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DEMEDICALIZING HEALTH: THE KITCHEN AS A SITE OF CARE

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Abstract

Attention to culinary care can enrich the framing of health within medical anthropology. We focus on care practices in six Latin American kitchens to illuminate forms of health not located within a singular human subject. In these kitchens, women cared not for individuals but for meals, targeting the health of families and landscapes. Many medical anthropologists have critiqued health for its associations with biomedicine/biocapitalism, some even taking a stance ‘against health’. Though sympathetic to this critique, our focus on women’s practices of caring for health through food highlights dissonances between clinical and non-clinical forms of health. We call for the development of an expanded vocabulary of health that recognizes health care treatment strategies that do not target solely the human body, but also social, political, and environmental afflictions.

What is healthy eating? We have asked students this question in anthropology courses taught in Seattle, New York, Santa Barbara, and cities throughout the Netherlands. Their responses typically reflect medical anthropology's attention to the polyvocality of perspective and diversity in patient experience (see especially Kleinman et al. 2006). They underscore the importance of valuing historical context and diversity of social conditions when designing culturally attentive treatment strategies (“some people value rice but for others rice is a food of poverty”; “in places with famine, people need meats and proteins but in places where vegetables are expensive they may need more vegetables”). Yet the target of ‘healthy eating’ of which they speak and write, with few exceptions, is a singular person. In other words, while students grasp that health is shaped by the cultural milieu, they understand health to be an attribute of the individual.

Our sense that this is a limited framing of health stems from ethnographic fieldwork carried out in Latin American kitchens. Rather than locate health within a patient-body, as is the norm in clinical practice, the women in our fieldwork sought to cultivate and nourish forms of health that were dispersed across collectives. Lynn Morgan observes that there is “no absolute, unidirectional relationship between where one works and what one thinks” (1990:948), and indeed, numerous ethnographic accounts located in biomedical settings – including our own – have illuminated that clinics can have rich social life, in which diverse forms of health are cared for by the many involved in treatment (eg. Cassell 2005; Davis 2012; Harvey 2008; Helman 2014; Livingston 2012; Pols 2006; Yates-Doerr 2012). Nonetheless, Morgan cautions that the terms of health that predominate in clinical medicine risk too much influence on anthropology's own lens of inquiry—leading to what she aptly dubs a potential to ‘medicalize’ medical anthropology. Her concern is in dialogue with an extensive literature on medicalization that details how social processes become framed in terms of individual pathology (eg. Canguilhem 1989; Foucault 1973; Lock and Gordon

1988; Zola 1972). Sharing Morgan’s concern, we ask: what can we learn about health by focusing on care within settings aside from clinics? In this article, we use kitchens as an alternative setting.

Our examination of the kitchen as a site of care takes two directions. First, in spending time with women who cared for broad networks of kin, we noticed considerable *prescriptive* dissonance between the concerns for health and suffering that emerged in medical clinics and formalized spaces of public health education, and those the women responded to in their kitchens (see Figure 1). Second, we noticed a *disciplinary* dissonance in culinary aims of health, and the common anthropological framing of health as a ‘technology of the self’ (Foucault 1988), referring to a method of governance reliant on idea that persons must be responsible for their autonomous bodies. We underscore and analyze these *prescriptive* and *disciplinary* dissonances through a series of six cases. In doing so, we argue for biomedically-oriented health providers to adopt a broader conceptualization of health in their work and its goals, and seek to enrich the framing of health in medical anthropology.

Insert Figure 1 about here

KITCHEN AS FIELDSITE: METHODS AND ORIENTATION

In this article, we draw on two long-term fieldwork projects examining the frictions between institutionalized medicine and everyday life approaches to health in Latin America (Carney 2015a; Yates-Doerr 2015a).¹ Megan’s research explored Mexican and Central American women living in the United States, and the structural constraints on their practices of eating and feeding. From 2008 to 2011, she conducted participant observation in women’s homes, kitchens, commercial sites of food procurement, private food aid programs, and public health settings in Santa Barbara, California, a region with a long history of seasonal labor migration from Mexico and some of the highest rates of poverty and food insecurity in the US. She also conducted dietary surveys, life

history interviews, and focus groups with 25 key informants, all immigrant women of Mexican or Central American descent. The majority of women had migrated from the states of Guerrero, Michoacán, and Oaxaca, all poorer, rural regions of Mexico. Women's residency in the US spanned from as short as three months to as long as 30 years. All but one of the women had children. In addition to interacting with key informants in their home environments, Megan also conducted informal interviews in various public health and food assistance programs, and community event settings. These included private food distributions, health fairs, coalition meetings of public health advocates, *promotores* (bilingual/bicultural community health workers) meetings, community festivals, and nutrition and SNAP (Supplemental Nutrition Assistance Program, formerly known as the Food Stamp program) outreach events.

Emily's research analyzed the emergence of obesity as a scientific and social concern in the highland city of Xela, Guatemala. During an intensive phase of fieldwork carried out from January 2008 to April 2009, she conducted ethnographic research in an obesity clinic in a public hospital, observing, recording, and transcribing hundreds of interactions between nutritionists and patients—most of whom were identified on hospital charts as middle-aged, women, and from low-income neighborhoods, and many of whom arrived wearing K'iche' or Mam clothing. Emily conducted formal interviews with hospital managers and staff to better understand the aims and institutional history of the clinic, collected relevant clinical documents and protocols including dietary guidelines and treatment plans, and visited 30 patients in their homes to gain insight into the reception of clinical protocol. Over a 16-month period, she also lived, shopped, cooked, and ate with 12 Guatemalan families where at least one member of the family had been diagnosed with a metabolic illness.

Our interest in how health is framed in clinical and non-clinical spaces raises the methodological problem of how and where to identify 'health' in our fieldwork. One strategy

might be to follow the term as used by our informants. But which term would we follow? The women with whom we spent time never spoke of health – the word we deploy here – because all interviews and interactions, including those observed between hospital workers and patients, took place in Spanish and not in English. We could take the Spanish terms *salud* or *sano*, routinely translated as ‘health’, but this would be limiting as in our field sites both of these terms explicitly connote biomedical institutions and their histories. Latin American cities typically have a *Centro de Salud* where individual patients are treated by biomedically-trained doctors, and a *Departamento de Salud*, where patient records are aggregated as part of statistical bureaucracy (Armus 2003; see also Walsh 2008). Several women who had raised and cared for numerous children said that they knew nothing at all about *salud*. *Sano*, which was encouraged in Latin American hygiene campaigns over the twentieth century (Briggs and Mantini-Briggs 2003; Morgan 1993; Pacino 2013; Stepan 1991), similarly conjured up images of doctors, nurses, health educators, waiting rooms, the clinical consultation, pharmaceuticals, and biomedical expertise. Listening for *salud* or *sano* would have led us to these kinds of spaces.

The dilemma of which terms(s) to follow is complicated because many of our informants were raised in communities where indigenous languages still had influence, even if Spanish predominated. We could track indigenous terms for health when these were used, but this is also not straightforward. In many Mesoamerican languages the words typically translated to mean ‘health’ also describe that which is strong, precious, beautiful, or simply good (for example, the K’iche’ word *utzil*, which refers to goodness or peace as well as health, or the word *ko*, which can also mean strong, hard, or resistant). Such fluidity in a word’s meaning is potentially revealing of health’s expansive qualities, but this fluidity does not imply that Mesoamerican concepts of health necessarily encompass strength, beauty, resistance, peace, and goodness— all at once. After all, while beauty and health may be identified through the same word, as speech unfolds in intricate

social contexts, this does not mean that being beautiful is, for example, necessarily tantamount to being healthy (Yates-Doerr 2015b).

Locating what we refer to as ‘health’ through words spoken in our fieldwork would be dissatisfying, and not just because anthropologists have long challenged the idea that words contain their meaning such that they can be cleanly translated across languages, cultures and histories (cf. Das 1998; Gluck and Tsing 2009; Mol 2014; Taylor 2011). It would also be dissatisfying because much of our research in kitchens took place through unspoken practices. Meredith Abarca shows in her research with Mexican and Mexican-American women that “the language spoken in the kitchen” relied on knowledges that became relevant in the practice of cooking rather than by being verbally articulated (2006:51; see also Cavanaugh et al. 2014). When Emily asked a household maid in Xela if she followed recipes, the woman laughed; although she cooked expertly, she could not – or perhaps simply would not – recite aloud the steps she took, or even the ingredients she used. When asked to say more, she took Emily’s hand. “It’s here,” she said resolutely, pressing the ethnographer’s fingertips against her own palms, ending the questioning with this clear message that the work of her kitchen did not proceed in words.

It is not that we do not like words. We listened carefully when women spoke of illness or suffering, *salud* or *bienestar*.² Still, for the purpose of unpacking health, it was insufficient to focus solely on the spoken word. Below, when we link care practices in the kitchen to health, this is not necessarily because women spoke in terms of health, but because of the insight we gained into diverse valuations of health that materialized throughout the time we spent shopping, preparing food, and eating with women— a fieldwork method that Renato Rosaldo has aptly called “deep hanging out” (cited in Clifford 1997:56). “Ethnographic involvement” (Harbers et al. 2002:219) in women’s everyday care practices inspired us to open up the terrain of kitchens as a site of health. Further, our use of the term ‘kitchen’ is not meant to reference an architecturally

discrete, bounded room reminiscent or derived from Anglo-Saxon, modernist architectural traditions (Oldenziel and Zachmann 2009). Many of our kitchens were not isolated from the rest of the home, but they were the ‘transformational spaces’ in which culinary care unfolded (Anagnost 2013; see also Sutton 2014).

Insert Figure 2 about here

We write of ‘culinary care’ to account for the various meanings of and intentions for health encompassed by practices, responsibilities, and rituals intersecting in the kitchen. We hope that this term might function as an opening, referencing the fluid, shifting health priorities relevant in kitchen settings. Many of the women in our research underscored the importance of *cuidar de la comida*, a phrase that translates loosely as caring for or through food (Carney 2015b). Women invoked the phrase when telling us about their plans for the day, when we entered their homes and found them busy cooking, and in more formal interviews when we inquired into their work lives, how they addressed health problems (existing or potential), and how they understood their own role(s) in families. Many anthropologists have noted that the burden of preparing food falls unduly on women, impeding their ability to care for themselves and leading to impaired health outcomes in clinical measures of health (eg. Carney 2015a; Weaver and Mendenhall 2013; Yarris 2011). What we find interesting about the way women spoke of *cuidar de la comida*, however, is that they did not identify an individualized or medicalized subject to whom care is directed or in whom health resides. By caring for and through food, women attended to the immediate event of the meal, to the histories from which the meal emerged, and to the futures it would help to produce. The health they sought to nourish was dispersed across collectives and time.

Our observations have been shaped by extensive anthropological literature on healing traditions in Latin America highlighting non-Western techniques of treatment. Much of this work has examined non-medical disease categories (*mal de ojo*, *susto*, fallen uterus, etc.), illustrating the

blending of biomedical and ‘folk’ approaches to illness (Jenkins 1991; Poss and Jezewski 2002; Weller 1983). We depart from this tradition in several ways. The forms of health in the kitchens that we outline below are not a form of ethno-medicine, that is, a systematic set of medical beliefs and practices. Rather, culinary care focuses on the relations that became relevant in practices of cooking and feeding, which may be shared between different groups of people and may sometimes not have people as the focus at all. It is not incidental that our kitchens are Latin American. After all, there is a vibrant Latin American tradition of connecting health to spirits, soils, and seeds rather than individual-level morbidity and mortality (Mares 2012; Peña 2012; Pérez and Abarca 2007). Yet we want to leave open the possibility that the forms of health we highlight do not directly result from beliefs held by a particular cultural ethnos, but that they may relate, instead, to how care is characteristically practiced in kitchen settings.³

We also suggest that kitchens, though they are not biomedical sites, are places in which women seek to produce and respond to very *real* forms of health. Below we provide six vignettes of *cuidar de la comida* – three in the highland Guatemalan city of Xela and three in Santa Barbara County, California – that we will then use to unpack approaches to health care that do not center upon individuals who experience suffering. By focusing on kitchen settings, we suggest that in some frames of health, ‘healthy eating’ may have little to do with individual bodies.

FORMS OF HEALTH IN CULINARY CARE

Case 1 (Xela)

Celebrations for Dia del Rosario – the patron saint of the city – are underway. For four weeks, culminating on October 7, a float holding the virgin will parade through the neighborhood during the evening to a parishioner’s home, where dinner will be served to family, friends, and many who are not well-known. The family hosting the Virgin on the

final night of the celebration is related to the family with whom I am living. The hosts also operate a *carnicería* (butchery), so there are high expectations for the food. When the procession arrives at its destination, the women I am with head straight to the kitchen. I follow and see several women tending to the meal. One stirs a large pot simmering on a brick oven; another is organizing cutlery; another lifts the lid of a kettle of spicy tea, assessing if it is hot enough with her eyes.

I take a seat among the circle of others in the living room. The mother of the household arrives with the *pepian*, a stew made with pork, which she serves on identical plastic plates to the crowd. Another woman follows behind her carrying tamales, sauce, and more tea. As is customary in this community, we say the Lord's Prayer, with its plea for nourishment, in unison before we begin. Then, for several hours we talk and eat. We are full, but women come with more food, filling our plates, again and again. There is no possibility of refusal or to adjust what they serve.

Back at home that night I am about to fall asleep when a low, soft chanting begins to emanate from the kitchen. I crack the door to my room and peer into the dark. The chanting stops for a moment, but then begins again. I listen for a while and then retreat back into my room. The next morning over breakfast I ask the grandmother of the house about this. She laughs, surprised I had heard her, and explains she was blessing the space, begging the Virgin to keep the family safe for another year. The K'iche' word for soul is identical to the Spanish (*alma*). She combines this with the K'iche' word for illness, when explaining she was staving off K'ex alma': illness of the soul.

Case 2 (Santa Barbara)

Dora is preparing a lunch of rice and beans. She shows me the reserves of leftover food from meals she has recently prepared, and which she enjoys sharing with the other families in her household: a pot of stewed black beans, a pot of *mole*, and a large vat of *pozole* from her husband's birthday celebration over the weekend. She tosses tomatoes, onions, garlic, chilies, and bell peppers into the blender and makes a salsa for her rice and beans. She says her salsas add flavor and nutrition to the meal.

Dora is originally from Honduras. Her father, a *campesino*, had grown coffee, rice, beans, and corn and she used to work alongside him in the harvests. She expresses nostalgia for meals in Honduras, saying food there is *todo fresco* (completely fresh). She especially misses making tortillas from corn grown in their fields.

Her aunt paid a *coyote* to bring her from Honduras to Santa Barbara six years ago. Dora's partner had died without leaving behind any resources to support their two children, compelling her to find work. Although she is glad her children are safe with her mother in Honduras, their absence is an ever-present grief. Dora hopes that she will eventually be able to bring them to live with her in the US.

When Dora began gaining weight, her mother blamed this on the store-bought food she was eating and suggested she become more versed in the kitchen. Although cooking had previously been of minimal interest to Dora, she now enjoys providing her household with home-cooked meals. She beams when explaining how she recently converted her partner to eating his meals at home with her. She tells me this took some adjusting for both of them, as he comes from a Mexican family and prefers Mexican food. She has since tried to cook more to his tastes, but she also gives him credit for trying (and enjoying) her Honduran style of cooking.

When the rice and beans are ready, she serves me a plate before serving herself. As I prepare to leave Dora's home, she invites me again for lunch at some future date, insisting that it gives her great pleasure to have people over in her home to eat her food.

Case 3 (Xela)

Dalia begins to prepare the day's menu weeks before her children – all of whom live in other cities – arrive for her youngest grandson's birthday celebration. On our trips to the market she tells me stories about corn. Over a period of several days she buys a handful of kernels from various market vendors, which she then cooks and tastes before settling on the one she wants for the main dish. Dalia, a single woman who pays her bills by renting the spare rooms in her home to university students, is not wealthy by any means, yet asks the vendors not how much their corn costs, but where it was grown.

The Wal-Mart owned grocery stores where we sometimes pick up staples are lined with Maseca—a mass-produced corn flour. The women with whom I live speak about how dry and flavorless it is. Some have begun to use it, but they are not particularly happy about this: they show me how the tortillas or tamales they prepare with it break apart in their hands. As we pass an aisle in the store where bags of Maseca are stacked high, Dalia tells me that it is filled with chemicals and its use has been connected to cancer. It contains formaldehyde, she says, whispering “a chemical for the dead!”

In the week before her family arrives I can hear her at work in her kitchen well into the night, pots moving from burner to sink and back to burner, the smells of charred pepper or roasted sesame seeds lasting through to the morning. She boils the corn herself, takes it to a neighbor for milling, and then sits for hours on end, patting the masa into banana leaves for the tamales she is making. She tells me, as we do this together one night, that she

is worried about her children and grandchildren. One son and the wife of another have diabetes and she is concerned for their health.

The time for the meal comes and though Dalia has spent weeks preparing it, it is over in a matter of hours and her children soon return to their homes. We are back in her kitchen when she tells me how glad she is to have put the time into the meal that she did. This is her chance to feed her family; she hopes it will keep them strong during their time away from her.

Case 4 (Xela)

Adela had worked as Esther's maid since she was in her teens. She was a small child when her family stopped growing corn on their land – they couldn't compete with prices of corn imported from the US. "We used to grind chile and to this we'd add onions and salt and we would eat this on tortillas. Every day. Three meals a day. This was all we ate." She explained that as her family sunk deeper into poverty, her father grew increasingly despondent and abusive. Because her mother was too frail to protect her, she escaped to the city, eventually finding her way to Esther's employment.

Today, the kitchen where we speak is full of food. She points to ripe, delicious vegetables, and chicken thighs in the sink. She tells me that none of the food has come from the nearby community Almolonga. When making purchases she looks instead for women vendors wearing headscarves from Llanos de Pinal. Both communities are just outside Xela, but Almolonga has an extensive export production and the soils of Llanos de Pinal, she tells me, are not full of the toxic chemicals of pesticides used for the quick, exaggerated growth of vegetables that come from imported seeds. She bought the chicken from a woman who travels to the city from the countryside only once a week. It's much

more expensive, but she doesn't trust most chicken sold in the market. You can tell from its taste that it has been imported, she explains. She will not serve tasteless food to the family, not after what she has endured. It is her job to keep them strong—and this necessitates that they eat delicious foods.

Unexpected guests – family, business partners, friends – commonly drop in on our meals. This is not a problem. She will ensure there is enough for all, no matter how many arrive (it helps that the thick, warm tortillas she serves are both inexpensive, readily available, and loved—they can extend any meal). She does not plan meals around the guests, but around the food. She considers what goes well together: delicate spices to please tongues, hearty substances to fill bellies.

Case 5 (Santa Barbara)

Pilar and her newborn son share a house with three roommates in Santa Barbara. The others had been covering the costs of Pilar's housing while she was pregnant. In exchange, Pilar had been collecting money from everyone to do all of the grocery shopping and cooking. Pilar has always loved to cook and she sees managing the food as a small gesture of her gratitude.

Pilar has been living in the US for only a few months. She left her home in Guatemala City several months ago, following an incident of gang violence that made her fear for her life. Her family encouraged her to migrate, even though it meant she would be estranged from two of her children.

Cooking has been her lifelong passion. In Guatemala she had operated a food cart business and also cooked for the 10 people with whom she shared a home. Her father, from whom she developed her culinary craft, died of complications related to diabetes. Pilar says

that she cooked his favorite meals for him up until the end of his life. This was a way to care for both him, and their relationship. Even in this critical-condition setting she did not isolate ‘health’ from the satisfaction – and even pleasure – entailed in the reciprocity of caring for him through food.

Today Pilar is preparing a Guatemalan-style chilaquiles. She shares with me part of her cooking philosophy: “when someone cooks with love, others enjoy the meal more.”

Case 6 (Santa Barbara)

Sharing with me some of her memories of Guerrero, Mexico, Betanía, a mother of eight, talks about the large table that her family once gathered around for meals. She also fondly recalls the dishes she used to make: *mole roja*, *birria*, *pollo verde*. Since joining her husband in the US nine years ago, she has developed type-2 diabetes. Her husband now also suffers from the disease. Betanía laments how he has become skeptical about her cooking and worries that the food she makes might be exacerbating his diabetes. She reenacts for me what is a regular exchange between them: “I tell [my husband] ‘You don’t have any [disease].’ ‘But yes, the doctor put me on a diet,’ [he says]. I tell him ‘Go ahead, eat!’ [He asks:] ‘It’s not going to do me harm?’ [I tell him] ‘It is not eating that will harm you!’” She thinks her husband has been too prudent about following the advice of nutritionists, and she is upset that he avoids much of her food. Moreover, she regrets having no one with whom to share her cooking on a regular basis. Although she lives with some of her children and grandchildren here in the US, they are not usually around to eat with her.

PRESCRIPTIVE DISSONANCE, DISCIPLINARY DISSONANCE

When focusing on women's culinary activities, we began to notice considerable fluidity in what it was that women valued as healthy; at times spiritual vitality was at stake, other times the concern was intergenerational connection or the strengthening of community ties. Moreover, the target of the care was often not any particular individual, but collectives that traverse biological and geographic kinship boundaries. Meanwhile, the clinics and health centers where we worked tended to seek to improve the health of individual patients. Their protocols framed health in fixed, standardized terms, able to be evaluated in the same way from person to person and compared across a population of people.

In the first case of culinary care taken from Xela, we see a clear challenge to a clinical model of health that places the individual body as the focus of attention and aims to increase the bodily autonomy of an individual patient (see also Struhkamp 2005). Here it is not individual eaters who decide what and how much to eat; instead, the women in the kitchen serve the meal they prepared together, without regard for individual preference. No one ever asked that his or her unique needs be attended to, nor was this individualized form of care offered. Later, when aiming to secure the family's safety – to stave off “illness of the soul” – the grandmother focused her attention upon the space of the kitchen rather than upon specific bodies.

Multiple temporalities and spatialities converge in the care seen in Dora's kitchen (case 2). The supply of dishes waiting to be eaten by visitors to her kitchen underscores her desire to engage in relations of conviviality that nourish social ties. In recalling the foodways of her homeland, she highlights the pleasures derived from eating foods grown on familiar soils. As Dora's decision to migrate was informed by the need to support her children, she now attends to obligations of care in multiple settings. Her activities in the kitchen have implications beyond this immediate moment and space, hinting at the meals yet to be shared and social interactions yet to unfold. Dora's expressions of culinary care serve as collateral against future disturbances and a dissolving of

social ties. The blending of cuisines is not just a means of cooking for her husband, but of cooking for their relationship as these meals are shared. Health, here, is not just an outcome of strong relations; instead strong relations are fundamental to what it is to have health (see also Brijnath 2011).

Care for dietary health, in the case of Dalia in Xela (case 3), depended upon knowing how and under what conditions food was grown. A clinician might look at corn and see nutrients, but Dalia looked at corn and saw histories. When she could not see histories, as was the case for the corn packaged in plastic, she saw illness and death. Cooking could connect eaters to their home and this connection could alleviate sickness and offer strength. One did not care for taste, texture, or flavor so as to influence or achieve the separate entity ‘health’; rather caring for taste, texture, or flavor constituted healthy eating.

For Adela (case 4), knowing how food was grown was also critical to eating well. She distrusted both factory food and local vegetables grown for export with pesticides. While caring for the household budget was important, it was also important to care for communities, broadly understood to include both neighbors and landscapes. Individual needs did not structure her cooking. She did not even cook for a specific number of individuals, but instead planned her meals around the food. Whereas pleasure may be positioned as a danger to health in biomedical formulations of food/nutrition (see Vogel and Mol 2014), here pleasure is both a means to and expression of health. In this kitchen, eating well both reflected stability and helped to secure and maintain it. Precarity was marked by scarcity, health by abundance.

For Pilar (case 5), culinary care was embedded in the practice of sharing and alternating responsibilities within households. She employed her knowledge and skills around food to cooperate in the pooling of resources with others in her home. These relations of reciprocity reinforced feelings of obligation among the members of her household (both in the US and

Guatemala), thereby sustaining social cohesion and building long-term trust. She alluded to the satisfaction that stemmed from consuming a meal that had been prepared “with love,” and how her own cooking facilitated the pleasure, comfort, and enjoyment of others, including her late father. While biomedical approaches to diabetes commonly attribute the onset and progression of the disease to a particular diet and aim to regulate the intake of certain foods (cf. Mendenhall et al. 2010; Rock 2003), Pilar’s care for her father indexes a radically different approach. Rather than the restrictive dietary mantra of much contemporary public health rhetoric, an emphasis on pleasure and the celebration of food stood prominent in how she cared for her father as he died. To follow from observations made by Farquhar and Zhang (2005), though the joyful pursuit of pleasure is not typically recognized as biomedical ‘health’, this was inextricable from the health that Pilar sought to cultivate. She cooked to express gratitude and affection; the joys entailed in eating as well as feeding food prepared with love were integral to health care in her kitchen.

With Betanía (case 6), we see how interruptions to culinary care illuminate its meanings. While invoking a memory around food, Betanía recalled the social life that once infused mealtimes. She contrasted this memory with the social isolation and perceived toxicity of living and cooking conditions that she has encountered in the US. Instead of being held in esteem for facilitating relations of care, she felt as if she were to blame for the disrupted relations with and deteriorating health of her husband. Aside from loneliness and nostalgia, she grieved for the loss of the conditions that made culinary care possible.

Insert Figure 3 about here

We draw from these cases to suggest that health, as it materializes through acts of culinary care, is not often directed at individual well-being. Concerns for sickness and suffering are prevalent in the narratives above. Kitchens were sites in which women could address corn

processed with formaldehyde or grown on toxic land, growing up in conditions of poverty, forced geopolitical migration, spiritual malaise, and strained relations; as spaces of addressing health, these kitchens facilitate valuable forms of healing. Women clearly cooked for families— though these were not organized genetically, but by who shared the home (see also Carsten 1997; Weismantel 1988). They also cooked for the sake of the meal (*cuidar de la comida*), which necessitated care for food, cooking skills, tradition, ancestors, and soils. To care for health in their kitchens was to address changes in the food supply, shifting workday schedules, immigration policies, the impact of violence, and inequities in property distribution. These were not problems that could be located in any one body; they were problems disseminated across diverse and shifting temporal and geographic landscapes.

The frictions that resulted from encounters between a biomedical focus on the individual and the kitchen's communal aims often had destabilizing effects for the many who straddled both kitchens and clinics. Individualized dietary treatments created confusing mandates for many women who spent their lives engaged in culinary care. In Emily's research in Xela's obesity clinic, she found that protocols for healthy eating often targeted individuals. A patient, isolated by a medical chart, was to be treated by personalized dietary recommendations. But kitchens are not set up this way, instead existing as communal spaces in which 'the individual' does not necessarily figure as relevant. When Emily visited one patient from the obesity clinic at her home, she found the woman owned a single-burner stove and a single pan to cook with. The patient simply laughed at the directive to prepare food separately for herself; she had a family to feed with these limited resources (see Figure 4). Other patients similarly found the clinic's individualizing guidelines to be ill-suited to the culinary care in which they were involved.

Insert Figure 4 about here

The attribution of health to the individual also added to women's own sense of isolation. For example, Betanía, in following the advice of the nutritionists, found her culinary expertise devalued, leaving her without anyone with whom to engage in the sociality, and its connection to health, that came with cooking. Others felt similarly frustrated that their means for building trust, cementing social ties, and sustaining long-term networks of support were cut off by approaches to dietary health that focused on individual physiology. Many women felt a heightened sense of responsibility to provide care through cooking at the precise moment that the expertise of their culinary labor was undercut by the mandate that they must care for particular bodies (see also Yates-Doerr 2011). Pilar's case is notable, however, because she was able to continue to engage in the reciprocity of pleasure entailed in feeding her father throughout his illness.

A practical reality in the kitchen is that what goes into a meal prepared for ten people is very different from that which goes into ten meals, each prepared for one. Dietary prescriptions, by locating health within individual bodies, have ignored this, overlooking the expansive forms of health that women were busy cultivating in their care for food. This prescriptive approach constrained resources, limiting the purchasing power of these households. Individualized dietary prescriptions also devalued women's culinary expertise, interfering with the potential of meals to facilitate and reinforce social ties.

We thus propose the term *prescriptive dissonance* to highlight ways in which health care directed at the individual risks ignoring the health concerns among target populations, in addition to impacting individual health in a detrimental way. A challenge that arises in making this critique is that biomedical health is typically measureable, and through these measures it becomes precisely definable. If we consider the standards of health used in obesity clinics, patient health was identified with a specific, calculable Body Mass Index range. Meanwhile, the aims and parameters of culinary care, which we are also calling health, are far less stable. This is a health

whose evaluation requires engagement with the context at hand: sometimes the priority might be spiritual strength; at other times it might be the security that comes from hearty food grown in safe soils; at other times it may be the stability of well-nurtured relations. There were no universal rules that could be prescribed and followed to achieve good health outcomes, since health was not a fixed object.

We also propose the term *disciplinary dissonance* to highlight the ways in which anthropological theory has been limited in its association of health with the experiences and expressions of an embodied (socially shaped but nonetheless singular) subject. In their insightful overview of biomedicalization, Lock and Nguyen (2010) suggest that health, once understood as an absence of disease, has today become imagined as a condition of the individual body to be continually sought. While this may be the case within biomedical frameworks, the health at play in the kitchens described above remains linked to a patchwork of families, communities, lands, and spirits. Even when pleasure in eating was the concern at hand, this pleasure was not individualized but inflected with pleasures resonating with other places and other times.

Our articulation of culinary care undoubtedly shares some similarities with an anthropological tradition of research on Complementary and Alternative Medicine (CAM). But whereas CAM focuses on “healthcare practices outside the realm of conventional medicine, which are yet to be validated using scientific methods,”⁴ it is hard to imagine that the techniques of culinary care are simply awaiting scientific validation. What, exactly, would be validated? Where would it be validated and who would do this validation? Whereas CAM pushes for the medicinal value of alternative medicines to be biomedically recognized, it would only make sense to think of the food in our kitchens as medicine if medicine was itself ‘de-medicalized’— that is, if medicine were itself stripped of its association with individualizing, prescriptive and technoscientific qualities (cf. Clarke et al. 2003). In this sense, the health practices associated with *cuidar de la*

comida are not simply an alternative means to achieving health; they open up the possibility of alternative forms of health altogether.

CONCLUSION

We seek to give words to things (events, habits, frictions) that have previously been unspoken... Perhaps care practices can be strengthened if we find the right terms for talking about them [Mol, Moser, and Pols (2010:10-11)]

By outlining forms of care that unfold in kitchens, and related notions of health encompassed by these practices, we aim to make space for non-biomedical framings of health within both clinical and anthropological discussions. Our research suggests that the unit of concern in the clinic – i.e. the body, the subject, the patient – may not be much of a unit at all in practices of culinary care.⁵ In the kitchens of our cases, potential ‘units’ of concern such as bodies, families, communities, lands, and spirits were often so entangled as to render any stability in these divisions meaningless (see also Carsten 2004).

Clinical aims are often individualized, measurable, and immediate (lower blood sugar, lower cholesterol, weight loss); in contrast, we have illustrated ways in which care in the kitchen attends to social and environmental relations. While women recounted stories of “making do for today,” they remained mindful of longer-term commitments spread across disparate temporalities and spatialities. These included practices of conviviality and reciprocity within households and social networks, obligations within transnational networks of care and transference of cultural knowledge to younger generations. Failure to attend to any of these matters would be a failure of what we as researchers might call health care.

Joseph Dumit (2012) has astutely demonstrated that US pharmaceutical companies have contributed to the recent expansion of concern for ‘health’. He shows that the US pharmaceutical industry has manufactured health as a quality of life that is constantly under threat and in need of pharmaceutical maintenance and protection (see also Cooper 2008; Sunder Rajan 2006). As we call to expand the concept of ‘health’ from clinics to kitchens, families, and broader social worlds, we are aware of possible resonance between our aims and those of the pharmaceutical industry. Yet we do not seek to expand health as a means of medicalizing kitchens. Rather, we suggest that what counts as health in people’s culinary lives may not fall within a biomedical framework in which the health of the singular patient is a desirable, relevant outcome of care; indeed, health in kitchens where we worked was rarely biomedical.

The question may be raised: why call the care that happens in kitchens ‘health’ rather than adopt the more general frame of the pursuit of “the good” (Mol 2011) or “the good life” (Fischer 2014)? Indeed, our informants tended to speak in terms of strength or satisfaction, not in terms of *sano* or *salud*. But including culinary care – care that treats the fracturing of families, land contamination, the fragility of spirits, the maladies of border politics, and care that nourishes relations and pleasures – in the framework for health draws attention to how much may be missed when medical treatment focuses on the suffering or wellness of the individual patient-body. By identifying what happens in the kitchen as health, we have hoped to make apparent the need for health practitioners to develop awareness of how and where prescriptive dissonances may arise in their strategies for treatment (see also Napier et al. 2014). We have also hoped to make apparent that sometimes – maybe even much of the time – the anthropology of health may have little to do with medicine.

In many ways, our analysis of *care in the kitchen* has been an exercise in “reification for the work of comparison” (see also Strathern 1987; Tsing 2014:223). We have taken a term that is

not spoken directly in our fieldwork – health – and we have deployed this to help build vocabularies that strengthen awareness of caregiving practices that do not necessitate and instantiate individual, human subjects. We have engaged in this work of “unfaithful translation” (Tsing 2014:222) so as to destabilize biomedicine’s grip on the notion of health – both within clinical spaces and within ethnographic theory. Several medical theorists have recently sought to counter the expansion of biomedicine’s moral authority by taking a stance “against health” (Metzl and Kirkland 2010). We have offered here a rather different tactic. Instead of ceding health to pharmaceutical and biocapital industries, we have sought to infuse the term with care that targets families, communities, and landscapes. The health we have outlined here entails processual care that cannot be neatly measured and which does not necessitate nor enact a solitary subject.

To return to the teaching question with which we began, it is our hope that thinking about expressions of health as distributed through social and material relations may help to diversify possible responses to the question, ‘what is healthy eating?’ In focusing upon culinary care, we have highlighted a need to attend not just to the social and historical contexts of the individual (what personalized diet will work the best for you?) but to the social and historical contexts of health. Since clinical information about healthy eating directed at individuals may not carry very far or be effective (consider, for example, rising rates of obesity despite a good deal of obesity prevention education and expanding clinical attention (Greenhalgh 2012; Greenhalgh and Carney 2014; Yates-Doerr 2015c), there is urgent need to conceptualize health from other places. Perhaps with this awareness, we may begin to dissolve some of the prescriptive and disciplinary dissonances underscored here. As anthropologists, we are merely at the beginning of building a vocabulary for talking about non-individualized forms of health.

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¹ Stephen (2009) has convincingly argued that Latin America is a cultural and not geopolitically bounded region.

² *Bienestar* often translates as well-being, a term that might seem less biomedical in connotation than *salud*, except that in Latin America *Bienestarina* is a popular nutrient supplement, with (bio)medical connotations.

³ Cameron, et al. (2014) and Hunt (2014) provide an excellent summary of the political and intellectual dangers of associating ontological multiplicity with a specific group of people. For an account of how a practice-centered approach to anthropology might depart from an ethnos-centered approach see M'Charek (2013).

⁴ This is the definition for Complementary Alternative Medicine given by the special interest group for the Society for Medical Anthropology. <http://www.medanthro.net/interest-groups/camim/> last accessed May 6, 2014.

⁵ In her study of cooking in kitchens in Spain, Ibáñez Martín has made a similar observation (2014). Whereas nutritional and dietary advice and recommendations make boundaries between good and bad fats, and good and bad bodies, in the cooking practices she studied, boundaries were

not so solid.