Anemia in the Andes

Health promotion and Ethnography in the Northern Peruvian highlands

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Thankfulness to my Supervisor Oscar Hemer.

I would also like to extend my gratitude to the Faculty staff at Malmö University’s Communication for Development Master’s program.

I would like to especially thank all those who participated in this study, patients as well as health care workers. They are, as it will become apparent, everything.

A Special thanks to Jorge and Daniela for taking time out, and off, in order to assist me in my fieldwork endeavours. Their warmth, kindness and utter optimism about the project was deeply moving and inspiring.

*Hay hermanos pues muchisimo por hacer*, Cesar Vallejo.¹

Naturally, my deepest gratitude to my family, friends, and especially to endless love and respect for Jennyfer.

Abstract:

In this study I will present an investigation conducted at two communities in the northern Peruvian highlands during the months of February and March of 2019. I applied an anthropological perspective to Communication for Development and investigated how health promotion concerning anemia was perceived by different groups (health care workers and Patients) at the communities. I applied an ethnomethodological approach and worked with an applied anthropology perspective as collected data through ethnography and semi-structured interviews throughout the communities. I found that perspectives that are hard to accommodate within dominating discourses – such as critical perspectives questioning inequality and poverty – may be less prioritized in favour of narratives that can be accommodated within a neoliberal context. Furthermore, I found that there exists a myriad of accounts of development and that development work cannot easily be accommodated within simplified dichotomies.
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INTRODUCTION

During February and March 2019, I conducted field work at two small localities in Perú’s northern highlands. Having worked before in remote mining communities in this region I had already gained some knowledge of the social reality of these communities. I had also been shocked and sad to see the harsh realities of exclusion and poverty that dominates this part of the country. Alongside the amazon rainforest regions, the Peruvian highlands have often been forgotten by central authorities down at coastal Lima; hence left behind when it comes to social and economic development. Infrastructure, education and access to health care are at best precarious, often absent (Mendoza, Nava, 2016).

I became interested a few years earlier in the study of how anemia – the pathology of iron deficiency in the blood stream, an emergent public health in Perú and the developing world (Ministerio de Salud del Perú, 2014;2017; Gonzalez et al, 2011) – was combated in these regions.

The prevalence of anemia in Perú is one of the highest in the developing world (Ministerio de Salud del Perú, 2014, 2017; Alcalde-Rabanal et al, 2011) with almost half of children below 36 months affected. Working with ethnography, interviewing, and the use of an ethnomethodological approach in this ambience, first occurred to me when out in the field on other assignments, as it became apparent that the struggle against anemia was something of a thorn in the side for a society that was changing – on the one hand economic development, liberalisation and modernisation had contributed to a drop in poverty rates from 55% in 2005 to only 22% in 2015, which of course is really quite impressive (Oxford Business Group, 2016). However, on the other anemia and malnutrition is still a persistent issue throughout Perú, especially in rural areas (Lopez et al, 2011).

Especially qualitative methodology the endeavour to attempt to capture realities that go beyond statistics and reports, seemed especially suitable
for this task. At the core of qualitative methods is a concern with subjective lived realities, rather than numbers, qualitative method is about going beyond statistics and providing access to lived realities of informants (Kvale, 2013; Kvale & Brinkmann, 2013).

Departing from theoretical work on Anthropology for development (Eversole, 2017; Gardner & Lewis, 2015; Mosse, 2005; Li, 2007) I set out to collect data by interviewing patients and health care workers throughout two communities in an isolated rural Andean region.

Through ethnomethodology I approach reality as a social construction where interactions, utterances and observable facts are interpreted as ways, through which, communities uphold their life worlds (Schutz 1967; 1970; Given et al, 2008 p. 293, Gubrium & Holstein, 1997 p.38-42; Berger & Luckmann, 1991) I attempt to recreate the lived realities, discuss them from an anthropological critical perspective and analyse of these relate to official policy documents from the Peruvian Ministry of Health (Ministerio de Salud del Perú 2014;2017).

This was far from an easy task, and over the next pages I will share what I discovered during the collection, elaboration and presentation processes of the material at hand. This text is a summary of the background of the research topic, my theoretical points of departure and the methodology used, the results of my study and suggestion for future research projects/directions. I would like to extend a warm thank you to everyone who gave me their time, helped me and made this study possible. I am forever indebted for your generous assistance in making this project possible, thank you!

Purpose

The purpose of this study is, to through ethnography and interviews create glimpses of the lived experiences of those beyond the statistics of anaemia in Peru. Nearly half the families in such rural areas are affected, it is perhaps one of the most serious public health issues currently in Perú.
Furthermore, the purpose of this study is to participate in the knowledge producing process about these communities. Through collection and analysis of ethnographic material and interview studies at two localities in the Northern highlands of Peru, create knowledge about the lived life worlds of such communities and how such data relates to health promotion regarding anaemia. My aim is to investigate possibilities of community-based health care promotion in such communities by drawing a picture of them based on ethnographic research and semi-structured qualitative interview studies.

**BACKGROUND**

*In this section I will provide the formulation of the problem of Anemia in Perú. I will review the role of Anthropology and Ethnography in Communication for Development in general, and for health promotion work. I will provide some context from Peruvian social reality that is deemed needed in order to have enough contextual knowledge for the Analysis and Discussion-sections.*

**Anemia in Perú**

Perú has among the highest prevalence of anaemia in young children and breastfeeding mothers in the whole of Latin America.

The prevalence for children ages 0-36 months is currently at 43.6%.

For the very youngest, ages between 6 and 18 months, around 60% prevalence is common in many rural areas of the country (Ministerio de Salud del Perú, 2014; 2017).

The negative consequences of Anemia are, unfortunately, far from isolated to childhood and adolescence. According to the World Health Organization (Unicef, 2001) cognitive, physical, emotional and social development throughout life may be impacted by childhood anemia. Often also, academic performance is affected and in effect individual social development (Zavaleta & Robilliard, 2017).
The Peruvian government has pledged to reduce anaemia by half (from around 40% to 20%) by 2021. The Peruvian Ministry of Health’s policy document entitled *Plan Nacional para la Reducción Y Control De La Anemia Materno Infantil y la Desnutrición Crónica Infantil en el Perú: 2017-2021* (*National Plan to reduce and control maternal and infantile anemia and chronic desnutrition*) (Ministerio de Salud del Perú, 2017) sets out the requirements from a legal, scientific and communicative perspective. It is focused on mitigation and decrease of anemia in the entire country by focusing on target groups, mainly rural poor (Ibid, p. 8-10). The plan also aims at reaching health care professionals across the country and empower them to promote healthier lifestyles in relation to nutrition in their communities. Public health spending in Peru is among the lowest in South America and amounted to only 308 USD per capita in 2015. Compared to ‘developed countries’ public health spending is relatively speaking even lower, when compared to for instance the OECD-average (Mendoza Nava, 2016).

Perú is a diverse country with huge variations in climate, customs, socioeconomic status, language and culture. Economically more developed regions are mainly located on the coastal plains. The Andes mountain range cuts through the country creating majestic, but difficult terrains. Different micro-climate, as altitude, distance to the ocean and expected rainfall variates, result in great variations in climate and therefore possibilities to produce different agricultural products (Vidal et al, 1994; Degregori, 2016). Social inequality permeates Peruvian society and huge differences between social groups remain even after years of strong economic development (Mendoza-Nava, 2016; Barron, 2005; Figueroa et al, 1996; Cespedes et al, 2018).

Inequalities are also reflected in the prevalence of certain health conditions such as anemia, as it has generally been shown that poverty and relatively poorer health are related to each other (Ngwainmbi 2014, p. ix Marmot, 2015) and in Perú this is reflected as in fact anemia, and especially severe
anemia, is much more prevalent in the Andean periferic regions than in the more economically developed coastal cities (Gonzalez et al, 2011). Hence, prevalence reflects general socio-economic level. All though anemia has attracted ever greater attention from authorities in Perú it remains an unresolved public health issue (Munayco et al, 2013) and the driver behind this study.

**Demography, Geography & Economy**

Peru has seen significant economic growth during the last three decades (Oxford Business Group, 2016). Nevertheless, huge social and economic inequalities persist, although poverty did decrease by almost half since the 2005 (Mendoza Nava, 2016). Nevertheless, poverty rose for the first time in 16 years in 2017 and inequality is still very persistent. What possible might make this panorama even bleaker is a tendency of slowing GDP-growth since 2015-2016 (Oxford Business Group, 2016). The inequality follows several patterns – racial, social, class and geography. About 44% of the country’s poor live in rural areas (Cespedes et al, 2018). Anemia rates are significantly higher in rural areas than in urban areas (Ministerio de Salud del Perú, 2014, 2017, Lopez et al, 2011).

**The Health Care System in Peru**

The Health Care System of Peru is fragmented. Peru has a mixed system where insurance coverage is divided between private, public, semi-public and entity specific health care insurances (WHO, 2019). Economic factors mainly
determine which system citizens will be affiliated to. The Peruvian Ministry of Health (Ministerio de Salud del Perú, 2017) attends to the very poorest through its’ SIS (Seguro Integral de Salud, Integral Health insurance – my translation). EsSalud is a semi-private institution that is comparable to some European systems where workers in sectors affiliated to this insurance will have a health insurance linked to their employment status. The private entities are in the main consisting of those catering to military forces, police forces, fire fighters, private health insurance and NGOs and beneficiaries (i.e. Red Cross, Religious entities, NGOs) (Alcalde-Rabanal et al, 2011). Accordingly, the Peruvian health care system can be described as a system of:

“...multiple providers of services and insurance, often performing functions with a high degree of overlap and little coordination. Health workers often work several jobs in multiple subsectors.”

The health care system in Perú reflect larger social processes of inequality and exclusion. Inefficiency and lack of funding makes coverage arbitrary at best, but often simply absent from people’s lives. The resulting system is sometimes unstructured, and more than 10% of the population completely lack insurance (Ibid, 2011).

Coming from a period of neo-liberal domination during the autocratic government of Alberto Fujimori, in the 1990s, Peruvian health care practises reinforced existing inequalities between creole coastal elites and largely indigenous rural populations.

Nevertheless, during the early 2000s a process of more inclusive policies was implemented as Alejandro Toledo - Perú’s first self-proclaimed indigenous descendent president - took office and pledged to reduce barriers of race and class that effectively permeated Peruvian society (Guerra-Reyes 2019, p.3-5).

In the wake of this period the existence, and validity, of traditional means of healing and health care were officially recognized and included to health
care policies. In 2006 the Ministry of health of Perú included an intercultural health strategy, alongside a gender equality and human rights perspective, to its’ health promotion strategies (Ramos Padilla, 2006).

Race & Class in Peru

Scholars Adolfo Figueroa and Manuel Barron (2005, 25) describes the role of ethnicity in Peruvian society as follows:

“The social structure encompasses class and ethnic relations...in Peru, horizontal inequalities among ethnic groups are severe and contribute largely to overall inequality. As a result, indigenous populations constitute the poorest groups. Inequality is a structural feature of Peru. Since the beginning of the colonial period – its foundational shock – inequality has always been there, persistently, just like the Andes.”

Inequality is perceived as ‘natural’ throughout Peruvian society. The subsequent barriers created between groups are often justified as ‘needed’ (Mendoza Nava, 2016). Class and ethnicity are often intertwined in the post-colonial stratification of Perú. Ethnicity is far from an easy concept to define in a complex post-colonial society like that of Peru. A nation of a largely mestizo people race relations in Peru are often difficult for outsiders to grasp at a first glance (Thorpe & Paredes, 2010 p.34). Race is categorized using specific names and terms in Perú. Those considered Cholos (Mestizos) or Chutos (Indians) are regarded with hostility and prejudice. Nevertheless, these categories are far from static – someone may be considered in Lima, Cholo or Chuto while in their hometowns in rural areas, they may be perceived as mestizo. Peruvian racial discrimination follows a pattern of auto-discrimination – whites will discriminate against less whites who will discriminate against less whites and so on in a chain reaction of racism and prejudice. The struggle against inequality has lately risen as a priority for scholars and politicians alike.
Studies have shown that inequality is an impediment to social and economic development at large. Social and economic inequality run parallel to several stratification principles. On the one hand, race and gender play a crucial role in social and economic participation. Alongside race, Peruvian society is stratified depending on income level, race, and geographic origin (Figuroa et al, 1996).

**National Plan Against Anemia & Malnutrition**

The Peruvian government has registered the elevated numbers of anemia and malnutrition in small children across the country and elaborated several policy documents that tackle this issue (Ministerio de Salud del Perú, 2014; 2017). The purpose of many of these efforts is to promote social and economic inclusion within current structures:

”The purpose of ‘National Plan to reduce chronic infantile desnutrition and reduce anemia’ is to promote infantile development as a public investment in human capital of the country which will allow for economic and social progress of all Peruvians, with inclusion and social equity.” (Ministerio de Salud del Perú, 2014 p.12).

The goal is to achieve a reduction of anemia prevalence in, especially, rural areas. In 2017 (Ministerio de Salud del Perú, ibid) a target was established for this endeavour:

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<tbody>
<tr>
<td>Cronic Malnutrion</td>
<td>13.1%</td>
<td>13%</td>
<td>11.4%</td>
<td>9.7%</td>
<td>8.1%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Anemia 0-36 months</td>
<td>43.6%</td>
<td>37.9%</td>
<td>33.2%</td>
<td>28.5%</td>
<td>23.8%</td>
<td>19%</td>
</tr>
</tbody>
</table>

The activities that are described in the documents (Ministerio de Salud del Perú, 2014; 2017) are mostly focused on intervention in breast feeding mothers (information campaigns), especially targeting groups in poverty. The plan argues that several factors, such as access to water, socio-economic status, geographic region, among others, affects prevalence.
Also, of importance for my analysis, that the plan for 2017-2021 mentions culture, food habits and culture, and intercultural communication, with a special recognition for cultural differences across the country, should be key areas of focus (ibid, 2017 p.28-39). The plan establishes that actions and intervention should occur, if possible, in the homes of the target groups or in their immediate proximity. This, according to research, is important and effective in order to impact lifestyles (Mbuya, 2016).

Concretely the 2017-2021 plan to reduce and control anemia promotes several activities on a national level where a majority have to do with distribution of supplements, vaccination, parasite treatment and other ‘medical interventions’.

However, there are also some social interventions; for instance domiciliary visits to families to assist them in their efforts to combat anemia is recommended, there is a focus on clinics and workshops where preparation of foods rich in iron (Activities 9 & 10, 12,13) (Ministerio de Salud del Perú, ibid p.37-38). Even though we have seen how local indigenous knowledge has been of importance to Peruvian health promotion before (Guerra-Reyes, 2019) the presence of promotion of local knowledge, i.e. local foods rich iron, local products, products produced locally, is not explicit in the document. This, as we shall see, seems to be an opportunity lost from an anthropological point of departure. There is, generally, an absence of inclusion of indigenous / local knowledge as a potential for combating anemia in most documents.

For instance, in one policy document (Ministry of development and social inclusion, 2018 p.73). The communications strategy is only described in terms of the medium, and that it should reach the entire population, but not in which ways the message should be adapted to, and include, rural groups.

In summary, the government effort to reduce anemia in rural areas of Perú is mainly focused on describing the problem itself accurately using statistics from the INEI (Peruvian National Institute of Statistics and Information) and focusing on establishing solutions based on medical interventions,
supplementary alimentation and control of medical conditions, but also mentioning an additional focus on culture and intercultural relationships and variations. As it seems, Peruvian health services and their interventions may mention culture, and inter-cultural communication, but often in passing. What really seems to be hard currency at the ministry – and as we shall see what is possible to accommodate within the dominating discourse – are numbers, trends and ratios.

As Guerra-Reyes (2019) showed in a study of maternal health promotion in rural Perú – numbers are what really matters. It is perhaps expected that no greater structural critiques of the general discourse of development is present in these documents, they are after all official government policies. Nevertheless, as we shall see in the follow section theoretical critiques of neo-liberalism, of development discourses and economic paradigms may be hugely valuable and beneficial to the analysis of development efforts such as Peruvian public health promotion campaigns.

THEORY

In this section I provide a short summary of theoretical work on Community based health promotion theory and Anthropology / Ethnography for development which will be applied in the field work conducted for this research project. I will also provide a very brief litterature review of previous studies relevant for this survey.

Development, neo-liberal narratives, capitalism and Anthropology

"...All that is solid melts into air, all that is holy is profaned..."Karl Marx (1848) – The Communist Manifesto

Modern industrial capitalism is arguable the strongest, most destructive, most transformative, and comparatively, most instrumentally successful
social system at gaining social dominance, that the world has ever seen. Wherever it has pushed forward it has destroyed traditional societies and replaced them with its’ paradigm of economic progress and the imperative of profit.

Through division of labour, the spread of products, services and governing ideology capitalism establishes itself as the dominant discourse that transforms everything that comes within its’ realms. Antoni Gramsci (1992) theory of cultural hegemony seems particularly fruitful for the analysis of the impact of modern capitalism in developing countries. Neoliberalism is pursued, and made legitimate in international relations, through channels such as the IMF, or the world bank, cultural neoliberal hegemony is sought and maintained through the legitimacy and ‘acceptance’ of such institutions (Cox, 1983, Gill et al, 2014).

It is cultural hegemony, government through culture, rather than through violence, that changes the world. It is through cultural power that capitalism and neoliberalism has conquered the world, or at least been relatively successful at doing so.

In fact, it is not violence, but culture, that dominates. Obviously, other discourses may be available, and culture may in fact be an arena for resistance (Rupert,2006).

Recently, it has become apparent that there was no end to history when the cold war ended (Fukuyama, 1989) but that in fact there exists compromising contradictions and fundamental problems within the very core of modern neo-liberal capitalism (ecological, social, et cetera).

Critiques of the neoliberal order is no longer a space reserved for critiques of imperialism but existing across different groups in the political and academic landscape (Nederveen 2009, p.66).

When we seek development, we seek change – but what change, or perhaps more accurately – who’s change? The point of departure goes somewhere along the lines: something is bad and needs to be improved and will be so by action. Theories concerning development usually, in one way or another, depicts the dialectics of cause
and effect. Within the frame of a such a logic; a health promotion program seeks to improve health, financial support programs pursue stimulus of economic development, and so on. But are such accounts of development, implicitly or unconsciously perhaps, also promoting certain narratives of reality? Are they perhaps, in fact, disguised tools of power and oppression? A central concern raised by scholars is that this at least to some extent true and that in fact development efforts are not solely about social and economic development; but that they also serve as to propagate dominating neo-liberal discourses of reality. Especially stemming from dependency theory, in the 1970s and onwards, scholars have proposed this to be the case in what is referred to as post-development theory. This view is fundamental for anthropological accounts of development, which is the most important theoretical point of departure for this text and which will be reviewed further on (Ferguson, 1994; Cowen & Shenton, 1995; Escobar, 1995; Long, 2001; Ludden, 1992; Scott, 1998; Thomas et al, 1999; Tsing, 1993). According to anthropological development accounts, health problems, social exclusion, poverty et cetera, are often seen and tackled in a linear, instrumental manner in ‘mainstream accounts of development’, even though it is potentially misleading to speak in terms like ‘mainstream’ development as it is clear that development organizations may be no strangers to using anthropological data in design, implementation and assessments of development efforts (Eversole 2017, p. 101-102). Nevertheless, such data is only a compliment to a structure dominated by instrumental reason. An example of such steps is illustrated in below figure (adapted from Eversole, ibid):

<table>
<thead>
<tr>
<th>Problem (Economic, Social, Environmental)</th>
<th>Target Group (Community, Industry, Region)</th>
</tr>
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<tbody>
<tr>
<td>Solution (Technical, Economical, Managerial)</td>
<td>Theory of Change (Inputs, outputs, Outcomes)</td>
</tr>
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Naturally there are a lot of variations, but the point is that aspects such as gender, interests of stake holders and so on, may be included. Most development professionals are not rigid and total strangers to anthropological data in their work. Nevertheless, be it donor-related reasons, politics or public discourse – many developments due work in this instrumental / rational way.

Critics will hold that this is will only accommodate ‘emancipated groups’ within this established instrumental rationale (Ibid, 2017).

A key critique has been that such development also implicitly distributes the governing classes and groups’ specific accounts and narratives of reality.

David Mosse (2004, p.4) points to how a now extensive literature makes the point that like colonialism development’s rational attempts to create cognitive and social control. State, and market, control is enhanced over marginal areas and groups where hierarchies of knowledge are reproduced – scientific / western over indigenous – development fragments, subjugates and erases the local and by the means of technical discourses development is depoliticized and power is naturalised. Development theories, it is argued, is not only about social and economic development but also about hegemony. Therefore, anthropology is important.

Development is not solely about economic emancipation but the spreading of a view of reality – that of market-driven neo-liberal capitalism. At the heart of these concern is a focus on who’s change, rather than what change. Mosse (ibid, p.5) argues, nevertheless, that critical accounts of development, which depict a static relationship between western interests and non-western subjects, are far from unproblematic as well. He argues that, although such accounts can be valuable, they potentially can become misleading as they wrongfully create a discourse of conflict and resistance that may not always be present in such a black-or-white simplistic manner. It is important to seek the narratives that are available out in the field. Perhaps most importantly, it belies reality as it fails to capture the richness of lived experiences of those amidst development efforts. Development
projects are perceived as a meeting point of several discourses and interests (donors, government agencies, beneficiaries, local authorities, et cetera) and it is the ability to make such groups subscribe to a particular idea or plan which will determine the level of influence of such an idea or plan (Ibid, 2004, p.7-10). Mosse’s main proposition on development is that policy often mainly functions to mobilize and maintain political support, hence the ideology of donors and ‘owners’ of the programs is more important than the actual lived social realities. Hence, the implementation of the actual program – in this study the Peruvian ministry’s plan for reduction of anemia – is not actually the central matter at hand, according to this proposition (Mosse, 2005)

There is not a clear-cut, simple dichotomy between developed and underdeveloped, communities may perceive development different from those intervening in their communities. Communities will identify with modernity and development on different terms; in a sense incorporating those aspect of it relevant to them and their livelihoods (Crewe & Harrison 1999, p. 134-135).

This may have some positive implications, as the adaptation of more advanced forms of agricultural knowledge that enhances subsistence production. But it may also have some more complex effects, i.e. they may perceive as ‘being developed’ as consuming processed foods rather than the foods traditionally produced in the area – regardless of health impacts. This was registered in this study; community members would sometimes sell own produced goods of high nutritious value and instead consume processed foods such as pastas.

Finally, Mosse (2005) adds that the importance of ethnography used in ‘development research’ is not the categoric question of success or failure of development project. It is rather ‘how’ they succeed (if they) or fail that is central.

In a sense, ethnography serves to map the gap that emerges between policy and reality. Guerra-Reyes (2019) pointed to in a study how Peruvian health officials quite explicitly told her, on one occasion, that at the end of
the day ‘it was all about numbers’. Hence, policy, and its’ implementation, was of greater importance than the reality it related to.

Anthropology has been described as (Eriksen 2017, p.3) the ‘art of making the familiar exotic and the exotic familiar’. Anthropology is an ‘applied storytelling of a sort’ which allows for understanding of the myriads of lived experiences that permeates complex human societies. In development contexts, especially in developing countries such as Perú, anthropological appears to be a highly useful tool in order to create, or understand, development as a social phenomenon.

I will now turn to a brief review of Anthropology for Development, and its’ significance for communication for development and its’ relevance to this research project.

**Anthropology for Development**

Anthropologists recognizes that development efforts hit the ground in a setting, physical as well as social. Hence, this setting will affect the outcome and the effectiveness of the development strategies. In general anthropologists have studied development in two ways; on the one hand studies of what drives social and economic development is of importance to communication for development. Secondly, anthropologists may also study how development agencies – international as well as national - affect societies at large with their development efforts (Eversole, 2017 p.31).

Anthropologists working within the field of development recognizes that development is above all a social process. Rather than a simple chain of cause and effect; development is deeply dependent on the social context within which it is proposed (Eversole, 2017 p. 23).

Anthropologists have, since long, often adapted a somewhat critical view of development as such. This has often occurred due to experienced drawn from field work across the world.

In a sense, witnessing rapid social change following in the after math of” development”, many anthropologists have questioned standard narratives
of social and economic development (ibid, p. 28-29). Anthropology coming from the so called ‘developing world’, in Latin America and Asia, has proposed a more nuanced understanding of development in relationship to those ‘being developed’ (Gardner & Lewis, 2015, p.58). Spanning from a somewhat murky past, Applied Anthropology, was early on developed in within the realms of the British colonial system as a means of gaining understanding of foreign ‘colonized subjects’. This was done in order to better promote British, and/or western,” civilized” values.

In the United States, at the same time, applied anthropology also evolved, but rather in relation to the relationship between the state and Native Americans. Obviously, since then, a lot has happened. Perhaps most importantly, as theory passed through a period of postmodern self-reflection, development anthropology became more focused on the creation of critical account of development and development actors (Gardner & Lewis 2015, p. 49,50,51,52).

Often, Development Anthropology is divided into two main fields of study, namely - Development Anthropology/Anthropology for Development. The latter mainly studies how actual development work can be conducted spanning from anthropological data, and Anthropology of Development contemplates in a more critical vein the ‘development’, and discourses of ‘development’, from a more critical perspective (Grillo, 1985, p. 29; Viola, 1998, p. 27).

Development professionals and Anthropologist may differ in some aspects of their respective epistemologies; the first group may often be focused on instrumental and discard anything that does not seem useful at first hand, whereas the latter may be more focused on knowledge that is might not be of immediate practical usefulness at first (Eversole, 2017, p. 31).

The applied anthropology that I work with in this study is located somewhere in between the two main veins mentioned above – on the one hand I am working towards creating understanding of development as a social phenomenon, hence I am applying a point of view that is to be located within the latter. On the other hand - one purpose of the study is
to contribute to potential solutions to the problem of anemia and malnutrition in Perú; hence there are also parts of the former perspective being applied. In fact, my view is that there are no clear boundaries between the two distinction – and it might be fruitful to argue that such a distinction is somewhat unrequired for (Gardner & Lewis, 2011). Anemia, regardless of what view we have of development, will affect children, nevertheless and potentially make them sick. My view is that this condition should always be what we strive at preventing, and if possible, we should deter from unnecessary ontological discussion of what is and what should never be in terms of anthropology, development and social reality.

Health interventions in developing countries often are well intended, but theories of health promotion are usually not sensitive enough of local idiosyncratic perceptions of reality (Viola, 1998, p. 41-43). Mainly, local indigenous knowledges of health, foods and/or treatments, are unfavoured and more occidental ‘scientific’ health interventions are favoured instead. We shall return to this later on.

**Applying Anthropology in Development work**

Robyn Eversole (2017, p.99) has argued that the application of Anthropology for Development programs may be understood as follows:

”Anthropologists understand that designing and implementing development initiatives is a social and cultural process – a process with people at the centre. They understand that development work on the ground seldom plays out in the ways that those who plan it expect, and they are trained to see why.”

Within an anthropological framework context is more relevant than problems. Rather than picking up a defined set of clearly articulated goals following an action plan (see previous section). Anthropological framework for development shifts the focus from problem to context, from target
groups to development actors, and it moves from technical solutions-focus towards what is perceived as a perspective on knowledge that should, and often does, include indigenous knowledges / local knowledges.

In summary, applying anthropology to development efforts essentially becomes about creating a Development Landscape, which can be defined as: “... overall setting in which any development action occurs. It includes specific contexts, diverse actors, what they know, and the institutions they use to get things done...” (Eversole, 2017 p.105). Hence, the approach itself is social and cultural, rather than technical / instrumental.

Even though it must be highlighted that anthropologist critiques of Development agencies / Development work are not as clear cut as it might seem. Even though public discourse from development agencies, authorities and others may seem at a first glance to be simplistic, technical and under-sensitive to the complexities of realities on the ground, many professionals within such organizations are in fact aware of such complexities (De Sardan, 2005 p.4). Hence, there is always a risk of ’preaching to the choir’ when offering critique of development that is based on ‘a lack of understanding of social reality’.

The Impact of Anthropological Development research on Peruvian Health Care Services

At the end of the Fujimori autocratic rule in Perú, moving towards democracy and under the rule of its’ first self-proclaimed indigenous descending president Alejandro Toledo, Peruvian authorities attempted to tackle the problem of exclusion of indigenous and rural groups into the health care system (Guerra-Reyes, 2019, p.3-4).

In the following period the peruvian ministry of Health produced reports and documents which promote the validity of ‘alternative’ amazon and Andean health practices, and their usefulness in health promotion and treatment (ibid, 2019, p.5). Through the creation of intercultural health,
differences between groups was supposed to be eliminated. As we have seen, Perú, is a diverse and unequal country – hence these priorities translated into social policy. Indigenous women were often seen as resistant, unmodern, and uninterested in development in the traditional meaning of the word (De La Cadena 1991, p.19).

Even though these efforts to achieve cultural sensitivity in the Peruvian public health care system are well intended, it has been shown in study by Guerra-Reyes (2019) that focus often shifts back to a narrow instrumental concentration on numbers. In a sense, at the end of the day results orientated ’management’ trumps ’culturally sensitive’ accounts of anthropological data as support for development efforts. In the policy documents analysed for this work – see Background – National Plan against anemia – anthropological/local knowledge is included as an aspect of the struggle against anemia (Ministerio de Salud del Perú, 2017 p.66). Nevertheless, the lion part of the document focuses on medical / clinical interventions and this part – the cultural aspect which mainly focuses on the preparation of foods – is clearly separated from the rest of the policy.

**Why ComDev?**

Communication in Health Promotion can, and often is, distributed through different channels (Corcoran, 2007 p.23). On the one hand individual and group level communication is common, but mass media communication, through organizations and through communities are all common methods used by practitioners across society and the world.

Kreps (2003) has pointed to health promotion as a resource that is added to communication strategies and that allows for health messages to be used in the avoidance of ill health. Social processes are increasingly important for health promotion theory (Davies et al, 2013 p.80).

But the perhaps most important lesson, from this study’s perspective, comes from anthropological development work. In the complex reality of international development agencies, national authorities, local actos – all
being involved in the transformative force of neo-liberal economic reform and development; accounts of reality, lived social realities, stories and feelings of those from the field is key to understanding the results of development efforts in Perú and beyond (Mosse, 2005).

In this study my aim will be to attempt to produce knowledge of at least part of this lived reality through ethnographic research in a rural area in northern Perú’s highlands. As argued by Moss (ibid) it is not what but how that is of important. This is what I set out to reveal in this study. I will depart from anthropological theories discussed above. Above all, I would like to attempt to tell the stories of those involved in my study. I express gratitude and thankfulness for their participation.

**METHODOLOGY & DATA COLLECTION**

*In this section I will provide background on my methodological perspectives, theoretical underpinnings and how data was collected, analysed and structured following my fieldwork at two Peruvian rural communities in the northern Andes.*

**Ethnomethodology**

Ethnomethodology is a socio constructivist approach to qualitative research. It focuses on portraying the everyday “ways” through which individuals make sense of their world. This is in no objective sense; it is presumed that ‘social reality’ is created and upheld through daily interactions.

Theoretical foundation is found in the phenomenology of Alfred Schutz (1967;1970) Interactions across human interaction (Given et al, 2008 p. 293, Gubrium & Holstein, 1997 p.38-42) is the practical way through which this approach assumes that social reality is created. Language plays,
perhaps, the most central role in this practice. However, other social interactions are also of importance (Francis & Hester, 2004 p.1-4).

The purpose of the ethnomethodological approach to social inquiry is to, through data collection and analysis, “discover” a social reality as it is created by those affected by it. Putting into practice this approach presented its’ challenges throughout my study.

In some of the interviews, me being a westerner, was an impediment to access. This is of course not something that is new to social sciences in general, and health promotion research (Sixsmith et al, 2003). An unfortunate consequence of the desolation and solitude of many of these communities is a peculiar relationship to outsiders like me. Respondents were often somewhat expectant – what should I say? What is the correct answer? – when any answer that comes to mind, the more sincere the better will be most helpful to me.

In my case I was fortunate enough to have the access somewhat facilitated as I worked with two contact persons who were familiar with the communities. Such individuals are usually referred to as Gate Keepers. They provide a bridge between oneself and different groups as they are effectively members of the communities. Nevertheless, it was important to critically access how interactions may be conditioned by ‘their interests’. Albeit true that my ‘gate keepers’ provided invaluable insight, and access to others which would have been difficult, if not impossible without their help. Nevertheless, they are in fact members of the group and will seek to promote their in-group interests (Gubrium & Holstein, 1997, Reeves 2010).

In my case they were Jorge, an agricultural engineer who teaches at a local university, and Adriana a coordinator at a health care centre – which allows for access to the community. I am deeply indebted to them for their excellent support during the research process.

Patients were often reluctant to open without first assuring themselves that they would be respected. Health care workers such as nurses and coordinators, on the other hand, appeared to feel more comfortable with the interview context per say. My interpretation is that this is due to being
more exposed to interaction with ‘outsiders’. When listening back to one of my interviews from the Health Care centre in Santiago de Chuco I could very clearly perceived the expectant timidity of participants. It was not entirely evident to me as I conducted the interview, I recall. On the tape I hear how Jorge and I attempt to get our informant to open with us. We sound insistent, not too different – it somewhat awkward to acknowledge - from two salesmen delivering a sales pitch. *This is good, go for it, participate*. It does not make me proud, but it was a great learning experience listening back to. *This is what I don’t want to do going forward!*

However, when something unexpected happens – a nurse comes out and asks for Zavaleta (a name) very loudly and repeatedly, and I make a joke about *not being Zavaleta but having a Maleta (bag)*, which does not seem very funny, but the rhyme and the circumstance makes us laugh together. After that point we have a more sincere discussion where the informants reach out and ask me about tips about avoiding anaemia. It becomes clear, from this interaction, that they have very limited knowledge of anaemia (for those unaccustomed to the Andean region please note that Guinea pigs are bred and consumed as a traditional important source of protein):

**Informant:** I like to know how to avoid anaemia....

**Me:** Well, do you raise animals like Guinea pigs or chicken?

**Informants:** Yes, we have some Guinea pigs, some lamb...

**Me:** So what you can do is that if you kill animals to sell meat in best case scenario you give some meat to your children and if you cannot at least take the blood to prepare *Sangrecita* (a typical dish made from animal blood). Also, you need to give your children some fruit, just a little bit a day but any fruit. Oranges, for instance, if you can grow them are good but also some lemon. This helps to absorb the iron.

**Informants:** Yes...

**Me:** You said you don’t come here often, why?

**Informants:** Well, we live far away, and it is difficult to come down to the centres and the town. It cost money and usually we only come if something is wrong. If you are very sick or if it is something very important.
This piece of information was only available through a contact made where we shared something together – laughter. What I learned from these sequences was the importance of reaching informants and gaining their trust. When this fails to happen, interviews are very likely to become like the initial part of the interview. The process of gaining trust is a long one. Unfortunately, for this project, it could not be as profound as it should have, or I would have liked it to be have been, due to the limited time, resources and scope.

I do not regard participants as mere agents of the social reality they live and work within but rather part of a symbolic cultural practices that upholds that very reality through customs, interactions and language. In my case my touring with Jorge and Adriana, meet and greet sessions around the villages, discussions with locals, were crucial to building a relationship of trust with informants. Especially important for me as a westerner working in a rural community that is profoundly different from me.

Culture, customs, way of thinking, social norms are fundamentally different and hence ethnomethodology proves to be an effective way to “keep an open mind” and allow for my informants to ‘show me their world’. This approach is especially suitable for the kind of project I am undertaking, namely, to attempt to recreate lived experiences of my informants through their words and observation of their realities. However, a note of caution. I believe that future studies could be conducted that ‘go even deeper’. In such studies scholar should consider staying with the communities for months, and perhaps even years, in order to create unique insight of ‘becoming one of them’ rather than being ‘an outsider looking in’. However, lack of time resources – and perhaps even scholarly maturity – were impediments to such efforts.
Preparation

The first obvious question that I needed to attend was this – what am I studying? To produce new knowledge, better knowledge or deeper knowledge? (Brinkmann 2013, 49-52). In my case the answer falls somewhere between the second and the last. I want to gain access to lived experiences of the communities. Hence, the knowledge being ‘produced’ is not new in any literal way, as much as it is new to us as outsiders. My first step was largely dedicated to setting up the interviews. Here my contact, Jorge, was of great importance as he could make appointment with health care workers, gain access to health care facilities and is well-known at the locality. I read my field notes from our first day in Santiago de Chuco:

“Walking the streets of Santiago with Jorge. His is saluting everyone, how are you? Joking, and talkative with everyone. With sit down briefly for lunch and a village drunk approach us. He asks for money; Jorge laughs talk to him and I offer to buy the drunkard lunch. He sits down at our table. “

It is very unlikely that I would have had this easy access to people and places without Jorge. If anything, Jorge is saving me time and opening doors.

On my field work location, I contacted Adriana who gave me access to similar facilities at her side (EsSalud) which was usually important. From my notes I read:

“Adriana presents me to everyone. We sit down in her office for a while and have a very nice chat. We connect and she explains the challenges they are facing. I am struck by how precarious everything is.”

Throughout my fieldnotes the words precarious, poor and deplorable appear often. This provides an important context to my interviews. These are very poor places, and people here work with very small marginals. I
need to prepare for this and make sure that I do not offend them by showing lack of understanding of their social realities. Apropos, I used a semi-structure interview style for the same reason. By doing this, being more relaxed and open, I managed to get my informants to open more than if I had used a more formal environment (in a university aula or similar and used information sheets et cetera. This needs to be decided beforehand – usually naturistic accounts such as my own use semi-structured interviews and positivistic research use more structured interview settings. Although, exceptions do occur (Mulhall, 2003). What was required of me, when working interviewing in the community, was to be open and clear that I was conducting a formal study and research, but still as open and casual as possible in order to allow for informants to be able to open. This is perhaps the greatest challenge when collecting data in rural communities that are quite different from one’s own cultural background.

**Making Contact**

A large part of the data collection process was carried out through interviews. All my interviews were voluntary, anonymous, semi-structured life world interviews. As far as it was possible, I attempted to conduct the interviews in the actual environment, meaning: if I was interviewing a patient, I attempted to primary do so at the health care centre. Nurses and other health care workers were primary interviewed at their respective workplaces (hospitals, health centres offices et cetera). Fundamental aspect of qualitative methods is the idea of experience, the gaining of access to the lived realities of informants. Interviews, or perhaps more accurately so, *Conversations* is an important way through which such access can be gained. The influential Norwegian psychologist Steinar Kvale (1996, 5-6) defines the semi-structured life world interview as:
“...an interview whose purpose is to obtain description of the life world of the interviewee with respect to interpreting the meaning of the described phenomenon...”

I attempted to get my participants to talk. This was my main objective. Get them to engage in conversation with me. About just about anything, and then if possible, get them to guide me through their lived experiences. This is a difficult art, and one cannot expect to be successful. But when one reaches that connection with informants that allows for such a profound exchange, unique knowledge production can follow. I was more successful at this when dealing with health care workers. Patients where mainly less talkative. Below follows an excerpt of an unsuccessful data collection during an interview:

Me “I would like to ask you madam what you know of anemia, and what you think of it?”
Respondent: “Well I understand that anemia is due to children not eating”.
Me:” Ok, great – did you receive this information during an information session?”
Respondent: “No I have never received any such sessions.”
Me: “Do you come often here to the health centre?
Respondent: “I almost never go.”
Me: “And why not?
Respondent: “Because of lack of time”
Me and at your home did they ever approach you to provide you with information regarding Zika, Dengue or other such things?”
Respondent: “That yes!”
Me “Do you know what causes anaemia?”
Respondent: “Actually I do not.”

What becomes apparent in above interview excerpt is that the participant does not engage at all with the questions. It seems, in fact, that she is participating with very little interest. Here I fail as an interviewer – my job would be to raise such interest, get her to develop her world view. In the above case this does not occur. This proved to be quite difficult with many
of the rural participants – perhaps cultural differences and a lack of trust, that could not be built up due to time restrictions, became decisive to establishing this barrier.

One can retrieve information, get answers, but this is not exactly what is sought. What is sought has more to do with the qualitative nature of lived experience, rather than “accurate descriptive accounts”. In order to do that more ‘narrative like replies’ than the above is required. For instance, when interviewing the health care workers this was far easier as shown by below excerpt:

**Me:** “What work is currently being undertaken at this locality in order to fight Anaemia?”

**Nurse:** “Well, to begin part of our work is teamwork. We unite Doctors, nurses and so on. Yes, it is true that we belong to the Ministry of health... They give us some key points to prevent anaemia. But in reality, the mothers – or the patients – do not see things the same way. We are giving out sulphate iron supplements in 4-5 months babies, which is part of what the Ministry guidelines tell us... But when we hand out this medicine the mothers do not take it seriously. They do not give it to their children, they do not take importance of it.”

A comprehensive narrative is present. Several factors – in my analysis they are most likely the setting, the level of comfort, the presence of Jorge (my enabler, or gate keeper), the legitimacy of what is being said – creates a setting where the informant can create a narrative about her life world. The nurse speaks of an objective, how it is perceived and speaks of the problems communicating with the community.

One could argue that she justifies, in a sense, what they are doing and provides an insight into the world of health care workers in this communities – under intensive pressure but also with a clear need to justify the high prevalence of anaemia in their respective communities.

My view on this matter is that scholars should be careful, especially like in this case when working with semi-structured life world interviews to make
sure that one reaches the informant on such a level that he/she feels comfortable enough to share their lived experiences.

In my study this was far easier with the professional health care workers than with the rural poor women seeking their attention.

The main challenge was access, in a sense, being an outsider, being European and interviewing rural, largely indigenous or mestizo population in a remote area can, affect the outcome of the interviews. Interviewing is a structured, guided, or semi-structured conversation with the explicit goal of producing knowledge (Given et al 2008, 470). One cannot always expect to get it right in every interaction. This was clear almost from day one of field work. What sets interviewing apart from everyday conversation is the extent to which the process is planned and reflected upon in advanced, and subsequently analysed (Brinkmann 2013,45).

Hence, one should as interviewer make sure to follow a specific structure. Even though this was true for me I realised the need for adaptation soon enough on the field. The structure of interviews grew organically as I progressed. I had to make informants relax, laugh, and have them talk about just about anything – if I could get them talking, especially the patients, I was making progress. I will now proceed to provide a short summary of the steps I took throughout this data collection process.

**Interviews**

In an introduction to Responsible interviewing Rubin & Rubin (2012) argue that some of the most important aspects of interviewing is flexibility and acceptances of respondents. Central to my work in this study has been based on Steinar Kvale’s (1996, 124) description of what an interview be, namely a:

"...interpersonal situation, a conversation between two parties about a theme of mutual interest..."
Hence, when I approached informants, I was very open and transparent with the purpose of the study. The purpose is to create knowledge about their situation, about malnutrition in the northern Andes of Peru and about how this might be, in the long run without making any promises I cannot keep, might potentially be beneficial to them.

Even though this is not necessarily always the case – sometimes interviewers will not reveal their purpose in order to collect ‘data undisturbed of this knowledge’ (ibid:127) – I had ethically believe that it is necessary to provide information regarding who I was, and the purpose of my study.

This also, I sensed, eased some of the tension they might have felt at the onset of the study. My interviewing mainly focused on getting informants to talk me through what happens in their lives (narratives) and I attempted to have them clarify/justify these narratives with follow-up questions.

**Analysis**

After finishing my interviews, I began the process of transcribing them.

Although tedious, and sometimes difficult, it should be thought of as part of the analysing process, or:

“…Transcribing necessarily means translating from one medium (the spoken word) to another (the written word), and researchers should think about how they are going to transcribe early in the process.” (Brinkmann 2013, 61).

For my analysis I am using an empirical phenomenological approach, where longer utterances narratives or opinions are condensed into shorter statements. The idea here is that there is an underlying essential structure of how we experience things (Kvale & Brinkmann, 2008, p. 205). This methodology has been refined by Giorgi & Giorgi (2003, p. 170) into four essential steps:
(1) Obtain a concrete description of a phenomenon (through an interview) as lived through by someone. Read the description carefully and become familiar with it to get a sense of the whole. (2) Establish meaning units in the description. (3) Transform each meaning unit into expressions that communicate the psychological sense of the data. (4) Based upon the transformed meaning units, articulate the general structure of the experience of the phenomenon.

As will become evident, I did this for two separate groups. On the one hand the patients and community, and on the other health care workers, as it become evident throughout the analysis that these two groups showed very different perceptions of reality.

The listening back to, transcribing and reading through interviews is helpful in many ways. For one, one notices things that were not there when interviewing. Secondly, it allows one to grow as a professional, to become better at the craft of interviewing. This latter was certainly true in my study – it made me more aware of lived experiences of rural people in Peruvian highlands and thus also better at reaching out to them moving forward. This is perhaps most useful come future studies but nevertheless it also helps when analysing.

**Report**

In much qualitative research writing is seen as a ‘method of inquiry’ (Richardson & St.Pierre, 2005). In a sense, often analysis and reporting are a simultaneous process (Brinkmann 2013, 67).

This has also been the case in this study. In fact, the first draft of the report was already created and discussed with my supervisor even before going out on the field. Reporting needs to reflect the needs and the reality of the text. This initial format changed a lot – departing from a more standard format of writing I was encouraged to engage in a more naturalistic, free way of presenting my results. This suited the format better but was more difficult. The finally decided to keep some standard aspect – as in for
instance the Introduction-background-method-results-discussion-structure – but I moved towards a freer way in presenting. As will become apparent from this method chapter I have already introduced some of the data. However, and this is perhaps an open advice for anyone engaging in this kind of studies – it might be worthwhile to not stick rigidly to a specific form and let it grow organically from the data. I moved towards this direction but due to the planning, and execution of data collection was largely carried out considering the previous more formal format, this was at times limited.

Observation and Ethnography

Ethnography is not just a method of observing, or collecting data, but a style of doing qualitative science that permeates the whole of process of creating knowledge – hence data collecting, writing and interaction with informants. Borrowing from traditional science, from creative writing ethnography often becomes a personal exploration as well as an exploration of the object of study. Or as argued by Campbell & Lassiter (2014:4):

“...at the end of the day, doing and writing ethnography is about engaging in, wrestling with, and being committed to the human relationships around which ethnography ultimately revolves...”

This ultimately is about empathy for the groups that one creates knowledge alongside, and perhaps more precisely so with. Collaboration is a key aspect of doing ethnography, working alongside key informants has raised as a fundamental key to success (ibid:5) and was crucial for this project. I stayed in touch with many informants on WhatsApp, chatting and calling each other after the interviews to talk about the work but also to just make casual conversation about many diverse topics. A positive part of this was that indirectly this involved informant in the writing process, as I discussed
with them, I had their views present while redacting and analysing my findings from my field work. Also, my ethnographic research in this study heavily gravitated around, and was used as a complement to, my interview study. Sometimes there is talk in the methodology literature of Ethnography of ‘Going Native’.

What usually is referred to is the act of penetrating into communities, becoming one with them and hence being able to observe reality as it is, rather than as it is presented to foreigners like myself. In short study like the one I conducted this is difficult. Especially when the group is – as was the case – very different from oneself. In my study I worked with two such Gatekeepers – Jorge & Adriana.

The crucial point about the was that they served as a connection between me and informants. In a way they communicated to the informants that “...it was all right...” to talk to me and that I was “...de confianza...” (to be trusted).

It is of course difficult to speculate on how I would have done without their help, but it seems not at all unlikely that I would have had a hard time reaching informants in a confident way similarly without them.

When observing in ethnographic research one needs to extensively be aware of oneself – the impact one has on the subject – but also to extensively take notes, if possible, photographs. Ethnography is, in a sense, to capture the moment, and thus one needs to be awake and ready because moments can essentially be glimpses. Short and difficult to grasp but deeply meaningful to participants.

The present is capricious, and its’ portrayal is a dialectic process where the researcher negotiates a narrative about what is happening with those involved. One example of the capricious nature of ethnographic research comes from one of my many field notes from the days out with Jorge in Santiago:

_I visit Jorge’s ‘Office’ a small room at the grounds belonging to the affiliate of University of Trujillo. We have a drink in his office – he treats me to some_
traditional cogollito (a strong alcoholic beverage made from sugar cane and fruits) from his native Cajamarca. It started to rain as we walked outside – the mist was coming down from the high mountains all around us. We sat down in a small hut and we talked to some of the locals. They asked me where I was from and I told them. Jorge explained to them the purpose of my visit and they told me they liked the kind of work I was doing. From that we went to have lunch at a small local restaurant. Warm lamb stew. It was very nice, and I decided with the old lady who ran the place to stay the night in a very small, very simple room she had. Everyone was very kind and welcoming – I wonder if it was because of Jorge or if they just were this kind and welcoming to anyone?

At a street corner we see some men standing around. Jorge tells me they are drunks trying to scrap up enough cash between the lot of them to buy booze. Sometimes, around here, he continues, they will buy alcohol from the pharmacy and drink it. I remember thinking that this sounded exaggerated and did not make a lot of sense from a cost-benefit (more booze for them money) kind of perspective that drunks may adapt. I remember feeling that he was trying to impress me, like check out our crazy drunks... Did this affect his gate keeping – his presentation of his version of the place?

Everything from the state of the health care centres, the people I worked with, the participants in interviews is ‘ethnographic data’ and important. The difficult part is to see it, capture it and reproduce it in a fair and inclusive way. One should be aware of shadows; one’s own and that of others. Jorge is a great guy, but he is a guy just like me with a shadow that will fall upon whatever he gazes upon, whatever he shows me. Unfortunately.

Research Ethics

When conducting qualitative interview studies one can be confronted with sensitive, and personal information. It is extremely important to seek informed consent from participants. I always took the time to explain
exactly what I was doing and why, I explained about how the work could be published. I also had a sheet of paper with me with my contact details, additional information Spanish about the project and in it I encouraged informants and others to reach out to me directly for any queries and/or additional questions.

**SOURCES**

In this section I will present the sources used for my analysis. There were two channels for data collection: visual ethnographic data and interview data. Naturally these channels complimented each other; i.e. I might be conducted an interview and recording it but during the interview I may have observed something which I noted down and hence produced ethnographic data. The opposite was true on some occasions, while observing I might be engaged in a conversation with a participant which slowly turned into an informal interview which in a sense created data that was located somewhere between ethnography and interviewing.

**Fieldwork**

I conducted ethnographic fieldwork and qualitative interview in two rural areas in the northern Peruvian highlands (the Andes). I studied two separate places due to the fragmentary nature of Peruvian society in general, and Peru’s health systems.

At one of the localities – mainly rural, mainly poor – the vast majority were affiliated to the SIS (MINSA, Peruvian Ministry of health), the health insurance for those living in poverty, or extreme poverty. This accounts of 60% of the population, even though it must be highlighted that my sample is in no way representative of the entire population. The other locality was a slightly bigger town, but still rural, with a more formal economy. Here a greater proportion is affiliated to the *EsSalud* health insurance.

However, both localities show similar tendencies for anaemia and health in general (both at about 40% which is the national average for rural areas).
Furthermore, both localities where located at a similar altitude (2,700 meters above sea level and 3000 meters above sea level) and in other ways had similar customs and traditions.

Private actors, such as private insurance schemes, military forces insurance scheme and/or police, et cetera, were not covered in my study due to the small number of Peruvians, relatively speaking, affiliated to such schemes. Furthermore, these schemes are concentrated to urban areas and even more limited in rural areas thus the relevance to lived experiences of rural Peruvians decreases further. Below follows a summary table of the interviews I conducted in this study:

**Interview Data**

Several interviews were conducted during this study, over several days, and I will present the key data used for my analysis below. I have divided the data into subcategories; beginning with those interviews coming from health care workers, followed by interviews with patients/users. This distinction is important – as was discussed in the previous section these two groups responded very differently indeed to the interview situation and hence there is a strong, undesired, discrepancy in the quality, quantity and usefulness of the data.

<table>
<thead>
<tr>
<th>Type of interview</th>
<th>Participants</th>
<th>Interviews #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus Group style interview</td>
<td>Nurses / Health care workers</td>
<td>3</td>
</tr>
<tr>
<td>Semi-structured Patient interviews</td>
<td>Patients (Mainly parents)</td>
<td>15</td>
</tr>
<tr>
<td>Semi-structured single interviews with health care workers</td>
<td>Nurses</td>
<td>3</td>
</tr>
</tbody>
</table>

**Ethnographic Data**

My other main source in this study has been ethnographic data collected while on site conducting interviews and walking around at the localities.
with my gate-keeper Jorge. This data was recorded by memory, tape recorder and field notes.

**INVESTIGATION**

*In this section I will and analysis of collected materials from field work in March 2019. I will discuss the data, analyse it, and point to theoretical and methodological points of interests for my analysis.*

In one of my interviews in Cajamarca a participating health care worker mentioned an interesting project she was involved in before starting working at the health Care centre. She explained how, not far from where we were talking, there was a community that used to have critically high levels of anemia in their very young.

She was involved by a local mayor who wanted to do something about it. The irony, or perhaps the tragedy, was that the community grew large quantities of lentils – rich in iron – which they mainly sold to buy other foods, such as pasta.

**Nurse:** I talked to the locals and explained to them that it was great that they were able to make profit on their lentils. But they should keep some for their children. After explaining how this would make their kids stronger, we managed to get them to start doing this. However, anemia levels stayed high. So, we went back to talk to them, and we realised that the reason why they were still affected was since they did not consume any Vitamin-C. As you may know this is needed for iron to be absorbed into the blood stream correctly. Now, we managed to get them to start consuming *salsa criolla* (a typical salad made of onion, Peruvian chili, lemon and salt) with their lentils and rice and this finally did the trick.

This episode gives some insight of the complicated processes that make out the social realities of development in the field. It also displays one of the many contradictions found in this study regarding health and development. Yes, it is true that there are many local resources that could potentially help
to resolve the issue of anemia, and potentially other problems too. However, this is far from always the case. In this case – what really kept the dwellers from consuming the very produce they sold alongside vitamin-C (for instance consuming fruits and/or vegetables containing Vitamin-C)? As often is the case there being myriad of cases, and different people internalise modernity and development differently (Mosse 2004, Crewe & Harrison 1999). Inside them, I believe, was the crisis of contradicting discourses. If you are a peasant in a neo-liberal context you grow to sell to make money to buy stuff. You are not subsistence farmers. Hence, farmers would be interested – sometimes – in consuming processed foods (like pastas and macaroni) lacking iron and other nutrients as this was perceived as ‘better’.

An important reason was the lack of knowledge, naturally, but there were other important explicatory factors. Villagers would not consume lentils as this was a commercial crop, to be sold, and to maximize profits they would sell it and consume other products that were of less commercial interest/value. This aspect displays an interesting backside of the spread of instrumental reason / capitalist model. Production is to make money, at first hand, not own consumption. To become developed, it seems, is to produce, sell and buy. Here anthropological data becomes important.

When the nurse considered local products, known customs (as the salsa used) and information the message came across. Is it possible that a different solution, such as getting the population to consume supplements at health care centres would help too? Absolutely, this is indeed a possibility. Nevertheless, as it was displayed in this study often this is problematic as mothers and children do not like the taste of supplements, they feel it makes them sick et cetera and hence often fail to consume them. In a sense, the nurse describes how the effort to combat anemia moved from a technical/instrumental approach to an anthropological view of ‘development landscapes’ (Eversole, 2017). This becomes apparent through ethnography – be observing, listening and participating with those who give us glimpses of their lives we engage with
them. We struggle with representing, but this the goal of our endeavour – hope to let their stories emerge from the text and the analysis. It should not be easy to take upon oneself to speak for someone else, this need to be a humbling task (Campbell & Lassiter 2014). The writing, reporting and analysis is in effect a simultaneous process in ethnography (Richardson & St.Pierre 2005, Brinkmann, 2013).

There are myriads of narratives, it is key to take them into account, to understand the setting and not fall into stereotyping of participants (Moss, 2004, Eversole, 2017).

I was standing with Jorge outside and he was showing me his small bio-garden where he was raising cuyes (guinea pigs) in some cages. Fog was racing down from the mountainsides and a slow drizzle began to fall, it was cold and vapor came out or mouths as we spoke. He was telling me that: ´...we got everything up here, you know, I am trying to tell these people...´ I raise the guinea pigs I use the excrement as fertilizer, and I grow pines also which is commercially a good thing as it produces wood and I can grow vegetables in the garden... They could really do this! But they are not... You know, in your countries, gringos like yourself, you hardly have anything, your countries produce very little – there is a lot of snow in the winter, right? You are productive... That is why you are productive. Here, in Perú, we are as the Peruvian botanist Antonio Raimondo – you know this guy who travelled all of Perú on horse back and collected plants and all that – he said we are beggars sitting on top of gold... This, I hate to tell you, is true a lot of times I am trying to make these people understand we could live better...´

What Jorge displays in above field note I made when we were chatting after having a bit of his famous cogollito – it was getting cold and night was falling and he was in a talkative mode – is a disappointment I often felt he carried around like a burden. A frustration with not being able to communicate how to adapt to modernity, to development. How to combine traditional subsidence ways of life with development, with modernity.
Another, perhaps the most important finding, of my investigation was the different perspectives of health care workers and patients. Sometimes this was even said pretty much plainly in interviews, even though I only understood when conducting analysis of my notes and listening and analysing the interviews that this was the case:

Nurse: “... we are giving out sulphate iron supplements in 4-5 months babies, which is part of what the Ministry guidelines tell us... But when we hand out this medicine the mothers do not take it seriously. They do not give it to their children, they do not take importance of it.”

The key question here, spanning from Mosse (2005) should not be ‘if’ but ‘how’ – obviously the situation described by the nurse is not ideal. One opportunity here is to understand the landscape rather than the problem. The proposed solution in the previous example – the nurse who had worked in a project involving a lentil farming community - integrated several aspects of the participants day-to-day life; their livelihood (crops), their foods, how to eat the food (lemon and onion) and the community was an active part.

By involving the community actively, rather than as a passive recipient, the effort becomes part of the day-to-day life and hence less alienating.

The reason given for refusal, later in the interview, was the taste. In fact, the mother did not like to give something to the child which made him/her vomit later. So, then they preferred not to do so. As seen in the official plans to combat anemia in Perú (Ministerio de Salud del Perú, 2014; 2017) food and food preparation is of importance. However, there appears to be a great opportunity when it comes to taking advantage of locally produced crops, local variations and so on. Perú is an extremely diverse land with climate varying literally from town to town; and to do what is usually done – propose to participants that they should make sangrecita, which is a blood sausage – is certainly not a bad idea but may shoot above the target if this is not common practice, and/or alien, in the specific region that the
health promotion campaign is conducted. Even though it is true that religious guidelines are sometimes mention – some evangelical groups will not consume certain foods – but this seems like a key area of development, and an opportunity to enrich program through anthropological data and ethnographic research.

The benefit would be to reveal the complex myriad of different accounts of realities (Mosse 2004, p.7) throughout rural Perú.

Below field notes points in the direction of there being a problem of representation and lack of voice of 'participants':

The health care workers and I, and Jorge, are all in a cherry mood. Perhaps this is not strange, even though we are quite different in many ways we had a few things in common. We have all taken part of upper higher education, although different careers. We are all familiar with the use of technology and we all experience life situations that are quite different from those of patients. This is palpable when speaking to the nurses. Phrases, thoughts and opinions are articulated more fluidly. It is certainly due to this closer cultural or social proximity that this occurs.

(This note has been scribbled down coming down from Santiago de Chuco to Trujillo on a late shuttle).

In the health care centre in the patient’s area the reality is different. I have a hard time finding participants, they are a bit reluctant to talking to me and was it not for the help of Jorge I may have had a hard time getting anyone to speak to me.

The environment is more spartan, it is dark and crowded in there. The proximity that occurs with the nurses is not at all present in the same way. (Note scribbled down shortly after the visit).

Health Care workers, and the patients, seemed to have different views of anemia and in a sense construct problem itself within the realms of a different discourse. Nurses and health care workers perceive themselves as” outside” the communities rather than within them. They do not use the term ”Nosotros” (We, Spanish), or any other term that would effectively include them into the community. More frequently the term ”Las Madres” (The mothers, Spanish) when referring to the patients.
Nurse: We tell the mothers that they need to take the additional nutrition (extract of iron) with their foods when they are breast feeding, and give it to the children when they are growing up... But due to reactions, due to uninterest, they often do not take them.

In the above excerpt the nurse is describing a situation where she is attempting to help them (the mothers / patients) understand the importance of taking certain actions to avoid anemia. Nevertheless, she is describing a clear difficulty in reaching her. In a sense, it seems that the nurse is internalising the development professional attitude towards development. Here practical knowledge is important, knowledge that seems of no, or little, practical value is discarded (Eversole, 2017, p.30).

However, as it was shown at some points in my study anthropological knowledge that may seem of little practical knowledge at a first glance may be greatly valuable.

Nurse: I was talking to a mother and she told me that... well she did not show any signs of interests... Like she really did not care... But then I asked her to listen to this and played a Huayno – traditional Peruvian highland music – that deals with anaemia... It is a really nice thing it speaks to people about anaemia and she heard and after that she became receptive and listened more carefully to my tips... She said should would speak to her husband and that this is really serious and that she was worried about anemia...Just like that I reached her!

It might be difficult, as westerners, to know why this particular huayno with the text chorus repeated throughout it ‘Con anemia no puede ser’ (It cannot be with anemia, from Spanish), would reach the mothers. Such data may only be retrieved, it seems, through interaction with the actual community, and attempted understanding of their lived realities. Nevertheless, the Peruvian authorities (this song is part of a government
campaign) implement as we have seen (Guerra-Reyes 2019) anthropological aspects of their health promotion efforts.

On the one hand aspects of traditional medicine, idiosyncratic differences and community roles may be promoted as part of the health promotion efforts. Nevertheless, they are often ignored in favour of western accounts of medicine (Viola 1998, p.40) and as was shown in Guerra-Reyes’ (2019) study numbers are usually favoured ahead of actual adapted strategies in the communities even though there have been some positive efforts in this direction in Perú as well. Below excerpt comes from the interview session with nurses in Santiago de Chuco and depicts how Jorge brings up traditional knowledge as a potential solution to the health problem of anemia with little, or no, response from the health care workers.

**Jorge:** There is this herb that grows on the rocks after it rains... Do you know it? Farmers used to eat it... Apparently this plan is very rich in iron... I don’t remember its’ name... Cocha something...

**Nurses:** Well, I have beard of this. We do not use it.

Previously in the interview we talked about the difficulty in getting "Las Madres" to attend the educational services that the health care centre develops in the town centre. Apparently, this has a lot to do with logistics, as much as with lack of interest. While at the health care centre, I found in interviews that mothers would only come down since they often lack the time or the resources to come down.

They will only make the journey when something is the matter, hence, to attend a cooking class in the main square where traditional dishes that are rich in iron are prepared is not an option for many of them. Numbers are important to them, as stated by one of the nurses:

**Nurse:** We are one of the regions with the highest prevalence, not only in this part of the country but in the entire country. You would think it is poverty that is the main reason behind this, and yes, it is true that it has a lot to do with it. But
honestly it is also about a lot of ignorance of the mothers... They do not simply do what we tell them, and it is a problem...

Often this discourse was repeated by health care workers in interviews. Yes, poverty is a big part of the problem but it is actually lack of education, lack of adaption, if you wish, of the “civilised” enlightenment of western medicine and knowledge that really is the problem behind elevated anemia numbers in the region. Still behind this narrative of ‘ignorant farmers’ getting ill due to their own subjective misconceptions and failure to adapt to development and modernity, there lurks another reality of which momentarily glimpses occasionally emerge. Below excerpt from one of my interviews as the EsSalud centre in Cajamarca reveals that other possible narratives exist but that they are often forgotten in the day-to-day operations of the health care centres:

Health care worker: Actually there is this place a couple of hours from here, it is a bit inaccessible actually, traveling north towards Cutervo, you should definitely go up there if you can at some time, where they involved local leaders, had the local council take on the matter and they really managed to address anemia in a way that no hospital managed. This was the way forward I believe. This is something EsSalud or Minsa does not simply do. Maybe it is lack of resources, maybe it is because they don’t want to... I really don’t know.

This health care workers have independently reflected on the use of anthropological data in the development work. Here it seems that the social fabricate of the community, the traditional ways of taking decisions, of addressing problems, was included as the channel through which anemia is addressed.

Patient: Due to lack of time we do not come here as often. But yes, I would like to learn how to combat anemia...
**Me:** Well, one option is to whenever you kill an animal, just any animal, is to collect the blood and use it to make ‘sangrecita’ (Local blood based dish)... This is rich in iron.

**Patient:** Yes, I could do that. Usually I give it to the cat or the dog... They are also hungry...

There has been a strong focus on Peruvian development campaigns on foods. Perhaps this reflects a general tendency of cuisine in Peruvian society (recently the Peruvian cuisine has received much international attention due to its’ variation and richness). This is a potentially positive idea where efforts can elaborate on existing traditions of cooking foods that may be containing nutrients that can mitigate anemia.

**Patient:** I don’t really know how to reduce this with anemia... I am surprised and can you tell me what should I do?

Often the above segment did occur during interviews, patients would tell me they did not know what to do, they felt it was very difficult to reach health care centres and they would ask me for advice. This was somewhat uncomfortable as I was hoping to register how the perceived anemia, and such interactions made it clear to me that many patients had not been reached successfully by the authorities with information.

**Nurse:** A problem is that they will sell their animals, their vegetables and often buy pastas and macaroni and other processed foods instead... Which we find absolutely ludicrous, and we tell them so, as they have perfectly nutritious high-quality goods that they sell – why don’t they consume those products instead, or at least some of them?

Basically, poverty, traditions, idiosyncrasy – are all set aside in favour of a narrative that was common among the health care workers. To an extent a lot of the patients fall ill because they ‘are ignorant’ rather than poor or
different. It is about being under-developed, and here clearly a western liberal perception of what development is, was internalised. Or as in another example from an interview at a EsSalud centre in Cajamarca:

**Nurse:** Here it is really a lot about ignorance... Honestly, we tell them what to do and they are not getting it... A lot of these people are very stubborn, it is typical of the mountain rural populations.

Or as expressed by a patient that was originally from a coastal region (traditionally more economically and socially developed) but now he was living and working in Cajamarca as his wife was from there:

**Patient:** I do not know if you know... But here in Perú the coast is you know Lima, Trujillo, Chiclayo, they are more modern places... Of course, it is not like Europe or Anything... But still... People up here are very machista\(^2\) and backward and therefore a lot of them become ill with anemia... Even though I am very much involved, I follow the advice of the doctors... Still my youngest daughter is suffering from anemia... It is so strange... Then you can imagine these people who don’t understand anything!

Spanning from critical work on development (Li, 2007; Ferguson, 1994; Cowen & Shenton, 1995; Escobar, 1995; Long, 2001; Ludden, 1992; Scott, 1998; Thomas et al, 1999; Tsing, 1993) it seems likely that often times anemia is justified within the paradigm of neoliberal capitalism. Factors such as poverty, lack of resources, are rationalised away in favour of accounts that blame the anemia on the peasants, on them being stupid ignorant or ‘beggars on top of gold’. Or as in the words of a patient:

**Patient:** We cannot come here too often; we need to work. We only come when something is really the matter.

\(^2\) Male Chauvinist, Machismo is the word attributed to describing patriarchy in practice in Latin American discourse. It is used by scholars and non-scholars alike.
A nurse adds that:

**Nurse:** We would like to go up to the *caserios* (isolated farms) but there is simply not enough resources...

One could argue that the main problem here is really the lack of resources, if farmers cannot come down to the health care centre due to poverty – would it not make more sense for health care workers to come to them, and when they don’t and farmers subsequently fall ill – who is to blame? The farmers, for being ignorant. The lack of resources, the social inequality – which may in fact be the root cause – is rationalised away in favour of a neo-liberal account that *responsifies* farmers, which can be accommodated within the dominating discourse (Li, 2007).

Using the ethnomethodological approach that I have adapted I am interested in understanding how social realities are created through interaction and conversation (Francis & Hester 2004) I found that there exists several narratives, a myriad of social realities and experiences, if you wish, in just these communities in the vast rural landscape of Perú. What this seems to indicate – as argued by Mosse (2005) ethnography for development needs to focus on the ‘how’s of such narratives and mechanisms. Some of these accounts, for instance the view that ignorance and backwardness, is more easily accommodated within a neoliberal discourse and is therefore more acceptable and powerful. Others, such as a narrative where farmers are unable to attend to health services, eat well, or access a better standard of living due to poverty, is less prioritized in public discourse.

Furthermore, using Giorgi & Giorgi’s (2013) method for structuring findings from qualitative research, I found that the realities constructed around what causes anemia, and how it can be avoided, differs a lot between health care workers and patients. For Health care workers I made the following summary:
<table>
<thead>
<tr>
<th>Concrete description as lived</th>
<th>Meaning units</th>
<th>Psychological sense of data</th>
<th>Based on 1-3: articulate general structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of knowledge of anaemia, lack of resource, lack of interest</td>
<td>Cause of anaemia is lack of knowledge.</td>
<td>Patients do not take seriously the interventions. Patients are held back by backwardness, machismo and lack of understanding of the seriousness of the issue.</td>
<td></td>
</tr>
</tbody>
</table>

A similar table could be constructed for patients, but naturally with different contents in order to better reflect their perception of reality:

<table>
<thead>
<tr>
<th>Concrete description as lived</th>
<th>Meaning units</th>
<th>Psychological sense of data</th>
<th>Based on 1-3: articulate general structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficult to attend health services. Lack of resources, Poverty, Lack of time. Lack of knowledge of Anemia (What is it?)</td>
<td>Lack of time, resources and information. Difficulty to attend health services due to distance.</td>
<td>Patients have other priorities and when it becomes critical because it is not high enough up on their ‘to do list’.</td>
<td>Material circumstances, where the most important is difficulty to attend services due to geographical, social and economic reasons. But other factors such as knowledge and social structure also affects prevalence.</td>
</tr>
</tbody>
</table>

Above should in no way be an exhaustive account of the differentiation in world views, but it serves from this study to create and antecedent to build upon. It demonstrates that different accounts of reality exist and that this, according to my study, becomes a problem when attempting to intervene in the communities.
Most health care workers are open to trying new ways of working, implementing new strategies – but all too often lack or resources, or in fact guidelines from the Ministry of Health encourages them to focus on certain aspects, serves as an impediment to such attempts. There is an effort on a basic level to work with anthropological data in health promotion programs across the country, but there seems to be a lack of clear strategy and resources to do so out in the field. Or perhaps, it could be argued that any account that is too critical of neoliberal accounts of reality is of lesser interest.

DISCUSSION

Participants of this study are some of the many people currently finding themselves at the frontiers of ‘neoliberal development’. Yes, in many ways thing have gotten better. For instance, more or less decent roads now makes the journey Trujillo-Santiago De Chuco about three and a half hours (20 years ago the same journey could take up to several days during the rainy season). Connectivity, all though still an issue, is slowly making its’ entry into the community. However, it is not an uncomplicated process of change, as we have seen. The idea of central authorities is for these communities to benefit from the larger trend of economic development in Perú. Following this pattern the logical consequence should be that their living standards and health improves as economic development advances.

However, this is only partly true. Yes, participant of this study have access to many things that were impossible to get their hands on only 20-30 years back. Nevertheless, it becomes increasingly clear that far from everyone benefits in the same way of modernity and development. Hence, it is fair to say that so far the struggle against anemia is far from over. I discovered in this study is that, even though anthropological data on local habits and customs is mentioned, and exists in the awareness of health care workers,
it is at best anecdotal and periferal. This consists of a cognitive dissonance of a sort present in health care professionals that was already observed by Guerra-Reyes (2019). On the one hand development – within the realms of the neo-liberal discourse – is considered a goal of intrinsical value. On the other, local knowledges may be useful in achieving this goal, but only if does not ask uncomfortable questions about the path of neoliberalism. Perhaps this fear is justified, at least geopolitically. Observing the total disaster of Venezuelan socialism of the 21st century, the corruption scandals of Lula and the Socialist party in Brazil and not to mention the solitude of Cuba – it might not perhaps be strange the Latin American countries fear socialism, and hence, the left-wing alternative to neo-liberalism much more than in other parts of the world. In essence – observing Latin America now, from the perspective of history, things have gotten a lot better. In the 1970s hardly no country in the region was a democracy, most were military dictatorships to the left or to the right. Economies were in shackles and, as been explained to me by several middle-class Latinos across the region, hardly anyone found a job. This has now changed, in the era neoliberalism Latin America has prospored, perhaps more than ever. In no other era has so many been lifted out of poverty, so much economic growth and bio-lateral colaboration, and by the way nowadays there are hardly no dictatorships left (and the remaining autocracies are all ruled by despotss proclaming socialism as their ideology of choice). Hence, neoliberalism is perceived, by many, as what works and socialism as that failed pipe-dream of past washed up revolutionaries. This contextual knowledge is important in order to understand the power and legitimacy that neoliberal discourses hold in many dominant parts of Latin American society, and Perú is in no way an exception. The power of this discourses clashes down on alternatives with tremendous power in rural areas. Hence, when nurses observe that ‘mothers’ are not doing what they tell them it is viewed as an expression of backwardness rather than a potential expression of cultural differention, or perhaps even resistance (which
requires intercultural communication). This is what we are talking about, this is the failure to connect with reality and progress. That is capitalism, neoliberalism and becoming like the rich countries. Period. Critical accounts are viewed with suspicion... Do you want this to turn into another Venezuela, I have been asked when I discussed equity, politics and social equality from a – in my view – fairly liberal European perspective and in no way arguing from a socialist viewpoint. This gives us a taste of how much neoliberalism has gained cultural hegemony in many parts of dominating groups in Latin America. But then again; those left behind the ‘miracle’ of ‘the boom’ are so evident, so palpable. They inevitably shines through as a sweeping question to the dominating discourse.

How the huayno reached the mother and created awareness, how peasant can’t afford to go to health care centres and are then seen as stupid. The contradictions of neoliberal capitalism comes shining through. Now, of course it is going to take more than a song to create healthy life styles. In this sense also their is awareness of anthropological data’s potential for influence. Nevertheless, there is a certain carefulness about it. Challenges related to poverty, social exclusion and natural disaster are all of great importance. Hence, to promote clinical interventions – vaccination, dietary supplements et cetera – is potentially a game changer. Nevertheless, it seems that an opportunity to take advantage of local knowledge, to help locals to develop their own ‘development landscape’ is often missed since it fits ill with this evolutionary view of development.

In fact, for a different, perhaps even more critical topic, relating to climate change indigenous knowledge has been flagged as a key factor to adaptation and fight against climate change by the UN (Raygorodetsky, 2011) – why could not global health promotion benefit equally from indigenous knowledge?

Of course, these are very different problems in scope, and casualty. However, it is apparent that they are problems that neo-liberal discourses, modern capitalism and market-driven solutions have a hard time coping with. Hence, indigenous, local, sustainable knowledge may have many
constructive points to contribute with when it comes to solving both these problems. I believe this is the case.
I found in this study that there is opportunity lost when it comes to application of anthropological data in health promotion regarding anemia in Perú. It is included in policy documents, but only marginally, and there is an opportunity when it comes to moving it center stage.
Health care workers often expressed a lack of resource, a lack of support from central authorities. This often impeded home visits (which is recommended in government documents) which is of course unfortunate. Furthermore, it makes it even more difficult to promote local knowledges as potential solutions to health problems (this requires time, implication, research and local knowledge). However, a reasonable question – and perhaps an interesting point of departure for future studies – is what the real cost of not taking advantage of local indigenous knowledge in a country with millions of indigenous citizens might actually turn out to be?

CONCLUSIONS

There is a risk of preaching to the choir when one speaks of ‘anthropological knowledge’, ethnographic research and local knowledge in development work. It creates a false image of, on the one hand, a group of development workers, perhaps located abroad or in some metropolis, who are utterly uninterested in the narratives of those ‘subject to development’. This is of course not the case. I am yet to meet such an individual (although, certainly he / she might exist somewhere in someplace). Nevertheless, one need to be fair and say that stake holders such as The Peruvian Ministry of Health, United Nations, Development agencies, Development workers and many more, are all aware of this knowledge.
However, and I believe this is important, we all have one thing in common. We share a common culture – we are westerns or ‘westernized’.

Hence, we have a rationality that is based on instrumental reason (this solution, this problem). There is nothing wrong with enlightenment style thinking, as has been often observed by philosophers and sociologists (i.e. Frankfurt school philosophy’s critique of enlightenment and dialectical reason) however such thinking also can become limiting and ‘blind to alternatives’ outside of the discourse. It is a view present in this study that this, unconsciously, sometimes happens with development projects such as the ones analysed.

It seems that for all the good things we think up about anthropology, about inclusion, about participative subjects, we tend to end up somewhere – is it to satisfy donors or even perhaps worse so ourselves? – in places where rational instrumental explanations are given to rationally assessed problems.

As mentioned, this does not need to be a bad thing. However, a lesson learned from this study is that unless we integrate a systematic, and well-planned, inclusion of anthropological data into our project we might ‘rationalise’ away such data as the project progresses. We might, as the nurses in my study, sometimes, although well-intended, see ‘mothers’ as reluctant to development instead of asking the obvious question – if the supplements makes them sick, and this is a problem, what solutions do we have that does not make them feel sick that might work? Are some of them ready at hand (local produce)? If yes, how can we help? What about structural inequality? Is it really so that they are ignorant – does it not make more sense to look at this problem from a resource perspective?

Speaking truly - but who’s truth are we speaking?

A few years back when concluding a degree in jurisprudence a Nepalese legal scientist once told me something, when discussing socio-legal perspectives on laws and norms. He argued that one when analysing foreign legal systems needs to be ‘aware of one’s own shadow’. What this means, basically, is that one need to be aware of that interpretation is
often very much influenced by our own assumptions of the matter at hand. Anthropology may still be the most effective way, as it ‘makes familiar exotic and the exotic familiar’ to disperse such prejudices and help us better understand ourselves, the other and the meeting of the two. Disperse the shadows that keep us apart. The speaking of others’ truths.

References


