

**Capitalizing on the “Downside of Social Capital”?
Gender, Class and Peru’s Participatory Health Reforms***

Christina Ewig

Assistant Professor

Women’s Studies Program and Department of Political Science

University of Wisconsin - Madison

110 Ingraham Hall

115 Observatory Drive

Madison, WI 53706-1397

USA

cewig@wisc.edu

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Christina Ewig is Assistant Professor of Women’s Studies and Political Science at the University of Wisconsin-Madison. She is completing a book manuscript on gender and the politics of neoliberal health sector reforms in Latin America. She was recently awarded a Fulbright New Century Scholars fellowship for research on gender and health reform in Chile and Colombia, and a Rockefeller Humanities Fellowship for a new project on gender and race in the historical development of Latin American social policies. Her most recent article, forthcoming in *Feminist Studies*, is entitled “Hijacking Global Feminism: Feminists, the Catholic Church and the Family Planning Debacle in Peru.”

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Abstract:

This article takes issue with the assumption that building on or mobilizing social capital is always positive, and explores the implications of the mixed motivations behind the use of social capital by public policies. Through quantitative and qualitative evaluation of one public policy, participatory administrative decentralization of state health centers in Peru (the “CLAS”), I examine the implications of policies which arise from the mixed motivations of using social capital to both generate democratic practices, and to increase the efficiency of public services. Moreover, I explore how the CLAS mobilized positive *and* negative forms of social capital. I argue that public policies that uncritically employ social capital risk reifying already present gender and socioeconomic hierarchies, thus amplifying the exclusionary aspects of social capital rather than its positive benefits.

“Social capital” has captured the imaginations of scholars and practitioners ranging from social scientists to educators, from local city planners to international aid agencies. These actors have sought to employ social capital to cure ills as distinct as low student test scores and poverty. In the arena of public policy, the concept of social capital has also unified seemingly disparate parties. Left-leaning public policy advocates view policies that promote social capital as part of creating more democratic societies. Neoconservative advocates have employed social capital to different ends, leveraging it to achieve greater efficiency in government programming for example. The mind-boggling prevalence of the use of social capital by scholars and practitioners across fields ought to give us pause. What are the motivations of this wide variety of actors that seek to employ social capital? What are the implications of using social capital for quite disparate ends? The aims to which these varied advocates put social capital to use are as different as the advocates themselves. Yet, these policy proponents appear unified in their belief that social capital will lead to positive developments. Can we be so sure that these varied uses of social capital will always result in positive outcomes? Perhaps most important would be to specify – positive for whom exactly?

I examine the implications that these competing objectives can have for policies that utilize social capital. Moreover, I question the fundamental positive evaluation that policy makers have had of social capital. I argue that public policies may just as easily employ negative forms of social capital as they do positive forms, and I critically examine the consequences of public policies that, wittingly or unwittingly, utilize the “downside of social capital”.¹ Specifically, I find that public policies that employ social capital uncritically risk reifying already present socioeconomic and gender hierarchies, thus amplifying some of the exclusionary aspects of social capital rather than its positive benefits. I make these conclusions

based upon a careful case study of participatory administrative decentralization in Peru's health sector in the 1990s. The policy of participatory administrative decentralization in Peru evolved from precisely the mixed motivations described above: it sought to generate social capital to strengthen democratic practices *and* it sought to leverage social capital to obtain greater efficiency of government health services. Absent from its formulation was contemplation that some of the forms of social capital it utilized might exacerbate gender and class inequalities.

Participatory administrative decentralization is not unique to Peru. It is a social policy reform which proliferated throughout the developing world during the initial process of neoliberal social policy restructuring of the late 1980s and early 1990s. The idea was to decentralize the administration of small scale state social services, such as pharmacies, food distribution, or health posts to community members. This reform was expected to generate social capital by providing incentives for community members to organize by allowing input into how state services were run. In addition, it sought to create more horizontal community-state relations through shared decision-making. The reform also drew on existing social capital to make services more "efficient". Cost-savings was achieved through the free labor of community members and joint administration was to create incentives for the efficient use of the resources.

In the first section of this article, I review debates on social capital and public policy with attention to gender and social capital. In section two, I sketch the political context of the establishment of participatory decentralized administration of state health centers in Peru. I then outline the research design and methods, followed by my findings, which assess: whether the policy generated social capital; how the policy employed social capital; and the gender and class related power disparities present in the social capital that was mobilized. I conclude with

discussion of the implications that the utilization of social capital had for the policy's dual objectives, and for socioeconomic and gender stratification.

Social Capital and Public Policy

After initial skepticism, there is now mounting evidence that public policies can both mobilize and generate social capital.² For example, government institutions can generate social capital (Rothstein 2001) or re-designing local government institutions may mobilize social capital (Lowndes and Wilson 2001 p. 645). Particular policies may generate social capital, for example school choice policies in the United States (Schneider et. al. 1997). Political events, like elections, have been shown to generate social capital (Rahn et. al. 1999).³ Social capital can also aid in the successful execution of public policies. In the arena of social policy reforms, Schwartz and Deruyttere (1996) argue that consultation with community members will lead to greater stakeholder commitment to reforms; improved targeting; more reliable data, and cost reduction. In health policy, social capital has been correlated with improved ability to implement health reforms and improved leveraging of health resources (Rico and Fraile 1998). Hendryx et. al. (2002) found that community social capital can improve access to health services.⁴

As the above examples infer, most political scientists and policy analysts have assumed that social capital is positive, and have judged that the mobilization of social capital by public policies is also good. Little contemplation has gone into what Portes and Landolt have deemed the "downside of social capital" (1996).⁵ This absence of critical reflection is in part because political scientists and public policy analysts have largely relied on the optimistic definition of social capital put forth by Robert Putnam. Putnam emphasizes the importance of social capital to the development of democratic governance. For Putnam, an ideal civic community demonstrates

strong social capital, which includes the pursuit of common good over private ends; political equality and horizontal ties rather than clientelistic ties; solidarity, trust and tolerance among citizens; and a strong associational life (1993 p. 86-91). Putnam limits his definition of social capital to its altruistic forms, ignoring its instrumental and exclusionary forms.

Definitions of social capital from earlier sociological work on the topic are not as normative. James Coleman (1988) defines social capital as “a resource available to an actor” which “inheres in the structure of relations between actors or among actors” (Coleman 1988 p. S98).⁶ Trust, social networks or associations are not, in and of themselves, social capital. Social capital is instead the resource which is drawn from these types of social interactions and leveraged for other ends. Social capital differs from human and physical forms of capital in that it is not a tangible resource located in a person or thing. It is lodged in social relations themselves. Similar to these other forms of capital, social capital can be leveraged by an actor (or a community), to achieve particular ends. Importantly for political scientists who celebrate social capital, Coleman cautions: “A given form of social capital that is valuable in facilitating certain actions may be useless or even harmful for others” (Coleman 1988 p. S98).

Alejandro Portes’ (1998) incisive commentary is useful in further illuminating the negative forms of social capital which co-exist with the positive forms highlighted by Putnam. Portes reviews an extensive literature in sociology, much of which focuses on how group ties are used to both move ahead in societies and to exclude others from the same networks that aid in one group’s success. Portes cites four negative consequences of social capital which have been identified in these studies: “exclusion of outsiders, excess claims on group members, restrictions on individual freedoms, and downward leveling of norms.” (Portes 1998 p.15). In the realm of politics, we must ask whether social capital can close channels to participation in political life

(rather than open these) and whether social capital may restrict individual freedoms by demanding group conformity. We must also consider whether public policies that employ social capital make excess claims on particular groups or reinforce the downward leveling of norms.

Even critical analysts like Portes have largely ignored the gender dimensions of social capital. Scholars have begun to explore this area, noting differences between men and women in the forms of social capital that they have access to, and the ways in which they use social capital.⁷ Several authors have also suggested that the “downside” of social capital is often gendered. Linda Mayoux (2001) found that women’s access to markets in Cameroon was stymied by negative forms of social capital, where men’s networks prevented their entry. Silvey and Elmhirst (2003) examined migrant women’s social networks, and found that the gendered and intergenerational hierarchies embedded in social capital brought unwelcome claims on migrant women’s remittances, constraints on their mobility and behavior, and perpetuated women’s exclusion from more powerful networks (2003 p. 871). Sandra Smith found that when women and racial minorities in the US used same-gender or same-race social networks, they were disadvantaged by these in the job market (Smith 2000). Questioning the motivations of those who mobilize social capital, Maxine Molyneux (2002) questions whether World Bank poverty policies that target women strengthen women’s capabilities or whether they are simply “parasitic on the ties of solidarity that may exist” (2002 p. 180).

These studies of the “downside” indicate that it is not only mistaken to view social capital in purely celebratory terms, it is also mistaken to view it benignly as a “resource” when it is riddled with questions of power. The hierarchies present within social capital need to be carefully examined to fully understand the impact of the mobilization of social capital by public policies on individuals, families and communities. Social capital can aid, but it also can

constrain, and the constraints posed by social capital often follow pre-existing class, ethnic, racial or gendered patterns of exclusion and domination. In addition, we must examine the motivations behind the use of social capital, and who actually benefits from this “resource”. Social capital has its benefits, but to whom exactly do these benefits accrue? On whose backs are these gains made? Finally, given the often mixed motivations behind the mobilization of social capital, are distinct objectives in the use of social capital compatible – the promotion of democratic forms of associational life and greater efficiency for example? I pursue these questions in the following analysis of Peru’s participatory administrative decentralization.

Participatory Administration: Context and Content of Peru’s “CLAS”

A combination of interests by public health advocates, democracy activists and international financial institutions (IFIs) led to participatory reforms in health sectors in the late 1980s and early 1990s. Since the late 1970s, public health experts advocated community participation as a means of overcoming scarce resources and promoting accountability in health systems. In the 1980s, processes of democratization in the developing world, and especially Latin America had led to a surge in activity in civil societies and an interest in building on this activity to strengthen nascent democratic institutions. In the mid-1990s, IFIs such as the World Bank and the Inter-American Development Bank (IDB) also began to advocate community participation. Interest in community level solutions was part of the post-Washington consensus softening of IFI outlooks, after much critique of their top-down, and only marginally successful, demands for economic stabilization. IFIs supported participation for its potential to lower health care costs and for the general belief that investment in the “organizational capacity of the poor” is key to poverty reduction (Narayan 1999 p. 2, Schwartz and Deruyttere 1996).

Participatory administrative decentralization of health services consists of the functional decentralization of the administration of local health services to a community board.

Administrative responsibilities typically include: setting community health priorities; clinic-level personnel management; and/or local expenditure and revenue-raising powers. The “Bamako Initiative,” a community health administration approach begun in 1987 by a number of West African countries, is the best-known example of such decentralization in developing countries.⁸ By 1996, participatory health decentralization based on the Bamako concept spanned 41 countries: 28 in sub-Saharan Africa, 5 in East Asia and the Middle East, and 2 in the Central Europe and Baltic Region and six in Latin America and the Caribbean (United Nations 1996). In the last decade, similar initiatives have spread in the industrialized world.

Drawing from the Bamako model and the international reform currents described above, in 1993 a small team of Peruvian policy-makers within the Ministry of Health proposed the participatory administrative decentralization of state health centers. President Fujimori approved the reform by Supreme Decree in May of 1994. In early August of 1994, the first twelve health centers converted to the model, and have since spread to every department in the country (Bendezú Interview 1998). Officially named the Shared Administration Program (PAC – *Programa de Administración Compartida*) this initiative has come to be known as the “CLAS”, an acronym for the Local Health Administration Committees (*Comités Locales de Administración en Salud*) central to this reform. The CLAS program was one of the earliest, and longest lasting of Peru’s contemporary health reforms, which began in the early 1990s.⁹ One objective of the program was to contribute to the restoration of primary-level public health services, which in 1993 were in a state of crisis.

The crisis in the health sector was a by-product of national economic and political crises of the early 1990s. As a result of President Alan Garcia's failed economic policies and threatened moratorium on debt payments, by 1990 Peru's annual inflation rate had hit 7,650% (INEI 1992) and international creditors had placed Peru in bad credit standing. Candidate Alberto Fujimori ran on a campaign platform against economic shock, but upon winning the election in 1990, abruptly implemented a draconian stabilization package. The stabilization measures caused inflation to rise to 21,316.3% between August 11th and 17th of 1990 (Cuánto 1991). Between October and November 1990, per capita consumption in Lima dropped 26.4 percent — with 88% of this drop registered in a reduction in consumption of health services (Iguíñez 1996 p. 273). Government spending on social services also dropped dramatically. Within the health sector, the public system serving the poor and informal sectors was hardest hit, with a budget in 1990 of just 15% of that spent in 1980 (MINSAs 1996 p. 26). The stabilization package eventually brought inflation under control to 57% annually by 1992 (INEI 1992), and by 1995 down to 10% (INEI 1996). On the political front, civil war between the Shining Path guerrillas and the military became intense in rural areas in the late 1980s, and by 1990 the Shining Path had begun to strike Peru's capital, Lima. Government health posts were a prime target, which led personnel to abandon rural and urban peripheral health establishments. In 1992, government security forces captured the leader of the Shining Path, Abimael Guzmán, and effectively controlled the guerrillas thereafter. Economic stabilization and an end of civil war set the stage for initial health reforms, among them the CLAS.

Peruvian policy makers sought to leverage social capital in order to attain greater efficiency of the health system and had more radical objectives of generating “good” social capital based on political equality. Peru had a long history of participatory initiatives, though

many of these were clientelistic. The CLAS policy team wanted to build on these participatory experiences, but give community members substantial authority in an effort to change clientelistic patterns and enhance democratic practices (Vera Del Carpio Interview 1998, Freundt-Thurne Interview 1998). Policy designers also expected that participatory administration would increase access, as community members would identify residents in need of health care who otherwise might not visit the health center. The team viewed participatory administration as a viable strategy for reaching traditionally excluded rural communities (Bendezú Interview 1998, Vera del Carpio Interview 1998, Freundt-Thurne Interview 1998). Community members would also determine who would qualify for free or reduced cost services due to financial need. Community monitoring of staff, habitually absent from health posts especially in rural areas, would improve efficiency and accountability.

Each health center that converted to a CLAS became a legally private, non-governmental organization. The center infrastructure remained property of the state, and each CLAS remained dependent on the state for the bulk of its budget, primarily for the salaries of the professional staff. Responsibilities of the CLAS committee included personnel management; setting health center fees and expenditure of the monies recouped through these fees; decision-making regarding who may be exempt from fees; and the yearly approval of a local health plan. As of 2000, the CLAS model covered 19% of all of Peru's public primary-level health establishments.¹⁰

In terms of generating positive social capital, it is important to further contextualize Peru and its regional variation. Rural Peru in the 1990s could be characterized as a least likely scenario for the promotion of positive social capital. The civil war had cultivated distrust between the rural indigenous inhabitants and residents of the coast and the government

(Portocarrero 1998). Engagement with Sendero Luminoso consumed communities, and those not loyal to the cause of the guerrillas became suspect, and then victims of violence. As the government sent troops to fight the guerrillas, and eventually armed self-defense militias, human rights abuses mounted. While some associational activity, such as the organization of local militias, resulted from the conflict with the Shining Path, the war severely injured trust in these rural communities.¹¹ Distrust, conflict and low associational levels among the rural population had predated the civil war. Southern highland populations in particular had experienced repression by the state in the 1960s when these organized for land reform, and historically peasant organizations, when organized, were ephemeral (Handelman 1975 Ch. 6).

By contrast, stronger associational life could be found in the poor, urban neighborhoods of Peru. From the 1960s forward, associational life in poor communities blossomed as squatter settlements boomed around Lima and other major cities, and residents organized to obtain legal land rights and basic services. With economic crisis in the 1980s, mother's clubs and soup kitchens run by women became another important locus of associational life. Some saw these mothers' organizations as a foundation for deepening democracy (Blondet and Montero 1995). Others were skeptical, citing clientelistic ties between these women's associations and political parties (Barrig 1991). In general however, observers of urban life in Peru saw democratic promise in the growing levels of associational activity between the 1960s and the 1980s.

In the 1990s, growing authoritarianism by the Fujimori government mitigated against positive forms of social capital in both rural and urban areas. Early in his tenure (1992) Fujimori staged a military-backed self-coup and closed the Congress until international pressures forced him to restore formal democracy. Political parties became fragmented and weak as a result of legal reforms and due to public dissatisfaction. The weakness of parties left few political

challengers, and many of the adversaries that did appear were threatened or bought off. Censure of the media was common government practice. By the end of his tenure, Fujimori's power rested in part on support from the military and in part on support he gleaned through cultivating vertical forms of social capital via neopopulist tactics of directly providing material benefits to those groups—primarily poor people—from whom he sought political support in return.

In summary, the likelihood of the CLAS reform generating greater levels of positive social capital was minimal for the rural highlands where the history of social capital was limited and where civil war had destroyed much of the basic social fabric. In the urban areas, positive social capital generation was more likely but constrained by growing authoritarianism.

Research Design & Methods

I carried out the research for this study in Peru in 1998 and 1999. I compared four CLAS health centers with four non-CLAS centers. The majority of non-CLAS health centers fall under a separate, centralized reform model with no community-level administration. All were primary-level health centers, six in urban areas and two in rural zones. I selected three geographically proximate CLAS in the northern urban periphery of Lima, and one CLAS in a rural province of Ayacucho. Because Peru is over 70% urban, I included more urban than rural centers my sample.¹² The difficulty of reaching the rural health centers and the dispersed populations that they served also forced me to limit my rural sample to one CLAS and one non-CLAS center. All CLAS centers selected had been CLAS since 1994, the first year of the reform. Because the CLAS health centers were far fewer than non-CLAS centers, I selected my CLAS sites and then chose non-CLAS centers that matched these as closely as possible. Using district-level census data from 1993 (the last census conducted) I narrowed my selection of non-CLAS communities

comparable to the CLAS communities based on socio-economic indicators. I then used community-level census data collected by the health centers themselves, and direct visits, to make further comparisons. I visited nearly all the non-CLAS centers in the Northern Cone of Lima.¹³ The CLAS were also in the Northern Cone of Lima. By limiting the comparison to the Northern Cone, I kept the regional health administration constant.

I collected qualitative information on the communities in order to keep factors that might effect community participation constant. Most of the urban periphery of Lima is composed of communities that originated as squatter settlements. Because the establishment of legal communities and obtaining basic public services takes significant community organization, date of settlement is related to levels of organization. Over time, community-organization tends to decline as basic legal rights become established. To keep levels of community organization constant, I selected a non-CLAS community that had been settled for a similar period of time as the CLAS community. I read local histories of these communities and spoke with persons familiar with all of the communities, to further determine previous levels “social capital”. Both of the final urban communities selected had similar histories of clientelistic political engagement with the previous *Alianza Popular Revolucionaria Americana* (APRA) government and the present Fujimori government, as well as less clientelistic forms of autonomous community organization. In addition, I controlled for the history of experience with the Shining Path. One of the three urban CLAS had had a significant presence of the Shining Path; Shining Path militants murdered the first president of that CLAS in 1994. To keep the presence of guerrillas constant, I chose non-CLAS communities that had some presence of the Shining Path.

My process of selecting the rural communities was similar. Because the rural CLAS selected was about a two-hour ride on public transport from the closest provincial city, I chose a

non-CLAS health center that was similarly located. Distance via public transport from the city was a proxy for economic development, as this determined degree of ties to commerce and provincial government. Both the CLAS and non-CLAS rural communities had had significant past experiences with civil war. Again, I compared district level census data and the local census data from the health centers to match socioeconomic levels. For all the health centers, I also observed the centers themselves, to match infrastructure and the size of population served.

I define “community” for the purposes of comparison as the geographic area served by the health centers. In the urban cases, it is a larger geographic area served by three geographically proximate health centers. In the urban sites, each community was composed of a number of squatter settlements, differentiated by name or number. The health center is located in one of these settlements, but serves eight to ten such settlements, all within a twenty-minute walk. In the rural areas each community was composed of a central village where the health center was located, and between ten and twenty geographically dispersed *comunidades*, or small communities composed of a cluster of homes up to three hours walking distance from the clinic. These communities were all poor, with the urban areas considered poor and the rural areas extremely poor according to government classifications.¹⁴

I employed a number of methods to compare levels of social capital: a survey; interviews with health center staff, CLAS members, and leaders of local community organizations; and observation of health center activities. The survey was stratified by socioeconomic level, location, and sex. Ten percent of each sample was of single mothers; the percent of single mothers according to district-level 1993 census data. With the aid of assistants, including a Quechua-speaking assistant in rural areas, we conducted the survey by knocking on doors and

interviewing residents. Other than some pre-selection to stratify based on housing type (a proxy for socioeconomic position) and location, this was random.¹⁵

To flesh out the relationship between the health centers and communities, I carried out sixty-five semi-structured positional interviews. These included: thirteen communal leaders; six group interviews with members of communal organizations; twenty-eight health professionals; twelve CLAS members; and the directors and a selection of staff from the regional government health authorities. I also spent hours conducting participant observation, including attending CLAS meetings, observing health campaigns, participating in health center events, and observing health center activities from the health center waiting rooms. I observed and participated in the activities of mothers clubs and communal kitchens in the surrounding neighborhoods.

Generating Social Capital? Survey says “No”

Did the CLAS succeed in its objective of generating positive forms of social capital? To determine this, we first collected data to establish the general levels of associational activity in each community. We asked survey respondents if they were active in neighborhood activities, what kinds of activities they were involved in, whether they had been leaders of these organizations, and how much time they spent on these communal activities. These measures provide a base-line of associational activity in each community and can be compared between CLAS and non-CLAS communities. Forty-three percent of survey respondents in CLAS communities and 47% of survey respondents in non-CLAS communities participated in some way in their community, a non-significant difference.¹⁶ Where there was a significant, and surprising, difference was the level of activity in the rural communities. Rural communities are traditionally thought to be less active because of lower education levels and lesser density of

population. However, 62.4 % of rural survey respondents reported being active in some community activity, compared to 34.3% of urban respondents, a significant difference.¹⁷ Many rural communities became more active in response to the civil war of the 1980s and early 1990s, organizing self-defense militias that still are active even though guerrilla attacks have subsided. Membership in the militias is often obligatory, thus inflating the rural figures higher than if it were voluntary. In sum, across the four communities, between 35 and 63 percent of residents were active in some associational activity, a number that should provide a significant base of social capital to build upon.

For Putnam, associational activities are those that “promote habits of cooperation, solidarity and public-spiritedness” (Putnam 1993 p. 89-90). In his study of Italy, Putnam included things like sports clubs, musical associations and health and social service activities (1993 p.106-109). The various kinds of activities that active residents were involved in the four Peruvian communities in this study included mother’s clubs, rural militias, neighborhood councils, soup kitchens, agricultural clubs, local schools, health promotion and sports teams. Mother’s clubs (which focus on the nutrition of children and the elderly) and rural militias were the most common and comprised 34 and 14 percent respectively of the activities of those who were engaged. Most of these activities would fit under Putnam’s definition of an associational activity that would build cooperation and solidarity.

Logistic regression results showed that the CLAS health reform did not cause more or less associational activity outside of the health center.¹⁸ This result might be expected given that the CLAS is specific to the health sector. But, the CLAS policy did specifically seek to draw from existing associational life to increase citizen participation in the health sector. I therefore asked respondents whether they had participated in a health center activity. The results were

similar for residents of CLAS and non-CLAS communities. Among residents with a CLAS health center, 29.5% had participated in some health center activity, compared to 24.2% in non-CLAS centers.¹⁹ The CLAS seemed to promote a bit more participation in health activities, but the difference is not statistically significant. The CLAS was not very successful at promoting associational activity, even associational activity in the health sector.

While some might find hope in the slightly higher rates of participation in health activities in the CLAS centers, further probing of what constituted “participation” reveals that the small amount of participation generated by the CLAS drew upon negative and gendered forms of social capital. When we followed-up by asking what a respondent’s participation consisted of, we found that “participation” in the health center meant a broad range of things – such as mopping the health center floor, going to the health center to receive government food aid, or attending an informational lecture on a health risk, like tuberculosis. Most frequently (48.9% of the time) participation entailed attending a health center lecture or receiving health services through a health “campaign” in which health workers try to increase coverage of particular services, such as vaccinations. While positive from a public health standpoint, these activities were passive, and imply vertical ties between health provider and resident.

These kinds of activities were also highly gendered. Both the CLAS and non-CLAS health centers targeted women to attend these lectures, to aid in vaccination campaigns, and to engage in “participation” like cleaning health centers, that is an extension of women’s domestic work, and which adds to women’s unpaid work burden. Rather than a positive lever for increasing social capital, much of the “participation” in health activities drew on pre-existing negative, gendered forms of social capital in which excess claims were made on one group – women. Men were not asked to fulfill these same obligations.

To further test whether the CLAS model promoted horizontal ties between residents and health center staff, I asked two survey questions: “Has the health center ever asked you for a suggestion?” and “Have you ever presented a suggestion to the health center?” These questions probed whether the health center opened itself to critique by community members, and whether community members felt they had the power to critique. “Yes” responses to either question would indicate a greater sense of equality and cooperation between residents and the health center. The results, again, do not show a significant difference between CLAS and non-CLAS centers, but more residents of CLAS communities were asked to give a suggestion, and more of these residents did offer suggestions. Of residents of CLAS communities, 15.8% reported that the health center had asked for their suggestions compared to 11.2 % of residents in non-CLAS communities.²⁰ In CLAS communities, 26.6% of respondents reported having made a suggestion to the health center, compared to 19.6% in non-CLAS communities.²¹ In terms of inculcating horizontal relations between the health center and residents, the CLAS shows some promise, but is not significantly different from the non-CLAS centers, four years into reform.

These survey results show that the CLAS was unable to live up to one of the objectives of its designers: to increase and inculcate less clientelistic, horizontal associational activities among the general population around public health services. Much of the community participation promoted by the CLAS was not only vertical, but also tapped into gendered norms that compelled women into taking-on the bulk of community health care responsibilities.

Interviews with Community Leaders: Limited Generation of Social Capital

Interviews with communal leaders give another layer of understanding of the form and content of participation in the health center. Communal leaders would be more likely to be

contacted by the health center, and to have an interest in health center activities. Due to their personal engagement with community associations, they would have an informed view of health-center community relations. My interviews with communal leaders in the urban, non-CLAS communities indicated that the relationship between the health center and the mothers clubs, health promoters, and communal kitchens were vertical. There was no regular communication between these organizations and the health center staff. The occasional interactions that took place consisted of talks by the health center professionals on particular topics, or when health center staff sought the volunteer labor of members of these organizations when it conducted health campaigns. Those interviewed also characterized the community-health center relationship as, as one interviewee put it, “a little distant”.²²

By contrast, in the urban CLAS communities, those organizations located in the squatter settlement where the center was located characterized community-center relations as very good. In all three cases the CLAS board members had close relationships with the neighborhood councils, the health promoters, the local communal kitchens and mothers clubs. The health center sought their input, and these organizations often brought their suggestions to the center.²³ Those organizations served by the health center but in neighboring squatter settlements, however, had a similar experience as those in non-CLAS urban communities, they had experienced only intermittent informational talks from the center staff, or no contact at all.²⁴ Thus, while the CLAS communities appeared better than the non-CLAS in terms of horizontal health center-community association relations, the geographic extent of this positive social capital was very limited.

In the case of the rural health centers, both the CLAS and the non-CLAS community leaders viewed community-health center relations as poor. There was no outreach by either

health center to the major organizations, such as mothers clubs, agricultural clubs, or the rural militias. In the case of the rural CLAS, CLAS members did report on their activities at the general community meetings called by the rural militias, but the leader of the militias characterized community-health center relations as “so-so” (Guillén Interview 1999), and the president of the district mother’s club stated that the health center had not contacted her organization in any way for the four years that she had served as president (Vaso de Leche Loricocha Interview 1999). The non-CLAS community leaders viewed their health center-community relations poorly as well. The militias commented that the health post was often left vacant by staff and cited no coordination with it (something I also observed) (Ronderos of Vinchos Interview 1999) while the mothers club stated they did not even want to enter the center because they felt unwelcome (Club de Madres Vinchos 1999). The poor results of the CLAS in developing social capital in rural contexts can be partly explained by contextual factors: cultivating social capital in the rural areas that have been historically the most excluded by state policies, and recently traumatized by civil war, is indeed a difficult task. This particular CLAS however, was not making an effort.

In summary, the interviews with community leaders reveal, in contrast to the survey, that some social capital has been generated between health centers and communities, but is confined to the urban settings, and to those settlements that are geographically closest to the health center.

Representational Mechanisms: Reinforcing Class and Gender Discrimination

While in the short term the CLAS were not contributing much to the social capital of the communities they served, I hypothesized that they might be promoting social capital in the long-run through modeling democratic representation. Evaluation of this thesis required evaluating

the representative mechanisms of the CLAS policy. Were the CLAS members democratically elected, and were they geographically and demographically representative of the communities they served? Did the election of CLAS members serve to enhance democratic practices in these communities?

Officially, the “general assembly” of the CLAS is composed of seven members. The community elects three members, while the head doctor of the health center appoints three other community members who are then approved by the government regional health director. The seventh member of the general assembly is the head doctor of the health establishment. Observers in Peru have criticized the CLAS structure, with three members appointed by the clinic doctor, as undemocratic. While a valid point, a more troubling issue is community participation in the election of other three CLAS members. In the survey, we asked whether the respondent knew that their local health center was community-administered. Only 52.6% of residents living in a neighborhood served by a CLAS center knew that their health center was community-administered. Of residents of CLAS communities surveyed, only six (less than 1%) had participated in the election of CLAS community representatives. Only 16.8% of those surveyed in CLAS communities felt that the CLAS representatives “represented their interests and needs.”²⁵ These results speak to the inability of the CLAS to represent general community residents. Moreover, all of the CLAS included in this study had vacant seats, indicating that there was not sufficient interest among the population to serve as a CLAS representative. Lack of interest could have been due to the lack knowledge of the opportunity, or the fact that CLAS representatives carry a large amount of responsibility for no pay.

If not democratically representative, are the CLAS substantively representative? The CLAS do effectively represent communal organizations. Even those members appointed by the

doctors were tightly linked to the community through their activities as mother's club presidents, former community health promoters, or militia leaders. That they were not democratically elected did not mean that they were unrepresentative of community organizations.

Representation was problematic with regard to geography, gender, and socioeconomic level however. All of the CLAS general assembly members were drawn from the neighborhood immediately surrounding the health center, even though each health center served a broader geographic area. The small geographic representation of CLAS members may explain why those community associations outside the immediate neighborhood of the health center did not have a strong relationship to the health center.

In terms of gender, the CLAS drew on existing patterns of local social capital. As a result, it reinforced patterns of representation that excluded women in rural areas and heavily represented women in urban areas. In the rural CLAS included in this study, only one of the six general assembly members was a woman – the rest were men. In the urban CLAS, the inverse was true. The majority of urban CLAS representatives were women, with only one or no male representative on each of these three boards. Because CLAS members rotate frequently, there are no national statistics kept on the gender of CLAS members. The male-dominance in rural areas and female-dominance in urban areas however is a pattern that CLAS administrators in the central Ministry confirmed (Díaz Interview 2000).

This gender difference in CLAS leadership across rural and urban CLAS stemmed from the types of pre-existing social capital leveraged in the two locations. In the rural areas that faced significant threats from the Shining Path guerrillas, the rural militias had become a very strong community force. While women participated in the militias, the majority of active members were male. Communal representatives in rural areas also were, by in large, male.

Mothers clubs and communal kitchens (usually dominated by women) existed in rural areas, but they were not as strongly organized as those in urban areas. By contrast, in poor urban neighborhoods, mother's clubs and communal kitchens were the significant loci of community activity, and were dominated by women.²⁶ Urban neighborhood councils, dominated by men, were declining in importance as many of the demands that these organized around, such as land titles and access to public utilities, had been met.

Each CLAS replicated existing gendered patterns of community leadership networks. This was problematic in the rural CLAS in that by drawing on exclusionary forms of social capital, in which males only were considered able community leaders, it served to perpetuate patriarchal power imbalances between men and women. In the urban CLAS, the analysis is more complicated. In some respects, the CLAS offered a new opportunity for real input and decision-making power for the women involved; decision making more consequential than that available through mother's clubs and soup kitchens. Yet, by concentrating women almost exclusively in the unpaid (and time consuming) CLAS member positions, the CLAS also added to women's unpaid community care work burdens, and risked ghettoizing participation in health as an extension of women's domestic duties. Moreover, it is notable that in two of the urban CLAS with male members, the males had been elected CLAS president, indicating that at times male leadership still prevailed, even in the urban context of strong female associational life.

In addition to gender disparities, the socio-economic position of CLAS members was also not representative. While CLAS members may have represented the poor, they did not represent the extremely poor of their communities. All CLAS members included in this study had a high school education, and often some post-high school technical training – they were in the upper educational echelons of residents of poor urban communities. Of those I surveyed, 35% of urban

residents had completed high school and another 17% had had some non-university superior training. By contrast, in the rural communities, only 4.7% had completed high school, and only 9.4% had completed primary school.²⁷ The majority of rural residents had no formal or only a few years of formal education.²⁸ Based upon observation of their homes, CLAS members were poor, similar to other community members, but were not extremely poor. Moreover, we know that CLAS members are unlikely to be the poorest of the poor because they are drawn from community organizations, which do not represent the poorest in their communities. Statistics on communal kitchens in Peru for example show that these organizations serve primarily the poor, some non-poor, and a much smaller percentage of extreme poor.²⁹

The economic position of CLAS members raises the question of whether they can adequately represent the needs of the extreme poor, especially given their responsibility of deciding fees for services and fee exoneration policies. Of the eight CLAS and non-CLAS centers compared in this study, fees were about the same and sometimes higher among the CLAS. Altruistic forms of social capital which might have led to lower fees out of solidarity with the poor, were not in evidence among the CLAS centers. The lack of altruism may have been due to the lack of representation of the extreme poor on the CLAS boards, or due to the counter-veiling incentives in the CLAS model to generate funds (discussed in the next section.)

In terms of exonerations, a survey of CLAS and non-CLAS centers contracted by the Ministry of Health does show the CLAS place fewer restrictions on exonerations for health care services than the non-CLAS centers. At the same time however, the CLAS are also less likely than non-CLAS centers to allow for full exonerations. Finally, the CLAS are less likely than non-CLAS to exonerate fees for medicines (Franke 1998). The degree to which CLAS compared to the non-CLAS use their social capital to increase economic access is small.

One of the elements of the CLAS design is that CLAS members decide who should be exonerated from fees, on the premise that they will know community members best, and ensure economic access for those who need health care and prevent the free or reduced cost use of services by “free riders”. Three of the four CLAS in my study opted-out of this possibility, deciding to avoid potential community conflicts over resources, and left exoneration decisions up to health care personnel. The fourth CLAS in the study did develop its own means-testing system, a system which drew on exclusionary forms of social capital. This CLAS asked community organizations to develop lists of persons they felt merited free health services. Persons on the lists then received a home visit by a health center staff member to verify their indigence. The President of this CLAS commented to me that in practice, “There are many cases where they [the members of local community organizations] favor their friends” (Interview Gerónimo). This is the reason he gave for follow-up home visits. Yet, this comment begs the question: how many who are not friends, never get a chance to appear on the list, because they are either disliked or have no connection to these organizations? Such a system demands that community members have social capital in order to get free or reduced cost health care, when those that need exoneration are in fact least likely to have such capital.

Leveraging Social Capital for Greater Efficiency

Finally, I evaluated the rules that defined the relationship between CLAS members and health sector workers. Did these rules create more horizontal, democratic relationships between this select group of community members and the state health workers? How was social capital employed by these rules to create more efficient, and responsive government health services?

The members of the CLAS boards were vested with important powers which gave the CLAS real potential to generate more horizontal state-community relations. CLAS members

make personnel hiring and termination decisions and review personnel performance on an annual basis. The personnel hired were selected by the CLAS from a pool of candidates approved by the regional health authority. In the case of a grievance, CLAS members could fire personnel in consultation with the regional authority. One of the urban CLAS in this study did fire its head doctor, who was reportedly used center funds illegitimately and treated patients with disrespect.

Given its supervisory role over personnel, the CLAS were effective at making sure that staff reported to work on time and were present at the health centers. One urban CLAS installed a time clock, and another demanded that if the clinic was scheduled to open at 8:00 AM, then staff should arrive by 7:30 AM in order to begin appointments by eight. In rural areas, staff absenteeism was widespread, and local community vigilance was one of the few solutions given the centers' distance from regional health authorities. Official absentee rates are not available (nor would they be reliable, as staff absenteeism is unsanctioned). Productivity levels provide an alternative measure of absentee levels and punctuality. Productivity data gathered by Laura Altobelli (1998) show that the CLAS have significantly higher productivity levels than non-CLAS centers, resulting in 25% greater service coverage than non-CLAS.

The CLAS also have significant fiscal powers. Part of the design of the CLAS was premised on creating incentives for these health centers to operate like small businesses which would compete for clients and income. CLAS set the fees for health services. While the income generated from fees is relatively small, the CLAS can spend this income as it sees fit, within ministry guidelines. The CLAS used the income from fees in creative ways. Some hired specialists or extended hours of operation, others used the money to improve their existing infrastructure by building annexes. One CLAS hired a veterinarian to administer rabies shots to community pets. The ability for the CLAS to innovate using fees is limited by the amount of

income generated. CLAS in better-off communities can charge more and generate more income. As they make improvements, they may attract more patients, and in turn, generate more income.

The ability to set fees has also instilled some adverse incentives. When CLAS compete with other CLAS for patients, this cycle can lead to some CLAS being able to improve at a faster rate at the expense of a neighboring CLAS.³⁰ While this may be viewed positively as “survival of the fittest”, the clients of the poorer, neighboring CLAS center are left at a distinct disadvantage. Rural CLAS operate in poorer communities, and have a lower volume of patients due in part to lesser population density. Rural CLAS’ ability to benefit from fee income is therefore very limited. Finally, the income from fees creates an incentive to make money, rather than serve the community, cutting against the altruistic forms of social capital that might have lead to greater economic access to services, as discussed in the previous section.

The final major power given to the CLAS is the ability to approve a local health plan each year, outlining community health priorities and health center objectives. This allows CLAS members to set the health agenda. In practice however, the health personnel wrote these plans and the CLAS simply approved them, without revision. At issue was a lack of expertise in health among CLAS members, most of whom only had a high school education, and a culture of respect towards doctors which led them to not question the health personnel’s judgment. Given these elements, CLAS members rarely questioned the local health plans.

Conclusion: Exclusionary Tales of Efficiency

The CLAS decentralized participatory administration policy was born of mixed motivations. One motive was to generate positive forms of social capital which would strengthen local democratic practices and cultivate horizontal state-society relations. A second

motive was to use the resources lodged in pre-existing community social capital to create more efficient and accountable local government health services. While the ends sought were different, they were not incompatible. More accountable health services for example, were quite compatible with the logic of horizontal state-society relations. It is on this count that we saw the greatest success in the CLAS. The institutional rules of the CLAS policy allowed community members on the CLAS board significant powers over local health professionals – most importantly, deciding who is hired and who is fired. Not only did this power vested in community members help even-out the power disparities between poor community members and the educated health professionals (thus creating more horizontal relations), it also lead to more responsive and accountable health services, as witnessed by the greater productivity of the CLAS centers than non-CLAS centers. This institutional design served to create positive, horizontal forms of social capital in this very small circle of CLAS members and health professionals, through rules that allowed for community social control over health center staff.

Other elements of the CLAS design however, utilized negative forms of pre-existing social capital to promote the end of efficiency, which cut against the objective of generating the more positive forms of social capital that lead to democratic practices. This was most clear in the case of using community social capital to weed-out potential “free-riders”. In the CLAS that developed its own system of exoneration, those who requested exoneration of fees for health care had to be identified as needy by local community organizations. As a result, the poor needed to have some social capital (in the form of ties to these organizations) in order to receive free or low cost health care. Given that the extreme poor are those least likely to have social capital in the first place, the use of social capital to decide exoneration procedures severely cuts against solidarity, in that it almost ensures that the extremely poor will not be served. Moreover, it

draws on practices of exclusion rather than inclusion. Nor did this policy generate efficiency, as the President of this CLAS related: sometimes exonerations were given based on friendship, rather than need. Thus, while dual motivations in the use of social capital are not necessarily incompatible, in some instances they may be. Policy makers need to think through the consequences that the use of social capital may have on each objective, to see whether the use of social capital may lead to competing, or undesirable outcomes.

Another crucial lesson is that policy makers must recognize that the use of social capital does not always lead to positive ends, as the above example of exclusion of the poorest of the poor illustrates. The discriminatory, gendered patterns of representation of the rural CLAS are another example of drawing on negative forms of social capital and perpetuating exclusion. In rural areas, the CLAS drew on existing social capital in which male community members were the only ones in strong associational networks. As a result, the rural CLAS board members were also almost entirely male. Predominantly male leadership on CLAS boards reified an exclusionary pattern by which women were excluded from community decision making roles. By drawing on negative forms of social capital, the CLAS program worked against more democratic practices by accepting uncritically social capital formations which excluded women.

While perpetuating undemocratic, exclusionary practices in rural areas, in the urban context the same policy offered opportunity. Women in the urban areas were offered a new arena of decision-making power through the CLAS. The concentration of women in CLAS in urban areas however ran the risk of the CLAS being diminished as “women’s work”. CLAS membership is a heavy, unpaid responsibility akin to women’s typical gendered responsibilities.

Finally, my survey results revealed that the CLAS did little to generate the kinds of associational activity that Putnam connects to democratic practices. The small amount of

increased health-related participation in CLAS communities, in fact, was vertical in nature and tended to draw on women's community networks and gendered cultural expectations to enlist women to help clean health centers, participate in vaccination campaigns and listen to health center talks on illness prevention. While it may be argued that these activities could generate more associational activity among women, this evidence is not clear. What is clear is that gendered notions of women's responsibility to family and community were mobilized by the CLAS to make excessive claims on this group.

To whom, exactly do the advantages of the use of social capital by public policies accrue? In the case of the CLAS, it was neither rural women nor the extremely poor. The state most clearly gained through more productive and efficient health centers, and some horizontal relations were instilled between a limited group of community members and state health personnel. Unfortunately, the more radical visions of the CLAS creating a greater associational life and more democratic practices were not realized.

The case of participatory administrative decentralization in Peru highlights how the mixed motivations behind the use of social capital by public policies may foreshadow a policy's mixed benefits. Policy makers need to be vigilant in asking, to what ends is social capital being put to use? Might these ends be in opposition, and thus negate desirable benefits in practice? More importantly, policy makers must realize that negative forms of social capital are mobilized as often as positive forms. By mobilizing negative forms of social capital, which are patterned on class, ethnic or gender power disparities, public policies using social capital can amplify rather than eliminate inequalities.

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¹ The “downside” of social capital was coined by Portes and Landolt, 1996.

² Fukuyama (2001) and Putnam (1993) argue that government cannot generate social capital.

³ I review only public policy and social capital and the “downside” of social capital. For a general review of social capital see Adam and Rončević (2003).

⁴ For a review of health and social capital see Macinko and Starfield 2001.

⁵ Except see Evans (1996), Foley and Edwards (1999), Portes and Landolt (2000).

⁶ Pierre Bourdieu was the first to employ the concept of social capital in two French texts (1979, 1980). Both Bourdieu and Coleman define social capital as an individual resource. Putnam extends the concept to resources available to a community. For discussion of this leap, see Portes and Landolt (2000).

⁷ See for example Neuhouser (1995), Burt (1998), Sapiro (2003), Carpenter et.al. (2004).

⁸ On the Bamako initiative, see McPake et. al (1993).

⁹ On the politics of Peru’s health reforms see Ewig 2004.

¹⁰ Data provided by Ricardo Díaz Romero, February 19, 2001.

¹¹ On the associational life of the militias see Starn (1999) and Degregori et. al. (1996).

¹² In 1993 70.1% of the population lived in urban areas. Estimates put that number at 72.2% for 2002 (INEI, *Perú en Cifras*. <http://www.inei.gob.pe>).

¹³ I am indebted to Ingeniero Antonio Moreno of the Región de Salud Lima Norte for introducing me to personnel at all health centers in Lima’s Northern Cone.

¹⁴ In 1999 47.5% of Peruvians lived in poverty. Among these, 18.4% were considered “extreme poor” (Encuesta Nacional de Hogares IV trimestre 1999). A person is considered poor if the total spending in a household does not cover all basic needs (food, water, shelter). An extremely poor person lives in a household that cannot provide a basic food basket.

¹⁵ My sincere thanks to my survey assistants: Claudia Gianella, Rocío Malpica, and Madeleine Pariona Oncebay.

¹⁶ N= 193, Pearson Chi-Square .141, Significance .707.

¹⁷ N= 193, Pearson Chi-Square 15.085, Significance .000.

¹⁸ Logistic regression testing whether program type (CLAS or Non-CLAS) causes general community participation (yes or no to the question of whether they participated in some community activity), show a significance of .707, from N=193.

¹⁹ N= 190. Pearson Chi-Square .670, Significance .413.

²⁰ N=193. Pearson Chi-Square .862, Significance .353.

²¹ N=191. Pearson Chi-Square 1.322, Significance .250.

²² Conclusion is based on interviews in which I asked if and when there were interactions between their association and the health center and asked interviewees to characterize health center relations (Elsa 1999, Health Promoters Mariátegui 1998, Comedor Montenegro 1999, Comedor “Tito Condemayta” 1999). Quote from coordinator of Comedor “Tito Condemayta”.

²³ Based on the following interviews: Gallardo 1998, Gerónimo 1998, Elisa 1998, Health Promoter CLAS Laura Caller 1998, Health Promoters CLAS Laura Caller 1998, Health Promoters San Martín 1998, Mautino 1998, Gualambo 1998.

²⁴ Vaso de Leche #3 1998, Comedor Sagrado Corazón 1998, Vaso de Leche San Martín de Porres 1998.

²⁵ All percentages in this paragraph are based on an N of 95, the number of residents interviewed in the two communities served by CLAS centers.

²⁶ In 1999 14,019 communal kitchens were registered with the government, serving 1,269,456 beneficiaries (Programa Nacional de Asistencia Alimentaria Unidad de Apoyo Alimentario <http://www.inei.gob.pe/>).

²⁷ These are similar to national figures for poor urban and rural neighborhoods.

²⁸ Given the tasks of CLAS members, such as accounting, reading and submitting legal documents, a high school level of education or above is necessary, even if it is not representative.

²⁹ Encuesta Nacional de Comedores Populares 1996, Insitituto Cúanto.

³⁰ One urban CLAS in this study had leapt ahead in improvements and patient volume, attracting patients who would have gone to neighboring CLAS.