“FOR THEIR OWN GOOD”:
AN ETHNOGRAPHY OF HEALTH EXPERIENCE IN THE SOUTHERN PERUVIAN ANDES

An Undergraduate Honors Thesis

Presented by

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ABSTRACT

Title: **"For Their Own Good": An Ethnography of Health Experience in the Southern Peruvian Andes**
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This paper is an ethnographic analysis of the systems of health care and control in the Nuñoa district, a rural agro-pastoral community in the Southern Andes of Peru. Located in a remote area at 4000m above sea level, Nuñoa has a complex history of inequality and poverty which manifests today in a variety of ways including poor health. In this thesis, I outline the resources available in this pluralistic health system, most notably national social assistance programs focused on supporting women and infant health and nutrition. Care and resources are not evenly distributed across the population. Though there is more access to biomedical health treatment in recent years, an inflated state apparatus controls and limits this access in complex bureaucratic fashion. I use interviews, participant observation, and case studies to provide examples of the local experience with the health clinic, social assistance programs, and social and economic inequality. Central to my thesis is that there is a pattern of surveillance which has evolved in order to contain and manage the conditions of health care, in an effort to perform modernity for the international stage. Building on past work in medical anthropology and medical pluralism in the Andean region, I show that the main problem is a disconnect between the state, those who have the power to create policy, and the families that are affected by these policies and programs.

TABLE OF CONTENTS

Prologue - Getting There

Peru is a place of spectacular ecological diversity. In less than 24 hours it is possible to travel from the jungle, to the high Andes, and down through the desert to the Pacific Ocean. If you actually took this trip, somewhere around halfway through your journey, you would reach the top of one mountain range and drive for miles through scrubby tundra with gold and brown hills and long flat spaces as far as the eye can see. Along the sides of the dirt road you would see grazing sheep, alpacas, and llamas. Clusters of houses dot the slopes. In the distance you might spot a small herd of vicuñas, a wild camelid relative of the alpaca, running away at the first sign of human presence. This place is the Andean Altiplano of Southern Peru, where if you go truly off the beaten path, you will find the town of Nuñoa, in the province of Melgar, at the very north of the department of Puno.

Peru is a very important place for me. The year before starting university in the United States, I moved to Arequipa, the country's second largest city, to learn about Peru, its language, and its cultures. I lived with three different host families, traveled from Chile all the way up the Peruvian coastline to Ecuador, graduated Peruvian high school, and took a semester of Hotel and Tourism at the Universidad Católica Santa María. In June of 2014, I arrived at the Jorge Chavez International Airport in Lima for my sixth visit to the country, excited to finally start the fieldwork that I felt would be the culmination of everything that I had been working towards for my entire undergraduate career.

Traveling to Nuñoa for a foreign first-timer requires a significant amount of gumption and readiness to step away from the typical tourist beat. There is no direct route from Lima to

Nuñoa because of the town's unique, very rural location. My journey took over 10 days because of all of the stop-overs, visits, and slow meandering journeys on both tourist and local buses.

After spending the requisite day and a half in the crowded capital, I eagerly boarded a bus to the southern city of Arequipa - a beautiful place to pause en route to the high Andes. I settled in happily for a 16 hour drive on the top floor of a luxurious double-decker. Floor-to-ceiling windows in the front only increased my excitement to catch the first glimpses of the coastal desert and winding road leading ever upwards to the base of the volcano *el Misti* which dominates the horizon in the city. No one should pass through Arequipa without spending some time basking in the sun and light reflecting off of the *sillar*, the white volcanic rock which dominates the architecture of the historic center and main plaza.

After a few days reconnecting with old friends and mentors in Arequipa and exploring old haunts, I headed to the chaotic area behind the official company bus terminals. Signs on every shopfront and driveway advertised a variety of destinations as close as the beach town of Camaná and as distant as the ancestral Inca capital of Cuzco. Drivers shouted out deals and departure times while grabbing at would-be travelers as they disembarked from taxis or pedi-cabs. Minivans, small tourist buses, and other informal vehicles stood with idling engines and roofs heaped with baggage waiting to reach passenger capacity and start on their lumbering journeys. Despite the arduous journey crowded with numerous buses and vans - not to mention taxis, moto-taxis, and pedicabs - the trip from Lima to Nuñoa, via stops in Arequipa, Puno, Juliaca, and Ayaviri, is filled with some of the most beautiful and scenic places in all of southern Peru.

Most visitors, however, take a shorter route and fly from the capital Lima to Cuzco, spend a day acclimatizing to the altitude, board a long-distance bus bound for the department capital of Puno, and disembark in the Melgar province capital of Ayaviri itself. From Ayaviri it is a quick moto-taxi ride to the zonal terminal where *combis* (small cooperative vans) wait until they have recruited enough passengers to fill the seats and then drive up the newly paved road towards Nuñoa.

There are no schedules. Anxiety has no place here. Everything is on *hora Peruana* and everyone arrives at their destination sooner or later; though it usually ends up being later. On the two-hour, cramped journey to Ayaviri from Juliaca (the region's largest city as well as its principal commercial hub), I was the last passenger to board the small rickety bus. After handing my luggage up to the driver on the roof, who had pulled himself up the ladder to finish loading baggage, I clambered aboard and towards the only open seat, a small space on the bench behind the driver and next to two women headed home from errands in the larger town.

The older woman was dressed in a traditional *pollera.* Her many-layered black skirt was carefully embroidered with colorful designs. She also wore a bright jacket and the ever-present *manta* (felted wool blanket typically worn around the shoulders) on her seat to protect her from any chill or cold. Her daughter, seated across from me, was a young mother dressed in an outfit that no one would look twice at in the United States: bedazzled blue jeans, sneakers, and a pink colored shirt. As I settled myself in and firmly wedged my backpack under the seat, the daughter of the older Quechua woman carefully passed her baby, wrapped in the traditional colorful carrying cloth used for carrying children and goods on their back (*k'eperina* in Quechua), across my legs to her grandmother. The rest of the van was filled with students returning home to visit

their families, municipal or health center workers coming back to work after their time off, and women and men returning with goods from Juliana that cannot be found in a place as remote as Nuñoa.

I realized something felt different from the moment I left the city of Juliaca in the second of four small vans it took to reach Nuñoa. Arequipa and much of the coast is plain desert. The landscape of the altiplano (at 3-4000m above sea level), a treasure of gold, yellow, and brown grasses. Hills and earth contrast beautifully with the brilliant blue sky and puffy white clouds floating above. My face was pressed to the window for the remainder of the drive as we wound up recently asphalted roads, occasionally stopping to let small groups of people in and out of the van in what seemed to be the middle of nowhere. As we approached the town itself, twists in the road and hills gave way to a wide paved space. I looked up to see three large statues of the Suri and Huancayo alpacas (native to the Nuñoa district) towering over the entrance and welcoming visitors to the town. The district proudly calls itself the "*capital mundial y patrimonio de la Alpaca Suri*".

Main road going into Nuñoa (paved as of ~2013)

The history and characteristics of Nuñoa District are similar to many other high-Andean regions. It is a small district, with a population of about 14,000 people. Residents subsist mainly on agriculture and livestock raised in the many tiny surrounding communities out in the *campo*. The *población* ('urban' town or population) region must be differentiated a bit from the *campo* populations (agricultural communities and farmland) because they face slightly different realities and challenges.

Town residents vary ethnically from more *indígeno* to more *mestizo*, depending on birth social status, as well as how they present themselves on the social and economic spectrum. They range from very poor families living in deteriorated adobe houses or properties where they are *cuidantes* (caretakers) for a wealthier owner. Others are shopkeepers who have a more stable income and status. Some are municipal and clinic staff often from outside of the District contracted to the state. There is also the occasional member of an old *hacendado* (rancher) family who appears into town once every month or so to check up on their animals and property holdings.

In contrast, out in the *campo* (the countryside whose population makes up more than half of the total district population) almost everyone lives in organized communities called *comunidades campesinos*, where indigenous traditions are more prominent. Women dress almost exclusively in traditional clothing, *polleras* as well as black bowler hats. They subsist on agro-pastoral production which includes their own animal and horticulture products and the sale of quinoa and cañihua, (cash crops that sell for comparably high prices in national and international markets). Families are rarely able to grow or produce enough basic agricultural products to meet their own consumption needs. However, they periodically sell wool, meat, and livestock to

acopiadores who travel from community to community buying small quantities of goods and then sell in bulk to large merchants or companies in the cities.

This short description of Nuñoa is important as an basic introduction for someone who has not been to or lived there. However, Nuñoa's reality is far more complicated. These generalities are the phenotype that is a manifestation of hundreds of years of history, oppression, class conflict, subjugation, and cultural existence in this remote part of the Andes mountains.

The region was occupied long before European settlers arrived on the continent in Incan and pre-Incan times as an important agricultural and trade town. Nuñoa proudly participated in The Great Rebellion of 1780-1782 (also known as the Túpac Amaru rebellion) in which indigenous groups rebelled against Spanish edicts, the Bourbon reforms of 1776, and laws which were economically taxing for indigenous and mestizo populations (Robins 2002). The rebellion swept across the indigenous and Andean communities. It was championed in the Nuñoa and Melgar area by local hero Huamán Tapara, whose statue on a rearing horse stands tall in a small plaza near the health center.

After the Spanish prevailed in the battle on the altiplano, Nuñoa was subjected to the same decline and devastation that was caused by the Spanish around the New World. The region very quickly became a place of exploitation and extraction of resources, especially of indigenous labor, which caused many of the original inhabitants to flee. Throughout the 18th and 19th centuries Nuñoa was divided between a relatively small number wealthy *hacendado* (rancher) families who owned large tracts of land and grew crops and animals primarily for export. Later, a massive agrarian agricultural reform swept around the countryside in the late 1960s and early

1970s. In this neoliberal reform the government expropriated hacienda lands and placed them in the hands of cooperatives.

More recently (1986-1992), Nuñoa was embroiled in the civil war between the Peruvian state and the terrorist organization *Sendero Luminoso* (Shining Path 1980-2000), which carried out its most vicious battles and attacks in the rural Andean regions around central and southern Peru. (Leatherman & Jernigan 2015). Conditions and stability have improved in this region since Sendero's fall from power. Nonetheless, many historic problems and inequalities persist in this post-conflict era, despite the reforms which have returned land to indigenous communities and brought extensive state, as well as non-governmental, attention and resources to the area.

Despite, or maybe because of its remoteness and complex history, Nuñoa has attracted its fair share of anthropologists. Since the mid 1960s, biological anthropologists have conducted long-term research on the human ecology (Thomas 1976) and biology of high altitude people and their adaptations to multi-stress highland environments (Baker and Little 1976). Others have studied food production, diet, nutrition, and health (Leatherman 1994), and on the health resources in the area (Morse and Stoner, 1986). Nuñoeños are generally tolerant of researchers. They have become accustomed to seeing *gringos* in town or at the old biological anthropology lab doing studies, collecting data, and participating in community events. Some projects lasted for many years on end but the personal connections forged to the people and place of Nuñoa last forever.

Nuñoa as seen from the hills surrounding the population center

In addition to my personal understanding of the history of Nuñoa through research and analysis of documents and local stories, I have also benefited from the knowledge of three generations of North American researchers who have worked in this part of Peru for over four decades. This body of research offers a continuing opportunity to longitudinally track shifting patterns of human and political ecology in a single place.

Before I arrived, I had carefully drafted and composed an extensive proposal for my fieldwork and undergraduate honors thesis. The proposal resulted from innumerable conversations on Nuñoa with my advisor, literature reviews on medical pluralism in the Andes, and my medical anthropology and anthropological theory coursework. My original plan was to focus on the hierarchies of health care in the context of medical pluralism. There have been significant changes in health care since the last study in the 1980s. *Boticas* (a type of pharmacy) have sprung up all over town. More people now attend the local biomedical clinic. I was told that there was less reliance on traditional ways of healing in recent years. My primary worry at this preparation stage was not necessarily the subject matter, but whether I would have enough data by the end of my fieldwork to write an interesting thesis. I need not have been concerned.

I arrived in Nuñoa late on a Saturday afternoon. It was a memorable day. Keiko Fujimori, former congresswoman and daughter of former president of Peru Alberto Fujimori, was rumbling through town with a massive entourage campaigning for a department-level candidate who was a member of her party. Orange flags with a large black "K" for 'Keiko' flew brilliantly in the afternoon sun. The crowd was a blur of orange t-shirts and party paraphernalia. Someone, or various someones, shouted loudly and unintelligibly through a speakerphone on a stage. The crowd cheered in response. The annual wedding season had begun as well and there were

multiple weddings in progress that weekend. Alcohol was flowing freely as men lounged in groups in public areas passing cases of Trujillo, Cristal, or Brahma beer amongst each other.

Aware of the fact that I would immediately be a conspicuous presence in town, I did not linger gawking at the orange mob. Instead I turned and resolutely dragged my suitcase, duffel bag, and a backpack down the stone-cobbled road that led from the terminal towards the river an my lodging. I repeated over and over the instructions I had received, determined to make it on my own without resorting to help from one of the bike-taxis, hovering uncertainly in my peripheral vision.

The straps of my luggage dug into my shoulders. I had over-enthusiastically stuffed them with notebooks, texts on anthropology research theory, a few novels and what I considered to be practical clothing. Staggering down the street, I smiled at the people who stared at me and whispered to each other in doorways. I nodded in what I hoped was an amicable manner towards the heads that suddenly poked out of upper-story windows to ponder my sudden appearance in their town. I had a strong desire to be a "good anthropologist and fieldworker" from the very beginning, whatever that meant. On a general level I had decided that I wanted to be friendly, but not impose. I wanted to be respectful and learn as much as possible, but not badger. One particularly affable elderly woman greeted me with a nod and a "*buenas tardes señorita*" as she swept out the entryway in front of her small store.

Morgan Hoke, a PhD candidate from Northwestern University working on her year-long dissertation fieldwork in the district, had kindly offered to let me stay with her. I eventually arrived at her little house on the river. The house blended into the rest of the adobe-walled buildings on the street. The tin-sheeted door was only marked as different by the long red string

tied to its door handle. Two young children in the neighboring doorway peered out shyly and pulled their newborn puppy back into their yard as I passed by. As the newest gringa in town I was regularly subject to equal parts curiosity and apprehension.

Morgan and I became fast friends. At that point she had been in Nuñoa for 3 months and the feeling of slight isolation that comes with doing solo fieldwork had already begun to set in for her. As a fellow English-speaker and foreigner I was able to sympathize and understand her perspectives and provide an outlet for many of her frustrations that would be unwise or impossible to express to those she was working with. I was thrilled to be the recipient of any and all knowledge she wanted to share. On her part, she was excited to launch into a comprehensive narration of the community and characters in town. This gave me a crash course in events, problems, and personalities that I could only truly appreciate after getting to know them myself over the next few months.

My fieldwork priorities quickly began to change and I realized that I certainly would not lack for data. During the first week of my fieldwork, most of my aforementioned preconceptions and research plans were altered by conversations and events that occurred in those first few days, and continued to occur on a regular basis. My optimistic vision of pastoral life in the *altiplano* was challenged.

Morgan's Nuñoan roommate, Milagros[1], who worked at the town *Municipio*, had just arrived back from Arequipa the same evening I arrived in town. She became the first chapter of my education in Nuñoan life. In typical Peruvian fashion, she was not hesitant at all about gossiping about her perspectives on the town and its inhabitants. The conversations we had over

[1] All names have been changed to pseudonyms to protect identities

the course of my fieldwork were both upsetting and fascinating, occasionally leading to important insights and declarations about class and social relationships that I may not have discovered on my own.

In fact, the first account that shattered my research initial proposal came from Milagros. For the first few days after my arrival, the wedding festivities continued, somewhere out of my sight but certainly not out of hearing. The music and singing echoed up into the clear night skies and bounced off the hills for long after the sun went down, making it nearly impossible to tell which direction they came from. One night, rather late, Milagros and a team from the Municipio were coming back from the province capital of Ayaviri. They had been driving the mayor's pick-up truck, one of the few private vehicles in town, when they came upon a one-man motorcycle accident on the road just after the fork to Santa Sofia. The man had been riding back, without a helmet and intoxicated from the wedding in Nuñoa, when he had lost control, crashed the bike, and died instantly upon hitting his head on the road. Jeanette and the *Municipio* workers called the ambulance from the Nuñoa clinic. There would need to be a mandatory autopsy. When the ambulance, a dilapidated white van manned by a few workers from the Nuñoa *Centro de Salud*, arrived on the scene and found the man dead, they declined to transport him back to the *Centro*. It wasn't their responsibility, they said. There was nothing they could do, and so someone else had to take charge of the deceased man.

Later I discovered that the most frequent use of the ambulances was not to carry sick or injured people to the hospital, but rather to transport clinic teams on their trips to visit rural health outposts, and to use as a place for them to eat lunch away from the supposedly prying eyes of their waiting patients. They did not want a dead body contaminating their lunchroom if it was

not absolutely necessary. My fascination and disbelief at the dysfunctional relationship between the health center and the townspeople had officially begun.

"Why are you here? What are you studying?" These were questions I heard often from people as I introduced myself, or was introduced by common acquaintances around town. The easiest response was that I was studying health systems in Nuñoa. A deluge of horror stories followed about experiences in the local clinic and the local outposts of the national social assistance programs. My fieldwork quickly shifted to prioritizing two areas of investigation. First, what were real people's experiences with sickness and their attempts to access the health center for health care? Second, I wanted to understand their experiences with attempting to fulfill the intensive requirements of a range of "social assistance" programs. This thesis is intended to reveal the unseen problems of health programs and structures that are supposed to serve those Peruvians who have few resources. On a broad level, I intend to provide insights into the everyday reality of what it is to live and fall sick in the *población* of Nuñoa Peru. My hope is that this paper will contribute to improved policies and implementation of social programs that function in the best interests of vulnerable Southern Andean populations.

Questions and Methods

My excitement about anthropology comes from the intensely human interactions and experiences that inform every detail of life. The most compelling aspects of fieldwork cannot be summed up in charts or tables, but rather in narratives and case-studies of real events. My goal is to provide an ethnographically grounded picture of the health care system and related social programs, and the challenges people face in accessing care and assistance.

From June through August 2014 I conducted research in the Andean town of Nuñoa in southern Peru with the population of those living in the town center, surrounding communities. I especially focused on those attending the local biomedical clinic. My goal was to provide an ethnographically grounded picture of the health care system and related social assistance programs, and the challenges people face in accessing care and assistance. I wanted to understand how people navigate systems of health care and assistance, the nature of interactions and experience when seeking care at the local clinics, the common themes and decisions made every day by the people of Nuñoa when they get sick; how they choose where to seek medicine or health care, and whether they even have a choice in the matter. In telling their stories, I take into account the dynamic social interactions and relationships often along axes of race, class, and gender that are the product of the economic, political, and social history of Peru. I created an ethnographically based account detailing how some Nuñoans today are subject to surveillance and controls, but also employ their limited agency to make decisions on where to seek health care for problems ranging from the common flu to culture-bound illnesses.

Hundreds of hours of participant observation and informal interviews and conversations made up the bulk of my observations. I conducted 15 formal full-length interviews with health providers and clinic staff, school officials, women attending the biomedical clinic, a social worker, store owners, market women, and a variety of other town residents as well as residents of surrounding communities in the campo. These sources are complimented by quantitative data from various ministries of the government, the social assistance program employees, the Health Center, and past surveys collected by other researchers.

While I waited to be approved to work in the health center, an endeavor that turned out to be politically charged, I interviewed two elementary school principals, managers of two of the social assistance programs present in town, a social worker involved in the far-flung rural communities, and many mothers who had given birth at the clinic or participated in the government programs. Three of my longer case studies involved hours-long interviews with people who had serious illnesses or long-term contact with the state and biomedical health system in order to understand their experiences navigating basic and higher levels of care.

As with all projects, there were limits to what I could accomplish. I did not delve in depth into the medically pluralistic domains of herbal remedies and folk illnesses. Instead I focused upon people's experience navigating the biomedical and state systems. Initially I experienced some difficulty earning the trust of those I sought to work with, principally those in the health center. It took a great deal of time to enter into any level of confidence with almost every demographic of people. Navigating relationships between social and economic levels of the community was intensely sensitive. Suspicion and an initial tendency towards self-protection remained a pattern with my first interactions and interviews of government and Ministry of Health employees. My status as a young foreign ‘gringa’ woman played a big role in whether I was accepted. It did help that I arrived on the heels of other researchers. However, there were still many difficulties and even some outright conflicts that I had to navigate.

Another hurdle that I faced was managing the shifting nature of my inter-personal relationships on the ground. The boundaries which differentiated formal versus personal relationships were at times so complicated that it seemed as if people could completely change their personalities depending on the particular context or day of our interactions. Initially, every

time I introduced myself to an employee of the state or to a health clinic staff member, our interactions began very formally. The majority of official positions around town were newly formed in the past decade or so, and are typically unstable career paths reliant on frequent contract renewal. Because of this, in order for Nuñoans to maintain a 'bureaucratic' image, they initially acted with a certain level of formality and distance towards me. As time passed I used small *chocolatadas* and invitations for coffee and conversation at our house as part of my methods, and as a way to break down the social barriers which prohibited frank conversation. In fact, it was eventually over these shared meals that I became privy to some of the most open opinions and stories.

For example, over cake, the obstetric team shared their anecdotes of when they first moved to the town, including racist and even eugenicist comments about the local population. One staff member shared how they felt that they had to "civilize and domesticate" the local folk upon arrival because they were so uncultured. Over coffee, one of the social assistance program employees told me that she wished a white *gringo* would come to town to impregnate some local women pregnant so they could change the genetic stock of the place. All of these same people had initially deflected my questions when I first arrived and instead directed me to complete a complex system of paperwork and acquire confusing permissions. They were inventing bureaucratic barriers that did not actually exist.

This fluidity between structure and informality is all-too-often central in the stories of abuse and vindictiveness that clinic patients and beneficiaries face as obstacles in their everyday lives. It was a minor inconvenience for me to have to work through these rules made up by local state and health center employees. However, these same practices cause serious repercussions for

patients and townspeople who are often not able to overcome the barriers to care often arbitrarily thrown into their paths.

This study is generally qualitative. I do not limit my information to quantitative description. Instead, I ethnographically expand on experiences and self-described realities. My own positionality played a major role in the type of information that people were or were not comfortable sharing with me. Thus, much of my analysis requires a degree of self-reflexivity and attention to the impact that my presence and status had on those around me. This is important in order to tell the story of health care in Nuñoa because it allows for the expression of complicated social, cultural, interpersonal, and systemic realities in the community in a descriptive and integrative manner. I weave a general discussion of pluralistic medical systems together with the experiential realities of life, history, and the formal systems of programs and control instituted by the government. My personal experience and the experiences of other researchers and anthropologists who have worked in Nuñoa informs my presentation and my analysis of the vibrancy and intensity of Andean life.

What is Health and Health care in Nuñoa?

The Alma-Ata Declaration of 1978 and the World Health Organization Constitution (45th edition, October 2006) both define health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This serves as a starting point for my analysis. At the same time, it is a broad definition that raises more questions than answers by generalizing terminology without specifying what this level of "complete…well-being" is or how to achieve it. Physical, mental, and social well-being are subjective and cultural notions.

Medical anthropologists attempt to provide some explanations and examples of different visions of when people are healthy, and local culturally-bound definitions of sickness, illness and disease, and their causes and treatments. Blaxter (2004) writes in her book entitled *Health*, "not only [is] a single all-purpose definition of health…impossible, but…attempts to impose one have never been very functional." (page 161)

Whether medical anthropologists study a hospital in the United States or a village in the Amazon, they bring their own notions of the defining characteristics of health and illness. In order to successfully learn about the health and disease patterns of the new environment, we must first realize all of these notions that we carry with us thanks to our personal histories are, for purposes of the new environment, bound to our native culture. In preparation for this research I drew on a number of important articles which cover topics from culture-bound illnesses and access to care, to more discussions of medical pluralism in general, or the co-existence of multiple forms of healing methods (Koss-Chioino et al 2002; Kleinman 1980; Baer 2004; Singer and Baer 1995). Ideas of what constitutes health can vary widely across and within different cultures, societies, economic levels, and even family household traditions. The moment of transition from 'healthy' to 'not healthy' is what orients people towards care and structures of medicine at their most basic levels in society.

Peru has a rich cultural history, reflected in culturally rich health traditions and systems. It is inaccurate to simplify approaches to health in terms of one or two explanations or systems. In the Andes, medical anthropology research has been limited. The first edited collection of works on medicine and health in the Andes region was published by the American Anthropological Association (AAA) and entitled *Health in the Andes* (Bastien and Donahue

1981). In my research, I approached the topic of health and illness through the lens of medical pluralism and the applicable styles of ethno- and home medicine (known as *remedios caceros*) practiced, as well as the use of the biomedical clinic in the town. Ethnomedicine is an anthropological catch-all phrase for folk, cross-cultural, or historically traditional health systems (Williams 2006). In the context of this investigation the term will generally refer to relevant non-'western' forms of treatment. Biomedicine is an approach to health care from a natural science perspective, traditionally involving western and often capitalist ideals (i.e. the ethnomedicine of western cultures). It has been referred to historically in anthropology literature as cosmopolitan medicine in order to avoid the biases inherent in terms like 'western' or 'modern' medicine **(**Leslie 1976; Dunn 1976) though today the term 'biomedicine' is widely accepted. In our globalized world, the growing intersections of biomedicine and ethnomedicine in non-western countries are increasingly relevant to the day-to-day lives of individuals, governments, health care providers, and policy-makers.

During my time in Nuñoa I interviewed many different people on the topic of health and their individual conceptions of illness and treatment. I anticipated some degree of dissonance between my understanding of biomedical treatment, and health care in general, and theirs. However, the overarching concepts of health were straightforward to process. I easily recognized most of the health concerns and symptomatology that were referred to during my conversations and interviews with both townspeople and Nuñoa Centro de Salud staff. What proved more complex was understanding both the local interpretations of these same biomedical labeled health problems and how users navigate the various systems to which they may or may not have access.

The Nuñoa district health clinic is called the *Centro de Salud.* It is the main source of biomedical health care for people in the area. There are also government-run social assistance programs which mandate frequent visits to the health center to keep track of data like height, weight, and hemoglobin (for anemia levels) of children in particular. If families want to receive aid they don't have a choice in the matter. They must visit the clinic and participate in the obligatory periodic "controls" which track the growth of their children and require vaccinations as well as a variety of other health and nutrition interventions. These programs then promote and even compel the regular interaction between biomedical systems of care and many of the poorest members of the community.

In 1986 Lucinda Morse and Bradley Stoner wrote an analysis of primary health care conditions and resources in Nuñoa. At that time, their survey of 1080 patient visits over 9 months in the local clinic revealed that 54% of visits were for preventative, obstetric, and family planning care, 39% were for illness, and 7% were for trauma related incidents. I found that without a close personal relationship with the clinic manager it is much more difficult to obtain comprehensive data and even more difficult to receive permission to observe individual visits in the clinic. Over the course of my research I slowly formed connections with the clinic staff. They gradually began to reveal their experiences as providers, their perspectives on the challenges, and key issues of the patients and the clinic.

When I went to live in Peru the first time, I set out to master Spanish, establish Latin American connections, and learn about the Peruvian culture from a wide community of Peruvians ranging from Trujillo in the north, to Lima, to Cuzco, to my host city Arequipa in the far south. It was clear that Peru is marked by significant social inequality. In addition, few people

have the same health care experiences or follow the same health care practices. For example, in Arequipa I got to know many medical students and a few surgeons in the public clinics there who were primarily focused on biological approaches to health care. They were very much at the mercy of the inconsistent state agencies in their job appointments, salaries, and training. In Cuzco, tea made with leaves from the coca plant was ubiquitously used to treat altitude sickness, as well as many other maladies. In Tacna, I received unmarked pills from a pharmacist friend to cure a stomach bug. In Trujillo, a close friend with an extreme sunburn was forced to wait for over three hours in a trailer doubling as an emergency room only to then receive a thick gel medication as treatment from a dismissive medical assistant.

I obtained reports from the statistics department of the Centro, which allowed me to compare and contrast the numbers with the self-reported issues from my interviews. The most common commentaries and concerns expressed by the clinic staff had almost no correlation to the reasons for visits to the Centro de Salud in 2014 (as reported by the statistics department of the clinic). Respiratory and digestive complaints are chief, first and second respectively, on the 2014 morbidity report. Regardless, both were dismissed almost out of hand by staff in conversations. They saw these complaints as a matter of course. The number of cases of "pregnancy, birth, and after-birth care" were statistically ranked 13th of 19 in order of most to least common issues, but they were in fact the most commonly talked about and highlighted cases that the staff brought up.

Centro de Salud 2014 Morbidity Report	Female patients	Male Patients	Total Patients
1. Respiratory system:	1755	1152	2907
2. Digestive system:	1523	835	2358
3. Infections/parasites:	640	269	909
4. Hematological and blood borne illnesses:	307	299	606
5. Endocrine, nutritional, & metabolic complaints:	283	225	508
6. Osteo-muscular:	302	136	438
7. External causes (e.g. trauma/ poisoning):	154	161	315
8. Urology:	206	55	261
9. Misc. abnormal symptoms classified by the lab:	179	79	258
10. Nervous system:	144	21	165
11. Dermatological:	99	38	137
12. Circulatory system:	75	41	116
13. Pregnancy, birth, and puerperium:	79	0	79
14. Eye-related complaints:	39	23	62
15. Mental and behavioral:	34	20	54
16. Ear and hearing:	18	17	35
17. Tumors	9	2	11
18. Certain complaints originating in perinatal period:	5	2	7
19. Congenital anomalies:	0	2	2
TOTAL:	5851	3377	9228
TOTAL %:	63.40%	36.60%	100.00%

Table **1**: Nuñoa Centro de Salud Dirección de Estadística e Informática Morbilidad General por Capítulos del CIE 10 - Por Grupo Etáreo y Sexo

The main health concerns that townspeople raised in casual conversation were *acidez*/ *gastritis* (acid reflux/gastritis), *sobreparto* (postpartum illness), respiratory issues (cough,

pneumonia etc), dental complaints, and *gripe* (general complaint for flu or cold-like symptoms). Nuñoans unanimously agreed that the health center and its staff was disrespectful and did not fulfill their treatment needs. Very few people reported that they went to the health center voluntarily. They were either forced to or had no other recourse.

Recognizing the reasons behind health choices and traditions is important to be able to effectively work towards the needs of a population. In this geographic area there is a great deal of work that still needs to be done. It is only recently that medical anthropologists have returned to Peru since the terrorist group Sendero Luminoso rose to power in the 1980s. This guerrilla army created immense upheaval and insecurity in the country throughout the two decades of its existence. However, since its dismantling, Peru has seen substantial economic growth. This is in large part due to the extensive mining and exportation of minerals and natural resources such as gold, bismuth, copper, zinc, and more. Mining activity makes up 14.7% of the country's gross domestic product (GDP). In 2012 it ranked 7th among the top mining producers in the world (PwC 2013). Nonetheless, the disparities in economic equality, as well as unequal availability of social services, remain substantial (Klasen et al. 2009). There is perpetuation of poverty in already impoverished communities. Racial hierarchies are also still very prominent in the country. Paul Farmer writes in his article *On Suffering and Structural Violence: A View from Below* "the poor are not only more likely to suffer, they are also more likely to have their suffering silenced" (Farmer 1996: 25).

Reflecting upon my fieldwork led me to question 'what is health care really'? Does something count as health care if it does not actually provide for or heal its users? There is a contradiction here in that people are being mandated to go to the clinic as they only state

provided option. Yet the system does not function adequately nor is it given the resources to do so. For our purposes here I will define sickness or illness "as an experience of disrupted well-being" or, as Nuñoans frequently expressed to me, "*malestar general"* - a general feeling of being unwell. Though in general one can differentiate among disease (pathology), illness (perceived), and sickness (adopting a sick role), these terms tend to be used interchangeably. Moreover, they sometime differentiate between *enfermedad* (illness/disease/sickness) and *desgracias* (usually associated with local folk illness of a more spiritual etiology). The distinctions, not so easy to understand in practice, become increasingly difficult to differentiate as more notions of the reasons and definitions behind poor health are added to the equation.

This thesis provides an ethnographic snapshot of health of pluralistic health care systems as well as of people's experiences navigating these systems. I begin by discussing the social dynamics in Nuñoa, which are rooted in longstanding divisions of class and ethnicity, then elaborate upon the social assistance programs which are designed to help the most impoverished. These programs are relatively recent additions to the health resource scene in the region. I then discuss conceptions of health and the pluralistic health system more broadly, focusing in particular on the Centro de Salud, the primary source of biomedical care in the District. In delving into people's experiences and treatment within assistance programs and in the clinic I hope to demonstrate what is sometimes a wide discrepancy between program policy intent and local implementation. The result is often that the people of Nuñoa are the ones who are caught in between a government which does not understand the reality on the ground, and implementors who sometimes abuse their power and do not work for in the best interests of the supposed beneficiaries.

Racism, Class, Community Dynamics and Compadrazgo

In attempting to explain or analyze health in a given population, we must understand the social context and diversity of health status wherever the investigation takes place. We must be as wary of overgeneralizing Andean populations as we would be in the case of the diverse populations within the United States (Oths 1998). In Nuñoa, complex social webs which are woven through ethnic, social, and economic community connections and boundaries should be prominent in any description of the site, as well as in analysis of health and health care. Ethnic and class divides dictate the interactions within the town and the levels of agency and various societal realms that people occupy (Crandon-Malamud 1993). The old feudal system of *hacendado-campesino* relationships which flourished from shortly after the Spanish colonization until the late 1960s, only began to be dismantled in the 1970s with the first agrarian reforms (Leatherman 1996). Remnants of these class and racial divides continue live on today. Though it is slowly becoming a system with less explicit discrimination against indigenous peoples, Nuñoa retains much of the flavor of the hierarchical exploitative systems of the past.

Shopkeepers and the weekly Sunday markets that bring goods into town from the distant cities or medium-sized towns scattered around the altiplano play increasingly important social roles. These systems of trade have been assisted by newly built roads and improved systems of transportation over the past few years. Looking beyond the surface, these connections between people of different statuses and societal levels reinforce the traditions of conditional community support and reciprocity typical in this area of the Andes (Mayer 2002**)**. They manifest in compadrazgo (god-parenthood) which operate as semi-reciprocal connections beyond the family

and between classes with roles based on what is appropriate by class. An example of this is my neighbor Milagros. Milagros has a widowed comadre who is very poor and lives on the outskirts of town. They have an affectionately exploitative relationship in which Milagros supplies her comadre with occasional items from her travels to Arequipa and Tacna, while Señora Estela sometimes comes to Milagros's house to prepare food for Milagros's guests, though she is never invited to participate in the meal itself.

Municipio staff, health workers, and teachers bring another level of class and status into the equation as of recent years. After the agrarian reform and diminished power of the *hacendado* class, these groups came to make up an increasingly important new middle class. Those who were on the edge between low and high class a generation ago now have annual salaries and some modicum of control over town activities. This is very much on display whenever possible, especially in events and parades which happen on important days in town such as the Dia de Independencia on July 27th where each group marches in a parade through the town.

Navigating health systems is like navigating any social system. Health systems and experiences are shaped by a whole range of class and interpersonal relationships, in this case compadrazgo and reciprocity, or lack thereof, between societal groups, all determined by class and race. At the forefront of these class divisions in Nuñoa is the large percentage of the population which lives chronically below the poverty line and, as a result, is subject to more control and reliance on the state programs than any other population.

Social Assistance Programs - Nuñoa as a District of "*Extrema Pobreza*"

In the past decade new social assistance programs targeting poverty and, specifically, maternal and child health have been introduced throughout Peru. Nuñoa is denominated a district of extreme poverty by the state of Peru. This classification comes from the Ministry of Economics and Finance (MEF) via the National Institute of Information and Statistics (INEI) and their analysis of a national household survey most recently conducted by the 'System Focusing on Households' (SISFOH) in 2009. This survey is separate from the national census and intended to measure the poorest districts of the country in order to implement and prioritize social policies and interventions. The interactions and overlap of all these programs and ministries are convoluted. It is relatively difficult to track which program is under which jurisdiction.

According to the INEI study, 49.7% of the Nuñoa population is in extreme poverty, and overall 80.5% of the district population falls below the nationally defined poverty line (INEI mapa de pobreza). Three main programs that have an important impact on the lives of people in Nuñoa: JUNTOS, Vaso de Leche, and Qali Warma. Two more programs, *Beca 18* and *Pension 65* provide scholarships to university students and financially support elderly populations, potentially in order to rectify the former systematic neglect by the state towards these groups in the past. These last two programs are less invasive and overall less impactful in Nuñoa every day life than the first three. This is primarily because it is uncommon for Nuñoan secondary school children to continue on to study at university and the pension program for the elderly comes with few eligibility requirements.

JUNTOS

JUNTOS is a social assistance program which was created in 2005 as part of the Peruvian national government's initiative to combat poverty and "reduce the income gap in homes of extreme poverty" (http://www.juntos.gob.pe/). Families register themselves and their children. If they are considered to qualify economically by the SISFOH survey, they are eligible to receive 200 nuevos soles (S/.) once every two months. At the current exchange rate, this subsidy is approximately 72 USD. JUNTOS is the dominant program that exists in the district of Nuñoa and arguably it is the most impactful on family life and personal economy. After just a few days in town I heard innumerable commentaries, primarily complaints, about the way JUNTOS is run and the services that it provides.

The program has gone through a variety of iterations depending on what is realistically enforceable. Currently, the requirements are three-pronged: participants must fulfill designated health "controls" in the local health centers (primarily height and weight measurements); children must attend school from the ages of 3-19; and each child must be registered for a national identity card and number within a month of their birth. In the past, additional requirements have included mandating that women complete a certain number of artisanal projects while waiting for attention at the health centers; requiring, but not providing funds for, an upgrade to gas stoves from dung burning fires to reduce smoke inhalation inside the house (often not a financially feasible option); and requiring attendance at trainings or lectures on a variety of topics decided upon by the local health staff. Currently only the lectures are still enforced, and usually timed so that they occur before the start of hours of attention on "control days" - a series of diagnostic and regulatory visits - either at the clinic or out in the communities.

JUNTOS height

JUNTOS weight

The iteration of JUNTOS that currently operates in Nuñoa stems from the legislation and laws that have been created on the national level. However, the reality of JUNTOS that people experience is based on the interpretation and implementation by the managers on the local level. There is often tenuous connections to the original rules and regulations after going through as many as five different institutions. First is the *Municipio*, because the child must have a national Peruvian ID and number, similar to the US system of Social Security numbers. Next is the *Centro de Salud*, which is in charge of the health "controls", mandated check-ups and nutritional screenings. These screenings must take place once per month for gestating mothers and children from 0-3 years old, and once per year for older children. The local schools also report classroom attendance to the JUNTOS office on a regular basis as part of the educational component of qualification. It is possible for the whole family to be suspended from the program during any distribution period if even one of the family members does not participate fully in all requirements. As if this lengthy list of demands were not enough, women must also contend with stigma, heavy demands on their time, and incursions on family life and their privacy that exist as

by-products of the program requirements. The reward for compliance is that they receive the S/. 200, less than 75 US dollars, every two months to help them try to make ends meet in their family.

To put this financial assistance in context, families receiving S/.100 per month would sound impressive to anyone in the Nuñoa region 20 years ago. Today, however, the economic landscape looks very different. Nuñoans rely on Sunday market-days to buy their food and supplies and the general economic demands are very different than they were in years past. For those who live outside of the population center, it is costly to travel into town to purchase food on market days and to each required visit at the clinic for themselves and their children for the health controls. The large percentage of people who do not have schools in their community must pay a family, relation, or *compadre* in town to house their child so that they can attend school and fulfill the attendance requirements of JUNTOS and the government. If the money was exclusively for food, perhaps families could scrape by on this subsidy of $30-35 (S/.100) per month. Unfortunately that is simply not the reality that they face. Based on over 800 surveys collected in 2012 from across the District, Nuñoa households reported median monthly food expenditures of S/.300. Many herding families are paid S/.500 or less per month and barely get by, living in a state of perpetual poverty. S/.100 per month (ultimately S/.200 every two-month distribution period) alleviates this burden slightly but hardly leads to a path out of poverty, as the program states is its intention. In addition to monetary costs, we must also consider the time costs that families, women in particular, face while fulfilling the various requirements. Typically the JUNTOS controls are scheduled by community or town neighborhood, published each month

in the Nuñoa Health Center and announced a few days in advance on the radio (which serves as the main form of information for people in far-flung rural places).

Community members who are not reliant on social assistance programs have a great deal to say about those who are. The dominant criticisms of women involved in JUNTOS are that they are lazy, do not want to work, rely on handouts, and don't properly use the money that they receive. On the other hand, they are also criticized if they try to work or get an education because then they have to take days off when JUNTOS controls fall on a weekday. Over the course of my research I was told by multiple people, paradoxically, that any woman who chooses to attend the local *Instituto* (a technical higher-education school; equivalent to an Associates degree in the US) in town is abandoning their children in favor of their own selfish goals.

Mario, the program manager, eventually agreed to provide me with some general information, though the lack of detail in our conversations was notable. He continued to be wary in his responses. Nevertheless, I learned that he is one of two contracted employees in charge of the program JUNTOS who travel from to Nuñoa from Puno, the capital of the department of Puno, a few times per month. Their responsibilities are to verify compliance and distribute funds. Every payment period they post a public list in town of those participants who have approval to receive their funds during that period and those who are temporarily or permanently suspended for failing to fulfill the requirements. Many of the programs and health clinics similarly publish lists of names of participants and intimate details about their conditions under the guise of

transparency. The reality is a public display of the participants' health and level of familial

Three women read the list of JUNTOS beneficiaries

stability, be it in terms of illness, household economy, or relationships.

Participation in JUNTOS is stigmatizing in itself. Even though the rewards are low, it does make an impact for families struggling to get by. Mario (a native of the city of Puno) said that he does not view the program as pure “assistentialism” because each household is required to fulfill such an extensive list of requirements simply in order to receive their benefits. Instead, he defines the program as support and incentive for individual improvement of health and education. This model parallels many similar models of neoliberal welfare reform around the world where recipients are expected to give something back and work hard for any benefits they may receive from the state. The dominant dialogue in town is one that we are very familiar with in welfare reform discourse in the United States. JUNTOS and other social assistance programs are said to promote lazy mothers who do not want to work or take care of their children. In reality, the processes women have to go through to qualify for each program are confusing and exhausting. They have little-to-no access to information or even an official list of requirements and, by registering, are subjecting themselves to almost unfettered surveillance and the whims of

those in charge of approving them for each cycle. The 1,171 Nuñoan families who are participants in the district are, in part, required to arrange their lives and those of their children around the strict mandates of the state, instead of following the practices that they lived by in the past.

It is telling that nowhere on the JUNTOS website (JUNTOS.gob.pe) is it possible to find a straightforward explanation of what is required to participate in the program. The website does not provide direction for program operation or resources for users. It includes only vague language explaining how its mission is to "intentan promover y garantizar el acceso y participación de los hogares en extrema pobreza con niños, niñas y adolescentes hasta los 19 años y gestantes en las áreas de salud- nutrición, educación e identidad; fomentando de esta forma el principio de corresponsabilidad.[2]" (JUNTOS.gob.pe). The program goals may be intentionally vague to allow their mission to capture as broad a set of social issues as possible and be justifiable regardless of the circumstances or political moment.

Vaso de Leche

Vaso de Leche is a social assistance program that was started in 1983 in Lima with the intent to support nutrition and supplement rations of poor children so they could overcome food insecurity. The program was started as a "survival organization" (Canada Refugee Board) and a soup-kitchen style initiative in urban Lima. It has spread since to 1838 municipalities around the country (MEF.gob.pe). The program is well established in the Lima and Callao districts of the

[2]"Promote and guarantee access and participation of those households in extreme poverty with children up to 19 years of age and gestating women in the areas of health - nutrition, education, and identity; in this way fostering the beginning of joint responsibility" (all translations are the author's unless otherwise noted)

national capital because it is one of the first successful examples of women's groups having an impact on national programs and policy. The then-mayor of Lima, Alfonso Barrantes, pioneered the program in the early 1980s with the intention to provide every child with one glass of milk per day. Soon mothers' clubs and popular women's leadership groups began to spearhead and promote it as a type of soup kitchen for children at a vulnerable period in their growth. Vaso de Leche has a reputation for being a contentious and politicized program because of its early history. Later, in 1992, members of the Peruvian terrorist organization the Shining Path systematically murdered over 30 community leaders who played important roles in Vaso de Leche and so-called 'survival groups' primarily run by women who worked to support their communities in extremely impoverished sections of Lima. They targeted leaders in these programs because they "perceived these groups as both enemies and stepping stones in their control of popular movements, aiming to take over and control them for use in their armed insurgency" (Research Directorate 1998).

Vaso de Leche is one of the main social support programs for mothers and children that exists in Nuñoa and is run through independent mothers clubs that are self-organized both in the town's urban population and out in the campo. In town there are a total of 19 mothers clubs based on social or neighborhood affiliation, while in the rural communities there tend to be 1-2 per community because of the smaller populations and logistical restrictions due to distance between households. There are a total of 52 different mothers clubs in the district and 1010 recipients for the 2014 distribution period.

According to national regulation, the rules should be the same across every location of the Vaso de Leche program. In practice, however, they are informally adapted to each local

region's needs and individual capabilities. The program arrived in Nuñoa around 1991 after the Nuñoans learned of its installation in the neighboring district of Ayaviri. There are two full-time employees for the program in the district: Señora Isidora, an elderly woman with a tendency to bring up casually shocking topics in the middle of otherwise normal conversation; and Rocio, a young woman from Nuñoa hired on a temporary 3-month renewable contract.

In order to participate in Vaso de Leche (VdeL), women must be a member of a mothers club and come to Rocio and Sra. Isidora at the Nuñoa office to register their children in January and again in June each year. They distribute portions of evaporated milk and dry oatmeal every two months according to how many recipients are on the list and the quantities that are delivered by the contracted providers. The budget is decided upon and then frozen once every four years by the national office in Lima and overseen by the Ministry of Economics and Finance (MEF). This means that regardless of however many families leave or join the program, they have the same resources available. If the number of women and children in VdeL rises, the quantity of milk and oats per mother drastically decrease. During the 2014 distribution period, every two months each registered child received approximately six 410g cans of evaporated milk and 2.8kg of raw oats.

Officially there are two priority levels for recipients of VdeL. First priority is gestating women and children from the ages of 0-6. If they register properly they are guaranteed access to the bimonthly foodstuffs. Second priority is children from the ages of 7-13 that are reported as undernourished based on the Centro de Salud height and weight calculations. Unofficially there is also a third level, in which Rocio and Sra. Isidora selectively assist others in need around the

town, primarily handicapped people and occasionally elderly people who do not have other obvious means of support.

Over the past 4-year period the Nuñoa district was allotted exactly S/.17,045 per month for VdL to be split evenly between the evaporated milk and oatmeal. They distribute food only every two months because the district population is so widely dispersed and mothers are not able to come into town with any reliable frequency. This means that every two month period there is S/.17,045 available for milk, and S/.17,045 available for oats. If we divide this by the 1010 children that are recipients it means there is S/.33.75 (around 10 USD) worth of milk and oats per child distributed every two months.

Despite these modest figures, this and other programs are criticized for contributing to a population of 'lazy women' who make no effort to feed their children on their own. During an interview with a longtime staff member of the clinic and botica owner, the subject of the assistance programs came up. Sr. Pepe was quick to inform me that women simply try to time pregnancies so they give birth every 5-6 years to continue to qualify for social assistance programs without putting in the work to earn money themselves. This man is a longtime Nuñoan who should presumably be able to relate better to the local condition of impoverished district members. Instead his views align with the upper class, the economically stable population, without actually being based in factual knowledge of the amount of aid provided. This perpetuates the cycle of stigmatizing beneficiaries rather than understanding them as victims of impoverished conditions and inadequate government assistance. From the governmental perspective, on the other hand, anything they do to increase food security for poor families is positive, regardless of the side effects or alternative possibilities.

Qali Warma

Qali Warma is a national school nutrition program that follows a number of other failed programs implemented by the Peruvian state and the Ministerio de Desarrollo e Inclusión Social (MIDIS). The name comes from a Quechua phrase meaning "vital/strong children." At peak functionality its goals are to: deliver shipments of nutritious food by contracted suppliers to individual schools around the area, prepare the food in the school for breakfast and lunch, and to serve two meals per day to the children at the school. The ultimate goals are "to promote school attendance, health, and nutritious diets" (http://www.qaliwarma.gob.pe/). The program is limited to pre-school and primary school levels, pre-kindergarten to 6th grade. Qali Warma started in 2012 and has reached 2.7 million children in more than 47 thousand institutions in Peru and state on their website the intention to reach 3.8 million schoolchildren by the year 2016 (http:// www.qaliwarma.gob.pe/) .

With this program there is, yet again, a disconnect between the stated goals and the reality on the ground. I visited the two primary schools in town in order to speak to their directors and learn about Qali Warma from the administrative perspective. Each director spoke at length about how the program had started in their school. Although the schools were only 5 streets apart, each system of implementation was completely different. One school tried and failed to prepare meals on location. Rather, during the 2014 school year, every time a shipment came in, school employees divided the food items among the families and required them to prepare lunch for their child's classroom on a rotating schedule, approximately once per month.

In contrast, the other school hired mothers for a very small stipend to serve as lunch-ladies and prepare meals for the whole school each morning and afternoon.

A previous nutrition program, Programa Nacional de Alimentación Escolar (PRONAA), only provided evaporated milk and soda crackers to schools. Mothers were still required to prepare meals for their child's classroom and had to supplement the meals with their own additional meat, vegetables, or starch. A major issue with the program locally is that, because of the centralization of this program in the department capital Puno and government capital Lima the committees in charge at the local level often do not receive their deliveries or the appropriate ingredients to prepare meals. They also have limited control over the process. One school director reported receiving only 7 of the promised 10 deliveries in 2013, the program's first year in Nuñoa.

The directors of each school head the Qali Warma administrative committees in their respective schools. Both expressed to me their dissatisfaction with any social assistance program. Their opinion is that these programs contribute to the laziness of the children's own mothers. One of the directors explained poverty in the region as "families who don't distribute their economy adequately." He was critical of what he sees as indiscriminate financial and nutritional support. Despite this, both directors agreed in conversation that better nutrition in their schoolchildren makes a positive impact on the level of their schoolwork and ability to take advantage of a primary education.

Summary of Social Assistance Programs

The social assistance programs in Nuñoa provide a limited level of assistance helping to meet basic needs and serve as stop-gaps to hunger for district families under the poverty line but have little impact on long-term poverty alleviation. They also make heavy demands on women's time, enable greater control and surveillance of rural indigenous populations, and stigmatize recipients as lazy, unproductive, and dependent - similar to criticisms of welfare recipients in the West. The Centro de Salud becomes inextricably twined with the programs because of its level of involvement with regulation and processes of approval. Health personnel and local program managers take advantage of their acquired power to manipulate and micromanage program beneficiaries. It becomes possible for new requirements and pressures to be invented and ultimately imposed on those who are vulnerable, as the head nurse of the Centro de Salud said, "for their own good." This variability in requirements and disempowerment of the women themselves leads to uncertainty, confusion, and anxiety for participants.

JUNTOS "control" at the Centro de Salud

The programs are important in temporary alleviation of economic burdens for the poorest families but create a high level of stigmatization which is socially harmful. Limited agency, imbalance of oversight, lack of understanding of the needs of a given community, and corruption all play a role in undermining the stated mission of these programs and prevent those who need

them most from benefitting. The Peruvian government has a history of longterm neglect of the needs of large groups of their citizens. The relatively recent attention to the health of these poor populations comes with a number of tradeoffs including overregulation and surveillance. Not only are they scrutinized by government departments and ministries, but over time the trend will move increasingly towards conditioning poor populations to monitor themselves to the standards of the state and behave in a state-approved manner. Here health (and availability of health care resources) act as a controlling process which then spreads to regulation of other aspects of patients' lives and habits. A further goal of these social assistance programs is to create a cycle of promotion and reinforcement of the biomedical services they offer, which in turn allows the Peruvian state to position itself as a modern democracy on the international stage.

El Centro de Salud & la Red Melgar

The Nuñoa *Centro de Salud* was opened in 1960 as a "sanitary outpost" (Calderón 2012) and has a history which is closely entwined with the history and development of the town. Everyone has an opinion on its past and everyone remembers the principal actors and characters who effected various stages of its development on a local level. What is ultimately important today, however, is the way that the Centro is structured and overseen, the hierarchies of employees, and individual accountability or lack thereof. The Ministry of Health, *Ministerio de Salud del Perú* (MINSA), functions in a very top-down manner. The policy and leadership comes almost exclusively from Lima, with networks spreading down from the national, to the departmental, to the provincial, and eventually to the district levels. The issue with such a centralized way of administering health care to the nation's most needy is that bureaucracy

usually prevails. It becomes difficult to move beyond the numbers and statistics to see what does and does not work.

The current head of the Centro and of all the community outposts is Doctor Benjamin Postigo Valle. Benjamin is a serious man in his 30s who was born and raised in Arequipa. By the time he completed medical school he was already married and had two young daughters. As is typical after medical school and internship, he then entered into a lottery based on grades and class ranking to determine where he would do his service years and get his first job. The highest achievers in the class go first and quickly snap up every available position in and around the cities and urban centers. The new physicians with lower rankings get more frustrated as their options are limited to an increasingly greater and greater distance from their homes. Dr. Benjamin did not reveal his medical school transcript to me, but it was clear, by his bitter remarks and constant travel back to the city to see his family during his bimonthly vacation periods, that rural Puno had not been his first choice. Soon after he arrived at the Centro the primary doctor, whom he was hired under, quit in favor of a job in Cuzco and Benjamin was left in charge.

Of course “in charge” is a relative term. Dr. Benjamin was effectively the administrator under the jurisdiction of the Melgar Health Network. He was frequently the only doctor ever on call to receive patients. Other key figures include obstetric head Señor Luis, a native Nuñoeño with a temper and local reputation of verbally abusing patients; Giuliana, an upbeat but serious head nurse with a long swinging braid, native to Nuñoa; Romina, the obstetrician; and members of their respective teams. In addition there are a variety of technicians and auxiliary workers who

have miscellaneous positions both in the town's Centro de Salud and out in the health outposts in the various communities.

The original health center was built in 1970. It was a small, dark, cold, and uninviting place. When the new health center was built in 2009, they had high hopes for the place. The municipal government had more than doubled the size of the building, and intended to increase staff and equipment to operate on a level that MINSA dictated as 1-4. This meant, according to Giuliana, that they were required to have extensive maternity services, conduct ultrasounds and x-rays, and do certain minor operations (personal interview). However, this rating was quickly reduced to 1-3 because of lack of staff and because they did not have the money to finish constructing the x-ray and ultrasound spaces. It is also very difficult to recruit staff from medical schools and hospitals in the cities to live in such a remote area, especially for any amount of time. Most stay for a year and leave as soon as they obtain the 'rural service credit' which helps them get a higher paying position in a city.

The old clinic in front, one of the ambulances, and the new clinic to the right

Because of the reduction in care level, the Centro can do fewer treatments than in the past and should officially be referring many of their patients, especially maternity patients, to the larger hospital in Ayaviri. However, because the requirements imposed by MINSA have actually increased, fulfillment of their 'metas' or goals, rather than quality of patient care, dictate how much money and support the clinic gets. Rather than primarily patients to the appropriate specialist or larger hospital, clinic staff became motivated to process and treat as many patients as possible at the Centro itself. Though this could be seen a positive impact, the reality is that patients are instead treated as quickly as possible. As is increasingly common, the numbers do not reveal the full picture of care nor the level or quality of services provided.

Marked social factions exist very prevalently within the employees at the Centro de Salud, which has an impact on how patients are treated. The vast majority of staff at the clinic are contracted employees of the state. Their contracts are renewed, or not renewed as the case may be, on a 3-month basis. Their jobs hinge on their completion of paperwork, levels of performance, and the occasional written exam depending on the position in question. On the other hand, *nombrado* or "named" positions have job security, no contract renewal, more days off, and are judged less harshly or frequently by the administration. These inequities in job security and productivity requirements create high levels animosity between the staff members and both factions heavily criticize the other. The differences in types of employee contracts lead to falsified paperwork, short appointment times on busy days, and a general lack of patient-centric performance. Focus is instead either on fulfilling the metas and requirements in order to get a renewed contract, or the amount of time left to their next vacation period. I often was

informed of the number of vacation days a staff member was awarded per month as it was seen as a key indicator of how the health network valued that person.

Interacting with the clinic staff, and hearing horror stories from patients on a daily basis, had a strong effect on me and my opinion of those who worked there. However, as I got to know them more on a social level and as I began my interviews of the staff, it became clear that their frustrations were just as fervent as those on the other side of the tall entrance gate, if perhaps not quite as individually impactful or excusable. The culture clashes between city-educated staff members and patients flowed both ways. Though the nurses and doctors made limited headway in understanding the perspectives of those they were supposedly helping, their frustrations with the patients' apathy and tendency to ignore advice were also understandable. Many times I heard complaints about the "*incumplimiento*" (non-compliance) of mothers. The general consensus was that if the women would just conform in deference to the superior knowledge of the staff, the outcomes would be much more orderly and positive all around. On top of this, the staff operated with a very low budget, limited reinforcement, few supplies, and high demands. The pharmacy was rarely stocked as antibiotics and pain relievers never seemed to arrive on schedule, or when they did, they expired in a matter of days or weeks. Internal complaints about staff behavior were rarely heeded because if one person did get fired, it would be a long road to replace them.

One of the questions I constantly asked myself in the field was whether the clinic operations could indeed be defined as health *care*. The Merriam-Webster dictionary definition of health care is: "*noun:* the maintenance and improvement of physical and mental health, especially through the provision of medical services" ("Health care" Merriam Webster 2004). Is that truly what happens at the Nuñoa Centro de Salud?

What Happens When People Get Sick? Medical Pluralism in Nuñoa

In Nuñoa, rarely does something follow the 'best case scenario'. Policies and programs created in Lima have a different iteration once they are put into effect on the ground regardless of the initial intentions of the lawmakers. This is particularly true in a place like Nuñoa, so removed from the world of politics and congressional maneuvering. There availability of an extra wool blanket during the cold months may have more of an impact than the most complicated and well intentioned government bill to stimulate the economy. Many Peruvians say that Quechua people in particular have long since resigned themselves to the fact that with such a difficult environment and way of life, they are never surprised if something (or everything) goes terribly, drastically wrong. It's a type of Andean Murphy's Law.

At 4000m above sea level, the everyday illness complaints tend to be predominately respiratory. Mild coughs, irritation when breathing, and runny noses are rampant around town. Despite the high altitude, stomach and intestinal parasites are common throughout the population especially in younger age groups. Stomachaches and moderate to intense indigestion are common; often referred to as *acidez* or *gastritis*. These illnesses, in their mild manifestations, tend to be treated first by preparing mates (teas) or topically with herbs, especially those native to the area like *muña* (for stomach issues) and *la ruda* (for luck and for the cold/wind). Problems like a*cidez* (which seems to be similar in symptoms to acid reflux and indigestion) and g*ripe* (a catchall term for respiratory and cold and flu-like symptoms) seem to be explanatory models developed in some ways from official biomedical explanations. Both sicknesses have a tendency to not be treated seriously or effectively by the biomedical realm. If medications and treatments do not work long-term, sufferers may arrive at a new explanation altogether (i.e., with similar

symptoms but a different explanatory model) resulting in the creation of something that resembles culturally bound illness.

The explanatory models of illness are not uniquely developed by each individual. They are a shared understanding of a conglomeration of symptoms and reactions to experiences and treatments that may or may not work, manifested as illnesses (Kleinman 1980). In this sense, a gripe (an *enfermedad* or disease) can become reclassified as a *machu wayra* (old winds or aires), a type of culture bound illness and *desgracia* (misfortune) for which there were few treatment options (Leatherman and Jernigan 2015).

These two illnesses, gripe and acidez, are also interesting in that definitions and descriptions vary according to who is experiencing them. We can see this in how acidez was explained and treated by two women: Milagros, a woman we lived with for much of the time and an elected Municipal worker; and Doña Maria, one of the town matriarchs and busybodies, and a local shopowner. Both women frequently complained of acidez or gastritis and elaborated on different facets of their sickness. In general the symptomatology involved pain in the stomach and esophagus, particularly after eating, acid reflux, and occasionally ulcers. Though they were both of a similar economic class in town, Maria was fervently religious and refused to participate in any indigenous-related activities; especially not superstitious herbal treatments. Milagros, on the other hand, was the daughter of a former mayor and, though she was upper class in Nuñoa terms, she was very engaged in the workings of the town. Surprisingly enough, she used herbs liberally when it suited her. In fact, she was one of the first to introduce me to *muña* stalks as a solution for my stomach pain. Both women refused to attend the local health center and instead relied heavily on biomedical care facilitated by their respective extended families in the larger

cities. Though it is common to hear Nuñoan upper class people complaining of such symptoms, others with fewer resources simply take any comparable discomfort in stride. As Crandon-Malamud (1991) showed, individuals make use of differing explanatory models not only to make sense of illness, but also to assert identity and reaffirm social relationships and status.

The medical system in Nuñoa is decidedly pluralistic, despite the recent suppression of organized traditional systems of care in favor of new biomedical state programs. Though my work did not primarily focus on explaining culture-bound illnesses (Carey 1993), in contrast to biologically defined diseases, the distinctions exist and some alternative sources of care can be found with investigation. Nonetheless, these resources are becoming less available over time as increasingly the aforementioned social assistance programs encourage, or mandate, general use of biomedicine and leave little room for the *parteras* (traditional birth attendants) and *curanderos* (healers) of the past. Indeed it was difficult to find an officially practicing partera or curandero anywhere around town.

Pluralistic health care resources available in town include traditional herb use, knowledgeable community members, marketplace vendors, pills and medication in the boticas, some private dentist and physician offices, and ultimately of course the broader MINSA Network of Melgar to which the Centro de Salud and the community health posts belong. The system is varied and it may appear that there are many options for where to seek care. At nearly every level there is a practice of manipulation of the patients and costly charges. Stories and case studies collected around town proved this again and again. Roxana, one of the young women whom I interviewed, fell victim to a mysterious illness which necessitated navigating every available health resource for over a year without receiving effective treatment. Her mother slept on the

floor of her daughter's room in the state hospital in Juliaca for 5 months while she was treated, and after much expense and having received little help, eventually had to return home to Nuñoa. She was then diagnosed with cerebral tuberculosis by one of the privately-practicing doctors in town and eventually her symptoms simply disappeared on their own. Roxana herself was so traumatized by her chaotic path through every possible level and hierarchy of care in search of treatment that she claims amnesia and defers to her family members to narrate details of her illness. Parts of our conversation suggested that she could indeed remember the year that she was ill but chose not to.

Medical pluralism is seen through these stories and is in fact the framework for experiencing health care through a sticky web that locals attempt to navigate each time they experience an illness episode. While use of different health care options vary by class and status, everyone constructs different hierarchies of resort from limited options.

The curanderos, romantically imagined in Western eyes, often resemble health peddlers who travel from market to market with their treatments. Some are natives of the *selva* (jungle and rainforest) and advertise both cures from their family traditions, herbal rubs, and, paradoxically, occasionally even Chinese medicines imported in colorful boxes. All medicines

are labeled first by problem (e.g. knee pain, rheumatism, Parkinson's, cancer), then by part of anatomy or organ (e.g. kidneys, spleen, intestines, heart), and lastly by ingredients (e.g. shark cartilage, coca, vitamin B12). Typically they are sought out as a last resort, sometimes even after private doctors or larger hospitals in the department capital have failed to find a solution, as curanderos tend to be incredibly expensive. There is also a tremendous amount of superstition surrounding the curanderos characters themselves. Patients in Nuñoa speak about preferring curanderos who travel north from Bolivia, rather than their Peruvian counterparts; primarily because Bolivian curanderos are renowned for being the best in their field. In addition, they trust them more as they are far enough removed from the dynamics of the local community that there is a smaller likelihood of inflicting malevolent treatments and curses.

Traveling medicine vendor from the Northern jungle

Two other types of visiting health specialist domains in the area are dentists and *medicos particulares* Dr. Tito who maintains an *oficina particular* (private office*).* These providers usually come from Puno, Juliaca, or Ayaviri and open on market days or major holidays when town is busy. They tend to target campo families and those who do not have the opportunity or time to take away from herding to visit a larger city. Lack of specialization is one of the primary complaints that Nuñoans have about health care in town. These two domains attempt to fill this gap. However, Dr. Tito, an ambitious local boy turned multi-specialization medical doctor, may

go too far. Early every Sunday morning he and his family unfurl many plastic-laminated posters and signs outside their home on the main road across from the marketplace. His notices advertise "X-rays, ultrasounds, medicine, pediatrics, OB-GYN, surgery, trauma, and urology." The more cynical townspeople stay away as they doubt any one doctor actually can cover all of these areas. Nonetheless, every morning as early as 4AM there is a line at the door of (primarily rural) men, women, and children seeking treatment and explanations for their various maladies. Dr. Tito also was one of the candidates for district mayor in the 2014 town election.

Dr. Tito's consultorio and family home

When wealthier townspeople have a health problem, even in the case of an emergency, they almost always go to one of the major cities to a private, or even large national, hospital for treatment. Poorer people do the same only when they have exhausted options closer to home. However, the realities that this involves for each class respectively could not be more different. People like Milagros and Doña Maria get on a bus and are received by their families or children who live in comfortable homes and have the resources to transport them back and forth to the hospital or pharmacies to get treatment. On the other hand, people like Roxana's mother must bring their own blankets to sleep on the hospital floor next to their ill family member and are

subjected to all signficant additional expenses on top of what is supposedly free under the national health care system.

On paper, everyone has access to free health care through the Seguro Integral de Salud (SIS) universal health care insurance, which targets the poorest populations. This program gives anyone the ability to get treatment, but is designed to provide basic care in local health which may be far from adequate. For any further care beyond the public clinics and state hospitals, especially for private specialized treatment, it is up to the patient to pay out of pocket. The lack of specialized care was a complaint voiced widely by those I talked to about the availability of health care in Nuñoa. Most people do not know when the clinic will be open or how long they will have to wait to see the doctor. Often, upon arrival at the health center, patients will not even be informed that the doctor is out of town. Long wait times, limited access to medicines, and inadequate communication all play a role in alienating patients from their own care, while simultaneously placing the burden of responsibility for health care on patients.

The health care systems cause trauma and confusion throughout Peru. No one part of the system works to support another. There is no cooperation between realms of care. In this place, decent health and health care are privileges that not everyone has access to; it is a commodity that often comes with great costs. The result is that many people who cannot afford quality care must resign themselves to the limited care and marginal treatment available in the local network.

Boticas - An Augmentation of the Realm of Home Remedies

One of the major evolutions in health care in Nuñoa that occurred in the last 10 years was the arrival of *boticas* in town. A type of pharmacy, these small stores are owned by Nuñoan

entrepreneurs and provide certain medicines for common maladies, such as cold, flu, and diarrhea medication, and other remedies to townspeople. The advent of these shops is notable because they contribute to locals' ability to take more control of their own health by expanding access to basic medicines. They also change the economic landscape of the town because they have become a major source of income for their entrepreneurial owners.

Every botica typically offers a range of medicines that include anti-cold, anti-ulcer, anti-cough, anti-fever, ibuprofen, and antacid tablets, as well as analgesics, antibiotics, antihistamines, aspirin, and a few different vitamin or nutritional supplement options. Conveniently, these shops are also an easy place to recharge cellphone minutes. In the summer of 2014, while walking in and around the central neighborhood, *Central Sur Progresista*, which surrounds the Plaza de Armas, I counted nine active boticas. Every one had been opened in the past few years.

I became close to two of the botica owners in the last month of my fieldwork and spent many hours sitting and chatting with them in their shops as people came in and out with various complaints. The oldest botica in town is called *Señor de Huancho*, owned by Juan Huanca and his wife. It is usually staffed by Sofia, their 32-year-old daughter. Señor Pepe has worked for over 30 years in the Nuñoa Centro de Salud. They opened the botica around 9 years ago to utilize his expertise and his wife's "*capitalismo*"-style entrepreneurial leanings. A corner of the botica is dedicated to the display and sale of novelty gifts and jewelry items intended to attract potential customers. The botica is attached to the front of their house and located on Jirón Ayacucho, a well-traveled street that leads from the Plaza de Armas to the Sunday market area and to the main road that leads into town. Sofia also belongs to the main women's crafts cooperative in

town whose members make alpaca wool sweaters and clothing for sale at a new shop in the bus and minivan terminal.

The other botica where I spent a great deal of time belongs to a relatively young woman named Gladys. She sells much the same items as Sr. de Huancho, but has some training as a health technician. Gladys was much more careful with me about her replies, always gauging what she thought I wanted to hear or pleading ignorance to many of my more difficult questions. Over time she revealed that her shop is not enough to support her and her family economically. She often travels during the week far out to the rural communities to sell medicine to herders and their families who are unable to come to the main town for care.

Many people seek out treatment and advice at boticas long before they will ever set foot in the Centro de Salud. Some advantages that they cite are: not spending hours waiting to be attended to, medicines that are always available, and ability to buy treatments in extremely small quantities - even one pill at a time. The health center pharmacy mainly provides antibiotics and ibuprofen, and often are not even supplied with those. Townspeople also learn that it is often not even worth going to the health center many days because it is arbitrary when the center will be attending patients or else they are left waiting hours for a doctor who never appears.

Another new feature of the pluralist health system is the stores that have begun selling nutritional remedies such as vitamins and herbal extracts, and a few specializing in Chinese and other alternative medicine. Principally propagated by traveling ‘specialists’ who come into town with the Sunday market, Nuñoans who are disillusioned with the health center have found alternative resources from people who attend them in a timely manner. Many of the users live in the campo and don’t have the economic resources to seek treatment outside of town and so rely

on those that are the equivalent of traveling or seasonal salespeople. These pluralistic resources and boticas can be considered extensions of the realm of home remedies because those who access health care at these sites still manage to avoid the control and subordination they would experience at the health center. In the pluralistic health systems of the past, people relied first and foremost on home remedies, herbal teas, and other infusions. Now the access to over-the-counter medications at boticas or in small general stores augments this access and ability to self-diagnose and treat minor ailments without having to go to the clinic.

Maternity & Control During the Period of Childbirth

During the thesis-proposal-writing phase of my project, more than one of my mentors mentioned that it is a common occurrence to change the direction of one's fieldwork while in the midst of the research. My advisor in particular repeatedly brought up interesting and very topical questions surrounding reproduction and maternity in the Andes. I was initially reluctant, preferring to focus on hierarchies of health care and pertinent resources. Yet once in the field, my mentors' warnings ended up materializing in my own research. The emphasis on maternal and infant health in the Ministry of Health's national plan made clear that these two topics needed to be examined. They rose quickly to the forefront of my research once I began work.

In 1984, the rate of infant mortality for the Nuñoa district was 116.8 per 1000 live births (Carey 1989). In the poorest communities, a rough estimate of infant mortality approached 200/1000 births. On a national level, the UN Population Division reports that in 2013 Peru had 21.16 infant deaths per 1000 live births compared to the United States' 5.4 (UN Department of Economic and Social Affairs). In 2012-2013, the department of Puno still had the highest rate of

infant mortality in the country, far above the national average of 40 deaths per 1000 live births (MINSA.gob.pe), though it is far lower than the level of the 1980s. As a result, government programs encouraged, and in some cases forced, women to give birth in clinics.

In 2011 and 2012 (the most recent statistics for births), the District of Nuñoa births were distributed as follows:

Nuñoa District	Centro births	Puesto de Salud	Regional Hospital	Home births	Total births
2011	122	5	29	15	171
2012	102	1	1	14	118

Table 2 - Oficina General de Estadística e Informática (OGEI) minsa.gob.pe

Maternal and infant health are two health objectives that make up top Peruvian Ministry of Health (MINSA) goals. The MINSA document *Plan Estratégico Nacional para la Reducción de la Mortalidad Materna y Perinatal* (National Strategic Plan to Reduce Maternal and Perinatal Mortality, 2009) is one example of this focus and closely parallels WHO Millennial Development Goal 5 to "reduce by three-quarters, between 1990 and 2015, the maternal mortality rate." (United Nations Report: 28)

> Este Plan Estratégico Nacional se propone suscitar adhesiones desde los poderes del Estado y permitir, con una adecuada asignación de recursos, alcanzar los niveles de reducción de la mortalidad materna y perinatal comprometidos y que evidencien tanto la preocupación del Estado por el bienestar de sus ciudadanos como por el desarrollo del país.[3]
>
> (National Strategic Plan to Reduce Maternal and Perinatal Mortality, 2009: 9)

[3] "This National Strategic Plan proposes to raise plans from the powers of the State and reach, along with an adequate distribution of resources, the goal of reducing to the promised levels maternal and perinatal mortality and as such the concern of the State, both for the wellbeing of its citizens and the development of the country, is clearly in evidence."

Throughout this document, its authors address "barriers to access" and intend to improve the maternal and infant health statistics of Peru to a level that represents national development and growth. The implication is that they can work towards legitimizing their geopolitical position with an internationally accredited effort to improve in health statistics. The main reasons for maternal mortality, the report explains, are the "complicaciones [que] se producen en los services de salud debido a la falta de atención obstetrica esencial."[4] (22) When an issue is simplified down to a single specific cause without adequate understanding of the situation and social relations on the ground, there is a danger that the implementation of programs intending to improve care may be ineffective and fail to serve the needs of the population. As Stone (2009: 50) writes, "it is the locally defined understanding of birth, alongside the formal and informal ways that birth knowledge is shared, that result in the variability that should mark birth across cultures and from women to women within the same culture." These more complex aspects of birth and the birth experience are de-emphasized by clinic staff in favor of basic health outcomes and statistics. According to Nuñoa staff, there has not been a case of maternal death in the district since 2009. The reduction of maternal mortality in the region is real; though it comes at a hidden cost. It is not enough to examine the numbers, we also have to understand the experiential contexts and realize that there are many alternatives that would be less traumatic and more effective.

Stoner and Morse's nine-month study of health and primary care resources in Nuñoa (1986) reports that out of 520 obstetric exams in the course of one year, nine babies were delivered by health center staff, and of those nine, only two were actually born in the health

[4] "complications that arise in health services because of lack of essential obstetric attention."

center. Today, as the head nurse proudly informed me during an interview, almost all births take place in the Centro de Salud. Any conversation with a staff member at the health clinic will eventually turn towards the topic of maternal and infant health as an area in which they have succeeded. The center staff's sense of futility and anger at lack of available resources or economic support is mediated somewhat by their self-reassurance about the difference they have made in reducing maternal and infant mortality.

The effort to continue to reduce these mortality statistics follow from the more concretely defined UN Millennial Development Goals (MDGs) of 1990-2015; primarily MDG 4 and 5, to reduce child mortality and to improve maternal health respectively. Many of the complaints expressed by Stoner and Morse in their 1986 analysis are still relevant today. Principally the lack of accessible dental care, the fact that women still receive very little helpful feedback on the health of their child unless it is in the form of chastisement, continued lack of confidence in the efficacy or reliability of clinic treatments, and health workers' limitations by government assessments which measure number of patients seen rather than quality of care. These are are still relevant today, perhaps even more urgent to resolve because of the larger district population. In the conclusion of their paper they write "many of the aforementioned problems derive from the highly centralized health care system and the subsequent lack of local input by both local workers and the population." (19) A little later they recommend "devising unit cells around health care workers where they are assessed by community efforts rather than the number of patients seen." (Morse & Stoner 1986: 19) This paper was published 30 years before my fieldwork and yet so many of the problems still rang true in my 2014 experience.

Fines and Fear

Morgan, the doctoral candidate I lived with in Nuñoa, focused a large part of her data collection for her dissertation on nutrition of lactating children. Thus I had significant contact with mothers from the *población*, as well as further out in the *campo*. I sat down with Luz Marina, Morgan, and a very young new mother my first day in Nuñoa. While conversing over the typical boiled potatoes and cheese, the topic of pregnancy and birth came up. When I asked generally about traditional methods of infant delivery, Luz Marina became quite agitated and described how a large *multa* (fine) had begun to be imposed by the clinic over the past few years on women using traditional birth methods. She proceeded to explain that mothers were, as of a few years ago, mandated to give birth in the clinic. If they give birth at home they were fined anywhere from S/.500-700 - more than an average month's salary for a herder or laborer in Nuñoa.

Pressures from the highly centralized Ministry of Health translate into *metas* (goals) at the local level, which ironically can have a negative impact on the way patients, and especially pregnant women, are treated within the system. These metas require quantitative reports of patient volume rather than focusing on measuring whether the patients' health complaints are treated effectively. For example, one of the metas specifies that the clinic staff must vaccinate a percentage of the children in the District or face repercussions based on lack of productivity. The reports are then sent to the *Red Melgar*, the headquarters of the health in the nearby town of Ayaviri, and analyzed for compliance or non compliance. Meeting these metas determine levels of economic support to the clinic. Individual contracts of the health workers depend on whether

they as an individual are following the demands of the *Red* (network). As the head nurse told me in an interview "cuando nosotros también no producimos, ¿qué pasa? Viene y nos llama la atención, o aveces somos arbitrariamente despedidos del trabajo[5]" (Personal interview with Giuliana). In order to meet both the individual and institutional goals, staff have begun a number of initiatives to pressure the community to behave a certain way. Most extreme is the invention of the home birth fine because it has completely changed the way families function, and potentially traumatized an entire generation of mothers. On the topic Giuliana simply scoffed, "Solo eso ha sido una...como para asustarlos ¿no? Pero nunca hemos cobrado S/.700. Nunca."[6] The lead obstetrician, Romina, told me that about a decade ago the staff had convened to talk about how to increase the institutional births (a declared goal of the Peruvian government) and decided upon instituting this fine, though it has no national or legal basis.

Clinic staff has also used fear as another method to increase the frequency of mothers bringing their children in to the Centro. Because autopsies are officially mandated in the case where cause of death is inconclusive, they began enforcing this regulation and performing autopsies on all children who died outside of the clinic to scare mothers into bringing their children in to the *Centro* right away. The parents were so frightened by the idea of their children being cut open that they no longer just turned to the *Centro* as a last resort. As the head nurse Giuliana told me "entonces los padres tambien se asustan porque los tienen que cortar a su bebe y todo. El fiscal tiene que llegar. Tiene que ser levantado por la policia, por el juez, por todo.

[5] "When we don't produce, what happens? They come and they criticize us, or sometimes we're just arbitrarily fired from our positions."

[6] "It was just to scare them, you know? But we've never made them pay S/.700"

Entonces por ahi tambien los papas se han asustado y se estan acudiendo[7].” Now a much larger proportion of parents bring their sick children in to the clinic as soon as the first symptoms appear to try to have a record of any disease or illness so that the staff has no reason to report unknown causes of death.

In the chapter on the structure of the *Centro de Salud*, I discussed in more detail the challenges that staff and medical professionals at the institution face, but here I must elaborate a bit on the experiences of the townspeople and mothers that are forced to negotiate through the medical system on a regular basis. On several occasions, while Morgan conducted surveys with mothers of children under 2 years of age, I took the opportunity to gather narratives of birth and maternity.

One memorable visit took place when we travelled by moto out to Pasanacollo to contact a few mothers who had been unreachable by cellphone earlier that week. We optimistically set off early one morning on the two motorcycles. Morgan and I with packed backpacks on “Gana”, the name of her knock-off Harley Davidson, and Vicky and Ceci on a glorified dirt-bike. Pasanacollo is an agricultural community about an hour’s moto ride away from the población of Nuñoa. It has one of the largest populations of any of the outer communities and its own *posta de salud* (health post) with a staff consisting of one doctor, nurse, nurse technician, and auxiliary staff member working in rotations. The reality, however, is that the staff is absent more often than not. Regardless of the posted schedule with assigned duties and on-call hours, the doctor in Pasanacollo is usually off on *dias de descanso* (rest days) in her home city and the nurse

[7] “So the parents also get scared because they have to cut their babies and everything. The [attorney general] has to come. They have to be attended by the police, by the judge, by everything. So there the parents also have gotten scared and now they’re coming in [to the clinic].”

technician has a habit of skipping his work days as well. The auxiliary staff person, who lives in *Pasanacollo* around the other side of the hill, has been working there since the post opened over a decade ago and fills in for the trained personnel most days.

That day we had a gorgeous ride out to the community. The dirt and gravel road winds up and around small hills, each time we crested the top of one, the whole altiplano stretched out around us - golden grasses and small streams snaking through grazing cattle. It was moments like these that I felt like the luckiest person in the world to be in such a beautiful, unknown place. The brilliant blue sky comes down to meet the mountains and, if you look closely enough, llamas and alpacas dot the hillsides, practically blending in to the vegetation with their brown, black, and tan coats. We rode through the center of the community, where the health post, school, old hacienda ranch house, a tiny store, and a few residential buildings are located. Ceci had an idea of where we might find one of the mothers on our list and so we followed her bike off the road, down a small lane on the *pampa* and we soon had to abandon the bikes and continue on foot. The woman we were looking for came out of her house to meet us after hearing a shout from one of her older children and began walking dubiously down the path towards us.

It turned out that her husband had registered her for the survey without her knowledge but she had no idea who we were or what we wanted. Initial suspicion was evident in her eyes. Vicky expertly and succinctly explained the goals of the project to her and pretty soon she nodded and we all settled down on the side of the path to begin. Morgan pulled out a bag of coca leaves and passed it around sociably. As they collected the general demographic information of the family I noticed that her newborn's birth card said "domicile birth." This was the first time I had encountered a woman who had given birth at home and I was anxious to ask her about it.

Though she and her husband both understood Spanish, they were more comfortable answering questions in Quechua so one of the research assistants translated for me. The couple had 5 or 6 children in total, and the new 5-month-old baby was by far the youngest. She was willing, though not enthusiastically so, to elaborate for us the story of her most recent birth.

All of her other children had been born before the Centro de Salud began to enforce institutional births and so she was used to laboring at home and not at all concerned about her pregnancy. The labor this time had come on very suddenly and she sent her husband to find a doctor in the posta in Pasanacollo. When he didn't find anyone there he continued on his motorbike to the Centro in Nuñoa and after pounding on the gate for a while, with no response, he returned home to assist his wife. While he was gone his wife had given birth suddenly and without pain. They informed the Centro of the birth and explained that they had attempted to find someone who could bring her to the Centro by ambulance but nobody was around.

The next day three staff members came out to their home; the head nurse, and two other people. They immediately began chastising her for not trying harder to get to the clinic to have an institutional birth and yelled that she was lying about not being able to find anyone: that she just wanted to get away with having her child at home. One of the men asked if her placenta had come out post-birth and when she said yes he continued to tear at her bed looking for it and she said he even looked in her vaginal canal. They gave her two shots without explaining what they were doing, just that they were to stop bleeding, and continued to berate the couple over the course of their visit. A few days later, the three staff members returned with a police officer and demanded that the couple pay the S/.700 fine. The woman and her husband reported that they simply sat still, stared straight ahead, and didn't respond to any of the abuse. Eventually the

Centro staff got fed up and left. At the time of the interview 5 months had passed and no one had returned to demand payment of the fine.

This couple's experience prompted more stories from the research team of reports they had heard from other mothers. One of the research assistants reported talking to a mother who had said that during delivery "decían que no estaba empujando suficientemente. Decían que si querían abrir sus piernas en el momento de quedar embarazadas, ahora tenían que que abrir sus piernas otra vez ahora para empujar."[8] (personal field notes)

La Casa Materna & Sobreparto

When women approach the time where they will soon go into labor they must make their own way to the health center in Nuñoa. Those who live far out in the campo must plan ahead and find transportation that is going to town, usually for the Sunday market one or two weeks before. They must collect all of their bedding, food, clothing, and cooking utensils from home, and move in to the Casa Materna in the health center complex. Those who do not plan ahead are responsible for getting to the clinic one way or another or face fines and abuse, as described in the story of the woman from Pasanacollo. I have heard of women who, after their contractions had already begun, were carried for miles in bedsheet-stretchers, in wheelbarrows, on donkeys, and on the back of dirtbikes in order to arrive at the clinic in time to have a clinic birth.

I was given a tour of the Casa Materna by the one of the lead obstetricians, who has been working on and off in Nuñoa since 1997. She holds a *nombrada* position and is originally from Arequipa via Juliaca. This house is for women who are close to labor to come and stay in the

[8] "They [the clinic staff] said that she wasn't pushing enough. They told her that if she could open her legs to get pregnant, she could open her legs to push the baby out."

days or weeks before giving birth. The intention is to have them close to the clinic at the time of birth and to have a place for them to stay during recovery afterwards. The outside of the building looks like any other dilapidated building in town, the door hanging crooked but not yet disconnected from its hinge. Inside there are four bedrooms with bare pallet beds, one bathroom, and the main room doubles as a kitchen. According to her "para no asustarlas, el piso es sencilla, de madera y las paredes de adobe para evitar que entre el frío porque están acostumbradas a vivir así."[9] (Personal field notes) The casa was unoccupied at the time but she wrinkled her nose and attributed a rank smell that permeated the building to women bringing their dirty bedding with them. A building next door with a collapsed roof has two makeshift *fogones* (stoves which rely on dried animal dung for fuel) for the families to use to cook their *chuño* (dehydrated potatoes) and meat.

Illnesses around the time of birth are also a concern, specifically the cases of *sobreparto* (literally translates to 'left over from birth'). Sobreparto has long existed as a culturally-interpreted illness in the Andean region with no parallel problem in the biomedical model (Larme & Leatherman 2003). It is used to name both post-partum infections, and other related illnesses or *debilidades* (weaknesses) connected to births. Symptoms may include weakness, pain, swollen limbs, rashes, headaches, sensitivity to foods, and/or painful urination. Linked closely to a woman's exposure to the cold and elements after giving birth, there are varying degrees of severity. In general, cold-linked illnesses are very common in the altiplano. People in the altiplano as a rule make sure never to sit on cold surfaces without a thick wool blanket

[9] "so [the mothers] don't get scared, the floor is simple wood and the walls are adobe to keep out the cold because they are used to living like this"

underneath them and limit air exposure to sensitive areas of the body such as the lower back, feet, and head (Larme 1998).

I myself was repeatedly chastised if my shirt every lifted to expose my skin while sitting down, or if I settled on a stone step without something underneath to protect me from the chill. Protection from the cold and the elements is even more important after giving birth and women take extensive precautions for the time period anywhere from one to three months after birth. During the first 30 days of this time women traditionally are expected to remain in bed in a room with walls lined with blankets to keep out the wind and the cold. They must consume an entire animal over the course of their rest period (usually a sheep or alpaca) and primarily eat meat and chuño. Their utensils are wrapped in cloth so they do not touch metal with their bare hands and they avoid bathing in water. They also avoid the sun, specifically situations where the sun could shine directly on their faces. All of these precautions are necessary in order to attempt to avoid sobreparto, and even so, months after giving birth a woman may still fall ill when an errant wind or cold strikes her as she herds her animals or crosses a cold stream of water in the hills.

These protections are not provided in the clinic. Once a woman begins labor, the obstetric team is called, and she is transferred into a room in the back of the Health Center. Some family attends, depending on who is available, but they are not permitted to be involved other than as general support. The woman is positioned horizontally on the bed and left uncovered up to her waist as she labors. Once she gives birth, the child is cleaned and given to her. Paperwork is completed to register the birth and put the newborn in the SIS insurance database. The mother is administered any medications (usually by injection) at this time. Many women stop taking both pre and post natal medicines, other than herbal remedies, when they leave the health center

because they are worried about side effects. The purposes of the medications are not sufficiently explained by the health center staff. Mothers receive a great deal of conflicting and confusing information along the way.

The obstetrician claimed that the medical staff is attempting to provide options for women to give birth within the clinic using traditional birthing methods. Nonetheless, I have not heard corroboration of this from anyone else in town. Supposedly there are plans to implement delivery rooms with facilities to accommodate for vertical birth. Romina explained that "they" (the women) use poles and bars to hold on to and remain upright. Here Romina mimed bearing down while squatting and holding on to something above her head. She says these will one day be installed in a special "traditional" room available for mother's use.

The clinic staff's emphatic reiteration of their successes with maternal and infant health and nutrition appeared to be almost as a justification for their failings on other counts. Left mostly unstated is the fact that these improvements have been made through a high incidence of mistreatment and coercion on the part of the Centro workers. Instead, much of the burden and responsibility is transferred to the women and their families as opposed to the clinic or state increasing the quality of care and resources. Yearly hand-washing, nursing, and baby crawling competitions are organized with prizes to promote each respective activity but efforts to ensure that clean potable is water accessible to all are lacking. Vaccinations are mandated for JUNTOS children, but explanations to mothers about the reasons and importance for giving the injections are unclear at best. Everyone acknowledges the lack of doctors, especially specialized experts, on staff at the clinic and yet every year there continues to be disruption in clinic administration, staffing, and logistics. The trends are instability, confusion, and lackof effective communication

between the different layers of the ministry of health, including its staff members and the district people. These perpetuated themes lead to a misuse of the available time and resources which results in ultimate unproductivity of this biomedical post in Nuñoa. And so, out of the limited agency they have to create change, the clinic staff and the wider health networks focus on birth and reproduction as two areas that they can actually impact.

Birth is generally acknowledged to be a unique and sensitive time for people in societies the world over. At the same time, where poverty and need for medical care intersect, a great deal of individual control is taken away. The situation develops into one of perpetuating "everyday indignities of structural violence" (Farmer 2010: 297). Why then do we so often pathologize birth in poor populations and remove a level of choice and freedom in the birth experience in the process of 'improving outcomes'? In Nuñoa especially, the period of pregnancy becomes a time in which health is controlled to a more extreme degree than any other time of life. It is a moment, like sexuality, during which bodies and populations can be regulated, manipulated, and governed. This form of "biopower" over the body and the population is what French philosopher Michel Foucault sees as central to the workings of the modern states, in which the body becomes exposed as the object of inspection, administration, and management (Foucault 1978). As Morgan & Roberts (2012: 244) write, this form of power also extends beyond the state: "the concept of reproductive governance highlights the intersections of international policies…and those occurring on the national scale where their effects are often executed, experienced, and analyzed." In Peru, no one sets out to harm or stress mothers. Unfortunately, there is a trickle-down effect of the international WHO and UN policies to the national level where legislation is produced. Policymakers work not only to solve problems within the country, but also to perform

for the international stage and prove to the global community that Peru is developing into a modern nation in a Western-dominated world. Health statistics are used as evidence for this modernization. The problem here is that these statistics are created almost synthetically from a collection of many unseen micro-events in health care where the (primarily female) health experiences are regulated and often traumatic on the local level.

One woman's experience in particular became very personal for us because of our close relationship with her. Lilian is the youngest sister of one of Morgan's two Nuñoan research assistants. Her story is important because she experienced many of the same issues that affect many women and families in areas like Nuñoa. Similarly, she resonates with the trials and tribulations of women across many neighborhoods and rural communities in Peru and around the world. Much of her dramatic tale revolves around the topic of birth, but it is also emblematic of broader issues of systematic vulnerability, control and inequality. Themes of power, control, and bureaucratically-enabled exploitation contained in her story create a more visceral narrative than the everyday mistreatment of local people in less dramatic general-care situations, but these dynamics are still very common.

We became intimately involved with Lilian's situation as she entered the final trimester of her pregnancy during the summer of 2014. Lilian was pregnant with her second child and had returned home from Cuzco to her mother's house a few months before giving birth to have her family care for her and escape an incident of domestic violence perpetrated by her husband.

Despite being registered for the universal national health insurance program, *Seguro Integral de Salud* (SIS), upon her return to Nuñoa the clinic staff refused to accept her for gestational controls. The rationale of one health center manager was that she had begun her

health controls and check-ups in Cuzco and so she had to finish them there. At the forefront of his logic was the concern that too many women were returning to their hometown to give birth and then moving away - disrupting the ability to track their health records and making it seem like the mothers had simply ceased to bring their children in to the institution and were "non-compliant". Non-compliance looks bad on paper, and the aforementioned metas demanded documentation of both pre and post natal care, an additional layer of the increasingly common surveillance of women through their health. The official expansion of this surveillance on the part of the state began in full force in the Alejandro Toledo with his administration beginning in 2001 (Morgan and Roberts 2012). The new administration attempted to differentiate itself from the abuses of the previous Alberto Fujimori administration, which was responsible for carrying out illegal mass sterilization of indigenous women. Toledo tried to accomplish this by promoting the rights of the unborn in an effort to counter fears that indigenous groups would be unable to proliferate their populations after the sterilization abuses. He passed new legal policies aligned with the ideals of the Catholic church: legally recognizing the sanctity of life at conception and requiring immediate registration of all pregnancies. As these programs of surveillance became normalized and access to reproductive (particularly contraceptive) care were cut back, it became even more permissible for local staff to dictate additional and often arbitrary requirements on women during the reproductive period. Many of these rules and controls have confusing and ulterior motives at best, though at their worst they could be deemed further violations of human rights.

Because the women who are affected by these programs and policies commonly receive neither the education nor explanation necessary to understand the procedures, prescriptions, and

diagnoses, there is often no one to enforce the rights and needs of the patients. Unless, of course, one happens to be friends with a very indignant gringa. In Lilian's case, Morgan accompanied Lilian and Vicky the third time they visited the clinic trying to get an appointment and argued passionately that the obstetric team had no right to deny Lilian services. Reluctantly, they finally agreed and set an appointment for 1:45PM the following week. What they neglected to inform her was that the entire staff leaves at 1:30PM each day. This was a way for them to pretend to be amenable while they kept their paperwork and reports clean. Vicky, Lilian's older sister, is a champion for the beleaguered and refused to accept this behavior. She brought Lilian back later that week and demanded that they see her and stamp her JUNTOS paperwork.

Unfortunately, officials continued to stymie the family and make their lives increasingly difficult at every turn. When Lilian finally went into labor and was brought to the clinic the same obstetric manager, Luis, admitted her and promptly left with the entire on-call staff to go to dinner. Her contractions got closer and closer together and at first when the only nurse who stayed behind called his cellphone the obstetric manager told her that Lilian still had hours before she would give birth. The nurse could see Lilian was reaching peak dilation, and when she called again he refused to take her call. The nurse had to deliver her baby boy with the help of the off-duty primary care doctor and the lead obstetrician only arrived after the cord had been awkwardly cut.

The problems did not stop there. Lilian was forced to remain in the hospital for a few days more because the placenta had not been fully expelled and she was experiencing excruciating abdominal pain and excessive bleeding. After ultimately expelling the remaining

uterine tissue she returned home and her mother called a friend who "sabía de las hierbas[10]" and the two older women took over, confining Lilian to her bed in her warm room insulated with blankets and continuing the herbal rubs that they had been treating her with prior to giving birth. Despite the mandate that women give birth in clinics and the failure of the clinic to effectively work with parteras, women do find ways to get additional treatment and care that they feel they need in a way that is more comfortable and makes more sense than the brusque requirements of the clinic.

Though we were able to visit Lilian in the health center, it was only after the fact that she was able to tell us the events of the birth itself. When she gave birth the clinic staff had required her to deliver in a horizontal position and left her body bare and uncovered up to her waist. This is unimaginably uncomfortable, not only because of the deep chill of nights in the altiplano, but also because of the freezing and bare ward where women are interned while they give birth. When Vicky stood up for her sister and yelled at the very tardy obstetric team as they returned, threatening to bring a judge to sign an official complaint, the nurse just accused her of lying and said that it wouldn't make any difference. More than two weeks later her son still hadn't received his certificate of birth or been registered for the state insurance system. In one last display of defiance and abuse of power they said they had misplaced his paperwork. Thus continues the pattern of implementing policies and attitudes in order to meet goals, quotas, and tracking populations. The wellbeing of the individual women and children in question ceases to be the primary concern, as long as the statistical trend-line continues to show improvement and modernization.

[10] "knew about herbs"

Lilian and her newborn baby swaddled next to her on the bed

Discussion & Conclusion

As much as I would like to leave these stories to speak starkly for themselves, and I truly believe that they can, the way to connect people across boundaries of geography and experience is by comparing stories to wider patterns that reflect those global and systemic inequalities so endemic to the human condition. These patterns involve systems of governance and control, which, though they may not have been initially intended that way, use the right to health as a way to accomplish broader political goals. Everyday experiences in Nuñoa revealed the repercussions of Peruvian political policy, that policymakers in Lima are either unaware of, or choose to ignore.

Before starting fieldwork I had a general concept of a project which would delineate the pluralistic medical system in Nuñoa. I wanted to map how people navigated different ways of care depending on change in traditions and modernization. I wrote a proposal based upon my

reading of the literature in medical pluralism as well as my knowledge from living and studying in Peru. However, Nuñoa is very different from Arequipa, though it is only a days journey away. My previous experiences had limited applicability, except that I was already familiar with the culture of the clinicians, doctors, and social workers who were working in Nuñoa for a limited time. I expected each generation to be clearly defined in their traditions, expectations and ideas. The topics that I ultimately deal with in this thesis are not issues that I noticed on my own as a critical researcher, but rather those that were brought up again and again by townspeople in multiple conversations. These are the issues that are the ongoing frustrations and the inequalities that matter to people in the District of Nuñoa.

The medically pluralistic system in Nuñoa is extensively supported, on the biomedical side, by the national state. Such programs are implemented in Nuñoa because of its status as a district of extreme poverty. Use of traditional medicine is discouraged and the stated goals of the Ministry of Health closely mirror those of the World Health Organization and the Millennial Development Goals. The policymakers in Peru are attempting to progress in certain internationally emphasized areas such as maternal and infant health, in part to control, surveil and help the poorest populations but also to perform on the international stage. There is a large disconnect between policymakers in Lima, the implementation of policies and programs, and the local needs of the beneficiaries creating a cycle of inequality, stigma, and ineffective programming.

In this thesis I have outlined these major disconnects and sources of tension through experiences of townspeople, case studies of health events, and interviews with patients, clinic staff, and social assistance program managers. During the three months I lived in Nuñoa I got to

know a wide range of people and gained their trust as I attempted to also create mutual understanding. The vast majority of the important data that I gathered comes from these day-to-day conversations. Frustrations exist on all sides: policymakers, implementors, and health managers who do not understand their target population, and patients and poor populations who struggle in the face of unrelenting adversity.

In the Health Center in particular, staff and nurses consistently tried to find ways to exert control in a show of compliance with their requirements. In addition, each staff member has their own ideas about the areas that they viewed as important for change in the community. Social assistance programs involve built-in methods of exerting this control, specifically through the lenses of maternal and child health and nutrition. There is little emphasis on general disease or illness incidence. The health center pharmacy goes largely un-stocked. People utilize the *boticas* springing up around town as well as rely on residual traditional beliefs such as herbal treatments. Little emphasis has been placed on hygiene. Such campaigns tend to be dismissed as pointless, except in some rare cases. This is evidenced in offhanded comments such as the one Milagros made once when talking about the need for improved water quality, "ni siquiera se lavan las manos, ¿para que necesitan agua potable?[11]"

It would be simple to chalk up the difficulties and failures in health and health care to an explicit desire on the part of an overbearing Peruvian government to control all of its people. This is not the reality. In practice, all of the involved factors converge in dysfunction. This makes the situation both better, in that no one is an inherently evil person out to cause pain and suffering, and also more complicated to resolve. However, for anything to begin to be resolved,

[11] "they don't even wash their hands, why do they need potable water"

we must first face the overarching disconnects between those who have the power to make decisions and the populations who are affected by these decisions and their different implementations on the local level. Only then can we solve the negative trends in rural health care that have existed in Nuñoa and around Peru for centuries, and address the inequalities that these perpetuate.


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