New arenas of state action in highland Ecuador:
Public health and state formation, c. 1925-1950[1]

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The quarter-century after the 1925 Revolución Juliana (July Revolution) was a key era in the Ecuadorian state's development of its capacity to administer populations. In this period the Public Health Service (Servicio de Sanidad), one of the government branches involved in this process, was simultaneously constituting itself as a particular kind of state institution and constituting new sites of state intervention, such as rural areas, indigenous populations, urban neighborhoods, and domestic spaces and intimate behaviors. In this paper I will use two projects carried out by the Sanidad to explore some of the dynamics of state formation in the Ecuadorian Andean highlands. The first is an eradication campaign against bubonic plague undertaken in the rural area Guaytacama (León province, now Cotopaxi) in 1926-27; the second is an outreach program in maternal-infant health established in Andean provincial capitals and county seats in 1935.[2]

These projects are both likely and unlikely places to find state legitimacy being forged: while one might expect legitimacy to be an effect precisely of "helping" projects of this kind, at the same time the particular ways that this occurred in the two cases I present were in some ways surprising. I came to this research with an interest in how public health might be an arena for the production both of discourses about the biology and behavior of subordinate groups, and of new forms of state intervention in the lives of such groups, assuming that one of the main aims of such projects was the imposition of new social mores as part of the process of constructing notions of national, urban, mestizo culture. On closer examination, however, I would now say that what defined "success" in these two projects was rather different than I first imagined. To anticipate my argument, these projects can be considered relatively successful ones along two lines: in terms of the metrics of the Sanidad itself – that is, in improving particular health conditions – and also, centrally for the purposes of this paper, in how they helped to construct a particular image and experience of the state. They were probably less successful in imposing new forms of living on subordinate groups.

In previous research I have argued that the Ecuadorian state in the first half of the twentieth century was characterized by fissures and gaps that allowed indigenous peasants (and others) to play some state officials off against others, generating room for maneuver to resolve some of their most pressing everyday problems.[3] Labor issues were central to liberal discourse and policies in the first decades of the twentieth century, so this dynamic was particularly marked in labor disputes. For Peru in this period, Paulo Drinot argues that there was a kind of co-production of the state by labor and state actors.[4] That might be an over-statement of the case for Ecuador – particularly since the peasant actors I studied were responding to immediate local needs rather than representing a larger-scale movement – but nonetheless I would argue that it was the actions of subordinate groups that in some ways brought the state into being in some areas of the Ecuadorian highlands (as David Nugent suggested in the rather different context of Chachipoyas, Peru[5]). At the same time, the liberal state's labor policies can also be seen as part

of a class project, aimed at loosening labor ties in the highlands in order to generate flows of labor to coastal agro-export populations, so the kinds of freedoms this involved for indigenous peasants were very specific ones. In the public health projects explored here, there is less evidence of state formation from below than there was in those livelihood struggles. Nonetheless these projects too were shot through with conflicts and disagreements, which seem to have been quite crucial to the ways that they were implemented and gained legitimacy.

Bubonic plague in Ecuador was an urban problem in the port of Guayaquil (where it first arrived via infected ship rats in 1908, triggering the establishment that year of the Public Health Service) and secondarily in the provincial highland city Ambato, but also eventually settled into an endemic problem in rural indigenous areas of Chimborazo province with somewhat different characteristics there than in urban areas. Although plague did not in the end reach the highland capital city Quito, measures were also taken there to prevent what many feared was the imminent danger of infection in the 1910s and 1920s. Eradication work in the county of Alausí in Chimborazo province, the first highland province on the rail line from Guayaquil, beginning in 1913-14 was oriented toward controlling outbreaks in the town and along the railway line – since infected rats travelled from the port on rail cars – although it did engage the rural indigenous population in a specific way, bringing day laborers from their peasant communities to undertake sanitary measures in town. The anti-plague campaign undertaken in Guaytacama in 1926-7 could be seen in contrast as one of the first sustained rural campaigns against the disease in the Ecuadorian highlands. This campaign pre-dated by several years Universidad Central Professor of Higiene Pablo Arturo Suárez's pioneering of new forms of empirical study of the living conditions of indigenous peasants, when he began to take his students from the Faculty of Medicine into the countryside in the early 1930s to undertake fieldwork as part of their training as future physicians and citizens.[6] The Guaytacama campaign thus also marks a relatively early engagement with the indigenous population on health issues.

In 1926, following a decade of cyclical outbreaks in the provincial city of Ambato (Tungurahua province), plague spread north into rural areas in León province, just south of Pichincha province where Quito is located. There are several examples in the Guaytacama campaign that suggest some of the worst that could happen with an eradication project; nonetheless, the campaign also seems to have been one of the most effective ones undertaken in the decades-long history of Ecuadorian efforts to combat plague. It is partly these contradictions that make this an interesting case for considering the dynamics of state formation.

Guaytacama was the location of a number of modernizing haciendas that had otherwise been advantaged by the construction of the railway through the area, especially for the intensification of dairy production to provision urban markets,[7] and whose busy trade with the infected port was indeed likely the cause of the zone's plague outbreak. Large landowners of the zone were quick to respond to the request from the Sanidad to assist in the anti-plague campaign. A handful of them – including Enrique Gangotena Jijón (who a decade earlier had been the first president of the modernizing Sociedad Nacional de Agricultura)[8] and recent two-time Liberal president Leonidas Plaza Gutiérrez – together contributed several thousand *sucres* toward the anti-plague campaign, to fund the purchase of supplies and other costs.[9] They also formally agreed that their hacienda administrators would ensure cooperation with the vaccination and disinfection teams among the indigenous peasant population on their estates. This does not seem a likely context for

developing trust in the state among the indigenous population. Other events made this even less likely, including the distribution of some adulterated anti-plague vaccine with fatal consequences, an attempted rape by drunk subaltern employees of the Sanidad of two indigenous female plague patients interned in the lazaretto, the burning of indigenous huts that had housed plague victims, and the deaths from plague of some indigenous peasants recruited to the squads carrying out anti-plague work. Indeed, there was an indigenous uprising apparently provoked by the campaign.

When plague broke out in Guaytacama in May 1926, the Sanidad was just in the process of appointing public health delegates to provincial capitals; prior to that, such officials had sometimes been appointed temporarily, on an unpaid (*ad honorem*) basis, to address severe outbreaks of disease. This was part of the reorganization and coordination of public health efforts that followed the 1925 Revolución Juliana which brought to power a nationalist cohort of mid-ranking military officers and middle class professionals who engaged in a series of administrative reforms. Well-respected (and still relatively young) physician Pablo Arturo Suárez – Ecuador's first specialist in tuberculosis – was appointed director of the Sanidad and he energetically carried forward new processes of coordination, research, and outreach. While the León delegate was appointed to his post in the provincial capital Latacunga the month the plague broke out in the province, he was busy setting up his services, so a special commission was sent from Quito under the supervision of Dr. Pedro Zambrano to organize the urgent anti-plague work in the Guaytacama area. A young physician with an interest in social medicine, Zambrano had written his thesis a few years earlier on the medical and social problems involved in prostitution in Quito, and went on to have a long career running the Sanidad's venereal prophylaxis service in the capital. We do not know what experiences led him to become interested in that area of medical research and practice, nor that oriented him in his successful management of a medical facility that dealt with venereal disease and the regulation of prostitution. In any case, in the difficult conditions of the plague outbreak outlined above, Zambrano showed an unusual sensitivity to the situation of the indigenous population in a number of instances. He could understand why local indigenous peons avoided work on the campaign due to fears of being infected – "as happened with the day worker Hualpa, who perished of plague on completing a fortnight's work; the product of his labour allowed his grandmother to buy him a coffin"[10] – and reduced recruitment for such squads. Then, one night when two subaltern employees at the lazaretto got drunk, locked the other employees in the bunk room, and attempted (unsuccessfully) to rape two female plague patients in the lazaretto, Zambrano immediately contacted the provincial public health delegate to send police troops to arrest them. When they were released from the Latacunga provincial jail a few days later, he protested strongly that such an abuse could not go unpunished. His reports make clear that he was partly concerned with the pragmatic problem of gaining the trust of the indigenous population, but he also characterized this incident as having sickened his spirit. Around the same time, a set of vaccine used in the campaign turned out to be adulterated, so that both vaccinated and unvaccinated alike died of plague, leading peasants to hide from the vaccinators. Zambrano reported that "the Indians are, like never before, completely pessimistic, they believe and no one can convince them otherwise that the vaccine is a poison that they are injected with in order to kill them."[11] Zambrano made extensive inquiries to discover the source of that specific shipment of vaccine, but was unable to clarify how it had been damaged. The following month an indigenous uprising occurred (apparently provoked by the anti-plague campaign) and in its aftermath the Indians fled to distant

communities. Zambrano's main concern was that the contagion might be spread, and so he provided certificates to Indians confirming their innocence in the uprising to encourage them (successfully) to return to their communities.[12] The provincial delegate in Latacunga joined him in urging that an order of release be issued to free the jailed leaders of the uprising, to respect an offer the public health officials had apparently made to them immediately after the incident.[13]

There are a number of striking elements in these accounts, such as the mention *by name* of an indigenous day labourer who had died of plague, and the reference to Indians as "pessimistic" rather than ignorant regarding the effects of vaccination. Director General Suárez, too, requested legal sanctions against those in positions of power, rather than against the relatively powerless, during that year's outbreak. These included a large landowner who had repeatedly tried to recruit agricultural workers from an infected zone despite the cordon sanitaire.[14] He also went straight to President Isidro Ayora (also a physician) with his request for punishment of the jefe político (political administrator) of Salcedo county and the teniente político (political lieutenant) of Saquisilí parish – who he argued were directly responsible for any increased plague contagion because they had permitted fiestas (and hence gatherings of indigenous people from different communities) to occur in their jurisdictions despite the plague threat – and even of the Governor of the province for having neglected to prevent this.[15] In other words, the Sanidad's officials showed a significantly more punitive attitude towards people in positions of relative power who undermined the anti-plague campaign by act or omission than they did towards indigenous peasants whom they implicitly recognized as innocent victims who had a reasonable basis for their concerns. Their reports and correspondence do show paternalism towards the indigenous population, but could not be accurately characterized as pathologizing that population. (This was a specific moment in how the Sanidad engaged indigenous populations in regard to anti-plague campaigns; the tone of campaigns in the late 1930s and early 1940s was very different, for reasons I have explored elsewhere.)

In both rural areas of the central highlands and poor urban neighbourhoods in Ambato, Suárez insisted in February 1927 on the importance of reforming sleeping conditions in dwellings. Based on research into plague transmission during the 1926 Guaytacama campaign, he developed a regulation requiring that people sleep on raised platforms rather than directly on the ground, to distance themselves from the fleas harboured by domestic animals as well as by rats that tended to enter huts at night in search of food (in rural areas rats generally lived outside, unlike in the crowded tenements in Guayaquil). He insisted on the importance of this measure, but recognizing the financial barriers to its adoption offered to provide one or two *sucres* per household to those who were unable to otherwise afford these *tarimas*; he also circulated instructions for their simple and economical construction. For the first time, Suárez also developed architectural norms for peasant huts (*chozas*) in the Andean countryside, emphasizing that they should have concrete foundations to avoid providing nesting places for burrowing rodents. These were difficult to enforce for economic reasons, but the Sanidad did finance the construction of a model hut to replace one that had been burned in the Guaytacama campaign. For the first time, too, compensation was paid to peasants in the area whose dwellings had been destroyed when the Sanidad had had to burn huts that had housed plague victims given the impossibility of disinfecting and fumigating these constructions. Perhaps it was partly due to the financial contributions by local large landowners that the Sanidad was able to pay this compensation, something that had never been done, for instance, in the Alausí area; perhaps the

indigenous uprising was also a factor. However, such payment continued in 1929 when another outbreak occurred in a different area of the province, so this seems to indicate a new procedure rather than an anomaly.

Given the continuing importance of rats travelling on rail cars in the spread of plague, Suárez also insisted that those who commercialized foodstuffs from Tungurahua and León provinces in the Guayaquil urban market modify the crates they used to ship their produce. His specific concern was that after the produce was unpacked in Guayaquil, the empty crates, often with fragments of cheese or butter or fruit still in them, waited in the railway warehouses to be shipped back to the central highlands. They attracted and harbored rats, which then travelled back to interior cities such as Ambato in the empty crates. The Sanidad developed two simple models of collapsible crates that could be built using the wood from the existing crates, with the addition of some hardware. The small merchants of Ambato protested bitterly about the expense and inconvenience involved, as did large landowners from the Guaytacama area engaged in commercial agriculture, such as the influential Plaza-Lasso family – precisely from whom a large contribution had been solicited for the anti-plague campaign a few months earlier, and moreover both the father and son of which would be national presidents – but this was another issue on which Suárez felt he was unable to compromise. Despite the unpopularity of this measure among both small merchants and large commercial landowners, he saw it as absolutely necessary to the health and welfare of the nation.[16]

During this anti-plague campaign, it appears that a change was taking place in how the Sanidad went about its work. The recruitment into the Service of members of a new generation of socially-conscious physicians seems to have been crucial to the success of public health campaigns. The ideas they brought to their work apparently included the need for the Sanidad to stand above local conflicts and/or the narrow interests of dominant groups in order to carry out reforms necessary for what they considered to be the good of the nation as a whole. Now, undoubtedly plague eradication campaigns were directed towards achieving for Guayaquil the status of a "first-class clean port" in order to remove quarantine measures and restrictions on international trade, which also had a potential impact on fiscal resources. In addition, the campaigns were clearly informed by notions of appropriate ways of living, although those ideas were also the result of the Sanidad's detailed research and observations on the specifics of plague contagion in the Ecuadorian highlands (rather than simply their own culture- and class-bound notions). Nonetheless, any success achieved in advancing these projects required establishing a notion of a state that stood above the specific interests of dominant classes, and sometimes also involved confronting other state officials at various levels. Indeed, there is evidence that these new state actors perceived a need to reform certain attitudes and behaviors not only of the poor, but also of members of dominant groups.

The liberal state of the early twentieth century had struggled to situate itself as a monitor of labor relations within highland landed estates – particularly in some of its provisions to oversee labor contracts well before the 1918 abolition of debt peonage (*concertaje*) – often coming into conflict with landowners in the process. In this public health campaign, in contrast, modernizing landowners seemed to take some pride in demonstrating their willingness to collaborate with the state at such an urgent moment; the Sanidad in turn needed to enlist their assistance in order to be able to proceed with work within their estates and to engage their labor pool as both objects of

the vaccination campaign and actors in the disinfection teams. At the same time, however, public health officials were at pains to differentiate themselves as state actors working to advance broader national well-being from the more narrow, private, and profit-making interests of that group.

We can measure success for this campaign both in terms of the eradication of bubonic plague from the area, and in terms of some Sanidad officials' openness to the concerns of subordinate groups; indeed it appears that the latter facilitated the former. Ultimately, then, the campaign's success can partly be attributed to the commitment of persons of integrity who oversaw its functioning, service-oriented individuals who believed in the mission of the Sanidad, sometimes sacrificing personal interests to that larger project.[17] The ability of the Sanidad to recruit this kind of person into its activities – and to pay them sufficiently so they could dedicate themselves full-time to public health endeavors – at this moment of administrative energy and social change seems to have been of key importance in advancing this perception of the state.

Let us turn to our second example. In 1935, partly in the context of a shifting terrain of jurisdiction among state institutions in health-related matters, maternal-infant health was re-defined as a preventative health issue, rather than primarily a curative issue to be dealt with after health problems arose. That placed the issue firmly within the mandate of the Sanidad rather than the Juntas de Asistencia Pública (public assistance or social welfare boards) that oversaw hospitals and clinics. The Sanidad was faced with the challenge of staffing a new program in provincial cities and county seats (as well as in poor neighborhoods in Quito) that would be based less in medical institutions and more in people's homes. The project aimed to address infant mortality by providing prenatal care and delivering babies and then following up with visiting nurses' monitoring of infant health. At the time, as outlined above, it was less than a decade since physicians had been appointed as delegates of public health in provincial capitals on a permanent basis. The numbers of private physicians in provincial capitals was also small: a 1938 survey,[18] for instance, indicated that almost two-thirds of all Ecuadorian physicians were practicing in the country's three largest cities, and most provincial capitals had half a dozen to a dozen physicians (Riobamba had the most, at 19; coastal Babahoyo had the least, only 3), while outlying areas of a highland province might have another one or two doctors. In this context, the Sanidad employed female paramedical professionals in this new outreach project, taking advantage of the availability of scientific (university-trained) midwives, whose numbers had been increasing since the turn of the twentieth century, and a newer group of professional nurses.[19]

This project of monitoring infant health from the womb through the first months of life, during visits to homes that also involved offering suggestions on household hygiene, reproductive health and child raising, displays characteristics of a project of state formation as cultural revolution, as well as a Foucauldian project of governmentality or administration of populations.[20] The methods engaged to pursue its goals on first glance appear to be quite heavy-handed, if we were to believe the claims of the provincial delegates of public health when they advertised these new services. As the delegate in Tungurahua province pointed out in the flyer that he produced to promote this program, "with the availability of free services of a professional, there is no reason to expose yourself to the dangers of empirics, to whom we will apply the sanction established in Article 56.4 of the Public Health Police Code (Código de

Policía Sanitaria), if they continue to illegally exercise the profession of midwifery."[21] These warnings extended not only to empiric midwives, but also to those who consulted them. As the delegate in Imbabura province north of Quito stated in a similar flyer, after describing the need for these new employees due to the ignorance of mothers and poor hygiene of their homes, "You must not allow your children to die, without first exhausting every resource offered by medicine, thus demonstrating your love. The death of a child due to the negligence of a mother is a crime that the Public Health Police Code quite rightly punishes very severely."[22]

What is striking, however, is how little the program actually resembled the way that it was described in formal documents. There were simply not enough medical professionals for the state to be in a position to enforce their use (other than in the largest urban centers, such as Quito): most physicians were not interested in practicing in provincial or county contexts, nor in engaging in the time-consuming work of attending laboring women; and state midwives could only be in one place at a time. Those who seemed to be the most aware of the Service's inability to impose such a program were those closest to the ground, front-line workers in this outreach program, who in this case were female employees of the Sanidad. Interestingly, considerably more internal documentation was generated by what were seen by some officials as the unruliness of such employees than by problems posed by the recipient population.

The hiring of female paramedical professionals in this program in 1935 fit into a larger state project to provide employment to women who were otherwise unprotected (for instance, unmarried, orphaned or widowed). However, while such women wanted and needed the security of state employment, they were far from passive in their roles. Indeed, one scientific midwife, Consuelo Rueda Saénz, had herself proposed the establishment of a very similar program to the Director of Sanidad some six years earlier.[23] Like many in her profession, she was a paternal orphan, and had registered in the midwifery program at the Universidad Central in 1900 (just after the inauguration of Quito's Maternidad or lying-in hospital), at the beginning of a decade that saw a significant expansion in enrolments in this field of study – at the time, the only area of university study open to women. She also took some basic courses in pharmacy when that second field of study was opened briefly to women in 1904. She went on to establish her midwifery practice in Quito, and again like many in her profession, she did not marry. She clearly aligned herself with state objectives to modernize birthing and displace empiric midwives when she wrote to propose an outreach program in 1929, and was among the first midwives hired to the new state program when it was established in 1935, moving from postings in Alausí, to Ambato, to Machachi near Quito (and then resigning from the national service to work for the municipality of Machachi).[24]

The character of these first women to attend university in Ecuador seems to have been forged in difficult life circumstances, and in several ways they did not fulfill traditional notions of virtuous and sheltered womanhood: for instance, attendance at a Catholic girls school was almost entirely incompatible with a decision to study midwifery; a disproportionate number of midwifery students lacked a male protector because they were either illegitimate daughters or, even more often, orphaned; and few professional midwives seem to have married.[25] One of the main ways, however, that we can identify the fact that professionally-trained midwives like Rueda did not simply reproduce physician goals within the outreach program (despite the way she herself presented the benefits of such a program in 1929) is from the disconcerted reactions of provincial

public health delegates to their work. These women were sometimes accused by their immediate supervisors of serious moral flaws: for younger women, sexual transgressions, for older women, other failings such as alcoholism. These are reflections, to be sure, of the difficult position of new female professionals in provincial cities where they often did not have a social support network, and the archival material can certainly be mined for an analysis of gender ideologies. More interestingly for our purposes here, however, in one telling complaint of a public health delegate it is revealed that a state midwife was working with the population to circumvent one of the main coercive methods used by such officials to enforce precisely the use of medical professionals: that is, the need to have a birth certificate signed by a professional physician or midwife in order to register a birth in the civil registry. However, the state midwife in question – none other than Consuelo Rueda – responded that she had signed a birth certificate for an infant whose birth was attended by an empiric midwife merely as an interim measure until people got used to the idea that they must seek professional care, and to help them avoid the difficulties they encountered with the civil registry if they did not. What this and other evidence suggests is that these front-line employees were modifying this state program in response to the everyday challenges they encountered in delivering it. Perhaps in part precisely because of these women's social backgrounds (and by this I do not simply mean their gender), portions of the population sought out state midwives for their services, and it may be that their more flexible approach to their mission enhanced their effectiveness. In many cases, they seemed to carry out their duties in spite of their supervisors, rather than with their assistance. This seems to have been recognized implicitly by more distant senior public health officials, who were supportive of these employees in contexts where their immediate supervisors were much less accepting of what they saw as their inadequacies; indeed, some state midwives ended up reporting directly to the regional director of public health in Quito, given chronic difficulties in their relations with the provincial delegates under whom they nominally worked. In other words, these subordinate female employees of the Sanidad were identified as both useful and dangerous to the state, by different constellations of state officials.

What can we say about the effectiveness of this program? This is difficult to judge given that another source of evidence of ambivalence of public health delegates to these female employees is that such officials were remarkably inconsistent in how they counted births attended by state midwives within their monthly reports of vital statistics in their jurisdictions. Nonetheless, we can piece together a picture of relative effectiveness of this outreach program: for instance, in the four and a half years that Consuelo Rueda worked as state midwife in Ambato she did not have a single case of puerperal infection among her patients, much less a death under her care.[26] And other evidence from Ambato indicates that a few years after the establishment of this program over half of the births in Ambato county were attended by physicians or the state midwife, while a few years before the program began there were at least twice as many births attended by empirics than by professionals in Ambato.[27] Now, of course, that is only one way we might assess effectiveness, and leaves aside the issue of whether we believe that scientific midwifery is essentially better than other kinds of birthing attendance. Nonetheless, this certainly constituted an important measure for the state. What we do know is that some portions of the urban population in provincial capitals and county seats judged these services to be attractive, when they registered occasional complaints against the state midwives regarding, primarily, their lack of access to them.

These two examples differ in important ways. The anti-plague campaign was a rural one that took public health officials into direct contact and negotiations with both indigenous peasants and the large landowners on whose estates they lived and worked. Ultimately, the resistance of both to elements of the anti-plague campaign had to be navigated by public health officials in order to move the campaign forward, as well as varying degrees of uncooperativeness by other state actors. Both the venues within which the maternal-infant health program was conducted (small cities and medium-sized towns in the highlands) and the population targeted for these services (urban women of limited economic means) was quite different, as were the state agents recruited to carry out this project. Some state officials' concern with the behavior of other state employees within this project suggests not only disagreements over how to proceed, but also the perceived centrality of images of the state in this program, when female employees acted in ways that their male supervisors perceived as unseemly for representatives of the state.

Despite their differences, both of these examples point us to important dynamics of how the state rules, in particular kinds of projects that were not fundamentally coercive. The multiplicity of views on how a program should be administered seems to have provided resources that enhanced the recipient population's acceptance of it, and hence its effectiveness. And the multiplicity of social experiences embodied by the different participants in delivering, for instance, the maternal-infant care program seem to have been both essential to how it was delivered to the general population, and a continual source of conflict internally. Some state employees' willingness to engage in conflict with other state officials over how best to offer services to the population may have confirmed their own legitimacy and that of the projects in the eyes of some members of the public. Certainly, this affected the texture and lived experiences of encounters with state agents and state programs.

As mentioned, I came to this research with an interest in exploring how the Ecuadorian Public Health Service imposed new ways of living on subordinate groups in the first half of the twentieth century – in a society marked by significant divisions of ethnicity, class, and gender – in the process participating in the social construction of notions of national culture. While the Sanidad was indeed involved in a project of that kind, what the archival materials suggest is that the successes that were achieved were more often where compromises and negotiations were engaged in, than where force was brought to bear. While "the state" included a constellation of different institutions that might work at cross purposes, even a single state institution such as the Ecuadorian Public Health Service could contain a multiplicity not just of areas of expertise but also social experiences embodied in the diverse employees in different positions and at different geographic locations, which seems to have been of key importance to how its programs were implemented. As an historical anthropologist, trying to think ethnographically about this material, a focus on the actions, perspectives and even lived experience of those delivering state programs seems a productive approach, to the extent that this can be gleaned from the documentation at hand. Indeed it follows a well-established tradition in anthropology of trying to understand social processes from the perspective of those involved. When it comes to state agents, however, it is also important to link to that discussion an analysis of the cumulative effects of those participants' actions.

There is perhaps a danger of taking too literally the protagonism of individuals when one uses the archives of the institution for which they worked, and documents that they themselves

produced. Nonetheless, those archives do not present a single view of any of its programs, but rather in the collection of internal and external reports and streams of everyday correspondence among differently-situated state agents, between them and other institutions, and with the public, a complex picture can be built up of constellations of actors that align and realign in different ways in relation to various programs. One effect of this very diversity seems to have been the construction of an arena in which "the state" might be seen as caring and compassionate, and an entity to whom – in its manifestation as specific front-line employees – members of the population might be able to make certain kinds of appeals. This state effect was not the result of a mere performance on the part of those agents, but rather expressed their own maneuvering through difficult situations (sometimes created by their colleagues) to advance projects they believed in. As the Sanidad began to undergo a process of professionalization in the 1920s and 1930s, it became a source of employment for varied groups, some of whom provide evidence of having both a deep commitment to the mission of the Service and also their own ideas about how its programs should function. The conflicts they engaged in to advance their work helped to strengthen their own claim to legitimacy, to form part of a state with a caring and effective presence in new social and geographic arenas.[28] If we step back from the everyday conflicts to gain a wider perspective, it becomes clear that these attempts to present an image (and in some ways a reality) of a robust and "real" state occurred at the least likely time: when government itself was extraordinarily unstable. In the decade of the 1930s alone were 15 regime changes in Ecuador; between 1925 and 1948 there were 28. While the Sanidad was working to set itself above and apart from local power struggles and the interests of dominant groups, it was also working to show that in an era of extraordinary political (and economic) instability, there was nonetheless a working state. Perhaps what is most striking of all is the continuous advance and expansion of public health programs at such a time of government fragility.

[1] This paper draws on several research projects funded by Associated Medical Services, the Wenner-Gren Foundation for Anthropological Research, and the University of Western Ontario, to whom I am grateful. I also very much appreciate the assistance of the directors and staff at the archives in which the research was conducted, especially at the Museo Nacional de Medicina and the Archivo General de la Universidad Central.

[2] I have discussed both projects at greater length elsewhere: "Confronting Plague: The Institutionalization of Public Health and Cultures of Hygiene in Ecuador," paper presented at the Symposium on the history of medicine in Latin America and the Caribbean, University of Manchester, September 2009; *Modernizing Women, Modernizing the State: Gender and Social Policy in Highland Ecuador, c. 1895-1950* (book manuscript in preparation). In those writings I undertake detailed explorations of what these public health projects can tell us about Ecuadorian society. In this paper I begin to reflect conceptually on these projects for what they suggest about processes of state formation; any feedback on these ideas would be much appreciated.

[3] See for instance "Shifting Paternalisms in Indian-State Relations, 1895-1950" in *Highland Indians and the State in Modern Ecuador*, edited by A. Kim Clark and Marc Becker (Pittsburgh: University of Pittsburgh Press, 2007), 89-104.

[4] Paulo Drinot, *The Allure of Labor: Workers, Race, and the Making of the Peruvian State* (book manuscript).

[5] David Nugent, *Modernity at the Edge of Empire: State, Individual and Nation in the Northern Peruvian Andes, 1885-1935* (Palo Alto: Stanford University Press, 1997).

[6] Mercedes Prieto provides a useful contextualization of that work within the larger history of dominant images of and policies towards Andean Indians in her *Liberalismo y temor: Imaginando los sujetos indígenas en el Ecuador postcolonial, 1895-1950* (Quito: FLACSO, 2004), chap. 4. For an analysis of related projects in Quito, see Eduardo Kingman Garcés, *La ciudad y los otros. Quito, 1860-1940: Higienismo, ornato y policía* (Quito: FLACSO, 2006).

[7] Carlos Arcos and Carlos Marchán, "Apuntes para una discusión sobre los cambios en la estructura agraria serrana," *Revista Ciencias Sociales* (Quito) 2:5 (1978), 13-51.

[8] On the SNA, see especially Carlos Arcos, "El espíritu de progreso: Los hacendados en el Ecuador de 900," *Cultura* (Quito) 19 (1984), 107-34.

[9] Various documents from May-July 1926, LCR [Libro de Comunicaciones Recibidas) -BAG [La Bubónica en Ambato y Guaytacama] 1926-27, ASS [Archivo del Servicio de Sanidad]/MNM [Museo Nacional de Medicina].

[10] P Zambrano to General Director of Public Health, Guaytacama, 31 May 1926, LCR-BAG 1926-7, ASS/MNM.

[11] P Zambrano to General Director of Public Health, Guaytacama, 4 June 1926, LCR-BAG 1926-7, ASS/MNM.

[12] P Zambrano to General Director of Public Health, Guaytacama, 6 July 1926, LCR-BAG 1926-7, ASS/MNM.

[13] León provincial delegate to General Director of Public Health, Latacunga, 6 July 1926, LCR-BAG 1926-7, ASS/MNM.

[14] General Director of Public Health to the Comisario Municipal de Calles, Quito, 19 July 1926, LCE-1926, ASS/MNM.

[15] General Director of Public Health to President Isidro Ayora, Quito, 15 June 1926, LCE-1926, ASS/MNM.

[16] See various documents and petitions from April, May, June, October and November 1927 in ASS/MNM.

[17] During the Guaytacama campaign Zambrano's wife was ill in Quito, but because his presence in Guaytacama was considered crucial to the success of the campaign he continued there until he was no longer needed. Suárez paid a more serious price for his medical commitments: having brought back an X-ray facility from his specialist studies in Germany, the result of many years of examining tuberculosis patients without the use of safety precautions probably helped to precipitate the stroke that caused his premature death in 1945. There were also serious illnesses and deaths by employees of the Service engaged in various campaigns against contagious diseases.

[18] "Nómina del Cuerpo Médico Ecuatoriano en el año 1938," *Anales de la Sociedad Médico-Quirúrgica del Guayaquil* Año XXVIX, Vol. XVIII, No. 1, Enero 1938, pp. 27-42.

[19] While nursing classes were initiated in Quito in 1917, formal graduates of the nursing school only began to be noted in university records in 1929, and their number increased in preparation for the 1933 opening of the new modern Hospital Eugenio Espejo in Quito. The training of nurses intensified considerably when the new Escuela Nacional de Enfermeras was established in Quito in 1942. The Sanidad's outreach campaign was designed to include both a midwife and a nurse, but budgetary problems in 1940 led to the elimination of the nursing positions in the maternal-infant health program.

[20] See Philip Corrigan and Derek Sayer, *The Great Arch: English State Formation as Cultural Revolution* (Oxford: Basil Blackwell, 1985); and the chapters by Michel Foucault and others in *The Foucault Effect: Studies in*

Governmentality, edited by Graham Burchell, Colin Gordon and Peter Miller (Chicago: University of Chicago Press, 1991).

[21] "Al Público," Ambato, June 1935, LCR (Delegaciones Provinciales) 1935, ASS/MNM.

[22] "Protección Infantil," Ibarra, February 1936, LCR (Delegaciones Provinciales) 1936, ASS/MNM.

[23] Consuelo Rueda to the Director General de Sanidad, Quito, 27 September 1929, LCR 1929, ASS/MNM.

[24] Information about Rueda and other female students in midwifery and pharmacy is drawn from enrolment records of the Faculty of Medicine at the Universidad Central in Quito, housed at the Archivo General de la Universidad Central (AGUC).

[25] The first two points are gleaned from the enrolment records at the AGUC. The third is based on the professional registries maintained by the Public Health Service; e.g., Dirección General de Sanidad, *Nómina de médicos y cirujanos, dentistas, farmacéuticos y obstetrices, inscritos en Quito y Guayaquil* (Quito: Imprenta Nacional, 1932), updated with handwritten annotations in 1937 (1937-Solicitudes, ASS/MNM).

[26] Consuelo Rueda to the Tungurahua Provincial Public Health Delegate, Ambato, 5 September 1940, LCR-Delegaciones Provinciales-II 1940, ASS/MNM.

[27] For instance, in February 1930, 24 of 73 births were attended by professionals; in March, 31 of 108; in April, 37 of 105 (Delegado de Sanidad de Tungurahua to the Director General de Sanidad [trimestral report], Ambato, May 1930, LCR-IAD 1928-1930, ASS/MNM). Some six months earlier the Delegado had reported (in a request to the Asistencia Pública that they outfit a small maternity ward at the provincial hospital) that the number of both still births and maternal deaths in Ambato was perhaps the highest in the country on a per capita basis, largely due to the fact that 90 per cent of births were attended by empirics (Delegado de Sanidad de Tungurahua to the Director General de Asistencia Pública, Ambato, 19 September 1929, LCR 1929-II, AAP/MNM; it is possible that the figure presented here is somewhat exaggerated to support his point about the negligence of the Asistencia Pública). In September 1938, in contrast, the delegate listed 29 births in the maternity clinic, 28 births at home with professional attention, and 48 births attended by empirics within the county boundaries; although part of the midwife's work may have been included in the first figure, more of it probably fell under the second.

[28] Christopher Krupa, "State by Proxy: Privatized Government in the Andes," *Comparative Studies in Society and History* 52:2 (2010), 319-50.