-structural critique of development, has been heavily criticised for ignoring individual agency. It is said that macro-analysis of power excludes the agency of the individual and focuses mainly on the formative powers of larger structures and institutions that are seen as external to the subject (Lie, 2008). By excluding subjects' agency to resist, form and manipulate within a certain framework and limitations, such analysis excludes parts of the relational aspects of power that Foucault posted in his time. *Post* post-development critique [sic] thus stresses the need for including actor perspectives in the study of development discourse, while at the same time stating that in analysis of macro processes it is still useful with a discursive approach to illuminate the structural framework and context in processes of development (Lie, 2008:119; see also Nustad, 2003). Foucault sees power as relational and present in '*all* social relationships, permeating society in a capillary way' (Gledhill, 2000 cited in Lie, 2008:120). Thus, resistance might be conceived in small everyday manoeuvres and individual strategies that counter specific forms of domination. In this thesis, the question of agency is an ethnographic matter and is illustrated by how people manoeuver through demands of registration and personal documents, and how they respond with, for instance, ridicule of educative top-down efforts from actors of the state.

Users of healthcare-systems take up, negotiate and transform hegemonic medical discourses and practices in their quest to avoid physical distress and maximise health (Lupton, 1997:94–95) In other words, they have agency. Seemingly, patients also seek the 'medicalisation' and the power of the professionals to make judgements about the patients' state of 'normality'. Instead of a struggle between the dominant and the less powerful, there is 'collusion between the two to reproduce medical dominance' (ibid., 1997:98). This is also relevant when looking at how individuals in the Andes seek social mobility through moving from ethnomedical practices, such as the use of traditional rituals, to the use of hegemonic biomedical healthcare systems to cure illnesses (Blaisdell & Ødegaard, 2014). Individual choice of healthcare practices is thus intertwined with discourses of 'race' and 'class', so by avoiding medical practices symbolically related to stigmatised racial categories, these individuals simultaneously attempt to negotiate and manage their own placement within racial categories.

The Term ‘Race’ and Racial Categories

The term ‘race’ has been an issue of discussion for decades in academic literature about social issues in Latin America (Wade, 2010). I have placed ‘race’ within inverted commas to stress that it is not a scientific term, but a social construction and merely an *idea* (Eriksen, 2010:5; Wade, 2010:12). Having presented Latour’s perspectives on science, it is interesting to add that he would not have used the concept ‘scientific’ in this, as science is for him also a construct. Nonetheless, the point is that ideas such as ‘race’ is something that ‘happens’ through perceptions, interpretations and categorisation of the world, not something that ‘is’ (Brubaker, 2002:169–175). ‘Race’, in its original meaning from the sixteenth century, referred to *lineage*, the idea of a stock of descendants linked to a common ancestor (Wade, 2010:5). In the nineteenth century ‘race’ became a concept of *type*, contemplating that human beings are separable into permanent categories with innate qualities that are passed on to the next generations (ibid., 2010:8).

In the early twentieth century, integration of race-concepts in scientific eugenic discourses became evidentiary through scientific racism. This implied a belief that ‘unfit’ individuals and ‘inferior races’ should have their reproductive capacities restricted (Wade, 2010:11). ‘Race’ and population control became interlinked in the scientific discourses that evolved at the time, similar to the way the breeding of domestic life-stock was regulated to eliminate unwanted traits. After the Second World War, in processes of dismantling scientific racism, one began to talk about ‘biological groupings’ that were not ‘biological races’ (Wade, 2010:15). In this, the concept of ‘ethnicity’ was formally introduced, especially in the phrase ‘ethnic group’. Since then, race and ethnicity have been heavily debated within social sciences. Wade (2002; 2010) has long argued that the two concepts should be kept apart, while others have argued that race can be seen as a form of ethnicity (see Eriksen, 1993). Yet, ethnicity is often problematised as a concept that tends to use a language of *place* instead of that of wealth, sex, or inherited phenotype. Since geography is included in racial categorisation, ‘social relations become concrete in spatialised forms’, thus creating a ‘cultural geography’, or what Taussig (, 1980 cited in Wade, 2010:16–17) calls a ‘moral topography’. Location, where people are from, is used to address differences and sameness.

It is hard to avoid the term ‘race’ when talking about society in Latin America (Wade, 1993:17). Historic and current racialised discourse tend to naturalise socially constructed traits such as race. The historic use of the term ‘race’ in Peru is similar to the previously mentioned

use of race in science and politics in Europe. In Latin America, the term has been used to scientifically categorise geographically bound racial 'types', such as *indio* (indian), *negro* (black) and *mestizo* (mixed ancestry). These categories were connected to specific traits that was said to explain conduct, emotions and intellectual capacity (see for example Espinosa, 1855; Paz Soldán, 1862; Paz Soldán, 1853). In the 'cultural fundamentalism' that ruled the scientific and popular discourses of the nineteenth century, the fundamental idea was that people are bearers of one particular culture that differentiates them from others (Grillo, 2003:158). Such Lamarckian[7] understanding of 'race' embraced an idea of characteristics being inherited (Ewig, 2010:14). In contrast to the focus on biological markers in Europe, the focus of 'types' and 'traits' was popular among Latin American *mestizo* elites, where education and 'moral spirit' were highly valued 'traits'. In contemporary Peru, cultural fundamentalism still exists as education and morality are seen as defining features of 'racial belonging' (de la Cadena, 2000). Additionally, categories of 'race' and ethnicity have historically been inscribed into geography. Coastal areas have been associated with the *criollo* (creole—Hispanic descendant), which was considered representative of the modern Peru, while the highland and the *serrano* (highlander) has been defined as primitive in elite eyes (Ewig, 2010:15).

Throughout the thesis, I follow Canessa (2012) in using the jarring term *indian* more frequently than the politically correct *indigenous* in an attempt to provoke reflection upon these notions. The term *indian* is European in origin, while the meaning and use have changed through time. By using it I aim to refer more explicitly to power relations within the history of colonial oppression (ibid., 2012:7). I write the word *indian* with a lower case 'i', following British English norms of not capitalising ethnic terms such as mestizo, black, creole, etcetera. Weismantel (2001:xxxiii) uses the term *indian* to expose a 'racist system' that divides into the oppositional categories of *indian* and *white*. Although we know 'race' is a construct, it is a social visible issue in the Andes and it 'naturalises economic inequality and establishes a social hierarchy that spans the continent' (Weismantel, 2001:xxx). Now, I will move on to the analytical value of events in anthropology.

[7] After the French biologist Jean-Baptiste Lamarck (1744–1829).

The Event in Anthropology

Events and situations have long been central within anthropological ethnographical tradition (Kapferer, 2010:1–2). Events, as Kapferer defines them, are atypical happenings that are likely to reveal the 'social and political forces engaged in the generation or production of social life'. An event might be something that 'broke apparent calm or routine of everyday life' and created tension or conflict (Kapferer, 2010:2). In the thesis, I use events and 'thick descriptions' to make possible a ground-based analysis (see Geertz, 1994).

Even though an exploration of events can be significant in analysis of hegemonic discourses, it is important to remind the reader that descriptions of events derive from my observations and conversations with community members. Events are not natural phenomena (Kapferer, 2010:17), which means that they do not describe some kind of static social order, but rather aspects of situated and fractured social processes. The event provides a 'site for innovative practice and (…) practical construction of cultural memory' (ibid., 2010:14). Events analysed in this thesis are done so at the basis of Kapferer's understanding events as a present-future oriented cases, and not something that can be reduced to terms of orders and structures, or relations connecting to a past (ibid., 2010:15).

Chapter Outline

Having introduced the main focus, theoretical framework and methodology of this thesis, I will briefly introduce the outline of the chapters. Chapter two provides a contextual backdrop for how the Peruvian State provides healthcare to its poor population. It examines poverty discourses and health-policies from mid-twentieth century until today, looking especially at how unpaid labour from local communities is used by the state to guarantee state services. Introducing the development-programme behind the *Metacentro*, I describe the government's plans for the centre, how the plans portray the community health agents, and how they are supposed to receive 'proper' biomedical health-knowledge.

Chapter three follow up on discourses of poverty, presenting Paulina, an indigenous poor woman experiencing the effects of stigmatising racial categorisation from other villagers and the state. I examine how already encompassing hegemonic discourses of poverty and 'race' establish how health-authorities conceive health and health-issues among poor villagers in Colca Valley. Food and nutrition is central to this chapter, as issues of health in the Andes are

categorically linked to bad nutrition by the Peruvian State and development discourse. Going back to the development of nutritional theory in eighteenth century Europe, I discuss how biomedical ideas of nutrition have manifested themselves in development discourse.

In chapter four I examine how ideas of hygiene is related to conceptions of 'race', class, modernity and development. By exploring discursive dimensions of an herbalist's public speech at the marketplace in Chivay, I address how his attempt to educate the by-standers in the topic of genital hygiene can illuminate dominant discourses on racial categories, gender and notions of modernity. I also explore the state's focus in development-programmes on 'purifying' and streamlining Andean femininity through training sessions of *capacitación*.

Chapter five builds on the previous chapters' exploration of poverty and development discourse and goes deeper into aspects of power, discipline and governmentality. By focusing on a health-development programme using community-based workers, I explore how the state attempt to discipline and establish truths through the *documentary techniques* of checklists and questionnaires. I discuss how discourses on Andean illiteracy contribute to shape state-actors' conceptions of people living in rural communities, and what these actors see as necessary to improve the living conditions for people living in poverty.

The last chapter contains a short summary of the thesis, concluding remarks about the thesis and thoughts on how to further examine the topic of how the state governs health and development in rural communities.

CHAPTER TWO

Poverty, Health and Development in the Andes

This chapter provides context and background for the ethnographic material discussed in chapter three, four and five. I start by introducing and discussing notions of poverty in relation to health, and explore how these are defined and perceived by international and national development institutions. With a closer look at health and poverty discourses, I ask who are perceived as poor, and why, and address the micro-politics of identity that are connected to being poor; how individuals negotiate and manage how they are placed within a racial category by 'outsiders', and what it means to be a woman in a patriarchal society. Then, I provide a brief backdrop for understanding the health-policies today, as well the development of the last century's population policies, before I move on to looking at how the state started using unpaid labour-forces to carry out state responsibilities in health-care and poverty matters. Through descriptions of the work of community health agents, I address questions of education, and how such voluntary workers are educated within certain discourses that legitimise scientific and 'modern' knowledge, while not giving credit to local indigenous knowledge of for example herbal remedies. First, I start with an introduction of *poverty* and *health*, two major key-words throughout this thesis.

Poverty Reduction in Peru

Peru is one of the poorest South American countries, despite of having rapidly reduced its poverty rates over the last 10–15 years. The country's debt and hyperinflation after the economic crisis in the 1980s, and the difficulty for Peru to fully recover from it, is clearly visible through the great regional end ethnic gaps in access to healthcare, education, formal infrastructure and formal employment (Rousseau, 2007:98). These gaps also existed before this crisis, yet in development discourse, such crisis' are seen as a 'step back' in socioeconomic development of the state. The poverty rates have, however, declined from 55,6 percent in 2005 to 21,8 percent in 2015 (World Bank, 2015). The reduction has been driven by the 'boom of primary materials', hence, due to an economic growth of six percent, Peru was ranked among the top ten of the world's fastest growing economies (Chavez, 2013). This economic growth is

perceived as very important for Peru's development, but the World Bank insists that to 'eradicate poverty and inequality' Peru needs to improve and increase infrastructure and social services, especially in areas populated by 'the most vulnerable' (ibid., 2013). This is achieved, according to World Bank President Jim Yong Kim, by the support of the Bank so Peru can take 'a more scientific, evidence-based approach to the delivery of development services' (ibid., 2013). Kim's notion of 'development services' is interesting because of the many things it insinuates. He acknowledges poverty as institutionally rooted, meaning that poverty can be reduced through better state-services and infrastructure. Yet, this notion of development tends to re-establish an idea of poverty being related to individual's lack of education, and that poverty can be reduced if 'the poor' are *informed* and taught (by state agents) how to behave 'correctly'. In the context of health, this argument draws on hegemonic discourse of what is 'correct' health-behaviour.

The World Bank's poverty-reduction paradigm, which empowers international poverty discourses, have a great influence on today's health-policies in Peru. Especially because of the World Bank's requirement of 'evidence' of development in terms of numbers and figures. Before I explore the details of the impact of this paradigm, I will discuss the notions of poverty within international poverty discourses.

Poverty Discourse and Aid

European conceptions of poverty are deeply related to the notions of class, where 'the poor' is understood as constituting a 'class' with clear and rigid boundaries (Broch-Due, 1995a:4). Thus, poverty has often been a direct result of lack of land-relations and capital. The universality of this notion of poverty, as European and North-American institutions of poverty-reduction and aid seem to take for granted, has over the last 30 years been challenged by anthropologists such as Broch-Due (see 1995a; 1995b; 1996). By using analytical perspectives on poverty discourses and dismantling the taken-for-granted concept of 'poverty', she has discussed the relativity of the condition of being 'poor'. Poverty, she argues, 'like all images and concepts, is an unstable construction, changing with context, culture and the social conflicts situated in history (Broch-Due, 1995b:4). Thus, who is regarded as 'poor', varies according to the societies' own cultural logic.

This fundamental critique of presupposed notions of poverty is highly relevant today, twenty years after. Gupta (2010:15) has for instance expressed a need for more knowledge

about what poverty means for those actually experience it. It is important to understand how 'the poor' as a global stock is a construction, in order to change the understanding of what poverty actually means. This is essential to create meaningful solutions to poverty. Gupta proposes that instead of being conceived as a *stock*, poverty must be seen as a *flow*. The state of poverty is not a set situation, but changeable, affected by historically grounded inequalities, asymmetries of power and access to global labour and commodity markets. This might be frustrating to social engineers, because it goes against the ideal of finding 'ready-to-use' and broadly applicable solutions to poverty-related problems. The 'one size fits all'-approach, Gupta argues, can nevertheless push more people into poverty, or increase social an economic inequality. In addition, such approaches also contribute to postponing a real discussion of development. The poverty-reduction strategies Gupta refers to, includes the 1999 Poverty Reduction Strategy Papers (PRSPs), the 'new Washington consensus' forged by the IMF and the World Bank. These are 'country-driven, result-oriented strategies that bring national development plans in line with neoliberal globalisation by emphasising growth, free markets and an open economy' (Gupta, 2010:14). The PRSPs have been heavily criticised for being nothing more than a 'new form of governance', in order to control developing countries and preventing a rise of alternative social and political models (ibid., 2010:14).

The World Bank introduced the poverty-reduction paradigm in the late 1980s, which continues to drive reforms today (Rousseau, 2007:97). Within this paradigm, there is a goal to privatise the financing and provision of services and to reduce the number of state financing and provision of services to the poor. This implies that social goods should be distributed to targeted selection of the population that is picked out through a cost-benefit analysis. In this poverty-reduction approach, public healthcare is provided through public health-insurance programmes that targets specific sectors in the population (ibid., 2007:101). Rousseau have argued, however, that instead of changing legacies of previous deficient policies, the new policies of targeted social spending have reinforced the segmented way social goods are provided among the Peruvian population (ibid., 2007:97). Thus, by following World Bank initiatives within the poverty-reduction paradigm, Peru has long been criticised for not paying enough attention to who 'the poor' (as the state categorise them) actually *are* and how they experience poverty, health, and other aspects of life (see for example Portugal et al., 2016; Rousseau, 2007; Ewig, 2010; Stephenson, 1999; Ødegaard, 2010). Instead, there has been an institutional focus on providing 'good numbers', while neglecting the targeted segments of the population and 'redressing unequal access to essential social goods' (Rousseau, 2007:115).

This is particularly clear for those categorised in less respected groups and categories. Poverty in Peru tend to be linked to the cultural construction of race, which has since colonial times emerged through public discourses and cultural racism (see for instance García, 2005; Boesten, 2007; Chossudovsky, 1997). The history of the relationship between poverty and racial categories, and how it is relevant for understanding social relations and structural violence today, is introduced in the following section.

Health-Policies in Peru

Scott (1998) traces the state's search to improve and perfect to the Enlightenment, when country-states began a search for perfection and social order. This included the idea that 'every nook and cranny of the social order might be improved upon: personal hygiene, diet, child rearing, housing, posture, recreation, family structure, and, most infamously, the genetic inheritance of the population' (Scott, 1998:92). Urban policy planning included utopian ideas stating that through perfection of social life, the world would experience less friction in processes of progress. The ground idea in these philosophies was the goal of perfecting man-kind. These social engineering philosophies are 'inherently authoritarian', only allowing for one single planning authority (ibid., 1998:93). From colonial times and up until today, the geographical landscape that is now Peru was subjected to this kind of urban policy planning on different levels, as for instance urban space, education and health-planning. After a grand food crisis in the 1920s and increasing protests against the oligarchy, in addition to imperialism and semi-feudalism that had defined the country for so long, Peru entered a new period of authoritarian government. The charismatic Juan Velasco gained power through a military *coup d'état* in 1968, leading a government seeking to change the order of things from above through 'state capitalism' (Bravo, 2012b; Klarén, 2000:342–343). The military government wished to end structural causes to class rebellion and social conflicts by redefining the semi-feudalistic pattern of distribution of riches and property, which up until then had given most advantages to upper class families with ties to the old colony lords.[8] During the military-government's first twelve-year rule (*Docenio*), there were two fundamental reforms; a land-reform and a dramatic expansion of the state (Klarén, 2000–343).[9]

[8] See was José Carlos Mariategui (1975), one of the most central critics of feudalism in this period.

[9] Including major educative, industrial and press-related reforms (Bravo, 2012b).

After the military changed their leader from Velasco to Francisco Morales in 1975, the country gradually started to notice the first symptoms of crisis in the economy and the redistribution model (Bravo, 2012b). When the military government lost the election to Terry Belaúnde and his *Acción Popular*-party in 1980, Peru was in a completely different demographic, economic and socio-political situation than in 1968. The population had increased from 13 million in 1972 to 17 million in 1981, whereas 65 percent of the population now lived in cities. Especially the capital of Lima was growing tremendously. There had been a downfall in the agrarian production, the international investments were absent, and the national debt had increased from 945 USD million in 1970 to 4127 USD million in 1976 (ibid., 2012b). Resulting from an increased use of money on military operations, the national debt had grown to grand proportions; the state apparatus a great enlargement; while the hacienda oligarchy, slave relations and semi-feudalism had been eliminated in rural areas. Ideas of egalitarianism and social justice had also 'rooted' amid people.

Following the serious economic crisis between 1975 and 1989, the public health-system in Peru collapsed. In 1985, food consumption had fallen by 25 percent compared to the 1975 levels, and the levels of infant malnutrition increased dramatically to levels of chronic undernutrition (Smith-Nonini, 2009:594). Chronic undernutrition contributed to the rise of tuberculosis by 30 percent from 1979 to 1983, making it the fifth most important cause of death (ibid., 2009). Economic crisis was followed by social instability stimulated by unemployment and radicalisation of unprivileged socioeconomic groups, more specifically the two guerrilla groups *Sendero Luminoso* (Shining Path) and *Movimiento Revolucionario Túpac Amaru* (Revolutionary Movement of Túpac Amaru—MRTA). One government after the other attempted to tackle this instability through political revolution. When Alberto Fujimori came to power in 1990, the International Monetary Fund (IMF) became one of the primary policy-advisors. Fujimori's regime instituted the so-called 'Fuji-shock', an economic shock-treatment inspired by Pinochet and the Chicago Boys' economic projects/experiments in Chile (Chossudovsky, 1997:192). It included the transfer of state ownership to private actors, a big reduction in public spending and dramatic cuts in state social services (among many other measures). Smith-Nonini(2009:595) argues that the changes that were initially made showed that primary healthcare was not a first priority, but rather 'just another programme'. Health-workers' salary dropped to 40–75 USD per month, followed by strikes initiated by both education and health-sectors. In comparison, the 1991 health-budget was less than a quarter of that of 1980 (ibid., 2009). The policies that were made have been criticised for removing

responsibility for ensuring the survival and well-being of local-community members from the state and onto women, as they generally were primary care-givers (Ewig, 2010). In addition to battling the high levels of inflation, Fujimori also empowered and supported the military in their hunt for and resistance against guerrilla groups in strong confrontations at the country-side (Bowyer, 2005:478).

Following the 'Fuji-shock', prices shot up overnight, making it difficult even for the middle class to boil water or cook (Smith-Nonini, 2009:595). As an attempt to handle the crisis, families began pooling resources to make ends meet in *pueblos jovenes* (urban squatter communities) by establishing *comedores populares* (community kitchens). The state on the other hand, conducted stabilisation programmes to reduce state intervention and to liberate the market system. Similarly, in other Latin American countries, efforts were made to soften the negative effects of macro-economic adjustment through the introduction of safety nets (ibid., 2009).

Increased Social Spending

After the hyperinflation was stabilised the money spent on social cases increased (Bowyer, 2005:479). The Emergency Social Programme (PES), which had been established in 1988, helped integrating several sectors in the society through social measures. Participation increased in programmes aiming to meet the need for food among poor in urban areas increased (Figallo, 1994:352). In Lima, originally local initiatives such as *comedores populares* (community kitchens) and *vaso de leche* (Glass-of-Milk) had already been operating for years. Food donations in the National Programme for Food Aid (PRONAA) started in 1992. The first months, the programme got economic support from limited national funds. When president Alberto Fujimori discarded the congress in an *autogolpe* on April 5, 1992, the possibilities for receiving external funds from abroad were reduced. The year after, however, the government doubled the economical funds for social development programmes, and PRONAA resumed the application process for external sources. Another state apparatus, the Social Compensation Fund (FONCODES), focused on the development of agrarian technology as a part of poverty reduction. The farmers' technological tools in agriculture were seen as old-fashioned, with negative influence on the biological local environment. These tools were included in discourses about sustainable development, which was put in contrast to agriculture (Figallo, 1994:353). It was thought that there was a need for technological change in the rural high-lands, but it was

discussed whether effective technology would have positive or negative consequences for the rural environments, and if it would reduce the centralisation that had already been in action for a long time (Figallo, 1994:353).

When Abimael Guzmán, the leader of *Sendero Luminoso* was caught in 1992, the civil war slowly ended. Initiatives were taken to restore the resources previously dedicated to public health (Smith-Nonini, 2009:595). Despite the processes and measures initiated in improving public health, civil rights were not improved, nor did they have beneficiary effect on the authorisation of the poor (Bowyer, 2005:479). Rather, Fujimori's social policy was used to establish clientelistic relationships on local levels as a part of building future political support among the poor. Yet, the relationship between the state and the population changed when the state started to show a different kind of presence in the rural landscape. People observed concrete and life-near changes organised by the state, such as improvements in infrastructure and schools, and also a symbolic presence by the president (ibid., 2005). Nonetheless, the various crisis's the rural population had experienced during the mid 1970s to mid 1990s provided severe consequences for the public's trust in the state. The state had little knowledge of local circumstances and priorities, and state-policy was influenced by technocratic interpretations of social, health-related and economic needs among the population (Bowyer, 2005:479). Nonetheless, the Fujimori-period also provided the start for what is now the social security health-system in Peru. In the following section, I will provide a brief on how this system works.

Health through Social Security Systems

Peru's healthcare system is based on two social security health-systems, that of the EsSalud (*Seguro Social de Salud*) and the SIS (*Seguro Integral de Salud*). The first is under the authority of the Ministry of Labour, financed by employers and employees, its beneficiaries being state-employees and formal-sector workers. The latter is a health-insurance programme that targets the 'poor and vulnerable' segments of the population (Rousseau, 2007:99). SIS has since its emergence in the 1990s been gradually expanded, and some politicians are even working for a universal health-insurance (Ewig, 2010:202). The current version of the insurance was created in 2002, through a fusion of the SMI (*Seguro Materno Infantil*) and the SEG (*Seguro Escolar Gratuito*) (Mathez-Stiefel et al., 2012). According to government websites, SIS' objectives are:

> (a) To construct a system for public and sustainable insurance which finances quality services to better people's health conditions through the *reductions of the mortality numbers*; (b) To *promote access* to quality healthcare benefits for the whole population, prioritising *vulnerable groups* in poverty and extreme poverty situations and; (c) To implement policies that generate an insurance-culture for the population (SIS, 2011, my translation and emphasis).

SIS is one of the elements in Peru's process of establishing a welfare state. An issue that has been clearly argued by international agencies, is the importance of redressing unequal access to essential social goods (Rousseau, 2007:115). The quote above illustrates how SIS is an attempt to secure health-equity by targeting the poor, promoting access to health-care for those who tend to fall outside such facilities because of urban or rural conditions poverty.

My emphasis on 'vulnerable groups' in the quote is to highlight the targeted segment of society, which I find interesting because 'vulnerable' may potentially refer to several categories of people. By confining the targeted groups into '*vulnerable groups* living in poverty and extreme poverty situations', the government narrows down large groups of poor people. The specific category of *vulnerables* (vulnerable individuals) includes pregnant women, mothers, and children (see chapter five). These groups of people are considered vulnerable because they face distinct challenges related to institutional and public discrimination, racism, and other issues influencing access to health-care and the labour-market. To understand the government's focus on *los vulnerables*, I will in the following discuss the role of women in healthcare.

Health and Women in Peru

There are many ethnographical examples of racial categorisation, cultural racism and discrimination in contexts of healthcare, poverty and development-programmes in Peru (Ewig, 2010; Ødegaard, 2010; Portugal et al., 2016). In addition to being a racialised, class-related phenomenon, access to healthcare is also noted to be a highly-gendered issue. Women's work is often within informal sectors; therefore, they do not access benefits as regular workers. Rousseau (2007) complement this observation by looking at how legacies of previous policies of poverty-reduction and reproductive health have formed today's situation of health-programmes and projects. In Latin America, women's body politic is a crucial site for how women's citizenship is defined (ibid., 2007:93). Historically, women have been seen as tools

for economic development and society because of their link to issues of reproduction and domestic space (Ewig, 2010:7). Women have for instance been excluded in development programmes for agriculture (Escobar, 1995:171). Women's position has been limited to programmes of health, family planning, nutrition, child care and home economics, while men have, in development discourse and practice, been conceived as the most productive workers. Until the end of the 1970s, the development apparatus perceived women just as mothers occupied with feeding their babies, cooking for their families, caring for sick children and growing home gardens. This is what Escobar (1995:155) calls the 'developmentalisation' of women and peasant. Men were considered as in *production* and women in *reproduction*.

The ideology of motherhood has existed in European imagination since the eighteenth century, during a time of attempting to define women's position in society (Lupton, 2012:142). The scientific production of knowledge about women until the early twentieth century saw women as 'incomplete adults' and stating that women cannot possess a 'masculine brain' if their uterus' were to function properly. Simultaneously, the uterus and ovaries were conceived as explanations to nearly all female complaints, while menstruation and pregnancy were treated as sickness and abnormal (ibid., 2012:143).

Concurrent with feminist movements for birth control and abortion rights in the early 1900s, the notion of population control was presented as an argument in favour of such rights. For some politicians and theorists, population control was seen as a cure for poverty (ibid., 2012:146). In Peru, Western pressures for population control have influenced notions of 'state family planning policy' (Rousseau, 2007:104). The first project of birth control started in Lima in 1964, but family planning has been on and off the political agenda according who's heading the government. Peru's expansion on family planning-policies began, as previously mentioned, during Fujimori's rule in the 1990s. The family planning-policies that was implemented were clearly Malthusian-inspired, based on nineteenth century ideas about how population growth among the poor and working class would surpass the earth's agricultural capacity and lead to mass deprivation (Ewig, 2010:42). The immense gender-gap became visible in discourses on family planning, where women were portrayed as 'irresponsible baby makers', while men were thought not to be responsible for their sexual behaviour (ibid., 2010:6). The gender-related inequalities in Peru can be said to intensify the effects of poverty, an issue I will briefly address in the following section.

Gender, Health and Development

Within global development discourse, gender equality and 'women empowerment' are established goals through the United Nation's Millennium Development Goals (MDG) (see United Nations). The process towards these goals is monitored by indicators of education, employment and political participation. 'Empowerment' is an important 'buzzword' within development discourse (see Cornwall & Eade, 2010). Empowerment is defined by the ability to *change*, moving from being disempowered and denied choice to acquire the ability to choose (Kabeer, 2005:13–14). To be empowered it is thus necessary to be disempowered in the first place. Poverty and disempowerment often go hand-in-hand because of a dependency on others to meet one's basic needs. According to Kabeer (2005:13-14) the absence of choice may affect women and men differently, as 'gender-related inequalities often intensity the effects of poverty'.

As 'gender' has become part of the global development agenda, especially through the MDGs, storylines, fables and myths have been created, formed and reframed (Cornwall et al., 2007:5). Principles have been established under labels such as 'poverty reduction', 'empowerment', 'rights', 'exclusion' and 'citizenship'. In order to explore the dynamics of such ideas, Cornwall et al. (2007:5) use the notion of myth, to make sense of 'how and why certain ideas gain purchase with diverse development actors and of the work that these ideas do in motivating development interventions'. Myths are narratives constructed by sets of 'familiar images and devices' that do something more than telling a good story. Myths have certain taken-for-granted and self-evident characters, and are argued to produce an order-of-things that reproduce certain values and norms. Within the context of development, ideas and myths of gender are managed through techniques of institutionalisation and 'sensitisation' (Cornwall et al., 2007:7). This is for example done through gender training, which is ethnographically illustrated later in this thesis as training of women about issues of health, hygiene and nutrition. Gender training was considered a 'major site of innovation' where behaviour is sought to change through new-established frameworks, activities and protocols. One of the myths that seems to have gained hegemonic status, is that of 'womanly virtue', based on 'essentialist notions of women's higher moral nature' (ibid., 2007:10).

Based on essentialist ideas of women, women tend to conveniently be targeted within development projects and programmes. In the Andes, women have been used in many unpaid work-situations. In the context of providing health-care, health-workers from Andean

communities have been used to expand the access to modern medicine in rural areas. Community health workers in community-based health-programmes in Bolivia in 1975, for instance, were thought to be motivated by the 'love of neighbour and welfare of the community' and work without salary (Bastien, 1990:282). Health-programmes using community-based health agents have been argued to be one of the keys to provide health-care and competent knowledge in poor populations (Standing & Chowdhury, 2008:2096). The use of community-based actors has been specially promoted in contexts of pluralistic health-systems in low-income countries as Peru, where many health-providers operate within unregulated markets.[10]

The 'new' public health-movement that arose in the 1980s made the notion of 'community' and its development fundamental (Lupton, 1995:58). Terms like 'community development', 'community participation' and 'community empowerment' became central in health-promotion discourses, emphasising the participatory nature of the movement. In health-promotional literature, the Ottawa Charter for Health Promotion of 1986 is often referred to as providing the main principles for the field:

> Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies, and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their destinies (quoted in Lupton, 1995:59).

The rhetoric is based on ideas that health-promoters should learn to work *with* individuals and communities rather than *on* them (Lupton, 1995). Lupton (1995:59) argues that drawing upon the critical pedagogy movement of the 1960s, which emphasised individual responsibility and autonomy, the discourse of empowerment used in health-promotion clearly privileges progress and control, central elements of an Enlightenment project. As we shall see later in this thesis, this 'health-from-below' approach is in practice often based on direct collaboration with officials 'from above' (ibid., 1995:59). Different kinds of conflicts appear when health-promoters are recruited from the community, as they are supposed to act as mediators between unprivileged groups and health-care providers, while simultaneously advocate for the former. As Lupton (1995:59) notes, 'health promoters often act as facilitators of co-option [sic] rather

[10] By 'unregulated' I refer to the 'lack of state enforcement of formal laws and regulations' (Standing & Chowdhury, 2008:2096)

than enhancing the agency of community groups'. The community is perceived from the perspective of the state, thus public health has the privileged role of shaping community health.

In Peru, community-based health-promotion projects are dependent on unpaid voluntary labour from the community. By considering the concept of work in this context, I will explore the developmentalist importance of such workers for the state.

Community-Based Workers

The use of community development workers is based on an idea that such workers, who are chosen from the locality, understand and empathise better with their clients than professional medical-personnel from urban areas (Standing & Chowdhury, 2008:2097–2098). The use of community development workers in healthcare programmes was recognised by WHO in the Declaration of Alma-Ata in 1979, which institutionalised primary healthcare as the paradigm for healthcare and healthy communities in places where access to 'competent knowledge' in modern medicine is difficult for poor populations (ibid., 2008:2097–2098). Since the early 1980s, however, the implementation of community health-worker programmes globally declined, due to increased economic and political instability, conflict, migration and lack of priority within economic policies (Standing & Chowdhury, 2008:2098).

I find it interesting to look at notions of work, labour and payment in the context of health-development programmes. Using the label 'work,' I refer to Weeks' (2011:14) definition of it as 'productive cooperation'. In her definition, such productive activity is not necessarily confined to waged labour: 'Work should be seen as a fully political phenomenon, rather than simply an economic one', as we shall see in chapter five (Weeks, 2011:14). I find the following understanding of work essential for understanding how the state can engage unpaid voluntary workers to fulfil the state's duties:

> That individuals should work is fundamental to the basic social contract; indeed, working is part of what is supposed to transform subjects into the independent individuals of the liberal imaginary, and for that reason, is treated as a basic obligation of citizenship (Weeks, 2011:8).

In Colca Valley, community-based public programmes rely heavily on unpaid voluntary labour. Projects and programmes such as the *comedor popular* (community-kitchen), *vaso de leche* (glass-of-milk) and *metacentro* (health-registration centre) are all depending on voluntary work

to continue their services. It is not a coincidence that women are those who mainly work in such programmes and organisations. As I have previously argued, women tend to be targeted in development discourse as the key-agents to societal and individual change. Yet, it has also to do with their roles within contexts of family care and the domestic sphere. By engaging women in work, waged or not, the state integrates women in relations that helps producing certain social and political subjects (Weeks, 2011:8). Thus, as important subjects in various social arenas, women are frequently understood as keys to creating and recreating governable subjects in domestic arenas. One of these community projects, which in Colca was just referred to as the *Metacentro*, is a state-based health-development programme employing unpaid voluntary workers. To understand the ethnography provided in later chapters about the *Metacentro*, I find it important to get familiar with the formal framework for this programme provided by state-institutions.

Centres for Health Promotion and Supervision

One of the Peruvian government's development programmes for improving health of the most vulnerable inhabitants, is a 'community-based' programme which main goal is to reduce chronic malnutrition. Chronic malnutrition is globally targeted by international health-organisations and aid-financed development programmes, as almost 45 percent of all child deaths are linked to malnutrition (WHO, 2016a). This 'community-based' health-development programme focuses on monitoring physical growth and development of pregnant women. This monitoring is carried out in many low-income neighbourhood-communities through a 'Centre for Community Promotion and Supervision of General Mother and Child Care' (*Centro de Promoción y Vigilancia Comunal del Cuidado Integral de la Madre y del Niño*—CPVC), informally called a '*metacentro*'. Through metacentro's that engage women and men from the local community, the Ministry of Health (*Minesterio de Salud*—MINSA) aims to fight 'direct and indirect causes of malnutrition' (Minesterio de Salud, 2015:6).[11]

The *Metacentro*'s function is twofold. To 'promote and supervise' health-behaviour in the local community, the *Metacentro* is both educative and supervising. The 'educative actions'

[11] The direct causes of malnutrition are identified as *low birthweight*, *inadequate alimentation* and *nutrition* the first 36 months and a *dominance of diseases* the first 24 months. The indirect causes are associated with the absence and/or inadequate coverage of *water* and *sanitary conditions* (Minesterio de Salud, 2015:6).

consists of *capacitar* (train/educate) families in the community, in what MINSA recognises as 'healthy practices' (Minesterio de Salud, 2015:12).[12] Education in 'healthy practices' consists of creating knowledge based on what the families already know, while 'respecting beliefs and customs' through 'exchange' of experiences between the families, community agents and health-personnel (ibid., 2015:12). Education and guidance are, in the *metacentro*-plan documents, key elements in the generating of 'favourable conditions in the community' (Minesterio de Salud, 2013:9).

The supervising part of a *metacentro* consists of registering health-data on specific vulnerable categories of the community, such as pregnant women and babies. Focusing on children's growth and physical development, mothers and mothers-to-be are both encouraged and coerced to follow up on regular check-ups, vaccination programmes, nutritional additives, educational programmes and ID-registration for the child at the closest health-centre or health-post. Supervising activities are regularly followed up by home-visits (Minesterio de Salud, 2015)

A *metacentro* is physically located somewhere within the community, often in a renovated community building. The volunteers recruited from the community, working at a *metacentro* are set to carry out educative and supervising duties. These volunteers are both men and women called *Agentes Comunitarios de Salud* (ACS), or 'Community Health Agents' in English. The *Metacentro* functions as a link between the state and the community, where the community agents constitute the embodiment of this link, which I will elaborate on shortly. First, I will go into detail on the *Metacentro*.

Supervising Health-Behaviour

An important detail of the *Metacentro* is the element of supervision, as reflected in the *metacentro* title (Centre for Community Promotion and *Supervision*). According to formal document plans, the communal supervising ('vigilante') activities: 'consists of supervising; that is, to care, to observe, to be alert of what is happening in the community in relation to all the conditions that follow good growth and development of girls and boys from pregnancy to the first three years of life' (Minesterio de Salud, 2015:14 my translation). This communal supervision is carried out by community health agents, with the 'active participation of the

[12] A session of capacitación is addressed in chapter four.

authorities and community leaders, accompanied by regional health-personnel' (Minesterio de Salud, 2015:14 my translation). Significant to the supervising activities, the *Metacentro*'s use a set of documenting objects, such as checklist-books (*cuadernos*), checklist-banners, and surveys. These are used to supervise *who* participates in the health-programme within the community, and *how* they are following it. Inside the *Metacentro*, there are two large banners on the wall that function to monitor certain aspects of health-behaviour; one for community surveillance of expecting mothers, and one for children under 36 months:

Banner template for community surveillance of expecting mothers[13]

N°	Nombres y Apellidos	DNI	Edad	Enero					Febrero
				Mes de Embarazo	Atención del Embarazo	Suplemento de Hierro	Vacuna	Paquete educativo	

Banner template for community surveillance of children

N°	Nombres y Apellidos	Fecha de Nacimiento	DNI	Enero						Febrero
				Edad	CRED	Vacunas	Crecimiento y estado nutricional	Suplemento de Hierro	Asistencia al paquete educativo	

These banners function as public 'checklists', as they provide detailed information about which individual is following the public health-programme. Both banners include the

[13] Retrieved from a government *metacentro*-plan (Minesterio de Salud, 2013:33–34).

columns for personal registration number (which counts the number of registered participants from the community), first and last names, number from identity card (*DNI*), and age/date of birth. The first banner-illustration above is meant for expecting mothers and contains columns for month of pregnancy, pregnancy care, iron supplement, vaccination, and educational package. The second banner-illustration concerns children and includes columns of age, growth and development control (*Control de Crecimiento y Desarollo—CRED*), vaccination, growth and nutritional state, iron supplement, and presence of/help from educational package.

In addition to these public checklist-banners, the community agents register similar information in checklist-books. As with the banners, there is one checklist-book for each category. Additionally, there are checklist-books aimed at children using the *Metacentro* playing area and toys inside the centre, as one of the other goals for *metacentro*'s is to 'promote children's playing and contribute to promote caution and autonomous activity for children under the age of three' (Minesterio de Salud, 2012:23 my translation). Every checklist-book is periodically checked by regional health-authorities, in order to be verified with *sí cumplió* (approved) or *no cumplió* (not approved) to confirm that *Metacentro*-goals are met (ibid., 2012:36). The checklists provide data used in periodic and annual reports (Minesterio de Salud, 2015:20).

Formally, only checklist-books and checklist-banners are used as documentary objects. However, in chapter five I will illustrate how health-authorities also used other tools to document health-behaviour. Chapter five also addresses issues of compensation and recognition, in which the community agents are promised through non-monetary stimuli (ibid., 2015:25–26). Such 'stimuli' come in the form of personal advantages, such as health-education materials, exchange of experiences, and preferential attention from health-personnel. Additionally, there are 'public and social' recognition, such as credentials and certificates as a community agent; baskets of food and kitchen supplies; a poster outside the community agent's verifying his/her status; equipment and clothing;[14] and finally participation in the public celebration of the day of the community agent,[15] parade and party participation, and regional meetings (ibid.:26). In the following, I will move on to an elaboration on 'who' are the community health agents, and why are they working as volunteers for the state?

[14] Such as a caps, west, boots, rain-poncho, flashlight, backpack, sweater, hats, blankets and more (Minesterio de Salud, 2013:26).

[15] *El día del agente comunitario de salud.*

Community Health Agents and their Work

The Community Health Agents are the central actors within a *metacentro*. Principally, their main role is to be link communication between the community and the authorities (Minesterio de Salud, 2012:32). They are elected by an assembly or in another way recognised by their community to do 'voluntary activities of promoting health and preventing diseases' (ibid.:32). This is done through coordination of health-personnel and other local and regional institutions that are representing their community. There are several actors who can become a community agent. The *metacentro*-plan suggests that it might be '*el promotor de salud* (the health-promotor within the community), advisory mothers, mobilisers or leaders and other voluntaries' (Minesterio de Salud, 2012:33).

One of the first priorities after electing community health agents is to *capacitar* (educate/train) the Agents through sessions of *capacitación* (training) consisting of a total of 16 hours of training (ibid., 2012). The *capacitación* is provided by health-personnel. In these sessions, the community agents are taught about the importance of 'growth and development in human life', activities that the *Metacentro* is supposed to realise according to the government plan, healthy practices for the expecting mother, healthy practices for the new-born and healthy practices for providing health to children under 36 months (ibid., 2012).

As communication links between the authorities and the community, the Agents are implicitly aimed to become role models of 'proper' health-conduct before the community. Through *capacitación* they are supposed to achieve authority before community members in questions of individual and collective health-conduct. *Capacitación* and other educational activities constitute a major part of development-programmes, both globally and in Peru. Within the Peruvian health-sector, *capacitación* consists of demonstrative sessions in topics such as hygiene in food preparation. It may also consist of educative lessons focusing on specific topics health-personnel find necessary.

Portugal et al. (2016) argue that although institutions such as MINSA and the Pan American Health Organisation (PAHO) acknowledge the importance of incorporating an intercultural focus in health-politics, interculturality has not been implemented in public health-services in Peru. Rather, there is a hierarchical relationship between state-actors such as health-personnel and individuals from indigenous rural communities, which is being reproduced through *capacitaciones* of mothers (ibid., 2016:28). Portugal et al. found that in sessions of *capacitación*, the information tended to be unidirectional, from the *capacitadores* (trainers)

towards the mothers, who were not encouraged to share their opinions and knowledge (Portugal et al., 2016:78). Mothers reported feeling evaluated, and that they were afraid of saying something 'wrong' or that the *capacitadores* would criticise them for not speaking Spanish more fluently.

Like development programmes such as Community Kitchens (*comedores populares*) and Glass-of-Milk-committees (*vaso de leche*), the *metacentro*-programme's ambition is seemingly to make women 'modern' and 'urban' citizens. Community workplaces can be understood as institutions that serve to sustain certain truths within the *conditions of possibility* in poverty discourses. As I shall discuss later in the thesis, in a Foucauldian understanding of discourse, institutions are inseparably interconnected within a *discursive formation* (Foucault, 2002 [1972]). In relation to public programmes of development and poverty-reduction, the programmes themselves can be understood as institutions that help define the rules and boundaries of who constitutes 'the poor' and who does not. Thus, those who make use of the public poverty programmes re-establish themselves as 'poor', meaning that the identity markers of 'poverty' is also re-defined through these programmes.

Summary

In this chapter, I described how health-practices have been influenced by the historical relation between the state and rural communities, how global development policies have affected development-policies and discourse in Peru and suggested that the *metacentro*-programme can be understood as aiming to make indigenous poor women into 'modern' and 'urban' citizens. I have suggested that development-programmes and health-programmes, established to improve the life conditions for poor populations in the Andes, do not merely aim to reduce health-problems for the poor and facilitating access to subsidised public health-care. In addition, they aim to transform poor bodies into a certain kind of citizen and change the health-behaviour of the poor. As we shall see in the following chapters, this transformation is endeavoured through various disciplinary tools within development-programmes and public healthcare, which tend to forsake the established goals of promoting and respecting local knowledge, practices, and individuality. Rather, I will argue, these institutions reproduce hierarchic structures and reinforce discourses of poverty that tend to legitimise discriminative practices.

The next chapter will examine hegemonic discourses of poverty and their implications on state policies of welfare and health benefits. It will discuss notions of the 'deserving versus

undeserving poor'; of who is perceived as 'worthy' beneficiaries of public healthcare or not and; investigate healthcare through a spectacle of nutrition. As nutrition is treated as an important factor in ensuring good health among the poor in Peru, I will investigate conceptions of food and nutrition within both hegemonic biomedical theory and in general ethnomedical knowledge. By looking at ethnographic cases and events, I inquire how health is interlinked with nutrition, poverty, and pregnancy within development discourses and framing some of the Peruvian State's development programmes.

CHAPTER THREE

Discourses on Poverty, Reproduction and Nutrition

In this chapter, I discuss how poverty-related health-issues and those affected by them are interconnected in poverty and development discourses. I examine how these discourses determine what is considered true by state-institutions of health, how ideas of what it means to be poor and who constitutes 'the poor' are expressed in relations between state-actors, middle-class professionals and beneficiaries. I follow Paulina, an economically poor woman living a tough life.[16] People like Paulina are often *beneficiares* (beneficiaries) of the state, involved in food- and health-programmes promoting education, access to nutritious food and general health-services. In this chapter I will go into two of these programmes, the *comedor popular* (community kitchen) and the *Seguro Integral de Salud* (SIS), a free health-insurance for those who 'qualifies' as poor.

The *comedor popular* is one of the state's projects for securing access to nutritious food for the 'vulnerable poor'. For those engaged in working at a *comedor*, it also involves educational sessions such as *capacitación* (training), meetings and check-ups from health-authorities form the state. SIS on the other hand, is connected to public health-centres and health-posts where social workers decide whether a person fits the necessary 'qualifications' as economically poor. In exploring power dimensions of state-projects for managing the poor I will look at poverty, nutrition and health through focusing on *discourse*. One of the advantages of analysing development and poverty as discourse, is that it is possible to separate poverty, suffering and suppression on the one side, and the theoretical and bureaucratic machinery that has monopolised the discussion, delivery and interventions of solutions on the other side (Nustad, 2003:136). I follow Broch-Due (1995a) in arguing that hegemonic discourse holding ideas of what it means to be poor contributes to shape state-projects of poverty-reduction. It means that symbolic identity markers such as health-conceptions, use of medicine, food-consumption and general behaviour are important in public and official determination of who is poor, what are the poor's problems and what needs to be changed about the poor to 'lift them out of poverty'. Before entering this discussion, I will present Paulina.

[16] As explained in chapter one, Paulina is the result of a collage of several interlocutors.

Paulina

I first met Paulina at a *faena*, a community-gathering for voluntary work on a new community building in Sumaq Llaqta. She had been up since four o'clock in the morning to help make food for the guests who were contributing to and celebrating the building. Paulina was a 25 years old mother with four children between the age of six months and seven years. The father of her children was a man at least ten years older than her who was married to another woman. He was living with his wife and their children in a different village, while Paulina and *her* children lived with her mother in a stone-house outside Sumaq Llaqta, where they lived off seasonal work at her mother's *chacra* (farmland) further down the valley. An outsider would perhaps notice the ragged, outgrown clothes stained with dried mud and dirt that Paulina's children wore every day. Their shoes were full of holes and their too short pants left their bare ankles exposed. 'Are you cold?' I asked them as winter started to make both day and night freezing cold. 'No,' they would answer, laughing and smiling, showing rows of unbrushed teeth. As the climate turned colder in the valley, the rose-red colour on their chubby cheeks intensified and the skin hardened and roughened up.

The children accompanied their mother everywhere she went: to the *feria* (market), the municipality and the *chacra*. The two eldest would run around her as they walked, while Paulina carefully held the hand of her three-year old and carrying her baby in a *lliqlla* (women's shawl) on her back. She looked like a stereotypical *campesina*: wearing a white *collagua*-hat,[17] pink velour-pants and a green embroidered *lliqlla*.[18] My middle-class interlocutors frequently talked about *campesina* women, especially Paulina, implicitly postulating knowledge of what kind of person a campesina is, what personal problems she has, and what she should do about it. One of the issues middle-class villagers often returned to was that Paulina had many children. They portrayed it as problematic, especially at such a young age and without a male breadwinner. At one level, they raged against Paulina's partner, telling him that he should not make her pregnant again and that he was lacking moral for keeping two separate families. Catholic and evangelical churches hold much power of definition in the Andes. Consequently, his living-situation was deemed as 'sinful'. Paulina evoked pity, being conceived as a victim

[17] The Colca Valley is commonly said to be inhabited by two indigenous groups: the *Collaguas* and the *Cabanas*. Different clothing is linked to different indigenous identities.

[18] See chapter four for clothes as identity markers.

of *machismo*[19] and poverty (I also noticed a deduction of her ignorance, since she kept up with her partner's nonsense). According to this logic, she had too many children to take care of, meaning that her poverty would be 'passed on' to the next generation of low-income peasants lacking formal education. At another level, middle-class people would object to what they saw as her 'lack of initiative'. Since I followed the development of the social relationship between Paulina and one of my middle-class interlocutors closely, I saw how this ambivalence developed into expressions of disgust and despair towards Paulina and her 'situation'. In the following sections, I will discuss the rhetorical ambivalence that emerged and how it circled around an idea of who does and does not fit into an idealistic image of an ideal society.

Rhetorical Ambivalence Towards the Poor

One day, one of my middle-class interlocutors in Chivay started talking to Paulina at the *feria* (market), and ended up inviting her for dinner. My friend, who was a teacher and deeply engaged in educational questions in Colca Valley, took pity in Paulina's situation as a young *campesina* mother and wanted to help her get a steady income so she could send her children to school. The teacher had many ideas for how Paulina could improve her financial situation and provide educational options for her children. Paulina's problem, the teacher told me, was that her eldest son was being bullied at school for his indigenous and poor background. Thus, if Paulina could transfer the boy to another school, possibly a private one, he would get the individual adjustments he needed. Agreeing that she would help Paulina achieving this goal (which, interestingly, the teacher made for her), the teacher suggested Paulina could make herself a street vendor, selling sweets and cake she could bake in the teacher's kitchen. Thereon, the teacher started giving Paulina small tasks, such as making *chicha* (maize-beer) for a wedding and doing laundry. If only Paulina was given the right tools, the teacher explained to me, she could create her own way out of poverty. This was not something the teacher normally did, but as a deeply devoted catholic she explained she could not look away from Paulina's miserable condition.

After a while, the teacher managed to get Paulina's children into a private school, through an agreement that Paulina would do special favours benefitting their school instead of paying a monthly tuition. From the teacher's perspective, however, this arrangement did not

[19] A term often used to refer to male aggressive sexual hunger.

work out well. One of the defining events that made her come to this conclusion, involved an agreement that Paulina would make *chicha* for a special festive occasion. 'She has a problem with time,' the teacher complained, explaining how Paulina had turned up at the teacher's house half a day late, at a time when the teacher had left Colca to go to Arequipa for business errands. Paulina, on the other hand, told me she had turned up several times at the teacher's doorstep (she admitted she came later than agreed), but no one answered the door. On a last try in the afternoon, the teacher's teenage nephew had opened the door, being able to call the teacher on her mobile phone to get instructions on what to do. 'First of all, there were no [sufficient] ingredients [to make *chicha*] at the house,' Paulina complained. When they finally found the *chicha*-barrel and some old ingredients, she was left to herself to finish the preparations so the *chicha* could ferment.

There was no doubt that Paulina and the teacher did not communicate well. The teacher argued that Paulina was unreliable. Paulina, on the other hand, did not defend herself before the teacher but complained that she had so much to do, especially since she had to travel between villages more frequently now. The teachers at Paulina's children's new school were also initially talking compassionately about the 'poor family'. Yet, this compassion was after a while accompanied by despite, as the teachers discussed how Paulina's children never brought their own food to school. Their criticism was mostly directed towards her capability to be a mother. Having so many children without being able to feed them was said to be irresponsible. Such critique illustrates how being a mother is tightly linked to the responsibility for providing food and nutrition (Lupton, 1996; Caplan, 1997). As mothers, women are expected to 'expected to practice "maternal altruism" towards their children and male partner' (Caplan, 1997:10). Purchasing and preparing food for the family is generally perceived as the major responsibility of women (Lupton, 1996:39). Mothers tend to be understood as keys to forming their children's eating habits and general behaviours, assuming their responsibility in keeping the household harmonious and socialise their children. The teachers at the new school seemed to follow this motherly norm when complaining that Paulina never provided food for her children. Consequently, the children ate other children's leftovers from lunch, or were given something by the teachers. The children then relied on the caring actions of others, who would (following this logic) take upon themselves the feeding responsibilities of the mother. Yet, the school-teachers' complaints about Paulina being an irresponsible mother expecting everyone else to solve her problems, were also complemented by pity concerning her inconvenient situation as a single mother or addressing her children's worn-out clothes.

The teacher's ambiguous feelings towards Paulina and her family were expressed in various ways, and the situation appeared stressful for both Paulina and the teachers. For instance, one of the teachers complained about Paulina's children's unwashed faces. She decided to 'solve' this by teaching the youngest girl the importance of washing hands and face before eating. 'She is adorable,' the teacher said after a while, emphasising how quick she embodied the routine of washing at school. Cleanliness proved to be a central topic in the Peruvian school-contexts, both as a devoted subject of education and as representation of the school itself (Stephenson, 1999:134-141). The case of Paulina demonstrates what I will show in chapter four, namely that the right way, it seems, is the clean way. An unclean child also symbolises and represents the lack of educational value within the child's school.

Amongst themselves, the teachers would often compare Paulina's children to each-other, sharing stories about their pupils. The oldest boy was sometimes portrayed as an 'impossible' case, said to be a notorious thief, liar and a slow learner (in contrast to the youngest). Some of the teachers tried to spend extra effort to make him able to follow curriculum made for children his age. Yet, other teachers agreed that Paulina's children were frustrating as pupils, that it was too late, since the oldest had adopted too many 'bad habits' in life and did not show any effort to learn. This frustration signalise a firm conviction that Paulina was considered a bad mother, who had not disciplined and cultivated her oldest boy into the civility and self-regulation of adulthood (Lupton, 1996:39).

The rhetorical ambivalence expressed by people around Paulina and her family, changed from compassionate remarks of her family's visible signs of poverty (such as stained, worn-out clothes and missing lunch-boxes) to frustrated outbursts about how the children suffered under their parents' faulty decisions. The teacher in Chivay, who initially promised to help Paulina, told me some months after the initiation of her beneficiary 'project' (Paulina's family), that she did not trust Paulina anymore. 'She is always late [when we have an appointment], sometimes she does not even show up at all,' the teacher complained, 'she just wants to receive (…) I gave her money. She has not returned it yet.' The teacher said she wanted to quit the project because she did not think Paulina had not enough will to work. To understand the rhetorical ambivalence people in Chivay experienced towards people living in condition of poverty, such as Paulina, it is interesting to look at the encompassing poverty discourses operating in Colca Valley, which is the topic of next paragraph.

Definitions of Poverty

People living in conditions of poverty such as Paulina, have through the last two decades faced a healthcare system in rapid change. Since the 1990s, there has been a general trend in Latin American countries towards increased social spending by the state (Rousseau, 2007:96). Women have been especially targeted in new social policy. This change in women's body politic was from the 1980s a more responsive approach to feminist demands of increasing women's rights (ibid., 2007). Previously mentioned Malthusian ideas on population-policies (that population growth is not sustainable to food production) continued to inspire policy making. However, population agencies increasingly focused on frameworks based on reproductive health and gender equity.[20] Yet, the social reforms initiated in the 1990s were subsequently reshaped and based on '(partial or total) privatisation of financing and provision of services' and a 'concentration of state resources in the financing and (often) provision of services to the poor' (ibid., 2007:97). In the social reforms, social goods subsidised by the state were distributed through a cost-benefit analysis, targeting certain segments of the population. This social policy applies also today, especially in the Peruvian social security system, SIS (*Seguro Integral de Salud*).

The public health-system in Peru is, as explained in chapter two, based on two social security health-systems, the EsSalud (*Seguro Social de Salud*) and the SIS (*Seguro Integral de Salud*). SIS is a health-insurance programme targets the 'poor and vulnerable' that provides healthcare at health-centres and health-posts (Rousseau, 2007). It is interesting though, that being 'poor' was never a concept my interlocutors used to describe themselves. This can be because of the relativity of perceptions of poverty as a state of living (see Broch-Due, 1995a). It is useful to look at poverty discourses to understand how poverty is perceived and evaluated. I will break down definitions of poverty within two contexts: that of the state, and that of the public. Poverty is formally defined by the state as based on *material* economy and access to infrastructural services (such as water and electricity). A poor person is measured by what he/she owns and his/her purchasing power (although the state is also preoccupied about the body in terms of diagnosis and ability to work). For the general public on the other hand, poverty is more about the state of the body. For villagers in Chivay, the physical and mental state of the body was described as defining in terms of 'voluntary' and 'involuntary' poverty.

[20] Especially after the International Conference of Population and Development (ICPD) held in Cairo in 1994.

My point is that to understand how poor people are categorised, measured and evaluated for welfare-benefits, we need to look at how villagers, either laypersons or health-professionals, perceive poverty.

First, let us look at formal definitions of poverty. For the Peruvian State, poverty is defined by socioeconomic levels or classes, divided into 'sectors'; from A (highest) to E (lowest). Within this system, a person's 'socioeconomic level' is primarily defined by income (APEIM, 2016:4). Additionally, there are other variables: the educational level of the head of the household, the predominant materials of the household, number of household members, number of bedrooms, and electric equipment such as telephone, computer, refrigerator, freezer, washing machine or microwaves (Bravo, 2012a). When talking about 'the poor', people generally refer to people categorised within sector E or D. Sector E is linked to low levels of education, low quality of housing conditions and access to food, that is, life conditions defining *extreme poverty*. Sector D is defined through higher levels of education and living standards than E, such as better access to water and electricity. Both sectors include housing often deriving from 'land invasions' (unregulated residencies). Such a categorisation defines poverty through private economy. Poverty-definitions by the general public, however, are not strictly reserved to this but more about to the physical or mental state of the body.

In Colca Valley, there was a general agreement that elderly without family or relatives to help them were 'poor' due to their old bodies.[21] Being 'truly poor' then, was connected to the physical state of the body. When explaining who are 'true' beneficiaries of welfare-services, a nurse pointed at a man in a wheelchair (see quote later in the chapter), stating that he was 'obviously' justly qualified for enrolment in welfare programmes. His physical handicap made his welfare benefits legitimate. Thus, to be considered 'poor' is to not be physically able to work. The general public's definitions of poverty, it seems, require *visible* bodily traits or conditions to consider an individual as 'deserving' help from the state. For example, being old or physically incapable to work is contrasted to *los perezosos*, that is, 'the lazy'. Yet, the general public's understanding of poverty is not reserved only to them, but tend to influence health-authorities and caseworkers aiming to verify whether a person is poor or not. In poverty discourse, poverty is, as we have seen in the case of Paulina, often perceived as interrelated to sexuality. Poor women in Peru frequently meet assumptions from health-personnel about 'sexual irresponsibility' and promiscuity (Ewig, 2010). Globally, theories of population growth

[21] Frequently referred to as *los abandonados* (the abandoned)

and family planning have alternated through the last two centuries. Family planning as a solution to poverty goes hand in hand with the belief that poverty derives partly from having too many mouths to feed. As for Paulina, her poverty is by some middle-class villagers portrayed as being reinforced because of her 'irresponsible' individual 'choices' of having too many children.

Poor Enough for Health-Insurance?

Poverty discourses establish certain rules and boundaries for who is considered poor, and what behaviour is perceived as suitable for people within this category. Narratives of the 'deserving' and 'undeserving' poor are prominent in political and development models, but are often criticised for being reductive (see Broch-Due, 1995a). One prominent narrative in Chivay involved the non-governmental organisations (NGOs) that had been operating in Colca Valley in the past. These NGOs provided material and financial support to 'the poor' by administering warm clothing, housing supplies, tools and helping establishing businesses. Most of these NGOs were now long gone, supposedly because of financial issues. According to the narrative however, they had left the poor with a bigger problem than before. They had 'spoiled' villagers like Paulina and made them reliant on NGO-support. The narrative said that NGOs had made people used to *receiving*, giving them 'bad habits' because they did not have to work. In reference to this story, I was frequently told by middle-class people living in Chivay that the state's public beneficiary-systems, such as free health-insurance and food-provision programmes, sometimes did the same.

Narratives such as the one of NGOs, are not uncommon within poverty discourses (Porio, 2003; Escobar, 1995). A frequent argument is that the aid-providers make people used to receiving benefits and that they are 'derailing the ultimate goal of community organising and development' (Porio, 2003:180). Within this line of argument, the NGOs are blamed for making people unable to 'leave' poverty. Similarly, some middle-class professionals in Colca Valley also blamed the new up-and-coming welfare system in Peru for 'producing' welfare cheaters and freeloaders. Among health-personnel and bureaucrats in Colca Valley, this was an issue that almost inevitably accompanied conversations about the *Seguro Integral de Salud* (SIS). I was told that as much as 80 percent of the population in the region have SIS, and that this

'obviously' included many who were not 'actually poor'.[22] This scepticism towards the expanding reach of insurance coverage was generally related to a mistrust in people's moral attitudes to spending public funds. On various occasions, I would be told that these days there are too many people covered by SIS that 'do not really need it'. A nurse shared reflections around this topic:

> It is partly the government's fault. Too many have been given SIS, but they do not need it. People say they are poor and do not have a job and therefor they need SIS. But SIS is just for the old, the actual poor and those with special needs (…) Many [patients] are *rude* [when they arrive at the Centro de Salud and Posta de Salud]. They might bring their SIS-card one day and not the next. I tell them that 'you have to bring the card, because I do not know you'. You see the man there, he needs SIS (a man in a wheelchair passes by and the nurse points at him).

One of the ground ideas in the nurse's speculation is that too many benefits from the state encourage laziness. Being a *perezoso* meant showing lack of will to work, such as the teacher ascribed to Paulina. As laziness is recognised as a bad quality in a person, it was also connected to other negative traits, such as being rude (as the nurse commented above). Descriptions of bad traits were often stated implicitly as a reason for not 'deserving' welfare benefits such as SIS. Such opinions may, or may not, give an idea of general conceptions of 'the poor' as a category in Colca. Nonetheless, claims as this fit into poverty discourse on the definition of 'need'.

In other parts of the world, such as post-communist Hungary, new welfare-regimes backed by the World Bank and IMF included certain assumptions of materialised needs (Haney, 2000). In Hungary, the new welfare system that brought new interpretations of client appeals as signs of individual pathology and defect. In the new welfare-clients were by caseworkers portrayed as different from themselves, as people who 'lie, cheat and steal' (ibid., 2000:65). Like some doctors and nurses in Colca, Hungarian caseworkers envisaged certain ideas of who their clients were and what kind of characteristics implicated certain problems. Socially produced poverty discourses changed in the policy-transition and caseworkers became preoccupied with the material needs and values of their clients. The caseworkers understood only their clients' needs in calculable values instead of attempting to envision how their clients

[22] State records estimate an average of 42,3 percent poverty in the Caylloma region, whereas 10,5 percent are considered extremely poor.

experienced their situation on social and psychological levels (Haney, 2000:64). The clients, on the other hand, experienced their need for social protection as unrecognised, leaving them with a narrow room for manoeuvring

The focus on the possibility of a person being a 'welfare cheat' is not uncommon in poverty discourses. It is linked to the inquiry of who is the 'deserving' and 'undeserving' poor, a classification with a very old history (Katz, 1989). Access to healthcare is within this logic an issue of 'acculturating the poor to the rules of consumerism'. The 'deserving poor', viewed as 'responsible consumers', are contrasted to the 'undeserving poor' who are perceived as 'irresponsible dependents' of the state (Maskovsky, 2000:135–141). Hence, one may observe that in today's consumption-based societies, having a body able to work implies expectations of using it to work and produce, meaning that bodies define if a person is poor. This logic underscores poverty either results from irresponsible choices (such as substance abuse), making you an 'undeserving poor', or due to unfortunate circumstances outside the individual's control (Katz, 1989; Maskovsky, 2000).

Testing for Poverty

A general question within poverty discourse regarding the 'deserving poor' is 'who among the needy *should* be helped?' (Katz, 1989:12).[23] This question is frequently included in goals of distinguishing the genuinely needy from those who were 'able-bodied'. To separate these two groups, health-authorities use means-testing as method. To inscribe to the SIS-system, 'proof' of poverty must be presented. Applying for SIS involves a visit to the office of social affairs at a health-centre, where health-authorities demand copies of an identity card (*DNI*) and electricity bills. Every registered person in the household are covered as long as the means-testing, that is, the systematic 'check-up' on whether or not a person needs the exoneration of healthcare fees, approves the necessity for health-insurance.

The electricity bill provides a household address and serves to determine whether a household has high expenses on electric equipment. As I have explained earlier, socioeconomic income in Peru is determined by income and property. Yet, the paradox of demanding electricity bills to determine a person's poverty status is that in some neighbourhoods, areas and villages,

[23] Debates about the 'undeserving poor' are frequent around the world, see for instance BBCs article on 'The Deserving or Undeserving Poor' (Magazine, 2010).

electricity systems are not always reserved to individual households. Some households do not even have access to electricity at all, or may lack ID-cards. Such ways of testing income are therefore criticised for being inadequate in reflecting the economic reality of poverty (see Ewig, 2010:129-134). Until recently, the ownership of electronic devices has been used as an operational criteria of low purchasing power. Electronic devices have become cheaper and more available in recent years and even a low-income family may own a television and high-tech mobile-phones.

Means-testing in public healthcare has also been criticised for contributing to gendered assumptions of poverty and reproducing stigmatising racialised categorisation of indigenous poor women (Ewig, 2010). Interviews done in the late 1990s show that there was a lack of procedures for determining who are eligible subjects for the health-insurance programme, which left social workers and health-personnel to their own ways of evaluation, such as 'simply looking at them' or evaluating 'personal criteria' (ibid., 2010:131). These evaluations sometimes relied on whether there was a male breadwinner involved, or on the judgement of women's sexual behaviours. A questionnaire would for instance ask detailed questions such as 'age of initiation of sexual relations' and 'type of sexual relations', implying that 'promiscuous' women were less deserving of social benefits (ibid., 2010:133).

Health-Insurance as a Gift

In an analysis of welfare-benefits it is interesting to look perspectives of the gift in relation to development-programmes. In Nustad's (2003) analysis of Norwegian aid he argues that the idea of development implies *tutelage*. Following his analysis, I propose that the relational bond between those who are poor and those who are not is expressed through the state's development-projects and poverty-reduction programmes. There is no such thing as a free gift, Mauss (1999) argued in *the Gift*. A gift creates relations between the person who gives and the one who receives (Nustad, 2003:21). The result of a gift is that the receiver is always in an unclear debt to the giver. Beneficiary gifts, such as free health-insurance, keep some of the same qualities as other gifts. They maintain a relationship. Yet, they are also different in the sense that beneficiary gifts aim to solve a problem: poverty and health. The power of the gift then lies in its capacity of defining whether or not an idea (such as 'who is poor') is true, and restrain other ideas (ibid., 2003).

Understanding welfare as a gift provides an interesting scope in looking at various attitudes towards beneficiaries of SIS. While most people talked about 'welfare cheaters' and those inscribed in SIS who were not qualified, one doctor stated that there are simultaneously individuals outside the SIS-system who could have inscribed (and qualified) as health-beneficiaries. This perspective suggests that it is a poor person's obligation to inscribe him- or herself into the SIS-system. Those who do not take advantage of the insurance-arrangements are viewed as short-term thinkers. 'They are irresponsible,' the doctor told me, referring to the importance of thinking ahead and securing a 'safe' future.

The doctor's statement promotes the individual citizen's duty to seek and receive the helping hand of the state, integrating him- or herself into the society. The individual citizen is then obliged, by what Mauss (1999) calls the obligations and expectations of the gift. These rules imply that 'in principle, every gift is always accepted and even praised' (Mauss, 1999:41). To receive the gift of benefits from the state is important to sustain a relationship between the citizen and the state. To reject it, would be 'to reject the bond of alliance and commonality' (Mauss, 1999:13). Thus, the individual citizen is responsible for obtaining and re-establishing a relationship with the state, and to make the 'correct choices' of establishing the state-citizen-relationship.

It is also possible to understand the doctor's statement in the light of Maskovsky's (2000:135) point that the individual is viewed as a consumer responsible for making the right choices. If he or she fails to get what's needed from the system, 'then it is not the fault of the system but the fault of the consumer, whom must have failed to make the right choice' (Maskovsky, 2000:135). The individualisation of such policy-logic deflects criticism away from the state, by focusing on eliminating state dependency.

Individualised and Gendered Health

The ideas of poverty that exists in public discourse today bears the fruit of poverty-theories developed many decades ago. In the early to mid-nineteenth century, poverty was linked to ideas of inherited qualities within each individual. Similar to the ideas of the relation between 'race' and specific personal qualities (which I address in chapter one and four), poverty was thought to be caused by certain inherited characteristics. Oscar Lewis first coined the concept of 'cultures of poverty' in the 1960s, believing that norms and values that perpetuated poverty would reproduce through generations of poor families, creating a cycle of intergenerational

poverty (Suh & Heise, 2014). Within this logic, the responsibility for their socioeconomic position was placed on the poor themselves. I mention Lewis' theory because similar conceptions to that of 'cultures of poverty' seem to be reproduced in poverty discourses today.

Poverty discourses are, as said earlier, heavily influenced by perceptions on population control and Malthusian understanding of poverty as interlinked with population growth (Ewig, 2010:42). Entangled in taken-for-granted perceptions of poverty, health personnel in Colca Valley tended to take up 'issues' of rural women giving birth to too many children. During pregnancy examinations or even the birth itself, rural women could be told by health-personnel that they should pull themselves together sexually. In what was experienced by women as rude comments or unpleasant scolding, health-personnel implied that giving birth to more than four children was irresponsible. Paulina told me about a meeting she had with a particular midwife. While she had been giving birth to her youngest in a hospital-bed screaming of pain, the midwife had yelled at Paulina saying that she should have known better (and planned) not to get pregnant with yet another child. From the midwife's perspective, Paulina had acted irresponsible on behalf of herself, her family (economy-wise) and the society at large (by contributing to population growth). For Paulina however, this experience was unpleasant and confirmed a rumour of the midwife's bad personality, which was said to be coloured by arrogance and top-down attitudes to indigenous poor women like Paulina.

Similar accounts of aggressive scolding from health-personnel are not uncommon and enters a long tradition of 'racist individualisation' in public healthcare in Peru (Ewig, 2010:155–156). Health-personnel attempt to take responsibility by personally educating women with many children. What probably are health-personnel's well-meaning intentions to train 'ignorant' uneducated indian women, is experienced as stigmatising for the women in question. Poverty discourse and narratives about who *are* poor tend to enforce tensions between middle-class *mestizo* health-personnel and rural indian and/or poor patients (and between health-authorities and beneficiaries). Clothes, language and behaviour provide symbolic markers of identity that can supply a stressed doctor with biased stereotypical information.

In the following, I will move to another important part of Peruvian poverty-related health-policies, which is the notion of nutrition. As health-policies over the years have turned the attention towards malnutrition, poor people's *diet* has become a concern for the state. First, I will provide a short brief on what is understood as 'good' and 'bad' food in Colca Valley, before I follow up by investigating how food also have symbolic values, and how it may serve as an identity-marker in poverty discourse.

‘Good’ and ‘Bad’ Food

Health in the Andes is understood as in correlation to what you eat and drink. There is ‘good’ and ‘bad’ food, categories that are connected to symbolic conceptions of hot and cold (see chapter one for more on Andean understandings of health). An example I found in Colca Valley of ‘cold’ food was lentils (*lentejas*), which is perceived as bad for the digestion on cold days, or during night. Such an idea has long history in the Andes, gradually being mixed with western and biomedical conceptions of food. To prevent catching a cold or influenza, onions, *aji* (chili-pepper) and garlic are considered *antigripales naturales* (natural anti-flu remedies). In addition to hot food and special ingredients, hot liquids are used to prevent or heal illness. Herbal tea (*mate*) is central to healing; made of hot water and a great variety of herbs, such as coca leafs, mũna,[24] cedrón,[25] chachacoma,[26] mint, and oregano. Warm milk is commonly valued for its nutritious advantages for children, while instant coffee is more of a ‘*mestizo* drink’. Hot liquids are especially important during mornings and evenings when the temperature is low. Cold liquids are said to be avoided during winter, but refreshing under the sun. Hot liquid porridges made of quinoa, *kiwicha* (amaranth), or *siete cereales* (seven cereals) serve to balance the body temperature during cold mornings.

In Sumaq Llaqta, the ‘natural’ state of foods are generally equalled to ‘healthy’ and ‘good’ food. Fresh food without artificial additives are commonly understood as the healthiest, especially if it comes directly from nearby *chacras* (fields). ‘Artificial’ food on the other hand, tend to be considered as *not* healthy. ‘Fatty food’ is generally mentioned as damaging for the health because of its ability to generate problems related to obesity, such as ‘fatty’ intestines, weak knees and a general poor body condition.

The ‘unhealthy’ characteristics of fat, sugar and additives are not necessarily linked to the ingredient itself, but to how it is *prepared*. While animal fat is seen as ‘natural’ to the animal body, some frying oils are conceived as ‘chemical’ substances that are processed through industry. ‘Good’ oils are made of plants and promoted as ‘low-fat’, while ‘bad’ oils are chemically produced. The importance of ‘natural’ qualities adds to conceptions of ‘healthy food’ as food made from basic and not prepared through ‘short cuts’. Yet, because ‘healthy

[24] *Minthostachy mollis*, an herb common in the South American Andes. Familiar in Ecuadorian Andes as *tipo*.

[25] *Aloysia citrodora*, a native South American herb. Also called *Hierba Luisa* in Spanish, or Lemon Verbena in English.

[26] *Senecio oreophyton*, an herb native to the North-East of Argentina and the North of Chile.

food' takes many hours to make, several women told me that they often did not have the time. Additionally, some of the nutritious food that has been traditionally consumed in the Andes, such as quinoa and kiwicha, are now too expensive to eat, due to their recent increasing popularity among health-oriented rich consumers in other parts of the world. Quinoa, which was initially refused as 'indian food' by Spanish colonisers, has with scientific 'discoveries' of its nutritional qualities been lifted in status (Gamwell, 2016 see also; García, 2013). Thus, eating 'healthy' every day was said to be an unreachable goal for a working mother.

Symbolic Boundaries of Poverty through Food

In the Andes, food is the source to more than just life, survival and pleasure. Food does also have symbolic values. It may say something about who you are, what labels you receive and what symbolic categories you are placed in (Ødegaard, 1999). Food might be used to express differences and similarities between 'us' and 'them'. The way a meal is prepared, what ingredients are used and how the ingredients are produced give indications to identity. It may be part of processes of reproducing stereotypes of the self and others.

Anthropologists doing research in other parts of the world have been struck by people's contradictory attitudes towards local and commercial foods (Graham, 2003:150). Locally produced food is highly recognised as providing strength and energy, but might on the other hand be object of denigration and shame. Similarly, commercial foods used in status-marking events such as fiestas might also serve as markers of poverty and economic insecurity (ibid.). Food and health are closely interconnected in biology, but also on levels of symbolism and knowledge. The symbolic meaning of food varies according to what kinds of identities and personal qualities are linked to particular kinds of food (Ødegaard, 1999). Food functions as a medium to establish and maintain social relations, contributing to shape subjectivity and to be part of how people experience and present themselves (ibid., 1999:64–65). Through Strathern's (1988) concept of 'personification', Ødegaard argues that specific types of food are given specific characteristics that encompass the people involved. 'Personification' refers to things that people give and receive, and that can be presented as parts of the persons involved, thus 'personifying' relations through transferring qualities and characteristics between individuals. 'Personified' food may thus express contrasts and similarities between human beings. Additionally, food can reproduce boundaries of class and ethnicity. Dichotomies like poor–rich, indian–mestizo, expensive–cheap, homemade–bought, used–new, are all symbolically

linked to food and to ideas of socio-economic status and class (Ødegaard, 1999:62–63). Food is not only important in the reproduction of boundaries between people, but also central in the presentation of the self. A *mestizo* (a person of mixed ancestry) might reinforce her class-belonging by expressing distaste against food usually associated with other socioeconomic categories, thus distancing her- or himself from these categories and re-establishing her/his own belonging. A 'mestizo diet' might be associated with rice, pasta, chicken, bread and butter (*comida criolla*), while an 'indian diet' (*comida andina*) corresponds with food that are easy to cultivate in highland areas, such as potatoes and broad beans. Especially *chuño*, a kind of freeze-dried potato, is linked to the rural highlands. *Chuño* is commonly associated with poverty and rural people, making it a strong line-drawing symbol closely attached to '*indio*' identity, in line with other identity markers, such as dried coca-leaves (ibid., 1999:62-63).

The proverb 'we are what we eat', points to processes of identification interlinking dietary practices and subject formation (Stephenson, 1999:158). A highland diet is above all distinguished by hard physical labour. By eating what you harvest, food itself becomes linked to body physique (Ødegaard, 1999:64). By ingesting too much '*mestizo*-food' there is considered to be a risk of becoming weak and fragile. Through this, food and diet also have the potential to change people. Just as food products, food preparations, hygiene and practices of eating take part in processes of boundary-making (ibid., 1999).

When folk-conceptions of food and health, comprehended within an ethnomedical system, meet biomedical scientific understandings of nutrition and hygiene in development-programmes, there is a tendency of tension between the two medical systems (Baer, 2003:11). In programmes aiming to modernise people's practices of food-consumption and hygiene, 'modern' understanding of food is often considered superior to the 'traditional' (Portugal et al., 2016).[27] To decompose 'modern' conceptions of food and health in hegemonic development discourse, we need to look at the development of nutritional theory within modern science.

Development of Nutritional Theory

The biomedical knowledge of food as we know it today has been gradually developed as nutritional theory since the eighteenth century's discovery of undernourished English soldiers in the Boer war (Lupton, 1996). At the time in Europe, one thought of food as connected to

[27] See chapter one for more on notions of modernity.

social class. For the poor, food was mainly fuel, something necessary for them to be able to work. The governing class in Britain were troubled by the fact that the men who were supposed to defend the British kingdom were not in physical condition to complete the job. Connected to this frustration, scientists started developing nutritional theory that classified nutrients as fat and proteins from their utility values, such as 'fuel' or 'tissue repairment' (Lupton, 1996:69). In addition to understanding food as a source to nutrition and building stones, the increased focus on the microorganisms within food affected the perception of food as a *pathogen*, a source of disease. Through cooking books and different media, one started instructing women how to keep a clean kitchen and to cook food 'scientifically'. In the US, a focus on children's health grew forth, and there began a 'new nutrition' movement. Moral responsibility was placed on the mothers, who were taught to provide the family with a nutritional diet. In the UK, nutritional experts were complaining about the ignorance of the working class. Especially women were blamed for not preparing the 'right' type of food for their families (ibid., 1996:72).

The idea that there was a problem with the whole population's health developed in the nineteenth century. What kind of diet a person followed turned into questions of moral and the capacity of the individual's self-control (ibid., 1996:73). Gradually, as the industry of fast food developed, people's food habits became categorised as 'healthy' or 'unhealthy'. Fast food can on the one hand be understood as an alternative that made it possible for women to combine the role as housewife and working woman. However, the moral responsibility that instructed women to make sure their families ate nutritional food became maybe more difficult to achieve for those in a double role as an active worker and housewife. Through decades it had been presumed that if you follow the 'right' diet, one is guaranteed a long life and good health, while following an 'unhealthy' diet results in diseases such as diabetes, dental diseases and high blood pressure (Lupton, 1996:74). The moral values that frame norms of food consumption and preparation is exemplified in the following section, which shows an inspection at a *comedor popular* and how the *socias* who work there were disciplined into a set of rules and norms that follow the logic of nutritional sciences.

Making a Clean Modern Citizen

As I will explore in chapter four, 'good health' is perceived as correlated to good hygiene. Now, I will discuss how health authorities apply conceptions of health and hygiene into one of PRONAAs (*Programa Nacional de Apoyo Alimentario*) food-programmes, *comedores*

populares (community kitchens). As previously explained, the local government provides the *comedores* basic food supplies (such as rice, beans and lentils) so they can prepare low-priced meals to people like Paulina. As the *Metacentro* referred to in chapter two, four and five, *los comedores* also organise *capacitación*, where the *socias* (volunteering women) and other women from the community are trained and educated in questions of health, nutrition and hygiene. Ødegaard (2006:245) argues that such sessions of educational training aim to transform women into 'modern' and 'urban citizens' based on what is considered women's 'domestic' tasks. Through these programmes women are made targets of 'expert knowledge', which they are thought to absorb and redistribute into their community (Ødegaard, 2006:245). The *comedor* is not only a place for guests eating low-priced meals, it is also an arena for educating women and transforming them through a hygienic cooking regime that complies with hygienic norms of modernity. In *capacitaciones* and inspections there is a strong promotion of 'correct' use and wash of kitchen supplies, and clear separation between food and garbage. The teaching of hygiene-standards is also emphasised in inspections by health-authorities. In the event below, the *comedor popular* was surprised by an unexpected visit from governmental inspectors, who sought to check and potentially correct the *socias*' hygiene standards.

> One day at the *comedor popular* in Sumaq Llaqta, a team of inspectors came unannounced from the Municipality. One of them carried a clipboard and checklist, while another had a camera. The team inspected the kitchen and instructed that the hygiene improved. They referred to garbage maintenance, cleaning of utensils and the personal cleanliness of the *socias*. In the *comedor* kitchen, one of the inspectors pointed at the floor saying: 'the cleaning cannot be like this!' On the floor, there where traces of cooking activities: small bits of paper, potato peel and spilled water from a saucepan. The same inspector looked at Paulina, one of the *socias*, and turned up his nose. 'I see you are not wearing an apron,' he said while taking out a nicely folded apron from the shelves. He unfolded it and stressed how important to was to use it while cooking.
>
> Afterward, there was a short meeting outside the kitchen area. The other *socias* were told that Paulina's hygiene-level was unacceptable in the *comedor*. 'If somebody gets sick [after eating], who is to blame? You would all have been to blame!' the inspector said. Apparently, he referred to Paulina's clothes, hair and skin. Paulina's clothes bore visible stains, something another *socia* explained as due to her lack of access to water at home: 'It is her own fault, she has not taken responsibility and thought about the

> future,' one of the *socias* explained after the inspection. Before they left, the inspectors gathered all the *socias* inside the kitchen for a last reprimand. One of them took pictures of the now freshly swept floor and the clean utensils covered with a kitchen-towel. They would keep showing up on surprise inspections, they said strictly. The *socias* nodded quietly while the inspectors left the building.

It is interesting to note that following the logic of the inspector, using an apron is important due to the idea that it protects the food from contaminating elements deriving from the clothes. His statements consider dirt as a matter out of its *proper* place, as pointed out by Douglas (2002 [1966]). In contemporary societies, the fear of 'germs' revolve around their invisibility. However, interestingly, the inspector's emphasis on the importance of using an apron is not only linked to a fear of germs, it is also connected to what he thinks about the person who is cooking. As I will elaborate on in chapter four, indigenous poor women tend to be conceived and characterised as 'unclean', conclusions drawn from ideas about their clothes, food consumption and 'rural', 'unmodern' practices (Stephenson, 1999). The body functions, perhaps on an unconscious level, as a symbol of broader social relations (Lupton:114). Thus, using an apron is not only to protect the clothes from food stains. For the inspector, the apron serve as a boundary-making shield, that protects the food from the cook.

The camera and the checklist the inspectors brought to the *comedor* can be understood as what Foucault (1979:191) refers to as 'documentary techniques', which serve to make the individual into a 'case'. As a 'case', a person is easier trained, corrected, classified, normalised or excluded (ibid., 1979:191). Such techniques are, in this context, the government's mechanisms of *biopower*, which function to discipline the *socias*. By 'checking' whether certain criteria are met, such as the use of apron or sweeping of floors, the inspectors re-establish the norms of what is perceived as 'healthy'. Inspections as this one follow up on *capacitaciones* in terms of promoting 'healthy' behaviour and discipline (Gastaldo, 1997:113–114).

Much have been written about the relationship between health-authorities and *socias* working at *comedores populares* (see Stensrud, 2006; Schroeder, 2006; Mejía Acosta & Haddad, 2014; Ødegaard, 2006; Portugal et al., 2016). Stensrud (2006) explores how power relations are reproduced and challenged in everyday life. In meetings and educative sessions (*capacitación*), poor women face the manifestation of asymmetrical relationships between them and state representatives (ibid., 2006:254). In a similar event to that presented here, Stensrud describes how *socias* at a *comedor* in Cusco were subject to an un-notified control.

The session made the *socias* nervous for days, talking frequently about how the inspector had been behaving badly by acting strict and rude. In contrast to Stensrud's example of this inspection in Cusco, the inspection in Sumaq Llaqta was not followed by protests towards the inspector's behaviour. One of the *socias* described the critique as justified, because of Paulina's dirty clothes and the unswept kitchen floors. It appeared that some of the *socias* were themselves eager to follow the principles of hygiene that they been taught in *capacitación*.

The Municipality's control of the *comedor* through unannounced visits is part of the mechanisms of control and discipline that follow development-programmes such as the *comedores populares*. Since it is the state who defines the conditions for how the *comedor* shall be run, it can be understood as a form of governmentality, a disciplining form of power based on self-run subjects (Ødegaard, 2006:245). In relation to the previously discussed poverty discourses and ideas of who are poor, I agree with Ødegaard's (2006:244) point that the state's development-projects in the Andes can be understood as a way to 'civilise' Andean women. Similarly argued by Stensrud (2006:262), the state uses *comedores* to implement conditions for relations of gender and power.

Summary

Poverty discourses provide insight in dominant perceptions of poverty and beneficiaries of welfare. This chapter has explored poverty discourse, especially in relation to benefits and development-programmes of the state. We have met Paulina, a poor young mother, in her encounters with certain expectations of who she is and what is needed to improve her situation. I discussed how middle-class professionals interacted with Paulina and her family, and how poverty is defined differently by the state, state-actors and laypeople. I argued that definitions of poverty can be contextual and changing depending on the 'goal', whether it is inscribing to a beneficiary-system like SIS, charity projects or development-programmes like a *comedor popular*. I also looked at how poverty is linked to reproduction and nutrition, in that having many children is considered as a risk for malnutrition. To combat malnutrition, the state organises community-based *comedores*, where voluntary community workers (*socias*) are trained in topics such as hygiene, nutrition and organisation.

Following up on poverty discourses, I will in the next chapter discuss discourses of 'race', class and gender. According to de la Cadena (2000:307–308), 'the Indian race' was conceptualised by Peruvian elites as hereditary backward and underdeveloped, while 'Indians

who did not behave like “sad victims” were “astute liars”’. As we shall see, colonial ideas of ‘the Indian race’ has heavily influenced poverty discourse and how categories of identities are conceptualised.

CHAPTER FOUR

Purifying Andean Femininity

In this chapter I explore how hygiene relates to ideas of gender, 'race', class, reproductive health and family planning. First, I look at a public speech at the Chivay market and focus in depth on how this speech is part of a greater narrative construction of female *indian* Otherness. Exploring the ambiguity of the *chola* identity, I address historical legacies of cultural racism. I move on to look at how notions of hygiene and modernity are historically interrelated in state development projects. These notions are explored in an ethnographic case where Community Agents, as representatives of the rural population of Sumaq Llaqta, are 'trained' through *capacitación*. The event is analysed considering how people are targets of education and transformation.

The Herbalist

It is late March and winter is slowly emerging in the Peruvian highlands. The temperature will soon start to drop at night, but the sun is as fierce as always. 'Soon the water inside the pipes will freeze at night,' people tell me. Most people get up before the sun, thus water is unavailable until the sun peaks out from behind the mountainside and melts the ice. In houses with wood-burning stoves, the heat from the fire offers comfort in the morning. The winter represents the cold and the troubles coming with it. Some of the smallest children have been taken out of school because of pneumonia. The cold, some say, makes the body more receptive to illness.

In schools and playgrounds, teachers and parents try to stop the youngest children from playing with water, which might soak their clothes and give them colds. Although water is understood as a life-giving element, it is also considered possibly dangerous when the temperature drops. At the same time, doctors and other middle-class 'elites' in Colca Valley discuss bad sanitary conditions as a consequence of people avoiding contact with water. Hygiene is a central topic among people living in the small-towns of Colca Valley, as it is not only an element of modernity, discursively constructing and re-constructing boundaries between symbolic categories of race and class, as we shall see in the following event.

> It is Thursday afternoon, and regular market day *feria* in Chivay. As people from other villages have come to sell their products or offer their services, the normally quiet market place is packet with vendors and buyers. Inside the *feria*, an herbalist is standing alongside a table filled with products *in natura*: roots, dried herbs, and branded plastic bags and cans containing medicinal mixtures. There is an audience of approximately 20 adult men and women surrounding him, seemingly listening closely. He is giving a lecture on health, specifically addressing the topic of hygiene. The herbalist is charismatic in his speech and excites his audience with his rhetorical pauses and carefully chosen words. He lifts a thick root up into the air so that everyone can see the thick milky-white liquid resin that seeps out from it and says: 'This is from a woman's [vaginal discharge], which is quite normal'. The resin looks almost like mucus the way it hangs from the thick root. The root itself is approximately ten centimetres in diameter, obviously deriving from a large jungle plant. 'So, my friends (…) As time goes without the woman changing her underwear, or neglects washing herself, the [vaginal] fluid gets darker. In the next step of the process you may see that the colour has become more yellow. This is not a good sign,' he says, holding up toilet paper folded in three, as if made ready for a toilet visit. The paper is buttered with a sticky, coloured and slimy substance.

The performance, including its illustrative objects, is part of a greater narrative of how many, especially those with little or no access to hot water, neglects personal hygiene when the temperature drops. The herbalist emphasises, in an understanding tone, that good hygiene gets more difficult in the cold, but argues that people, particularly women, expose themselves to dangerous diseases because they do not prioritise personal hygiene. In his understanding of poor hygiene, it develops into a state of impurity and his goal is to explain how this 'impurity' is worsening over time. To illustrate the point, he holds up more toilet paper 'samples', each one representing a level of deteriorating impurity.

> 'Look how dirty it [the toilet paper] gets [over time] if she does not wash herself,' he says and adds a short rhetorical break before he continues: 'the impurity becomes not only part of the outsides of the body, but it wanders inwards and makes her dirty on the inside as well.' With an increasingly dramatic voice, the atmosphere grows even more intense and people pay close attention. Toward the end, he raises his hand holding a paper with a highly visible spot in dark red, in strong contrast to the white paper. 'Finally, it develops to CANCER!!' he shouts with a deep and serious voice, as he watches his audience and finishes the last message of his public speech: 'change

> your underwear every day, women! Nobody wants a woman who is filthy on the inside, or what, men?' The men look at each other and at the women present, while they nod and grunt in agreement.

With this last statement, the herbalist endorses the individual responsibility of women to maintain good hygiene. Within this logic, the punishment for bad hygiene is disease; if you get sick it is essentially your own fault.

A Public Discourse of Hygiene

By focusing on hygiene, the herbalist acts upon a discourse in which hygiene is one of the most important aspects of health. Being a salesman at the market, he is a commercial agent dependent on selling his natural remedies to people who prefer his medicinal products instead of, or in addition to, pharmaceuticals. When talking about women in the Colca Valley and their medical challenges, gynaecologists would more often address reproductive issues than the troubles of hygiene. Poor genital hygiene, nonetheless, would be addressed directly as an influential cause of infections, creating problems related to reproduction. A recurrent message was that in a worst-case scenario an infection could cause a pregnant woman to miscarriage. The actors involved in the discourse of hygiene are generally actors of *biomedicine*,[28] such as doctors, gynaecologists and other health-personnel. However, the medical worry of infections as a rural problem was also something that other members of the society picked up in form of gossip. One of my middle-class friends from Lima, who was working in Chivay, once portrayed a stereotypical image of elderly women in Colca; that they wear embroidered wool skirts, *polleras*, which would be dirty and smelly because of infrequent washing. Because 'such women' would sit down in their *chacras* (fields) and urinate under their skirts, the skirts would smell of urine. 'Due to the cold they do not wash [during winter],' my friend explained, asserting that this is just the way it is. Others would emphasise that 'in the villages (*pueblos*), you do not have water [supply network],' expressing that she understood *why* there were low standards of hygiene. These explanations come from people living both in Chivay and Arequipa, whose statements I normally understood as influenced by emphatic (although sometimes demeaning) approaches towards those they saw as 'rural', 'poor', and 'people of the popular masses (*gente de pueblo*). Combining gossip and medical discourses on genital

[28] A term explained in chapter one.

infections, such narratives feed into a general discourse of *andino* identity, which tend to include negative stereotypes, especially of rural *andina* women.

For decades, the state has considered hygiene as an important educational topic in the rural Andes. Hygiene has been set as equivalent to modernity, making it a sign of *desarrollo* (progress). In progressive narratives in Peru (see chapter two), the emphasis on reaching a state of modernity implies leaving 'non-modern' practices behind and replacing them with the ways of modernity. Within the context of health, a modern state of living would (according to Peruvian health-authorities) imply keeping pet animals vaccinated and outside the house, arranging house furniture in ways that facilitates cleaning and separates children's and parents' sleeping area, access to flush toilets and sanitary disposal of garbage (I will come back to these in chapter five).

Women have been actively included and targeted in development programmes and discourses since the late 1970s (Escobar, 1995:155). Emerging as a new field, Women in Development (WID) developed within a framework of 'discovering' that women had been neglected within development interventions (ibid., 1995:13). Over the years, popular notions of 'women are less corrupt than men' and women being 'closer to the earth' have been deployed within development narratives (Cornwall et al., 2007:2). Being both glorified and victimised within narratives of gender and development policies, women are often presented as 'keys' to development issues.[29] In some contexts, women are linked to a presumed 'natural' reliability that feeds into the myth of women as less corruptible than men (ibid., 2007). In Peru, however, the domestic sphere as the core of womanhood is a dominant representation (Stephenson, 1999:59). When employed in development discourses, this representation interlinks womanhood, the domestic, motherhood and family health, providing a hegemonic ground-base for encouraging myths that produce and reproduce a generalised picture of women as keys to, and responsible for, development and modernity.

Why Women?

The herbalist's central message is that a woman might become a source of disease if she is not careful with her personal hygiene. He addresses women and does not even mention men, which is not unusual in discussions about health, where mostly women and children are mentioned as

[29] See for instance the policy report 'Women: the Key to Food Security' (Quisumbing et al., 1995).

subjects of disease. His focus on women brings up questions such as how women are portrayed as obstacles to health and modernity and as subjects in need of transformation.

Within discourses of development, there are obvious paradoxes in the representation of women. On the one hand, women represent a problem for modernity because of their symbolical connection to the 'traditional'. The 'traditional' has a long history of interlinkage with 'backwardness' and as argued by early development theorists, has nothing to contribute to the process of development (Escobar, 1995:78). On the other hand, women represent a solution for issues of health and modernity, because of their essential symbolic interconnection to the home. In both critical studies and popular characterisations of women, notions of the 'biologically fixed' nature of women's reproductive activities link them to the domestic space as if it was the core of womanhood (Stephenson, 1999:59). Thus, the woman is symbolically a key to health and to modernity.

Hygiene is given a specific focus in government development projects, based on the implicit idea that indigenous women are not concerned with hygiene. Stephenson (1999) for instance, examines how the modern state in Bolivia sees indigenous women as dirty, whereas Schroeder (2006) illustrates how women are considered as lacking basic organisational skills, skills which programmes such as community kitchens (*comedores populares*) may provide. By teaching women about hygiene, nutrition, organisation and trade, the idea is that they will take these skills home and use them in other areas of their lives (ibid., 2006:665–666). Providing care for children is often viewed as a woman's responsibility and rarely includes men and fathers. A common idea of a man's responsibility is that he is supposed to provide a stable income and thus an economic base for healthy upbringing.

Public healthcare in Peru has legacies from internal colonialism in the late nineteenth and early twentieth century. Healthcare discourses were linked to broader ideas of national development, such as seeking 'racial improvement' through population growth (Ewig, 2010:33). By raising health and nutritional standards, the Peruvian version of eugenics, *la autogenia*, the authorities sought to improve 'the race' (ibid., 2010:34). European immigration was encouraged by Peruvian elites, so that (specifically white) Europeans would provide the premises for a 'robust internal market'; and by 'civilising' and populating the country in a eugenically 'progressive' matter (Contreras, 2004 cited in Ewig, 2010:35). J. B. Alberdi, a politician in Argentina declared 'to govern is to populate'; explicitly stating a prevalent political idea in Latin America during the late nineteenth century. (Ewig, 2010:35).

In their interconnection to reproduction, women's bodies were defined as physically weak and deficient. Women's social status was affected by the idealisation of them as 'mothers whose sexual honour was to be protected' (Ewig, 2010:34). From doctors' eugenic point of view, women were fundamentally considered as reproducers (with some claiming women were 'akin to cows and just as dirty') (Mannarelli, 1999 cited in Ewig, 2010:34). The hygiene campaigns of the 1910s and 1920s were popular among middle-class and elite Peruvian women, making it important for them to distinguish themselves from 'ordinary', or poor, women (Ewig, 2010). At the time, the medical focus on mothers originated from a scientific medical discourse adopted from France that glorified 'keeping women *in* reproduction' emphasising that women should rear 'their children according to modern medical principles for the good of the country' (ibid., 2010:38). The maternal–child health-programme that was developed in the early twentieth century identified mothers as responsible for infant mortality. The sexual conduct of women was seen as potentially harmful for the health of an unborn child and was one of the issues doctors in the growing public health-system sought to control. Hence, Ewig (2010:38) argues, the individualisation of infant mortality 'drew upon and reinforced gender inequalities (…) Women became intimately responsible for social reproduction, sexually controlled, and blamed for child deaths, while men had sexual freedom and little such responsibility'.

The expanded individualisation of women's problems today, in relation to their own and their children's health, violence and sexuality may also be reinforced by the expansion of mass media. Mass-marketing of pharmaceuticals and 'natural medicine' is present through television, posters, news and social media. Dumit (2012) has mapped the implicit strategy of marketers in the way they approach a person. Presuming that a person lacks knowledge of health and drugs, the first step is to raise awareness through *education*. The second is to *personalise* the risk and to let it become a part of the individual's story (Dumit, 2012:65). The third is to provide motivation to self-diagnose, to go see and convince a doctor and lastly, branded compliance. Health-campaigns, both commercial- and state-related, aim to 'increase knowledge' and to 'motivate change' (Lupton, 1995:108). By constructing a dualism between the civilised and the grotesque, health-promotional campaigns place the responsibility on the individual, 'warning' what will 'happen to *your* body if you are not careful (ibid., 1995:120).

Women in the Andes are frequently conceived as more traditional and more rural than men (Weismantel, 2001; Ewig, 2010; Stephenson, 1999; de la Cadena, 1996). As a binary opposition between tradition and modernity within the hegemonic discourses of gender,

development and health, it is women, not men, who are considered as lacking modernity and are in need of change. The Andean women themselves have various ways of facing such perceptions. In contexts where topics of *machismo*, family violence and women empowerment are central, some of my interlocutors embraced narratives of suppression. For instance, *socias* (volunteers) at the Centre for Women's Emergencies in Chivay would do campaigns and door-to-door visits in smaller villages to question women at their doorstep to find out if there are violence issues in the family. One of the *socias* once told me that because of machismo and alcohol, a lot of women suffer and need to be informed of their rights and possibilities in cases of violence. At the same time, the ideal of female independence of men is strong in the Andes, and women like to give the impression they are independent and better off without men (Stensrud, 2015:114). Maybe because of this, feminist development ideas of female liberation seem attractive to them. However, the acceptance of narratives of oppression are visible through similar statements, which was uttered by one of Stensrud's Peruvian interlocutors: 'Women will never be equal to men. Although you want to be the same as a man, you can't. Society itself does not allow it. The society in which we live is like that' (ibid., 2015:116). This statement concords with narratives of gender and development policy, in which women are portrayed as both heroines and victims:

> Heroic in their capacities for struggle, in the steadfastness with which they carry the burdens of gender disadvantage and in their exercise of autonomy; victims as those with curtailed choices, a triple work burden and on the receiving end of male oppression and violence (Cornwall et al., 2007:3).

Cornwall (2007:3) argues that as 'gender' has been incorporated in development policy and practice, story-lines, fables and myths have been created. 'Myths' in this sense, are narratives that produce an order-of-things that evoke the effective features of values and norms (ibid., 2007:6). What does it mean then, when women embrace this dualism? Imasumaq, one of the women who was working actively in several of the local organisations in Colca, was quite eager in embracing narratives about the need to fight female suppression. In various contexts, she talked about independence and the importance of women standing up for their rights and needs. Through social media, she has positioned herself as a woman *in* empowerment. One way she established this position is by documenting her own participation in development programmes. In one of her posted pictures, she is posing before the camera in her work-clothes while a construction inspector inspects her work. Decorated with the words *las mujeres sí podemos* (we women can do it), she presents herself as young and idealistic. In her self-

presentation, she uses herself as symbolical evidence within a discursive narrative of gender development. She places herself within a category of women who are *going somewhere* in a linear continuation of development (see Bravo, 1990). I will look more into progressive ideas of empowerment and education of women in chapter five, whereas the following paragraph dives into the ambiguity of these rural women.

The Ambiguous Chola

Labels like *indigenous*, *cholo*, or *indio*[30] have historically been detached from 'race'. Especially the term *indian* has a long history in Peru. For example, the identity of the *indio* was attempted changed during the agrarian reform in the mid nineteenth century through substituting the label *indio* with *campesino* in government documents (Klarén, 2000:342). This was part of an extensive set of complex revolutionary reforms, where the Velasco military-government (1968–1975) used the indigenous 'Great Rebellion' leader Túpac Amaru II (1738–1781) as a symbol for his government's 'indigenous nationalism'. Velasco sought to reclaim and integrate the indigenous masses into a unification of a nation (Klarén, 2000:121–122). The 'indian problem' was a highly discussed issue that had emerged in the early nineteenth century alongside debates of Peru's national identity (ibid., 2000:247). In these debates, the longstanding oppression of the indigenous population had been argued to be naturalised into a 'problem of culture'. Yet, in the Velasco-government was an attempt to label the problem of this oppression as a *socioeconomic* problem by now speaking of *campesinos* instead of *indians* (Klarén, 2000:342). However, a change of term does not simply change the content.

This conceptual interlinking between peasants and *indians* is transferable to European conceptions of poverty (and its legacies in previous colonies). Such conceptions of poverty often interlink poverty to a lack of capital and land ownership, thus perceiving peasants, in terms of the landless proletariat, as a 'class' of poor constituted by clear and rigid boundaries (Broch-Due, 1995a:4). Yet, in Peru this interlink and the hierarchies ascribed to it tend to be relative, depending on context and relations in which hierarchies can be expressed. For some of Seligmann's (2004:156) market women interlocutors in Cusco, the *chola* identity was connected to the dresses they wore in festival's and traditional dances, while they in everyday contexts considered themselves *campesinas* (peasants). Many women who work in the marked

[30] See chapter one for an elaboration on the use of racial categories in this thesis.

in Cusco would call themselves *mestizas* rather than *cholas,* although others regularly refer to these market women as *cholas*.[31] The ambiguous nature of these categorisations

In popular imagination, the chola appears in a distinctive hat and an embroidered wool skirt called a *pollera*. She is a market vendor, romanticised in literature as a tranquil element that gives the city a more human face (Weismantel, 2001:xxv). She is a migrant from the highland, and her position is betwixt and between two cultures, the *indian* and the creole (Spanish descendant). Literally, the word *chola* describes a racial category between indian and white and has many demeaning connotations. In some contexts, the word is simply synonymous to *indian* (ibid., 2001:xxxiv-xxxv). In Peruvian colonial and post-colonial literature there are romantic stories of white men's sexual conquest of youthful cholas, who were reckoned as their racial inferiors (ibid., 2001). However, in such literature there are also insinuations of an undesirable necessity for mestizo and creole men to have sex with indian women to prove their manhood and whiteness (Canessa, 2012:248). Not being expected to have liked or initiated it, male sexual desire appears as an erotic power instead of a sensual aesthetic. Meaning the indian woman's body was accessible to creole men, but not the other way around (Canessa, 2012:249).[32] Sexual intercourse became an act of conquest and of the racially defined ideology of *mestizaje* (ibid., 2012:89).

The term *mestizaje* derives from early colonial days and was initially used to address a 'mixed' racial category of the Spanish and the indian in official law (Ødegaard, 2010:13). As a 'product' of the mixture of the conquerors and the conquered,[33] who elsewhere were classified in clearly distinctive ways, the *mestizo* appeared as a threat to this order. *Mestizaje* has later been integrated into nationalistic ideology as something of positive connotations, such as modernisation and development. In the Peruvian context, *mestizaje* is defined as both an 'ideology of the nation-state' and as processes of change in which 'indigenous people redefine their "Indianness" and become *mestizos*' (ibid., 2010:13).

The *chola*-character is ambiguous in popular culture. Sometimes the *chola* is portrayed as having ambitious intentions that results in bodily corruption and urban vice (Weismantel, 2001). Elsewhere, she is depicted through humorous characterisations of a tough and fierce but

[31] Note that also many who consider themselves non-indian and 'part of the world of the Spanish' refer to themselves as *mestizas* (Seligmann, 2004:129).

[32] See Sommer (1991:128).

[33] Often due to rape (Ødegaard, 2010:13).

dumb, backwards and funny-looking woman.[34] Through the mix of fear and frisson, fascination and repulsiveness, the term *chola* holds an ambiguity that racialises market vendors, and redirect attention from women's occupation onto their bodies, which degrades through sexualisation (Weismantel, 2001:xxvii). During spread of AIDS throughout Latin America in the 1990s, there was a popular joke depicting this ambiguity in Andean sexuality: 'Why is there so much AIDS in Brazil and so little in Bolivia? Because the indians are so ugly they don't even have sex with each other' (Canessa, 2012:262).[35] This joke refers to how highland indians of the Andes are by mestizos and creoles perceived as the physical embodiment of a harsh and unforgiving Andean environment (ibid., 2012:262).

Symbolic Boundaries of Poverty through Clothing

Clothing associated with the chola have changed (expanded) from being specifically *polleras* and hats to velour sweat-suit and fleece blankets. In the Colca Valley for instance, female vendors use fleece blankets to warm their bodies. They wrapped the blanket around their lower body and legs, sometimes also as a shawl around the upper body. This is an effective and cheap way of keeping warm but it is specifically associated with *indio* and *chola* identity. On visits to Arequipa, people would comment that I kept warm as I had learned in Colca: 'you look just like a person from *el campo* (the countryside),' they would say, finding it amusing that a foreigner would adopt this practice. This reaction might be interpreted in relation to Stephenson's (1999:6) argument that 'clothing worn by Indians and *cholas* is considered to be, by definition, unclean'. Hence, 'indian clothing' is reserved to people categorised as *cholos*. Additionally, as it is indian women who produce and wear native Andean clothing, they become particularly identified with disease and contagion (ibid., 1999:6). *Cholas* of the market are denoted as 'vulgar' and 'grotesque,' and in Lima, elitist 'intellectuals' like Mario Vargas Llosa see the city as being slowly strangled by highland migrants (Weismantel, 2001:20). The market itself, in addition to the market vendors, is considered by civic leaders to constitute a threat to civil order (ibid., 2001:20).

[34] Such as the character '*la Chola Cachucha'* by a *limeño* (a person from Lima) stand-up comedian: https://www.youtube.com/watch?v=RXdr4nQfIrE

[35] The idea of the asexual indian stands in contrast to how health-personnel refer to people they see as *indios* and *campesinos* (farmers) as reproducing 'like rabbits' (Ewig, 2010:148).

Using Turners' concept of clothing as 'the social skin,' Ødegaard (2016:3) argues that clothing may be understood as a medium communicating ideas of self and other, past and future. Stressing how the ethnic identities of women are situational, negotiated and contextually shifting, Ødegaard (2016:9) illustrates how clothing is used by *contrabandistas* (smugglers) to act upon public officials' conception of them as just 'humble farmer-women' transporting agricultural products from their villages to the city. By dressing up in *polleras*, braids and bowler-hats on their journeys, these women use clothing as a site for dramas of socialisation. Self-presentation as ignorant and humble in encounters with public officials comes to their advantage (ibid., 2016). In poverty discourses, elements such as food, clothing, skin, hygiene, are frequently linked to racial categories. Certain kinds of clothing, such as the *pollera* (embroidered skirt), the *lliqlla* (carrying blanket) and traditional hats, are symbols of tradition and used by individuals as identity markers (ibid., 2016:3). In Colca, lack of heating resources (blankets, warm clothing, stoves) was said to become visible on a person's skin during cold season. Within this logic, chapped skin, especially on hands, feet and cheeks due to the cold are embodied physical markers of poverty.

To my interlocutors in Sumaq Llaqta, however, these physical markers did not necessarily mean that someone was 'poor'. For what is exactly 'poor'? Chopped skin on the hands after daily laundry-routines in cold water did not mean that a person had problems providing food to her children, nor did the use of indigenous hats or *lliqllas*. Yet, *polleras* were not very common among young women under 40. These women mostly used '*mestizo*' clothing from the market, such as pastel-coloured velour pants and cotton jumpers. The types clothing seemingly connected to indian identity have expanded, including 'modern' textiles, such as *polleras* of polyester, velour pants and velour jackets.

In urban areas, native ways of dressing are ridiculed, especially by the young (Ødegaard, 2016:6). Similarities can be observed in Colca, as many reserve their native dress for festive occasions. Those wearing *polleras* on a day-to-day basis tend to be middle-aged or elderly, while the younger generations wear urban *mestizo* clothing. According to Ødegaard, the adoption of new ways of clothing is a way to signalise social mobility, and reflects a 'desire to redefine indigenous identity' (ibid., 2016:6). Clothing is then an active way of realising oneself, in addition to the other objects a person acquires and consumes (ibid, 2016:5). Yet, within the poverty discourse, clothes are material entities that are produced by the 'materiality of the discourse' (Schaanning, 1997:204). There has been a shift in what kinds of clothes are associated with indian identities. However, the 'new' ways of dressing are incorporated in a

network of existing statements, tools and institutions, meaning that the kinds of clothes linked to indigeneity and poverty incorporates also these 'modern' textiles.

Why Cancer?

In a previous section I asked, 'why women' in order to deconstruct a public discourse of hygiene operated by herbalists, among others. Now, it is important to now turn the gaze towards the element of cancer and examine why cancer was the elementary threat in the herbalist's story, and whether cancer symbolically represents something else?

Unfortunately, I was not able to contact the herbalist after the event described earlier. Without knowledge of his thoughts about hygiene, health and cancer, it is only possible to speculate what led behind his educational speech. First, I want to establish a context for his preoccupation with cancer and infections related to bad genital hygiene. In Peru, cervical cancer is the form of cancer that kills most women (Luciani et al., 2013:641; PAHO, 2013). Cervical cancer can develop from the Human papillomavirus (HPV), a sexually infectious disease (WHO, 2016b). Knowing that cervical cancer is caused by a sexually acquired infection with one of certain types of HPV, one of the possible thoughts behind the herbalist's message is that bad genital hygiene is due to transmission of a virus which might cause repeated infections. However, it is also relevant to look at the aspects of the herbalist's message that concern notions of modernity. Concepts of hygiene and modernity have since the late eighteenth century gone hand-in-hand, mutually including each other. An interpretation of the herbalist's message may therefore be that the alternative to proper hygiene is 'backwardness' and illness.

Cancer is probably one of the most feared diseases today, a fear that is strategically used in the marketing of remedies. The common statement is that *risk* of disease should be minimised through a certain kind of lifestyle, diet and remedy consumption. Understanding illnesses as risk implies that by reducing these, you are considered healthier (Dumit, 2012:118). In Peru as in other countries, using risk as sales tactics is not uncommon. Cancer is often used as a specific disease that threatens if you do not follow the commercial's recommendations, such as in this radio commercial for Chinese medicine that campaigned in Peru in 2015:

> Chinese medicine cures [everything]. For all human diseases, there is a cure in Chinese medicine (…) Most people take something that only calms down (*calmar*)

> [the disease] but does not cure (…) [Suddenly] there is a moment when you realise you have stomach cancer.

Firstly, the commercial version of risk is that if you do not use *true* medicine, which in this case is medicine within a Chinese medical system, you can become ill. Thus, the choice of medical system and remedies affects risk. Secondly, the commercial makes use of a biomedical understanding of cancer implying that cancer is precancerous cells or tumours that cause or will cause symptoms, and/or kill (Dumit, 2012:118). This complements an idea that any kind of unwanted substance in the body may cause cancer. Similarly, the herbalist promotes cancer as a dangerous outcome if you (1) do not choose the right medical framework and (2) if you do not get rid of unwanted substances (such as bacteria).

The discourse of hygiene enters a greater context of Peruvian national discourses of modernity, where modernity is objectified as something you may 'obtain' or 'possess'. In Bolivia during the 1920s and 30s, pedagogical manuals for rural coeducation and urban girl's schools would link hygiene, fashion and modernisation through models of consumption (Stephenson, 1999:6). As a way of introducing girls to values of the liberal market economy, schools would have hygiene campaigns where school children would act out trips to the store to buy soap and toothbrush. Such campaigns have a long history in public schools and hospitals. In the colonisation of interior provinces, such as the Amazon, public health-services became an important tool. 'Colonisation… on a scientific basis' would involve an exclusive focus on health-issues from the part of the Ministry of Public Health and Social Assistance (*Minesterio de Salud Pública y Asistencia Social*) (Cueto, 2004 cited in Ewig, 2010:39). Doctors, such as social medicine pioneer Carlos Enrique Paz Soldán, explained that 'the modern coloniser is a hygienist. Without health, there is no lasting possession of the earth' (Paz Soldán cited in Ewig, 2010:38). During the late nineteenth and early twentieth centuries, it was believed that health-interventions in places far away from civilized society could improve the 'racial' and 'moral' life of the country (Ewig, 2010:40). In line with the contemporary racial theories at the time,[36] the *mestizo* was perceived as 'more likely than indigenous peoples to have healthy hygiene

[36] 'Race' was used as a scientific term to assort what was understood as geographically bound racial categories, such as '*el indio*'—'the indian', '*el negro*'—'the negro' and '*el mestizo'*—'the *mestizo'* (mixed ancestry). These categories were connected to specific (but varying between each theorist) traits that could explain conduct, emotions and intellectual capacity. See chapter one and J. Espinosa (1855), M. Paz Soldán (1862) and M.F. Paz Soldán (1853).

habits and to exploit the land rationally' (ibid., 2010:38). Thus, health was connected to racial categories and capacity for production.

Peru has a long history of viewing poor, indigenous, and immigrant groups as carriers of disease (Ewig, 2010:131). The *chola*, as an indian woman, then finds herself within several categories historically recognised of potential carriers of disease. According to this imagery, her transformation into a subject not symbolically carrying disease achieved through cleansing her from problematic parts of the chola identity, streamlining her into a character not out-of-place, but in-its-place.

Purification of Andean Femininity

The *chola* is both cherished as a representation of regional and national culture, and considered a stranger to urban life by Latin American elites (Weismantel, 2001:21). There is an unsettled racial identity that holds the source of the chola's offensiveness (ibid., 2001:45).The market's dirtiness is by elites seen as deriving from the women themselves. If we follow Douglas' (2002 [1966]:3) thoughts on pollution and matter out of place, the existence of the chola market vendor violates 'the ideal order of society' (see also Weismantel, 2001:45-47). Douglas' (2002 [1966]:xvii) argument is that 'classification is at the basis of human coordination', so a rationally organised society requires classifying Pollution is thus produced by the mixing of categories. Cleaning up the categories by streamlining these, making clearer distinctions, is a way of forming a special kind of citizen that fits into a rationally organised society.

One of the ways in which the *chola* might be streamlined, seen from the perspective of scientific medical discourse, is through hygiene. Hygiene may function as an ideological phenomenon. When hygiene is conceived as a concept of modernity, both bodily hygiene and hygiene related to private and public spheres are ideologically relevant. Correct consumption of sanitary products, such as soap, napkins, paper and nappies, is encouraged by medical experts and public officials. This consumption becomes internalised through a discourse of hygiene. A personal experience for me during fieldwork, was to discover that I, as an individual, had internalised discursive norms of hygiene from the Norwegian society. More specifically, it is not enough to *use* and *consume* products of hygiene, it has to be carried out in what is perceived as the right way. One day at the *comedor popular* in Sumaq Llaqta, when I was working with two *socias*, the soap to wash the dishes had run out. I notified one of them, since we used to buy such things ourselves at the closest *tiendita* (small shop). She looked around the kitchen. In the window, there was a plastic bag of laundry detergent, which she gave to me

saying ‘we may use this’. My instinct immediately told me that this was wrong, how can you use soap made to wash *clothes* to do the *dishes*? Obstructed by my own insecurity, I had to convince myself that *soap is soap* before I could pour the powder into the water bowl.

Laundry detergent in a kitchen might be *matter out of place*, but why, when detergent is still soap? An explanation lies in hygiene discourse. Instructions on the detergent-bag instructed that the powder was for laundry, implying that the product was useless elsewhere. The discourse of hygiene makes possible rules of use and the possible ‘punishment’ for breaking the rules.

The discourse that makes the rules for the use of soap, also makes the rules of nappies. Being ‘modern’ products, disposable baby-nappies might be seen as more hygienic than traditional cloth nappies. The plastic and paper, sterile and bleached white, are materials related to modern production and consumption. After one of my interlocutors told me that her baby had got a rash, I noticed that I only saw her changing his disposable *Huggies* nappy two-three times a day. Even on our weekend-trip to her village, she did not bring more than a couple of nappies, added to the two she bought when we got there. Later, nurse Valeria mentioned that plastic nappies have, during later years, become more popular among mothers in Colca Valley:

> [Mothers] around here *no tienen cuidado*. They let their children walk around all day with the same nappy (…) Before, you would use *pañalitos* (cloth nappies). I think that is much healthier with those, especially because you must wash them well.

In a discourse of hygiene, the use of disposable nappies requires a certain kind of practice, such as multiple changes a day and a big consumption of nappies that are thrown away when they are dirty. Dirtiness in terms of defecation means garbage and is not perceived as something that is possible to wash away. Thus, if nappies are used in a way that do not follow the strict regulations of hygiene, then they are not hygienic. Rather, they are viewed as a source of disease and dirt. In the prolongation of clothing, nappies and other sanitary products, such as sanitary pads, might be seen as an extension of the dirtiness of clothing among the ‘poor’.

A middle-class friend of mine in Chivay told me that ‘in the old days, it was considered unhealthy to wash while menstruating, because it might interrupt the cycle’. In addition to other practices and taboos, there were also different rules regarding what to eat during the menstruating cycle. Menstruation is perceived as dirty and taboo in many contexts and as a time-period that requires special care and/or caution. The strong symbolic values of menstrual blood are, like faeces, connected to dirt and to context (that is, in what context does the

menstrual blood appear). In *Blood Magic*, Buckley and Gottlieb (1988:26) follow Douglas (2002 [1966]) arguing that menstrual discharge is 'out of place', breaching the natural boundaries of the body (see also Martin, 1990 for more on imageries of body-boundaries). 'Menstruation blood,' they write, 'is seen as polluting when it symbolically encodes an underlying social-structural ambiguity regarding women and things female' (Buckley & Gottlieb, 1988:28). Thus, menstrual blood on clothing is understood as polluting and in need of greater cleaning processes than if it is on cotton pads, which might be thrown away. The symbolic value of this 'cleaner' option, however, relies on the practical possibility to get rid of the dirtiness before it gets time to 'infect' or 'pollute' the carrier/wearer. In a conversation, a nurse complained to me about women's bad habits concerning changing babies' nappies. Additionally, she expressed resentment about women wearing the same sanitary pad all day. 'They might get a sore or allergies', she said, adding up a general scepticism towards such products. 'They are filled with chemicals. Some people, including myself, use sanitary cloth that I clean (…) Sanitary pads such as Always and Nosotras are not any good, and I use it just in emergency cases'. The nurse, who identified herself as a modern kind of Andean woman, would use herself and her own choices as an example of healthy behaviour. Mixing 'old ways' with hygienic practice, she was never afraid to express criticism towards medical products with flashy brands, such as the bright pink 'Nosotras'.

As we have seen so far, one of the important imageries used in descriptions of the body is that of the 'dirty body'. The imagery of the body as having clear boundaries includes a conceptions of a clear separation of the self and the nonself (Martin, 1990:441). In this, the nonself world is perceived as foreign and hostile. Martin (1990) has for instance analysed metaphors of the body as an expression for nationalist ideologies. Whereas she suggests that body-metaphors used to describe the body scientifically is powerfully linked to features of contemporary societies related to gender, class, and race (ibid., 1990:422). Thus, imageries of the *chola* as a low-class, female indian market vendor can then be closely interlinked with body-metaphors in medical science (and its health-workers) and popular medicine (and actors such as the herbalist).

Health-personnel, such as the mentioned nurse, tended to use their cultural knowledge and assumptions of what they thought were 'common behaviours' among Andean rural women. Generalisations of what defines Andean rural women, are also integrated into standardised sessions of *capacitación* (training). In *capacitación*, issues related to health and their presumed causes (based on cultural knowledge and generalisations), the *capacitadores* (educators), which

in the following section are health-personnel, add their own ideas of who their pupils, their problems, and the needed solutions are into the total mesh of universally produced health-development programmes. This is more specifically addressed in chapter five. However, the following section provides a case of *capacitación* that illustrates the dominating discourses of health, women, Andean family lives and development.

Education in Family Planning and 'Healthy' Homes

One of the most important elements of the *metacentro*-programme is the educational training courses that community agents, and other members of the community, participate in. Such courses, called *capacitación*, are normally one-way oriented from the *capacitadores* (trainers) to the community-members. Someone needs training and someone is in charge of providing the necessary knowledge. In the governmental plans for *metacentro*s there are various programmes where *capacitación* is a tool for development and education, whether it is training of health-personnel, community agents, or other community members. In *capacitaciones*, the Community Agents in Sumaq Llaqta get training in topics like hygiene, nutrition, and healthy habits. They are taught by health-personnel and social workers (1) how to keep a healthy and hygienic home; (2) how to keep a healthy and hygienic body and; (3) how to make certain kinds of choices in family planning and sexual habits. The Agents are expected to implement and pass on these presumably 'new' knowledges and practices in their own families and social relationships.

One day, the Community Agents and myself waited for the *capacitadores*. On the *Metacentro* entrance door there was a hand-written poster: 'training: healthy lifestyle for pregnant women and children and family planning for all young people, youngsters, gentlemen and ladies. At 4pm, do not miss it!'[37] Even though the poster seemingly invited 'everyone' to come, only the Community Agents were present. Two social workers and a midwife eventually arrived to lead the *capacitación*. The midwife sat down on a stool, without greeting anyone present in the room. Although I had not met her before, I was familiar with her notorious reputation as rough and frightening.

[37] '*Capacitación: estilo de vida saludable para gestantes y niños y planificación familiar para todos jovenes, adolescentes, cavalleros, señoras. Las 4.00pm ¡No falta!*'

> Juan Antonio (one of the social workers) started inspecting the *Metacentro*, chatting casually with the Community Agents about the importance of their work. He led them towards two registration-banners that covered two walls.[38] 'These need to be properly filled out,' he said while pointing at the blank space. Only one of the many rows had been filled out with personal health-information of one individual. He fetched a whiteboard marker and explained how the banners should be used as a way to show *how* physical development in children and pregnant women are documented. One of the Agents giggled in the back. He snapped annoyed at another agent who was writing something in her *cuaderno* (checklist-book): 'do not write, now you are going to learn!' he shouted. She quickly closed her book and put it behind her back. 'Here you write the total number of pregnancies,' Juan Antonio explained while pointing at one of the columns. The giggling crowd seemed to annoy him, because he interrupted Rosmery (who always lightens the mood by goofing around) and her giggling whispers to her neighbour. 'Have you been pregnant?' he asked abruptly. 'Yes,' Rosmery answered as she straightened her back in a soldier-like manoeuvre. Her face looked surprised, like a child who had just been scolded, but her manoeuvre revealed hints of the teasing I have seen her doing of health-personnel and other authorities before. 'Okay, have you ever aborted?' he asked. 'No, never,' she answered. 'Then you will write the total number of pregnancies [included possible abortions],' he continued as he pointed at the banner with the whiteboard marker. '*¡Callate tú!*—Shut up!' he suddenly yelled at Ximena, who was giggling because of something Rosmery whispered in her ear.

This kind of playful teasing and giggling might be understood as a way for the Community Agents to question or shake the foundations of the state's development ideology. Goldstein (2003) has in a compelling way treated humour as resistance, as a commentary to political and economic structures of society. Thoughts and feelings that are difficult to communicate publicly might be put forward by humour. Humour can challenge power and express disobedience to authority (Goldstein, 2003:5). In this sense, the giggling at the *capacitación* can be understood as mockery of the project, while the goofing around can be understood as 'acts of insubordination' (Kuldova, 2016:124–125). Yet, an act of insubordination is not always resistance, but may also be 'a considerable price for the momentary satisfaction of symbolically inverting the prevailing order' (ibid., 2016:124–125). Simultaneously, Kuldova argues, by

[38] Chapter two includes templates of these wall-paper tables.

mocking the educated and powerful the game of clientelism is still played because it is pragmatically stupid not to play.

In their ridicule of the registration-banners, which the Agents know that no one else but themselves will see, paradoxes of this development project become visible. The ridicule poses questions of the meaning of this kind of *checklist*, as it is not sent to authorities for evaluation, such as the *cuadernos* (which I will come back to in chapter five). If the authorities do not see these registration-banners, are they as important as the *cuadernos*? Although there was a lot of restlessness among the crowd of agents, nobody explicitly questioned the necessity of the registration-banners. However, considering the way the Agents tried to increase the efficiency of their formal registration tasks, I assume everyone in the room thought about the double amount of document work the banner registration would produce.

After the banner explanation, the midwife suggested that we moved on to the family planning-*capacitación*, which was 'the reason why they were there in the first place'. Benches were placed in front of the midwife, who was ready to start to talk about family planning. She began by saying that there had never been as many pregnancies as that particular year, so it was extremely important that the Community Agents directed people from Sumaq Llaqta to health-centres and health-posts to attend family planning counselling:

> **Midwife**: Family planning is free, regardless of whether the person has SIS[39] or not. Help us by sending people to the *Centro de Salud*. You live here [in Sumaq Llaqta] and you know your neighbours. You know who has *novios* (boyfriends) and who probably needs information about family planning (…) There are both feminine and masculine condoms. Women can take *inyectables* (injectable hormones) that are fabricated chemically, but these are the same hormones as we [women] have in our bodies already. *Es una picadura* (it only a little sting), nothing else (…) There is no *choque* (physical shock) like with an *inyección* (injection).
>
> One of the Community Agents, the only male present, raised his hand to interrupt the midwife with a question.
>
> **Man**: What is the contraceptive method for men?
>
> **Midwife**: Well, [for men] there is the condom and *bisectomía* (vasectomy) which means that you cut (…) under the testicles and stitch it back together. You have to be

[39] *Seguro Integral de Salud* (SIS) is the free health-insurance for the poor that was discussed in chapter three.

> careful [and use other contraceptives] for three months. For the women, there are also the *dispositivo intrauterino*, also called *la T* (intrauterine contraceptive device).
>
> The man raised his hand again.
>
> **Man**: What about natural methods?
>
> The midwife snorted.
>
> **Midwife**: There is no such thing as natural methods to avoid pregnancies. They are not secure. If you already have a child and it does not matter if you get another one, you may do it. But if you have four children it is not [a] secure [method]!'

To my surprise, the midwife brought up a complex and historically uncomfortable topic in the history of Peruvian health-policies: the state's sterilisation campaign in the 1990s. 'People complained afterwards (…) but now you have to go to Arequipa [to get a vasectomy],' she said. Looking slightly uncomfortable, she quickly asked Esmeralda, the other social worker, to take over and talk about nutrition. She had been sitting passively behind the others, following the lecture. Picking up on the speech of the importance of wall-paper tables, she showed the Agents how to fill out the forms that supervise nutritional values for children. Her voice was remarkably calm, a huge contrast to the midwife's loud and resounding voice. The *capacitación* continued with a lecture on how homes should be physically organised:

> **Esmeralda:** Parents and children should sleep in separate rooms to avoid risk of infections and possible transmission of diseases. It is also good for the children to have their own bedroom, because it makes them more independent and less afraid of being alone (…) The parents should have their own bedroom to get privacy (…) There should be a separate room to cook, because you do not want to sleep in the same room as the gas [tank], which may cause asthma (…) It is important to wash hands as often as necessary, [for instance] after a visit to the toilet. Not everyone does this, or what?

Esmeralda's question was asked in a rhetorical tone of voice and received only mumbled answers. '*Exacto* (exactly), very good,' she replied to the inaudible answers. The last part of her speech concerning domestic infrastructure made an impact on Ximena, who some days later proudly showed me how she had refurnished her home according to the advice given at the *capacitación*. Ximena, her husband and two children lived in a house with two rooms, which had been transformed into three rooms after her redecoration. The entrance door and hallway, that gave place to dressers and toy storage, were separated from the sitting and

sleeping area with a curtain that hang from the roof. The two beds that previously were placed together were now drawn apart. 'They told us it was important to not sleep in the same bed, and to keep the furniture away from the wall because of spiders. But the most important is to refurnish once in a while so the spiders do not nest,' she explained. After every capacitación she took the advice very seriously and made sure she could stand as an example before others. After refurnishing, she was the one of all the Community Agents talking the loudest of the importance of 'healthy' homes, a topic I discuss in the following section.

Healthy Homes

Women, as previously noted, are frequently targeted in development projects because of their connection to the domestic sphere, their educational role as mothers, and their responsibility for providing the family with nutritional food. The metacentro health-development programme is an illustrative case for the State's development strategies, as it has a strong focus on women and motherhood. All work related to the *Metacentro* concerns care; of an unborn child, a baby, toddler, youth, or an elderly person in the family. The idea that women are 'natural' caregivers has been criticised as an 'essentialist' view, which means that the caregiving characteristic has been ascribed to women as inherent in being female (Olesen, 1997:398). The idea of women as 'natural' care providers is fundamentally established in Peruvian societies, both in the Andes and among the governing elites in Lima. It influences everything from education and work to the state's development projects. Women are viewed as symbolic 'keys' to society development and social engineering.[40] Therefore, the state's emphasis lies in creating women into a 'certain kind of citizen' (Ødegaard, 2010:180).

The social worker stressed that the parents' and children's sleeping area should be separated to increase the independence of the children, an important value in a 'modernised' or 'developed' society. The emphasis in his lecture was also on the *risk* of disease if adults and children are sharing beds. By referring to *disease*s, he built on the notion of *dirtiness* associated with indian identity, thus seeking to avoid pollution by separating categories such as adults and children. Following Douglas (2002 [1966]), pollution is a source of danger, because it refers to the mixing of categories. Within this logic, adults sleeping in the same room as children is

[40] Scott (1998:91–93) used the concept 'social engineering' to highlight some of the key elements in western scientific mentality, that is the ideal of improving social order through science and technology.

polluting according to 'modern' symbolic structures of categories, but explained through a biomedical lens, in which the notion of dirt is dominated by the knowledge of pathogenic organisms (Douglas, 2002 [1966]:44).

Hygiene has not only been associated with modernity and health, it has also played a part in civilising projects of protestant missionaries. Among Chinese Americans in Chinatown of San Francisco, USA in the late nineteenth century, protestant missionaries saw 'healthy homes' and hygiene as qualities of whiteness and Christianity (Shah, 2005 [1999]). 'Whiteness' was an important symbol for hygiene, for instance through white surfaces in indoor bathrooms. Women were seen as more 'naturally inclined' to maintain a hygienic household than men, and middle-class women identified 'moral purity as a definitive component in their conception of womanhood' (ibid., 2005 [1999]:28). Parallels may be linked to social values in Peruvian middle-class societies that seem to draw similar lines between hygiene and morality, as illustrated by the recommendations by the social worker in the previous example. The nineteenth century medical advice literature, as Shah (2005 [1999]:20) calls 'gendered programmes of care and cultivation of the domestic space', also functioned as preparation of individuals for their essential roles as citizens in the public sphere.

Transformation through Capacitación

Capacitación (training) is common in both state and NGO projects in Peru. Sessions as the one described earlier, where the *capacitadores*' (trainers) emphasise hygiene and contraceptives, are based on a presumption that women in the Andes are ignorant to contraceptive knowledge (see Ødegaard, 2010; Portugal et al., 2016). A 2016 report from the *Instituto de Estudios Peruanos* (IEP) (Portugal et al., 2016:79 my translation) marks the reproduction of hierarchy and inequality through degenerating phrases such as 'perhaps you want that your children become like you?' which are used by the capacitadores (personnel that provides training and knowledge) in the training of rural women:

> 'We are killing their intelligence with malnutrition, they are not going to manage school, the same at the University, where they are going to suffer to get in. Or perhaps you want that they become like you, does somebody want your child to become like you?' she stressed the question and the mothers answered all in a loud choir: '*noo!*' (Observation of health-personnel in Portugal et al., 2016:79, my translation).

An argument relevant to the discussion of *capacitación* is that the state agencies organise them through women's groups in an attempt to make inhabitants into decent' citizens (Ødegaard, 2010:46). Following Foucault' argument that disciplinary power functions as training and creation of individuals, I argue that the use of *capacitación* of Community Agents and other women in the community is an effort from the state agencies to produce a 'proper' type of individual citizen (Foucault, 1979:170). Although the *metacentro*-projects involving this kind of health-training are said (by government-plans) to form a space for exchange of knowledge, the events are not in practice established with a platform that facilitate mutual exchange. As the report from IEP states, in *capacitaciones* there is a visible hierarchic structure of what kind of knowledge that is valued the most and perceived as 'correct'; the knowledge possessed by the *capacitadores* (Portugal et al., 2016). Citizenship is 'more than just the legal status of [a] member of a national political community with certain rights and responsibilities' (Lazar, 2013:3). These facts draw towards a conclusion that training is nonetheless a way for the state to discipline its citizens into the type of citizen that the state prefers.

Summary

In this chapter, I have discussed hegemonic discourses of hygiene, womanhood, 'indianness', and efforts to create transformation through educational training. Opening with a re-narration of an herbalist's speech at a *feria* in Chivay, I looked closely at the racial category known as the *chola*, and general ideas of this category. Looking at the ambiguity connected to the *chola* identity, I especially focused on notions of hygiene, sexuality, and femininity that tend to colour the production of stereotypes of what is a *chola*. Further, I examined how perceptions of the *chola* becomes included in *capacitaciones* (training) arranged by the state, because of the *capacitadores* presumptions of what it implies to live as a poor indigenous woman in a rural environment. Finally, I argued that *capacitación* is a method for transforming the presumed *cholas*, into becoming certain kinds of streamlined citizens in favour of the Peruvian goals of *developing* into a modern society.

The following chapter will follow up on the inquiries regarding the state's efforts to create, or transform, not only the living standards, but the practices and conceptions of health among poor rural indigenous Andeans.

CHAPTER FIVE

Documenting Health?

Poor indigenous women with little formal education are main targets for health-development programmes in Colca Valley. Previously, I have explained and discussed the Peruvian State's social policies on health and poverty issues. I have also exemplified who are perceived as poor, and discussed symbolic identity markers connected to poverty, such as hygiene, disease and reproduction. Following up on the discussion of the educative sessions of *capacitación* (training) from the previous chapter, this chapter focuses on the Community Health Agents in Sumaq Llaqta; Imasumaq, Ximena and Rosmery, who are volunteers from the local community working without contract or formal payment at the *Metacentro.*[41] Except from community-work, these women do not have formal jobs, but work fulltime caring for their children (and other family members) and doing domestic work in their own homes. They frequently involve themselves in community work in other institutions, yet being Community Agents at the *Metacentro* is their official and central role in Sumaq Llaqta. They go through *capacitación* to be trained in topics of 'healthy practices' to gain the knowledge that health-personnel and health-authorities expect the Agents 'passing on' to their families and the community.

This chapter elaborates on two events involving the Community Agents. The first event relates to the Agents' work of mapping health-behaviour, which is carried out through registering health-data from individuals in a door-to-door visit. Following the orders of health-personnel, the Agents use a graphic questionnaire to locate problems of health and health-behaviour in their community. I discuss the use of a questionnaire and checklists as techniques of governance and discipline of not only the other community members, but the Community Agents themselves. The second event concerns a prolonging conflict between the Community Agents and health-personnel about five months' absence of *canastas* (baskets of food and kitchen-supplies), which are given to the Agents on a monthly basis. These *canastas* serve as recognition and 'non-monetary stimuli' for the Agents' work (Minesterio de Salud, 2015:25). By exploring social dynamics and power relations between health-personnel and the

[41] A nickname for *Centro de Promoción y Vigilancia Comunal del Cuidado Integral de la Madre y del Niño* (Centre for Community Promotion and Supervision of General Mother and Child Care).

Community Health Agents, I examine their ambiguous position within the local community as both actors of the state and members of the community.

Through these events, I explore how health is constructed, and problematise whether the focus on 'health' in the *metacentro*-programme could just as well have been on something else. If so, what may this programme achieve if health is not the point? I find that health and health-development programmes do not only serve to reduce malnutrition and create a baseline for better health for rural villagers in the Andes; it also serves to create a certain kind of citizen. In investigating these queries, I apply analytical perspectives on aesthetics and literacy in the Andes following Rama (1996) and Salomon and Niño-Murcia (2011). Looking at documents used by Community Agents, I explore how these are connected to pre-colonial and colonial literacy practices (Salomon & Niño-Murcia, 2011). Arguing that scripts and documents constitute the framework of work and ritual in the Andes, they examine power-relations incorporated in documents by posing inquiries such as 'how does such power get into scripts in the first place? What is it about a text that makes it compelling?' (Salomon & Niño-Murcia, 2011:153). The focus on power further implicates the works of Foucault (1979; 2002 [1972]), especially in the examination of the power of writing. Hierarchic structures continue to be reproduced through asymmetric power-relations within health-development programmes; targeted individuals are sought transformed only on state-terms; additionally, the increasing individualistic approach in development-programmes tend to remove the focus from structural issues and causes to poverty and bad health. Before getting into these discussions, however, I will present the event of the door-to-door visit where the Agents searched for health-problems in Sumaq Llaqta.

The Door-to-Door Visit

One day, the Community Agents had been told by health-authorities to do a door-to-door visit in Sumaq Llaqta. I was allowed to go along, and was told that we were going to ask people some questions and collect ID-numbers from those whose numbers were 'missing' from the *Metacentro's* record. To help them ask relevant questions, the Agents had received a new questionnaire that identified 'problems', which a social worker had briefly explained to them how to use.

> I followed Imasumaq, Ximena and Rosmery through muddy streets looking for signs of people being home. The streets had no formal names or numbers and were poorly

> lit by light-posts on a corner here and there. Rosmery threw a couple of pebbles on a tin-roof of a house that had lights inside. We heard a dog bark on the other side of the adobe-walls, so Rosmery suggested we checked the next house. Imasumaq and Ximena had walked further down the street and stood talking to a woman by her gate. As Rosmery and I went on to the next house, a young woman approached us from the dark street. I immediately noticed her beautiful youthful face. She could not have been more than 17 years old, and carried a baby in a *lliqlla* (blanket) on her back. Apparently pleased with finally running into someone, Rosmery enthusiastically greeted her and explained to her that we were out looking for people who could answer some questions about health. The girl said she was on her way to another village, but it was no problem to answer some questions. Rosmery grabbed a questionnaire from her pocket, but quickly realised that she had no pen. She disappeared into the dark street in which Ximena stood talking with a lady in a doorway, before she returned with a pen. 'Let's see,' Rosmery said, looking at the questionnaire. She led the girl closer to a light-post close-by. 'Hmm, no, this is not relevant' Rosmery said, scanning the questionnaire with her eyes, as if she was looking for something in particular. The girl moved impatiently. Rosmery hurried through some of the questions, repeatedly stopping herself halfway through a question, as if assessing the relevance of it. When one of the questions addressed the topic of suicide, she immediately dismissed it, while apologising to the girl: 'this is of course not relevant for you'. After a while rushing and stumbling through the questions, Rosmery called for Imasumaq to help her understand one of the illustrations. The girl was clearly getting impatient. Imasumaq, who appeared confident in the situation, tried to help Rosmery with the questionnaire. In haste, Rosmery completed the form and said goodbye to the girl, but shortly after realised that the form also had a signature space on the back. Rosmery disappeared in the dark as she ran after the girl to fill in the blanks.

After a while, the Agents and I gathered again. They had filled out the questionnaire for three women and collected ID-numbers from two families that had forgot to bring their ID-card when visiting to the *Metacentro*. They decided we should finish up and return to the 'base'. Back at the *Metacentro*, it was clear that it had been difficult to understand and use the questionnaires. Nobody complained about the form of the questionnaires, but I never saw them use it again. Ximena gave me a questionnaire and explained briefly how it was organised. 'It is about asking people about their health,' she said. In the next section, I will present and try to explain how the Agents and I have interpreted the questionnaire.

Detecting Problems Through a Questionnaire

The Ministry of Health's government plans (2012; 2013; 2014; 2015) contain detailed sketches of activities, responsibilities and documentation at the *Metacentro*, yet, the questionnaire is not mentioned in either of them. It was handed over to the Agents from local health-authorities, who probably had made it themselves. Most of the Agents were reluctant to say anything about the questionnaire, and behaved like it was not a problem to use or understand it. They seemingly repeated what they had been told in *capacitación*, that it was a simple questionnaire about villagers' health. Even Ximena, who had tried to explain how it worked, avoided to elaborate on the topic after giving me a copy of the questionnaire.

Basically, the questionnaire seems to aim to 'locate' problems related to health and social life among members of the local community. There are no specific questions formulated in the questionnaire, only drawings and keywords illustrating specific 'problems'. Nonetheless, the questionnaire's use of drawings and demands for the Agent's personal information can provide detailed knowledge about power-relations between Community Health Agents and the regional health-authorities who have made the questionnaire. Additionally, the childish drawings can say something about how the Agents and other villagers are perceived by health-authorities, and what problems they assume they have. To discuss the meaning and purpose of the questionnaire and how it is connected to other strategies of data-collection, discipline and governance, I will present the copy that I obtained from the *Metacentro*:

Frontside of the questionnaire[42]

FICHA DE REFERENCIA DEL AGENTE COMUNITARIO DE LA SALUD

NOMBRE DEL ACS:.....
MICRORED:.....EESS:.....
LOCALIDAD:.....SECTOR:.....CODIGO:.....FECHA:.....
FAMILIA:.....DOMICILIO:.....DNI:.....

NIÑO (0 a 11 años)	CRED incompleto	Sin vacunas completas	Sin Sulfato ferroso vitamina A	Respira agitado y con ruidos	Tiene diarrea o caquita con sangre	Esta pálido (anemia)
ADOLESCENTE (12 a 17 años)	Sin evaluación integral	Triste, deprimido o ansioso	Enfermedades de transmisión sexual	Sobrepeso – obesidad	Embarazo en adolecente	Ludopatía y otras adiciones
JOVEN (18 a 29 años)	Sin evaluación integral	Triste, deprimido o ansioso	Comportamiento inadecuado	Sobrepeso – obesidad	Enfermedades de transmisión sexual	Sin tamizaje de VIH
GESTANTE Y PUERPERA	Gestante y puérpera sin control	Pérdida de sangre o liquido por la vagina	Hinchazón de pies, manos y cara	Fiebre, dolor de cabeza o calentura	Hinchazón y dolor de mamas	Escalofríos y sangrado con mal olor
ADULTO (30 a 64 años)	Sin Planificación Familiar	Sin despistaje de cáncer (CU-	Hipertensión – dolor de cabeza	Diabetes	Deficiente salud bucal	Sin plan de atención integral
ADULTO MAYOR (65 a mas años)	Hipertensión – dolor de cabeza	Diabetes	Deficiente salud bucal	Catarata	Adulto mayor frágil	Abandono
ENTORNO FISICO	Presencia de chirimachas	Vivienda insalubre (corrales y pircados)	Falta de servicios básicos (agua, Desagüe)	Inadecuada crianza de animales	Perro sin vacunas	Disposición inadecuada de residuos(basura)
PROBLEMAS SOCIALES	Violencia física o Psicológica	Tuberculosis	Alcoholismo drogadicción	Sin SIS u otro seguro	Suicidio	Accidentes de transito
ACTIVIDADES EDUCATIVO COMUNICACIONALES	Participación en capacitaciones	Elaboración y difusión de material educat	Participación marchas y eventos	Sesiones educativas y demostrativas	Participación en campañas de atención Integral	Participación en campañas de limpieza

[42] The questionnaire was given to the Community Health Agents by regional health-authorities.

Backside of the questionnaire

.....desglosable.....

REFERENCIA

NOMBRE DEL PACIENTE REFERIDO: .....

PROBLEMA IDENTIFICADO:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
43	44	45	46	47	48	49	50	51	52	53	54									

NOMBRE Y FIRMA DEL ACS.....

CONTRAREFERENCIA

NOMBRE DEL PACIENTE:.....

DIAGNOSTICO:.....

TRATAMIENTO:.....

INDICACIONES:.....

ACS:.....

Firma del personal de salud

The questionnaire's frontside is designed as a checkered table, divided in categorised rows of questions. Each square contains keywords and a drawing that illustrates the indicated 'problem'. First, there are six age groups containing 'problems' that the Agents are supposed cross out. The first age group is children (0–11 years); the second is adolescents (12–17 years); the third is young adults (18–29 years); the fourth is women who are pregnant or have recently given birth; the fifth is adults (30–64 years) and; the sixth is elderly over 65 years.

Following the age-related issues, there are sections detecting relevant environmental and social problems. The physical environment category mostly contains hygiene-related issued, such as living too close with animals, having unvaccinated dogs, inadequate garbage facilities, lacking pure water and/or flush toilets, and the presence of *chirimacha* insects (triatoma infestans). The next category includes a wide range of 'social problems': physical and/or psychological violence, tuberculosis (risk of contamination), alcohol or drug addiction, being without health-insurance (SIS), and being exposed for a risk of suicide or traffic accidents. Finally, the questionnaire investigates the individual's participation in community-education activities, such as *capacitaciones*, marches and health and hygiene campaigns.

The questionnaire requires personal information from both the Agent and the respondent. On the frontside it asks for 'reference' data for the Agent, while the backside requires personal information of the respondent who is referred to as a *patient*. The Agent cross out the 'identified problems' and sign the sheet. The final section is set up for health-personnel to indicate diagnosis, treatment, explanation and to confirm the name of the Agent. This personal information is interesting, because it is not detailed enough to provide a follow up on the 'patient', which could have been a goal for health-personnel trying to ensure sick person's health. The use of the term *patient* is interesting to look at as a process of *medicalisation*, which refers to how many aspects of everyday life is 'medicalised' in order to 'maintain health' (Lock & Nguyen, 2010:67). The term points to problematic aspects of the relationship between health-authorities and members of the local community, as it facilitates the classification of people as people that needs to be 'fixed' medically. This aspect complement the communication of that community members are *in need* of assistance and help from state-actors.

The Questionnaire's Purpose

A reoccurring question towards the questionnaire concerns *why* health-authorities would want to indicate problems through this kind of survey. From a methodological perspective, the questionnaire is not meant for collecting data to create statistics of health-issues, nor does it facilitate personal visits by health-personnel to individuals indicated to have 'problems'. The first option would have required that the investigation was performed by professional data-collectors who could have provided anonymity for the respondents, a script with more specific questions, and a systematic implementation of the survey. I exclude the second option because of the lack of required personal data for the person in question, who are only required to give her or his first- and surname. Instead, the questionnaire appears to be more about the *agent*.

The Agent carrying out the survey-interview is required to apply personal information and information about the *Metacentro* she is affiliated with. By handing the questionnaires over to regional health-authorities, the Agents record their own activity. The questionnaires may be understood as a way of documenting who is doing her job within a system of discipline (Foucault, 1979). In addition to documenting the agent's work-activities, the questionnaire does something with how respondents and agents understand health and health-behaviour. By using colourful drawings to define 'bad' situations and conditions, the questionnaire functions as an educative tool. Additionally, the Agents are given an opportunity to share knowledge about what is 'bad' and 'good' health-conduct. For example, not having vaccinated the family dog,

or not having access to tap water, are recorded as environmental problems. Through this specification of what is 'normal' and what is not, the power of the questionnaire includes an 'exercise of discipline' (Foucault, 1979:170). The training of the individual targets the Agents conducting the survey, although they are not set to answer the questionnaire themselves. In addition, the questionnaire introduces ideas concerning hygiene and illness for their respondents.

In this act of discipline, there is also a question of literacy, of how Community Agents are comprehended by both regional and national health-authorities. Literacy is not only relevant to projects following ideologies of modernisation, it has a long history in the Andes that is related both to post- and pre-colonial eras.

Discourses of Illiteracy

Since *la conquista* (the conquest) of Andean regions, Spanish colonisers and their successors have stereotyped Andean peoples as 'oral' cultures, and as 'tragic Rousseauian resisters against alphabetic regimentation' (Salomon & Niño-Murcia, 2011:1). The outsider's view of Andean peoples is that they are marginal members of the world of letters, barely consumers of the written word, and at least not producers of it (ibid., 2011:2). As I have discussed in previous chapters, 'illiteracy' has in development discourses routinely been blamed as the reason for rural inequality, as if it is something inhered in the peasant condition. Development institutions such as the Pan American Health Organisation (PAHO) for example, portrays indigenous women as 'triply disadvantaged due to their sex, ethnicity, and rural residency patterns that limit their access to resources' (Cooley, 2008:151).

Literacy, or the lack of it, is often connected to indigenous identities and indigenous languages. In Peru, the state has historically not conceived of indigenous languages as taking part of the nation's alphabetic graphic community (Salomon & Niño-Murcia, 2011:7). Under the first presidency of Belaúnde Terry, he promoted 'alphabetisation' as an economic development strategy.

> Rural Andean villages were and to some degree still are perceived in cities as linguistically and racially stigmatised margin of the transatlantic community of the Roman alphabet. Yet as the independent Republic of Peru took shape after 1825, villagers had already thoroughly internalised the graphic order despite having no schools of their own (Salomon & Niño-Murcia, 2011:10).

Thus, it might be a presupposition among health-authorities that indigenous people are all illiterate to certain degrees. However, the long-lasting idea of *indios* as illiterate latecomers to the bookish world is an oversimplification. As soon as Spain and the papacy sought to reduce *indians* to a regulated peasantry, it also unintentionally made them privy to the scripts and protocols of regulation (Salomon & Niño-Murcia, 2011:10). During colonial times, the Spanish Crown dedicated an enormous amount of resources to higher education, and to the training of *letrados* (Rama, 1996:29). The *letrados* were a 'lettered elite' with close connections to institutions of the state (ibid., 1996:vii). The training was practically reserved the *letrados* alone. In contrast to English colonies in the North, even the Bible was prohibited reading material to commoners in Latin America until the middle of the eighteenth century. This made reading and writing an exclusive and 'sacred' activity in Latin American societies (ibid., 1996:30). Written documents and those managing them have played, and still play, central roles in organisational contexts in Peru. Except from bureaucratic documents and plans implemented in government work, documents are also central in community tasks. In *ayllus* (kinship corporations) and communities, collective tasks such as canal cleaning, cattle branding, or road mending are not considered finished unless they are complemented with a document. Thus, 'the document is coequal part of the social fact, no less than its ritual or its labour', meaning that documents are ritually important in the Andes (ibid., 1996:153).

In relevance to the ethnographic examples, it is interesting to examine who are the *letrados*, and who are not. Who are perceived as *letrados* might as well be relative. To the Community Agents, the health-authorities might represent an educated elite that is concurrently respected and admired at the same time as being perceived as arrogant and ignorant of practical realities in poor rural communities. For the rest of the community, the Community Agents themselves might be conceived as possible *letrados* working with documents before the state. On the other hand, trust in state-officials and the state as an institution responsible for people's well-being tend to be relatively low in Peru. It is also possible that the inhabitants of Sumaq Llaqta perceive the Community Agents as not particularly trustworthy, because they are ambiguously also representing the state.

Checklists

On a weekly basis, the Community Agents register and supervise health-data for children and pregnant women in their community. As explained in chapter two, the *Metacentro* is part of a strategy to contribute to improve health-practices and reduce malnutrition. Through the

Metacentro, the community is supposed to be provided with regular and opportunely health-controls; education in health and healthy practices; and a 'production of favourable community conditions that facilitates an adequate growth and convenient development of boys and girls' (Minesterio de Salud, 2015:6, my translation).

Playing sessions, that is, children who plays with state-provided toys inside the centre, were part of everyday functionalities of the *Metacentro*. Children in the community came by to play, either alone or accompanied by a parent. In addition to the children, mothers and elderly came by from time to time, and were registered in the suitable *cuaderno* (checklist-book) according to the categorisation of the visitor. There were one agent and one *cuaderno* for each category: one for children playing at the *Metacentro*, one for the elderly, one for pregnant women, one for babies, one for toddlers, and one for older children. In the *cuadernos*, the Agents would fill out personal information such as name, address, ID-number and health-details. As mentioned in chapter two, these checklists need to be verified by associated health-personnel and regional authorities in order to confirm that goals are met (Minesterio de Salud, 2012:36).

Each *cuaderno*, which is a regular notebook based on checkered paper, contain hand-made checklists. The plain front-covers were decorated by drawings glued to the front, covered by plastic film to protect the drawings. This decoration is something the Community Agents did to amuse themselves when there were few visitors at the centre. Inside the books, the rectilinear lines separating the information squares were often of the colours red, purple, blue or green. The text inside the squares was written with neatly placed printed letters, always with another colour than the lines, and perfectly placed inside the squares. Filling out the checklists was a time-consuming activity. In days when there was a lot of information to fill in, in addition to making checklist-pages following a specific table template, the Agents complained about the stress and the work-load following the checklists. At one point, I was asked to help them organise new sets of checklist-books by drawing lines and filling out info in one of the books according to a template. Later on, I realised that my work had been 'corrected'. Not having understood the aesthetics of these books, I had messed up their system, using a black marker for lining up *crooked* squares, and writing the text inside the squares in *black*. Without correcting me specifically, I noticed their looks when seeing the result of my 'help'. They later made the sheet I had done anew, this time in its 'correct' aesthetic form: one colour for *straight* lines, and another colour for the text inside the squares.

One day the Community Agents were very proud to have come up with a system that reduced the repetitive work. Ximena, who invented the system, explained that if the paper

sheets were cut in a certain way, the template would stay on the first page, making it possible to turn the pages and fill in new information without also having to fill the template anew. As she explained, I noticed the other women's excitement, so I asked what they thought about the new system. Imasumaq controlled her excitement and nodded discretely, while Rosmery answered for her: 'it is genius and saves us much work!'

Aesthetics of Documents

To the Community Agents, the new checklist system was a way of gaining ownership to a foreign system. By transforming the checklist template by colouring and decorating the *cuadernos* (checklist-books), the *cuadernos* become more 'theirs', and, according to themselves, the system of work was 'perfected'. The Agents reproduced and reconfirmed their ownership of the checklists.

An interesting observation is that the Agents decorated their *cuadernos* similarly to how I had seen school children organise their school books. In learning how to write, school children are instructed to use a variation of colours in order to learn rules of writing.[43] Thus, majuscule letters would be in one colour, dots and periods would be in another colour, and so on. A teacher, who was not from Colca, told me that this teaching technique is more common in rural areas than in the cities. Accordingly, the Community Agents' aesthetic efforts can be perceived as an attempt to act 'educated' the way it is expected in schools. 'The capacity to see (*voir*),' Bourdieu (1984:2) states, is 'a function of the knowledge (*savoir*)'. However, taste operates in a classifying way, as 'social subjects, classified by their classifications, distinguish themselves by the distinctions they make' (ibid., 1984:6). What is considered 'tidy' and 'proper' in the eyes of the authorities might be different for the Community Agents. The power of distinction in the notion of 'taste' functions as a marker of class, and is sometimes actively used by groups to create distance. On the one hand, the 'childish' way of decorating the *cuadernos* can be encouraged by health-authorities organising the *Metacentro*'s office-supplies. On the other hand, the agent's aesthetic taste can be interpreted as a way to appear schooled. The Agents' 'schooled' behaviour can be understood as an attempt to fulfil the expectations of the health-authorities. However, for formally educated health-authorities, the Agents' aesthetic taste can

[43] During my stay in Chivay, I taught English to children in a primary school and could observe and discuss this style of writing with other teachers.

contribute to the reestablishment of them as 'uneducated'. Nonetheless, the relationship between the Agents and health-authorities is not clear, due to vague instructions.

There is no doubt about the time-consumption of the checklists. For the Agents, the aesthetics of the checklists is just as important as the act of filling them out. The agreement between the Agents and the health-authorities is that every month the checklists will be handed in and approved, and the Agents will receive *canastas* (food-baskets) as reward for their efforts. During my stay in Sumaq Llaqta, however, the Agents had not been rewarded for several months, which I will show in the following event.

The Power of Writing

One of the Community Agents' most important work tools are the *cuadernos* (checklist-books), which are used by health-authorities to generate periodic and annual reports. The questionnaire complements the *cuadernos* in the Agents' work of documenting health-behaviour in the community, although it is not mentioned in the MINSA's government plans. A relevant question in the analysis of this documentation process is *how are documents "good to think with"?*[44] Documents, especially in light of power and their connection to their role in socioeconomic hierarchies, can be conceived as formative and defining. Through an analytical lens of the *power of writing*, it makes sense to perceive the checklists and questionnaires as ways of making certain ideas ratifiable. Rama (1996) sees the power of writing as derived from the power of command, meaning that writing is always associated with people of privileged statuses. Words became ratifiable through textual transformation, a process that had to go through a specialist, such as a scribe, notary, or a lawyer (Salomon & Niño-Murcia, 2011:155). An analysis of the process of transforming words into text can potentially be inspired by Latour and Woolgar's deconstruction of how realities are produced in science. The notion of *inscription devices* (explained in chapter one), imply that certain kind of systems serve to transform a material into a new form in a manner that conceals the process of producing the truth (Law, 2004:20). Through an analytic link to Latour's ideas of the production of science, I suggest that the power in documents and scripts lies in that they can establish 'facts' by hiding the process behind the transformation the material. To Latour (1988:155) words are materials of power that may resist or give away similarly to all other materials. Thus, Latour and

[44] A phrase initially coined by Lévi-Strauss in 1962 in his book *Totemism*.

Woolgar's main argument is that 'specific realities are constructed in sets of practices that include particular inscription devices' (Law, 2004:22). To produce a textual script requires additionally some kind of literacy, which can be perceived as the fundamental backdrop of this kind of power.

Furthermore, ideas of what it means to be a person linked to 'poor or extremely poor communities' are defined through documents. Universal plans and models made out on paper is based on presuppositions that there is an objective reality out there waiting to be captured and conceptualised through formal models made by an 'objective' observer (Escobar, 1995:62). These ideas, although symbolic and metaphorical in their form, constitute imaginaries of the Other, of an 'objective' reality of peasant, indigenous, poor communities and families. Rama (1996:29) argues that the *letrados* mentioned earlier in this chapter organised ruling hierarchies through specific articulations of the relationship to power and authorities. By the help of the order of signs, the emerging colonial 'city of letters' was provided with 'laws, regulations, proclamations, certificates, propaganda, and an overarching ideology to sustain and justify the whole' (Rama, 1996:29). These signs were especially important since the Spanish Kingdom, under colonial days, was located so far away. 'Documentary techniques' such as the use of checklists and questionnaires by state-actors serve to make the documented individual into a 'case' that can be trained, corrected, classified, normalised or excluded (Foucault, 1979:191). Documenting individual physical development is a way to make the individual comparable to a 'normal', which is not only about 'normalised health' in terms of physical development. It is also about the individual being 'normalised' in other standards, because as I have shown in previous chapters, health is also connected to personal hygiene, to homes, to what you eat, to what clothes you where, and to your work. The *power of the script* is, however, not only related to the individuals who get documented through checklists. It is also, as I shall discuss in the following section, connected to the Community Agents, as their conceptualisation of health and health practice is influenced by the documents they work with.

The Cultural Construction of 'Health'

As noted, the questionnaire and checklists seems to be more about the Agents than about the inhabitants of Sumaq Llaqta. The government-plans focus on the *metacentro*-programme as a way to reduce malnutrition of babies and toddlers. The checklists are said to be essential in this effort, in the encouragement of women to attend health check-ups and educative sessions. Thus,

the state presents documenting health as an effort to better health, because patients are 'automatically' integrated into a public healthcare system. Through health-documentation, the state can re-establish its connection with citizens that tend to fall outside a public welfare-system due to poverty, discrimination, or lack of (access to) information. Yet, there are more dimensions to be considered. The state's incorporation of patients into their dominant health-system also contributes to shape individual comprehension of health (Lupton, 1995:58-61), as the documents used by community agents define what is 'good' and what is 'bad' health, living-standards, nutrition, and behaviour. The questionnaire provides information of what is 'bad', the *problems* the community has to face collectively, through a community-based programme. The *cuadernos* (checklist-books) establish what is normal through the continuous documentation of data regarding children and pregnant women' physical traits (weight, height, vaccinations, etcetera), thus making the individual into a measurable 'case'. Other checklists, such as the checklist-banners explained in chapter two, serve to make visible this normality in addition to discipline the participants into actually register themselves.

Under the arrangement of 'empowering' the underprivileged poor trough educational activities, the *Metacentro* serve as a tool in community development of public health. Favouring 'community participation', 'community development' and 'community empowerment', such programmes are part of a public health-movement that arose in the 1980s (see chapter two). The use of the term 'community' in 'community development' has been criticised for assuming that a 'community' is a united group sharing the same interests, failing to recognise that 'individuals may be part of many different "communities", depending on the types of subjectivities they favour at the time' (Lupton, 1995:60–61). The differences within the groups are obscured as the term in bureaucratic rhetoric is used synonymously for a 'target group' identified for management. This critique is applicable to the *Metacentro*-programme as it may highlight the state's purposes for it. The state applies 'community development' policies relying upon scientific expertise, emphasising neutrality, yet public health discourse corresponds to other social policy governmental activities. Science and scientific expertise are in Latourian thinking *not* independent of the apparatus that produce information about reality (Law, 2004:31). The paradox in this applies to that neutrality and independence constitute the essence of the scientific project, yet the communication of *neutrality* in community development programmes happens through non-neutral community health agents. In requiring documentation processes in the development programmes, scientific fundamentals are applied, in addition to a top-down organisation of the programmes. Yet, 'community development' also

stress the importance of community participation and decision-making. In relation to the *metacentro*-programme, the paradoxes of colliding political principles become visible in the Agents documentation-activities, in *capacitación* and their ambiguous role within the local community.

The Missing Canastas

'*Me da cólera*—I am furious,' Ximena said to the other Community Agents. We were at the *Metacentro* discussing a lingering situation of outstanding reimbursement from the health-authorities. As pay for their voluntary work at the *Metacentro*, the Agents were supposed to receive *canastas*, baskets of food supplies, once a month. The last months, however, the Agents had not received anything, despite repeated attempts to make health-authorities in Colca accelerate the process of the 'payment'. The Community Agents discussed disappointedly if they should visit the health-authorities one more time.

> 'They say [the *canastas*] will arrive on Wednesday, but they owe us five months already,' Ximena complained. The other agents nodded while staring at the floor. 'I hope they are right,' she added, as if trying to grasp a hope. She did not seem convinced, so Imasumaq, the *presidenta* of the *Metacentro*, tried to cheer her up. 'We should [talk to the social worker] straight away,' Imasumaq said confidently. As *presidenta*, she functioned as contact-person between health-personnel and the *Metacentro*. Yet, Ximena was not convinced and reminded everyone that *señor* Juan Antonio was working that week.

Señor Juan Antonio (a social worker) was commonly referred to by the Community Agents as *el que grita*, meaning 'he who yells'. This was a characteristic that people in Sumaq Llaqta frequently used to criticise state-actors' bad behaviour. His bad temper was well known among the Community Agents, who he had orally reprimanded on various occasions. At one instance, he had got annoyed because of errors they had made in the *cuadernos*, the checklist-books that register health-information. In the discussion of Juan Antonio's potential reaction to their inquiry, they decided to wait another week. This way, they could rather speak to Esmeralda, the other social worker, who was generally considered a nicer person.

Checklist Deficiencies

The following week, I accompanied two of the Community Agents, Imasumaq and Ximena to talk to Esmeralda about the *canastas* (food-baskets). Imasumaq had brought her one-year-old daughter, who she carried on her back in a *lliqlla*, a woven blanket. When we finally arrived Esmeralda's office, she welcomed and placed us in three chairs in front of her desk. 'What may I help you with, ladies?' she asked. Imasumaq and Ximena immediately started to tell her about the missing *canastas*. Esmeralda listened patiently to their frustration, interrupting only with short comments:

> **Esmeralda:** The *cuadernos* [checklist-books] you handed over needed a lot of work. I am registering [the data], but I cannot register at lot of health-information without knowing the ID-number of the person. Repeatedly, I have corrected mistakes [that you have made] (…) so the *cuadernos* were sent [to the regional authorities] a little late (…) Nevertheless, now all information has been sent.
>
> Esmeralda's voice sounded frustrated as she tried to assure them of her work-efforts. Imasumaq interrupted her.
>
> **Imasumaq**: But when we talked to *señora* Patricia at the [authorities' office] she said they did not get documents from you.
>
> Esmeralda glazed out the window from behind her desk and supported her head with her hands.
>
> **Esmeralda**: Patricia makes it difficult. There is always something missing (…) [The regional authorities] do not want to give money. Patricia is formal, she should [rather] say it like this (…) Find solutions. She has not said anything to me about the statistics that are supposed to be presented quarterly. Before it was every month.
>
> Esmeralda shook her head. Imasumaq was quiet for a while, until she took a deep breath and replied.
>
> **Imasumaq**: We have small children and earn nothing. [Patricia] just sits there and gets paid. We really need what we can get, be it money or food. We have been working for *free* until now.
>
> Ximena sat quiet and nodded her head in agreement. Esmeralda stood up from her chair and grabbed one of the blue binders from the shelf behind her.

> **Esmeralda**: I do not know why [the authorities] do not want to give [food baskets]. They always get money (…) Maybe they prioritise differently. Patricia says she did not get the papers, but it is a lie. I always deliver the papers the same day.
>
> Esmeralda turned the pages in the binder as if she was looking for something. Ximena and Imasumaq looked down at their hands. Imasumaq's baby yawned behind her. The sky darkened outside Esmeralda's office.
>
> **Esmeralda**: We're on the wrong foot here. I told Juan Antonio from the beginning that I should take care of everything that has to do with the *Metacentro* (…) you get different messages and it is hard understand them.
>
> For the first time since we arrived at the office, Ximena finally said something. Hope was in her voice.
>
> **Ximena**: *Señor* Juan Antonio said that the Health-Centre could manage the payment, and that we will receive what is owed to us since January in cash [instead of *canastas*].
>
> **Esmeralda**: Bah, that is not right. But it is true that there are deficiencies in the *cuadernos* [checklist-books]. There are several numbers that are not registered
>
> Esmeralda showed us one of the *cuadernos* she had yet not returned to the Agents. The discussion continued like this for yet another hour.

When we left Esmeralda's office, Imasumaq and Ximena seemed partially relieved and confident of her support and explanations. The next day at the *Metacentro*, the frustrated mood had calmed. However, the Agents' trust in the regional health-authorities and their administrational efforts was weakened. Some of the Agents even said that working at the *Metacentro* was not worth the time when they were not compensated as promised. It was still uncertain if they ever would receive the *canastas*, so Imasumaq said she would revisit Patricia at the regional authorities' office. '[Patricia] wanted to send an inspection to the *Metacentro*. *Viva es*—she is clever,' Imasumaq said, determined for a rematch.

Contrasting Perceptions and Expectations of Documents

The event described above depicts a longer conflict between the Community Agents and the local and regional health-authorities. From the authorities' point of view, the checklists provide data used in periodic and annual reports (Minesterio de Salud, 2015:20). Such reports constitute

parts of a global system of development policies, where institutions such as the World Bank (as explained in chapter two) line out universal models of development that emphasise the importance of *measuring* and *documenting*. Peruvian health-authorities operate within a discursive framework that values the production of health-data. This skill requires knowledge that the 'professionals' at these institutions have acquired through years of formal education, practical training and experience in their respective workplaces.

What seems most important from the Community Agents' point of view, on the other hand, is the *way* the documents should be filled out. From an analytical point of view, the Agents have embraced the health-authorities' emphasis of a *proper* filling out the *cuadernos*. The registration of ID-numbers is essential to this 'correctness'. However, acquiring ID-numbers is not unproblematic. Today, there are still some who do not have an ID-card, especially among elderly and in rural communities. The main reason for people's reluctance towards stating personal information, however, was mistrust. Lack of trust in authorities have, as I have elaborated on in chapter two, long historic roots in Peru. In addition to the intensive sterilisation campaigns in the mid-1990s (Lerner, 2011), Peru also has a history of mass violence in the internal armed conflict, which reached its extreme in the late 1980s to early 1990s. Suspicion and violence towards civilians were extreme in rural areas, however, the Arequipa region was spared, supposedly because of the Shining Path guerrilla leader Abimael Guzmán's family connections to the city of Arequipa. [45]

Trust is not only an issue between patients and health-personnel, it is also an underlying concern in the relationship between Community Agents and health-authorities. Just as the Agents are being criticised for the content of their *cuadernos*, they too express suspicion towards the health-authorities' apparent lack of order. During the meeting, issues of contradicting messages are specifically addressed as a problem. It is also not clear what the Agents may expect as compensation for their work. In the initial agreement between them and the authorities, they were supposed to receive *canastas*, as illustrated by the following picture from a 2015 government plan (Minesterio de Salud, 2015:27):

[45] See for instance Degregori (2012) for further reading.

Community health agents and health-personnel with canastas at a metacentro in Ancash[46]

In the government's 'reinforcement plan' from 2015 (Minesterio de Salud, 2015:25), it is specifically stated that there should be an increase in the frequency of recognition and non-monetary stimuli for community agents. The focus on this kind of stimuli has increased between the 2012 and 2015 government plans, implying that it might be a general experience that such stimuli is important for the men and women who volunteer as community agents. Thus, the framework for the Agents' voluntary unpaid labour is changing, also within the development of government plans.

The miscommunication between the Community Agents and social workers is exemplified through Ximena's complaint of Juan Antonio's reassurance that the Agents would be monetary compensated by the Health-Centre itself, a statement Esmeralda denied during the meeting. Catching Juan Antonio in a lie increased the Agents' lack of trust in him. Being 'yelled at' was frequently mentioned in descriptions of encounters between 'non-professional' workers (or patients with low socioeconomic status) and professional health-personnel (including social workers). Among the Community Agents, there were repeatedly told stories about health-personnel's scolding and ridicule. Rosmery once described an unpleasant visit to the social worker's office:

> [*Señor* Juan Antonio] scares me. If he is not pleased with your work, he yells. Rosmery was yelled at because she had not written [the checklist data] well enough. 'What am I to do with this?' he said [to us]. 'I cannot read the name, you have to figure out who

[46] The picture is taken from the 2015 *Metacentro* plan (Minesterio de Salud, 2015:27).

> this is.' Then he said that if we worked a bit harder we might get some extra pens (…) What does a pen cost, fifty centimos?[47]

At the time, the Agents laughed of the idea of 'extra pens' as a reward for their work efforts. As Rosmery specifically comments, pens are not expensive, nor are they personally very important to the Agents. Put in contrast to food supplies or money, pens are in this context portrayed as irrelevant payment for the work and energy the Agents invert at the *Metacentro*. The time they spent doing *metacentro*-work, would take up several hours of the afternoon. On occasion, the Agents would complain about everything they had to do during a day, and how meeting the expectations from their family, social relationships, and the state (through personal bureaucratic errands) was very difficult while at the same time fulfil voluntary 'obligations'.

Rosmery rejected the unpleasantness of the visit through ridiculing Juan Antonio's suggestion that the Agents should be paid in office supplies. From his point of view, however, it could seem that workers who are not paid at all would be happy for even small rewards. To the Community Agents, however, Juan Antonio's suggestion signalised a lack of valuation of their work. Coming back to Mauss' (1999) main arguments discussed in chapter three, it seems that the work the Agents invest and *give* to the state is part of a relation that requires some sort of gift in return. The reward the Agents receive as a 'thank you', says something about how the Agent's work is valued. In suggesting *pens*, Juan Antonio then express that the Agents are rather poorly valued, in contrast to what the Agents have been told to expect.

To further explore the *canasta* event, I will elucidate the purposes of the *cuadernos* (checklist-books), and how they are understood and used by the Community Agents. As explained in chapter two, this kind of knowledge distribution-tactics is based on the idea of using community development workers who live and work in rural areas to pass on knowledge and skills to local populations (Standing & Chowdhury, 2008:2097–2098). However, as a community worker becomes an actor for the state and its health-system, *ambiguity* in terms of relations, responsibility and financing tends to become an issue. I will discuss this in the following section.

[47] 0.15 USD

Ambiguity

The Peruvian State's use of community health agents prompts inquiries of how they are positioned in society. 'Are they community or health system agents?' is a central question that prods the topic of ambiguity (Standing & Chowdhury, 2008:2098). The name *community health agent* implies that the individual is working for the community. It also refers to that the individual *represents* the community. Simultaneously, a *community agent* is also a representative for the state. Thus, the Community Agents face several alternatives in how to position themselves, something that potentially evoke ambiguity. This ambiguity concerns how they are perceived in their local community, how they are perceived by health-personnel and how they perceive themselves. Eventually, a dilemma rises: to whom do they answer to?

In terms of work, the Community Agents do not work formally for a salary, but they do have an employer and a contract. Returning to Weeks (2011:7–8) (see chapter two), work is something that every individual is expected to do. It is a 'social convention and disciplinary apparatus', meaning that economic outcome of work is not the only logic of work. The Agents' employer is the state, represented by regional and local health-authorities. By working in community projects, these women take part in a relation that forms them into 'disciplined individuals, governable subjects, worthy citizens, and responsible family members' (ibid., 2011:8). As ambiguously representatives of the state, the Agents also represent a specific biomedical perspective on health. The state's use of community-based health-development programmes has yet another aspect, which is that the state seek to produce a rational, active, responsible citizen that acts in ways that ensure the citizen's productive capacity. By avoiding loss of manpower in labour because of sick-days off work, the improvement of Peruvian health can also ideologically legitimise that the state spends its resources on public health-promotion (Lupton, 1995:62). The kind of citizen that the Peruvian State seeks to form is that of a healthy, clean, streamlined manageable individual. The state and state-actors attempt to promote a specific kind of self through shaping of discourses, activities and engagement of 'community' participation. The state's efforts in the *metacentro*-programme is not only about health or malnutrition, but effectively about changing community-members of Sumaq Llaqta. The health-development discourse dominated by the state assumes a 'free subject' who can choose between a number of actions (ibid., 1995:61). Yet, it also constructs a duality of the state on the one hand, providing according to the 'needs' of Peruvian citizen, yet on the other hand the state tell its citizens their needs.

The Agents understand themselves as important contributors to health in their community. They *know* that malnutrition and bad health is a problem in poor neighbourhoods, especially in rural areas, because they have experienced it and seen it themselves. As mothers, they express a feeling of responsibility for doing something for the future generations. Yet, my ethnography indicates that their local knowledge is not sufficiently appreciated in the *metacentro*-programme. In the *capacitación* in chapter four, the midwife stresses the importance of the Agent's knowledge of who needs information about contraceptives. However, in many encounters between Agents and health-personnel, the Agents' *lack* of knowledge was provided explicit attention. Rather, the relationship between agents and health-authorities was characterised by a strong hierarchy. Health-personnel tend to take for granted that they have 'true' knowledge, and that the Agents need to 'update' their knowledge. This goes against what has been manifested in the government plans (described in chapter two) where 'exchanging' knowledge between people from the community and health-personnel is stressed as essential.

In this chapter, we have seen this disconnection between plan and practices manifest itself through how the Community Agents made huge efforts to make the *cuadernos* (checklist-books) neat and correct. Stensrud (2006:256) has described how women in *comedores populares* fear that the authorities responsible for the *comedor* would punish them if the documents containing information about accounts, storage and meeting protocols were not properly in order. The consequence of errors was feared to be critical for the *comedor*, as the authorities had the power to stop food-contributions from the state, or close down the *comedor* (Stensrud, 2006:256). Similarly, the Community Agents in Sumaq Llaqta feared that local health-authorities would stop the monthly *canasta*-rewards. However, when this first happened and the Agents realised that even though they had followed instructions given by health-authorities they were still refused *canastas*, they suspected a misuse of power. After a while, when the Agents saw that the problem was not about them but the communication between local and regional health-authorities, they acted and went into confrontation.

Another aspect of this hierarchy is that the Agents are not passive 'receivers' of new knowledge. They reformulate and negotiate what information they share with others in their community. Much of the information was not merely 'passed on' by the Agents. Although Imasumaq on occasion incorporated an instructive attitude, discussions of what practices were 'healthier' than the other where not common at the centre. If we visualise the hierarchy of knowledge as a linear structure where health-authorities are placed on top, the Agents would

be understood as located somewhere in-between the authorities and people from the community. However, it is not absolute that community agents take on the authority to promote health-information, yet if they did, people from the community are not passive listeners and 'receivers' of knowledge. There is no reason not to believe that people evaluate the health-competence of a community agent just as they would for a doctor or a nurse. For instance, the visitors to the *Metacentro* tended to be the same individuals, who were already friendly with the Agents. They might be met with strict requirements and scepticism from their own community, even though the idea is that they have already gained trust from within the community because people know them. Just as this chapter has explored power dynamics and relations between community agents, there is need for more information about how such agents are received and understood within the community.

Summary

This chapter has explored power dimensions of documents, and the hierarchic relations between the Community Agents of Sumaq Llaqta and the health-authorities of the Colca Valley. Constituted of three parts, the chapter first explored how a graphic questionnaire, said to be detecting health-related problems in the community, is actually a way for health-authorities to 'educate' and discipline the Agents. By looking at perspectives of aesthetics and literacy, I explored how these are understood as co-related. In the second part I looked at the event of the missing *canastas*, and how the Agents confronted the health-authorities. Then, I discussed the Agents' ambiguous roles within Sumaq Llaqta, and in relation to health-authorities of the state. Finally, in order to bring up an essential question for understanding the *metacentro*-programme, I discussed how 'health' is not actually the point in the development-programme encompassing the organisation of the Community Agents and the *Metacentro*. Rather, the programme makes use of *documenting techniques* and *inscription devices* that serve to discipline and ratify certain realities, or truths, before the community members, including the Community Agents.

CHAPTER SIX

Governing Rural Health

In this thesis, I have illustrated how health appears in public and formal discourse as an individual and collective condition that implies a certain kind of behaviour, living standard, and food consumption. By looking at development discourses, state-run development programmes, and conceptions of health and poverty in the Colca Valley, I have aimed to illuminate paradoxes in the governing structures in rural Peruvian Andean societies. I have provided ethnography focusing on how certain women are targeted and set to represent the poor, rural, and the indigenous in health-development programmes. Through this focus, I have explored how power in hegemonic discourses on health draw upon the micro-politics of identities. Health-authorities that represent the state tend to follow taken-for-granted perceptions of the identities and needs of the individuals that are exposed to empowerment- and development-strategies. State-actors base their educative strategies on presumptions rather than a humbler approach in interpreting who are in need of training, what they know, and what they perceive as important.

Throughout this thesis, I have drawn largely on Critical Medical Anthropology approaches to the state, gender, development and health. Additionally, the Foucauldian framework of analysis has helped to scrutinise the taken-for-granted ideas of poverty, indigeneity and femininity and the educational activities that the Community Agents are subjected to. The thesis builds on descriptions of historical relations between the state and rural communities, and how these have shaped practices of health. Inspired by literature on global development policies, I have explored how these relations have affected the state's policies and development discourse in Peru. I suggested that the *metacentro*-programme can be understood as a tool to transform indigenous poor women into a certain kind of modern, clean and healthy citizen. Further, the thesis discussed how poverty discourses interacted with how health-authorities understand community health. I explored notions of 'the poor indigenous citizen' and proposed that such an individual does not fit into the ideology of modernity that the Peruvian State seeks to follow.

Through discussions of poverty discourse, the thesis analysed an event where an herbalist held a public speech about the hygiene of rural women. Through an analysis of

historical and contemporary discourse on racial categories, hygiene, gender, class and reproductive health. I argued that identity is expressed and interpreted through physical markers such as clothing, food, skin pigmentation and hygiene. The analytical exploration of discourse provided a base for investigating the state's modernisation projects in the rural Andes. In the comparisons of the *metacentro*-programme, which aims to reduce child malnutrition, and the *comedores populares* (community kitchens), I discussed the use of education to change health-behaviour and standards of living. As we have seen in the presentation of the inspection at the *Comedor Popular* in chapter three, and the *capacitación* at the *Metacentro* in chapter four, health-authorities tend to discipline community volunteers in a top-down manner, in which complicates community contribution and shaping of what is needed, and how to provide public assistance to citizens in rural areas. In an exploration of this top-down approach, I discussed how volunteers, Community Agents in particular, are expected to 'receive' health-knowledge, and redistribute it into the community. Further, I examined the state's ideas of literacy, and its use of documents in the *metacentro*-programme, drawing on Foucauldian and Latourian ideas of modernity and governmentality. By using the power of science, the state makes use of *documentary techniques* as essential mechanisms of discipline towards a goal of creating 'normal' and 'docile' bodies for the state (Mol, 2002:57-58). Drawing on this theoretical framework, I questioned if better health is the *only* goal of health-development programmes, discussing how such programmes also serve to transform the state's most 'inconvenient' inhabitants into streamlined citizens.

The Hegemony of Science in Development Discourse

A central element in ideologies of modernity, and tightly linked to scientific knowledge, is the notion of hygiene. Hygiene was for instance, as I mentioned in chapter four, particularly central in the pedagogical manuals used to 'develop' rural indigenous children in Bolivia during the 1920s–1930s (Stephenson, 1999:6). The ideology of modernity idealises the neutrality in science, which the Enlightenment placed in contrast to superstition (Latour, 1988:7). To measure and document citizens (through *inscription devices*) are central activities in the production of realities within science. The process of transformation of information and knowledge serve to conceal the process of reality-production, so science can appear as independent and definite (Law, 2004). I agree with Latour's point that scientific knowledge of hygiene, food and health is not detached from the social world, but continuously produced by

statements and inscription devices. In the Latourian way of thinking, to be integrated into processes of modernity requires purification. Thus, hygiene is not only about pathogens and bacteria, as it holds symbolic and cosmological qualities that define what may be considered 'modern' or not.

Controlling Female Reproduction

This thesis contributes to academic research on development, the state, healthcare and women. Yet, the elephant in the room that has not been addressed in this thesis, is the absence of men in these development programmes. Although *comedores populares* and *metacentros* are not exclusively for women, and men may participate, it is rare that they do. In a patriarchal society like Peru, men tend not to be linked to the domestic spheres that include cooking and child rearing. In the Colca Valley, I knew of only one man who was registered as a *agente comunitario de salud*, and illustratively, his responsibility was to keep order in the documents. Possibly, his presence at *metacentro* events was perceived by health-authorities to be particularly important communicate that health is also an important topic for men. Yet, to include men in health-development programmes is not highly prioritised in the formal government plans, something that can be explained as an effect of the especial focus on women in development discourse. As I discussed in chapter two, the emphasis on who needs to be targeted in development programmes is linked to *who* is perceived as relevant for improving children's health and nutritional levels. Development discourse tend to draw on a discursive construction of women being disempowered (Kabeer, 2005:13-14). An additional consequence of the lack of focus on men in health-development programmes is that they can be attributes less and less power of definition within domestic spheres, in relation to child rearing. Women's position as 'guardians of the home' is furthermore not subject to change, but rather reinforced and reproduced.

The last two decades, Peru has become a country with an expanding repertoire of political projects of development. Yet, such programmes have been thoroughly criticised for reducing larger structural problems to issues that can be fixed technically, implicating that issues of development, such as gender rights, poverty and health, turns into 'something that is ahistorical, apolitical and decontextualised' (Cornwall et al., 2007:7–8). Bureaucracies tend to 'incorporate information on their own terms, privileging that which fits in with their own views of the world and the shared analytical framework of those within such organisations' (Cornwall

et al., 2007:8). The previously mentioned top-down strategies by health-authorities is affected by the requirements from global institutions, such as the WHO, demand for numbers and documentation. The health-authorities' emphasis on the 'correct' documentation practices at the *Metacentro* through checklists and questionnaires, however, removes the focus on long-term solution to the problems, such as malnutrition. Thus, my analysis of the documentation techniques of the state links back to Scott's (1998:92-93) point that the state's essential project since the Enlightenment has been to map and document in order to perfect the nation and its citizens.

In Critical Medical Anthropology, the increasing formalisation of birth practices is an interesting and important research focus that will be needed in the future. According to Foucault (1981 [1978]), biological life is political, and controlling female reproduction and caretaking provides control of the population. The state's expansion of health-systems serve to collect information about citizens, and establish norms of what is 'normal' and 'pathological'. In the province of Arequipa, there has already been some cases of home-births that has been regarded as 'clandestine' and made headlines and protests in online media (see Palomino, 2016). The formalisation of birth can be said to be a way for the state to automatically introduce new-born citizen into the state system. Scott's (1998) argument on how a modern state counts and organise land and people is a suitable framework for researching this. Additionally, if a person is not born in a hospital, witnessed and documented by medical personnel, the state may possibly not be able to identify the child. Palomina (2016) describes in a blog post how a mother in Majes, a district in Caylloma, Arequipa, went to a hospital to register her baby, who was born at home, and was arrested for kidnapping. For in a world where people depend on documents in order to be identified, every individual who is not connected to a document is possibly dangerous. When people are told that it is illegal or clandestine to give birth at home, what follows is a forced change upon ethnomedical practices of home-births and the indigenous knowledge. The tension between the state's ideologies of modernity and ideologies of indigeneity is central to changes in Peruvian societies, and investigating this tension from below will continue to be central to social anthropologists in the future.

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