Planning Quechua Families: Indigenous Subjectivities, Inequalities and Kinship under the Peruvian Family Planning Programme

Rebecca Irons

University College London

PhD Anthropology

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I, Rebecca Irons, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.
ABSTRACT

Quechua people have a fraught history with the Peruvian national family planning (FP) programme, with an estimated 300,000 individuals (forcibly) sterilised during the 1990s Fujimori-government in a biopolitical act that saw indigenous people as less ‘desirable’ and therefore sought to restrict reproduction in this group (Ewig, 2010).

The state is now targeting the ‘rural, poor’ (often synonymous with ‘indigenous’) specifically for family planning intervention once more, based on perceived unmet need in this population. Now, for the first time in history, the 2017 national census included a question about identification of indigeneity, further suggesting heightened governmental interest in the demographics of this group.

State intervention in Quechua reproductive health is not limited to FP. In 2005 an ‘intercultural birth’ policy was introduced that sought to bring women away from communities and into hospitals through the implementation of ‘Quechua cultural elements’ of birth amongst the biomedical settings. However, it has been argued that this policy was a veiled attempt to alter the subjectivities of Quechua women through an enforced association with biomedicine, thereby ‘whitening’ them (Guerra-Reyes, 2014). Social whitening through biomedical-association is well documented in the Andes; for example, women may seek IVF treatment or caesarean scars as proof of their interaction with the ‘whiter’ biomedical environments (Roberts, 2012). Yet, not all Andeans actively seek this racialised subjectivity, and instead may have it forced upon them as an imposition of state ‘coloniality of power’ that hierarchies race in Peru, to the disadvantage of the indigenous (Quijano, 2000). Such reproductive health policies can irreparably disrupt not only corporeal-subjectivity but kinship relations (Berry, 2010), inalterably affecting subjectivities at multiple levels.

Through an ethnographic investigation into the contemporary FP programme offered to low-income Quechua women free-of-charge in a health-network in rural Ayacucho, this timely study interrogates if/how, through biomedical FP, the Peruvian state influences indigenous subjectivity, inequalities, and kinship.
IMPACT STATEMENT

As a work of anthropology focusing on global health concerns, this thesis has the ability to impact cross-disciplinarily, in and outside of academia. The new knowledge presented would prove beneficial to a number of stakeholders from different disciplines and non-academic positions, including public health policy makers, governmental health ministries, NGOs, and charities working in the health sector. The text analyses and suggests recommendations of improvement for a Peruvian health network serving the indigenous Quechua population, with a focus on women’s experiences. Thus, this work could be used to give further insight into the intersections of state-health services and vulnerable populations, responding directly to the UCL Grand Challenges of Global Health & Human Wellbeing and therefore contributing to the overarching research focuses of UCL.

The benefits within academia specifically would come from this work’s contribution to knowledge and development of theory, addressing topics of particular importance and widespread concern at present (decolonial academia; gender; race). This could benefit not only other anthropologists but a diverse range of scholars working across disciplines, including those within the social sciences & humanities, but also extending further to global & public health, women’s health, and medicine.

The impact of this study has both local and international potential. The results of the thesis were presented to the Ministry of Health Peru so that the findings could be communicated to policymakers who could then take the recommendations into consideration for future policies. Here, the potential for impact is significant as this approach could eventually have a direct health benefit on the population with whom the research was undertaken.

Internationally, the impact will be made through dissemination of outputs within academia, through submission to international scholarly journals, in both English and Spanish in order to reach a wider audience (five peer-reviewed articles published thus far from this research). Other forms of public outreach, such as the UCL Medical Anthropology blog and in-house magazine, have also be utilised to disseminate the research further.
Firstly, I would like to thank the *Vilquinos* who kindly participated in this study, answering my questions with patience and allowing me into their world. This study would not have been possible without their kind cooperation.

My thanks also extend to those working for the Ministry of Health Peru, both in Vilcashuaman and Huamanga. I am indebted to all the *obstetras* who shared their professional wisdom, opinions, and time with me whenever I asked. In the Ayacucho Directorate, I am particularly grateful to Lorena Roca for her continued help and support with logistics. This project could not have come together without her.

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Apu</td>
<td>Mountain deity</td>
</tr>
<tr>
<td>Ayni</td>
<td>Andean ritual non-financial exchange</td>
</tr>
<tr>
<td>CHIRAPAQ</td>
<td>Centre of Peruvian Indigenous Cultures (Centro de Culturas Indígenas de Peru)</td>
</tr>
<tr>
<td>Combi</td>
<td>Mini-van, public transport</td>
</tr>
<tr>
<td>Ligada</td>
<td>Sterilisation/ To be sterilised or mistreated obstetrically</td>
</tr>
<tr>
<td>Minka</td>
<td>Andean ritual non-remunerated community work</td>
</tr>
<tr>
<td>MINSA</td>
<td>Ministry of Health Peru (Ministerio de Salud)</td>
</tr>
<tr>
<td>MMPV</td>
<td>Ministry of Women and Vulnerable Populations Peru (Ministerio de la Mujer y Poblaciones Vulnerables)</td>
</tr>
<tr>
<td>Movimiento</td>
<td>Feminist NGO, Lima and Regional Departments</td>
</tr>
<tr>
<td>Manuela Ramos</td>
<td>Mother earth; Andean deity</td>
</tr>
<tr>
<td>Partera</td>
<td>(Sp.) Traditional Midwife (see TBA)</td>
</tr>
<tr>
<td>PromPeru</td>
<td>Peru tourism board</td>
</tr>
<tr>
<td>Obstetra</td>
<td>(Sp.) Biomedically-trained midwife</td>
</tr>
<tr>
<td>ReproSalud</td>
<td>Rural reproductive health programme, 1990s</td>
</tr>
<tr>
<td>Salud Basica</td>
<td>Previous government funded-health programme under Fujimori</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birthing Assistant</td>
</tr>
<tr>
<td>Tienda</td>
<td>Small store</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>Vilquino/a</td>
<td>Person from Vilcashuaman province</td>
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ONE
INTRODUCTION

Mejor que estar lleno de hijos que muerto, ¿no señorita?
Better to be full of children than dead, is it not señorita?

- Soraya, Thirty-five, Willka Waman

Notorious for the tragic family planning programme of the 1990s that resulted in an estimated 300,000+ enforced sterilisations of mostly rural, indigenous people, ex – president of Peru Alberto Fujimori finally faced legal prosecution for these reproductive health abuses in April 2018. Following the constitutional crisis that ensued after the 1992 auto-coup in which he dissolved congress and assumed control of the military, this infamous figure was hailed as the Peruvian people’s champion for ordering the capture of Shining Path leader Abimael Guzman and decapitating the terrorist threat. Now he appeared frail and defeated. The greying president was wheelchaired past a group of hungry press, his bony fingers perching limply onto the armrests of the chair and his skin dull and decaying (BBC, 2018a). Having had spent the last nine years under arrest for human rights crimes and corruption, Fujimori had been pardoned in December 2017 on the grounds of poor health¹ (BBC, 2018b). He played the part splendidly, weakly saluting the cameras and wobbling vulnerably as the chair rattled over the cobbles. Groups that had been campaigning for women’s justice for many years, among them Movimiento Manuela Ramos, Somos 2074 y muchas mas, DEMUS, and Flora Tristan, saw a victory in this long-overdue prosecution. Finally, justice for those men and women who had suffered at the hands of a post-colonial, racist, elitist government’s enactment of their biopower through neo-Malthusian population policies that sought to discourage the procreation of the ‘less desirable’ rural, indigenous poor.

¹ This pardon was once again revoked by current president Martín Vizcarra in October 2018, after the resignation (after the discovery of a financial scandal) of ex-president Pedro Pablo Kuczynsksy who had originally released the pardon of Fujimori (BBC, 2018b).
When news broke that President Fujimori had finally been prosecuted for his role in the past sterilisations, it seemed possible that this violent chapter of Peruvian reproductive history might be coming to an end. Where my original proposal for the research on which this dissertation was based stated that those sterilised individuals were ‘yet to receive justice’, that line could now be changed to a more positive conclusion, could it not?

In many ways, this dissertation seeks to answer that question, not only as it relates to the past but also the contemporary context of national family planning (FP) in Peru, a country with a long history of discriminatory policies towards the indigenous – those who have been invariably framed as a ‘problem’ or hindrance to national progress since colonial times.

Illusions of change in reproductive policy towards indigenous and impoverished Peruvians brought about by the Fujimori news, at first seemingly so positive, might be challenged when one discovers that out of an estimated 300,000 people sterilised, the ex-president was actually only accused of responsibility in five of those cases (BBC, 2018a).

Furthermore, and significantly, the Peruvian state is now explicitly targeting the rural, indigenous poor as primary recipients of reproductive health care, and FP in particular. The contemporary national FP campaign, ‘Planifica tu futuro’ (‘Plan your future’) stated low-income, rural poor people as the demographic with the highest unmet need for contraceptives in 2015, therefore offering a tidy justification for renewed intervention in this group² (MINSA, 2015).

At first a seemingly neutral framing, it has been highlighted how ‘rural poor’ can often be synonymous with ‘indigenous’ in the Andes (Ewig, 2010), albeit that less-evocative terminology may be presently used in FP campaign materials. Considering the historical obstetric violences enacted on this group, current FP campaigns that target the indigenous yet again may raise concern. Are there

² See Appendix 1.1
any contemporary issues with lack of information, misinformation, or discriminatory practices as in the past?

Importantly, obstetric and structural violences\(^3\) are not the only significant theme worthy of attention within FP. As a concept enacted through state policy, FP speaks to numerous other key areas of anthropological study: kinship and family, subjectivity and the self, gender, race, inequality and rights. As Ginsburg and Rapp have delineated:

“By using reproduction as an entry point to the study of social life, we can see how cultures are produced (or contested) as people imagine and enable the creation of the next generation, most directly through the nurturance of children. But it has been anthropology’s longstanding contribution that social reproduction entails much more than literal procreation, as children are born into complex social arrangements through which legacies of property, positions, rights, and values are negotiated over time. In this sense, reproduction, in its biological and social senses, is inextricably bound up with the production of culture” (1995: 1-2) (emphasis added).

Attendance to FP design and implementation can give valuable insight into much wider issues of health, personhood, governance and coloniality beyond limited concerns of population and reproduction alone. Through the analytical lenses of coloniality of power (Quijano, 2013; 2000), reproductive governance (Morgan & Roberts, 2012) and biopolitics (Foucault, 1990a), this dissertation aims to investigate the translation of state reproductive health policy into local Quechua-indigenous realities in order to enhance understandings of the multiply faceted and at times, unexpected, ways that contemporary health policies and politics affect the lives and communities of subpopulations within a post-colonial, Andean Latin America.

It further seeks to voice Quechua understandings and subjectivities regarding biomedical FP and changing kinship structures both within and outside of the clinic setting in order to understand the complete picture of reproductive health in the region.

That said, it will also address issues and themes that speak to much more than reproductive health alone. The chapters within this dissertation will seek to explore the complex relationships between coloniality, biopolitics, and race, as

\(^3\) Structural violence refers to institutionalised forms of violence such as racism, sexism and nationalism (Farmer, 2006). Obstetric violence refers to those violences enacted in reproductive health (Diaz-Tello, 2016). See chapter three for in-depth discussion of the terms.
they are enacted through contemporary state-health services and beyond. This will allow a reflection on further issues of nationalism, indigenous ontology and epistemology of the body, self, and environment, biopolitical entanglements with neoliberal Peru, and the concept of racial fluidity within Latin America and the biomedical paradigm.

Previously, research looking at the relationship between biomedicine and Quechua maternity has been undertaken (Guerra Reyes, 2013; 2014), however the relationship between Quechua subjectivities and FP/contraception has yet to be explored.

Here is an opportune moment to clarify what is meant by FP and contraception as addressed in this dissertation. By (biomedical) contraception, we are referring to all hormonal and barrier methods offered to patients using free-of-charge (for low-income individuals) state health insurance, Seguro Integral de Salud (SIS). Hormonal methods include the one- and three-month injection, the oral combined pill, the three-year implant, the hormonal intrauterine device (IUD), and the emergency contraception pill (ECP). Barrier methods include the male and female condoms and diaphragm. Other methods of contraception available to rural Peruvian women include the Copper-T, Sterilisation (tubal ligation), and (information on) natural methods (such as the rhythm method, lactational amenorrhea and billings method). The main biomedical contraceptive methods discussed in this research are the implant, the injection, the pill, and sterilisation. Family planning (FP) as it is referred to here includes all of these contraceptive methods but further expands to the associated discourses that accompany these.

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4 Only legalised in MINSA health establishments in 2016, the emergency contraceptive pill was still unavailable in the field site, and so does not feature in the analysis. See Irons (2019a, 2019b) for further discussion on the ECP in Peru.  
5 Although a wide range of contraceptive methods are available in theory, in reality MINSA health centres and posts may not stock them all - as was the case with the field site of the present research. This accounts for lack of use for some methods, such as the female condom and diaphragm for example - they did not exist within the field site. Furthermore, some options may have been available to participants but not within the rural health network. For example, tubal ligation would require a trip to Huamanga city hospital.  
6 It is important to note that it has also been argued that caesarean births (and the promotion of them) may also be framed as a method of biomedical family planning, as women are ‘unable’ to carry another child for three years after a c-section (Erten, 2015). There is certainly the case that a c-section constitutes a form of imposed child-limiting on the part of the surgeon and hospital.
There is one study, now almost twenty years old, that speaks specifically to Peruvian-Andean FP. That is Peruvian anthropologist Carmen Yon Leau’s *Hablan las Mujeres Andinas* (2000). This was a report funded by Peruvian feminist NGO Movimiento Manuela Ramos, looking at their ReproSalud programme in the Andes during the period 1996-2000 (the time of the sterilisations, it should be noted).

When I discussed the present project with Carmen at the start of my own fieldwork, she wondered if my project would find anything ‘new’ or different to what she had reported. Now that the data has been collected, the answer to her query is *no, not necessarily*. But, crucially, neither was it an attempt to update and quantify FP preferences as she did (although that is not to deny the worthiness of such an endeavour). Instead, this work is an exploration of indigenous subjectivities, both personally-corporeally and in kinship and community terms (to include indigenous concepts of community, such as the animate environment), and how these are affected by state-provided contraceptive and FP services in the contextually specific context that is post-conflict Ayacucho.

**Research Questions and Aims**

Such a study was guided by central research questions that sought to provide a framework of investigation into a complicated and invariably fraught topic. Those guiding questions were:

1. How are Quechua corporeal and personal subjectivities and kin relationships affected by the state FP programme?
2. Do contemporary state reproductive health policies correspond to indigenous understandings of FP, health and wellbeing?
3. In what ways are the use of state-FP services influenced by wider societal and community factors (such as the historical and political context of sterilisations, NGOs, gender)?

Secondary questions that guided this research were:
1. Are there any contemporary issues with lack of information, misinformation, or discriminatory practices as in the past?
2. What are the gendered dimensions of state-provided contraception among the Quechua?
3. What non-state actors (such as NGOs) are influencing indigenous family planning and reproductive care, and how are these conceptualised?

Through a careful attendance to these core questions, this dissertation will contribute not only to understandings about indigenous cosmologies, aetiologies, and understandings of reproductive health, FP, and contraception but also to contemporary interactions between the Andean indigenous and the state in Latin America.

**Background and Literature**

Peru was once considered a problematic case in regard to maternal health and FP. Until recently, they had the second highest rate of maternal mortality (MM) in South America (PHS, 2007: 5). Researching in the 1990s, Larme (1997, 1998) observed the effects of poverty and maternal ill-health on indigenous Peruvian communities in the Southern Andes, concluding that the harsh conditions and lack of allocated health care led to instances of gender-selective infanticide. Not isolated to Peru alone, selective infanticide through a lack of dedicated care was observed and analysed in Scheper-Hughes’ Brazilian ethnography *Death without Weeping* (1989), also reflective of conditions of poverty in that region. Although more recent data from Andean Bolivia suggests that Aymara communities may continue to practice infanticide for reasons including ‘family size’ and ‘poverty’ (de Hilari, 2008), this data no longer figures in contemporary literature on Peru. There are several reasons for this, and they hinge around the changes in policy on rural maternal health and contraceptives, supposedly reducing the need for infanticide based on the above reasonings.

To begin with, from 1999 to 2005, MM in Peru was cut in half (Bristol, 2009), and because of this the country has been hailed as an example of success. Whereas in 1993 there were a reported 448 deaths per 100,000 live births in rural areas, by 2005 this had fallen to 240 per 100,000 (Ewig, 2010: 7).
This success is largely attributed to the introduction of the Intercultural birthing policy, first implemented in Ayacucho and run by the Ministry of Health (MINSA). This policy came into full force in 2005, and was framed as a way to reduce MM in rural, impoverished areas by bringing (particularly Quechua and other indigenous) women into state-run hospitals where they could give birth under the supervision of biomedically trained doctors and obstetricians, instead of at-home with a traditional midwife, a *partera*, as had previously been the majority of cases. This scheme involved the implementation of various ‘Quechua-cultural’ features to entice women into the sterile MINSA establishments, including the use of the birthing rope, permissibility of ‘Quechua’ birthing practices (such as herbal teas and use of woollen stoles and rugs), and the presence of family members, among other things. This programme of ‘intercultural birth’ has been hailed as a great success (Bristol, 2009), with the programme in Ayacucho recently receiving particularly warm praise from the United Nations Population Fund (UNFPA, 2018). Indeed, the numbers speak for themselves.

However, as Guerra Reyes explores, the actual implementation of this policy on the ground often omits the Quechua features it was supposed to have. Instead, this policy serves little but to obligate women into state-controlled health centres where they can be imbued with biomedical and national discourse about *(racialised)* subjectivities, she argues (2013, 2014).

Furthermore, Guerra Reyes suggests that whilst the numbers do indeed ‘speak’, they may misrepresent the local realities, instead pandering to the criteria laid out in the Millennium Development Goals (MDG), giving the illusion of success (2019). And they have done so- Bristol (2009) praised the programme precisely for its dedication to reaching the MDGs.

Berry (2010) also offers a criticism of a similar intercultural birthing programme in Guatemala. This policy aimed to encourage indigenous Maya women into hospital-births and away from their traditional-midwives, *comadronas*. Similar to Peru, women who did not comply may have found that birth certificates were withheld from their new-borns, meaning that they would not be registered as official ‘citizens’ in the country and therefore be unable to access future
government services such as education, health, and legal nationality. Yet furthermore, Berry found that in bringing indigenous women away from their communities to give birth in a hospital, their subjectivities were deeply affected. Birthing would often be a community event, where the participation of relatives and others was a very important thing for both the birthing woman as well as the new-born infant, who would be initiated into his or her community during this process. Hospital births took this away from indigenous Mayans, thereby forever altering subjectivities to the disadvantage of the patients that the policy purported to serve.

Although maternal health programmes aimed at Quechua women have received mixed responses, if we glance a little further back in Peru’s history, before the intercultural birthing policy even, an even more damaging policy can be seen in FP. In the 1990s when Larme (1998) was writing about infanticides as a reaction to hyper-fertility, the Peruvian state was purportedly taking this into its own hands through its sterilisation campaign.

Beijing, 1995, The Fourth World Conference on Women: The international event at which President Fujimori gave a speech, as the only male head of state, in which he announced the legalisation of surgical sterilisation as a new method of state-provided contraceptive in Peru (Necochea Lopez, 2014: 1). A year earlier, at the 1994 United Nations Conference on Population and Development in Cairo, the agenda had changed from a focus on population to individual rights of women – a focus that Alberto Fujimori had supposedly taken on board when developing the new FP programme for his country (Rousseau, 2009). However, what was framed as a way to reduce poverty and increase ‘development’ through increased access to FP services has been accused of sinister undertones. This programme – the National Programme of Reproductive Health and Family Planning (Programa Nacional de Salud Reproductiva y Planificación Familiar) (PNSRPF), came into force one year after Fujimori’s faux-feminist-leaning speech at Beijing, and lasted four years until 2000. The expansion of available contraceptive services offered to women followed a neo-Malthusian development logic that framed poverty as a consequence of unconstrained fertility. However, it was targeted at certain people in the country – poor, rural,
and mostly indigenous, mixing poverty with racism and sexism (Boesten, 2014: 24).

It has been noted that mass-sterilisation programmes as a form of ‘development’ are not new nor unique to Peru. As Ewig observes, the case of Peru reflects “an old story of the instrumental use of women by national planners…as a means of controlling population growth and promoting economic development” (2006: 633). Indeed, calculated, mass-sterilisations have occurred all over the world, targeting tribal caste groups in India, Native Americans, Puerto Ricans, and African Americans, to name a few (Rodriguez-Trias, 2008; Washington, 2006). However, what makes Peru different was Fujimori.

This populist president had seemingly aligned himself with feminist-rights groups, ‘Hijacking global feminism’, as Ewig has put it (2006). His cabinet was fairly equal in terms of gendered employment (Rousseau, 2009), and his policies seemingly catered for the rural poor of the country (such as the construction of rural schools and hospitals) (Boesten, 2014: 23). As Peruvian family-planning historian Raul Necochea Lopez admits, he ‘cheered’ when Fujimori gave his 1995 speech (2014: 1). Such a public persona contrasted drastically with the FP policy that would follow, and the nation was blind-sided. Indeed, it has been noted that one important factor that kept Lima-based feminists hoodwinked was the fact that they had whole-heartedly supported his policies in the first place (Ewig, 2006).

It was not until 1999, when Lima based lawyer Giuliana Tamayo blew the whistle on thousands of enforced sterilisations taking place in Ministry of Health (MINSA) establishments throughout the country, with her report Nada Personal (1999), that the issue came to light. Yet until today the events and protagonist surrounding the PNSRPF remain shrouded in accusation and misdirection, as the aforementioned legal case against Fujimori suggest.

Through the FP programme that targeted the fertility and continuation of specific groups of Peruvians – the rural, poor, and mostly indigenous, the state enacted biopower (Foucault, 1990a) over a sub-section of the population. For Foucault,
a biopolitics of the population relies upon state interventions and regulatory controls of citizens, an “anatomo-politics of the body” (1990a: 139) in which governments administrate bodies and manage life. Through biopower a state can foster life in certain groups, or disallow it to the point of death (1990a: 138), achieving this control over the population, the fostering of those deemed more desirable and the dis-allowment of those deemed undesirable, through numerous techniques of subjective discipline and control. In the example of sterilisations, biopolitics resulted in the reproduction of an ‘undesirable’ group – the racialised indigenous, seen as an ‘Indian problem’ in Peru’s history (see discussion below) - to be halted completely, however there are also less dramatic biopolitical techniques to curb reproduction within communities. FP in Peru has historically positioned the poor and indigenous as hyper-fertile and in need of greater discipline and control so as not to be a burden on the nation, while at the same time not interfering in the reproductive and FP decisions of wealthier, usually ‘whiter’ and urban, women who have not been framed as ‘undesirable’ in the same way (Necochea Lopez, 2014). One way of controlling the reproduction of ‘undesirable’ populations includes withholding information or providing incorrect information, as occurred during the sterilisations when women would be lied to about the reversibility of their operation (Rousseau, 2009). Other coercive means may include health worker deception. For example, French health workers in Paris were found to be slipping the pill in with other prescription medications to be given to African migrants without their knowing the effect these would have on their fertility (Sargent, 2005). These biopolitics are not limited to contraception. As Guerra Reyes (2014) describes, the state is currently using maternal health policy to control Quechua women’s reproductive bodies once more, and similar state policy against the indigenous has been enacted in other Latin American countries too (Berry, 2010).

Not limiting its scope to maternal health alone, Leinaweaver describes how the Peruvian state uses biomedical categories of ‘wellness’ in order to remove indigenous children from their parents (2009), thus manipulating kinship and the continuation of community of this population through numerous biomedical policy interventions. Such a scenario echoes other colonial endeavours in which ‘native’ children were removed from their families in order that the state might
attempt to turn them into ‘acceptable’ citizens through re-education and kin isolation, as occurred in colonies such as Canada, New Zealand, and India (Procher, 2009). Such practices continue today, from the Amazon to aboriginal Australia, where post-colonial governments remove children from their communities in order to ‘protect’ them from their indigenous parents. In these cases, as in that of Peru, the state frames this as a protective act for the children, who would otherwise be harmed by their indigenous parents, a practice which Segato suggests is a part of the coloniality of power (2014a: 139)(see below).

Biopolitics is not limited to racialised reproduction either. As Gammeltoft (2014) argues, the Vietnamese state controls ‘selective reproduction’ of future Vietnamese citizens not based on race necessarily, but on subjective concepts of ‘population quality’ formed in a context of post-conflict residues of Agent Orange-related birth defects. Gammeltoft explores the local specificities of biopower in her field context, to suggest that historical processes are important to understanding when analysing reproductive choices and the state. Referring to biopolitics and racialised reproduction, Bridges (2012) makes the argument that this biopower is stratified. Studying racialised reproduction of black women and state in the US, she notes that whilst the Foucauldian theories of discipline and power may still be applicable to impoverished female patients on state welfare, they may need to be revised somewhat. That is, they “might not be as ubiquitous and random as Foucault suggested. There might be an intentionality to power and discipline that would allow them to be directed towards certain subjects thought worthy of discipline” (2012: 349) (emphasis added). If some people are considered more ‘worthy of discipline’ than others, there would arguably be processes in place to discipline them uniquely amongst their fellow compatriots. As has been seen, for Peru those who may receive this stratified biopower would be the indigenous Quechua who have historically had their reproductive subjectivities disciplined and may continue to experience similar treatment from the government through its national FP programme and reproductive and sexual health services.

With this as a backdrop, MINSA-run FP services continue to be offered in rural, indigenous areas of the country, and there is demand for this. Furthermore, as
with the maternal health policy changes, there has been positive development (statistically) in regard to FP and contraceptive usage across the country. When compared with other Latin American countries, Peru has one of the lowest unmet needs for FP at 8% (by way of comparison, its Northern neighbour Ecuador has a 7.4% unmet need, but fellow Andean nation Bolivia has a 20.1% unmet need) (CEPAL, 2013). According to the Demographic Health Survey (DHS) definition, unmet need for FP applies to women of reproductive age who are married and sexually active, fecund and/or have a desire to avoid pregnancy in the following two years or at all, and are unable to access FP methods (Bradley, 2012). Thus, in Peru there is widespread availability of contraceptives and high use of FP (Sedgh, 2012), although there is some discrepancy between urban and rural areas, with rural departments Ayacucho and Loreto showing over double the national average in unmet need for FP (ENDES, 2013a:10), meaning that women in rural areas have less access to contraceptives even if they want them.

Recent statistics for Peru show that 78.6% of women across the country have used a contraceptive method (whether medical or natural) at least once in their lives (ENDES, 2013a: 131), with the most popular methods being the injection, the pill, and the male condom (130). Trends suggest that Peruvian women are more likely to use FP methods if they have either no children, or between one and two (139), suggesting that 1-2 children may continue to be the nation-wide preference as argued by Yon Leau (2000).

Two thirds of Peruvian women receiving contraceptive methods and FP advice do so from an establishment run by the Ministry of Health (MINSA) (ENDES, 2013a: 142), suggesting that the state plays a large role in the reproductive lives of many women in the country. Those who do not attend MINSA-establishment use private sources (e.g. private doctors, pharmacies, NGOs). When Peruvian women discontinue use of an FP method, the overwhelming reason given is undesirable secondary effects, such as headaches, weight gain, and nausea (2013a, 146).

Therefore, Peru presents a picture where a large number of women are seeking, accessing and using contraceptives in state-run health establishments.
Necochea Lopez also notes that the expansion of clinics offering free FP and contraceptive services in *pueblos jovenes* (shantytowns) suggests a growing desire for contraception services on the part of poor Peruvians (2014: 148).

In fact, whilst popular opinion suggests that indigenous fertility has historically been higher and indigenous family sizes larger, studies undertaken in the 1960s instead suggest that in that time, indigenous women actually had lower fertility and a desire for smaller family sizes than their urban counterparts (Heer, 1964; Stycos, 1965). That more recent research suggests a pan-Andean preference for 1-2 children (Yon Leau, 2000) presents the picture of a long-standing desire for smaller families amongst indigenous Andean families. In fact, Yon Leau’s participants suggested that women were happier when they did not have many children (2000: 51). Abundance of children is considered a problem by the Quechua themselves, and women who do have larger families may be referred to as *wawasapa* (‘abundance of babies’) (2000: 49). Thus, evidence suggests that Quechua women *do* want to use FP methods of some kind and have historically done so. Previously, however, this may have only been obtainable through ethnomedical, plant-based contraceptives that were once widely discussed in the literature on Andean reproductive health (Hern, 1976; Maynard-Tucker, 1986; 1989). More recently, however, as state health policy has changed, so too have preferences (and choices).

It is thus important to acknowledge that, despite potential obstetric violence and myriad other complications towards hormonal contraceptives and FP services that appear in the literature and within the following pages, there is still a desire and a demand on the part of poor, indigenous women. That said, one should approach glowing statistics on reproductive health with caution, urges Guerra Reyes (2019), as they may not reflect similarly successful realities for all involved on the ground.

In her ethnography on maternal health and black women on state welfare, Bridges also points out that although discourses surrounding biomedicine construct a specific, undesirable subjectivity around race in the government hospital setting, women nevertheless seek out biomedical services for the perceived benefits that these can provide (2012: 94).
Although coercion has been shown to exist in the Peruvian FP context, (Guerra Reyes, 2014; Ewig, 2010; Necochea Lopez, 2014), this does not discount that (poor, indigenous) women also seek and desire the ability to plan their families and take greater control over their fertility.

However, importantly, the crux is that this may not be on their own terms. By virtue of their indigeneity, poverty and gender, they continue to rely upon the state’s dictations about how they 'should' be using and subjectivity experiencing their reproductive bodies.

**Race and ‘Modernity’**

In his work on the ‘Coloniality of Power’, Peruvian sociologist Aníbal Quijano has argued that one of the significant legacies of European colonisation in Latin America was the concept of biological 'race' (2013: 534). He states that “the idea of race, in its modern meaning, does not have a known history before the colonization of America”, with this idea being used “as a way of grating legitimacy to the relations of domination imposed by the conquest” (534). Quijano suggests that in Peru and elsewhere there was the imposition of perceived difference, based on a concept of physiological 'race' that was previously alien to the native populations. He says that:

> "Coloniality of power was conceived together with America and Western Europe, and with the social category of 'race' as the key element of the social classification of colonized and colonizers. Unlike in any other previous experience of colonialism, the old ideas of superiority of the dominant, and the inferiority of dominated under European colonialism were mutated in a relationship of biologically and structurally superior and inferior" (2007: 171).

The restructuring of society according to artificial 'racial' categorisations can be seen in post-colonial societies' adoptions of apartheid, for example. Whilst Latin American countries have not experienced this social policy in the same sense as South Africa, for example, Hegenhougen (1995) has suggested that in countries where clear social divisions exist between elites of European descent and the indigenous, in the absence of overtly racialised state-policy this can be seen as a functional apartheid:
“In countries throughout the world, the structure and practice of a functional apartheid persists… While we may share in the celebration of the collapse of apartheid in South Africa we should not be blinded to the tenacity of apartheid in its various guises and its destructive consequences throughout the world. Groups of people are marginalized, exploited and abused, as a result both of their ethnicity and of their class; for being ‘the Other’, …‘Inditos’…supposedly not true and equal citizens in their own countries (the ‘others’, those apartheid: set aside). Whether apartheid is official government policy or de facto (functional) may be a significant distinction but the health impact on ‘the others’ may not be obviously distinctive (281).

Here it is noted that whether or not apartheid is political or functional may not be so clear a distinction when it comes to the health of the disadvantaged groups. Thus, following on from Hegenhogen’s important mention of the health effects of functional apartheid, Washington (2006) advances the theory of medical apartheid – the unequal treatment of some ‘races’ by the medical establishment (discussed further below).

Importantly, the effects of coloniality did not end at racial classification and consequent apartheid-segregation alone. For Quijano, this ‘coloniality of power’ involved various facets of Eurocentric governance that relied upon the disruption of pre-conquest American societies and is a structure of governance and societal structure that continues to present itself through contemporary Latin American governments. He continues:

“So, coloniality of power is based upon ‘racial’ social classification of the world population under Eurocentered world power. But coloniality of power is not exhausted in the problem of ‘racial’ social relations. It pervaded and modulated the basic instances of the Eurocentered capitalist colonial/modern world power to become the cornerstone of this coloniality of power” (2007: 171).

As Mignolo argues, this colonial matrix of power controls four interrelated areas:

“control of economy (land appropriation, exploitation of labor, control of natural resources); control of authority (institution, army); control of gender and sexuality (family, education) and control of subjectivity and knowledge (epistemology, education and formation of subjectivity)” (2013: 3)(emphases added).

Thus, under colonialism the colonised ‘other’ was relegated to an ‘object’ to be dominated and used to extract resources for the European powers by way of slavery and labour. This continued into the present under coloniality, divided into Mignolo’s areas of domination. In a nutshell, although colonialism and colonial, sovereign states no longer exist in name, the underlying structural powers that constructed them continue. Mignolo refers to this process as as
‘internal colonialism’, when in South America “a Creole elite (i.e. white elite from European descent), took the power from the hands of the Spanish and Portuguese monarchies, and re-enacted it in their own hands” (2013: 3). With white internal-colonial powers overtaking colonialisit control, the line of racialised-power-structures continued without challenge. Thus, Catherine Walsh suggests that “while colonialism ended with independence, coloniality is a model of power that continues” (2013: 83).

Significantly, Quijano’s ‘coloniality of power’ expresses a particular relationship to ‘modernity’, seeing it as Eurocentric and intrinsically related to coloniality (2007, 2013). As Escobar comments on the subject, “there is no modernity without coloniality, with the latter being constitutive of the former” (2013: 39). For Quijano, ‘modernity’ is an element of ‘cultural Europeanisation’ that was “transformed into an aspiration” (2013: 23).

Although ‘aspirational European-ness’ has not been specifically suggested as an analytical lens within reproductive health in the Andes, Peruvian anthropologist Lucia Guerra-Reyes develops the concept of ‘aspirational whitening’ (2014), which she employs in relation to Quechua maternal health care amongst rural Peruvian populations, and can be considered within this coloniality-modernity ‘rationality’ (Quijano, 2013) as expressive of an underlying and persistently Eurocentric and ‘colonial’ way of framing racialised aspirations and ‘development’. As Segato keenly observes, eurocentrism and racism are but two sides of the same coin (2015: 53), and thus we can logically move from aspirational Europeanness to a racialised aspiration of race equated with the European objective: whiteness, and specifically, a \textit{white modernity}.

Thus, aspirational whitening or whiteness is a consequence of the Eurocentered coloniality of power and is bound up with a specific kind of ‘modernity’ that herein refers to a Eurocentered, colonialised, racialised ‘modernity’. Throughout this dissertation, when ‘modernity’ is referred to as aspiration, it refers to the understanding of ‘modernity’ as within this framework.

\footnote{Canessa also employs similar terms regarding aspirations and race in indigenous Bolivia, which he has called “whitening for social ascension” (2012: 255). However, this term arguably suggests more deliberate desire on the part of the person doing the whitening, thus the less definitive concept of ‘aspirational whitening’ has been selected for this work.}
Whilst race may have been constructed during colonialism, it has arguably continued institutionalised through certain mechanisms.

One institutionalised arm of coloniality is the production of scientific thought, that which includes biomedicine and extends beyond to all understandings of the natural body and world. As Castro-Gomez states, “scientific thought positions itself as the only valid form of producing knowledge, and Europe acquires an epistemological hegemony over all the other cultures of the world” (2013: 287). Indeed, if colonialism invented ‘race’ originally as Quijano has argued, then [Western] science took this up as fact, unable to be challenged as it has become supposedly ingrained at the level of the gene (Wade, 2007).

Marks (2017) discusses how it is [Western] science that invented and supported the concept of biological ‘race’ through the development of supposedly ‘objective’ human classification and categorisation based on observable physiological difference, and subsequent hierarchical values given to those categorisations, based on the invented category of biological ‘race’. Within the medical world, these categorisations were then used to take action against specific groups of people who fell into them. Marks gives the example of screening for sickle-cell anaemia in the US in the 1970s (2017: 99-100), to show how African-Americans were targeted for what was essentially a eugenic programme based on a perception of biological and immune difference based on ‘race’, even when the evidence does not hold up to this. He argues that, “all groups of people have their own genetic idiosyncrasies, as a result of their unique histories, but they do not map on to race” and that in the case of sickle-cell anaemia specifically, it is “associated with Old World populations at risk from malaria, which includes a broader region than just tropical Africa, and places Saudis and Indians at genetic risk as well” (101). However, the public health sickle-cell anaemia programme discussed in Mark’s work targeted only African Americans, resulting in suggestions to a supposedly ‘medical necessity’ to limit reproduction within this population.

Washington expands upon the treatment of African Americans by the medical establishment within the United States, to argue that since colonialism the state
has undertaken a regime of ‘medical apartheid’ against this population (2006). This finds its roots in the colonialist construction of ‘race’, when European colonists de-humanised black slaves to the point at which they found it acceptable to undertake medical experimentation not only without consent, but without anaesthesia. Washington also notes instances of un-consensual female sterilisation - the ‘Mississippi appendectomy’ (190) as it is here referred to and suggests an ongoing and disturbing coloniality of power enacted through biomedical institutions in regard to reproductive health. Such treatment of African Americans in the United States continues in public hospitals, as Bridges (2017; 2011) discusses at length. Here, using colonial notions of hierarchical race that have been carried through in scientific and medical discourse, the state portrays, interiorises, and mistreats black, low-income women’s reproductive concerns, an expression of biopower.

These racial hierarchies are found across the Southern American continent as well. However, in countries like Peru, scholars have argued that race may be more fluid than colonial scientific categorisation might have one believe.

**Fluidity of Race in Peru**

According to the coloniality of power, since the conquest people in Peru have been branded as inferior or superior based on a racial hierarchy that knew no existence before the arrival of the Spanish. Peru is a ‘pigmentocracy’ (Telles, 2015), a social hierarchy based on skin colour (pigmentation), as are other countries within the continent with similar colonial pasts. Silverblatt (2009) calls Spanish colonialism a “revolution of identities”, a concept that she sees as “fluid, malleable...identity as born out of of a dynamic between individuals and the givens of cultural and political life – the relations of being – through which humans make themselves” (ix).

This fluidity and malleability of identity carries into understandings of race. Thus, if the concept of ‘race’ is a colonial introduction, it has been argued that it is not a fixed one. Here, Silverblatt suggests that we see “race and identity not as things but as processes of living’ (2009: x) (emphasis added). The presence of process suggests an ability to reposition identity. In Peru, the concept is invariably used by individuals attempting to move up the social hierarchies by
moving fluidly through racial categories, and De La Cadena describes this process:

“According to the hegemonic regional ideology, “Indian” and “mestizo” are closed, bipolar constructions, standing in diametric opposition. From this perspective, individuals have an identity, according to a cluster of characteristics that mark their personage. Thus someone is either Indian (Quechua-speaking monolingual, illiterate, and peasant or livestock raiser) or mestizo (a migrant or urban resident, bilingual in Quechua and Spanish, and literate). Contradicting this regional identity of fixed, bipolar ethnic categories is a fluid, protean, and contingent process by which people attach ethnic labels to themselves or others. Depending on the circumstances of daily life, a person has almost limitless possibilities to construct, and mix, Indian and/or mestizo identities” (De La Cadena, 1995: 331).

In her work, De La Cadena argues that indigenous people in Cuzco would often perceive a move through race, from Quechua/indigenous to mestizo, based upon the obtainment of formal education (2000). As one received more education, one effectively became whiter. Garcia Elena’s work on intercultural education in Cuzco further supports this theory (2005). Wade (2017) has also addressed the concept of mestizaje (mixture), which is widespread in Latin America and has led to the rejection of a concept of ‘race’ by some. However, ‘mixture’ has its counterpart: ‘purity’, neither of which are necessarily fixed categories. As Wade states: “in the pursuit and maintenance of hierarchies of value and power, relative purities are carved out of the sea of mixtures” (2012: 4).

Closely linked to formal education is the whitening effect of migration, from rural to urban. Ewig also notes how migration from rural villages to urban environments can be accompanied by a movement through race (2010), with urbanity associated more to whiteness and ‘modernity’; both related categories under coloniality. As she has stated, “race is…tightly linked to geography” (2010: 15). Guerra Reyes summarises, the “aspirational whitening process…accompanies the creation of an urban persona” (2013: 261), and Necochea Lopez confirms the existence of an “enduring urban bias” in nation and FP and beyond (2014: 30).

One’s profession, more often than not linked to level of education, also has the ability to whiten (De La Cadena, 2005). Drinot discusses how, historically, the Peruvian state has encouraged indigenous and rural workers to enter certain
industries as a form of whitening (2011). This comes along with discarding professions that are associated with indigeneity – principally agriculture- in favour of ‘modern’, ‘white’ careers, a discourse that paints agriculture as ‘backwards’ and undesirable. Quijano makes clear that the ability to control labour (of the ‘object’, the colonised) is an integral element of the coloniality of power (2000), thus the artificial desirability of certain jobs over others could be inserted into understandings of colonial powers.

It is important to notice here how all of these are interrelated: one may migrate to a city to receive a formal education, and afterwards be offered a job in an urban environment, thus compounding their access to white/mestizo identity markers. These boundaries have become increasingly fluid over the last century as identity markers that were once completely unobtainable for all but an elite, racialised few, have become increasingly accessible to wider sections of Peruvian society. (e.g. land ownership). However, many of these opportunities have long been closed to women, leading to De La Cadena’s assertion that “women are more Indian than men” (1995). This is an important consideration and will be discussed in more depth below.

As mentioned above, if European scientific thought and biomedicine are closely associated with coloniality and the invention of race, then it is perhaps unsurprising that it is through subjective negotiation with biomedicine than racial fluidity has been identified in Latin America as well.

**Biomedicine and Whitening**

In Andean Peru, boundaries between races may be permeable and fluid (De La Cadena, 1995), with the obtainment of ‘social whiteness’ an aspiration that can be sought by those who chase it, or alternatively imposed upon those who do not.

One notable way in which a person can seek aspirational whiteness is through their relationship to biomedicine and its artefacts, and the literature has come to increasingly reflect explorations of such experiences. Here, ‘biomedicine’, ‘whiteness’, and ‘modernity’, all belonging to Eurocentric scientific and hierarchical tradition, are often juxtaposed with ‘folk/ ethno-medicine’, ‘indigeneity’, and ‘tradition’ – racialised knowledge systems and
epistemologies that were framed as ‘inferior’ under colonialism (Castro-Gomez, 2012). Yet, people may have agency in this, as Crandon Malmud’s (1991) work suggested. Studying medical pluralism among the Aymara in Bolivia, she found that people would associate themselves with different medical frameworks as a strategy to negotiate ethnicity and political standing as it benefited them. So, to associate oneself with biomedicine would ingratiate oneself to social whiteness, for example, as would Aymara medicine allow a person to subsume an identity within an indigenous community. Reflecting on this, Baer concludes that “medical dialogue served as an idiom by which a person defined his or her ethnic identity” (2015: 417). Whitening strategies are not simply limited to medical dialogue or the treatment of illness, however. One can also move along a racial ‘continuum’ through seeking out biomedical services in reproductive health – an endeavour that may whiten not only oneself but also future kin.

Roberts (2012a), studying IVF in post-colonial, Andean Ecuador, notes that “IVF clinics attracted patients... through their ability to whiten patients and their potential offspring” (2016: 47) (emphasis added). Patients who attended private, costly IVF services may have done so out of a desire for fertility assistance, but also to obtain the social whitening that this experience could potentially afford them. The association with this biomedical technology, and a patient’s ability to afford it, could be seen as much as an indicator of ‘whiteness’ as skin colour.

In another study, Roberts argues that Ecuadorian women will specifically seek out caesarean scars as a way to whiten:

“In Ecuador, middle-class women... eagerly pay to be scarred... scars and the bodies that carry them enact a racialized relationship... browner bodies can withstand vaginal birth... [but] ... when women pay for caesarean sections, the private scars make them whiter and more worthy” (2012b: 215)(emphases added).

In Roberts’ body of work on reproductive health in the Andes, women use financial capital to pay for private biomedical health services that afford them social whiteness through the various visible (caesarean scar), and non-visible (IVF-pregnancy) results of that treatment. Women are paying to be whiter, even if absolutely nothing has been done to their skin pigmentation.

However, this association with biomedicine and whitening is not always at the request or desire of the woman herself. When poorer women in Latin America rely upon state-provided reproductive health care they may also experience a
degree of social whitening that comes along with an enforced association with the biomedical frameworks, discourses, and practices that are inherent within state-provided health care. However, unlike those individuals who actively seek this out, this may instead disrupt their subjectivities and create unforeseen and negative consequences on other areas of their lives.

**Subjectivities**

Berry (2010) defines subjectivity as “someone’s own understanding of his or her own place in the world. Subjectivity is about an individual’s internal processes, dispositions, or understandings, as opposed to other people’s judgments or attributions about an individual” (2010: 5). From this perspective, subjectivity would reflect a person’s held views and perceptions about who they are and what that means to them. In her research in Guatemala, Berry gives an example of medical discourse influencing subjectivities when she looked at the consequences amongst indigenous Kaqchikel Maya women of the Safe Motherhood initiative (SMI)(introduced in 2005)\(^8\), that encouraged women to stop giving birth ‘at home’ with a ‘traditional midwife’ (TBA)\(^9\), and instead give birth in a biomedical hospital. She states that one of the significant consequences of this campaign has been to “unintentionally encourage a shift in subjectivity among Kaqchikel Maya villagers” (2010: 5). Thus, in her work she found that indigenous women’s understanding of their own place in the world changed because of a government-mandated alteration in reproductive health policy that forced them into biomedical hospitals – a significant conclusion. This occurred in large part because the biomedical birthing model overlooked the moral requirements of Mayan birthing frameworks. For example, family members would usually be present during a home birth and the father would assist in the birth. These features were not available in the hospital setting; the denial of which to the family and community inalterably affected the indigenous women’s subjectivities against their will, even if ‘unintentionally’ (as Berry thought it was). This research raises an important point about subjectivity: it

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\(^8\) The SMI was introduced in 2005 by the WHO after unsatisfactory reductions in global MM. This initiative sought to bring women into hospitals where they could receive biomedical care, particularly in emergency cases, that may have led to maternal and/or infant deaths if birthing at home with a TBA only (Berry, 2010).

\(^9\) In Guatemala the traditional midwives (TBA) are often referred to as *comadronas* or *iyomas*. In Peru, they are *parteras*. Although their services differ, they share common characteristics such as the ability to manipulate the foetus whilst in-utero (to turn the head downward-facing for the avoidance of breech-birth) and provide ritually-significant pregnancy and partum related care.
may be a view that a person holds ‘about themselves’, but it is very much enmeshed within relationships of power that can influence that view. For example, in Foucauldian understanding, “subjectivity is not a state we occupy but rather an activity we perform” and further it “is not distinct from but rather is formed in and through relations of power” (1990b: 173). Thus, state medical discourse, such as that discussed by Berry (2010), contributes towards one’s “practices of the self” (Foucault, 1990b); the way that we form our subjectivity and “constitute ourselves as subjects” through the daily behaviours and activities that nevertheless are constrained by institutions of power (Taylor, 2011b: 173).

It has been argued that the Peruvian government has attempted to influence Quechua subjectivity, and specifically the racialised way that indigenous people see themselves, through the maternal health policy – the intercultural birthing model, introduced in 2005. On this scheme, previously discussed above, Guerra Reyes states that:

“interculturality in Peru has supposed only a change in the discourse, but not in the practice of health care, and the intercultural birthing policy merely provides a veneer of cultural respect while functioning as a mechanism of reproductive governance (Morgan and Roberts, 2012). It has become a new way to impose a ‘moral regime’ that will normalize birthing in the health centre and reduce other birthing options, “modernizing” and medicalizing indigenous women’s bodies as part of an ongoing nation building effort which equates modernity with urbanity, and both with social whiteness” (2014: 1)(emphases added).

Therefore, in this view, rural, Quechua women are experiencing social whitening through interactions with biomedicine, although this is not necessarily desired but enforced upon them. It is within the same institutional and populational context of Guerra Reyes’ study that the present research takes place, only here, with FP and contraception as a focus instead of pregnancy and birthing alone. Furthermore, although she is an anthropologist, Guerra Reyes’ work was principally public health focused, which may have unintentionally excluded the ethnographic richness and deeper understandings of lived experience provided in more anthropological works. Importantly, this work aims to draw the connections between local experiences of FP and the wider Peruvian nation and discourse on race, ethnicity, and indigenous subjectivity, putting this into conversation with coloniality theorists and actively taking a decolonial approach to scholarship in doing so.
Interestingly, the fluidity and permeability of race within Latin America arguably supports Quijano’s theory that colonialism introduced it as a concept in the first place. If it was never a reality ‘existent’ or ‘fixed’ in Peru, then this may explain its malleability today. The crux comes in the coloniality of power and the ways in which ‘race’ is hierarchied, and who has the ability to puppet the biopolitics of the nation.

The State and Indigeneity

Following from the discussion of coloniality, and the perception that ‘whiteness’ is an aspiration to be sought in Peru through biopower and (often racialised) subjective transformations, comes the necessity to explore how the government has approached those Peruvians who do not fall under this umbrella of ‘desirability’.

Enter the so-called ‘Indian Problem’ in Peru. Starting at the time of the Conquest, the new category of ‘Indian’ was imposed upon the indigenous of Latin America. With colonialism new “social relations founded on the category of race produced new historical social identities in America – Indians…such identities were considered constitutive of the hierarchies, places, and corresponding social roles” (Quijano, 2000a: 534). Furthermore, Quijano presses that through colonisation, the known-names of Latin American peoples – Aztecs, Mayas, Quechuas, Aymaras, and others, were reduced to that one racial identity of ‘Indian’, meaning that “all of the dominated peoples had been deprived of their own historic identities” (2000b: 219). This ‘problem’ was constructed around the idea that the ‘Indians’ were not only racially inferior but morally and physically dirty and unhygienic (Wilson, 2004) and were therefore not suitable as citizens to develop the nation in their ‘organic’ forms. Although the colonial, and then republican government, may have presented this as a ‘racial problem’, Jose Carlos Mariategui, leader of Peru’s first communist party, instead suggested that the ‘Indian problem’ was a socioeconomic one (1928), and most importantly, it was a question of landownership and the reclaiming of the land that had been stolen from the indigenous population at the time of the conquest. Segato (2015: 42-43) argues that Quijano developed the coloniality of power perspective from Mariategui’s theories, seeing the appropriation of
indigenous lands and the consequent racialisation of the indigenous subject to keep those holdings, as part and parcel of colonialism (Quijano, 1993). Since this time the indigenous have long been excluded from projects of nation-building in Peru, allowed only part citizenship which is often conditional on factors such as adherence to state-mandated labour (Drinot, 2011), and more recently, adherence to subjectivities regarding kinship and health (Guerra Reyes, 2013). Historical movements that seemed to forward indigenous interests, such as the rise of Indigenismo and Incanismo in Cuzco, have merely served to advance the interests of mestizo elites who were not necessarily concerned with the situation of the Quechua (and other) indigenous peoples (De La Cadena, 2000; Van de Bergh, 2000). Barrig sums this up with the phrase that encapsulates the attitude towards Andeans of supposedly noble Incan ancestry as opposed to those who supposedly are ‘Indian’ and problematic for the nation: ‘Incas Si, Indios No’ (‘Incas Yes, Indians No’) (2001: 30).

Historically the indigenous have been excluded from the national project, and as Garcia explores (2005: 4-5), indigenous activism is often overlooked. Thus, observers of Latin America often note that Peru does not have anything by way of an ‘indigenous movement’ to the extent that neighbouring Andean countries Bolivia and Ecuador may have.

Fast forward to today, and the Peruvian state has recently become (re)interested in the ethnic/racial make-up of the country’s citizens, with particular emphasis on data-collection regarding indigenous identity. The 2017 national census, the first to take place since 2007, included a question asking Peruvians to auto-identify their ‘ethnicity’ for the first time in history. Eight possible categories were listed from which a person could elect their ‘clasificación étnica’, among them: White, mestizo, Quechua, Aymara, Afro-Peruvian, Nikkei, Amazonic and ‘other’. Although these categories were seemingly framed as ‘ethnic’ identities, Villasante (2017) argues that the majority of Peruvians would have understood these to mean ‘racial’ identities. She highlights the inconsistencies of this census approach, citing the curious paradox “of dividing the habitants of a country according to their ‘ethnic origin’ whilst at the same time defending the unity of the nation” (2017). That said, Peru is not the first Latin American country to show interest in ‘ethnicity’ in its national
census, as Telles shows for Brazil (2015). The recent resurgence of state interest in a country’s ethnic make-up suggests, on the surface, an attempt to become more multi-cultural and inclusive. This is concurrent with other recent policies in Peru, particularly in their intercultural approach to maternal health (discussed below), and so should come as no surprise. However, Telles argues that such categorising of ethnicity is complicated, arguing that “the categories that national censuses use are often based on politics, elites’ ideologies, and technical considerations about which identity questions and ethno-racial categories work best” (2015: 40). Indeed, the ability of a government to obtain and analyse the population statistics of their citizens is an important part of governmentality and administration (Foucault, 1990; Scott, 1999, Hacking, 1990), and in Peru the data has previously shown that Quechua and Aymara people are highly disadvantaged compared to white citizens in relation to education (Telles, 2015: 50), which in turn can be used to create targeted policy to address these breaches. This is precisely what the Peruvian state has done thus far in health policy, and particularly reproductive and maternal policies, as has been discussed. Now that there is a more recent and comprehensive profile of who and where the indigenous people are in the country, it will be important to remain attentive to those policies as time goes on. Safe to say indigeneity is firmly back on the map as a classification that apparently needs to be categorised and identified statistically in Peru.

In the same breath, one can take note of media portrayals of Andean indigenous people in popular culture as a potential signpost to state, and public, opinion as to the permissibility of discriminatory behaviours towards Quechua people. The 2017 release of the Peruvian-produced comedy film ‘La Paisana Jacinta: En Busqueda de Wasaberto’ (‘The peasant Jacinta: Looking for Wasaberto’), and its box-office success, offers a comment on indigeneity and potential acceptability of discriminatory attitudes towards it, in Peru. ‘La Paisana Jacinta’ is the character of a television show of the same name, played by actor-in-drag Jorge Benavides. The caricature of Jacinta is a Quechua indigenous woman who has migrated from the Southern Andes to Lima for work. The comedic value of the programme hinges on Jacinta’s inappropriate and embarrassing actions, juxtaposing her rural upbringing with the
demands of the capital city. She utters her catchphrase, “ña, ña, ña”, (supposedly based on sounds within the Quechua language), is missing numerous teeth, wears her hair in two plaits, and appears in a pollera (Quechua skirt). She is undeniably racialised, and the show is purposefully offensive in its presentation of this.

The television show-version of Jacinta caused Peru to be evaluated by the United Nations Committee for the Elimination of Racial Discrimination (CERD) in 2014, and the release of the feature-length film (against the advice of the UN) once again caused an evaluation of Peru by the CERD in 2018 (Chirapaq, 2018a). A CERD spokesman commented: “In other countries, such an offensive show wouldn’t last. It wouldn’t need a censoring intervention of the government since it would receive a massive public boycott and the show would be taken off. What worries me is that, in Peru, this show is a mainstream success” (Wouton, 2018).

The film has been criticised as racist and troublesome for what it says about permissibility of such attitudes in Peru. For example, Cuzco lawyer Griselda Pumayali stated to a journalist:

“It’s understandable that every individual has his or her personal reasons for watching the movie. Some people ask themselves questions, others do not. But on a macro-level, it shows that the civil society of Peru lacks consciousness. Our Andean ancestry, an essential part of our nation’s roots is constantly denied and mocked. Culturally, it still has value, but in everyday society, everybody wants to be as white as possible. Obviously, colonialism has blood on its hands for this behaviour” (Wouton, 2018) (emphasis added).

Despite all the complaints the film was the highest grossing Peruvian production of the year, with 47,000 people attending nationwide screenings on the opening night (Peru21, 2017). Furthermore, the government refused to take action under ‘freedom of expression’, and Jacinta is still a presence in Peru. Babb has signposted the enduring popularity of Jacinta as proof that “stereotyped notions” of indigenous women “are deep seated and they persist in the wider society” (2018: 214).

This representation of indigenous women in popular culture is certainly important to bear this in mind as one proceeds through the following chapters
regarding treatment of the indigenous in Peru. Through the census the government is attempting to quantify and locate indigenous people, whilst at the same time permitting the circulation of media that belittles and mocks them. The extent to which this is cause for concern will become clearer as the government begins to formulate further policies based upon the ‘new’ data about indigenous demographics that they now hold.

After an exploration of historical and contemporary Peruvian state treatment of the indigenous, both in reproductive health and beyond, it becomes clear that there is a long-standing concern in regard to unequal and discriminatory policies and attitudes towards this group. Historically the state used biopower to decimate indigenous reproduction through a sterilisation programme, and now we know that the state (and the public) are once again ‘officially’ interested in the demographics of this group. Thus, the research within this dissertation presents as both necessary, timely, and even urgent, as the landscape of state-indigenous relationships may be again disrupted if the motivations behind the recent national-census and FP campaign focus’ are understood to be potentially discriminatory and harmful to Quechua people. Therefore, the present work could also prove valuable in specific Quechua contexts in light of this, where evidenced scholarship on the issue may be needed to provide support for those communities that may face targeting again in the future.

Even when direct physical violence is not involved, state policy has the ability to affect and disrupt subjectivities and kinship through biomedical policy, thereby interrupting indigenous lifeways, potentially to their detriment and increased inequality.

Furthermore, Morgensen (2014) has argued that biomedicine, and particularly as it presents in global health endeavours, it is itself a form of ‘colonial biopower’ (190) towards indigenous groups. In this view, these populations are considered so vulnerable that even with public health interventions their eventual disappearance is presumed inevitable. This is the “biopolitical logic of settler colonialism, which presumes or seeks Indigenous elimination” (191), although this is in fact brought about largely by the treatment of these populations by states and international agencies’ approach to indigenous health. Such concepts of colonialism (coloniality) and biopower are core theoretical perspectives that have been used to ground the present work.
Theoretical Perspectives

Coloniality of Power

It is important to discuss and justify the theoretical frameworks employed within this dissertation so that this work can be properly positioned academically. To begin with, one must note what the coloniality of power is, and what it stands for, as much as what it does not.

Essentially, this is a theory arising from Latin America (although it does not necessarily apply solely to that context) (Segato 2015: 36, Escobar, 2013: 44). Further still, it is a theory arising from Peru. A Peruvian perspective developed by a Peruvian sociologist, viewing his own country’s structural and societal makeup. Furthermore, Aníbal Quijano was a Peruvian academic who chose to remain in the country, unseduced by the foreign institutions bidding for his residency (Segato, 2015: 37), right up until his recent death in 2018. Whilst his theories have gained widespread academic purchase, it is necessary to recognise their source so that one may understand the context in which they were developed, as Segato urges (2015: 37). Escobar has argued that through Latin American decolonial theorists (particularly those belonging to the ‘modernity/coloniality research program’, principally Aníbal Quijano (Peru), Walter Mignolo (Argentina), and Enrique Drussel (Mexico)), “‘Latin America’ itself becomes a perspective” (2013: 44). Whilst that is acknowledged, Segato suggests that it nevertheless remains important to bear the original context and authorship in mind to best understand and apply this theory, as its roots at times may be lost in the continent-wide Latin-America perspective proposed (she mentions Mignolo & Drussel by name)(2015: 37). So, we continue with the understanding that the coloniality of power is a Peruvian perspective on Peru, although it can indeed apply to many other contexts and has developed beyond its original authorship to become a Latin American theoretical standpoint – and one of the four most important to ever come from the continent, according to Segato (2015: 35)\textsuperscript{10}.

\textsuperscript{10} Along with liberation theology, the pedagogy of the oppressed, and dependency theory (Segato, 2015: 35).
This also allows us to note how a perspective of the coloniality of power is different from studies of post-colonial societies, arising from contexts other than Latin America. Specifically, postcolonial studies, arising principally from Asia and Africa, are not the same perspective as the coloniality of power, writes Segato (2015: 37). Importantly, she discusses how the main difference between these theories lies in the perspective of racial construction and coloniality (2013: 40), discussed above. An important thread throughout this dissertation is that of racial fluidity and subjectivity, anchored in the Latin American perspective.

Thus, whilst it is important to acknowledge the scholarly contributions of notable postcolonial theorists (e.g. Said, 2003; Asad, 1995; Appadurai, 1993; Spivak, 1988), in large part their omission from the pages of this dissertation are preempted by immersion in the Latin American perspective of coloniality, which the reader may agree is more relevant to the context and experiences discussed within this work.

**Biopolitics and Reproductive Governance**

An exploration of the justification for a reliance on the theories, particularly of biopower, of Michel Foucault, a French philosopher, within a dissertation that speaks to coloniality may be necessary. After all, Mignolo has called the thinking of Foucault, and others working within the same academic tradition, ‘Eurocentered’ (2013: 306)\(^1\), and that is something that one may seek to avoid when analysing Latin American societies from the perspective of coloniality.

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\(^1\) Another academic working on Peru, Paulo Drinot, has also called the relevance of Foucauldian theory to the Peruvian context into question (2011). Drinot has put forward an argument that contests the existence of disciplinary biopower, suggesting that instead, for indigenous Peruvians it is *sovereign*. Using the example of the striking miners in the Andes, Drinot argues that “governmental projects are executed against the population”, and therefore such governmental projects are abrasive towards the population precisely because they “operate primarily with the sovereign power” (2011: 233). He goes on to argue that “the biopolitical administration of the populations that are perceived as disobedient or directly hostile is executed not via governmental power (via behaviours that make a population comport themselves as they should), but via sovereign power, police, or discipline. There is generally no intent to govern via the extension of freedoms to these populations; in fact, it is their freedoms that are perceived as the problem” (240). In his view, indigenous Peruvians are perceived as needing a different kind of governmentality than others; they are not extended freedoms in the same way. However, there is a specific reason that he argues for sovereignty. Drinot’s population of study are considered ‘un-worthy’ of freedoms because they are anti-capitalist; they were protesting against mining and were therefore seen to be hindering the capitalist nature of Peru’s progress. This led to their being insulted and eventually referred to as terrorists (*terrucos*): “what better way to demonise those that opposed a new mining concession or the privatisation of communal lands than to associated them with Abimael Guzman [Shining Path leader] and his followers” (241), Drinot muses. Because of these factors, Drinot’s population of study was biopolitically governed with sovereign rule and denied the freedoms extended through governmentality.
However, Castro-Gomez (2007) (Colombian scholar) argues against Mignolo, suggesting that although Foucault could be read this way in terms of the contents (focusing predominantly on the development of European governance), when one considers the form of Foucauldian analysis then other, wider applications exist beyond eurocentrism (2007: 164). He suggests that “Foucault’s analysis of power is not necessarily Eurocentric, and moreover has the potential to be utilised as a valid analytical lens to think about the complexities of the…relationship between modernity and coloniality” (2007: 165). Namely, that Foucauldian analysis also allows for a heterarchical understanding of power, as opposed to the purely hierarchical view propagated by coloniality. Castro-Gomez suggests that to see the global systems of power as purely hierarchical (with the Eurocentric/ western powers affecting those post-colonial societies) serves only to invest the system with “magic powers…a sacred character” (2007: 171), resulting ultimately in an inability to challenge such magnificence. Instead, he suggests that Foucauldian thought allows us to analyse power relationships from a multitude of levels that can bring to light those power structures obscured by a unilinear understanding of global/ local power. Furthermore, Foucault’s insistence that power is enacted at the level of the body has relevance in the present study and contributes to an analysis at the corporeal level.

Although the hierarchical understanding of power that coloniality propagates may be seen in certain contexts (e.g. the state and citizens), there are other forms of heterarchical power also at play in the context discussed.

For example, bringing this to health perspective, and reproductive health in particular, Morgan & Roberts' theory of ‘reproductive governance’ in Latin
America (2012) leans on a multifaceted, heterarchical understanding of relationships of power that affect reproductive capabilities in Latin America. They define reproductive governance as:

> “the mechanisms through which different historical configurations of actors – such as state, religious, and international financial institutions, NGOs, and social movements – use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviours and population practices” (2012: 241).

Thus, although power does often come from the state, and this is a central argument within the dissertation, reproductive governance is also enacted by community, environment, NGOs and others, as Morgan and Roberts argue. Thus, we can recognise multiple powers using a Foucauldian analysis of a post-colonial society, that may otherwise be drowned out when one relies upon top-down coloniality of power alone, although this does not discount the applicability of this perspective, so long as it is understood that this applies only to some powers.

Whilst this is not to discount the coloniality of power, as mentioned, often structural power is hierarchically disseminated by the state to the population, as analysis within this dissertation will show, power also comes from other actors and this is important to acknowledge with the assistance of Foucault and Morgan & Roberts.

**Intersectionality**

Finally, following on from the earlier discussion of coloniality, the introduction of a concept of biological ‘race’, and accompanying inequalities structured around this notion, are not the only aspect of contemporary coloniality that can be found in Peru, or the rest of Latin America.

As Lugones notes, “‘coloniality’ does not just refer to ‘racial’ classification. It is an encompassing phenomenon, since it is one of the axes of the system of power and as such it permeates all control of sexual access, collective authority, labor, subjectivity/inter-subjectivity and the production of knowledge from within these inter-subjective relations” (2013: 372). Importantly, according to Lugones (2013) coloniality also pertains to gender. Guerrero (2003) has
called this ‘patriarchal colonialism’, whereby she argues that indigenous women experience coloniality as a “double burden because they must deal with both racist and sexist attitudes” (65) (emphasis added). Segato also recognises the link between the roots of Latin American patriarcado and colonialism (2014a, 2014b). Thus, this incites scholars to take an intersectional approach to their analysis.

Intersectionality was first introduced by black feminist scholar Kimberle Crenshaw (1989), who observed that women of colour were often left out of analyses of sexism (applied to white women) and racism (applied to black men), rendering them invisible. She notes that “black women are sometimes excluded from feminist theory and antiracist policy discourse because both are predated on a discrete set of experiences that often does not accurately reflect the interaction of race and gender” (1989: 140). To this we can further add other intersections such as sexuality, economic poverty and political status (e.g. refugee-status), that compound each other. In regard to intersectionality and coloniality, Lugones continues:

“intersectionality reveals what is not seen when categories such as gender and race are conceptualized as separate from each other...though everyone in capitalist Eurocentered modernity is both raced and gendered, not everyone is dominated or victimized in terms of them...[because of this]...the logic of categorical separation distorts what exists at the intersection, such as violence against women of color...it is only when we perceive gender and race as intermeshed or fused that we actually see women of color” (2013: 373-374)(emphasis added).

Thus far, scholarship addressing the question of coloniality in Latin America, particularly that arising from the Modernity/coloniality research program (of Quijano and others), has failed to properly address the important question of gender in its analysis. As Escobar (2013) notes, out of all of the areas of importance that have hitherto remained outside the purview of the Modernity/coloniality research project, gender is the most pressing (2013: 46). In the specific case of Peru, Florence Babb also notes that prominent scholars discussing coloniality, including Quijano, fail to consider gender in their discussions of social inequalities (2018: 21).
Indeed, taking more notice of women and discussing their current situation in Peru is extremely pressing when one considers the (institutionalised) gendered inequalities and violences that the country has experienced.

For example, feminicide has become a growing concern within Peru as elsewhere, with numerous frenzied media outlets reporting on the most horrific of violent gendered attacks. Particularly gruesome was a 2018 attack in Lima, when a 23-year old woman, Eyvi Agreda, died from her injuries after a rejected lover threw acid over her body in a public bus, taunting, “if you can’t be mine then no one will have you” (Peru Reports, 2018). Later that year in the northern Andes (Cajamarca) another man threw acid over his ex-girlfriend as revenge because she did not wish to take him back (Peru21, 2018). Gendered violence has also previously been linked to contraceptive use, when in 2012 a Lima woman, Ruth Sayas, was murdered by her partner who dumped her cadaver in a wasteland after she publicly admitted use of emergency contraception on a Lima gameshow (El Comercio, 2012).

Segato sees feminicide as a result of coloniality, arguing that “without a doubt, we can speak about a crowing barbarism in ‘modern gender’, or what some call ‘the gender genocide [feminicide]’ (2015: 72), which she attributes to (colonial) modernity and the expansion of the market.

When referring to indigeneity specifically, De La Cadena (1995) argued that ‘women are more Indian than men’, and that “indigenous women are the last link in the chain of social subordination; they are the least ethnically or socially mobile” (333)(emphasis added) – a now well-known maxim in Andean literature and still widely referenced. Thus, her thesis pertains to the concept that a (Quechua) man and a woman may come from the same village, and even live together under the same roof, yet he may have more access to ethnic mobility and therefore social whitening than she. De La Cadena’s argument, now over twenty years old, stemmed from her observations that women had less access to the ‘mestizo’ world of public marketplace, street, and interactions, for example, thus rendering them more ‘Indian’ due to their lack of access to the same factors which gave men the option of cultural mestizaje (1995:343). However, as Babb (2018), and Weismantel (2001) discuss, women’s roles may
be changing with their increasing access to the marketplace and to wage labour, and thus may in turn incite a change in their ability to access ‘cultural mestizaje’ (becoming more mestizo/whitening). Furthermore, the fairly recent changes to reproductive health policy, such as the abolition of women’s need to receive male permission to access contraception in 1996 (Boesten, 2010a: 94), and importantly, the intercultural birthing model in 2005 that forces women into biomedical (‘white’) settings, may also interact with their access to cultural mestizaje in ways that De La Cadena could not have known in 1995. Indeed, on the ‘women being more Indian’ concept, Babb notes that De La Cadena may be changing her views more recently, suggesting a more “nuanced understanding of indigenous lives…that may modify her earlier view” (2018: 185).

This is not to deny that women in the Andes may still be considered more indigenous than men and have less access to certain realms of experience, such as finance and social mobility, but that one should not necessarily discount their agency either. This is where an intersectional understanding becomes important, and it must also be remembered that it is not only gender or race that shapes a person’s experience, and the aim is for an encompassing understanding of lived realities.

Alcalde, who studies gendered violence in Peru, argues that “women’s lives are shaped by factors that include, but are not limited to gender. These factors…include race, migration, cultural background, class, and kinship ties” (2010: 16). She suggests that one must study not only violence through gendered relations but also structural and institutional violence towards women, supporting an intersectional approach.

So, it is important to remember that Quechua women are not only disadvantaged because of a racial or ethnic identity, but that disadvantage is also gendered. However, it is the ‘intersecting inequalities’ (Boesten, 2010a) that they experience that positions them in relation to all violences. In the case of this study’s participants, it is not only being a woman that affects life experiences, but a racialised indigenous-Quechua woman, living in a rural area of the country with a uniquely fraught history in regard to not only civil war, but state health policy.
Furthermore, the participants in this dissertation also rely upon state welfare services as they are economically disadvantaged, allowing us to add the adjective ‘poor’ onto the list of intersecting inequalities that shape their experiences.

Therefore, only through an intersectional approach that acknowledges the compounding factors that impact the agency and (in)visibility of these women, can we come to understand their realities.

**Structure of the Dissertation**

This dissertation will approach the research questions through in-depth examinations of varied, but profoundly interrelated, themes that together seek to deepen our understanding of the contemporary Peruvian FP landscape and Quechua indigenous experiences of this.

The present chapter has presented the context of the research questions to be addressed and has explored the complex ways in which this relates to historical Peruvian policies, not only towards reproductive health, but to the indigenous peoples as a racialised group upon which biopower (Foucault, 1990) has been exerted. The discussion on the coloniality of power (Quijano, 2000) elucidates the framework within which we can understand the processes of racialised inequality in contemporary Peru, and how this deeply interacts with Quechua experiences of biomedicine, subjectivity, and the family.

The second chapter will discuss the methodological approach to this dissertation’s research, through a discussion not only on methods used, but also an exploration of the population and terms and the place of the health centre and MINSA in this. It is important to provide a full context in order to properly understand the experiences of the participants described within this dissertation. Furthermore, and following from the discussion of coloniality, it is necessary to include an in-depth discussion on the terms used when writing about an indigenous population so as not to invisibilise them, as history has so often done in Peru.
Having done this, chapter three will begin the exploration of reproductive health and the state by taking the sterilisations as the entry point. It will be seen how complicated this situation potentially is and elucidate the different actors that have shaped the perception of this time, thereby permitting a discussion of reproductive governance (Morgan, 2012) beyond the state alone. Using ethnographic examples and the testimonies of Quechua women, it will be suggested that the sterilisations are best seen as an event along a continuum of (obstetric and structural) violences (Cockburn, 2004) that have been enacted towards indigenous women in Ayacucho, and that did not necessarily begin with sterilisations, nor end when Fujimori’s FP programme ceased. This will allow us to question how contemporary experiences of obstetric violence are potentially invisibilised in favour of others, and in doing so, allow us to address this.

With the history of the sterilisations properly discussed, chapter four will shift its gaze to a focus on the specific setting of the MINSA health centres and posts where Quechua women receive their contemporary FP services. It will be seen how in the past, indigenous families were encouraged to change their racialised subjective self through the promotion of aspirational whitening ideals promoted in FP discourse (Necochea Lopez, 2014; Ewig, 2010). These discourses, whilst no longer as obvious as before, are still present within the health establishments attended by rural Ayacucho women, as this chapter will discuss at length. Through this it will be possible to interrogate contemporary racialised subjectivities about the self and see if and how the clinics are continuing to encourage whitening as in the past. Furthermore, this chapter will explore the ways in which indigenous patients are ‘disciplined’ by the health centres, so that they conform to the discourses promoted by them.

The fifth chapter will then turn to the topic of gender within the health centres and FP, to ask if and how wider structures of coloniality have not only constructed, but continue to reiterate gendered disjuncture through the MINSA health establishment discourses and behaviours. Gender inequalities are often discussed in matters of FP, and in Latin America, these discussions have relied upon the concept of machismo to analyse gendered violence and responsibilities in regard to fertility control (Boesten, 2010a; Yon Leau, 2000). Whilst this chapter will also explore the role of machismo, rather than rehash
the same arguments, the aim will instead be to explore the power structures underlying the inequality and show how the health centres contribute to this. Through doing so, it will be possible to contribute to the growing literature on if and how men are ‘planned out of family planning’ (Gutman, 2013) in Latin America, and how this is locally reflected in Andean Peru. Once done, it will be possible to suggest ways that this contribution can be changed to benefit the patients served. However, caution will also be advised, as will be discussed regarding NGO promotion of the ‘gender focus’ and the potential for reproductive governance that this brings.

Moving on from the gender focus, chapter six will look at discourses of parenthood as produced by the FP discourse, and how subjectivities of ‘good’ and ‘altruistic’ (Rapp, 1999) parenting are influenced by this. Furthermore, it will be explored how Quechua parents experience a tense relationship with these discourses, their citizenship remaining ‘potential’ (Gillespie, 2016) until they are able to satisfy certain MINSA-promoted behaviours intended to professionalise their children, whilst also reprimanding them for ‘incompetent’ and unsatisfactory approaches to finances. Through this discussion it will be possible to understand how discourses of professionalisation carry heavy undertones of racialised subjectivity and an inherent migratory aspect that encourages Quechua youth to abandon rurality and associated indigeneity in order to move to the whiter, urban cities through seeking ‘professionalisation’.

Following from this, chapter seven will turn to a slightly different protagonist in the form of the health workers, and the obstetricians in particular. This is important to explore in some depth as they are key players in the deliverance of state FP discourse and also in potential cases of obstetric violence that Quechua women suffer. Thus far, the literature has often portrayed these workers as racially different from their patients, thereby providing an explanation for maltreatment (Ewig, 2010; Guerra Reyes, 2014). This chapter will suggest otherwise for the specific field site discussed, as health workers are instead often Quechua themselves and also under pressures and coercions from the state that inhibit their abilities to perform satisfactorily in their jobs, including gendered inequalities within their workplace. Furthermore, state-health workers have recently come under fire from
individualised blame for the sterilisations of the past (Villegas, 2017; Gianella, 2014), placing them in situations of greater personal and professional precarity than previously experienced in Peru. Whilst this chapter will not seek to absolve health workers from responsibilities or roles in accusations and experiences of obstetric violence from Quechua women, it will suggest that it is necessary to understand the structures behind this in order to change them for the better, for both the Quechua-patients as well as the Quechua-state-employees.

With the focus back onto the corporeal experiences of female participants, chapter eight will turn to a theme of extreme importance within Quechua contraceptive-understanding, which is cancer. According to Quechua aetiologies, the hormones within the biomedical contraceptives produce an accumulation of blood within the womb, resulting in cysts and/or tumours and therefore deadly cancer. By itself, this can lead to an avoidance of use, or fear of the health posts. However, the chapter will go on to explore this in more depth, arguing that Quechua women see obstetricians as pishtacos, an Andean ‘bogeyman’, because of complicated relationships between aetiologies of cancer, clinic (in)visibilities, and deep-seated mistrust. Furthermore, the discussions within this chapter will introduce an interrogation of Quechua perspectives on pharmaceuticals and hormones, and how these interact with corporeal subjectivities (Sanabria, 2016; Ecks, 2008; Biehl, 2004).
Figure 2.1. A Vilquina rests on the grass outside the Incan Sun temple (with Catholic Church on top) as villagers gather for a wedding.
“Anthropology studies human societies; but ethnographies are about places as well as people...Before I can explain anything about the people of [Vilcashuaman]...I must first describe [Vilcashuaman] itself: where it is and what it is”  (Weismantel, 1992: 38)

Introducing Ayacucho

Vilcashuaman
Research was undertaken in the Southern department (county) of Ayacucho, which straddles the Peruvian Andes and is bordered by the departments of Huancavelica, Apurimac, Cuzco, Junín, Arequipa and Ica (Figure 2.2). Along with its two neighbours Huancavelica and Apurimac, Ayacucho comprises one of the poorest departments in the whole country. The percentage of the population that live in ‘extreme poverty’ is almost three times the national average (INEI, 2018: 8), with half of those living in extreme poverty being speakers of an indigenous language (2018: 9). For example, in rural areas of the department only 17% of the population have access to drinking water (2018: 12). It is also one of the departments with the largest number of Quechua speakers’ (INEI, 2018).

Ayacucho department is divided into eleven provinces; Huanta, La Mar, Huamanga, Cangallo, Vilcashuaman, Victor Fajardo, Huanca Sancos, Sucre, Lucanas, Parinacochas, and Paucar del Sara Sara (Figure 2.3). Each of these provinces is further divided up into districts.
Research for this study was undertaken in the province of Vilcashuaman. This is one of the poorest provinces of Ayacucho (INEI, 2009) and also has one of the highest numbers of Quechua speakers in Ayacucho department (INEI, 2013)(and therefore in the whole country), as well as being one of the regions targeted for the PNSRPF (MMJDH, 2018), hence why it was chosen for study. The population of the entire province is 33 600 (Martinez Fuentes, 2015), although this is spread out in predominately smaller villages of 100-500 inhabitants.
Figure 2.3. Map of Ayacucho Provinces

Source: https://commons.wikimedia.org/wiki/File:Ayacucho_mapa_politico_by_jms.png

Figure 2.4. Map of Vilcashuaman Districts.

Source: app.seace.gob.pe/mon/ProcesoReporteGarfPb
Vilcashuaman is divided into eight districts: Vischongo, Concepcion, Vilcas Huaman, Huambalpa, Saurama, Carhuanca, Accomarca, and Independencia (Figure 2.4).

Research was carried out principally in the northern districts of Vilcashuaman, Vischongo and Concepcion. The capital of Vilcashuaman province carries the same name as the province itself, although there is ongoing debate about whether or not the correct spelling is ‘Vilcashuaman’ or ‘Vilcas Huaman’ (with a space) (Martinez Fuentes, 2015: 26). To avoid confusion, when referring to the capital city of the province, the Quechua place-name shall be used- ‘Willka Waman’. When referring to the province as a whole, the Hispanicised ‘Vilcashuaman’ will be used.

In Quechua, ‘Willka Waman’ means ‘sacred falcon’, and it is said to be named by the founder of the town, the Inca Pachacutec (Figure 2.5), in honour of the Apu (mountain deity) ‘Pilluchu’ that people in Vilcashuaman assert takes the form of a (sacred) falcon with outstretched wings, looking towards the coast and guarding the province (Figure 2.6).

Reproductive Health in Ayacucho

Recent statistics shows that 68.9% of women living in rural Ayacucho use some kind of contraceptive method (whether hormonal or natural) – this is only slightly lower than the 73.3% of urban-Ayacucho women (ENDES, 2013b: 10), which in turn is also only a few percentage points lower than the national average, suggesting that contraceptive use in Ayacucho is only minimally less than the rest of the country. However, unmet need for contraceptives stands at 16.3% in rural Ayacucho (14.4% urban), making it over double the national average of 8% unmet need.
Figure 2.5. Statue of the Inca Pachacutec with a falcon, Plaza de Armas, Willka Waman

Figure 2.6. Apu (mountain deity) Pilluchu, Vilcashuaman
This suggests that in a country where contraceptives are in relatively widespread use with good availability, and although women in Ayacucho are using contraceptives, some in rural Ayacucho may nevertheless encounter a lack of access to FP methods when they want them.

Out of the participants interviewed in the present study (70 women), the most commonly used method of contraception was the three month injection, followed by no method and the pill (figure 2.7), suggesting that there may have been unmet need due to the relatively large lack of biomedical-contraceptive use in the sample compared to the rest of the country.

In terms of family size, women in Ayacucho have 1.8 children on average, which despite the persistent prejudiced views that Andean women are hyper-fertile, is actually in line with the national average of Peru (MINSA, 2018: 19). In a study looking at Andean women’s preferences for FP, two children (one of each gender) was stated as the ‘ideal’ across the Peruvian Andes (Yon Leau, 2000). In the participants of this study, the most commonly stated ideal was also 2, although the average was 2.6 children each, which is slightly above the average of the department as a whole, though still not an exaggerated number (note, the sample quoted is by no means representative of the province but is given to present an idea of the FP data of the women upon whom this dissertation is largely based).
Because of ongoing issues in regard to accessing health services the department of Ayacucho has been central to a number of reproductive-health related programmes that deserve mention here.

Beginning in the 1990s, Ayacucho was one of the eight departments selected for the ReproSalud project during the period 1995-2000. This campaign was conjointly run by Movimiento Manuela Ramos, a Lima-based feminist NGO with a regional office in Huamanga, and the U.S. Agency for International Development (USAID)\textsuperscript{12}. At its core, ReproSalud worked by fostering

\textsuperscript{12} USAID has a long history of operation within Peru and has held a presence in the country since the 1960s, contributing millions in aid to the public health sector and beyond. For example, in 1998 alone, during the ReproSalud campaign, $21 million was donated to the public health sector (Chavez, 2007: 4). Between 1994 and 1998 $85 million was provided for family planning (ibid). However, USAID have also used their influence to intervene in matters of contraceptive availability in the country, by pressurising previous governments to remain silent on the provision of emergency contraception (EC)(legalised in Peru in 2001), for example, and thereby forwarding their own political agenda in the country (Chavez, 2007). USAID are not currently running any campaigns in Ayacucho, ReproSalud or otherwise. Although not a focus of this dissertation, it is worth nodding to president Donald Trump’s global gag rule and the impact that this may have on global aid receipts of US funds, restricted if they engage in ‘abortion related activities’ (Bingenheimer, 2017)– which can include the provision of EC and Sterilised.

![Figure 2.7. Interview Participants Current Contraceptive Use](chart.png)
collaboration between Manuela Ramos-trained workers and local women’s groups (such as mothers clubs), who made auto-diagnoses about reproductive health issues within the community. This was framed as an empowering exercise for women (Boesten, 2010a: 83), and the auto-diagnoses produced a stream of literature and consequent recommendations to the Ministry of Health based upon these findings (for different province reports see: Ancash (Calisaya, 2004); Ayacucho (Salcedo, 2004); Huancavelica (Condori, 2003); Puno (Alarcon, 2004)). A report specifically on contraception and family preferences amongst Andean women was written by Yon Leau (2000), although it should be noted that ReproSalud also aimed to reach male participants (for further literature on this project see Boesten (2010a), Anderson (2001), MMR (2006), ReproSalud (1998)). It is important to mention this project as it was one of, if not the, most significant (recent) reproductive health interventions in the region. Furthermore, MMR continue to operate within Ayacucho (although no longer directly in Vilcashuaman), so it is worth remembering that they were present in the past. Significantly, the period of ReproSalud took place at the same time as the sterilisation programme PNSRPF (1996-2000) - a fact that shall be retuned to in the course of the dissertation. Finally, although it has been acknowledged that the project had many positives, it has also been highlighted how long-term and sustainable advancements of women’s right and reproductive health will rely on ongoing efforts in this area (Coe, 2001). ReproSalud is no longer in Vilcashuaman, and although people do remember the project, no ongoing political efforts to continue its work have been made.

To move on to state intervention in maternal health, Ayacucho has been a forerunner in the introduction of policy in recent history. In 2005 when the intercultural birthing policy was introduced, Ayacucho was selected as one of the trial departments for this new programme. And this has proved very fruitful on paper, as Ayacucho now shows a rate of 97.6% institutional births (ENDES, 2016), receiving praise from UNFPA for the ongoing efforts of the MINSA Directorate in Ayacucho for implementation of this policy (2018).

derapeutic abortion – which is legal in Peru (Gianella, 2017). This may spell an uncertain future for USAID funding in the Peruvian context, although Peru is by no means liberal on abortion policy.
Institutionalisation of ‘intercultural health’ policy does not stop at the health centres however but extends to state higher education also. For example, Ayacucho’s largest public university – *La Universidad Nacional San Cristobol de Huamanga* (UNSCH)– was the first in the country to introduce a post-graduate diploma on ‘intercultural health’ (Guerra Reyes, 2013: 60). Students studying a nursing degree in UNSCH take classes in ‘traditional medicine’ (Cabrera, 2017: 143), and other medical students have the opportunity to make *pagapus* to Apus during training. For all intents and purposes, institutionalised medicine in Ayacucho appears to the onlooker to be very much integrated and dedicated towards delivering on the intercultural model. In this, caution may be advised, however. As Guerra Reyes argues, the success of such a scheme may be mainly found in numbers that adhere to the MDGs, rather than present a reality of on-the-ground successes (2019).

There is no ‘intercultural contraception’ policy to speak of, however it is pertinent to note the changing process of medical orientation in reproductive and clinical health more generally in the region’s institutions.

**The Shining Path and Inca Paths**

The quiet department of Ayacucho became famous in the 1960s as the initiator and seat of Shining Path violence across the country. *Sendero Luminoso* (the Shining Path) was a communist revolutionary movement led by Abimael Guzman (*nom de guerre* ‘president Gonzalo’); a philosophy professor at UNSCH. The movement took its name from a saying of Jose Carlos Mariategui, who was the leader of Peru’s original communist party: “*El Marxismo-Leninismo abrirá el sendero luminoso hacia la revolución*” (“Marxism-Leninism will open the shining path to revolution”). Although Guzman formed the movement in 1969, Sendero’s first public act did not come until 1980, when *Senderistas* burned the ballot boxes in the Ayacucho village Chuschi in protest of the government (de la Serna, 2012: 1). The movement then spread throughout the country, recruiting mostly indigenous farmers with their ideology of social change and greater equality, and eventually arriving to Lima where *Senderistas* planted car bombs and hung assassinated dogs from lampposts, among other attacks.
The Shining Path threat ended (for the most part) in 1991 when Alberto Fujimori captured Guzman – later publicly displaying him in a cage while he paced and raged before being sent off for life imprisonment in Callao (Degregori, 2010)\textsuperscript{13}. When the Truth and Reconciliation Commission (TRC) Report was released in 2003, it estimated that 69,000 people had died, with thousands more being internally displaced (CVR, 2003). More recent estimates place the death toll lower at 48,000, with further evidence suggesting that the Peruvian state is culpable for a substantially larger share of the killings than does the Shining Path (Rendon, 2019). Out of those deaths the majority were Quechua-speaking, rural civilians from Ayacucho and surrounding regions. Women and children were not spared and suffered sexual violence through rape and torture at the hands of the military (Boesten, 2010b; Theidon, 2007). In her study on child circulation in Ayacucho, Leinaweaver (2008a) argues that the war was important for framing kinship within these circumstances, writing that:

“I chose to work in Ayacucho because I thought that a study of the interaction of historical and political processes with practices of kinship and social relations was essential for understanding the broad and overarching effects the war had on Peruvian lives” (2008a: 26).

Thus, it is important to bear the war in mind whenever working with populations in Ayacucho, and furthermore, it is important to consider how this may affect wider social issues, including FP.

Yet, long before the advent of the Shining Path in Ayacucho, Vilcashuaman had been an important site for the Incas as well. The Qapaq Ñan (the royal Inca road – which famously forms the ‘Inca Trail’ in Cuzco) runs through the province, connecting it to Cuzco and beyond to Ecuador via the ancient paths (figure 2.8).

Vilcashuaman was an important site for the Inca, particularly in regard to water. For example, an Inca puytoq (canals/ aqueduct) was built to direct water from the mountain to the capital of Willka Waman, and still stands, and functions, today. The small village of Intiwatana is also home to Inca baths, boasting similar impressive architecture from the Incan period (Perez, 2007). Because of these ruins the region is projected to have an influx of Inca-related tourism in

\textsuperscript{13} For further discussion of Peru under the Shining Path see de la Serna, 2012; Theidon, 2012; Degregori, 2010; Starn, 1998; Poole, 1992.
coming years, helped in large part by the ongoing construction of a multi-million soles (S/76 million) asphalt road linking the remote villages of Vilcashuaman to Huamanga capital and beyond to Lima (Martinez Fuentes, 2015).

The new road is important to mention in further detail as it marks the beginning of change for the province, and for the people. It takes one from Ayacucho’s departmental capital, Huamanga, to the capital of Vilcashuaman province, Willka Waman, in a mere 2-3 hours. Participants who have lived their own lives in the province commented that when they were children, it could take them up to two days to make the same trip (accounting for seasonal mud-slides that block roads for long stretches of time, in addition to the political context that may have influenced road traffic thirty years ago). So, until 2015 when the new road was built, Vilcashuaman remained relatively isolated when compared with other Andean provinces.

Roads are important in Vilcashuaman, and across the country, as Harvey and Knox express in their ethnography on roads and infrastructure (their chosen field-site for this topic was Peru (2015)). Their informants often argued that “the lack of decent roads was a fundamental block to Peru’s future prosperity” (22),

Figure 2.8. The Qapaq Ñan (Inca Road), Vilcashuaman
and the authors note that in the history of the country “roads came to be firmly associated with an ambition to integrate, modernize, and civilize” (29). As such, roads are “state space”; they attend to the “future imaginaries” of the nation (19) through connecting arterial communities to larger urban settlements. Indeed, the roads have historically brought the state directly to the people of Vilcashuaman. The last major road construction in the rural province was the dirt paths in 1963, a feat that is credited with bringing the first state presence, the health post, to the people of the province (Martinez Fuentes, 2015: 63). This new stretch of highway is much more ambitious than intra-departmental connections; in 2015 it was announced that there were plans to continue the road on to Abancay (Apurimac department) (La Republica, 2015). It is not without notice that the realisation of this plan would join Vilcashuaman to the asphalted highway that leads directly to Cuzco, allowing for easier access between these two touristic destinations, and potentially placing Vilcashuaman on the ‘gringo trail’,

However, while the new roads are poised to bring ‘modernity’, capitalism, and urbanity to the region, they may also wipe over that which came before, both literally and metaphorically. One example is the erasure of Shining Path trails, that are asphalted over as the roadworks expand. Another brutal example of this erasure comes with the death of Pelagia Gutierrez Vega in January 2018, a Quechua farmer and rising ambassador for indigenous women after she starred as the protagonist of the documentary ‘La flor que Vive’ (The living flower)(Chirapaq, 2013), a film that portrayed the local uses of medicinal plants in Vilcashuaman; she was a protagonist of the fading knowledge of Andean ethnomedicine. On the afternoon of Sunday 7th January the combi in which Pelagia was using to travel from Willka Waman to Huamanga was crashed into by a truck as it careened around a narrow corner,

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14 The ‘gringo trail’ is a common term for the main overland/backpacker tourist route through Peru. This generally sees travellers journeying down from Lima through Ica, Arequipa, Puno, Cuzco, and finally, Machu Pichu. This route is well served by transportation due to its popularity. The addition of a Cuzco-Vilcashuaman stretch would theoretically provide a bus-route loop back to Lima (the best current option is a flight), which makes it strategically placed.
a truck heavily laden with consumer goods that it was carrying from the city to the villages (Chirapaq, 2018b). It crushed the humble minivan leaving it smashed beyond repair. In the combi three people died and another ten were seriously injured, but the driver of the truck survived unscathed (Diario El Correo, 2018). This tragedy was a consequence of the road, of the slow creep of urbanity into rurality. Before the asphalt road there would have been much less regular road traffic, and potentially less collisions due to this. Roads are therefore not only ‘state space’ (Harvey & Knox, 2015) that bring ‘modernity’, but they can also contribute towards the erasure of history and in the case of Pelagia, an important and unique agent of indigenous medicine.

It is important to have this contextualisation of the province and the current processes of change it is undergoing in order to have a greater conceptualisation of the population of study.

Quechua Population and Terms
As the discussion around the national census highlighted in the introduction, defining someone as ‘Quechua’ is perhaps more ambiguous than at first appearance. Quechua can refer to someone’s language, and indeed a person may speak Quechua without auto-defining themselves as ‘Quechua’; they may define themselves as ‘Quechua’ based on their maternal language alone and not due to a perceived ethnic identity. It could be seen as a racial marker, although this is also fluid in Latin America, depending on numerous associations such as education, employment, medical orientation and others, as discussed above.

Furthermore, it may depend on context; as De La Cadena argues, in Peru ‘women are more Indian’ (1995); thus, cohabiting couples of the same origin and cohabiting may consider themselves, and be considered by others, as belonging to different ethnic groups when together, but this again may change when operating as lone agents.

Therefore, a note on terms is needed. This dissertation addresses the ‘Quechua indigenous’ people, and there are multiple justifications for doing so in the context of Vilcashuaman.

The first is denominated by the topography in which one lives (Muñoz, 2014: 99). In the Andean region there are four principal ecological zones that are
based upon a locale's metres above sea level (m.a.s.l) (which therefore denotes the climate and vegetation; and therefore possibilities for agriculture; and therefore work opportunities and trade relations, etc. Hence the ecological zone-categorisations arguably construct much more than just altitude). These zones are: Yunga (2,000-2,400 m.a.s.l); Quechua (2,400-3,500 m.a.s.l); Suni (3,500-4,000 m.a.s.l), and Puna (4,000-4,320 m.a.s.l) (Martinez Fuentes, 2015: 27-28). Although there are topographical variations in the province, and particularly in the south of Vilcashuaman (where fieldwork was not carried out), Vilcashuaman’s capital ‘Willka Waman’ is situated at 3,470 m.a.s.l, making the centre of the province topographically ‘Quechua’, and thus the inhabitants ‘Quechua’ also, according to this perspective.

Secondly, the Quechua identity may be given for one’s maternal language (Muñoz, 2014: 86). The majority of people in Vilcashuaman speak Quechua as their mother tongue (Martinez Fuentes, 2015: 27), and most, if not all, younger people are bilingual with Spanish. In all of the interviews carried out participants stated Quechua as ‘the language they use at home’ (‘el idioma que se usa en casa’), even if they were interviewed in Spanish.

Notably in fact, 89.6% of people from Vilcashuaman speak Quechua as a first language (INEI, 2013: 38), the second highest in all provinces of Ayacucho. As the department has one of the highest Quechua speaking populations across Peru, this makes Vilcashuaman one of the highest Quechua-speaking provinces across the whole country.

Garcia (2005) complicates the identification of Quechua-language with indigenous identity in an anecdote from her fieldwork in Cuzco. When her brother came to visit her, she noted, he was surprised to find that men wearing ‘modern’ clothes (in this case, a Chicago Bulls jacket, a Ninja turtles t-shirt, and Levi's jeans) were also speaking Quechua: “The man was riding a bike, and his son is wearing a Chicago Bulls jacket. How could they be Indian?” (2005: 2) he asked, startled. Such distinctions lead to greater questions concerning ‘modernity’ and ‘indigeneity’; the topic of Garcia’s work, and the present dissertation as well. Indeed, in Vilcashuaman such incongruencies could also be found between expected indigeneities and realities. For example, the
majority of people used some kind of ‘Quechua’ clothing/accessory identity markers, although this varied widely between age, sex, activity, and location. For older women, this may have meant wearing their hair in two plaits, a bowler hat, a pollera (skirt) and embroidered cardigan. For the younger women, they may have worn branded trainers and brightly coloured leggings instead of polleras. The ‘traditional’ double braids could frequently be observed as transformed into stylish French-plaits, inter-woven with coloured ribbons.

However, in Vilcashuaman one thing did remain a constant: the quipi (manta). The quipi is a long piece of rectangular woven cloth that is used to transport things on the back (produce, goods, babies). It is wrapped around the shoulders and fastened with a knot at the neck, or for lactating women, is slung diagonally across the back and fastened at the chest, so that the infant may be manoeuvred around to the front of the body for lactation, and later re-positioned to the back once more. Even for those younger women who may not adopt the full range of ‘traditional’ clothing, the qipi was in widespread use, and perhaps with good reason as it is highly practical.

Many people listened to Quechua-language ‘folk’ music and Peruvian cumbia. They also listened to Swedish dance-artist Avicii and watched Korean soap operas. And, importantly, many people consulted ethnomedical curanderos, seeking relief from troubles such as mal de ojo (evil eye), susto and aire\textsuperscript{15}. They also visited the biomedically-focused health centres, and independent pharmacies that sold biomedical pharmaceuticals.

Thus, as Garcia found, outward appearances of indigeneity are not always reliable. Indeed, indigeneity as an identity is a contested term in itself, so further justification for the use of the identity ‘Quechua’ may be necessary.

This leads us to the last (although certainly not least) marker of Quechua identity: how the people perceive themselves. The short answer to that, taken from the aforementioned 2017 national census, is that they see themselves as ‘Quechua’ (INEI, 2018). The census-data is simplified, of course.

In an pre-census analysis of the problematics of indigenous auto-identification, Chirapaq (2017) suggested that “in general terms, “to be quechua” or to have “a

\textsuperscript{15} Mal de Ojo, Susto and Aire can all be considered ethnomedical afflictions, and are not generally treatable with biomedicine but require the services of a Curandero (ethnic healer).
quechua identity” is not evident for the population, to speak of a quechua culture is the result of an anthropological extrapolation” (8), and that indigenous people tended to refer to themselves “as campesinos...an economic-productive category and not an ethnic-cultural category” (26). All that said, Chirapaq undertook a study in the south of Vilcashuaman and found that more than 80% of people identified themselves as part of the ‘pueblo quechua’ (32)\textsuperscript{16}. The political motivations behind this themselves could be analysed in a dissertation-length study themselves, however for the purpose of this study, we shall take Vilquinos’ word for their ethnic-identities as final (whilst acknowledging the complexity of this)\textsuperscript{17}.

Thus, referring to the research participants as ‘Quechuas’ is justifiable from numerous perspectives, and shall therefore be employed. However, there are a few other terms employed in the following chapters, and that may appear in the quotations of other researchers, that require a little more explanation. The first is the denomination of people by the place where they live – in this case, Vilquino (masculine/ neutral) and Vilquina (feminine). It is quite common across the Andes to refer to a person, or for them to refer to themselves, using the place of birth as an identity (Weismantel, 1992). Galindo (2015) suggests that “consciousness is local”, as “despite a common past, peasants do not define themselves as Andean or Indians but instead rely on the name of their birthplace” (2015: 4-5). This can become even more specific, for example, the use of a village name (e.g. if you lived in the village of Sarachongo you would be a Sarachongino), but no such specifics will be used here, relying instead on the provincial ‘Vilquino/a’ where used. This is both to keep anonymity and for ease of reading.

At times the phrase ‘campesino/a’ is used. This refers mostly to one’s lifestyle and is a more fluid concept than ‘Quechua’ or ‘Vilquino’. For example, someone living in the countryside, el campo (campesino = one who lives/works in el

\textsuperscript{16} It is pertinent to note that Chirapaq, ‘The centre for indigenous cultures of Peru’, have undertaken a fair amount of research in Vilcashuaman specifically, including documentaries, articles, and research projects, as will be mentioned throughout this dissertation. The founder of Chirapaq, Tarcila Rivera Zea, sits on the UN’s Permanent Forum on Indigenous Issues (UN Women, 2017), and therefore the work of this organisation has significant impact on indigenous Peruvian women more generally. The fact that Chirapaq consistently select Vilcashuaman for its studies give further support that this region is considered emblematically ‘Quechua indigenous’.

\textsuperscript{17} Please see chapter nine for further comment.
campo), who works as an agriculturalist or pastoralist, would be a campesino. It is often translated as ‘peasant’, which may also be used, but does not carry the same necessarily negative connotations as its English equivalent. This can change depending on circumstances, for example, one may be a campesino but if their children migrate to Huamanga to work in an office, they would cease to be a campesino (although they may still be Vilquino/a and/or Quechua). As Muñoz suggests, “for a Quechua who is faithful to their identity, if they go to live in the city they will no longer be a campesino, but still a Quechua” (2014: 87).

There are other words that are used to refer to the population of study that will not be employed except where a quotation from another researcher has used them – they may then be used briefly for consistency of discussion, but dropped once that literature is no longer in conversation. These descriptions are most commonly: Indian, Indio and Cholo/a. It is elected not to use these descriptions intentionally as they are considered insulting by some (Muñoz, 2014: 89), and importantly, may be technically incorrect. For example, the term ‘Indian/ Indio’ originates in the voyages of Christopher Columbus when he mistakenly ‘discovered’ the new world on a search for a new passage to India- hence the use of the term ‘Indians’ for native Latin Americans. But it is incorrect geographically, and importantly, it is a colonial term.

Quijano argues that categories such as ‘Indian’ were a part of the colonialist construction of race and hierarchies (2000b), thus in naming the group with whom this research has been undertaken as ‘Quechua’ and not ‘Indian’, there is the attempt to restore their historic and contemporary identity to them and not contribute to the ongoing inattention to history found in some works. That said, in his work on Bolivia, Canessa consciously elects to use the term ‘Indian’ instead of ‘indigenous’ in order to situate his participants within this history of colonialism (2012: 32). Yet, whilst this may be employed as a historical-contextual mechanism in Canessa’s work, it arguably does little to decolonise, which can more consciously be achieved through use of self-identified naming of participants; here Quechua.

Thus, whilst it is acknowledged that academics may consciously use ‘Indian’ to refer to indigenous Quechua people without any offensiveness intended with
their use, here the aim is for accuracy and a decolonial approach, hence the term shall be avoided where possible.

Cholo/a is complicated in a very different way, as the meaning inherent in this term varies across the country and context (see Weismantel, 2001 for an in-depth discussion on this). However, increasingly the term ‘choleando’ is used to refer to one group of Peruvians looking down upon another from a racialised perspective (Babb, 2018: 18; Bruce, 2007). Although the phenomenon of ‘choleando’ is rather rife in Huamanga (Cabrera, 2017: 41), in this dissertation is elected to avoid use of this term both in order to maintain neutrality and also because it was not used with any frequency in the field site.

In a recent work, Babb summarises her approach to the naming of her informants:

"I am aware that my reference to "Andeans" or “Andean women” may seem at times to collapse the complexities of those I am seeking to render as fully as possible. Language limits us as we use words that have a geographic reference but which tend to obscure salient cultural, economic, linguistic, and other forms of difference and power. I caution readers that in this work I sometimes make expedient use of terms that do not do full justice to the wholeness of people’s lives" (2018: 19-20).

Therefore, in referring to informants as ‘Vilquino/a’, ‘Quechua’, ‘campesino’, ‘Andean’ or (at times) ‘Indian’, it is understood that these ascribed identities may unintentionally obscure others, however as Babb writes, the limitations of linguistics may cause this to be so, and it is undertaken with the mutual understanding between author and reader that this is the case.

**Gender Considerations**

Research participants were mostly women. This is both methodologically relevant, and academically justified as it attends to an ongoing gap in the literature on inequality in the Andes. As Babb notes, “current scholarship on desigualdad (inequality) rarely considers gender” (2018:18), with “Peruvian scholars examining race relations” rarely taking “gender into account in discussions of social inequality” (21). There is a growing presence of feminist scholarship coming from Peru and the Andes (see Lugones, 2013; Barrig, 2001; Paredes: 2012), however, as many scholars point out, Peruvian feminism often runs into problems of distance and a lack of understanding of indigenous
women’s issues (Coe, 2001; Stavig, 2017; Babb, 2018; Ewig, 2010). Barrig’s (2001) study of the incongruencies between middle-class Lima feminists, working to advance women’s issues in the country whilst actively engaging in hierarchical relationships with their indigenous maids, discusses this very issue. On this, Babb elaborates: “urban coastal currents of feminism often reveal the traces of modernist and colonialist expectations that rural women have a cultural deficit and must leave behind past practices and worldviews if they are to gain rights as Andean women” (2018: 46). Ewig (2006) has argued that the reason that Lima feminists were so slow to whistle blow on the sterilisations of indigenous women was due to the fact that they had little knowledge or understanding of highland realities. This dissertation seeks to underscore indigenous women’s experience, and for the reasons stated above the methodology also refrained from relying on the perspectives of Lima-based organisations (feminist and otherwise) for clarity on indigenous issues, instead going directly to the regional factions where possible.

Furthermore, in an ethnography attending to indigeneity and race in Peru, it is important to underscore that this differs between men and women, even when from the same communities. De La Cadena argues that in the Andes “women are more Indian” than men. This complex process is largely based, in her analysis, upon access to, and ability to participate in, elements of the mestizo world:

> “it is in the intimacy of everyday relations in the street, marketplace, and village that implicit decisions and identities are made about who is, and who is not, Indian…within the regional and local confines of modern patriarchy, modernization has reinforced the Indianization of women, while opening the option of cultural mestizaje to men” (1995: 343).

De La Cadena’s assertion that women are considered differently from their male counterparts in terms of indigeneity may still hold sway, however it is also necessary to point out that she is referring predominately to labour. Babb (who has undertaken a great deal of study of women’s work in Peru, see 2018; 1998) debates this: “When de la Cadena described Andean women are “more Indian”…she acknowledged that women who gained experience as marketers were already acquiring the modern urban skills that might enable them to appear less Indian and more mestizo, but she claimed that local men and
women devalued such activity as “not really work” (1995: 330)” (2018: 197). It may be that through work, women were engaging in the world of the mestizo more than De La Cadena took note of, but there is an omission still.

As has been discussed, biomedicine is associated with and related to the white, *mestizo* world. In rural Ayacucho, it is mostly women, not men, who come into contact with biomedicine and the associated power structures and discourses that are associated with it. Does this change anything?

While men avoid the health posts, women are in attendance. In this arena it is *women who are relating to the artefacts of the white/mestizo world*, more so than men. That is not to turn the tables on De La Cadena’s assertion, as there are still many arenas in which men take authority (for example, the regional government was comprised of male figureheads).

Another important gender consideration is education. For example, in Ayacucho, 19% of women are illiterate, whereas for men this is only 5% (INEI, 2018: 14). Women complete 8 years of schooling on average, and men complete 9 (2018: 16). Thus, women are still at a disadvantage to men in terms of education and corresponding ability to not only seek employment and self-realisation because of this, but also the ability to understand, engage with, and anticipate processes of government in which they may need to assert themselves (for example, with local cash-conditional scheme JUNTOS, discussed later in the dissertation). It is important to bear in mind, as communities continue to undergo processes of change, that this may not be the case forever.

The above discussion leads us onto the practical reason for focusing overwhelmingly on women, which is dictated by the principal subject matter of the ethnography.

FP services, in their current state in Peru, are women’s services. The only male-led contraceptives on offer are condoms and vasectomies. However, Vilcashuaman has no health posts or centres capable of performing vasectomies, so this reduces the male-led method in the context of this study to
one. This is not Peru-specific; as Guttman argues, men are often ‘planned out of family planning’ across contemporary Latin America (2013).

Social welfare services more broadly are also women-centred in the Andes. Health policy in Peru focuses on the mother-infant relationship (Ewig, 2010), and within MINSA networks there are ‘focalised’ health care packages specifically for ‘high risk’ population groups including pregnant women and children (Guerra Reyes, 2014: 110). Other forms of social welfare present in the region are JUNTOS, a conditional-cash transfer programme, and CunaMas, a child-monitoring programme. CunaMas is directed towards the mother-child relationship, as with other biomedical health services. JUNTOS is not specifically directed at women to the exclusion of men, however as Meltzer (2013) notes, it is considered women’s sole-responsibility to participate in the conditional activities required by the scheme. Therefore, in questions of social welfare and biomedicine, including where conflated, women are the protagonists. Indeed, men are scarcely present within the health posts (as patients), and it is a highly gendered space. Nowadays, contraception services are largely female led, although this was not always the case. Before 1996, women had to demonstrate spousal consent before they could obtain contraception. Although this may have given women more autonomy vis a vis their husbands, Boesten (2010) highlights how it may also have had the adverse effect of making women more open to coercion from health workers. As rural women are more likely to be illiterate, monolingual Quechua speakers than men, prior to the change in law male partners would have been able to stop their wives from signing suspicious consent forms (in theory) (2010a: 94).

That said, a few male patient-husbands were interviewed in order to gain the male perspective where possible, and male participants were present during some participant observation in the hospital and home. When it comes to reproductive health in Ayacucho, men had previously received greater attention (e.g. during ReproSalud, see above), but this is no longer the case. Thus, whilst men do feature in the pages of this dissertation, they were not the main participants for the aforementioned reasons. That said, it has been important to attend to masculinities as they apply to the Andean system of gender, and
particularly to coloniality as men and gendered impositions were especially affected during colonialism (Segato, 2014a). Therefore, this element of male lives will be considered in this dissertation, but always as they apply to FP and reproductive health, and with women as the centre of the discussion.

Finally, it is important to remember the intersectional context in which women are placed, and especially the gendered relationships they may experience. As addressed previously, violence against women is a particular issue across Peru. Out of all the departments, Ayacucho has one of the highest rates of feminicide in the country, with recent census data showing that 1.33 out of every 100 women is killed by a man (MINSA, 2018:34). Such a statistic in the department creates an urgency to address issues that can affect the domestic context, such as FP and contraceptives, especially as previous studies have suggested that reproductive health may be a cause of domestic tension (Yon Leau, 2000).

**Further Context Considerations**

Finally, there is another, less visible ‘identity’ that has historically been ascribed to the people of Vilcashuaman and needs to be mentioned briefly here. This region was one of the provinces that supported the Shining Path. Theidon notes how people from the northern provinces of Ayacucho, who eventually condemned the violence, looked down upon the southern provinces as ‘those people’ who were guilty of atrocities (2012). Indeed, Theidon’s informants actually blame Vilquinos outright for the initiation of the violence, with one of her informants commenting: “There were about sixteen people who initiated Sendero Luminoso in Vilcashuaman” (2012: 332). There were consequences for this from the military, towards the Senderistas and the innocent campesinos alike. The Vilcashuaman district of Accomarca is hailed as one of the bloodiest examples of military violence during the conflict. In 1985, 69 women and children were searched for Sendero Luminoso propaganda and weapons, but when none were found they were herded into a building where they met a horrific end at the hands of a grenade tossed into their midst (Poole, 1992: 8). General perception of this time has led to the ascribed identity of ‘terruco’ (‘terrorist’) for Vilquinos (and other people in Southern Ayacucho provinces). This is an unpleasant term that has come to denote negative racial ascriptions of ‘Indianness’, that nowadays is mostly used to insult. As Aguirre (2011) notes,
the word *Terruco* is now used to “stigmatize sectors of the Peruvian population…in general persons of Indian origin” (104). Being a province of ex-*Senderistas* and of majority Quechua (*Indian*) descent, *Vilquinos* may embody the very meaning of the stereotype to those who view them with judgement. Here it is important to remember that whilst the term ‘*terruco*’ was not specifically used in the fieldwork context, accompanying ascriptions that stigmatise ex-*senderistas* as racially inferior continue to be present in Ayacucho.

**The Health System in Peru**

Across the country medical pluralism is employed in regard to human health. This incorporates different medical systems, including biomedicine and ‘ethnomedicine’, which have historically been understood as able to care for different ‘kinds’ of illness, e.g. biomedicine for diseases of the body, ethnomedicine to treat ‘social’ and/or ‘ethno’ illnesses such as *susto* (fright), *mal de ojo* (evil eye) and *aire* (bad wind) (Miles & Leatherman, 2003). Within the two systems different practitioners operate. For example, in biomedicine one finds doctors, obstetricians, dentists, nutritionists, nurses, paediatricians, psychologists and surgeons, etc. In ethnomedical healing, one may find *curanderos*, *shamans*, or *yachaqs*. *Parteras*, an indigenous midwife, can also fall under the banner of ethnomedicine.

Ethnomedical practitioners will seldom have formal training, instead learning their craft from relatives or a mentor, although there is no standard route of entry and *yachaqs* have reported learning from Apus (mountain deities), and catholic spirits (Orr, 2012: 518). In addition to this knowledge ethnomedical practitioners may use herbal remedies.

On the other hand, biomedical practitioners are all required to have formal degrees in Peru. Biomedicine can also include pharmacists, who do not need formal qualifications even though they may make diagnoses.

As Orr (2012) shows, rural people in the Southern Peruvian Andes will often consult practitioners in both fields of healing for the same affliction, although they will more likely persist with an ethnomedical practitioner even if the positive results are not greater than with a biomedical practitioner. The reason given for this is the perception of the nature of the two alternatives – principally that
whereas doctors are interchangeable (supported by the rotations and
campaigns within MINSA health centres), ethnomedical practitioners each offer
a ‘new’ and ‘fresh’ take on a medical problem (2012: 527).

In the present study ethnomedicine appears only peripherally due to this study’s
focus on biomedical practices and subjectivities. Furthermore, it is important to
note that whilst ethnomedical contraceptives have previously been recognised
under use in rural Peru – predominantly as plant/herbal-based remedies,
usually ingested with a tea or applied to the genitals (Maynard-Tucker, 1989;
1986; Hern, 1976) - recent statistics for Ayacucho show that only 1.1% of
women now use ‘folkloric methods’ of contraception (ENDES, 2013: 49), thus
suggesting that a plurimedical approach to ‘family planning’ is not necessarily
so prominent as it may be towards other health questions (such as mental
health, as in Orr’s work).

That said, it is important to understand the plurimedical context in which people
operate and the fact that the health centres are not their only option. Even so,
women are required to attend biomedical consultations if they wish to receive
certain benefits (birth certificates, cash transfers) under state policy. They
cannot necessarily desist with this service as Orr’s participants could have,
because of these restraints.

_Vilcashuaman MINSA Network_
Peru’s official health system can be broadly divided up into five different
sectors: the Ministry of Health (MINSA), which provides services for 60% of the
population; EsSalud, catering for government-sector workers and their families
(making up 30%); the Armed Forces (FFAA), National Police (PNP) and the
private sector, taking the final 10% (WHO, 2011).
When it comes to FP, two thirds of all Peruvians use the services offered by MINSA. Out of all MINSA establishments the most frequently used for FP services are health centres and health posts, with hospitals only coming in third (ENDES, 2013: 143). This being the case, research was carried out in those locations most frequented for contraceptives: health centres and posts.

MINSA establishments are all ranked within region-specific networks, and individual centres and posts will be ranked according to their position in the network. These dictate systems of patient referral and employee progress reports. The network studied was part of the larger Cangallo-network that reports to Huamanga hospital (directorate). Ranking determines the procedures and equipment available to the establishment, as well as how they are staffed. For example a rural satellite post may only have one staff member – a nurse or technician, whereas a health centre may have over 50 to include doctors, dentists, obstetricians, psychologists, nutritionists, nurses, pharmacists and
technicians (It is due to the sizing of establishments and staff that the place-names of the posts have been anonymised completely).

Health centres may be equipped with birthing facilities and sonogram machines, whereas smaller posts may have no equipment. However, regardless of size all are able to give contraception to a greater or lesser extent. For example, posts can give the pill or condoms, but are rarely stocked with the implant.

As the focus was on smaller health centres and posts, in keeping with where patients access FP, the Vilcashuaman micro-network was the specific focus of fieldwork (figure 2.9). Within this network key field sites were Willka Waman and Sarachongo health centres, as well as three key satellite posts belonging to this network: Pilpintumarca, Llamallata, and Michibamba. Having said that, research was carried out in many other areas and MINSA health establishments around Vilcashuaman, although visits may have been infrequent. The network studied offered Seguro Integral de Salud (SIS) to patients who qualify as low income. Having SIS allows patients to access free-of-charge health care such as contraceptives maternal care, childcare, and doctor and dentist check-ups. It is available to both men and women. SIS is predominantly provided to poorer, mostly rural, Peruvians (Guerra Reyes, 2014). Women who receive SIS and have children may also be eligible to receive other state welfare, such as the S/100 monthly stipend provided by the JUNTOS conditional-cash transfer programme for women with children under three years old, as well as free-of-charge child day-care and additional house-visits and workshops provided by the CunaMas welfare programme.

The Health Workers
The key health worker informants were obstetricians, although there is need for clarity of terms here. In Europe or North America, an ‘obstetrician’ might be considered a clinical speciality that may involve surgical responsibilities. In Peru, obstetricians are restricted to minor interventions and work principally in childbirth, prenatal care, FP, and cervical cancer screenings. Specialist training is needed to undertake sonograms or perform biopsies, for example. Any serious complications, such as caesareans, must be referred to gynaecologists or surgeons. Thus, ‘obstetrician’ may mean something different in Peru to that
which a European or North American readership may imagine. Obstetricians in Peru may be more comparable to the Western midwife, although it would be incorrect to call the informants in this research ‘midwives’, as the Peruvian translation of this category would be *partera*, and that means something else. *Parteras* are now officially categorised as traditional birthing attendants (TBAs), and since 2005 it has been illegal for them to assist childbirth in Peru (Guerra Reyes, 2014).

Thus, for clarity of role, herein the ‘obstetrician’ health worker informants in this dissertation shall be referred to by the name they call themselves; ‘*obstetras*’.

Other health professional participants were nurses, doctors (general practitioners), dentists, nutritionists, and technical assistants (*tecnicos/as*). Workers were employed under different contracts, although all were employed by MINSA. Some held permanent contracts (*‘nombrados’*), some were on contracts lasting between one to six months, and others were completing their mandatory year of rural service, ‘SERUM’, that all future MINSA employees must complete in Peru before seeking permanent employment within the national health care system.

The majority of the health workers came from Ayacucho, and most spoke Quechua as a maternal language. *Obstetras* were predominantly women. It is important to note that whilst they may be identified as ‘Quechua women’, following the previously discussed markers of Quechua-identity, they are different from their patients when we consider the situation from an intersectional perspective. Namely, the study participant ‘patients’ are low-income and relying on free state-health care, whereas *obstetras* in the study had attended higher education and would have had more social and financial capital. The significance of this is discussed further in chapter seven.

As the health network studied is identified, extra care has been taken to anonymise those health workers who participated in the study. For this reason, no further details are to be given about health workers – not the job title of those who participated, nor their distribution within the health network, nor any other identifying features. All place names have been changed (in the case of
smaller, thus identifiable, posts). No names were used to refer to individual obstetras within this dissertation, lest they become identifiable by any means. Whilst this may de-individualise them that was not the intention, and their confidentiality must remain paramount.

Data Collection

Research for this dissertation took place over twelve months of continuous fieldwork during 2017-2018. The present research project methodology is ‘mixed-methods’ and multi-sited. It is an ethnographic study using qualitative research methods such as semi-structured interviews and participant observation.

Language

Before arriving in the field, I was already fluent in Latin American/ Peruvian Spanish, and took four months of Quechua lessons in Lima, gaining the ability to engage in basic conversations and understand basic phrases in the language of the field site. Even so, the majority of participants were proficient in Spanish, with the majority of monolingual quechua-speakers beyond reproductive age.

Participant Ages

All participants were aged between 18-60 and were able to give their consent (see table 1.2 and 2.2 for age breakdowns).

Participant Recruitment

The majority of participants were recruited by convenience sampling, whereby participants were approached for interview and/or observation by virtue of their being present within either the health establishments studied (in the case of both health workers and patients), accessible due to researcher participation in events, or within the immediate vicinity of the village(s) inhabited. Snowball sampling was used in some cases, where a participant introduced me to another member of the family or acquaintance and so on.
Participant Observation

The key method of data collection was through participant observation, which was carried out in the health establishment waiting rooms and consultation rooms where explicit consent was given. It was further undertaken at relevant meetings within communities (such as JUNTOS and CunaMas), MINSA and state-specific events (such as International Women's Day March, Peru Independence Day March), and community-wide social and ritual events (such as Vilcas Raymi festival, Carnival, Yaku Raymi festival).

Although non-clinical contexts may not immediately present as obvious field-sites, as Rutenberg (1997) has argued when it comes to discussing contraception there may be a significant ‘buzz’ outside of the clinic, thus observation was not limited to the clinical context. In addition to observation within specific spaces or events, I lived in two separate locations during the period of fieldwork where it was possible to observe and experience daily life in the province. The first was in the village of Sarachongo (200 population), and the second in the larger town of Willka Waman (1000 population). Two different locations were inhabited in order to give a wider view of different experiences within the same province and health network. Every effort was made to interact with the hosts of each location and understand their day-to-day lives and interactions.

When discussing health concerns, the collection of qualitative, un-structured ethnographic data adds much needed flesh to the bones of more rigid methodologies. For example, Susana Ramirez Hita, conducting research in the Andes, has highlighted how the collection of ethnographic data through participant observation can be particularly useful to complement epidemiological research (2013). On her research on Quechua health, she has argued that epidemiological data and strict quantitative techniques do not represent local realities (2009), thus arguing for an ethnographic approach in order that the ‘full picture’ be presented. As she states for the Peruvian-Quechua-health case:

“In the prolonged cohabitation with a certain group, the data is not impersonal like when the survey technique is used… the subjects, in the information obtained through the ethnographic method, become the central element, not the abstracted data of reality; in this way, the data constructed from the daily life in which the ethnographer is inserted are richer and more complex than those that have been decontextualized from their frames of origin. The subjects are immersed in complex contexts of multiple
Following from Ramirez Hita’s argument, the methodology here expands to not only rely upon ‘impersonal interviews’, but to include ethnographic richness through the prolonged residence in the field.

Guerra Reyes (2019) has also underscored the limitations of (public health) numerical and quantitative data in regard to Quechua maternal health research. She argues that data may present positive statistical outcomes, speaking to the UN Millennium Development goals (MDG) in her case, whilst overlooking the subtleties of reality on the ground in rural Peruvian clinics.

**Interviews**

One-hundred formal, semi-structured interviews were undertaken in total. Eighty of these were with Quechua patients and their partners, seventy of whom were female and ten who were male (see table 2.1 and 2.2. for socio-demographic information of patient-participants), and twenty were with health workers. Personal information such as exact profession, age and sex are not identified for health workers for reasons of confidentiality (see discussion above). Interviews lasted from five to sixty minutes, depending on the rapport and willingness/ contentedness of the interviewee to discuss the topics at length. Thus, despite the relatively large sample, the depth of responses varied a lot. However, all interviews contributed towards the development of recurring themes and overall understanding of experiences and context.

Interviews were used for specific reasons. The first was to complement the ethnographic data that had been collected and allow the researcher to identify certain themes occurring in people’s experiences of FP services on a wider scale. Interviews allow the researcher to focus on specific questions and themes of interest.

Interviews were also used as a way to begin a conversation with individuals who may otherwise be wary of talking to a foreign researcher. If literate, participants could read the interview questions (which the male participants all requested to do) and ensure that they would be comfortable with the proceeding interview. If not, they could withdraw.
Finally, it is important to mention expectations of researchers in such a context. Both the MINSA Ayacucho Directorate, as well as individual health workers, expected to see me undertake interviews with patients and workers, and became suspicious if and when I did not do so. In a context where ethnographic participant observation is not common among researchers, a lack of formal research methods encouraged disquiet amongst those in the research context. Other colleagues within my PhD cohort reported similar issues of ‘researcher expectations’ and obligations to interview formally because of this, therefore this may not be limited to the Peruvian context alone.

Interviews were undertaken in Spanish or basic Quechua and recorded where consent was given. They were later transcribed and translated (where excerpts were used within the discussion).

Participants were interviewed in a location that they deemed convenient for them, which was most often at home, a place of work, or open public space (e.g. in a restaurant or public square). This meant that interviews occasionally took place within the health establishment setting (within private, concealed rooms), if the participant requested so.

In addition to formal interviews, fifteen informal, unstructured interviews were completed with other key actors in and outside of the province. In Vilcashuaman, unstructured interviews were conducted with others operating within (ethno)medicine but not related to the state health services, including three parteras (indigenous midwives), two curanderos (ethnomedical practitioners), and one shaman.

In Huamanga, unstructured interviews were undertaken with two staff members at Manuela Ramos Ayacucho, and two members of the UNSCH Medical school. Additional informal interviews were undertaken in Lima with two representatives from the Ministry of Women and Vulnerable Populations (MMPV) and three staff members from UNFPA Peru. These were voice-recorded with permission and where appropriate (i.e. if the interview was planned and not impromptu).
Table 2.1. Female Socio-Demographic information (Interviews)

<table>
<thead>
<tr>
<th>Age</th>
<th>Job</th>
<th>Language(s) spoken</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>Stay at home</td>
<td>Quechua</td>
<td>52</td>
</tr>
<tr>
<td>26-35</td>
<td>Agriculture (remunerated)</td>
<td>Spanish</td>
<td>16</td>
</tr>
<tr>
<td>36-45</td>
<td>Administration</td>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>45+</td>
<td>Other</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Table 2.2. Male Socio-Demographic information (Interviews)

<table>
<thead>
<tr>
<th>Age</th>
<th>Job</th>
<th>Language(s) spoken</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>Stay at home</td>
<td>Quechua</td>
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</tr>
<tr>
<td>26-35</td>
<td>Agriculture (remunerated)</td>
<td>Spanish</td>
<td>6</td>
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</tr>
<tr>
<td>45+</td>
<td>Other</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Permissions and Ethical Considerations

This research methodology was approved by the UCL REC (Research Ethics Committee), and the MINSA Ayacucho Directorate. All participants were informed about the study and of their right for unconditional withdrawal at any time and gave their verbal consent to be interviewed and to have their interview voice-recorded if permitted. Research and observation were never undertaken covertly, always overtly.

All participants’ names, locations and identifying features (such as appearance, children, or workplace) have been changed for confidentiality.

Limitations

In addition to the limitations inherent within the methodological approach, it is important to mention what one will not find within this dissertation. Essentially, there are two areas of importance to reproductive health research more
generally that are not approached as direct themes within these pages. These are religion, and abortion: two themes that often interact and I have discussed at length in regard to Peru in other works (Irons, 2015, 2019a, 2019b).

The analysis of the data has been led by the opinions, conversations, experiences, and focus of the participants themselves. Both religion and abortion may be present within the lives of participants, however these were not raised with any frequency to merit their own chapters. Importantly, the key focus of this study was the interaction between state-provided health services and indigenous people. As the state is secular, and abortion is illegal in Peru so not offered or openly discussed as a possibility within health posts, greater attention to these topics would diverge too much from the specific research focus.

Furthermore, it is important to underscore that abortion as understood in a Western biomedical-scientific paradigm is not necessarily presented the same way in rural Quechua communities. Indeed, as scholars such as Hammer (2001), Morgan (1997), and Platt (2001) have all discussed, ‘abortion’ as understood in contemporary Western vernacular relies upon an understanding that a foetus and/or human being has developed inside the uterus, and can thus be removed from that womb in an abortifacient act. However, in Quechua body understandings, the first three months of a ‘pregnancy’ start with a clotting of blood that may or may not ‘become’ a human child. Thus, amongst participants, ‘abortion’ was not raised in the same conversations as contraception, even if that might be the case in other fieldwork contexts where the two are more closely related. This concept will be further addressed in chapter eight, however it is worth the brief description here to explain its direct omission from the body of the text.

Abortion is illegal in Peru, except in the case of therapeutic abortion used to save the mother’s life. However, due to physicians’ ability to use conscientious objection in order to deny this service (Casas, 2009), often based on religious grounds, it is difficult to obtain an abortion even if under such conditions,

\footnote{In the debate on abortion, religion plays a large role in its illegality. Although the state is secular the Catholic Church still has influence in reproductive health and governance (Morgan, 2012). For example, the church contributed towards restrictions on the Emergency Contraceptive pill for many years, citing it as ‘abortifacient’.
leading many women to seek clandestine abortions at great personal risk. In Vilcashuaman were women to seek abortion they would have needed to travel to Huamanga and away from the health network studied here.

On the second omission, religion and contraception were also not themes mentioned by participants in relation to contraceptive choice nor FP, in the context of state-provided FP. The Peruvian state is secular and does not promote religious ideology directly or overtly within health establishments. Furthermore, whilst the Catholic Church (the largest religious influence in Peru) condemns abortion, there has been more ambiguity towards other contraceptive methods, relying on a moral discourse, ambiguous at different times in Peru’s history, that those who cannot properly parent their children should not necessarily procreate (see Necochea Lopez, 2014: 126-148 for further discussion).

Other actors of reproductive governance that are mentioned within this dissertation, such as Manuela Ramos, are also not religiously affiliated (see Ewig, 2006 for further discussion).

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19 It should be acknowledged that whilst this statement holds true, there are some exceptions. The current Peruvian government under president Martin Vizcarra is secular and in name, should be separated from the pressures and will of the church. However, this has not always been the outcome. Coe (2002) highlights how the presence of government extremists has undermined reproductive rights advancements within the government itself, and particularly so within MINSA. She notes that certain ministers have historically been affiliated with Opus Dei (The prelature of the Holy Cross and Opus Dei) – a Roman Catholic global organisation that explicitly stresses that its members promote their faith through both their everyday lives and their working environments and responsibilities. Arguably, the presence of government ministers who are members of Opus Dei necessarily dictates their involvement with the restriction of contraceptive methods that are not in accordance with Catholic teachings, thereby comprising the secularity of the state. Coe states that “officials in the [Peruvian] government have relentlessly pursued an agenda aimed at undermining public programs, reducing funding, harassing advocates and researchers and refusing to negotiate with international donors or civil society organizations” (2002: 1). The ex-Archbishop of Lima, Juan Luis Cipriani Thorne, belongs to the movement for example, and Opus Dei themselves insist that “to be a governor/minister and to be a catholic cannot be separate things” (Delpiazzo, 2002), therefore it is both pervasive and difficult to weed out of the state and health ministries. Such features may represent a challenge to the secularity of the state in Peru in some cases.

20 Pope Francis’ comments on contraceptive permissibility in Peru further support this notion, when in a 2016 visit he suggested that hormonal contraceptives were permissible to fight zika virus (Washington Post, 2016). Going further than this still, following from his successful 2018 tour of Peru and Chile, Pope Francis released his document, ‘Gaudete et Exultate’, which raised the question of motive amongst anti-abortion activism. He commented: “Our defence of the innocent unborn, for example, needs to be clear, firm and passionate. Equally sacred, however, are the lives of the poor, those already born, the destitute, the abandoned.” (The Independent, 2018).
It might have been possible to have introduced religious institutions as another means of ‘reproductive governance’, and the church has undeniably played an important role in contraceptive availability in Peru over the years (Necochea Lopez, 2014). However, this is a subject that requires far more depth than would have been possible within the space of this dissertation, and furthermore, has been covered already in the literature (Necochea Lopez, 2014; Ewig, 2016). Further analysis of this kind may have to be reserved for future research on this subject and field site.

A further and important limitation was the unavoidable obstacles imposed by virtue of my positionality as an ‘other’, further discussed below.

**Researcher Positionality**

In her work on biomedicine and the reproductive body in Brazil, Gregg suggests that when one foregrounds “power and inequality in [their] work”, one should make clear their “own position in the power grid”, whilst also recognising that “the goal is ethnography, not autobiography” (2003: 10). Following from this advice, it is pertinent to briefly offer a reflexive account of my positionality here, how my presence was experienced by informants, and how I have attempted to resolve arising issues in this context.

Firstly, I am a white, unmarried, and childless English woman, coming from a British University. Whilst once anthropological works may have presented themselves as unaffected by the ethnographer, this is no longer the case, and so should not be the case here either. As Rita Segato notes, one now finds their own ethnicity “exposed and explicit” (2015: 12), and this certainly deserves further comment before commencement of the dissertation.

Whilst I made every attempt to remain neutral, it must be stated that I formed friendships with *both obstetras* and Quechua women in the province – although my friendship with one ‘group’ may have dictated a lack of friendship with another in individual villages, this did not present as too great a problem (i.e. I did not receive overt hostility from one group over my association with another).
I often went on house-calls and school-presentation-visits alongside obstetras, which could have indicated to those patients present that I ‘worked’ for the health centre too. However, it should also be noted, as will be expanded upon in chapter seven, that numerous health workers actually came from the surrounding villages and knew the people from a young age – thus, there may have been some circumstances in which the local people seeing me with a health worker may have improved, rather than limited, their trust in me. That would depend entirely on the context and the health worker’s circumstances, however, but it is worth noting.

A number of participants, both Quechua women and obstetras, became comfortable enough with me to address me informally, calling me ‘Rebequita’, or ‘Bequita’, the diminutive of my name. The use of informal first-naming suggests that those Quechua women did not in fact equate me with the health workers, as I had feared they might, as they would strictly refer to them as ‘doctora’ and never by their name, even if they knew them personally. Even when not addressing a ‘doctor’, all health workers are referred to in this way as a sign of respect for their position. Similarly, Quechua people may refer to others outside of medicine using their titles. For example, they would call an engineer ‘ingeniero’ instead of using a first name, a teacher ‘profesora’, and other ‘professionals’ may be called ‘licenciada’ (‘licensed’) to refer to their position. The fact that I was called by my name could also reflect that fact that people were not sure what I was or could be seen as a lack of respect. However, in the context of Vilcashuaman it is more likely that my ambiguous status and the familiarity with which key informants came to share with me dictated my (informal) naming.

Due to the field-region’s relative isolation, many people had never experienced a meeting with a foreign person before, and therefore my habitation in the province did not go unnoticed. For example, upon returning from an extended trip to Lima I was approached by multiple people I had never met, commenting on their surprise that I had once again “re-appeared”. Children would occasionally approach me when I was sat on one of the benches in the plaza de armas, a shy hand outstretched to brush my pale skin before its owner
ran off in giggles. I was an anomaly for many, a ‘bicho raro’ (‘a strange creature’), as one health worker once called me.

However, this identity was not perceived as fixed for the people of Vilcashuaman either. Over the course of my fieldwork, I seemingly came to stand in for contemporary concerns that people perceived in regard to the unknown ‘other’, and these were varied.

Upon my original arrival, it was rumoured that a ‘gringa’ archaeologist had moved into town to study the ushnu ruins in Willka Waman. This was largely positively slanted as potentially ‘good for tourism’, although in previous years a ‘chino’ archaeologist had been chased out of Pomacocha village, accused of coming to steal the ‘Inca Gold’ (he may have been studying the Qapaq Ñan that runs through that region). After some weeks of never meeting this ‘other gringa’, I eventually found out that the rumour referred to me. I was also accused of being a ‘pishtaco’ and asked to leave one residence because of this. Pishtacos are considered to be Andean bogeymen, who traditionally steal fat and blood from highlanders (Weismantel, 2001), but more recently have been related to the theft of children and body organs for sale (Schepér-Hughes, 2002). When the creature presents as a child-stealer, they may be called a Ñaka in Vilcashuaman.

It is not uncommon for female anthropologists to be accused of child-stealing (Van Vleet, 2008), particularly if they are unmarried and childless like myself. It is less common for females to be accused of being a pishtaco/ Ñaka, as they are more traditionally male (Weismantel, 2001), however that is not always the case.

Some of this may be down to pure coincidence. A few days before I arrived in Willka Waman, a child had run back from the chacra claiming that he had been chased by a Ñaka. I was retold this fact many months later by a friend in the village, after it had been confirmed that I was not, in fact, stealing children.

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21 People in Peru may refer to someone as ‘chino’ if they have Chinese ancestry and does not necessarily refer to a person of Asiatic descent. This term can also be used for a person of Japanese descent, although the more common term for them is ‘Nikkei’. Thus, this archaeologist could have been a foreigner like me, or could have been Peruvian- the term used does not give clarity on this.
Following even more strangely coincidental events, I was also accused of being a vampire; a creature that due to its blood-sucking, night-time activities, is synonymous with the *pishtaco* (Wachtel, 1992). It so happened that the ‘mother’ of my first host family in the village of Sarachongo was born in the coastal town of Pisco, a place famed for the devastating earthquake that shook the whole region in 2007. It also so happens that in this town there exists an elaborate legend of an English ‘vampire’—Sarah Ellen—who was rumoured to be the wife of Dracula and was buried in Pisco cemetery 1913\(^{22}\). Among other misdemeanours, such as raising the dead, Sarah was believed to steal newborn babies (*Enemigos Publicos*, 2017). When the earthquake destroyed all the tombs but Sarah’s, the threat of this English vampire was flung back into collective consciousness. In Sarachongo my Englishness was not overtly considered a problem until a 7.1 tremor hit the neighbouring province of Arequipa (BBC, 2018c), and I was suspected of being somehow connected vampirically to the event, as my deceased *paisana* Sarah had been in 2007.

After this I moved to a different locale and presented as ‘Europea’ instead of ‘Inglesa’. It should also be noted, however, that such accusations have also been made against Quechua-speaking/identifying, Peruvian anthropologists when working in rural Andean locations (Vicente Torres, *Universidad Nacional de San Antonio Abad del Cusco*, personal communication). Therefore, omitting the coincidence of Sarah Ellen and my own shared Englishness, such accusations are not uncommon or necessarily based on an anthropologist’s foreignness.

Finally, and most importantly, I believe that it is necessary to interrogate the appropriateness of my undertaking such research in the first place. In this I have looked to the work of Rita Segato, who has questioned anthropological intervention as it applies to the coloniality of power (2015). In her view, the only kind of relevant and appropriate anthropology is an *anthropologia por demanda*/*anthropologia on demand*; “an anthropology contingent with the demand of those who would have previously been objects of our observation”, an anthropology that can “help [the subject] to achieve a greater wellbeing and

\(^{22}\) This is quite a well-known tale across Peru and has been reported on internationally (e.g. Daily Mail, 2009), although I had not previously come across it until the time of my field work.
understanding of their own problems” (2015: 13). In this dissertation I cannot claim to have undertaken research on the demands of the community itself, however I did proceed in discussion with MINSA Ayacucho who directed me towards Vilcashuaman due to a lack of information regarding FP in this area. In this (perhaps limited sense), it was an anthropology on demand. Furthermore, at the conclusion of both the project and the core chapters of this dissertation I returned to Ayacucho to present and discuss this work with MINSA Ayacucho, where we were able to discuss potential areas of improvement for the health network in Vilcashuaman. This will be returned to in the conclusion.

That said, it serves to be recognised that Segato is an Argentine-Brazilian anthropologist, whose positionality would differ from my own as a white British scholar. To complement her view, therefore, I have also looked to Florence Babb; a white, North American Andeanist-anthropologist who has recently put decades of her own work into dialogue with Andean scholars to interrogate her own positionality (2018). Babb discusses the possibilities of working towards a greater decolonial anthropology, through collaboration with local actors as well as framing one’s work in dialogue with Andean scholars (2018: 219-220), although she recognises the complications in expecting local collaborators to take interest in one’s own project (220), as I also do.

Whilst I was not able to ‘officially collaborate’ with any party within the communities, in this work I have relied upon Andean scholarly works as much as possible within the context of my research, and when this has not been possible, I have looked to work coming from Latin America and published in Spanish and Portuguese where feasible. A great deal of the following dissertation has been written in dialogue with Peruvian academics such as Aníbal Quijano, Lucia Guerra Reyes, Marisol de La Cadena, Maruja Barrig, Maria Elena Garcia, Alejandra Ballón, Carmen Yon Leau, Alberto Galindo, amongst others.

Bolivian Aymara-indigenous scholar Silva Rivera Cusicanqui has previously criticised the lack of engagement with southern scholars on the part of Western academics. She argues that ideas run from the South to the North and are transformed (2012: 104), citing an example that it is entirely possible, and publishable, to write books on public health and identity in Peru without ever consulting Peruvian scholars. The aim was for this dissertation to not be a study
of indigenous subjectivity and experience without consulting Peruvian scholars whenever possible\textsuperscript{23}.

In order to recognise the intersectional, (and de-Eurocentered) approach of this work, I have further looked to black feminist scholars, particularly North American anthropologist Khiara Bridges, writing on reproductive health and Foucauldian biopower, to develop my analysis of biopolitics and the subaltern woman more conscientiously.

Although all attempts were made to take a decolonial approach towards the scholarly work that I have engaged in, this has not always been possible, at times due to relevance of research undertaken by Euro-American scholars on the topic of study. For example, I acknowledge a sizeable reliance on the work of North American/ European scholars Christina Ewig, Jelke Boesten, Kimberly Theidon, and Jessaca Leinaweaver to develop this dissertation’s arguments. However, in the context of the present dissertation, this was unavoidable.

I have also presented my work in this dissertation to the scrutiny of Peruvian academics, both in the context of academic events in the country, and in Peruvian academic publications (Irons, 2019b, 2019c, 2019d). Early on in my fieldwork, one participant did not want to interview with me because, in her words, I would just “take her back to my country”. On this, the advice of my second supervisor, Jennie Gamlin, remained firmly at the front of my mind: the moral duty that we hold to publish in the country of our fieldwork, in Spanish (in her and my case), so that a local readership can engage with, and dispute, one’s work. Having presented my work in Spanish, in Peru, and with a mind to continue doing so, I hope that my work can enter into dialogue in the country where it is arguably most relevant. Furthermore, I invite criticisms of my research from the country where it has been undertaken, in order that it can be developed to be of service to them in the future.

\textsuperscript{23} One must also acknowledge that Cusicanqui indeed criticises some of the ‘Southern’ scholars – among them Quijano (2012: 103) and calls elite Bolivian scholars a “caricature of the West” (97), calling into question the validity of their work also. One would hope that eventually, indigenous studies be comprised of literature by indigenous authors entirely, supporting Cusicanqui’s laments. However, until this day, Peruvian and Latin American scholars, even if elites, must be relied upon for consultation.
In doing this, I can hope that I will not be fulfilling the fears of the
aforementioned participant and taking her ‘back to England’, but leaving her
behind in Peru as she wished.
Figure 2.10. Plaza de Armas, Pilpintumarca, Vilcashuaman.

Figure 2.11. View over Sarachongo, Vilcashuaman.
Figure 2.12. *Plaza de Armas*, Willka Waman, Vilcashuaman.

Figure 2.13. Women gather in Michibamba, Vilcashuaman.
Figure 3.1. Andean cemetery to represent the sterilisation-deaths. (Note the Catholic columbarium and use of Inka Kola bottles as flower vases, adding additional context underscoring both the ongoing presence of colonial religion and the increasing consumerisation of the Incas). A deliberately evocative image, inspired by Ballon’s photographic essay of the forced sterilisations (2012: 11).
THREE
STERILISATIONS

I don’t know how old I was when it happened, twenty something…my husband had gone out to work and an obstetra from here, from the health post, came and insisted. I told her no, my husband isn’t here, and he wouldn’t want it, but they kept coming back and threatening me. I told them I didn’t want it, I didn’t want to spend all day in bed and my husband didn’t want it either- what happens if you get sick, he told me. Before they had ligada (‘tied the tubes’) of various women, and they felt bad afterwards, so that’s why I didn’t want it. We were the last that they told to do it…I didn’t want it. They took us…that day they arrived at my house with the ambulance, they told me it would take just a little while and that I wouldn’t feel anything…that’s what they told us. They took us to the hospital. After they took us…well I didn’t want it, I didn’t want to go so they grabbed me, it was two men, who were with their…[covers mouth with hand]…that thing they use to operate, the mask. Where we there but as I didn’t want to go the two of them grabbed me, I think the obstetra was also there. I didn’t realise that they had put anaesthesia, and because it seems they had put anaesthesia I don’t remember how it happened. But I remember I saw there was blood in the bin, but as the two of them had grabbed me I couldn’t do anything. When I woke up it hurt, “estas bien?” she asked me [the obstetra], “sí” I told her, and they brought me back to my house in the ambulance. It hurt me and until now I still feel the pain, my waist hurts, sometimes it hurts me here [rubs her abdomen], and it hurt me to do it. I was fine before but after I was ligada my abdomen hurts. Before I was in the chacra and everything was fine, but now after a little work it hurts me this part [abdomen]. I thought that afterwards I would never have another child, I wanted just one more because my last child was a girl, and the rest are female. The child that died [before the sterilisation she miscarried] was a girl too…there are no boys. When I arrived back home afterwards my husband told me he wasn’t going to attend to me because he had to work. “Why did you let them take you like that?” he told me, but the doctor [from the ambulance] told him “no señor don’t worry, everything will heal”. They only gave us some pills, some pastillitas, those ibuprofens, nothing more. I don’t know why they did this…sometimes they say that the women shouldn’t have so many children, maybe because of that. It should be our decision. We are various that have been ligada in the village, but another señora died now, they told me that she was living in Jachaqocha but now she died. It’s true that now I don’t go to the health post, sometimes I go to Huamanga if I am bad to get a check-up.
Sometimes they talk about it. There are meetings with the other women who have been *ligada*, but I don’t go there, I don’t want to go there. There was a man from Willka Waman that came from the town hall and they said there was a meeting there in the third floor, but I didn’t want to go, I went once but I didn’t go back.

Sometimes they say the women can’t maintain their children and sometimes there isn’t work, that’s what they said. When you have lots of children, they don’t have good health. But I only had three, well four with the other one that died. But what can I do? Now I am just with my partner and nobody else, so when I’m bad I just go to Huamanga. They told us once in Willka Waman that we could get *Seguro* (SIS) so that they can attend us in the *post*, but I don’t want to go. There were other women too [that were sterilised], but they say that they died. They came from all over, and almost three people have died, I heard…no, five in Vilcashuaman. We don’t think about it anymore.

- Silvia, Forty-three, four children (one deceased), Pilpintumarca

I like having a big family, so they maintain you, so they help like her [gestures to her small daughter playing on the dirt floor]- look how much she helps her mother. You need more children so they can help their mother and their fathers. If I was alone how would I manage? The smaller children are always crying.

They never gave me the *ligadura*, they only gave me an injection, the *ampolla* they call it. It’s the one for those that don’t want to have any more children, that was the one they gave me because I did not want more children, *manam wawanchikpaq!* Only the injection to not have more children, nothing else. Here they have given *ligadas*, so the women don’t have more children, seventeen…twenty years ago, in Pilpintumarca they died, and here in Llamallaqta they died too, two have died. They also tried to do it to me, but after the women got sick I said no. I put my name down in the *post*, I put my name down myself, but my husband said that he didn’t want it. “What if you die?” he said. So, I just escaped, I went up to the *chacra*, far away so they didn’t do it. I wanted to do it, I put my name on the list at the *post*, but I didn’t do it as my husband didn’t want it.

_Ellas querrían_, they all wanted it! Me too, I also wanted it, but in the end, I went up to the *chacra*. I decided I didn’t want it and my husband kept saying “what if you die, who would be responsible?” That’s what he said, and so he changed my mind. And now look, they died.

_Cuando uno no quiere, nadie puede hacerte estar de acuerdo._

When one doesn’t want it, no one can make you.

_Cuando uno quiere, claro._

When one wants it, fine?
I wanted it too, but I couldn’t. I already had seven children when they came then. But my husband didn’t want it.

- Reyna, Forty-Seven. Ten children (two deceased), Llamallaqta

Addressing the legacy left by Peru’s forced sterilisations is complex. Despite the fact that Fujimori has been accused of culpability in limited cases, there continue to be conflicting and complicated stories from different parties involved – the health workers don’t always say the same as the women, and testimonies from women in Vilcashuaman also show that the women involved may not necessarily report similar experiences.

Silvia was forced but Reyna was apparently free to choose and declined; a testimony that contradicts the dominant narrative somewhat (whilst not making it any less true for women like Silvia). Indeed, just as some women may choose to use other biomedical contraceptives despite maltreatment or health concerns, so may some women choose to undergo medical sterilisation. Even omitting biomedicine, Quechua traditional medicine can be used to sterilise if one consumes a mate (tea) by boiling the nail of the mule, a sterile animal24, suggesting that sterilisation as a concept is not only not restricted to biomedicine, but also that it is not only forced upon one but may also be undergone using ethnomedicine.

That said, whilst Andeanist scholars, both Peruvian (Villegas, 2017; Ballón, 2014; Gianella, 2014; Tamayo, 2014) and Euro-American (Ewig, 2010; Boesten, 2014) argue over terms, there is an acceptance amongst activists and the scholarly community that enforced sterilisations did happen, to a more or lesser grand scale. According to such views, the PNSRPF that sterilised an estimated 300,000 people was based on Neo-Malthusian reasoning that strove for targeted population control of the poorer working classes (largely the indigenous rural peoples of the Andean and Amazon regions), who were seen as hyper-reproductive and resource-depleting, through the promotion (and coercion) of artificial birth control mechanisms.25 It has been argued that using

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24 Interview Don Pancho, Quechua healer, July 2019.
25 Ewig (2010) distinguishes between the theory of Thomas Malthus (1700-1800), ‘Malthusianism’, and ‘Neo-Malthusianism’: “population growth, stimulated by the working classes, if left unchecked, would outstrip agricultural capacity, leading to a general decline in living standards…pure ‘Malthusianism’ advocated sexual restraint of the working classes, and ‘Neo-Malthusianism’…accepts artificial birth control” (42). In the case of the PNSRPF, ‘Neo-
forced sterilisations to achieve this goal was tantamount to genocide (Citroni, 2014: 95), and Fujimori has been accused of such (Bosch, 2002). According to the UN definition of genocide, if a mass sterilisation-campaign had taken place with the degree of malintent that Fujimori is accused of, then it certainly would equal genocide:

“Any of the following acts committed with intent to destroy, in whole or part, a national, ethnical, racial or religious group, as such: killing members of the group; causing serious bodily harm to members of the group; deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part; imposing measures intended to prevent births within the group; and forcibly transferring children of the group to another group” - Article 2 of the Convention on the Prevention and Punishment of the Crime of Genocide (UN, 1948) (emphasis added).

According to the UN definition, and beyond prevention of births alone, the PNSRPF was guilty of: killing members of a group (eighteen women have been reported dead as a direct result of enforced sterilisation (Ballón, 2014: 35)); causing serious bodily harm (e.g. women report mutilation (41)); and deteriorating life conditions as a result of the sterilisations, (patients were unable to work, earn a living or pass on cultural knowledge (41)). Furthermore, children continue to be removed from their indigenous parents based on biomedical categorisations of mental ill health (Leinaweaver, 2009). Based on the data, there is justifiably great cause for concern over the sterilisations, and Vilcashuaman did not escape this period.

In the province a total of one hundred and thirty recorded enforced sterilisations were documented after the Ministerio de Justicia y Derechos Humanos (MINJUSDH) (Ministry of Justice and human rights) released a call for those affected to register themselves in the list of victims in 2016 (see appendix 3.1). In the region, the Ministerio de la Mujer y Poblaciones Vulnerables (Ministry of women and vulnerable populations) (MMPV) had undertaken the task of seeking out and bringing together affected individuals to encourage them to register and await justice. However, if one considers cases where a woman was sterilised but refuses to document herself on the victims list, such as that of Silvia (opening testimony), then the count in Vilcashuaman may exceed the

Malthusianism’ is the more appropriate term, “when artificial birth control in Peru supplants sexual restraint as the primary means of population control” (43), as was (and continues to be) the case in the MINSA network.
current number documented. In fact, last year the MMPV reported that a further twenty-three cases had been filed. Therefore, the one hundred and fifty-three-odd is a tentative account that may continue to grow as the word spreads about the victims list, or potential avenues for reparation that communicating with the MMPV may bring.

According to Ballon’s investigation, MINSA recommended sterilisations for women who had more than three children, were under obstetric risk, and who had a minimum age of thirty (2014: 181). The average age of victims in the Vilcashuaman sterilisations is 50.4, which would have put them at around thirty years of age in 1996-2000 during the PNSRPF. The average number of children was 4.4, which also would have satisfied the purported MINSA regulations. However, thirteen out of the one hundred and twenty-nine reported victims had less than three children, and one (male) had no children at all. That said, their status of obstetric risk is unknown, so this factor may have been satisfied as far as the health staff were concerned (although this would not apply to the sterilised man).

As mentioned, and as per the nationwide campaign, there were also male sterilisations in Vilcashuaman, with 3.87% of those targeted being men. This is only slightly lower than the national average of male sterilisations during the period 1996-2000 7.48% (Ballón, 2014:32). They were all Quechua speakers and 58.9% were rural dwellers. However, this may reflect the demographic composition of Vilcashuaman more generally as opposed to targeting of specific groups within the province. For example, as mentioned in the introduction, Vilcashuaman is one of the highest Quechua-speaking provinces across the whole country, and has a rural population of 68.3% (INEI, 2017:87). Therefore, whilst the population that were forcibly sterilised were largely rural Quechua speakers and on the surface may suggest a direct targeting of a sub-population within the province, this actually reflects the overall majority demographics, so at least in this case, these characteristics may not have necessarily been sought for individual sterilisation- it may have genuinely been women with larger families as health workers claim (although that does not absolve the PNSRPF).

It may come as a surprise to learn that health workers mentioned sterilisation as one of the most popular options for women today. According to national statistics, in Ayacucho female sterilisations have actually increased from 4.2 and 5.3 in 1996 and 2000 (the period of the PNSRPF), to 5.4 in 2009 (INEI,
This suggests that people are not necessarily put off sterilisations per se, although there may be a more encompassing embodiment of fear towards all methods more generally, as will be discussed in the following section.

To be sure, even one forced sterilisation would be a tragedy, and over one hundred within a relatively small province is indeed a grave offence. However, the numbers are perhaps not quite as large as reported. If 300,000 plus sterilisations were performed on mostly rural, indigenous Quechua people, then one of the predominately Quechua regions might have expected a much higher incidence of sterilisations. On this, Stavig suggests that the numbers may be an overrepresentation:

“There has been a tendency in some of the literature to inflate the number of forced sterilizations. One is led to believe by some accounts that all 297,000 sterilizations reported by the government were forced...this was simply not the case and actually did more harm than good by painting campesinas and other sterilized people as not only ignorant, but as victims, wholesale” (2017: 180-181).

Stavig poses the question, why?

Such inflations may be promoted by both Human Rights activists and the Catholic Church, she argues. These agents, Stavig claims, seem to “have been the only ones to read what happened to the indigenous community as a possible genocide” (181). The human rights system is more likely to respond to a situation when there are a larger number of victims, particularly when those victims are sympathetic (181), and the Catholic Church used this incidence to support their earlier resistance to the introduction of sterilisations to the FP programme in the first place (Ewig, 2006). That said, the aim of this chapter is not to dispute the wider national context or offer an analysis about the sterilisations writ large – that has been done elsewhere (Villegas, 2017; Ewig, 2010, 2012; Ballón, 2014, Gianella, 2014, Boesten, 2014, Tamayo, 2014; Citroni, 2014). Instead, it aims to present and discuss the local effects of this event on one province, whose histories and experiences of it may differ from others in the country, even amongst other Quechua communities. However, it is important to bear in mind, as the above discussion attempts to show, that there are no definitive conclusions as to this event, and women within the same community may not present homogenous testimonies of it either. That said, the legacy that has been left behind by those who have experienced the forced
sterilisations has resulted in an embodied fear passed on to subsequent generations.

This chapter will present and discuss the legacy of sterilisations as experienced by women in Vilcashuaman today. Building on the opening section, it will be shown that whilst there is silence surrounding the sterilisations this may have become expressed in an embodied fear towards the health establishments and FP services in general. That said, the validity of approaching the sterilisations as a discrete event in the past will be analysed with respect to the ongoing obstetric violences that women may experience. It will be possible to see that whilst the sterilisations were a significant event, they do not necessarily hold such an easily defined place in the ongoing experiences of Quechua women. Thus, it will be suggested that women experience sterilisations along a continuum of violence(s) (Cockburn, 2004), obstetric, structural, and otherwise, that do not necessarily dwell on a past when the present is also troubling. This way it will be possible to interrogate those actors, and particularly those Lima-based NGOs, that promote sterilisation awareness and justification causes whilst overlooking contemporary concerns, as an example of non-state reproductive governance (2012).

**Embodied Fear and Mistrust**

SILVIA: Sandra [eldest daughter] is in the University [in Huamanga] studying literature and there we rent a room for her because she doesn't want to stay with family. Sometimes she tells me, ‘oh how I would like a little brother (hermanito)’, because now they are three of them, but what can I do? She tells me to have one more, and I tell her first she has to finish her studies and then she can find a partner of her own.

RI: Does she know about your situation [that she was sterilised]?

SILVIA: No señorita, I didn't tell them anything, now she wants a little brother but what can I do? I cannot tell them what happened.

It is usual over the summer break (the Christmas period) for children who are usually away studying to return to their villages to spend time with the family, and Sandra had returned to Pilpintumarca to pass the festivities in her native community. Passing through to visit Silvia one afternoon, I met Sandra perching on the low dirt wall outside of their humble adobe dwelling, the small maize
chacra lending its leafy shade as the Andean iconic plant was now in full bloom. Dressed in bright pink tracksuit bottoms with her hair piled on top of her head and secured with a scrunchie, Sandra cut a figure drastically distinct from that of her mother’s muted skirts and plaited hair. She was a woman back from the big city, and over her summer break we began to get acquainted. As it turns out, Sandra was restless that Christmas, as she had met a new boyfriend in Huamanga (against her mother’s wishes), and tentatively began asking me about contraception, knowing that I was researching this topic. However, she was reluctant to visit the Pilpintumarca health post to enquire about this, apparently based on her mother’s bad experiences (albeit that those remained unexplained and mysterious to Sandra).

SANDRA: Here, you go for family planning, and then the next day everyone is talking about you in the plaza. There’s not much trust and they’re not professional…they should be more reservados (reserved) with their patients. You tell them a problem, for example you have some illness, and they spread it around in the plaza, and everyone talks.

RI: Did you have this experience?

SANDRA: No, but my mama did…but I don’t know what exactly.

Sandra and her boyfriend were having unprotected sexual relations and she seemingly felt comfortable talking to me about it – as an outsider to the village I would not gossip to the rest. However, I encouraged her to go to the health post if she felt that she had medical concerns, where they could provide her with further information and contraception free-of-charge, if she wanted it. We agreed that she could tell people she was going there to undertake our interview as people in the village were used to such requests from me. That way Sandra would avoid the gossiping she so feared, as had happened to her mother. “My cousin works there you know…it always makes me afraid” she confided to me before she finally admitted that she was curious to go. Sandra did go eventually, but it wasn’t easy for her to overcome the feeling of fear that she had towards the health post and her perceived consequences of

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26 Although now living in Huamanga, Sandra’s SIS was still tied to the Pilpintumarca health post; this is why she was unable to simply go to a different health establishment in the capital where people would be unable to gossip – she would not be attended there.
consulting there. This fear was not based on her own bad experiences as she avoided the post and so had little to tell about whether or not she would be treated well. Instead, it was based on her mother’s bad experience, although Sandra did not know the details. Silvia never told Sandra, nor her other children, what had happened to her although her avoidance of the health post and her fear of village gossip had seemingly been passed onto her daughter. This silence made Sandra fearful of the FP services and general experience of the post as well, even if she did not know what she was afraid of exactly.

Silvia is not the only sterilised woman in Vilcashuaman to respond with silence. Marisol, a forty-something (she did not know her age) year-old from a different village, Michibamba, who was forcibly sterilised also points to post-sterilisations silences:

MARISOL: It was around the year 1996 I think, they had taken us by lying to us and they said they would give us food for our children if we went, but they didn’t. They explained it to us more or less, then they took our [blood] pressure to see how you are. Two, maybe three women from here went, and they [the health workers] were from here, the señora worked here, right here in the village. We came and they started taking our pressure... you are a bit weak so we will give you an injection they told us, just like that. How old are you, are you studying, they asked us questions like that. After I woke up, we were all lying down, us three women. “wake up, wake up!”, they were telling us to wake up, and then a man grabbed me. “Don’t be afraid! No te asustes!” He told me, “Calm down!”

They told us they’d give us the injection for being weak. I spent a night there, and then my husband got annoyed, “how could you do this?” he said, “I didn’t authorise this” he said27. They said there was a campaign, but I don’t know why they did it to us.

RI: What did you do afterwards, when you got back home?

27 It should not go unnoticed that the law about women requiring their husband’s permission to receive contraception changed in 1996 (Boesten, 2010a)- the same year that the sterilisation programme began. In this chapter’s testimonies women mention that their husbands did not agree or did not ‘authorise’ their sterilisation, becoming angry at them for this. As the law would have only recently changed at the time, such comments should be taken in light of this. It can be considered that those women whose testimonies, here and elsewhere, include such comments are highlighting perceived health workers’ flouting of the law of that time, and not necessarily their gendered domestic relationship (although that cannot be ruled out, it is nevertheless important to make the distinction).
MARISOL: Nothing, nothing. We didn’t tell anyone, and we haven’t tried to claim anything, so we’ve stayed just like this. I only had two children and nothing more. I wanted four, two girls and two boys, but now it is like this.
I went to Lima two years ago, and before [in Huamanga] they had told me I was just ‘tied’ (amarrado), and that if I wanted to have more children they could untie it (soltarlo) and I’d have more children. But in Lima they didn’t want to do it, they said they couldn’t do it.
Nobody came to help me afterwards, so now I am just here with my two children and nobody else. I am separated from my husband, now it has been seven years! Now I work in the house, and sometimes in the chacra if I can. I didn’t tell anyone why though.

Silences are important to address, although Theidon urges caution when doing so as one must understand the motive behind the omissions. For example, in her work addressing the silences surrounding the mass rapes of the Peruvian internal conflict she distinguishes between oppressive silences, and silences of agency (2007: 454). Are women like Marisol using their silences to gain agency, or because they are unable to discuss their experiences?
Ballón suggests that the silences surrounding the sterilisations are due to a fear of stigma as patients are scared that their communities will see them as an ‘easy woman’ because sexual intercourse will no longer result in pregnancy, and as ‘useless’, for the same reason (2014:34).
Fear of stigma may be the cause of silence with Silvia, as Sandra showed clear concern that the villagers might gossip about her after a trip to the health post. However, it may be wise not to make neat assumptions about silences in this case, and instead afford them more ambiguity. For example, Labanyi writes:

“Silence can mean something more complicated than acceptance of repression… Silence can mean respect or fear for the repressive authority, or an attitude of defiance, or a way of safeguarding one’s intimacy from ideological colonization by the state – or an ambivalent mixture of these (and other) things. It is important to recognize that silence can have multiple meanings” (2009: 26).

In the case of the sterilisations, silence on the part of the patients may very well be about avoidance of shame and stigma, although no woman said this directly. In the case of Silvia, her intent may have been to protect Sandra and stop her from going to the health post where she may experience a similar fate of sterilisation or violence. As Silvia noted in her testimony, it had been health workers known to her that had imposed the sterilisation, and furthermore some of those same workers continue to be employed. Therefore, if these workers
could have abused the her trust and gone against her husband’s wishes (as she said), then Silvia arguably might have thought that those same people could do the same to Sandra. Yet, because it could be considered stigmatising for Silvia to openly talk about what happened, her reaction instead seemed to be silence and avoidance of the place where and people that were involved in the event. This silence could act as a protection against her daughter, in that it presupposes a complete lack of encouragement or blessing for Sandra to attend the health centres.

Marisol’s silences appear to be related to the lack of interest from the post-nobody came to help afterwards, and besides, she had spent a long time believing that the ligadura was reversible and even travelled to Lima to do so. After such a harsh disappointment, what was there to tell?

That said, these silences do not necessarily indicate that women have forgotten what happened. For example, Theidon notes how “to ‘forget’ is a leitmotiv in the countryside of Ayacucho, and many people insist that “now we have forgotten everything”, as if saying it could make it so” (2004:67). Even for those who were not directly affected by the sterilisations, arguably a fear of health-post protocol continues. For example, I encountered much initial resistance to my writing down notes, or even my producing sheets of paper to scribe observations during interviews. When I asked one woman why people so mistrusted my jotting down on paper, she replied that: “Before they made people sign things, they made us put our name, and used this to denounce us”. Indeed, paper documentation is widely mistrusted in the Andean region as it is, with “the formality of paper” acting as an “icon of coercive state power” (Ellison, 2017: 524).

Nevertheless, fear and mistrust of the health post has seemingly been passed on as a legacy in the case of Silvia and Sandra, and potentially others. In relation to biomedical contraception specifically, the silence surrounding it may have resulted in misunderstandings, as Sandra’s comments suggest when discussing her mother’s silence on all-things contraception and reproductive health:
*Mis papas, como te digo,* how do I say it, they are these people that when you tell them this [about contraception], they see it badly, there’s not much *confianza* [trust].

I learned about contraception when I went to the city, people there told me about it. I have a friend and she’s more *abierta*, more open...she knows a lot about these things. She uses the implant, and so I learn from her. She’s from the *Selva* [jungle]...her parents talk to her about these things and because of that they trust each other more, they’re more liberal. Here we are shyer to talk about these things, but they are not.

Sandra admitted that she would have liked her mother to talk to her about contraception and relationships, but Silvia was too ‘shy’ compared to her friend’s Amazonic parents, Sandra sighed. Here there was a mother who had kept a silence about reproductive health due to a ‘secret’ event that she had not had control over and now wished to spare her daughter from, and a daughter who misinterpreted her mother’s silences as prudishness, instead wishing that her mother could be more open like ‘other people’s parents’. Of course, one can also recognise that the lack of parent-child discussion surrounding contraception in this context may not only have been down to trauma, but could reflect wider influences, such as the cultural taboo of openly discussing sex.

That said, this case is particular, and it would be arbitrary to suggest that Silvia’s very negative experience with ‘contraception’ did not influence her approach to talking about this with her children in some way. In such cases, then, the sterilisations did more than punish one life as they interrupted parent-child relationships too, thus attacking kinship at multiple levels, both ensuring that future kin would not be produced as well as rupturing relationships between exiting kin.

Silvia’s silences thus did not go unnoticed by her daughter, however. As Labanyi suggests, “a memory does not have to be narrated to exist: silence offers the possibility of reflecting on what is remembered”, and, importantly, “memories are transmitted not only through words but also *through the body*” (2009: 28) (emphasis added). For Silvia and Sandra, these silences arguably became embodied both through a troubled intimate relationship, but also through the fear and mistrust that Sandra had embodied towards the health post-experience in FP.
Theidon also discusses the phenomenon of embodied fear that is passed from parent to child after a traumatic event in the concept of “la teta asustada” (‘The frightened teat’ (lit.); ‘The milk of sorrow’\(^{28}\))(2004: 77). In this instance an ‘intergenerational’ transmission of ‘toxic memories’ are passed from the mother to the baby through her breast milk or in-utero (2004: 77). This may result in a child who is more susceptible to epilepsy or other leaning difficulties. Further, Theidon notes how there have been other reports of women living through trying times experiencing difficulties in their pregnancies, which she likens to la teta asustada (2004: 78).

Clearly, sterilised women cannot transmit toxic memories to foetuses in-utero as the very nature of their traumatic event renders this an impossibility, however, the transmission of embodied fears from parent to child through behaviours that this concept illuminates remains a possibility\(^{29}\). Theidon takes the transmission of memories ‘through the body’ literally, however, this can also be symbolically as in the case of intergenerational embodied fears towards health networks and contraception shows, for example.

Olujic suggests that once a war (or traumatic event) has ended, the focus returns to the individual body and an ‘embodied terror’ (1998: 31) from the memories. It is individual women (and men) who suffered from the sterilisations, but a legacy of embodied terror in this context also remains, supporting this view.

Sandra finally went to the health post on a day when I was working in another village and was attended by one of my key obstetra informants, a friendly woman who could be trusted not to ‘gossip’ as Sandra feared. She had gone to receive contraception and had been asked to take a pregnancy test as protocol before she could receive it. Later that day I received a phone call from the obstetra.

\(^{28}\)The concepts behind La Teta Asustada, or the Milk of Sorrow in translation, were adapted into a film of the same name in 2009 (see Llosa,2009).

\(^{29}\)In fact, emerging epigenetic research suggests exactly this; that trauma and PTSD can be passed from a mother to her foetus in-utero (Ryan, 2016). This has been shown to have happened across the world following wars or traumatic events during pregnancy. For example, amongst Tutsi survivors in Rwanda (Perroud, 2014); Holocaust survivors (Kellermann, 2013); and following the 9/11 attacks in the US (Engel, 2005), to name a few.
Rebequita, that girl you sent to me…she’s pregnant.

In that moment one could picture Sandra, an embodied fear of the health post experience and years spent avoiding it on the advice of her mother, causing her to forgo the contraception that would have avoided this unwanted pregnancy in the first place. But importantly, Sandra was a young woman at only nineteen years old, who was now pregnant and unable to talk to her mother about her personal and reproductive life due to a perpetuating silence incited by an event twenty-plus years ago over which her mother had no control. This sterilisation, and others like it, affected more than one life – intergenerational suffering is another troubling consequence of the past, as Ballón also found in her research on the sterilisations (2014). Before moving on, it is also worth mentioning my own positionality here, as I was an intermediary between Sandra and the obstetra who phoned me specifically to tell me of Sandra’s pregnancy. As an observer and a friend to both, perhaps my neutrality could be questioned here, as through the obstetras call I was brought in on Sandra’s confidential situation. However, it should be noted that she had already told me as much herself, and potentially relayed this back to the obstetra. It is therefore possible that the obstetra thought that I may have been giving counsel to Sandra and had wanted me to be informed of her situation to do so effectively. Indeed, this raises questions of positionality as I became ‘invited in’ to intervene in situations, yet it is important to remember that this was not a case of patients and obstetras in two distinct camps between who one must have chosen a side. As chapter seven will show, the line between ‘obstetra’ and ‘Quechua’ is blurred, and thus so too was my role in relationships. As the next section will discuss, ‘the sterilisations’ were not the only event of obstetric violence that has happened to Vilcashuaman women in recent (and contemporary) times. An embodied terror of sterilisations may be hard pressed to find release when considered within a context where women continue to experience an ongoing continuum of violence(s) (Cockburn, 2004), a concept that also throws the framing of sterilisations and associated violences as ‘in the past’ and not ‘the now’ into question.
Understanding Obstetric and Corporeal Experiences on a Continuum of Violence

“Do you know of any women who were sterilised (ligada) in your village?” I asked Blanca one afternoon as we chased peach lumps around our bowls of depleting mazamorra with rusting spoons. “Yes, my tía”30 she replied solemnly, “…she died”.

A few years before, Blanca’s aunt had tragically passed away from a mystery illness (Blanca guessed it was cancer) that the community had identified as a direct result of her being ligada at the health post. However, after more discussion it seemed that the tía’s death, although most unfortunate, was due to complications with the ‘copper-T’ and not tubal ligation, the protagonist of the PNSRPF. When probed about ‘the operation’ she had been given to stop her having children, the copper-T insertion was the procedure to which Blanca referred, and not the tubal ligation procedure. Furthermore, it appeared that the dates provided by Blanca of her tía’s experience did not coincide with the 1996-2000 PNSRPF period, and so may not even have occurred during the sterilisation campaign. Why, then, did Blanca say that her tía was ligada, in response to that question?

Indeed, similar responses towards questions about the sterilisations were to be found amongst many other conversations, in many other villages and encounters.

On numerous occasions I was given a ‘lead’ to interview a woman who had been ‘ligada’, to find that when I tracked them down, their troubles had come from the complication of a different contraceptive method, overwhelmingly the copper T31.

For example, as one Vilquina Doris (fifty-two) described:

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30 ‘Tía’ (‘Aunt’) is used as a sign of respect and intimacy amongst community members and does not necessarily refer to a blood relative.

31 Elsewhere, the Copper-T has been reported as toxic due to its metal content. For example, in Brazil, women perceive that the Copper-T can “kill sperm” (De Zordo, 2012: 8). Although no women in Vilcashuaman suggested that this contraceptive might render them sterile or cause death because of an inherent toxicity, it is worth bearing in mind.
They put the *T-de-cobre*, but I was afraid that it would fall out. So, I asked them to take it out, but after they took it out, I couldn’t become pregnant anymore. *Me había vuelto estéril*, I had become sterile.

When first entering the field, I had framed ‘the sterilisations’ in concurrence with the dominant view as portrayed in the literature and media. That is, as an event belonging to a specific period of time, around which one could comfortably put a bracket and determine a start and end point (and question people about specifically). However, beyond the testimonies quoted in the first half of this chapter, it was hard to pin down stories that addressed the specific period of enforced sterilisations under Fujimori. People often responded with anecdotes about very different (though also tragic) contraceptive failures resulting in infertility and death. They were not always, and often not, referring to the sterilisations of the PNSRPF, though.

At first, I pondered whether the question was being misinterpreted and practiced other ways to pose it (the *Fujimori* sterilisations/ the mass sterilisations/ the FP programme in the 1990s), but I could not find what I was looking for. Perhaps, because I was looking for the wrong thing; a thing that did not always exist in the form in which I had been seeking to identify it.

‘The sterilisations under President Fujimori during the years 1996-2000 as part of a national development programme’ have been arguably bracketed as a discrete event within a specific historical timeframe, consisting of specific actors and behaviours that were supposedly unique to that time. Following from Stavig’s (2017) comments in the introduction, actors such as human rights activists and the catholic church (to which can be added feminists, lawyers, politicians, NGOs, academics) have used this event in certain ways, to certain ends, depending on their own agendas. This is not necessarily to criticise those different organisations’ actions, but to clarify that to see ‘the sterilisations’ as an isolated historical moment may be reducing and removing it from the embodied contexts in which it took place. To be sterilised, or *ligada*, from the perspective of the various organisations taking an interest in the topic, incites a call to action, justice, reparation, advocacy. That specific status, as a woman who has been *ligada*, makes one an agent to whom these organisations speak. However, for the remote communities where the sterilisations took place, they
could be seen as one event within a series of other events and potentially carry less significance for the communities as a whole than assumed by interested organisations. For example, Silvia and Marisol’s *ligaduras* were clearly an unjust tragedy, but so was the Copper-T-related death of Blanca’s tía. Thus, to *be ligada* may mean something different for the organisations that advocate against it than for the women in the communities in which it took place. It can be argued that to *be ligada*, in the context of Vilcashuaman, means not solely to have received a tubal ligation in the limited period of 1996-2000, but to have experienced any kind of reproductive injustice that resulted in pain, reduction of quality of life, or even death. In this narrative, to have received the copper-T and die as a result, like Blanca’s tía, means that she was *ligada* just as to have had a tubal ligation (and have died as a result) can mean the same.

In the context of rural Ayacucho, violence has been enacted against women across long stretches of time. With this in mind, certain periods may not significantly stick out to people as necessarily more important (or more gruesome) than the rest- they are somewhat on a continuum where negative experiences have unfortunately been a staple in the rural life of Vilcashuaman: a ‘continuum of violence’ (Cockburn, 2004).

Violences experienced by women in Ayacucho may come in various forms.

The concept of *structural violence* was first introduced by Galtung (1969) to refer to the violence enacted by a social structure or institution that limits people from meeting their basic needs. Farmer (1996), who has developed the concept of structural violence within medical anthropology, defines it as the:

“social arrangements that put individuals and populations in harm’s way...The arrangements are structural; because they are embedded in the political and economic organisation of our social world; they are violent because they cause injury to people” (2006: 1686).

Thus, institutionalised forms of violence such as racism, sexism and nationalism can all be considered as structural violences. De Maio argues that structural violence can be seen as the very *embodiment of inequality* (2015: 675). If we understand the legacies of sterilisations producing an embodiment of fear towards biomedical reproductive health, then this is arguably an extension of an
embodied inequality in the country. Indeed, as explored in the introduction, Quechua people in Peru have long been on the receiving end of institutionalised racism and ethnocentrism, and in the case of women, sexism, thus ongoing structural violence has been enacted against this group since, arguably, colonialism.

Gamlin & Hawkes (2018) recognise a ‘violence continuum’ of structural violence in Mexico, arguing that in the case of violences against men and masculinities we must acknowledge that this is historical, and that furthermore, violations interrelate (54-55). In the case of Quechua women’s reproductive health, one can understand the interrelating violences enacted against women not only through the concept of structural violence, but obstetric violence.

Obstetric violence “refers to disrespectful and abusive treatment that women may experience from healthcare providers during pregnancy, childbirth and the postpartum period, as well as other element of poor-quality care” (Williams, 2018: 1208).

It is a relatively new concept, first arising as a legal term in 2007 to address high incidences of reproductive-related violences against women in Venezuela (D’Gregorio, 2010: 201). Whilst it principally referred to those violences enacted in maternal health, the term goes on to include instances of coercion and mistreatment of women in contraception and FP choices as well (Diaz-Tello, 2016). This would include coercive sterilisations, but also extend to other experiences that incite fear or mistrust of reproductive health care on the part of the health workers, such as the spreading of malicious gossip in a community that might lead to other forms of violence enacted against a woman.

It is further important to note that obstetric violence as a concept came from Latin America and can thus be considered somewhat as a Latin American ‘perspective’ (Escobar, 2013), albeit that the term is gaining purchase in other contexts as well.

In the case of Peru there is good reason to suggest that the continuum of violences experienced by Quechua women did not cease along with Fujimori but continues today. Significantly, the Defensoría Del Pueblo is currently
concerned about the rate of obstetric violence (violencia obstétrica) within highland communities (2016: 85-88), suggesting that this issue is not restricted to isolated pockets of people but is problematic enough to warrant investigation by a larger body.

Returning to the concept of a continuum, when studying the different violent experiences that women go through, Cockburn began to observe “a connectedness between kinds and occasions of violence. One seemed to flow into the next, as if they were a continuum” (2004: 43). A continuum of violence, be that obstetric violence, structural violence, sexual violence, gendered violence, and military violence, may all roll into the same array, when we consider the specific experiences of Ayacucho women.

Specifically, Cockburn and Boesten (2010) refer to a continuum that addresses sexual violence in the form of war and peacetime rape. In the present case, the violence extends beyond this and encompasses other, interrelated violent events, such as the sterilisations but also contemporary expressions of obstetric violence such as contraceptive coercion. Therefore, it is possible to herein refer to a ‘continuum of violence’, based on those violences outlined above, as the violences experienced by Vilquinas may encompass the violences referred to by Cockburn (wartime rape) but go on to include many more additional violences. Furthermore, the plurality of violences attends to the differential yet interconnected violences that women experience as part of the intersectional inequalities faced in Peru more generally.

Importantly, the sterilisations do not stand alone in time; they occurred at the tail end of the Shining Path violence that shook Ayacucho particularly hard. While the Shining Path leader was captured in 1992 by the Fujimori government, only four years later the communities of (accused) ex-Senderistas in Ayacucho were being sterilised. It is important to remember that those health workers performing the sterilisations were the same people that worked before the PNSRPF and continued to work after it ended too- some until today. As Silvia mentioned, she knew who had taken her to be sterilised, it was “an obstetra from here, from the health post”. Had she had returned for treatment later on, she may have encountered the same person again working within the modified
FP service, suggesting continuity of health post protocol, potentially blurring any stopgaps on the continuum.

Significantly, the period of terror involved sexual violence towards women in the form of mass rape, and women in the department of Ayacucho were particularly affected by this (Boesten, 2010: 115). Although no interviews in the present study addressed this issue directly, it may be fair to conclude that a number of women in Vilcashuaman were likely affected based on the data that highlights the prevalence of sexual violence across the department (CVR: 2003:3).

Troublingly, Boesten (2010) makes clear that rape and sexual violence are not confined only to war time. She says that “the characteristic of vulnerability to violence, or the profile of victims has strong connections with peace time, which suggests the existence of something beyond a temporary ‘state of emergency’” (2010: 308). Therefore, the possibility of peacetime sexual violence rolling into state-sponsored reproductive and obstetric violence need be recognised. A continuum of violence towards women through war and peacetime begins to emerge, which Boesten states “forces us to examine the underpinning norms, values and institutional structures that normalize certain violences and exceptionalize others” (2010: 113). If those structures that perpetuated one kind of violence are still present it is futile to suggest that they would diminish along with the change of actor in the presidential palace.

Stavig also alludes to a continuum of violence when she highlights the historical context into which the sterilisations were inserted: “Forcibly sterilized campesina women conceptualized the violation of their rights: as part of a slow, 500-year genocide punctuated by moments of extreme violence” (2017: 176), a context which she notes was only addressed by the critical human rights feminists. Cockburn further relates these norms not to solely racial genocide as implied above, but to gender inequalities, arguing that:

"a gender analysis suggests that it is meaningless to make a sharp distinction between peace and war, pre-war, and post-war…gender is manifest in the violence that flows through all of them and in the peace processes that may be present at all moments too. To consider one moment in this flux in the absence of the next is arbitrary" (2004: 43).

In summary, violence is rooted in underlying structures that continue to exist outside of the changing case of politics or social movements, and this
continuum can be seen in regards to wartime sexual violence against women leading to obstetric violence against women’s sexual and reproductive bodies once more, using the FP service to do so. Further, Olujic suggests that when sexual violence is used in a war it can be seen as a weapon of torture against the victims (1998: 40). Forced sterilisation has also been analysed similarly, “satisfying the first requirement of the definition of torture” (Sifris, 2010: 523), under the UN convention against torture and other cruel, inhuman or degrading treatment.

In this light, to see oneself or to talk about others as ligada may be an expression and recognition of one’s insertion into this continuum of violence, rather than a claim of experience related specifically to a bracketed historical moment. That is not to say that all violences are equal. However, from the perspective of women who have experienced, and continue to experience sexual and obstetric violences, focusing solely on historical tragedies whilst oppressive relations of power continue to enact violence on their bodies may be problematic. As wartime rape rolls into peacetime, the expressions of violence against women’s sexual bodies arguably flowed into the sterilisation campaign. Do they then meander through to present day health post behaviours and obstetric violence that carries on? Problematically though, it is often only those obstetric violences belonging to the discrete period of FP under Fujimori that receive the most attention.

The present argument has not been to discount the experiences of those women (and men) who were sterilised under the PNSRPF but to draw attention to the historical context and ongoing continuum of violence, at times somewhat unaddressed amongst the noise of anti-Fujimorism. In this context it can be argued that to be ligada means to have been reproductively violated by the state health system writ large, and not only to have experienced a medical sterilisation during 1996-2000.

This is an experience that has had negative effects beyond those personally experienced by the patients. Arguably, this violence has affected an embodied fear towards the health posts, thus potentially encouraging a continuation of the continuum as fearful women avoid the health posts and as a result, as in Sandra’s case.
Reproductive Governance and Selective Attention to Events in the Continuum

The state is our enemy, the state is the patriarchy. The state sterilised more than three hundred thousand women. The state is a medium, but not the end goal of our struggle.


At present, this continuum of violence is not necessarily recognised by health/feminist NGOs and other actors who take an interest in, and campaign for women’s reproductive rights in Peru. It would appear that contemporary obstetric violence is not so large a concern as the past sterilisations, and it is necessary to explore the motives behind certain highlights and omissions in public knowledge of reproductive health in Peru, and who may be behind some of this32.

When it comes to the sterilisations, Ewig (2006) has previously discussed how feminist groups, (she specifically mentions Manuela Ramos), may have been slow to take action against reproductive health abuses as they had not only fought a hard-won battle against the Catholic church to have sterilisation legalised, but had also sat on various round-tables concerning the PNSRPF of the 1990s. Admitting the presence of reproductive abuse within clinics would be somehow proving the church ‘right’, and this could not be done.

In Ayacucho, and in Vilcashuaman specifically, at the time of the PNSRPF, Manuela Ramos and USAID’s reproductive health programme ReproSalud was also taking place. This programme was still mentioned by participants in the present study as a success, and here no direct criticism of ReproSalud shall be offered. This is the programme upon which Yon Leau’s report on Andean FP

32 In fact, I reiterate that myself, and other anthropologists with whom I have consulted, have not been immune to this bracketing either. For example, when the proposal for my doctoral research (and subsequent dissertation that you now hold) was just an embryo itself, I was advised by Andean anthropologist Andrew Canessa that in my project on reproductive health amongst the Quechua I needed a much stronger focus on the sterilisations. However, the data on which this chapter is based suggests the opposite; did I really need to focus more on the sterilisations? Why not contemporary obstetric violences? Why do we continue to think that this one element of the past is the most significant in the life of Quechua women? (responses in present chapter section).
preferences was made in 2000 and would have structured policy and approach towards desired rural FP preferences then and now, as was its intent. However, it serves to point out a few notes of concern.

From the dates and locations of research, it can be noted that not only was Manuela Ramos undertaking a reproductive health programme in the region remotely, but that they had sent in at least one anthropologist to rural communities to observe its success. Babb (2018) and Coe (2002) have argued that Lima feminist groups often overlook indigenous women’s issues as they are so removed from them in the city, and Ewig concurs that the lack of Lima-feminist understanding of the rural context led to a lack of sterilisation-alarm (2006). Yet, does this always stand?

We know that researchers were in the area at the time, researching FP preferences (Yon Leau, 2000) and infanticide (Larme, 1997, 1998), to name a few. These may not have been clinical ethnographies, but the presence of conscientious investigators during the PNSRPF does make one question the reasons why nobody noticed mass-sterilisations until Guilia Tamayo came on the scene in 1999 to write her report.

Here, Tamayo was credited as the main whistle-blower and praised for her activism efforts in forwarding women’s rights. Notably however, in a later interview with Maruja Barrig, Tamayo is quoted as calling the sterilised women an ‘ignorant population’ (2001: 36), suggesting that whilst she may have ‘done well’ in highlighting the problem, she did not necessarily respect the women or see them as equal to herself, a problem which Babb notes is ongoing today (2018).

It is acknowledged that it took a long time to take notice of the sterilisations, and it should also be acknowledged that the past was flung swiftly back into public conscientiousness only when Keiko Fujimori, the daughter of Alberto Fujimori, first ran for presidency in 2011. Whilst onlookers may have at first wondered whether a female president may have advanced women’s rights, this was quickly counteracted with a nod to her father’s disastrous FP programme (Olivas, 2011). Keiko ran again in 2016, and this time was publicly tied to clandestine abortions and risk to reproductive health, as well as feminist groups
highlighting her woeful lack of attention towards sexual health education. Far from being a champion for women, both of Keiko’s presidential campaigns were tarred by suggestions that she would not attend to the reproductive health of Peruvian women.

It was during Keiko’s campaign periods that the sterilisations came back into public focus. To give two successful examples of media campaigns during this time, we find:

1) The Quipu project, an interactive online documentary of testimonies whose stated aim is “to shine a light on the sterilisations” so that affected women may use the archive “in their fight for recognition and reparation” (Quipu, 2019), which was started in 2013, and, 2) Somos 2074 ('We are 2074'), a Peruvian campaign that was started by GREF (El Grupo de Seguimiento a las Reparaciones a Victima de Esterilizaciones Forzadas) (The reparation group for the victims of enforced sterilisations), which explicitly aims to seek reparations for affected women, and was started in 2015 (DEMUS, 2019)– also in time for Keiko’s second stint at presidential running.

In itself, the introduction of these campaigns is simply timely, and Keiko never did make it to become the president of Peru in part thanks to the negative press drummed up by such anti-Fujimorism campaigns. However, if it is so that Quecha women continue to experience obstetric violence on a continuum, why are these groups not focusing on this too? Indeed, Quipu’s publication materials do state that “our intention is…that these abuses will never be repeated” (2019), and yet potential contemporary abuses are not documented by them. Quipu came to Independencia district in the south of Vilcashuaman province to collect testimonies for their campaign and could have potentially observed similar situations to those (that will be) reported in this dissertation, but they did not report on this. Why do some such groups continue to overlook indigenous women’s issues whilst claiming to be champions of their reproductive health?

33 Quipu in particular could be questioned. Before even arriving to the field, I volunteered to translate and provide subtitles for their online interactive documentary as I was originally supportive of their plight. Upon arriving in Lima, I met the team, and being that we seemingly shared the same campaign for justice, all relations were all cordial until, it seemed, I started working in Vilcashuaman. On one particular occasion, I was invited to one of Quipu’s meetings in Piura, and made arrangements to attend (including purchasing bus and flight tickets – the journey between Ayacucho and Piura is rather far - an expense and plan that they knew I had made), only to be ignored repeatedly before the event. I could see that my WhatsApp messages had been read, thus this was not just a misunderstanding where my messages did not get
One generous explanation could be the limited approach of data collection within these organisations. Ramirez Hita (2013) has noted how, when researchers are working with rural health in Peru (and beyond), an ethnographic approach is sometimes thwarted by the demands of the employer. To put this in local context – Peruvian anthropologists and researchers may often be contracted to undertake research projects destined for a specific outcome of an NGO or other organisation – Yon Leau’s report on FP (2000) for Manuela Ramos is one such example of this. This lack of extended ethnographic research may, as Ramirez Hita observes, lead to the presentation of narrow realities – or to put it more bluntly- only seeing what one came to see. During my fieldwork I witnessed this mode of working first hand, when one Lima anthropologist (whose name, employer, and university affiliation shall remain anonymous) came to Willka Waman for a grand total of two days to compile a report for their employer on the work of parteras in the region. I sat in on the meetings, which barely scratched the surface of the realities that I had seen over months of research, yet even with such limited time the final report (potentially destined for policy) would be built on scant data and presented as authoritative.

Importantly, in the case of sterilisation reporting for example, this means that contemporary issues and the ongoing continuum of reproductive violence experienced can get overlooked as they are not on the (political) agenda. This arguably suggests a form of reproductive governance (Morgan & Roberts, 2012) on the part of those NGOs and campaign groups that have focused on the sterilisations. In selective reporting, and consequent selective attention from other interested political and civil society parties, including human rights groups such as Amnesty International, these groups have the ability to formulate and through, for example. Although the following accusation was in no way confirmed and is offered only by way of including a Vilquinas understanding of this organisation, when I complained about my wasted time and money to an informant/friend one day in Vilcashuaman, they responded that Quipu had been paying women in Independencia to provide their testimonies for the documentary, thus calling into question the authenticity of this campaign (and also potentially explaining the sudden coldness when I started fieldwork in that region). I did contact other members of the Quipu team later in Lima to try again to interview them and quash the concerns of this Vilquina, however the staff always gave the excuse that they were away at their beach house on the Lima coast and unable to meet, thus I was unable to follow any of this up. Consultations with two colleagues working specifically with feminist groups in Lima confirmed that they “would not be surprised” if the above were true, with one calling Lima feminists a “snake pit”.

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define those reproductive issues which they see as the most pressing, and simultaneously render others invisible.

This is not to criticise reporting on sterilisations in general terms, but to suggest that if Quechua women in Ayacucho do experience a continuum of violence as this chapter has argued, then omission (wilful or not) in reports, documentaries, and campaign materials can be seen as reproductive governance on the part of NGOs and campaigners. Furthermore, as the quote at the beginning of this section suggests, feminist organisations in particular see their own role as apart from the state, suggesting a civil reproductive governance divorced from the ‘enemy’ government.

Only when the full picture of obstetric violences against women are reported and addressed will change be able to take place. Until then only selective groups of women, here those who are on a list as having had been sterilised during 1996-2000, receive assistance and attention to better their situations. One does not need to be against this outcome in order to be for a more encompassing attention to obstetric violence against Quechua women, yet this has yet to be realised to a similar scale.

**Conclusion**

It serves us to return to the question of framing: how the past is framed, and how this interacts with the present. Or how it does not interact with the present, to be more precise. This chapter may have thrown up more questions than it has answered, however the remainder of the dissertation will seek to address...
those enquiries. Thus, one finds a situation in rural Ayacucho that is different though not unrelated to that which is presented in the mass media concerning reproduction in Peru. Women were sterilised against their will in Vilcashuaman, and it is important to emphasise that such violence is necessary to address and keep in the forefront of one’s mind, commensurate with the degree of women’s suffering. As the first part of this chapter has shown, even if women do not openly talk about their experiences with the health posts and sterilisations, the fear and negativity that they endured as a result of the PNSRPF does not simply disappear but arguably becomes embodied and passed on to other people, for example, Silvia’s post-sterilisation concerns being passed onto her daughter. This must be remembered; especially as later chapters will deal with prominent local fears towards contraception in Vilcashuaman (principally cancer).

However, other lines of enquiry also emerge from these experiences. The suggestion that the sterilisations may have been over-reported upon, much as the deaths were in the TRC (Rendon, 2019), could suggest that certain parties have motives for doing so and exaggerating visibility of this issue to a global audience. This arguably suggests a ‘politics of life’ (Fassin, 2007), which can be seen as a politics that “give specific value and meaning to human life” (500). This differs from biopower as it does not refer to the governing of populations, but instead the evaluation of human beings and existence, in Fassin’s case through allocation of humanitarian aid. Here, the exaggerated visibility of female sterilisations could be seen as a ‘politics of life’, whereby lives taken due to this specific obstetric violence are presented as more valuable than those lost in other contexts (e.g. the war, or contemporary violences for that matter). Again, here the motive is certainly not to discount any woman’s experience of sterilisation or offer any support towards the government that implemented such a FP campaign, but to interrogate the situation as it has been here presented. In this, one can return to Reyna’s testimony, first presented at the opening of this chapter. It followed Silvia’s testimony of sterilisation, which itself is in keeping with other testimonies presented by Quechua women of their sterilisation. Reyna’s testimony, however, is completely different. She directly references an ability to reject and escape sterilisation, even after putting her name down on a list (giving her ‘consent’). These stories are not presented in
the campaign materials of groups such as Manuela Ramos or Quipu, most likely because they would introduce a modicum of doubt if not to the validity of indigenous women’s testimony then at least to the generally-accepted force and insinuated evil of the health workers involved in the PNSRPF. The ability to present some information and invisibilise other information suggests that NGOs in Peru, working towards justice for sterilised women and other matters, are enacting reproductive governance and a politics of life. Although it should also be recognised that these concepts are somewhat limited in their sweeping generalisations – not all NGOs or activists work in the same way, of course – they are useful to help us begin to understand the landscape of post-sterilisation campaigning in Peru. Based on their campaigns, certain groups of women may receive reparations for what they have suffered. Now, no one is suggesting that this is wrong. However, it allows an omission of other obstetric violences from public notice. This brings us onto a reflection of the second point, which is that women in Vilcashuaman have suffered numerous violences on their sexual and reproductive bodies, from war-time rape to sterilisations to contemporary obstetric violences and contraceptive coercions. There is no one space in time where violences were performed against them, but an ongoing continuum of violence. Focusing narrowly on one bracketed time period allows public focus to omit the others, thus giving some NGOs the ability to select which reproductive issues are more important than others. Frustratingly, this approach does not necessarily improve the experiences of women in Vilcashuaman today.

Whilst this chapter has focused on experiences, both of the past and present, in and outside of the biomedical setting, the following chapter will turn its gaze to more in-depth focus on the MINSA health establishments themselves. Attention will be given to the ways in which (racialised) subjectivities are manipulated through the health centre’s FP programme, and a discussion on the ways in which Quechua women are disciplined into accepting such subjective impositions will be presented.
Figure 4.1. A young woman reads the signs on the door of a family planning consultation room.
FOUR
FAMILY PLANNING

When one first approaches the maternity building at the Willka Waman central health centre they will see the main entrance emblazoned with the words, “Tu decide en que posición” (Figure 4.2). “You decide in which position”, a reference to the 2005 MINSA Intercultural birthing initiative that aimed to merge ‘Quechua’ birthing practices with biomedical ones in a bid to reduce MM in the country through the complete transfer of all rural births from home to hospital. A rope and birthing stool stand in the corner of the labour room, lost amongst the biomedical implements and hubbub, and usually in darkness. Here lies the ‘proof’ of the Peruvian State’s intercultural approach to birth and reproductive health, their face to the world. I once happened across a photographer from the Lima-based indigenous organisation Chirapaq who was standing outside this entrance, his DSLR camera snapping away at the encouraging words pasted onto the building. Perhaps those images would be used to evidence the existence of interculturality within rural health posts, I wondered. If so, they would be misleading.

Just as Guerra-Reyes found in her study of the intercultural birth initiative in Peru (2013; 2014), I too never happened across the policies’ real-life implementation. The vestiges of the policy represented inclusivity in the images, but not in practice. A further example comes from the inclusive-language used in maternal-health displays within the health centres. Across one wall a series of women (identifiably Quechua with their clothing and hair) displaying the different causes for alarm during pregnancy is accompanied by Quechua explanations (figure 4.3). At first glance, pregnancy appears to be a Quechua-inclusive event within the health centre. However, Guerra-Reyes concludes quite strongly that this initiative “only supposed a change in the discourse, but not in the practice of health care, and that the Intercultural birthing policy merely provides a veneer of cultural resect while functioning as a mechanism of reproductive governance (Morgan, 2012)” (2014: 1). Guerra-Reyes’ study was undertaken in the Northern Andean department of Cajamarca, a region demographically similar to, but historically distinct from, Ayacucho. In the
southern Andes there has been apparent intent to promote intercultural education beyond that which may be found in other areas of Peru.

As mentioned in the introduction, in 2003 the San Cristóbal National University of Huamanga (Universidad Nacional de San Cristóbal de Huamanga) (UNSCH) was the first in the country to implement a 'Diploma in Intercultural Health' (Guerra Reyes, 2013: 60). Although this course has since been discontinued, there are other ‘interculturally-themed initiatives that remain within the University’s medical school. For example, nursing students take a course in 'traditional medicine', for which their parents must attend in final sessions in order to share their own experiences of ‘traditional’ medicinal plant use in Ayacucho (Cabrera 2017: 143).

Walsh has argued that interculturality is a ‘necessary component’ towards decolonisation (2012), and Menendez has referred to the use of intercultural medical teaching in Mexico, similar to that described in Ayacucho, as one way to challenge the hegemonic medical model (model medico hegemónico) (MMH) that has resulted as a constant expansion of the biomedical discourse and discounts other forms of medical knowledge that fall outside of its discourse (Triana Ramirez, 2017: 268). Cabrera also references the expansion of ‘science and technology’ into the Peruvian health care system, which he sees as part and parcel of globalisation and the implicit dominance of the occidental world. However, he concludes that whilst this is not necessarily a bad thing, as a result “the ancestral medical system will continue to be invisible for western rationalities” (2017: 42), suggesting that a genuine intercultural health system is still far away from realisation.

Castro-Gomez further suggests that the authoritarian dominance of Western forms of scientific knowledge, here biomedicine, serves to maintain the legitimacy of coloniality (2013: 287).

With that in mind, and despite the attempts to promote intercultural birth, Ayacuchan health institutions also show similarities to those studied by Guerra-Reyes in Cajamarca, perhaps reflecting a more pervasive nation-wide (and continent-wide) approach to intercultural health. Menendez underscores how interculturality as a concept is a constant process and is not a recent occurrence within medicine nor society; intercultural processes always occur
whenever different societies come into contact (2016), and Cabrera expresses similar sentiments (2017). Yet within health policy this term may have been somewhat co-opted to achieve, as Guerra Reyes suggests, a policy-in-discourse-alone in order to forward coercive practices through reproductive governance (Morgan, 2012), disguised as an initiative to reduce MM (Guerra Reyes, 2013: 257). Furthermore, she concludes that the intercultural birthing policy in Peru forms part of an “aspirational whitening process that accompanies the creation of an urban persona” (261) when directed towards indigenous women; its aim is to create a woman who associates with and makes use of biomedicine, with all of its related associations to whiteness and urbanity. It was not to attend to the ‘cultural’ aspect of patient’s birthing experiences as it claimed. Here, interculturality is used only as the carrot with which to entice indigenous women into hospitals where they can be whitened and urbanised through biomedicine’s modernising touch. However, this focussed only on birthing; women were already within the health establishment’s consciousness, unlike FP which is not necessarily a compulsory service (in all circumstances). Furthermore, birthing is an event that has occurred long before the biomedical framework of knowledge transversed the ocean with colonialism, thus there are definitive pre-colonial and/or ‘indigenous’ elements that could be co-opted for incorporation into biomedical birth (albeit mainly material elements). On the other hand, contraceptives and FP, whilst existent as a concept that people have had access to for as long as birthing, are distinctly ‘biomedical’/‘modern’ in a different way as biomedical contraceptives and health centre FP are deeply imbued with discourses around the ideal family and (moral) comportment of sexually active individuals.

So, how does family planning fit into the intercultural health schema?

There is no dedicated ‘intercultural family planning’ programme in Peru. This may be because ‘family planning’ as the concept and discourse within MINSA finds no real parallels with a ‘cultural’ FP: it is purely biomedical, in a way that birthing is not. Birthing obviously existed long before the existence of modern health institutions, and therefore so did the development of cultural (read: non-
Figure 4.2. ‘You decide in which position’, Willka Waman.

Figure 4.3. ‘Signals of Alarm’ in Quechua, Willka Waman (Left to right: ‘Bleeding, Water, Fever, Swollen hands and feet’
biomedical) ‘elements’ ripe for co-optation (such as the use of sheep’s wool\textsuperscript{34} to wrap the new-born, herbal remedies\textsuperscript{35} or post-partum ‘chumpi’\textsuperscript{36} belts, as per the Peruvian case). Modern ‘family planning’, however, has not existed in the same way. This is of course not to suggest that people have not been conscious of pregnancy prevention or have not employed methods to do so before the advent of modern (hormonal and barrier) contraceptives. There is evidence of an ongoing use of medicinal plants for contraceptive use across the Andes (Maynard-Tucker, 1986; Bussmann, 2010; Necochea Lopez, 2014; Gonzales de la Cruz, 2014), as well as the employment of intentional behaviours for contraceptive purposes (e.g. carrying heavy loads, undertaking strenuous physical work) (Hammer, 2001). Furthermore, the 2014 Demographic Health Survey (DHS) for Peru found that 22.4% of women still used ‘traditional and folkloric methods’ of contraception across the country (2014: 146), suggesting that non-biomedical practices remain active today. Included under the rubric of ‘traditional methods’ are periodic abstinence, withdrawal and ‘folkloric’ methods (138), although the ‘folkloric’ contraceptives remain unspecified. However, these methods falling outside of the modern biomedical family of contraception are not specific to Quechua or other indigenous communities (apart from perhaps ‘folkloric’ methods), and so could not easily be subsumed under an ‘intercultural’ banner that purported to tailor hospital services to this demographic. That said, why are folkloric methods not integrated into an intercultural model of family planning?

The simple answer is that these methods, mostly comprising of plant-based medicines, amulets and rituals, are not seen as reliable contraceptives (Maynard-Tucker, 1986: 308). Based on a perceived lack of scientific validity, they have no place within the biomedical health system. Furthermore, there are those within MINSA who would see these methods as deliberately abortifacient rather than contraceptive. As this is illegal in Peru it would be difficult to

\footnotesize
\begin{itemize}
  \item \textsuperscript{34} In Vilcashuaman, sheep’s wool is an important part of health care practice as it protects from Aire; an ethnomedical illness that is produced because of contact with the bones and/or carcasses of the dead, and/or a sudden change in temperature. Post-partum women are also at risk of contracting Aire as their bodies are left more ‘open’ after birth (Gonzalez, 2017: 183).
  \item \textsuperscript{35} Hampi; or medicinal remedies that cure the post-partum body (La Riva Gonzalez, 2017: 173). Other herbal remedies such as waltasqa, made from various Andean herbs including coca and rosemary, may be drunk to ‘close’ the ‘open’ post-partum body (Huaman, 2008: 24).
  \item \textsuperscript{36} Chumpi: the post-partum body is tied with a belt right after childbirth, otherwise the womb may start to wander and end up in the heart, causing death (Huaman, 2008: 24).
\end{itemize}
integrate ‘cultural’, ‘folkloric’ contraceptives into a health network that is bound to a specific law of governance.

FP in Ayacucho is therefore able to carry on under a strict biomedical discourse with no interruptions from those concerned with intercultural health policy. That is not to say that it does not interact with the intercultural birthing policy discourse, as indeed they are deeply entwined. However, with no need to allude to cultural sensitivity, the FP programme is free to pursue a staunch biomedical relationship to contraception and to the associated discourses of modernity related within.

This is apart from the token references to ‘natural’ or ‘traditional’ methods such as post-partum lactational amenorrhea for example, which is referenced in leaflets and FP literature. Yet like the intercultural birthing elements that are forgotten in practice, so too is this method, with post-partum breastfeeding women receiving hormonal contraception as a matter of protocol in Vilcashuaman, rather than encouraged to exclusively breastfeed for the recommended six-month period.

The following chapter will explore the question of biomedicine, (‘aspirational’) whiteness (Guerra Reyes, 2014) and FP as it relates to the health network in Vilcashuaman by focusing first on the MINSA literature and propaganda within the local establishments themselves.

This will lead to a discussion on how the Peruvian ‘branding’ of ‘Marca Peru’ is present in FP, and the associated discourses that this brings in relation to an imagined community (Anderson, 1983), the ‘New Peruvian’ (Lossio, 2014), and how this relates to the coloniality of power (Sajines, 2013).

It will then turn to a more theoretical discussion of discipline and docility by examining women’s ‘reproductive privacy’ (or lack thereof) (Bridges, 2017). This chapter will ultimately aim to present and discuss the various ways that the health posts influence subjectivity to their own ends.

**Biomedicine, Whiteness, and Family Planning Discourse**

The recent history of FP in Peru has reflected a pervasive discourse of ‘aspirational whiteness’ (Guerra Reyes, 2013: 261), not only due to contemporary policy implementations but also through the health programme advertisements that were scattered across the country. As touched upon in chapter one, this concept refers to the notion that social ‘whiteness’, through
behaviours and activities that influence a person’s [social] ‘race’ (but not their skin colour necessarily), is presented as an aspiration which one is encouraged to pursue in order to improve themselves and their lives. However, as race may be seen along a ‘continuum’ in Latin America, this leaves both flexibility and ambiguity within the concept. For example, one may be born into a ‘Quechua’ family, yet seek aspirational whitening through self-presentation of dress, but this still might not make someone necessarily ‘socially white’. On the other hand, becoming white may be imposed upon people as a concept to which they are expected to aspire, for example, through state health campaigns that present ‘whiteness’ as inherently desirable and aspirational, and indigeneity as the opposite. These kinds of campaigns have been seen historically in Peru. Back in the later 1960s the Peruvian state had begun to overtly juxtapose the undesirability of supposed rural, indigenous ‘uncontrolled fertility’ with urban, whiter ‘controlled fertility’ (Necochea Lopez, 2014: 6) (Figure 4.4).

Moving onto the 1990s and FP campaigns, Ewig (2010) discusses two examples of MINSA advertisements and notes how the particular representations of decrepit, rural indigenous families juxtaposed with white, urban success stories contributed to the eventual programme of sterilisations and ‘eugenics’ of Fujimori (2010: 153-155). She states that, “in the form of posters, billboards, and calendars hung on state health clinic walls advertising in poor urban neighbourhoods, in a neo-Malthusian vein, emphasized that more children would cause greater poverty” (153). One Lima poster to which she refers “send[s] the message that fertility control can lead to an elevation in class status” (2010: 154) (Figure 4.5). A billboard exhibited in rural Ayacucho “telescopes a racialized message. By controlling one’s fertility, one will “Live happily”, as the billboard states – and apparently simultaneously become white and lose indigenous cultural traditions” (155-156) (Figure 4.6). Such propaganda implicitly suggested that one could whiten oneself through FP, and as Guerra Reyes concludes, these ideas remain in regard to birthing policy. However, Ewig’s examples occurred in the run-up to the sterilisation

37 Ewig does not use the word ‘propaganda’ for these ‘advertisements’, however this is an appropriate term, based on the Oxford Dictionary definition (Oxford Dictionary, 2018); “Information, especially of a biased or misleading nature, used to promote a political cause or point of view”. These family planning ‘advertisements’ were political and biased, directed towards the acceptance and dissemination of both racist ideologies, and a ‘eugenicist’ health campaign (Ewig, 2010: 154).
programme some twenty years ago; after that tragedy came to light, one might expect that such brazen discrimination might have ceased. If so, one would be wrong. Although contemporary FP propaganda is cautious not to be so extremely blatant in its promotion of discourse, there are subtleties remaining that allude to a continued relationship between biomedical FP and aspirational whiteness. The propaganda that can be found within local posts and health centres is arguably the most obvious (although it should also be remembered that in the
Figure 4.5. ‘Family Planning poster in an urban health post’ - ‘Only you can decide how many children to have’. In Ewig, C. Second-Wave Neoliberalism: Gender, Race, and Health Sector Reform in Peru (Penn State Press: Pennsylvania), 154.
Figure 4.6. ‘Family planning billboard in rural Ayacucho’. In Ewig, C. Second-Wave Neoliberalism: Gender, Race, and Health Sector Reform in Peru (Penn State Press: Pennsylvania), 155

Figure 4.7. Family Planning Consultation Room Poster, Vilcashuaman.
first of the following examples these are the personal choices of health workers themselves, and not state-mandated).

The first image (Figure 4.7) hangs on the door to the FP consultation room in the village of Pilpintumarca. The message is so plainly obvious that it is impossible to miss. White, blonde people (the likes of which do not even really represent average urban *mestizo* Peruvians but those of European descent, the whitest of the white) are people who use FP services. Therefore, the message is sent that *if you use these services, this is the kind of person you are emulating*. This image was traced from an official poster (in which the people had black hair and white skin, but no other identifying features). It is usual for health workers to create their own displays based (with varying degrees of fidelity to the original) on official campaign materials.

The second example is of the painting that hangs in the birthing room of the larger health centre in Willka Waman (Figure 4.8) Here, FP is not specifically mentioned, however due to its room placement it can be surmised that it is also intended to represent certain aspirations for those new mothers that are left

![Figure 4.8. Post-partum room painting, Vilcashuaman.](image-url)
staring at it all day (as they often were). The woman is of clear indigenous
descent, however the baby that she is holding is noticeably much whiter than
she is. Were this not in a birthing room one might read the image differently,
perhaps of an indigenous maid or empleada\textsuperscript{38} caring for the racially whiter child
of her employers (and that may have been the artist’s original intention). Yet
when placed in a birthing room it arguably sends a different message; If one is
indigenous then one must aspire for one’s children to be whiter than oneself.
Aspirational whiteness again presents as a concept within the health centres,
here through promotional materials.
Although these examples could be brushed to one side as mere expressions of
local health worker discriminations that are not representative of the wider state
health system, it is wise to remember Foucault’s “microphysics of power”
(1979: 26, quoted in Lynch, 2011: 22); the theory that power is not always
necessarily imposed from the top of a hierarchy, as was once the case under
sovereign power, but that power can be affected from below. If we are to
investigate power relations, this is where we must begin; “power develops in the
first instance in specific, local, individual choices, behaviours and interactions”

If one then turns to the State’s offerings in the form of the ‘official’ FP leaflet
(produced by the Ayacucho regional MINSA), it is most anti-climactic (Figure
4.9) (see appendix 4.1 for the full leaflet).
Martinez (2018) argues that the analysis of health pamphlets within public
health settings in Latin America can be very useful in understanding the ways
that wider discourses are promoted, explicitly and implicitly, to patients. She
suggests that health-leaflets can be illustrative in “locating race (racism), gender
(sexism), and class (classism), and framing these social phenomena within their
historical and political contexts” (2018: 113). Thus, an analysis of Andean
subjective imagery and health discourse within health post leaflets will be
explored to unpack issues (-isms) represented through this literature.

\textsuperscript{38} Domestic worker
In the MINSA FP leaflet in Vilcashuaman the representation of FP users shows characters that, whilst their skin is a light colour and their clothes are not ‘indigenous’, is not obviously discriminatory either. They have black hair, and the woman on the front is wearing pigtails; not quite the indigenous plaits, but closer to it than blonde curls. When examined on its own and out of context this leaflet provides little evidence towards whitening aspirations within the contemporary FP discourse.
However, when considered in context amongst the range of propaganda leaflets for other medical (reproductive) concerns, an inconsistency can be noticed. In the leaflet for pregnancy related anaemia, the woman and her daughter wear plaits, and the husband wears a bowler hat (Figure 4.10). They are indigenous. In the leaflet about pregnancy testing, the woman wears plait, a long skirt and shirt/cardigan combo.
Figure 4.11. Pregnancy Leaflet, Vilcashuaman.

Figure 4.12. Pregnancy Risks Leaflet, Vilcashuaman.
(typical of Ayacucho) (figure 4.11). She is indigenous. In the information sheet concerning warning signs during pregnancy, again the woman depicted wears an indigenous hairstyle and clothing (figure 4.12). There is evidently no conflict between representing pregnancy and its associated problems with indigeneity; indeed, these information sheets are consistent with the idea behind the intercultural birthing policy. It is the FP propaganda that moves away from these ideas; slowly, and gently, but nevertheless present. Compared to Ewig’s examples the contemporary insinuation between use of FP and improvement of class and ethnicity is subtler but has not disappeared.

It must be noted that these are the only examples where aspirational whitening and FP is explicitly linked, but this does not mean that it is limited to pieces of propaganda. It can be found in the discourses surrounding professionalisation, migration, and subjectivity, as will be addressed in subsequent chapters.

Figure 4.13. Family Planning leaflet introduction, Vilcashuaman
To return to the propaganda; the FP leaflet might subtly promote aspirational whiteness, but that is not all it does. It also frames FP and pregnancy in a specific way that aims to serve certain ends.

The inside cover of the leaflet reads:

Why is family planning important? You protect your life and care for your health. All pregnancies have risks...why would you risk your life and your health for unnecessary risks with an unwanted pregnancy? Many abortions in bad conditions or undertaken by an unqualified person have killed thousands of women across the world. If you use contraception you are also caring for your health by avoiding a pregnancy when you are very young...or old...you also will avoid having children too frequently...which can be damaging for your health, and that of the baby (figure 4.13).

Here, the very first motive given for use of FP explicitly states that prevention of maternal mortality is the key reason to avoid unwanted pregnancy. It assumes that unwanted pregnancy would be damaging to a woman’s health due to her apparently inevitable mistake of seeking clandestine abortion and frames the choice to use FP as one of self-care. However, it also frames “all” pregnancies as inherently risky and dangerous. Furthermore, it suggests that the way in which to manage this inherent risk is through biomedical intervention which in this case is through biomedical contraceptives. This echoes an ongoing global trend towards the (bio)medicalisation of women’s reproductive health (Inhorn, 2006) and the pathologisation of the reproductive body. The key reason to use contraceptives, the leaflet suggests, is for health concerns.

As Davis-Floyd shows in her ongoing work focusing on childbirth in the United States, pregnancy has undergone a transformation from what was once considered a natural, woman-led experience to one which is both technological and technocratic in nature, approaching the birthing body as inherently pathological and risky (1992; 1987). David-Floyd calls this paradigm the “technological model of birth”, in which women’s bodies are conceived of as faulty machines that require technical intervention in order that they work properly. This is achieved through procedures that deconstruct “the natural process of birth...into identifiable segments”, which are then “reconstructed as a mechanical process” (1987: 484). The technician in Davis-Floyd’s work comes in the form of the biomedical surgeon, tinkering with the failed cogs and levers of a woman’s reproductive system using his cold-metal medical tools. Similar
sentiments towards the reproductive-body-as-machine are discussed in Martin’s work on the North American female body (1987). In this work Martin argues that the reproductive body is represented as a failed machine in popular science understandings of the reproductive body, to which she contrasts the male reproductive body which is hailed as exemplary. More recently, Bridges (2011) suggests that the production of ‘risky’ populations, such as through the implied riskiness of all pregnancies as in the current Peruvian case, has the ability to coercively affect new subjectivities (2011: 170). However, Bridges goes beyond mere signposting of the ways that pathologizing the reproductive self can influence self-perception, writing that “the imputation and projection of risk is just one medical discourse, just one medical practice, that deeply affects the individuals it encounters and who encounter it” (169). This process creates biosocialities, and technoscientific identities, she claims (169-170). As in, the act of presenting the pregnant body as inherently risky and in need of biomedical intervention can influence women’s bodily subjectivities so that they too begin to embody this viewpoint and, consequently, seek the inferred biomedical care to combat their own inherent bodily riskiness.

The focus on MM in Peru that led to the introduction of the intercultural birthing policy as a way to combat the problem could be seen as initiating this discourse. It was, and still is, considered that giving birth at home with a traditional partera and away from the biomedical care offered at the MINSA establishments is a risk in all cases, suggesting that the pregnant body is somehow inherently risky (and that indigenous births with indigenous midwives are all risk-filled). This is confined to the indigenous, rural populations, as middle-class Limeñas (Ingar, 2016) and wealthier women across the world ironically have more access to homebirths (MacDorman et al, 2012). Zadoroznyj suggests that “the social and cultural context in which women give birth tells us much about society’s core values” (1999: 267), and in the current case, this then suggests that MINSA’s core values undervalue indigenous women’s choice making.

The intercultural birthing policy may have been the first to alter their racialised, biosocial subjectivities and infiltrated people’s self-perceptions through a

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39 Biosociality is a concept developed by Rabinow (1992; 1996) that refers to the entanglement of the social with the bio, or a form of understanding the social based upon the biological. In this
promotion of aspirational whiteness and biomedical reliance, but the FP discourse completes the job. Dangerous, risky reproductive bodies need the intervention of biomedical contraceptives to manage them, otherwise you risk dying like the “thousands of women across the world” who did not heed the advice of their doctors. Furthermore, as ‘all pregnancies have risks’, there is no moment of escape or relaxation. You must use contraception forever, it is implied, because each and every pregnancy that you undertake will risk “your life and your health”. Furthermore, now that women have come to understand their reproductive bodies as dangerous and risky if left unattended, they are encouraged to incorporate biomedical care into their lives as a constant.

This does not necessarily gel with the Quechua notions of corporeal subjectivity and personhood, particularly as this applies to inherent medical ‘risk’ in pregnant bodies, as Quechua parteras exemplify in their practices.

Teofilia was an eighty-seven-year-old partera who had lived her whole life in Willka Waman. She had learned her practice from her mother, who had learned it from her mother before her too. Despite the health centre’s policies to stop women visiting parteras, Teofilia claimed that most pregnant women in the town would continue to visit her before their due dates for a quick check up. The reason for their visits, she suggested, was to ensure that the baby was well-positioned, as a partera can physically manipulate the foetus in-utero to avoid a breech birth, a practice which is considered too ‘risky’ by MINSA biomedical standards. However, the real risk to women was perceived by Teofilia as emanating from the health centres, and not the inherently ‘risky’ pregnant body, as the MINSA discourse suggests. Teofilia suggested that women visit her before entering the obligatory biomedical birthing arena to ensure that they were physically optimum before entering the ‘risky’ health centre environment where they could be poked, exposed, cut open, drugged, and more, if and when the obstetras found reason to do so. Above all, health centre births carried the risk of caesarean, which were physically and emotionally taxing for women. For Quechua subjectivity, it is not necessarily the pregnant body that is the risk, but the health centres themselves are the potential source of ‘risk’. That said, Vilquinas may increasingly come to perceive pregnancies as inherently risky,
and therefore in need of limitation and spacing, as biomedical discourse becomes more embodied over time.

Indeed, power structures and their ability to form the way that one views and interprets their body, their subjectivity, is an important dimension of coloniality. As Schiwy notes, “the construction of subjectivity is the third dimension of the coloniality of power” (2014: 128). One’s subjectivity and particularly a subjectivity that is not Eurocentric is portrayed as an impediment to development (Quijano, 2000), resulting in the pressure from colonial powers to alienate oneself from this subjectivity in order to achieve the ‘desirable’ [Western] ‘modern’ self (Segato, 2015: 51). As Mignolo noted, the coloniality of power serves over varied domains, of which formation of subjectivity is one (2013: 3). In encouraging Quechua women to subjectively see the pregnant body as inherently risky, the saviour of which is presented as the [white/Eurocentric] biomedical establishment, and particularly the uninterrupted and faithful use of biomedical contraceptives, this subjectivity is formed as inferior and weaker in relation to an imagined hierarchy of racialised persons, as Quijano has suggested be the case (2000).

Therefore, the pathologizing and promotion of the risky reproductive body that extends from the intercultural birthing policy to the family planning rubric in Peru may encourage alterations in practices of the self and, ultimately, corporeal subjectivity, resulting in an increased indigenous-reliance on biomedicine to rescue them from invented dangers and the new threat posed by the racialised unruly self. Furthermore, as Guerra Reyes (2014) argues, this new subjectivity ties in with aspirational whiteness in Peru, thereby contributing to an intersectional change in subjectivity of self.

Indeed, the discourses promoted within family planning propaganda in health centres is not limited to local or overtly racialised understandings of the subjective self either but extend to wider understandings of the nation and one’s place within it. Specifically, family planning propaganda in Ayacucho promotes an image of Peru’s nation branding campaign of ‘Marca Peru’, a country brand that speaks to a specific kind of ‘imagined community’ (Anderson, 1983) built upon a wholly racialised nationalism that does not necessarily acknowledge or
include Quechua people as members without an implied necessary subjective change of self.

Marca Peru and Family Planning

A spiralled ‘P’ and the name of the country forms the ‘Marca Peru’ brand image. This increasingly distinctive brand for Peru has slowly gained mounting traction internationally and it can be found printed onto almost anything in the country – t-shirts, bags, hats, surf boards, trucks, planes- it is even now minted onto Peruvian one-sol coins. As someone who first visited Peru a few years before the creation of Marca Peru, I can remember a time when a souvenir would have come without the fancy lettering. Now it is inescapable, even in remote regions it finds its way onto a community wall, a child’s notebook or the side of a van. Indeed, the very reason behind its creation was to achieve a far-reaching influence and coverage- a symbol of and for Peru. A particular kind of Peru, that is, made up of a particular kind of racialised Peruvian. 

Marca Peru is not only displayed within commercial advertisement. Importantly, it is being used as a subtle but highly significant communicative mechanism in FP propaganda within rural Ayacucho (Figures 4.14; 4.15). These images are found most often on the doors of FP consulting rooms where they are easily visible to all patients, whether women who are attending FP consultations or others who are passing, thus their reach is wide. Marca Peru sneaks its way onto the campaign of the health network in Vilcashuaman: ‘Planifica tu familia para vivir mejor’ (plan your family to live better), promoted by the central Ayacucho MINSA directorate and elaborated from the larger national campaign ‘Planifica tu futuro’ (Plan your future), in which specifically poorer, rural Peruvians were stated as key targets for intervention (see appendix 1.1). The P of ‘Planifica’ (Plan) is the distinctive P of Marca Peru. It is not necessary to include the rest of the Marca Peru logo as it is the ‘P’ that is important (being that it is the emblematic design of the campaign around which the rest hinges).

40 This particular image displays a family that could be considered more ‘Quechua’ than the images on the other ‘Marca Peru’ image and the FP leaflets. However, note how the family is presented as small and nuclear, with just one daughter. As a preference in the Andes is for sons (or one of each, failing that)(Yon Leau, 2000), this image arguably implies that a [Quechua] family that ‘plans’ remains small with one child, even if the gender of that child is not the desired one. Thus, it contributes to the wider discussion of ‘modernity’ as non-indigenous in a more subtle, yet no less impactful, way than the other examples.
However, what is particularly important about the use of *Marca Peru* within FP is what *Marca Peru* itself stands for and promotes, and further, what kind of Peruvian *subjectivity* it promotes.

*Marca Peru* is a nation-branding campaign which was first released in 2011. Like other country-branding campaigns it operates “as a technology of power in the configuration of emerging cultural and political formations such as national identity, citizenship and the state” (Canepa, 2013: 7). This symbol is positioned to represent the *new* Peruvian nation, and thus reflects elements of this ‘nation’ as it is imagined by those who have the power to create that projection. The visual includes a swirly white ‘P’ against a red background. These are the colours of Peru’s flag and so represent the nation that is ‘Peru’. The spiral graphic is a symbol found in many of Peru’s ancient cultures and the legacy they left behind. Geocentric circles and other ‘swirls’ can be seen in different geographic regions and from disparate groups of ancient peoples across the country, such as in the Nazca lines (Ica), Caral (Lima), and Moray (Cuzco), for example.

Using a symbol that is synonymous with a pre-colonial past conjures images of the ‘Andean Utopia’ (Galindo, 2015) that has long been sought as a romanticised ideology by those who were colonised. This pan-Andean concept, introduced in Galindo’s *In Search of an Inca* (2015)[1986] was/is the project to confront the current realities, and “an attempt to reverse dependency and fragmentation, to search for an alternative path in the encounter between memory and the imaginary: the rebuilding of Inca society. And the return of the Inca ruler” (2015: 5). From this, even today one finds that “reference to the Incas are common in speeches. No one is surprised when people offer ancient technology or presumed moral principles as answers to contemporary problems” (2015: 5).

However, when we see a perceptibly pre-colonial Andean and/or Incan imagery in promotional campaigns such as *Marca Peru*, it must be understood as referring to a specific understanding of pre-colonial Peru that is not necessarily based on inclusivity. As Lossio muses, “Principally in Peru today, we are not just ‘In Search of an Inca’, but also ‘In Search of a Brand’” (2014: 13) (emphasis
Figures 4.14, 4.15. ‘Planifica tu familia para vivir mejor’, Marca Peru Family Planning campaign stickers, Vilcashuaman
added), thus allusions to inclusive, potentially decolonial utopias must be understood within this incompatible context of neoliberal branding.

In fact, Galindo’s concept of the Andean utopia, of returning to a perceived world of greater equality before the conquest and under Inca rule, may reflect a somewhat romanticised version of the pre-conquest past; “The Inca Empire is a sort of inverted image of Peruvian reality: it appears to be the opposite of the dramatic injustices and inequalities of Peru today” (2015: 7), he states. Furthermore, it is pertinent to bear in mind that symbols that glorify the Incas, although they might appear on the surface to refer to Andean peoples, and specifically contemporary Quechua peoples, are not necessarily in their benefit at all. Barrig notes a common maxim in regard to the Peruvian state’s treatment and view of how the indigenous should be presented and/or come to subjectively see themselves: *Incas Si, Indios No* (Incas Yes, Indians No) (2001: 30). In *Indigenous Mestizos* (2000), De La Cadena builds upon this, and unpacks how the concept of *Indigenismo* and the increased attention to the Inca past, such as in *Marca Peru*, became taken up by the Cuzco elites. She argues that elements of contemporary Quechua life (for example, language and traditional dress) were adopted by elites in their self-promotion as the ‘noble Inca’, an identity opposed to the oppressed state of the now-denigrated Quechua peasants. Thus, this referencing of the Inca symbolism in nationalistic campaigns like *Marca Peru*, this *Incanismo*, is not an inclusive, decolonising, utopic project at all. Van de Berghe and Flores Ochoa argue that *Incanismo* and the increased “reverence for the Inca past and for all aspect of indigenous culture, including the Quechua language…are elite phenomena” (2000: 7). So, this must be considered in the discussion of *Marca Peru* and its glorification of a specific kind of exclusive Andeanness that *Vilquinos* do not necessarily satisfy.

However, the P does not just refer to the nation’s history but represents a symbolic link between past and future ‘Peruvians’ as well. This representation of a shared humanity can be found in the human fingerprint one can visualise in the swirl. Incidentally, fingerprints are more than mere symbols for illiterate Peruvians, who are most likely to be rural and female (Ewig, 2010). Fingerprints are used in lieu of a signature on official documents and are always provided within the health posts as patients must ‘sign’ and/or ‘fingerprint’ before being able to receive medical care. Thus, the fingerprint may be principally associated with others within an ‘imagined nation’, but importantly for Quechua and other
people who rely on state services (with the associated paper-based bureaucracy), is additionally associated with their dealings with the state. *Marca Peru* is further associated with [Western] ‘modernity’ and the technological age as the ‘P’ invites comparison with the ‘@’ sign; a symbol of modernity and the age of the internet (Garcia, 2011).

All of these elements – the pre-colonial, supposedly ‘utopic’ Inca history, past and present humans of Peru, and discourses of modernity, are cleverly combined in *Marca Peru* and the new construct of nation. Canepa (2013) calls this a ‘technology of power’, that offers “a set of narratives, repertoires and a roadmap for Peruvians to rehearse, play and perform as the *New Peruvian*...it is summoned as the foundation for a *new national utopia*” (2013: 10)(emphasis added). However, as she notices, in the *Marca Peru* campaigns there is a distinctive ‘white-washing’ of these aspirational Peruvian protagonists (2013: 11). Video campaigns that accompany the graphic materials showed a group of Peruvian ambassadors – chefs, actors, singers, surfers, as they ventured to bring ‘Peruvianness’ to non-Peruvians through the sharing of Peruvian products and cultural experiences. However, these ‘New Peruvians’ did not racially represent the Peruvian nation, but just a small [white] part of the population. To be a part of the nation, to be a new Peruvian, is one encouraged to assume aspirational whiteness as well?

Lossio argues that *Marca Peru* creates a poor simulacrum of the country through its campaigns (2014: 9). It is “a copy without an original, an image of something that does not exist in reality in contemporary Peru. *The horizontal, democratic interaction of a woman from the Andean world with a white woman from the city is not a normal event*” (9) (emphasis added). Therefore, the idea of the ‘New Peruvian’ and nationalism that *Marca Peru* represents is an imagined identity that does not (yet/ will never) exist. It seeks to turn the currently ‘false Peruvians’ (Lossio, 2014: 3) into the new (read: acceptable) Peruvian, in this case through the projection of a particular image of racialised identity (Canepa, 2013: 7). *Marca Peru* rejects some Peruvians as they currently are- those that are non-white and are ‘Indios’ (not ‘Incas’) (Barrig, 2001). It encourages an ‘imagined community’ (Anderson, 1984) that is racialised and aspirational, and finds no current parallels with the lived realities of Quechua Vilquinos. Of course, it is necessary to note that the meanings behind *Marca Peru* may transform as they move through different social spaces. For example, the brand
may hold special importance for those with sustained and direct work in tourism, such as Lima-based eateries and Inca-tourism agencies in Cuzco, whereas it may not be associated so intensely with the Inca past and imagined nation in Vilcashuaman. That said, as the province attempts to highlight their tourism potential with increasing vigour, the social space in which the brand occupies in the current context may come to reflect that of Marca Peru’s more ‘obvious’ contextual location in due course. Indeed, it is through membership in the wider ‘imagined community’ that extends beyond one’s own province that makes this branding so salient in the first place.

Anderson suggests that nationalism is based on the imaginary connections that people who have never met will make with one another: “It is imagined because the members of even the smallest nation will never know most of their fellow-members, meet them, or even hear of them” (1983: 6), he writes. Through devices such as Marca Peru, those in power can envisage themselves as part of an imagined community with Andean rural peasants without ever having to meet them or understand their reality.

Because of the inherent hierarchical relationships involved in Anderson’s concept of an imagined community, Sajines (2013) argues that this is another expression of the coloniality of power, albeit shrouded in a false sense of camaraderie, when this has never existed in Latin America’s history of social hierarchisation (2013: 154). He argues that this “community that Benedict Anderson theorized as ‘imagined’…is just another myth of modernity created to legitimate the political hegemony of the dominant sectors” (2013: 154). In Sajines’ view, an imagined community in Latin America is a mechanism of the dominant forces to make everyone else acknowledge, and contribute to, some kind of falsely united national community, thus obscuring the oppressive structural violences inherent in that insincere utopic community of compatriots. Such coloniality on the part of the Peruvian state is no surprise, but the fact that it is present within FP propaganda through Marca Peru symbolism in the clinics suggests that aspirational ‘New Peruvian’ self should be achieved through planning one’s family in accordance with nationalistic values of ‘Peruvianness’. Through FP, it suggests, one can become part of the ‘imagined community’ that is Peru – a community from which Quechua people have historically been excluded and continue to be excluded. It pretends to include them and pre-
colonial Andean life-ways through its nod to the Incas and other ancient Andean cultures, yet as De La Cadena (2000) and Barrig (2001) note, this is simply another mechanism of racialised elitism and the coloniality of power that oppresses the indigenous through a false projection of inclusivity that simply serves to legitimate oppressive powers of the state (Sajines, 2013).

However, the state does not exact its brand of subjectivity through MINSA leaflets and promotional materials alone, of course. In order to discipline a population so that they act and think in a certain way they must first be rendered docile, as Foucault (1990b) suggests. This is a task with which rural health workers are charged as front-line combatants.

Privacy and discipline

(LLamallaqta, January 2018)

“Ima?!” comes the irritated voice from behind the iron door, now holding on slightly less tightly to its hinges after the obstetra has banged upon it thrice. “What?!” the resident asks, dropping the polite Quechua interrogative ‘-taq’ from her question to imply our lack of welcome. We back away slightly as a guard dog snarls at us from atop the roof of the house, and the obstetra insists that she be permitted entry in order to update her records of the woman’s reproductive health. This patient has not visited her local health post in a while, and rather than allow her to seek medical attention only as and when she decides to herself, it will now be forced upon her. We have come on one of the workers’ frequent trips into the villages for a surprise visit to test women’s urine for hCG, the pregnancy indicator, and check whether she is using contraception or not. This patient is all clear, although she is told off for not coming for regular health centre visits - she should be using contraception, the obstetra insists.

Later that day we spend a good three hours outside another woman’s residence, a waiting game intended to smoke her out with boredom. The

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41 A moment may be taken here to reflect upon my positionality within this situation, as I had accompanied the obstetra and not the patient in this incident. The health centre approach here could have positioned me as a potential member of state power alongside health workers, however it is also important to note that at the same time as I may have undertaken participant observation with the obstetras, I also did so in village events and festivals, and ate and lived with the people - thus making my position more ambiguous and not necessarily definitively aligned with the health centre, despite incidences such as that outlined here.
house lay amongst a mosaic of chacras, and in order to reach it we had to skilfully scale a few plants and boulders before meeting the final hurdle; a humorously aggressive 'guard' turkey who was roaming freely, his wattle akimbo with annoyance at our approach. This family clearly did not want uninvited guests either, and had we not collided with the woman’s adolescent daughter on the road we might not have made it successfully to the door without attack. Her daughter claimed she was ‘out’, however the obstetra challenged this assertion as she had seen her mother earlier descending the road back to the house. And so, we waited; if she was inside, she would have to leave eventually, and if she was out somewhere, we would be there upon her return. The grand fuss to weed out this patient was over an apparent spontaneous miscarriage or self-induced abortion that she had neglected to tell the health post about. A previous pregnancy test had been positive; however, she had seemingly managed to play the health workers off against one another and successfully received a three months’ supply of the oral contraceptive pill which they suspected she had taken to induce abortion. The aim of this cat and mouse was clearly to scold her for her lack of discipline and for her audacity in using her wit to get her own way. Yet it was also to ensure that she could be safely protected with a new FP method – no more unwanted pregnancies for her. After much waiting we eventually gave up and started back for the health post. This woman had managed to remain invisible to MINSA for one more day, but it didn’t matter. They would go back.

Why do health workers chase non-attendant patients all over the countryside? Why do they wait outside their homes and insist upon an audience? Why do the women even let them in and agree to be prodded and tested?
The majority of patients in Vilcashuaman, and across rural Peru, are reliant on their SIS under public health insurance (Guerra Reyes, 2013: 114 - 115); a system which provides them with free cost health care and pharmaceuticals provided through the MINSA health establishments. The gratuitous nature of this health insurance, or social welfare, might be seen as a reasoning behind state insistence with compliance – the women are beholden to the system in effect. Bridges describes how patients using the Medicaid system in the US
become disempowered legal subjects by accepting the financial aid; a system which further acts as a way to bring them into the state regulatory apparatus (2011: 43). Once in the state medical system, it is easier to monitor a woman, but as Bridges notes, it is still not possible to simply compel a woman to act as the state wishes (45). This is achieved, she notes, through the promotion of immorality; for example, a “pregnant body unsupervised by the medical establishment” (46) is an immoral one that does not care for the unborn foetus within it. Similarly, in Peru, Guerra Reyes calls this the imposition of a ‘moral regime’ in regard to the intercultural birthing model (2014: 1). A woman who does not use contraception is also exposing herself to immoral and irresponsible risk, as the previously discussed FP leaflet suggested. This merits and justifies the intervention of health workers, in their view. However, in the second incidence mentioned above, it can be seen how irresponsibility and immorality were outright assumed without any input from the woman (in fact, she did not appear in order to defend herself; perhaps because she knew that her side of the story would be considered irrelevant). The possibility that she could have miscarried naturally and wisely sought the pill so that she could avoid any further pregnancies whilst her body recovered from the recent trauma was not even considered, for example. In the first visit the patient was unable to refuse to take a pregnancy test on the request of the obstetra – this again suggests a suspicion that she might have been pregnant and attempting to conceal it from the health post. If so, the fact that this would be anything other than her own prerogative speaks volumes. The health post feels that it is entitled to know every single reproductive detail of the patients whom it attends, even going so far as to stalk them in their homes. In short, to be a female SIS patient in rural Ayacucho means that one is stripped of one’s privacy; if the state wishes to know personal details about your intimate body, they will hunt you until you provide those details, and you will give in or face the potential loss of your health care.

In a work of legal anthropology concerning pregnant women on state welfare, Bridges asserts that one’s poverty can in effect strip one of privacy rights. As she terms it, “the poverty of privacy rights” reflects the absolute lack of privacy bestowed upon a pregnant woman who uses state medical care:

“When the government demands intimate information from a pregnant woman, when it shares that same information, when it enters a poor mother’s home to investigate
claims of child neglect, when it removes a child from her family and places her in foster care, and when it funds the costs of childbirth but not the costs of abortion, the government is actively invading the private lives of poor mothers” (2017: 60).

The Peruvian state is involved in very similar activities towards poor, indigenous women in Ayacucho. Homes are targeted for information retrieval and women are unable to permanently resist this. Leinaweaver shows how the state also uses biomedical categories of (un)wellness to discriminate against poor, indigenous mothers and remove their children from them to put them into care (2009). Abortion is illegal in Peru and scaremongering around this is apparently promoted by MINSA, if we glance back to the FP leaflet warning of death-by-abortion.

It would be fair to assert that SIS patients lack informational privacy as they are hounded until they provide intimate medical details to health workers on demand. Informational privacy facilitates reproductive privacy, Bridges argues. Denying women informational privacy therefore, “helps the state and society accomplish the end of ensuring that poor mothers cannot be sovereigns over their reproductive lives and bodies” (2017: 152). In this sense, the MINSA intrusions into women’s homes to demand information deprive women of their reproductive privacy; this in turn implies reproductive governance through the surveying activities described at the beginning of this section (Morgan, 2012).

Finally, Bridges, referencing Foucault, states that “visibility can be radically disempowering...poor mothers are radically disempowered by their ability to be seen by the state” (2017: 87).

Visibility to the state through lack of privacy goes beyond uncomfortable intrusions into one’s garden by health workers brandishing sticks for one to urinate upon. Visibility speaks to something much grander; to disciplinary power (Foucault, 1991), and the concept that knowing that one is being seen, in this case by the potential uninvited drop-ins of obstetras at your home, makes one aware of one’s actions.

However, the crux here is that even when the state (health workers) are not present at your door, one would self-discipline oneself based on the knowledge that they could be watching at any moment.

One would ideally go to scheduled health check-ups, use contraception and keep a close eye on pregnancies even when the state’s presence is not felt. The point of surprise house calls is therefore to ensure discipline, and self-
Discipline, within the population, i.e. to ensure that women are using contraception and not getting pregnant.

Finally, as Bridges has argued (2012: 349), Foucauldian theories of discipline and power may need to be revised somewhat to acknowledge the fact that whilst they may be applicable to impoverished women patients on state welfare, arguably some people are deemed more worthy of disciplining by the state than others. If so, this suggests that the state might develop different processes and structures by which to uniquely discipline these groups. Thus, there is a stratification of (bio) discipline and power evident (Bridges, 2012).

The Peruvian, and likely other, state welfare systems, arguably disciplines those considered less valuable; those that are unable to pay for their own private health care and so unable to escape visibility to the state; those unable to pay for privacy rights. The poor, predominantly indigenous people. However, there are other elements at play in the production of ‘docile bodies’. The process of ‘othering’ the reproductive behaviours of one group of people is a potential way to render those bodies docile and manageable.

Conclusion
Cabrera says that Peru is a fractured country (2017: 40), and the state apparatus treats some Peruvians differently to others, particularly when those people rely upon state health care as their only option: the poor, rural, indigenous (Guerra Reyes, 2013: 161). The biopolitical control over life or death, and particularly the control over the reproduction of new life, is a concern for a fractured state, where some bodies are considered to be more deserving of discipline than others (Bridges, 2012). This stratified biopower is an important point to consider, as not only is it racialised in Peru to apply overwhelmingly to the indigenous, but it also reflects the idea of coloniality where racial hierarchies were introduced to ensure that some racialised groups, deemed more worthy of control than others, continue to be treated differently today in a post-colonial Peru.

Here a continuation of a long-standing impetus towards the whitening of the indigenous Peruvian can be observed within FP discourse and practice, giving further evidence towards the expanding literature dealing with race and biomedicine in Latin America (Roberts, 2012a, 2012b; Berry, 2010; Guerra Reyes, 2013). It is not enough to simply use biomedical objects, here
contraception; one must also adhere to the associated discourses and act accordingly. Then one will be closer to pursuing this “aspirational whiteness”, which Guerra-Reyes points out has strong ties with rural-urban migration, as will be further discussed in a later chapter. It is important to note here that measures of discipline and the production of docile bodies that respond to this discipline are deeply imbued within the biomedical discourse within Peru; indeed, this involves a relationship of power between state and citizen, and one which continue to interiorise racialised indigenous individuals through discourse and practice.

The following chapter will expand the discussion on subjectivity and kinship by looking further into gendered relationships in regards to health-post discourse and FP, to interrogate the ways in which the state manipulates gendered understandings and how this can affect the lives of both Quechua women and men, potentially to their disadvantage.
Figure 5.1. A young Quechua couple pose outside the Sun temple in Willka Waman.
When it comes to the gendered nature of FP in the Andes, men are predominantly portrayed as obstacles to contraception use. Represented as jealous, violent and controlling, they are thought to hinder their wives and girlfriends’ access to biomedical contraceptives in a bid to prove their own virility through rampant seed-sowing. Studies show that women who experience domestic violence in Peru are also those more likely to have unintended pregnancies (Cripe, 2008), seemingly supporting this notion. Machismo, the pan-Latino patriarchal dominance exerted by men over women, is often and widely given by health workers as the reason why Vilquinas will not use methods, for example. If women are found to be using contraception, then they may be accused (sometimes with violent consequences) of infidelity. The idea behind this, cites Yon Leau, is that “having children consolidates a woman’s status and as conjugally united, they contribute to her ‘respectability’, reaffirming in front of everyone and, especially, in front of other adult men, her status as a married woman” (2000: 64). In this view, a woman who uses contraception to avoid pregnancy will be without the constant accompaniment of a child hanging off of her skirts, the absence of which may signal to other men her availability.

Indeed, looking back at studies from the seventies and eighties, it is a long-standing trope in the literature on Latin America that men seek an abundance of children as evidence of their sexual prowess and fecundity (Mason, 1987), the obtainment of a large family with multiple women supposedly acting as proof of how ‘macho’ one is (Nicassio, 1977).

Gendered inequalities have arguably been present in reproductive health policy in Peru for some time. For example, only after 1996 were women able to obtain hormonal contraceptives from MINSA without their husbands’ permission – a law that seems bound to inhibit women’s freedoms and corporeal autonomy in the most extreme of ways. That said, Alcalde’s informants at a Lima women’s refuge described creative ways that they used to get around this law, such as using sons to forge husband’s signatures (2010: 114).
On the other hand, Boesten argues that the abolition of this law, whilst wrestling back reproductive control from Quechua men, placed it squarely into the hands of state health workers instead; “although this change in the law increased the freedom and autonomy of women with respect to their husbands, and has therefore received ample approval from progressive forces such as feminists, it has also made it easier for health care providers to deceive women, as rural women are less likely to be literate” (2010a: 94).

Other changes in reproductive health that have been perceived as helpful to disenfranchised women may also have accidentally contributed towards negative gendered outcomes. For example, Alcalde describes how the sterilisations under Fujimori were, for some women, “a way to protect [their] health by resisting [their] husband’s control of [their] body” (2010: 114). She writes that “it is worth noting that even in this largely oppressive environment, women who were not coerced benefited because they had access to a free and efficient form of FP. Through sterilization, the women were able to translate into reality their desire for a limited number of children and to silently but sternly reject men’s demand for more children” (2010: 112-113).

In the literature on global FP and gendered relationships, the theme of women’s agency and strategies of resistance to male demands is often explored. For example, women may hide their pill packets to remove evidence of contraceptive use from their partner’s gaze (Teixeira, 2012); they may take the emergency contraceptive pill after intercourse without their partner knowing to avoid pregnancy (Osei, 2009); they may consciously choose the injection over the pill as this leaves no ‘trace’ (Delavande, 2008; Hall, 1997), and they may seek abortions in order to avoid pregnancy as a last resort (Palomino, 2011). In previous research undertaken within a MINSA health post in the Peruvian town of Huancayo, central Andes, I similarly found that women employed various ‘strategies’ in order to obtain and use contraception without their partners finding out. In that case, the three month injection was valued not only because the injection was ‘invisible’ (it does not leave identifiable bodily marks nor packets-in-bins), but also because the three-month time frame coincided with the compulsory three-month childcare appointment that women using SIS and JUNTOS had to comply with. Thus, their visits to the health post every three
months was easily justifiable to their husbands and they could get the injection clandestinely every time they went for their child’s appointment (Irons, 2015).

It is acknowledged that women must often use strategy to contracept behind their partner’s backs, and this was also the case in Vilcashuaman. For example, although smaller health posts all offer contraception, women would reject this option and instead travel to the larger health centres where they could go unrecognised. For example, one doctor in Willka Waman commented that one of his patients “hides from her husband” by travelling some way from her village to the main town, as in that post “the obstetra would tell her husband about her contraceptive method that she’s using”. This concern over intra-community ‘reporting’ on women is widespread, as the comments of Sandra in an earlier chapter explored. However, when it addresses a woman’s concern over potential domestic violence if ‘caught’ by her husband, it is something one needs to take serious notice of.

This chapter will mention some instances of women’s strategies to use contraception, but that is not the main focus here as this has arguably been addressed many times before in previous literature. Here, the greater interest will be not in the effect of gendered inequalities, the clandestine contraceptive use produced as a result of widespread gendered inequalities and violence. Instead, the focus will be mainly on analysing the contemporary practices and gendered experiences of Quechua people as related to the cause, historical and contemporary, of this gendered imbalance and the health centres and state’s role in this. The data will be put into conversation with theory in this way specifically because it is sorely lacking from literature of medicine and gendered relationships in the Andes, and particularly so when addressing reproductive health and contraceptives where men and women are often presented as unequal, without much attention given to the colonial roots of this issue. Most importantly, in the words of Morgensen (2015), “tracing any form of colonial masculinity to its historical roots may create useful tools for Indigenous or non-Indigenous people who wish to interrupt or undo its power” (1). Thus, this way, the present chapter may hope to contribute towards the endeavours of those hoping to address the coloniality of power in the Andes.
Thus, we proceed from the understanding that addressing women’s strategies of agency to go around their partners is arguably akin to putting a bandage on a wound, rather than healing that abrasion. In order to deconstruct the structures (institutionalised and otherwise) behind gender inequalities that lead to contemporary problems, such as in FP, it is important to know how those ruptures occur in the first place.

In this instance, that sore, that gendered laceration, may be a colonial wound.

Indeed, this gendered agency and contraceptive strategizing mentioned throughout the literature may not have always been needed in pre-colonial Latin American indigenous societies. In the Andean region a predominant view towards pre-colonial gendered relationships is that of complementarity (Babb, 2018), rather than the current view of inequality and domination. In this view, whilst each individual was seen as existing within a gendered category, those genders complemented, rather than conflicted with, each other. This all changed with colonialism, when the coloniality of gender (Lugones, 2013) disrupted this complementarity to make gender relationships unequal, a situation that continues to be promoted through the coloniality of power today, argues Lugones (2007, 2013).

These colonial gendered categories arguably became the norms, and Butler (1988) argues that gendered ‘norms’ are powerful because they become institutionalised and thus are hard to challenge as one begins to see them a somehow ‘natural’ or ‘given’, when this is not the case. On this, Boesten (2018) writes that “Butler proposes that the ‘truth’ about gender and our sexualised bodies is the result of the mechanisms of power and the revindication of knowledge. The historical and cultural processes expressed through institutions, discourse and practice have a naturalising effect on the way we understand the order of things, which includes our understanding of the masculine and the feminine” (Boesten, 2017: 293). The way that this is institutionalised is through the normalisation of the framework:

“Normalization, the institutionalization of the norm, of what counts as normal, indicates the pervasive standards that structure and define social meaning. Norms are at once everywhere and nowhere. They are obvious when we are talking about the sorts of standards against which one can be tested with respect to intelligence or body mass, for example. But they are less conspicuous when they are unspoken, what we may
In Peru these gender ‘norms’ may correspond differently to the urban/modern/coastal Peruvians compared to the indigenous, and furthermore the questions of gender normalisation take on different significance depending on one’s race and class (Boesten, 2017: 297-8). Boesten says that “the norms that guide gender identity in the interior of rural, indigenous communities or inside of middle-class, educated criollos can be substantially different…gender roles are different in different cultural scenarios” (2017: 297-298). This means that indigenous understandings of gender expectations and ‘norms’ may be different from those produced in other parts of Peru, and thus it is important to consider this within any analysis.

In addition, Boesten states that “not only is racism institutionalized in Peru…but so is sexism. As a result, class relations are gendered as well as racialized”, and consequently, these “existing inequalities made abuse in health services possible” (2010a: 4) (emphasis added).

She further points out that whilst governments have increasingly become “keen to address women’s issues both in legislation and policy…these efforts are often constrained by existing inequalities and prejudices” (2010a: 7). What Boesten fails to underscore here, however, is that not only may existing inequalities facilitate contemporary abuse within the health centre context, but that the health institution in Peru may also be constantly reaffirming those existing (gender) inequalities and thus compounding the ability for abuse, as this chapter will explore.

Furthermore, it is not only the government, but also NGOs that aim to address gendered inequalities, as will be later discussed in this chapter. Those existing inequalities may inadvertently be reinforced by those agents as well, as will be later discussed in the case of feminist NGO Manuela Ramos.

Approaching the subject of gendered relationships and norms in FP from the perspective of the coloniality of power urges us to examine how not only race but also gender was introduced during colonialism, in order to inferiorise the native populations and disrupt their lifeways so that they followed the dominant, Eurocentric models instead.
As Lugones has argued, coloniality refers not only to race but also to gendered classifications (2013: 372). This she calls ‘the coloniality of gender’ (2013). Lugones argues for the importance of interrogating and understanding gender for an analysis of the coloniality of power:

"Understanding the place of gender in pre-colonial societies is pivotal to understanding the nature and scope of changes in the social structure that the process constituting colonial/modern Eurocentered capitalism imposed. Those changes were introduced through slow, discontinuous, and heterogenous processes that violently inferiorized colonized women. The gender system introduced was one thoroughly informed by the coloniality of power.... thus in understanding the extent to which the imposition of the gender system was as constitutive of the coloniality of power as the coloniality of power was constitutive of it. The logic of the relation between them is of mutual constitution" (2013: 383).

This ‘coloniality of gender’, which in this view was imposed during colonialism, still affects the contemporary systems of power and state that disadvantage women, and very much relies upon the intersecting inequalities, introduced through the coloniality of power, such as race, mentioned by Boesten (2010a). Indeed, race and gendered inequalities compound upon each other for Quechua women. Lugones continues:

"it should be clear by now that the colonial, modern, gender system cannot exist without the coloniality of power, since the classification of the population in terms of race is a necessary condition of its possibility" (2013: 383).

If one understands the contemporary Peruvian state as operating through the coloniality of power then one might also expect to find the coloniality of gender (expressed through hierarchical and disharmonious gendered relationships) within state institutions, such as the health centres. Indeed, Morgensen suggests that states are "mediums for settler-colonial...power over indigenous people’s relationships to...health" (2014: 191), therefore we could fairly expect to see this demonstrated through MINSA programmes also.

In order to respond to this proposition in depth, the present chapter is an exploration of the ways in which FP and sexual and reproductive health discourse is gendered in Vilcashuaman, and how this fits into pre-colonial and contemporary Andean perspectives of gender and gendered relationships.
The concept of *machismo* as it applies to the FP context will first be explored using the framework of the coloniality of gender to interrogate it. Institutionalised elements of the coloniality of gender, such as women’s roles as reproducers and repositories of responsibility and suffering (Schiwy, 2013) will be discussed and explored in regard to health centre discourse in both FP and sexual health, as well as contraceptive propaganda framing. Finally, the ‘enfoque de género’/‘gender focus’ development discourse promoted by feminist NGO Manuela Ramos in Ayacucho health centres will be addressed in order to analyse the different potential actors in both reproductive governance (Morgan, 2012), and also in the promotion (inadvertently or not) of colonial gender frameworks in Vilcashuaman. This way it will be possible to probe the ways in which the coloniality of power/gender are continuously reiterated through FP and reproductive health discourse, potentially exacerbating present gendered inequalities in the region unnecessarily. Furthermore, it will be possible to analyse if and how *gendered subjectivities* are formed or manipulated through this coloniality of gender (Mignolo, 2013), and thus make recommendations on how to address the current disjuncture.

**Gender Complementarity, Machismo, and the Coloniality of Gender**

I came to know Delia through one of the small *tiendas* that I visited in Willka Waman to buy water and try to get in some Quechua practice. She would often sit outside eating mandarins and waiting for her five-year-old daughter to finish school, and whenever she was present as I passed the shop on my way back to my room we would get talking. She had three children, I learned, but two had now moved to Huamanga. She complained often of her husband, who in over a year of knowing her (and eventually visiting their house multiple times) I never met, so absent was he. Delia bemoaned his extra-marital affairs and lack of presence in their lives, pinning it on *machismo*: “They say that the problem here with our husbands is *machismo*, señorita. Sometimes they go out drinking, my husband goes for days at a time, I know he has another woman…”. Delia also had a small *tienda* (that was rarely open), but when passing on one lucky afternoon that it was, I encountered a great row as I entered into the gloomy interior. Delia’s elder daughters had returned from Huamanga for a visit, and upon obtaining the mobile phone number of their father’s mistress, had decided to place a call, eventually shouting at her down the phone and hanging up. This
was an issue, Delia later admitted, because she had known all along who it was; a woman who lived right around the corner and could now make more problems for her. Although one could argue that it was Delia who was being wronged by her husband, she was the one now afraid of reprisals. Whilst the problem of his drinking and womanising was pinned on machismo, the problem of interference would be pinned on Delia. Machismo is not only a concept brought up when it comes to alcohol or infidelity, but was also present in the health centres, as some health workers described:

(Doctor, Willka Waman) You know, the problem is there is a lot of machismo here. That is why some women don’t use contraceptive methods. There’s this woman, you know she hides from her husband to come here from her village, because in the health post there the obstetra would tell her husband about her contraceptive method that she’s using.

(Obstetra, Michibamba) I have to bring up the injection from Willka Waman to this village, because there are just so many women that use methods without their husbands knowing. One woman never even leaves the house, she doesn’t use contraception or visit the health post. I have to wait until the husband goes out before I can go to visit her. It seems to me that she likes that her husband hits her.

(Obstetra, Llamallaqta) It would be better that you don’t interview the men here, Rebequita…they don’t always know if their wives are using methods and you might make them suspicious, there is a lot of machismo.

Machismo, expressed in reproductive health as male opposition to their wives and girlfriends employing FP, has been called the “‘traditional’ obstacle for women in using contraceptives” (Boesten, 2010a: 93). In regards to FP, machismo has been employed as a catch-all motive for non-use of contraceptives across Latin America (Sable, 2006, 2009; Sternberg, 2000), with men seen to be barring their female partners from accessing reproductive health as a way to exert dominance and ensure the continuation of their virility through expanding offspring. As the opening story and health worker quotations suggest, health workers and others consistently portrayed machismo as a principal issue in women’s obtainment of contraceptives. It is represented as though machismo were a gendered issue ingrained within communities (Barrig, 2001). However according to the coloniality of gender (Lugones, 2013), the
disruptive (male) behaviours and attitudes that are expressed through *machismo* may themselves be a colonial imposition.

Thus, before it is possible to address this issue of *machismo* within reproductive health it is important to first understand the processes that produced *machismo* and how they relate to the current state and coloniality.

When addressing coloniality, understanding the ‘coloniality of gender’, which Lugones defines as the analysis of “racialized, capitalist, gender oppression” (2013: 747) in post-colonial societies, is both important when addressing contemporary gender inequalities and violences that trouble countries such as Peru, as well as specific in its contextual nuances. As Walsh (2013) argued for the coloniality of power in general, Lugones also argues that “unlike colonization, the coloniality of gender is still with us; it is what lies at the intersection of gender/class/race” (2013: 746). In the pan-Andean context and beyond it is of particular importance to attend to the question of gender and the consequences of colonialism:

“understanding the place of gender in pre-colonial societies is pivotal to understanding the nature and scope of changes in the social structure that the [colonial] processes...imposed...[it is] also pivotal in understanding the extent and importance of the gender system in disintegrating communal relations, egalitarian relations, ritual thinking, collective decision making, [and] collective authority” (Lugones, 2013: 383).

In the Andes, a predominant view towards pre-colonial gender relationships is that of *complementarity* (in those cases where scholars contend that the concept of gender existed at all, that is. We shall return to this momentarily). Gender complementarity is based on the concept that although pre-colonial Andeans recognised a difference between genders, each was one part of a ‘team’ that complemented each other in tasks and each held complementary, though different, roles in the community, ritual, and governance. The idea of gender complementarity is still present within some rural communities and amongst Peruvian scholars (Babb, 2018: 22), particularly so in terms of agricultural task-division. For example, the man and woman are thought to undertake complementary tasks in planting crops, with one example being the woman leading and the man driving the *yunta* of bulls, or with the woman inserting seeds into the soil for fertilisation, and the man watering them (Harris,
A further example comes from complementary roles in weaving (men learn to use upright looms, women use backstrap looms). Harris argues that “it is this unbreakable division of labour in weaving that is given one of the most urgent reasons for marriage” (2000: 171). She calls this concept of complementarity *chachawarmi*, the combination of *chacha* (man) and *warmi* (woman) (2000: 165) (in Aymara – in Quechua this would be *qariwarmi*). *Chachawarmi* refers to “the conjugal pair as a unit” (2000: 165) that “is used in the definition of gender roles” (164).

The concept of gender complementarity has been carried through to FP preferences specifically, with Yon Leau suggesting that the pan-Andean preference for two children, one of ‘each’, is down to the idea of gendered balance and complementarity in all aspects of life (2000: 66-67). This imagery is also carried into human reproduction.

After initial conception, a process of ‘maturation’ is thought to occur in the womb, with the woman’s menstrual blood coagulating and slowly developing into a foetus over time with the sustained “alimentation” of the male sperm (La Riva Gonzalez, 2017: 175). La Riva Gonzalez describes the woman as being “associated with the land that receives the seeds”, (2017: 175). Furthermore, this complementary process of gestation sees both parents contributing to different parts of the foetal body over time through their respective contributions of blood and semen. The female blood ‘grows’ the flesh and blood of the child, and the male semen ‘grows’ the bones (2017: 176).

This process could be contrasted with [Western] biomedical, Eurocentered and colonial concepts of the male semen ‘attacking’ the passive egg in a hierarchical, one-time event of dominance (Martin, 1991). For example, Martin’s discussion on the representation of the relationship between the egg and the sperm in medical textbooks, a “romance based on stereotypical male-female roles” as she puts it, gives a particularly good example of how gendered relationships have been portrayed in Western scientific thought and how these might compare with Andean views.

Within medical textbooks, Martin found that male and female reproductive organs were persistently represented in a hierarchical and unequal gendered relationship. The female menstruation, a signification that pregnancy had not occurred, was represented as a ‘failure’ (1991: 486), with the slow depletion of
ovum from birth to menopause seen as reflective of women’s aging and degeneration over time (487). This is opposed to the representation of the male physiology, told in “breathless prose” (486). Whereas women ‘degenerate’, men ‘produce’ agelessly (487). Furthermore, and importantly, medical textbooks consistently represent fecundation within hierarchical gendered terms; the female ovum a passive ‘sleeping beauty’- “a dormant bride awaiting her mate’s magic kiss”, “the queen to the sperm’s king” and depending “on the sperm for rescue”, as Martin quotes from scientific texts (490). The male sperm, in contrast to the egg, have a “mission” to “assault the egg” (490), with wording enhancing the perception of the female-egg’s vulnerability in contrast to the strength and virility of the male-sperm. Although Martin suggests that imageries of this process are slowly changing as new research comes forward, these stereotypical elements are often regurgitated in the contemporary literature (492). As she writes, “that these stereotypes are now being written in at the level of the cell constitutes a powerful move to make them seem so natural as to be beyond alteration” (500). Although Martin writes about North American scientific texts, these are produced within biomedical discourse more generally, thus they are relevant to the present discussion.

Thus, the coloniality of gender carries through to medical and reproductive representations as well as societal ones, which is an important point to remember as it shall be returned to later.

In her exploration of pre-conquest Peru, Silverblatt (1987) calls pre-colonial gender relationships ‘gender-parallelism’ (1987: 20). She suggests that in pre-conquest Peru the people worshipped masculine and feminine goddesses that complemented each other, supposedly reflected in the daily life of the people:

“Women and men acted in, grasped, and interpreted the world around them as if it were divided into two interdependent spheres of gender. Armed with this understanding of the workings of the world, and of the role of humankind in it, Andean mortals structured their cosmos with goddesses and gods whose disposition reflected these conditions of life” (1987: 20).

These deities proceeded the Incas and were seen as the god of the heavens Illapa (masculine), and of the earth, Pachamama (feminine). Silverblatt states that, “the Pachamama, who embodied the generative forces of the earth, needed a male celestial complement to realize her procreative powers. So Andean thought paired her to the god of thunder [Illapa] as bestower of rain”
(1987: 21) (emphasis added). She acknowledges that when the Incas conquered the Andes, they introduced their own deity into the panopticon of the divine, the (masculine) sun god Inti, and ordered that select women leave their natal villages to serve him (1987: 80). However, it was after the arrival of the Spanish colonialists that the Eurocentric understandings of gender were imposed, Silverblatt argues. These gendered concepts, the coloniality of gender that exist still today, are the cause of inequalities and violence, in this view. Hardin (2002) also argues that unequal gender relationships were introduced during colonialism, with the widespread encouragement of machismo. Machismo “is used to describe Latino masculinity and refers to the cultural expectation that males must show they are masculine, strong, sexually aggressive, and able to consume large amounts of alcohol” (Flake, 2005: 354). Furthermore, in the Andes this alcohol is no longer the traditional home-made ‘chicha’, formulated from maize fermented with women’s saliva, that represents an indigenous relationship to the land and kin42, but now the bottled beer from the cities, a drink that produces violence and represents the ‘modern’ capitalistic world (Barrig, 2001: 88).

Hardin argues that machismo developed out of the Spanish conquest as a “product of the rape of indigenous women, the response to indigenous imperial ritual, and the sublimation of indigenous male sexuality. It was a response to social and religious control of the male body” (2002: 1). Smith (2015) further argues that not only was a ‘sexual colonisation’ enacted against indigenous people, but that the logic of colonialism itself is predicated on sexual violence (70).

Focusing on indigenous groups in the US, Guerrero writes that “Native men were perceived as emasculated by Spanish colonisers” (2003: 67) due to the absence of strict gendered hierarchies as back in the Iberian peninsula (and religious tradition from which the Conquistadores would have come). She

42 The ritual consumption of alcohol holds importance in the Andes beyond an expression of machismo. Drunkenness involves a change in speech, whereby people are able to verbally challenge the existing social order (Harvey, 1991). When men and women drink the maize-chicha specifically, produced in conjunction with the land, they become drunk and spill the alcohol on the earth, ‘irrigating’ it. They may also fall over themselves, making them closer to the land (Dransart, 2002). That said, Harris (2000) argues that the altered state of consciousness induced by alcohol not only serves to establish “contact with the sacred” but also is the prerequisite for violence, including gendered domestic violence (161): “people speak of drinking and fighting as part of a single whole” (2000: 152). Whilst alcohol may be used to interact with the land and non-human actors, this may be more limited to ideas around chicha, as Barrig suggested (2001).
follows that “what the sexist Western Europeans mistook as the subjugation of Native men to their women was actually the gender role dynamics of an egalitarian society that valued both women and men” (ibid). However, after the arrival of Europeans to the Americas this egalitarianism was to change, leaving a legacy of ‘patriarchal colonialism’ (2003: 65). Segato has also commented on the current patriarchal structure of society in Latin America today, *el patriarcado*, arguing that it is a consequence of colonialism (2014a, 204b).

‘Patriarchal colonialism’ (Guerrero, 2003) is a useful concept to think with when addressing post-colonial indigenous peoples, although it is arguably more rigid than the coloniality of power/gender as it presents patriarchy, or paternalism, as the only structure existent in colonial and post-colonial societies (Guerrero, 2003: 65), whereas the coloniality discourse (power/gender) suggest the possibility for subjective change.

To return to the idea of *machismo* and violence in Peru specifically, Barrig (2001) discusses this with reference to the concept of ‘Amor Serrano’/‘Andean love’, and the expression “*Mas me pegas, mas te quiero*”/“the more you hit me, the more I love you” (2001: 91).

Van Vleet notes how this phrase/concept is often used by “‘urban mestizos’ to describe Quechua-speaking campesinos in a derogatory way” (2008: 170), based upon the widespread idea that indigenous communities, and gendered relationships in particular, are somehow inherently violent. However, others do recognise that this may be a colonial imposition.

One of Barrig’s informants, working for an NGO, stated that “it was during the Spanish domination where all the negative behaviours were identified; violence, alcoholism…men dominating women…in the time of the Inca men did dominate women, but nothing like during the time of the Spanish” (2001: 93).

It is interesting to note that in Andean ritual fighting, *tinku*, young men embody the bull, shouting “*soy toro carajo*” (“I am a bull carajo”) whilst they charge their opponent and bellow like the animal, the aim being blood-spill and even death (Harris, 2000: 147). However, in the Andean *Yawar Fiesta* (Blood Festival), in which a live bull fights a live condor, the imagery explicitly represents the aggressive, violent bull as the *Spanish coloniser*, and the cunning, swift condor as the dispossessed indigenous Andean (Hiroyasu, 2013). The bull is always killed at the end of *Yawar Fiesta*, thus in this ritual confrontation the Quechua
always vanquish their colonisers. It is therefore pertinent that when Andean men express ritual violence towards people in their own communities during *tinku*, they embody the symbol of the coloniser – further suggesting that male violence may be a condition of coloniality.

That said, Barrig (2001) argues that pre-colonial gender-complementarity was not necessarily quite the harmonious experience as some scholars suggest, and instead presents an idolisation and romanisation of the past that was not necessarily the case. Aymara feminist-scholar Paredes has argued that the existence of the sun virgins, *los virgenes del sol* (as mentioned previously by Silverblatt) underscore gender inequalities in the pre-colonial Andes, as women were expected to serve men, and particularly the male sun-god *Inti*, during religious ceremonies and thus could not be considered as equal, or necessarily complementary, to them (quoted in Ströbele-Gregor, 2013).

However, as Babb (2018: 21-22) notes, the ideas of gender complementarity are persistent within academia amongst Western as well as Andean scholars. Furthermore, Babb sees it as a viable alternative to the imposition of western frames of knowing: “Gender complementarity…has offered an alternative to the dominant feminist framework of analysis originating in the North, *which assumes that different means unequal* (2018: 22) (emphasis added), she argues.

In opposition to Babb, Schiwy has noted that “Gender complementarity has…*not necessarily meant equality or equal value*” (2013: 139) (emphasis added), questioning those neatly packaged assumptions about pre-colonial gender relationships further.

As a more temperate medium, Segato recognises the concept of ‘gender’ in pre-colonial societies, however she suggests that it was used in a different way in these societies than it was/is applied under the Coloniality/modernity rationale. Principally, gender has been co-opted and manipulated so that colonial impositions of gender relations take over, whilst an appearance of timeless continuity in indigenous communities is perceived from the outside, and thus remains unquestioned (2014a: 613). Furthermore, Segato recognises a pre-colonial patriarchal system, however she calls this “low intensity community patriarchy”, which relied more on a concept of *complementary*
difference. This was changed under colonialism, to the “high intensity modern-colonial patriarchy” that Latin American societies currently experience (2015: 69), and which promotes and supports moralised-sexualities and disruptions of gendered roles that result in violence and dis-equilibrium. Although the debate on the precise nature of the coloniality of gender is ongoing, what we can take from this is that the arrival of the Spanish conquest affected a different structure of gender relationships that was based upon the Anglo-Christian understandings of genders as hierarchised, and that unequal gender relationships are, at least to some extent, as a result of the imposition of coloniality that sees all human ‘categories’, whether race or gender, as unequal with one superior to the other. Whether Andeans lived harmoniously in complementarity pairings before the conquest is not entirely clear; however, those colonial impositions of ‘naturalised’ superiority-inferiority can certainly be seen in gender as well as race.

Whilst machismo might be seen as the male consequence of coloniality, it could be argued that marianismo is the female side of the coin. Specifically, marianismo is the view that women should strive to emanate the Virgin María-to be sexually chaste, obedient and subservient, accepting of the gender hierarchy, and with reproduction as a key part of their identity (Stevens, 1973). Schiwy has also argued that colonialism brought with it a focus on women’s reproductive capabilities above all others, with women expected to take the responsibility for their own suffering. Men, on the other hand, were encouraged to see women as possessions to be controlled (2013: 139). Schiwy quotes Choque Quispe (1998), who argues that under colonialism the indigenous Andean woman became a commodity “whose value hinged on her reproductive capabilities as the primary source for a new identity; for Indian males the possession and control of the Indian woman acquired dramatic significance” (12)(emphasis added). In this understanding, colonialism brought with it a focus on women as reproducers (marianismo), and men as possessors and controllers of those women (machismo).

That said, Navarro (2002) contests marianismo as a post-colonial imposition of scholarship upon Latin American women and finds it wanting and “seriously flawed” (2002: 257). It fails to take into consideration the specificity of lived
experience, it is argued, and overlooks “the historical specificity of gender arrangements” (257), she says.

Whilst not disagreeing with this criticism necessarily, it is true that, in the case of public health and state welfare specifically, in Peru the focus has been overwhelmingly on the mother-child relationship (Ewig, 2010: 17), thereby promoting certain ideas about womanhood within corporeal health-subjectivities. Furthermore, Navarro’s criticism comes (perhaps correctly) from the fact that Stevens (1973) was a North American scholar whose theory became applied by other Western scholars, without interrogation, to the Latin American woman. In this case, we have attended to the historical specificities of gender in Peru, which may still suggest an imposition of marianismo from colonialism.

A great deal of literature on the subject has omitted the male opinion on this matter, instead relying on female contraceptive users to describe their experiences with their husbands. As men are not perceptibly present in Latin FP policies (Gutman, 2013), there is justified reason for the woman-centred focus. In fact, there may not be a great deal of variation in the reasons given for men’s lack of trust in contraceptives between men and women; jealousy and fear of infidelity arise time and time again as motives (Yon Leau, 2000; Boesten, 2017, 2010a). Thus, it may not be surprising to note that men state similar reasons for their own objections to contraception, and that of their peers. However, to understand machismo in the contemporary context, and how it affects women, it is arguably necessary to include some male opinion as well.

Here, this will be presented through a case study of Eloy, a husband and father in Vilcashuaman, which shall be interspersed throughout the remainder of this chapter. Whilst this example clearly cannot be representative of all Vilquino men, I have chosen to focus on Eloy for a number of reasons. Firstly, by virtue of his steady, year-round job (he owns one of the little restaurants in the main plaza of Willka Waman), Eloy knew everyone in the immediate village, and was able to provide comment not just on his own behaviours but that of many other village men. This is significant, as some men might migrate away for seasonal work, or live in between Vilcashuaman and Huamanga/Lima, and therefore not hold a consistent view of local events. Secondly, I also knew his wife, Erminda,
with whom I had become friends with at the start of my fieldwork when we had both decided to take a midday break in the sun of the plaza and begun talking. I therefore knew them both relatively well for an extended period of time and had more opportunities to observe and participate in their lives than any other couple. Finally, as a couple their recent life events meant that they had many thoughts and comments surrounding the important themes of this work. Erminda had given birth recently, with complications, and she was currently trying to avoid further pregnancies to focus on her son Miguelito. Furthermore, they did not necessarily agree on all ideas and plans of family size and FP and there was some observable tension here, thus making them an ideal couple with whom to focus a case study. Although the use of a case study here means that the conclusions are not necessarily applicable to everyone, from the rich and varied conversations and events involved with Eloy and Erminda, one viewpoint on gender in Vilcashuaman can be fleshed out.

In opposition to the stereotypes of Quechua men presented in some literature, Eloy could be seen as potentially quite liberal. For example, I knew from conversations with his wife that he both ‘permitted’ her to get the implant and was not violent towards her, instead encouraging her to study English with me in order that they could eventually move away from the province and send their baby son to school in Huamanga (“the school here is no good”, they often lamented). They hoped that Erminda would find administrative work there with her language skills if she were able to improve enough.

Eloy had grown up in Willka Waman and had seen and overheard many a local drama. When a woman in one of the smaller villages was allegedly stoned to death by her jealous husband, he was happy to discuss his views behind the motivations of this, and other instances of, gendered mistreatment:

> When a couple are together all the time, working in the chacra, they must get tired of each other, because of this there is *maltrato* (bad treatment). It can be from a lack of understanding, or sometimes because jealousy, I think it’s mostly because of jealousy. Either one of them can provoke that... now it has reduced a bit in the province, but you know sometimes the women make men jealous, and out of nowhere you start to get suspicious, and that is where the arguments arise.
Eloy was careful to always present an equal partnership between himself and his wife. As he said both would make each other jealous equally, he claimed, and this balanced relationship extended to contraception and FP:

RI: Who should decide which contraceptive method a woman uses?

ELOY: Both, both should decide, no? Both should decide which one they will use.

RI: It is said that sometimes men do not want their wives to use methods, why do you think that is?

ELOY: That is down to each person. A lot of people think that if you [woman] use methods, then they [men] don’t know where you will be, that you are going to cheat, you’ll cheat because of jealousy, won’t you! It’s that, I’ve never seen a man say, “yes my wife is using contraception”, because anyone will tell him ‘marica’ (‘gay’), “she can go with anyone that she wants to now”. Easily she can be unfaithful to me now, but when a woman doesn’t use protection, she is more afraid to be unfaithful [because she can get pregnant].

Despite Eloy’s purported egalitarian views towards contraception in his own relationship, he highlights an important point concerning what he thought were male views towards the use of FP methods - the opinions of other men and what this might say about one’s relationship and position of authority. In this view, one may seek to pursue a more equitable relationship with one’s wife, but the wider societal expectations of masculinity will always exert pressure, as Boesten also suggested (2010a). Perhaps because of this, Erminda had once confided that it was Eloy who had pressurised her into becoming pregnant with their son Miguelito even though she had not felt that she was ready (she was eighteen at the time, he was forty).

Such marital pressures were also present in many women’s decisions about childbearing, often above and beyond the number of children that they had originally planned for. Returning to the opening story of Delia, for example, one might remember that she had two adult daughters (both 20+ years old) and a five-year-old, as well as a tense relationship with her absent husband. Although I never asked her outright, the situation seemed to suggest that the youngest child had been conceived, after a twenty-plus-year break in childbearing, as an attempt to keep her partner by her side after the older children had left home.
(and he was technically now ‘free’ to leave himself). The experience of Janet, another Vilquina from a smaller village, also suggested a desire for children in order to ‘keep’ new partners.

(Sarachongo, July 2018)
Janet was quiet throughout her consultation; it was sad news. Her unborn baby’s heart had stopped beating and she was to be sent to Huamanga for an ‘intervention’. Did she want someone to fetch her husband, the obstetra asked, signing off papers and preparing to accompany her. Janet did not know what to do. She already had two other children with her ex-husband, a man that had abandoned her a few years prior, and was relying on the birth of this baby to ‘keep’ her new partner. She had become pregnant upon his request; although she had only wanted two children originally, she was willing to do this to ‘hold onto’ him. Her apparent grief over the painful loss of a child was mixed with the pending grief of another loss; would this man abandon her too when he discovered that she would not be able to bear him a biological child? “You can get pregnant again”, the obstetra reassured her, knowing full well that this may be classed as an ‘aborto’ in Huamanga, resulting in the likely (perhaps ambiguously consented to) insertion of the three-year implant. Janet and her partner would have to wait a while for another pregnancy - time in which their relationship may sour irreparably.

It is a stereotypical and widespread scenario of male virility, often concurrent with machismo, that may lead Vilquinas to bear more pregnancies than desired at the pressure of new partners’ wishes to sire biological offspring. However, in contrast to other investigations in the Andes that suggest men pressurise female partners to remain constantly pregnant and with young children to publicly signal marital status (Yon Leau, 2000: 64), in Vilcashuaman this situation predominantly occurred where a woman already had children with a prior partner and her new partner wanted one of his own - a claiming-of-territory to warn off other men, to put it crudely. Alcalde (2010) also found similar situations amongst poor women in Lima. On this she suggests that “the

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43 In Spanish the word ‘aborto’ can be used to signify both miscarriages and induced abortions – either way this would likely be classed as an obstetric risk and the patient persuaded to use a long-term hormonal contraceptive method such as the three-year-implant.
children marked the women’s bodies as “used” and as dangerous reminders of the limits of men’s control over their partner’s sexuality. The children from previous unions became clear, public statements that the men with whom the women lived in the present had not always controlled their sexuality” (2010: 117).

This line of thought speaks to Eloy’s comments that a man might call another a ‘marica’ if their wife openly used contraception – underscoring a potential competitive, aggressive side of machismo and intra-male inequalities, as well as intra-gendered aggressions they generate for some men. However, as Lugones (2013) and Hardin (2002) argue, machismo may have arisen out of the consistent emasculation of the indigenous male under colonialism, thereby suggesting that insults meant to emasculate within their context may refer back to the colonial wounds inflicted upon Andean masculinities historically.

On this, Segato delineates how coloniality forced indigenous men to “try and reconfirm abilities of resistance, aggressiveness, the capacity to dominate and seek ‘female tributes’…that permitted them to be recognised as masculine subjects” (2015: 133). The colonial wounds that indigenous males suffered caused the “emasculatio of men…that requires reconstruction through the use of violence” (2015: 133). Indeed, this violence may be exhibited towards women, as the concept of machismo might suggest, but also towards other men. Segato (2015) highlights how colonialism forced the indigenous male to consistently reaffirm Eurocentric notions of ‘masculinity’ and ‘virility’ to the white male, who Hardin notes frequently sought to co-opt the indigenous woman through rape and violations (2002). Thus, when Eloy shows concerns over other men’s gazes, this arguably arises from a colonial concept of masculinity whereby the indigenous male must always be on guard lest a [white] man attempt to unite with the indigenous woman. In this view, the machismo expressed can be interpreted as a colonial consequence of the treatment of indigenous men and women by the coloniser – and it continues to create friction and disrupt kinship in indigenous communities still.

These expressions of machismo go beyond satisfying male competitiveness, however, as they affect the behaviours of women, down to the personal experiences of the reproductive body.
As in the case of Janet and others, this may even be to the extent that she is pressured into reproducing more offspring than she ever wanted as a result of these pressures.

In these kinds of behaviours, of inter-male teasing and subsequent desires to control their virile images through increased offspring, one can notice the reinforcement of gender norms based on the colonial framework of *machismo*. The subjective normalisation of subjects through policing of the self, and of others, acts as a form of discipline (Feder, 2011: 59). Feder describes how a situation in which a boy may be teased by his peers, not indifferent to that of Eloy suggesting a man might be called a ‘gay’ for ‘allowing’ their wife to use contraception, is part of a “panoptic apparatus that operates to ensure properly gendered subjects” (2011: 59).

These gendered norms are arguably institutionalised by the coloniality of power/gender, and places such as the health centre help support and promote these ideas. It is perhaps no surprise that this occurs in a context wed to the health centre services; “Of all the technologies, medicine comes to play the most important role in the development of “the norm”” (Feder, 2011: 61).

A final contemporary expression of *machismo* is that of male infidelity on account of their supposed uncontrollable virility and sexual voracity. In one lively conversation between health workers in Sarachongo, male libido was suggested as the reason that men always want more children:

TECNICA: Men always want to have more children because they can’t go without sex.

OBSTETRA: A man can’t even stand up to one week without it!

TECNICA: Ah, but it’s easier for men than women, because they have ‘Manuela’ (‘their hand’ – ‘Manuela’ is a play on words. *Mano* = hand in Spanish, so ‘Manuela’ is both a woman’s name as well as a reference to masturbation).

DOCTOR 1: And when Manuela is too tired?
This conversation raises many questions beyond purported male desire for children. For example, the tecnica says that it is easier for men to wait for sex as children: "I think if a woman is unfaithful then her daughter will be unfaithful!"

**DOCTOR 1:** No, if a woman is unfaithful then her daughter will be unfaithful!

**DOCTOR 2:** Ah but it is not like that. If you just can't wait... you can wait.

**TECNICA:** Well they have two... today it's your turn, not your turn...

**OBSTETRA:** Ah that's why men are more unfaithful!

**DOCTOR 1:** Infidelity is genetic. Scientific studies prove this!

**DOCTOR 2:** Ah but it's not like that, you just can't wait... you can wait.

Health posts and reproductive health in particular are highly gendered spaces. Gendering reproductive responsibility is present in conversations but is institutionalised within the health establishments. Masculinity, such as violence and infidelity, are naturalised. This does not only present in reproductive and culpable for discussions, whereas the consequences of responsible and culpable for disruptions, whereas the consequences of being unfaithful and more likely to cheat. Women are consistently presented as somehow sexually chaste as they do not masturbate and therefore do not present an idealised version of a heterosexual relationship, in this view, whilst also pleasure-seeking outside of that relationship. The conversations about mother-daughter genital infidelity instead of father-son. This conversation about male infidelity, he chose to support his scientific data by referring to mother-daughter genital infidelity instead of father-son. This conversation about male infidelity, he chose to support his scientific data by referring to mother-daughter genital infidelity instead of father-son. This conversation about male infidelity, he chose to support his scientific data by referring to mother-daughter genital infidelity instead of father-son. This conversation about male infidelity, he chose to support his scientific data by referring to mother-daughter genital infidelity instead of father-son. This conversation about male infidelity, he chose to support his scientific data by referring to mother-daughter genital infidelity instead of father-son. This conversation about male infidelity, he chose to support his scientific data by referring to mother-daughter genital infidelity instead of father-son.
making these spaces more important locations within which to impart the state’s discourse of gender. This then contributes towards the colonial, “patriarchal domination” of the state (95). In such state space when it is gendered in this way, women’s bodies are those that are rendered docile which arguably makes reproductive governance (Morgan, 2012) over the female body easier to enact, as women are obligated to occupy health-post space due to the myriad state schemes in place (e.g. as a condition of JUNTOS conditional-cash transfer receipt; hospital-birth as a condition of birth certificate receipt, etc).

The previous chapter has explored the way that contraception and FP discourse aim to discipline and alter the subjectivity of the female reproductive body, however it has yet to be explored how this relates to men and gendered relationships more widely.

One of the key disciplinary techniques of power is that of responsibility and blame regarding the woman. She is charged with carrying out MINSA family-planning wishes and if this does not happen according to the discourse, she is blamed; omitting the participation of male partners and in the process, absolving them of responsibility, whilst at the same time reinforcing gender norms about what roles people are expected to perform.

That women should become culpable depositories of responsibility even in the face of institutionalised gender inequalities has been highlighted as a mechanism of the coloniality of gender (Schiwy, 2013: 139). As Choque Quispe notes, “the creation of a new prevailing order [colonialism] prompted indigenous thought to make women responsible for their suffering and problems” (1998:12) (quoted in Schiwy, 2013:139) (emphasis added). Thus, through ongoing coloniality of power, Quechua women become responsible for the problems in their lives and communities, and particularly when it comes to questions of reproduction as this is supposedly their ‘primary new identity’ (Choque Quispe, 1998: 12).

As men (whether fathers or otherwise) are often absent from the gendered health spaces they also remain uninformed about services. Thus, arguably the entire weight of responsibility for FP, and the blame for ‘unhealthful’ outcomes,
falls to women by virtue of their visible presence within the clinics, exacerbating gender inequalities rather than helping them. One such effect of this is the production of feelings of exclusion, which scholars have argued may lead to suspicion and consequently in some cases, violent behaviours (Yon Leau, 2000; Boesten, 2010a).

Returning to this chapter’s case study of Eloy, when asked why he thought that men might have an aversion to their partners’ use of contraceptives he responded:

*Por falta de conocimiento,* it’s because they don’t know any better. Here there isn’t even training (*capacitación*) or anything, they don’t train them, there are no talks about contraception… they need to give talks.

Here, Eloy mentions what he sees as a fundamental problem with FP in the health posts - that men are not included in it. “They need to give talks”, he urges, “here there isn’t even training”.

Boesten also makes the argument for inclusion of men within talks and workshops on FP: “men’s opposition to modern contraceptives might also derive from feelings of exclusion because of the emphasis on women in the politics of reproductive health…Men are more than willing to attend workshops on FP as long as they are considered as part of the process” (2010a:94). Because men are shut out of these services within the health centres, it is argued, they mistrust contraception: “male anxieties about women’s use of modern contraceptives are reinforced by their exclusion from the ‘modern’ family planning process” (104). Obstetras do not present the lack of male inclusion within FP as intentional; they are ‘welcome’ to join their partners in these consultations if they wish, although they very rarely did.

From this, it is important to note a way in which men’s relationship to the state may differ from that of women. Note that Eloy suggested that ‘they’, meaning the health centre, should be giving ‘talks’, and Boesten’s participants also requested MINSA workshops (2010a). Here, there is arguably a desire to *interact with the state.*
Whilst sitting in the maternity waiting room, another man complained to me about the obstetras:

They shouldn’t argue like this in front of the patients, es como si los padres pelean delante sus hijos, it’s as if parents are fighting in front of their children.

Curious that he should metaphorically understand the health workers as parents and himself (and the other patients) as their children, a patriarchal understanding of the state indeed. However, not one that men necessarily reject. When De La Cadena argued that ‘women are more Indian’ than men (1995), the reason for this was the differential relationships that men and women have with the ‘modern’, the ‘urban’, and even state institutions. Due to increased opportunity to travel away from villages for work, as well as higher literacy and bilingual rates and thus ability to interact successfully with white and mestizo Peru, men traditionally have more access to the realms of power (even if, once there, they are on the bottom rung due to their indigeneity). This arguably suggests that if MINSA were to attempt to incorporate men more in FP programmes, they may already be pre-dispositioned to receive the message. Yet, they are excluded.

This omission of men in FP is not specific to Peru, however. As Gutmann suggests, men have been “planned out of family planning” by Latin American governments’ “local application of the female contraceptive culture”, meaning that whilst policy might formally mention male participation, “in practice men were at best an afterthought; policymakers did not judge the participation of men in contraceptive use as necessary, possible, or worthwhile, and therefore little effort has ever been made to involve men” (2013: 53).

In the FP services at least, men do feature in theory. Amongst the official women-led contraceptives on offer and promoted (the contraceptive pill, the implant, the one- and three-month injections, copper-t, sterilisations, emergency contraception, rhythm method, lactational amenorrhea) there are two male-led options: condoms and vasectomies. Although unequally weighted compared to female-led contraceptives, this is reflective of contraceptive availability and does
not immediately suggest intentional exclusions uniquely occurring within Vilcashuaman.

Yet, even the limited male-led contraceptives on offer have been positioned as a woman’s responsibility, the condom being the prime example of this. As one poster promoting condom use (figure 5.2) reads:

Amiga Solo tú decides sobre tu cuerpo…exige a tu enamorado que use condón y evitaras un embarazo no deseado.

(Friend, only you can decide about your body, demand that your lover uses a condom and you will avoid an unwanted pregnancy).

A leaflet directed towards the avoidance of adolescent pregnancy expresses similar sentiments of female responsibility (figure 5.3):

Chicas, si decidieron tener relaciones sexuales con sus enamorados, exijanle el uso del condón para estar seguras y protegidas.
El uso del condón no solo es decisión de los chicos. Las chicas debemos exigir su uso para evitar un embarazo no deseado.

(Girls, if you decide to have sexual relations with your lovers, demand that he uses a condom to be secure and protected.
The use of a condom is not only a boy’s decision. Girls should demand its use to avoid an unwanted pregnancy).

In a few lines of condom-rhetoric, these MINSA promotional materials appear to position the condom as a woman’s responsibility to demand, instead of as a male responsibility to provide (or the responsibility of both equally). Women are told that condom-use is not only their partner’s responsibility but theirs as well, which could suggest complementarity, but then women are told that it is they who must demand it from their partner, thereby re-allocating the responsibility back to the woman. If she has to demand, this suggests that she may face resistance. Such discourses as those presented on these campaigns further serve to strengthen the normalisation of colonial gender roles and behaviours, in suggesting that women must convince their partner that they need contraception it takes away a man’s role in engaging in FP.
Male aversion to condom-use thus becomes an issue that women alone are burdened with the responsibility of tackling. As one female patient joked:

¿No hace mal al hombre señora? Don't they [condoms] make the man sick? Oh, or those are stories that men say to avoid using one! Oh, better that I don't ever fall sleep then!

That sleeping-with-one-eye-open is this woman’s solution, albeit in jest, instead of venturing to ‘demand’ that her partner use condoms, suggests an embodiment of reproductive responsibility.

Considering that vasectomies cannot be performed in Vilcashuaman, and condoms are therefore the only male-led contraceptive available within the province, such discourse accomplishes the unequal aim of extracting the only male-led contraceptive from the responsibility of men, making it another female-led contraceptive responsibility. In doing so, men are shut out from contraceptives and FP. Now the condom is “not only a boy’s decision” but something that girls must “demand”, as if that might even be a possibility for all women, within a context of machismo and widespread gender inequality where women may be at risk from male partners across Peru (Alcalde, 2010).

It is not only the contraceptive decisions that men are planned out of however, but potentially the experiences of childbirth as well. Under the intercultural birthing policy, men and other family members are supposed to be permitted attendance at the birth of their child (if the woman chooses), by law (Guerra Reyes, 2013: 2). However, they may be effectively deprived of that as well. Returning to Eloy’s experiences of his son Miguelito’s birth, he commented that:
Figure 5.2. Condom poster, Vilcashuaman
When my wife gave birth, she was there in Huamanga and she had a caesarean, but they didn’t let me inside. They told me that it was just a little room… that no one apart from the doctor could enter, that I was going to contaminar (contaminate) the room! He saw me like I was dirty, so we fought and argued for that but in the end, I had to wait there outside… we fought really badly, so I asked him [the doctor] for his information. “What is your name?” I asked him, I wanted his details, I wanted to know because they gave her [his wife] a caesarean but I couldn’t be there with her… it was an emergency and we had to come all the way from here, but I had to wait outside when we got there [to Huamanga].
Here, Eloy showed some futile resistance in demanding the health worker’s ‘details’, although any complaint filed would likely not have gotten very far as the doctor would claim that as this was a surgical procedure and not a normal birth, any (unsterilised) external visitor would pose a risk. Had anyone thought to include Vilquinos in talks about this policy, Eloy might have known that and been spared what he viewed as humiliation and exclusion from the birth of his son. In biomedical speak, the ‘contamination’ that the doctor mentioned meant *germs*; yet perhaps in the mind of Eloy, it was a potential insult of Eloy as the ‘contaminated’ *campesino* one. Indeed, lack of male inclusion in MINSA reproductive health issues and policy likely produces such misunderstandings on a regular basis. That said, issues within health centres are not always based on misunderstanding, as one event within the post-partum room suggested.

(Sarachongo, June 2018)

Two women had given birth the night before and were both ready to be released in the afternoon as no complications had arrived in either birth. Their immediate families had already arrived with supplies and food, gathering around the new-born babies and helping to pack up the women’s belongings in preparation for their release. Before anyone can go home, they need a final visit from the health-worker entourage to fill out some forms and check that everything is ok with the mothers; this is also the point at which women are ‘offered’ contraception.

An *obstetra*, a doctor, a nurse and a technician enter the room, and whilst they nod to me in recognition, the women’s husbands are quite literally *shooed away*. “¡Afuera!” the *técnica* admonishes, kicking the air behind the two husbands with comical exaggeration as they bustle quickly out of the room, to the laughter of all her colleagues. Only the women and health workers are left, and after being checked and approved for release, they are both asked right out which method they choose, with no suggestion that there is the option to go home without one. They both say the implant had been recommended to them during their consultations, and it was immediately agreed amongst the workers that that is what they would be given, again without any consultation with the women whether this is their preference or not, or whether they have had the method explained fully to them or not.
Such experiences are very important for two reasons. Firstly, the post-partum context is a key site in which women are ‘offered’ contraception and may find it hard to refuse. As a woman from Sarachongo stated in her interview, “they would not let me leave until I accepted the implant”, and other women have been told that “sí o sí” they must receive contraception before going home with their new-born. Such behaviours when women are effectively coerced into receiving contraceptives reflect obstetric violence.

Furthermore, that they are encouraged to use post-partum contraceptives does not necessarily correspond purely to health concerns inherent with becoming pregnant too soon after a birth. Indeed, exclusive breast-feeding is widely recommended, and thus consequent lactational amenorrhea is wholly possible (and included in the Vilcashuaman FP literature as a method). Therefore, hormonal methods are not immediately necessary post-partum if one is considering protection against another pregnancy so soon after birth, as using this natural method would protect against pregnancy for those first six months anyway.

Yet, women are all given hormonal methods sí o sí. This suggests that the post-partum room is an optimum opportunity to recommend the three-year implant as a way to protect against pregnancy long-term, feeding into the biopolitical control of poorer Peruvians nationwide. By overlooking lactational amenorrhea and instead pressuring patients into long-term, hormonal methods, obstetras ensure that they will not get pregnant for an extended period of time, thereby coercing women into extended child-spacing when other options might have been available to them were they permitted to choose.

What is further important to note here is that male partners were excluded from this, and herein enters a complicated debate. As Boesten (2010a) noted, when the law changed in 1996 and women no longer needed their husband’s permission to seek contraceptives this may have made it easier to coerce women as they no longer had their male partner present to disagree with the

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44 This practice is not necessarily confined to Vilcashuaman and is arguably a more national goal. At the 2018 Conference of The Peruvian Obstetrics College (Colegio de Obstetras del Peru), one speaker stated that “100% of post-miscarriage women in the country go home with a method, but it should be that 100% of all post-partum women also go home with a method”. In such a context we are speaking about obstetras working under MINSA, and therefore predominantly with poorer women across the country, hinting that the national goal may be for one hundred per cent of poor women to be given contraception immediately after childbirth.
authoritative medical figures and prevent the coercion. When male partners are ‘kicked out’ of the post-partum room, in time for their wives to be coerced into using long-term hormonal contraceptives, similar issues may arise. That said, in other cases women may not wish for their partners to be present as coercion may occur from within their domestic relationship. Such a Catch-22 expresses the intersecting inequalities faced by Quechua women today, and underscores difficulties in negotiating the best policies to ensure their agency and wellbeing.

To return to the post-partum room example, when men are banished this might not only pave the way for contraceptive coercion of their partners, but also compound their feeling of exclusion that result in contraceptive misunderstandings and instances of gendered-violences down the line. In the above example, the técnicas showed her complete lack of respect for the husbands, not only by banishing them from what was to be a discussion concerning the health and hospital-release of their partners and new-born children, but also through her rather distasteful treatment of them.

Importantly, some men may not always allowed to participate in the birth, as Eloy’s experience showed, nor in contraceptive decision making, if they are shooed away and kept out for such occasions. Under such circumstances, and as Boesten has argued (2010a), not only are they ‘planned out of family planning’ (Gutman, 2013) from a policy level, but they are outright excluded from participation in reproductive health services in a local clinical context as well.

As Berry (2010) outlined in her Guatemalan study, when the biomedical ‘intercultural’ birthing policy was introduced amongst the indigenous Maya it inalterably changed women’s subjectivities in part because in Kaqchikel birthing rituals the male is meant to play a central role in the birth of his child. In omitting male partners, the hospitals irreparably altered indigenous subjectivities both corporeally but also their gendered subjectivity and how this applies to reproductive health and the reproduction of future kin. If male partners are also excluded from births in Quechua communities then a similar effect may occur on subjectivities of both men and women in Peru also.
In a context of *machismo*, where suspicion of health posts and reproductive services is common as it is, their exclusion in decision making by health workers may serve to fuel those fires and disadvantage their female partners in the future if they are unsupported by their husbands. However, such events also place the entire responsibility (and any concurrent blame) about reproductive decision making onto women, thus exacerbating unequal relations.

The state that enacts the coloniality of power incorporates control over gender and sexuality (Mignolo, 2013: 3). In the specific case of the Andes, the coloniality of gender suggests that gendered relationships were changed to become more unequal under colonialism. These structures persist today; whether we use the terms *machismo* and *marianismo* to understand them or not, unequal gendered relationships in Peru and the continent are existent. As the above discussion has suggested, these gendered relationships may not only have been introduced during colonialism but are today carried through in state discourse and institutionalisation of unequal gender norms. The way that gendered roles are promoted within the health centres reflects Schiwy’s (2013) suggestion of women as responsibility-bearing reproducers and men as controlling possessors of their women.

In terms of reproductive health more generally, it is not only FP, and the lack of contraceptive use, that is positioned as a woman’s responsibility and fault, but also the presence of sexually transmitted infections (STI) as well.

In Vilcashuaman obstetra consultations, STIs are *always* a woman’s fault because of a perceived lack of feminine hygiene. It is her ‘fault’ for not washing her genitals – either because this apparently causes infection (lack of hygiene might cause urinary tract infections (UTI), but not STIs), or because the implication is that her lack of hygiene may have caused her partner to stray. There was scarcely mention that a man might have ‘brought home’ an infection from an affair or indeed that his personal hygiene may have been unsatisfactory, only blame and admonitions that the women must also convince their husbands to take medicines to avoid the malady’s unwelcome return, as the following consultation suggested.
“Regla blanca”, the obstetra diagnoses the patient after a brief discussion about her symptoms. ‘Regla blanca’ or ‘descenso’ is the catch-all referral to STIs and UTIs here in Vilcashuaman; any itching, malodourous, swollen, bumpy or reddening genital symptoms are classed as such. This is not an uncommon thing to hear in the health centre, and the patient seems unfazed by this diagnosis. “¿Te lavas tu parte regularmente? Do you wash your ‘part’ [genitals] regularly?” the obstetra enquires as she scribbles details onto the medical form. “Sí doctora”. “With soap? With water?” “Sí doctora”. The obstetra seems unconvinced and repeats the questions, asking the patient about her hygiene routine in more detail, insinuating that this health complaint may be purely due to her lack of proper washing. A desk drawer is pulled open and two blister packets of pills are produced, one for the woman, and one for her husband, along with some condoms. “It is very important that your husband takes all these pills too, or the descenso will come back”, the patient is told, slipping the collection of medicines into her woven-plastic bag. There is no further discussion of the patient’s condition, and she does not ask about it anymore.

At a glance, this patient’s health concerns of ‘regla blanca’ may have been from poor hygiene; however, that would not merit her husband’s use of medication. Because of this, the diagnosis instead would have been an STI, which might make one question why the woman was questioned so intensely about her genital hygiene if this was not the issue at hand (medically speaking).

Sexual health is constantly related to questions of hygiene in the health posts, and rarely refers directly to questions of intercourse. This extends to the presentations provided by MINSA within local schools where obstetras would occasionally lead short workshops with village teenagers, thus the confluence of a lack of hygiene and STIs is instilled from school age onwards. Importantly, UTIs can be caused by a lack of hygiene, however, UTIs do not produce the kind of symptoms displayed during presentations on the consequences of poor intimate hygiene; cottage-cheese discharge seeping out of reddened vaginas and penis glans colonised by fierce yellowing lumps are the general order of the day. Women’s blame in all of this may be partly circumstantial; as health centres are gendered spaces, and women’s services (e.g. smear tests) require
that women expose themselves more frequently than men, they are therefore more visible and present – if an STI diagnosis is made, it is the woman who it will likely be made from. However, disdain is sometimes evident, for example one patient was told by an obstetra “you smell disgusting, you need to wash” after being intimately examined. Yet, it paints an insufficient picture to understand lack of hygiene as purely a corporeal issue; it is moral as well.

Martinez (2018) similarly describes how poorer Venezuelan women with cervical cancer (or abnormal cells) are perceived to be hygienically, and by extension, morally (sexually) inferior due not necessarily to their medical condition but to their poverty. She notes that there is no scientific evidence to suggest that a lack of hygiene might produce cervical cancer (2018: 61), thus the perception of lack of hygiene is a moral one based upon the assumption of unprotected intercourse; a moral transgression (2018: 73). Here, as in Vilcashuaman, perceived moral transgressions are interpreted in the biomedical context as someone being ‘unhygienic’ or ‘dirty’.

To describe physical dirtiness, such as bad smells, visible dirt, and discoloration, the adjective ‘cochino’ is often used. ‘Cochino’ is a Spanish word that is linguistically rooted in the word for ‘pig’ (Garcia-Hernandez, 2013), and is still often used to refer to filthy animals. For example, my neighbour’s white-coated dog was nicknamed ‘cochino’ on account of his predilection for rolling in the mud and, consequently, giving himself brown-dreadlocks. However, in this case it was never acknowledged that the pet owners may have had the responsibility for keeping him clean – his cochino-ness was instead presented as seemingly innate to his animal-ness. However, being ‘cochino’ also carries a moral value.

Two obstetras both mentioned high incidences of ‘regla blanca’ as one of the major health concerns for women in the region. When asked why, the response was that men (not women, this time) are cochino. When probed further, ‘cochino’ in this context refers to a lack of moral hygiene, namely, that men are often unfaithful to their partners and therefore bring home STIs – they are ‘dirty’; they are sexually unclean. Yet back in the consultation context, this ‘dirtiness’ becomes transmuted to women’s physical hygiene, blaming women again for
sexual diseases, even if during interviews with an anthropologist the obstetras acknowledge the opposite.

Importantly, the discourse of women-as-unhygienic is a highly racialised one. Meltzer argues that in Peru there are longstanding “moral-racist narratives of indigenous/poor/non-citizens as idle dirty, and destitute” (2013: 649). Ideas about hygiene, and indigenous people’s perceived lack of this cleanliness, go beyond racist rhetoric alone, however. This is also a colonial imposition of hierarchical value.

Wilson (2004) describes how in the past, Andean indigenous were effectively denied citizenship rights as they were kept away from public spaces due to a rampant hygiene/disease discourse promoted by the urban, white elites of the time. The indigenous were seen as physically and morally unclean and permitting them to inhabit public spaces was thought to be a risk as they might contaminate these areas, the solution being racial segregation.

The fact that women’s hygiene continues to be called into question under public health discourse suggests a continuation of such views, however here, as Boesten (2010a) suggests, there is a particularly gendered nature to this (lack of) hygiene. Martinez (2018) similarly found that whilst women in Venezuela perceived male-partner unfaithful behaviours to be the cause of their cancer, the health workers consistently blamed women’s behaviour for the reproductive affliction (2018: 79).

In fact, even if a woman’s husband is known to be unfaithful, she may be blamed for that as well, suggesting a persistence to blame women for everything, as suggested in the health-centre conversation of the previous section. This is further suggested by ethnomedical, as well as biomedical, healers.
Every few months a visiting shaman from the jungle region of Pucallpa came to set up residence in the province. A sparsely decorated room with a little table in the corner is filled with a few exotic artefacts – dried lizard, snake ‘venom’, a suspiciously plastic-looking skull, and a transparent-glass penis amongst other things. Jungle shamans are well-known for their love magic (Millones, 1990), and attending to women who wish to win back errant husbands is a big money-spinner for Shaman-David as he travels around the mountain departments of Peru. How does one win back one’s lover?

David explains that men often look elsewhere because women have ‘let themselves go’, and they have stopped caring for their appearance, in his opinion. Watching me eye up his ritual implements with interest he confesses that he rarely uses those items - those are to cure envidia, susto, or daños – all ethnomedical ailments that the local curanderos can deal with successfully as well, depriving David somewhat of that selling point. Instead, to help a woman win back a lover and reignite their sexual desire, David marches them to a

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45 This shaman differed from the local curanderos; he treated different complaints from the Andean ethnomedical afflictions treated by curanderos. Jungle shamans, for example, are said to excel at love magic, hence why David features in discussions of gendered relationships and love more than curanderos do in this dissertation (see figure 5.4).
beauty salon and tells them to make more effort. He might splash on a bit of perfume. That is the best way, he winks knowingly⁴⁶.

From this, it is also important to note that it is not purely in the health post context that women are blamed for gendered problems, but within the context of ethnomedicine as well, suggesting a potential degree of [sexual] reproductive governance (Morgan, 2012) on the part of ethnomedical healers also.

The suggestions that women’s bodies must be preened and perfumed to be clean and (following from the shaman) sexually desirable is deeply rooted in notions of Foucauldian disciplinary practices of the body (Bartky, 1997). Responsibility and blame around cleanliness, STIs and harmonious relationships fall squarely on women’s shoulders – what Bartky (1997) calls the “modernization of patriarchal domination”, the aim of which is “to produce a body of a certain size and general configuration; those that bring forth from this body a specific repertoire of gestures, postures, and movements; and those directed toward the display of this body as an ornamented surface” (95). Blaming women for male infidelity and subsequent potential infections through calling into doubt their physical and moral hygiene not only serves to absolve male responsibility, but arguably supports the previously mentioned male objections to contraceptive use and machismo; women are ‘cochino’, the health centre promotes the idea that they hold the blame for STIs, so it must be they who are the untrustworthy ones, thereby normalising these gender subjectivities.

Furthermore, that women are portrayed as in need of greater ‘hygiene’ practices, physically and morally dirty, itself arguably serves as a moralising regime. As Guerra Reyes argues, Andean women’s reproductive preferences are often framed as an ‘irrational moral regime’ that is presented as in need of change through health policy intervention (2014: 4). The health centre focus on

⁴⁶ Interestingly, one of David’s other main works is to address male STIs – something that is rarely presented at the health posts. Men are too ashamed to attend, he says, and he often sees young men presenting ‘penile secretions’ who wonder if it is the result of *mal de ojo*. He sends those customers to the health posts, he says. Whether or not they actually ever arrive is dubious, however it hints at a local understanding of male STIs being of social rather than biological origin (one becomes afflicted by *mal de ojo* on account of another’s ailment-causing envy, of which they may be conscious or not).
women’s purportedly ‘bad’ hygiene practices as causing STIs and potential infidelity on the part of their husbands serves to moralise female hygiene and suggests that Quechua women are somehow immoral by virtue of a lack of this hygiene at present. This way, a focus on female responsibility and culpability within reproductive health and associated gender inequalities acts as a moralising regime, rather than simply a public health concern.

Drawing on Briggs’s concept of ‘sanitary citizenship’ (2004), Martinez (2018) has argued that when poor women are portrayed as physically and morally unhygienic due to their behaviours, they become ‘unsanitary subjects’ to the state; the “antithesis” of “moral and modern citizens” (2018: 108). She argues that this “exclusion from citizenship” due to perceived unsanitariness “is not formal or legal but rather is accomplished precisely through the everyday practices of configuring them as threats to the nation through their diseased fertile bodies” (2018: 108). It could be argued here also that through the way that Vilquinas are treated in regards to their perceived (lack of) (moral) hygiene in the health posts, these are also ‘everyday practices’ that render them excluded from a ‘modern’ Peru: one where women are white, ‘hygienic’ and plan their families according to biomedical principles.

In this, the FP discourse misses the opportunity to address unequal gender relationships and instead promotes what Moeller calls the global ‘gender effect’ (2018), whereby women are burdened with the full weight of responsibility for community and familial developments whereas men are overlooked and dismissed from these duties. She argues that the focus on women-as-developers of their communities is a long process starting from colonisation, through to slavery, through to globalisation (2018: 27), resulting in “conditions that make poor racialized girls and women of color disproportionately responsible for the well-being and future of others” (38). This simultaneously denies them empowerment and agency.

**Conclusion**

If an ongoing problem in contraceptive use and FP has been identified as a result of unequal gender relationships and machismo, then the health centres seem to do little to discourage such perceptions. Through campaigns and the way that workers perceive these issues, such as blaming machismo for
everything whilst at the same time personally telling women that it’s their responsibility and fault when things go wrong, MINSA institutionalises these harmful gender norms that contribute towards disruption. Through attending to the coloniality of gender, it is possible to see how the coloniality of power is at work here – specifically, how a society in which pre-colonial gender relationships would have looked different (if complementary or otherwise), has changed to become more violent and unequal as a result of colonial impositions of gendered categories and subscribed roles within those ideals. Babb has argued that a (re)-focus on the notion of Andean gender complementarity, whilst not necessarily romanticising this view or taking it at face value, might be one way to begin to decolonise the coloniality of gender in Peru, and thereby work towards more equal gendered relationships that do not promote this institutionalised disjuncture as within the health centres. This may be a start however here it is necessary to note what gender complementarity misses. It presupposes that genders, although complementarity, fall into two categories of male and female with subscribed roles.

There are some that suggest that the concept of gender, whether complementary or unequal, is a colonial concept in its totality. For example, Horswell (2003) argues that the Andean gender binary, even if complementary, is a colonial construct itself. He suggests that there were numerous gendered categories within pre-colonial Peru, and importantly, that these categories did not depend solely upon heterosexuality. The gender complementarity discourse somewhat naturalises heterosexuality, for example, in seeing the harvest process of female: insert seeds, and male: water seeds as reflective of human reproduction and sexuality, there is little room left for those who play neither role. In this, these strict binaries, the famous ‘Andean dualism’ is limiting. Instead Horswell suggests that we should break with the sex and gender bipolarity when addressing pre-colonial Peru (Lugones, 2013: 382). Schiwy concurs, arguing that “the notions of femininity and masculinity are themselves colonial constructs that have pressed more complex notions of gender, sexuality, and desire into a binary” (2013: 125). If one were to decolonise gender within health centres and beyond, the reliance on a strict notion of Andean gender complementarity would render invisible those outside of the binary, thereby whilst addressing inequalities based upon gender, one would
create new inequalities based on sexuality, thus excluding homosexual and non-binary sexual orientations in the process.

A further point that serves elaborating upon here is sexuality, and particularly the sexuality of indigenous women, whether heterosexual or homosexual, and how this is somewhat invisibilised within the health centre discourse. Even considering that a key reason that people may seek contraceptives is in order to enjoy sexual pleasure without pregnancy concerns, indigenous couples are consistently presented as sexually active for purpose other than this (e.g. childbearing, territoriality over partner, etc). One must bear in mind how the introduction of the contraceptive pill to the Western world in 1961 was considered a key moment in the history of human sexuality; people could now put unwanted pregnancy fears aside and enjoy sexual intercourse as a pleasurable pastime (Eig, 2014). Although the medical world may have once “treated intercourse as a sanitized, emotionally neutral act” (Higgins, 2007: 240), there has been an increasing process of change towards this. For example, the changing of the phrase ‘reproductive health’ to ‘sexual and reproductive health’ suggests increased medical consideration of sexuality, Higgins and Hirsch argue (2007: 240), although this is still a process underway. The lack of attention to sexual pleasure in FP has been called “the pleasure deficit”, leading to a publication in The Lancet arguing for greater inclusion of pleasure promotion in sexual and reproductive health, the inverse of which may actually undermine effective use of contraceptives (Philpot, 2006). Increasingly, this pleasure deficit is being addressed in FP contexts (Higgins, 2007), and was specially promoted during the Fifth International Conference of Family Planning (Kigali, 2018); pleasure is absolutely fundamental to FP, it was argued; the core reason why people choose to have sex. Yet, as Ströbele-Gregor (2013) laments, although indigenous women are increasingly visible in politics and activism, their bodies and sexuality continue to be erased from reflexive discussion (2013: 80). This was expressed through the earlier mention comment of a técnica about it being ‘easier’ for men to withstand sexual abstinence as they could masturbate, in which not one member of that conversation acknowledged the fact that women are equally as capable to masturbate.
This omission of indigenous sexuality within the health centres may in fact be a part of the coloniality of power, Segato argues (2014). Along with colonial views of genders also came the moral attachment of sin to sexual relationships, whereby sex outside of the marital couple came to be considered as a moral transgression. She calls this the *pornographic gaze*; under coloniality, sex outside of marital procreation became sinful and dirty, whereas for pre-colonial indigenous Latin Americans sex and sexuality did not carry such values (2014: 593). Thus, indigenous sexuality continues to be analysed under this *colonial pornographic gaze* and is thus rendered too immoral a subject to be addressed within a state institution. Even if that institution deals directly in sexually related matters, these are rendered moral questions, as the discussion within this chapter has elaborated upon.

It has been seen how colonial, institutionalised gender norms are promoted, reiterated, and enforced within the FP discourse in health centres, arguably to the detriment of the population who suffer under unequal gender relationships. Women experience the brunt of physical and psychological violences; however, it is also important to note how gendered ideals such as *machismo* hurt men, and particularly men who do not act in this way. Whilst gendered norms are deeply ingrained within the wider post-colonial Peruvian society, state institutions such as health posts can begin to address their own role in reiterating harmful colonial gender binaries.

Taking the focus of gender from contraception into parenthood, the following chapter will look at the subjective constructions of parenthood and FP within the health centres to explore further the way that kinship may be affected by wider state discourse.
Figure 6.1. A mother cuddles her baby under a painting in the maternity ward.
Poor parents, and women who are mothers in particular, are considered to be ‘at risk’ by the state—a category that is both negatively value laden and also justifies governmental intervention. Those who qualify for, and avail of, the free government health insurance ‘SIS’ (Seguro Integral de Salud), are part of this risky population, and as a previous chapter discussed, indigenous pregnancies are framed as inherently risky in all cases. As Bridges notes on poor women in the United States, “their ‘risk’ status is…substantiated by their search for state-subsidised health care. Presumptions of the ‘riskiness’ of their bodies and lives are confirmed by their very presence at the clinic” (2011:167). In this view, those who are ‘at risk’ due to their poverty also have bodies that are risky and ‘unruly’ (2011: 16), especially so when one addresses their supposedly out-of-control reproductive capabilities. As chapter four showed, the FP discourse situates contraception as a necessary panacea for the risk inherent in “all” pregnancies, thereby underscoring this risky reproductive body for SIS-users.

The risk factor helps to justify state intervention in the reproductive bodies of poorer women (such justifications were used in the past sterilisations under Fujimori, for example) (Ewig, 2010), principally through the government FP programme. However, addressing risky mothers does not stop there—other state welfare programmes also target this population. For example, the JUNTOS conditional cash transfer programme was also developed for ‘at risk’ populations as a way to alleviate their poverty through finances (Meltzer, 2013: 643). The risk element inherent in these populations is not simply that they are poor, however, but that they are poor mothers. They have made the supposedly unreasonable decision to have children whilst poor; “the decision to reproduce while poor is an irrational, irresponsible one”, made by women who allow their “poverty to intersect with motherhood” (Bridges, 2017:109), and therefore need to be kept an eye on by the state. This supposedly justifies state intervention into, and control over, their lives, and furthermore, their kin. They cannot be trusted to make ‘good’ reproductive decisions, in this view. Furthermore, as this chapter will argue, because such irresponsible decision making led to their being pregnant while poor, they have their claim to full citizenship thereby revoked until the time in which they can successfully deliver competent,
professional children who are ethnically, culturally, and racially superior to their indigent mother, in the state’s view. It should also be noted that neither FP under SIS, nor JUNTOS, actually require that the woman be the principal recipient of services or welfare (men can access contraception, JUNTOS requires only a ‘household representative’ (Meltzer, 2013:648)), therefore the fact that women are targeted underscores an unequal approach to gender roles, as the previous chapter discussed. Therefore, despite their purported claims to empower and attend to those ‘risky’ women’s needs, these programmes may end up potentially entrenching “traditional gender roles- the role of women as mothers” (Meltzer, 2013:648).

This chapter will first address the way that the FP service is framed not only as a service for (sexually active, of-age) partners, but also as a service for children, thereby placing a moral responsibility for ‘maternal altruism’ (Rapp, 1999) on mothers. Furthermore, it is important to consider how framing services as targeted towards children may subsequently conceal accusations of mistreatment towards infants, as these services insinuate that women are unable to care for existing children due to a lack of conscientious FP. Segato (2015) reminds us that in the ‘colonial world’, state initiatives to ‘rescue’ indigenous children from supposed maltreatment on the part of the parents may be an excuse to intervene in intimate spaces of kin and community (2015: 72). Elsewhere, the Peruvian state has already removed indigenous children from parents based on accusations of mental unfitness to parent – a biomedical frame of reference (Leinaweaver, 2009). Thus, such an approach needs to be questioned.

The ‘professionalisation’ discourse will then be discussed, to show how this contributes to the rural-urban migration push as an aspiration for children; a feature of ‘aspirational whiteness’ as Guerra Reyes highlighted (2014). Finally, the emphasis on the finances of FP shall be queried. Necochea Lopez has found that financial concerns are often not the key reason that people may use contraception in Peru (2014), yet the health posts not only teach this but contribute to the prejudiced discourse of the money-orientated, ‘welfare-queen’ (Bridges, 2011) Quechua woman that results in discriminatory practices. This will lead to the conclusion that through the FP (and other state welfare programmes) discourses, women are encouraged to limit childbearing in order to (re)produce a desired kind of family; limited children who all move away from
their rural homes to become urban (and ‘whiter’) professionals. At the same time, this discourse scolds women for becoming more financially-orientated (a narrative arguably incited by the health post and other state institutions in the first place), thus placing Quechua mothers in a catch 22 and keeping them forever just that little bit out of reach of embodying the promoted desirable woman and reaching a full citizenship status in the eyes of the state. This state of subjective liminality may result in more governable individuals, whose possible transgressions may cost them a great deal more than they would financially independent Peruvians elsewhere.

**State Welfare: Looking after the children**

The Peruvian state offers welfare programmes to low-income families besides the free health care provided through the SIS system, the most significant of these being directed explicitly at the betterment of children. Indeed, development and health programmes in Peru have long targeted the mother-infant relationship, seeing this as that needing the most care, investment and attention. In relation to public health, women and children have been the ‘primary’ clients due to a history that saw “the molding of mothers as central to nation building and betterment” (Ewig, 2010: 17).

The two welfare programmes with the highest visibility and coverage in Vilcashuaman are JUNTOS (‘Together’), a conditional cash transfer programme from the *Ministerio de Desarrollo y Inclusión Social* (Ministry of Development and Social Inclusion) (MIDIS), and *CunaMas* (‘Cradle Plus’), a parental education and accompaniment programme. Both organisations explicitly deal with the mother-child relationship, although they are slightly different. JUNTOS provides a monthly sum of S/100 to support child-related costs, on the condition that the parents will ensure a child attend school and health check-ups, and that the mother herself will also commit to regular contact with her JUNTOS organiser through monthly meetings. In Vilcashuaman, JUNTOS members also had to attend mass smear-test days at the regional health centre and participate in various other MINSA events. Some JUNTOS programmes explicitly demand that its members use FP (Molyneux, 2011), although this is not a nationally official condition of payment receipt. Either way, the child-focused programme involves commitment from the female parent above and beyond factors that relate directly to her welfare-recipient child.
*CunaMas* representatives visit new mothers in their home to monitor their parent-child interaction, although where *CunaMas* has an established centre the programme also functions as a form of daytime child-minding and parental education. Willka Waman does possess such a centre - a bright, white, brick-built beauty sandwiched in between the crumbling adobe exteriors of the local housing. This programme is also explicitly targeted at the betterment of children through the counselling and education of the female parent who is believed to be the primary care giver.

In contrast to these two programmes, FP under SIS is not *explicitly supposed* to be a state welfare service directed at the betterment of poor children, but a medical service used exclusively by adults or adolescents engaging in sexual relationships, and it is administered by a completely different ministry to the others. At first glance at least. Yet like the JUNTOS programme that uses the conditional aspect of the cash transfer to influence women’s behaviours above and beyond that mandated by the programme, so does the FP service wield a similar power in reverse - a service directed at and used exclusively by adults is framed as one whose aim is to specifically benefit children. Indeed, the health centre and the JUNTOS programme (more so than *CunaMas*) are intimately and publicly related.

The conditional smear test events are one example of how health workers use women’s entrapment within the JUNTOS mandate to meet their own goals, in collaboration with the JUNTOS coordinators. However, they do not allow women to solely participate in private JUNTOS events at the health post, but they must publicly support the health centre and display themselves as recipients of government aid to ensure the continuation of payment. The obligatory participation in a MINSA ‘maternity’ parade presents a good example of this.

(Willka Waman, May 2018)

A banner strung across the front gate of the health centre proudly announces the ‘Week of Healthy and Safe Maternity’ (*La Semana de la maternidad saludable y segura*). The official campaign materials include the additional words ‘and voluntary’ (*y voluntaria*) on the end of that tag line, but that detail of agency and reproductive freedom does not make it onto the promotional materials here in Willka Waman.
We have spent the morning inflating enough balloons to hand out to everyone in the late-morning procession that is scheduled to filter through the town and arrive in the middle of the plaza de armas just in time for lunch and the guaranteed presence of the greatest possible audience. Bunches of balloons are pushed into my hands and the crooks of my elbows as I am shuffled towards an expansive group of local women huddling around the health centre courtyard. As I begin to pass them out, I notice that the hands into which I am dispensing balloon triages are familiar—these are all women that I have seen before at JUNTOS meetings. Their participation in this parade is compulsory if they want to receive the monthly welfare sum, I learn, in addition to the other list of activities for which they are seemingly on call. I am shunted to the front of the procession to accompany the health workers and being one of the tallest ones there, I am expected to hoist the health centre’s banner.

We begin to march, chanting as we go, “Si estas embarazada, acude a tus controles!” (“If you are pregnant, go to your controls!”); “¡Wawita sana, mamita feliz!” (“Healthy baby, happy mum!”); “¡El Perú se desarrolla y Avanza!” (“Peru develops and advances!”), and finally, with one of the health-workers taking the lead, “¡No al embarazo no deseado!” (“No to unwanted pregnancy!”). “¡NO!” the procession counters with gusto.

The JUNTOS mothers have been trailing behind us, waving their balloons and half-heartedly joining in with the chanting. Some have brought along small children, perhaps because they had no one to leave them with at home. When the parade comes to a stop in the plaza, I notice most women quietly slip off, likely to return to whatever activity they had to abandon in order to support the health centre’s current whim.

Did the health centre genuinely rely on their numbers and support to help promote health care and safe pregnancies to other women in the village? Or were they there just to make up numbers, or to act as a visual warning to the

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47 Situations in which I am caught between my Quechua participants who know me outside of the health centre, and the role that obstetras and other health workers expect me to play in events such as the parade, are a feature of my fieldwork and invite reflection on my positionality. Whilst I was asked to help the health centre and JUNTOS here, an activity which could position me as a ‘member’ of the health centres (and by implication, outside of the community somewhat) so too were the women in a similar boat. As their participation was a requirement to receive state funds, so arguably too was my presence a requirement if I wished to continue fieldwork in the health centre. Ultimately then, my positionality here could be seen as ambiguous and sympathetic to both sides.
rest of the community what are the humiliating consequences of ‘uncontrollable pregnancy’ and poverty, paraded around as they have been?

Any way one looks at it, the JUNTOS mothers had little choice to reject the health centre demand that they participate in its self-promotion. Even so, evidence of the fact that they may have felt humiliated by this could be seen in their demeanor as they paraded through the streets; eyes down, jostling to be in the centre of the crowd and less easily-identifiable, and balloons held low to obscure faces, were just some of the ways that the women attempted to avoid this visibility to their community.

Considering the theme of the parade, it could be argued that their presence was utilised to act as a cautionary tale to the rest of the town that came out to watch (uncontrolled) motherhood and poverty will result in your humiliation to your community at large. Whilst the women may not have felt humiliation at receiving JUNTOS money or attending the health centre as such, there is evidence to suggest that being made so visible to everyone else, especially as their position as ambiguous, produced this feeling. For example, others came out to observe us, standing in the doorways of small tiendas and peering out of windows, yet they were not looking at the workers necessarily, but the Vilquinas, and whispering amongst themselves. The important point here is that they may not have known that the women involved were a part of JUNTOS; only that they were somehow collaborating with the health centre’s vocalising about the need to control pregnancy. Importantly, this event further demonstrates the blurring of lines between state development programmes (JUNTOS is from the Ministry of Development) and MINSA activities - in motherhood they meet. The catch here is that FP doesn’t necessarily have to include children directly, unless we talk of avoiding their existence. In fact, it is not a service that children can use at all contraceptives are strictly for adults. Furthermore, it is a service that carries the potential to contribute towards the personal development of adult life projects away from the family as, in theory, contraception can support a couple’s postponing or spacing of children where unwanted families might otherwise hinder more personal goals. Indeed, the FP leaflets do allude to this, listing as reasons to use contraception: “you can become realised as a woman and a
person”, and “you can take care of your relationship with your partner” (see appendix 4.1). Yet, this is not necessarily affected or narrated in practice. The potential for women (and men) to pursue personal life projects was seldom mentioned within FP consultations, the assumption seemingly being that there may have been nothing necessarily to pursue. Conversations frequently pivoted around wanting one’s children to do better than oneself (as discussed below), rather than wanting to better oneself in order to better one’s children (or one’s life in general).

Instead, taking a leaf from the book of its development-programme bedfellows, the FP programme discourse and execution arguably places children as a central beneficiary, losing much opportunity to consider the potential empowerment of its adult users. They are represented as but conduits to the (re)production of successful and appropriate (and limited) Peruvian children.

To use the larger health centre in the provincial capital as a case study, the architecture and designated-spatial geography of consulting and treatment rooms is most telling as to the target recipients of each service. The chosen health centre consists of two main buildings (general medicine, maternity building) and three smaller auxiliary constructions (psychology, pharmacy/dispensary, and administrative offices/meeting rooms) within a brick-fenced wall, guarded by an imposing iron gate that is always open (see appendix 6.1). The buildings are arranged around a central plaza where patients often sit and wait when the weather is good. Of interest here are the two main buildings. One is the ‘maternity’ building. It holds all the consultation rooms and equipment that one might associate with maternity and women’s general services- a birthing room, smear test equipment, sonogram machine, etc. The other main building houses more general medicine but could comfortably be seen as the ‘children’s building’. This is where the ‘growth and development’, early stimulation’ and ‘paediatric medicine’ consultation rooms can be found, and where a modest children’s soft play area is located.

The FP consultation room is located nestled amongst children’s services. Of course, one could always argue that women who use the maternity building

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48 See Chapter five for discussion on gendered relationships and the FP discourse.

49 Other important services, such as psychology and pharmacy, are found in the smaller auxiliary buildings.
might already be pregnant so not need immediate access to contraception, however it should be stated that the majority of obstetras (and all their patient files and equipment) are all located in the [relevant] maternity building, not amongst the nurses and medics that attended to the children, so even non-pregnant women would logically direct themselves to the maternities building for contraception as it is obstetras who deal with this service. Instead, it could be suggested that the spatial geography of the health centre underscores something more fundamental; FP is in with children’s services because it is seen as a service for children. In this, it is not meant to say that contraceptives are being offered to children, but that the primary beneficiaries of FP are interpreted to be children, and not women, men, or couples.
Medical geographers discuss how built environments are influential in determining human health, particularly the spread of illness and disease, as people move through certain spaces in their environment that formulate their health behaviours (Nepal, 2009). However, theories from medical geography could also be applied here, to understand how people’s reproductive behaviours may be influenced by the built environment of the hospital.

The construction of space through which people move and navigate is also an important element in Foucauldian theories of discipline, his ‘art of distributions’. In order to create discipline, one must order space and the way that people can move through it, the result being that they perceive their actions as natural choices even if they are subconsciously coerced into taking them (1991). Hoffman writes that “Foucault insists that disciplinary power creates a cellular form of individuality by ordering individuals in space…within this enclosed space, disciplinary power produces an organic individuality by exerting a control over bodily activities. This individuality is ‘organic’ in so far as it lends itself to disciplinary practices all on its own, as if spontaneously and natural” (2011: 29).

Therefore, in laying out the spacial geography of the health centre in this manner, women who attend children’s services will gravitate from each required consultation to the other, ticking each child-orientated check-up off the list, as if spontaneously. If FP has been arranged into this space, it could be argued that the aim was to create discipline and frame the programme in a certain way.

This discourse surrounding FP as directed towards children played out time and time again in the consultation room, and most usually, when a woman was
being reprimanded for ‘excess’ births and lambasted that she should cease in order to focus on supporting those offspring that she already had. As one obstetra lamented, when the mother gets pregnant again, “Los hijos sufren” (“The children suffer”). Once a woman had one child health workers would extol the virtues of sustained contraceptive use with particular focus on the three-year implant that could ensure successful child-spacing for an extended period.

It was imbued with further desirability through obstetras’ representations of its rarity. For example, at one of the smaller health posts I observed a consultation where the obstetra waved the boxed-method in front of a patient, telling her “these are expensive, we don’t have many, aprovecha (take advantage)”, presumably because she believed that the method would become instantly more attractive to this woman through its purported exclusivity and financial value. Such bating highlights the obstetra’s assumption that poorer women can be seduced by expensive things, that they are interesada, a pervasive notion discussed further below. This patient said no, but others willingly agreed to the method after a lecture about child limiting, and how excess children would harm the future of the others through resource consumption. Indeed, when a poorer woman becomes a mother, she becomes shuffled into the state’s varied welfare programmes that in assorted but interrelated ways, begin to disregard her as an individual and focus more intensely on her value as a vehicle through which children can be ‘properly’ raised. This is seen to be an impossibility within the larger families that poorer women are assumed to have, and therefore child limiting emerges as a central discourse in the health centre and beyond.

Almost every single health worker lamented at some point that uncontrolled fertility, and a lack of resources to support those children, was a key issue that needed to be overcome. Limiting births is therefore promoted not as a goal to reduce a woman’s issues and/or improve her way of life, but as a maternal duty to one’s living children.

In her ethnography on amniocentesis in the United States, Rapp (1999) refers to the difficult decision that women go through to terminate pregnancies of disabled children as a kind of ‘maternal altruism’ (1999: 249-50). When a mother discovers that her expected foetus has a disability, she is presented with
the choice of pregnancy termination as a form of ‘altruism’ to her other children, and to herself. The decision to keep a disabled child, in these cases, might have meant that the existing family members suffered, and so the woman was called upon to make a difficult decision. It could be argued that in Vilcashuaman women are also called upon to display ‘maternal altruism’ by limiting the birth of children that they may have otherwise wanted, to protect the existing family members from suffering.

Although the discourse does not surround physical disability, it focuses on a different kind of handicap: resources. Additional children may drain the available resources of those already alive, the narrative goes, and so it is the woman who is expected to display maternal altruism through limiting her births. The way to achieve this, suggest the health posts, is through the use of biomedical contraceptives. Poor women are therefore encouraged to use FP services and contraception as a way to ‘altruistically’ attend to their existing children, as opposed to considering personal motivations to avoid pregnancy, for example.

This is a complicated narrative that extends beyond ‘innocent’ state concerns for the future of the children. What the different programmes (SIS-FP, JUNTOS and CunaMas) all have in common, besides being directed at the betterment of children using the mother as vehicle, is that they are all directed specifically at poor mothers.

Bridges discusses how a ‘moral construction of poverty’ functions to suggest that poor people are somehow morally lacking, or are poor because of a lack of work ethic, laziness or unconstrained sexuality. Poor mothers are of particular concern to governments as these women, “according to dominant cultural narratives, made the immoral choice to allow their poverty to intersect with their motherhood. The danger is that they could make immoral choices with respect to the children in their charge” (2017:80). Simply by being poor, and in receipt of state welfare such as JUNTOS funds or free contraceptives under SIS, these women may be automatically thought of as more likely to neglect their children, hence the insistence of government programmes’ focus on the mother-child relationship, and the health -post mantra of child limiting.
This is further highlighted by the way that Quechua children’s problems are blamed on the parents, even when another (non-Quechua) culpable person has been identified.

For example, during one JUNTOS meeting in Sarachongo a female attendee stood up to complain that the school professor had been hitting her child, resulting in them wetting the bed every night. Although the woman insisted that the child had become nervous because of the aggressive teacher, they were promptly and publicly told that the bed wetting was because they had not been properly caring for their child instead. Perhaps unsurprisingly, this was an opportune moment for the JUNTOS coordinator to tell the women present (around forty) that they should all be using FP methods to ensure they don’t have more children that they cannot care for: “it’s your responsibility to do this to care for your children”, she emphasised, before moving on to other JUNTOS matters.

State accusations of insufficient parenting towards indigenous people are not new in Ayacucho, as Leinaweaver found in her study of forceful child removal based on biomedical categories of wellbeing (2009). She states that biomedical criteria frequently “appear in the files as a way to declare families inadequate by measuring the unfitness of birth parents and the threats to children’s well-being” (2009: 194). However, those biomedical criteria are open to interrogation. For example, in the adoption files studied, (lack of) food and subsequent malnutrition was often mentioned, yet this is common across rural, impoverished communities and not necessarily representative of wilful bad parenting, or even the fault of the parents (194). Furthermore, parents were diagnosed psychologically as unfit to parent, based on actions that could just as easily be considered ‘sheer desperation’ (196) to have their children returned to them.

Similarly, in indigenous Brazil, Segato (2014a) found that the church and the state present as ‘saviours of the children’ (144) when they remove indigenous children from their communities over (legal) concerns that the parents may commit infanticide (based on previous ‘customs’ of disposing of one member of new-born twins, or of disabled children, for example). However, Segato argues that this tension is based on a misunderstanding of life and death within Amazonic societies, instead painting these communities as ‘ignorant’ and
‘barbarous’, who are “unable to appropriately care for the lives of their children” (2014a: 149), when this is not the case. She suggests that infanticide here is not down to ‘customs’, but an adaption to adverse conditions of poverty and insecurity (151), which Scheper-Hughes similarly found in her study of selective child-abandonment in Brazil (1989). Although Segato did not necessarily support infanticide, it is important to acknowledge and understand the motivations behind these practices and avoid the condemnation of indigenous parenthood based on the colonial, Western view of life and death.

In Vilcashuaman it is arguably women’s indigeneity and poverty that results in the perception of their lack of parental fitness, and in some cases, subsequent removal of the child.

Bridges further suggests that poor, racialised women do not enjoy full citizenship because of their situation; “the conviction that moral deficiencies cause poverty serves to justify depriving poor mothers…their citizenship is partial. They are second-class or semi-citizens” (2017:55). Arguably, their citizenship status becomes dependent on their ‘good’ participation in welfare activities- attending the correct meetings, joining the parade, and using contraception. Gillespie calls this ‘potential citizenship’. Based on her research into JUNTOS in Ayacucho, she concludes that “mothers are approached not as people who are assumed to be citizens, but as potential citizens who have to enact it first. Social inclusion does not appear to be based on the assumption that being a citizen is an automatically inclusive status, but rather it is a value-laden process that requires individual response and action” (2016: 200). Full citizenship is the carrot that is dangled just out of reach for poor mothers, so long as they adhere to the instructions of their JUNTOS coordinator and the MINSA obstetras. Therefore, it could be argued that whilst the discourse may differ for wealthier women (as Bridges concludes, for example), the misdemeanour of being a mother while poor is sufficient ground for women in Vilcashuaman to experience their full citizenship metaphorically revoked, only to be earned back if they perform satisfactorily as mothers. Far from a comment about all maternities, to be a poor mother in rural Ayacucho is to lose one’s value in the eyes of the state- that value can only be redeemed if one shepherds one’s existing children to a predetermined goal: Professionalisation.
A Future Generation of ‘Professionals’

Maria-Eugenia had just given birth to her sixth child and was bent over the newly printed birth certificate, silently feeling the Spanish words out in her mouth as she followed the sentences slowly with her finger. I sat down to tactfully offer her my help, noting that she may be illiterate, and engage in some informal conversation while she waited for the medical team to come in and discharge her from the centre. Her new-born was wrapped up tight in a blanket and sleeping soundly, her other children left at home in her village with the eldest, a thirteen-year-old, to care for them. I asked Maria-Eugenia if she was thinking about having more children in the future, a question to which she laughed. No, she said, the cost was too high:

RI: What costs are there involved?

MARIA-EUGENIA: Oh, education!

RI: But education is free, isn’t it?

MARIA-EUGENIA: Yes, but the uniform costs, their notebooks, to send them to study… I want them to study…

RI: And what would you like them to study?

MARIA-EUGENIA: I don’t know exactly; I just want them to be professionals

RI: …Like doctors or engineers?

MARIA-EUGENIA: [laughing] I don’t know, it doesn’t matter, whatever they want to study, as long as they become professionals.

Becoming a ‘professional’ is a frequently cited desire for one’s children, even if people could seldom delineate a particular profession that they wanted their children to pursue. The profession itself is not necessarily of importance, but more so the associated increase in status, and the lifestyle change. This is a fairly common goal for youth across Peru, as Crivello (2011) shows in a study spanning different regions of the country, who all offer variations on this same idea. Professionalisation is closely associated with both education and migration, factors that can supposedly offer a ‘pathway out of poverty’ (2011:1) for
disadvantaged people. Due to a lack of higher education facilities in rural villages, obtaining further studies must necessarily be undertaken in urban centres. For the people of Vilcashuaman, this means either Huamanga (Ayacucho departmental capital) or Lima.

The concept of becoming a professional, however, is not only associated with higher earnings. The very nature of professionalisation means migration, and that is almost always from rural to urban centres (Crivello, 2011). That also implies a move from agricultural work to urban employment, and a completely different lifestyle from one’s predecessors. Additionally, and importantly, rural-urban migration can suggest a migration of personal and racial identity (Ewig, 2010:15), and Guerra Reyes has explicitly linked rural-urban migration with aspirational whiteness (Guerra Reyes, 2013: 161); From campesino to city dweller; from Quechua to Spanish; from Indigenous to Mestizo or white (Weismantel, 1992).

Becoming a professional may therefore result in the unmaking of a campesino, with the discarding of all the associated concepts inherent in the transformation. Indeed, this suggests that ‘indigenous’ is placed as hierarchically inferior to ‘white’ or ‘mestizo’, as the coloniality of power (Quijano, 2000) suggests is the case in Peru. Indeed, this supports the Eurocentric, colonial worldview in which the urban and the white are framed as subjectively ‘superior’ to the rural and the indigenous, with the health centre seemingly promoting this very idea.

Indeed, in Vilcashuaman, a physical migration through space could result in a subjective migration through race.

The professionalisation discourse is not only present in conversation and expressions of desire but can also be explicitly seen within clinic propaganda. For example, displayed on the walls of health posts is a poster for nutritional supplements designed to reduce anaemia in children (figure 6.2). Innocently enough, the poster encourages parents to feed their children plenty of appropriate foods, complemented by the ‘supplements’ of biomedical powder, for six months, in order to cure one’s child of anaemia. A speech bubble reads, ‘Sin anemia tus wawitas seran grandes profesionales’/ ‘without anaemia your children will be great professionals’, with an arrow directing the viewers’ gaze to photographs of the suggested ‘great professionals’; a girl in a medical jacket, and
a man in a yellow hard hat (we presume an engineer). What is interesting is the juxtaposition of said professionals with the ‘non-professionals’. Separated by the pink sachets of nutritional supplement are the professionals and the ‘before’ children; a little girl wears two long plaits and a bowler hat, which can be identified as Quechua indigenous clothing/hairstyle. Next to her is a little boy who, although wearing non-indigenous dress, has clearly sunburnt cheeks which is a distinctive feature of highland (and therefore potentially indigenous) children due to the extreme weather conditions of direct sun and harsh winds that create the cracked, reddened and ruddy cheeks distinctive of people living in the mountains. Put simply, the ‘before’ children can be identified as more indigenous. When one turns to the ‘professionals’ however, we observe lighter skin, perhaps even enhanced through increased light exposure on the photographs. The woman’s hair is straight and unplaited, the man has a smooth complexion. In this poster, the suggestion is that feeding your children nutritional supplements can make them ‘professionals’. ‘Professionals’ are white and urban, whereas ‘non-professionals’ are anaemic indigenous children, in this narrative. Although a nutritional supplement cannot change a person’s ethnicity, the ability of biomedicine to ‘whiten’ a person is well discussed in the literature on the Andes. However, it can also be surmised that in addition to biomedicine, ‘becoming a professional’ can also whiten a person. Therefore, when people speak of wanting their children to become ‘professionals’, they may also be pointing to a desire to become aspirationally whiter.
Garcia discusses Peru’s long-standing relationship with ‘the Indian problem’ and education, a mechanism of professionalisation, and highlights how all nation-making projects addressing said ‘problem’ have all, ‘remarkably’, focused on the language and education of indigenous people. Furthermore, she suggests that education is “one of the principal mechanisms through which ‘Indians’ were to be transformed into citizens” (2015:63) (emphasis added). As the professionalisation discourse prevalent in the health posts insinuates a need for education (and

Figure 6.2. ‘Healthy and intelligent babies without anaemia’ poster, Vilcashuaman
accompanying migration), it can be suggested that this too contributes to a pervasive discourse about citizenship and indigeneity. Following from Garcia, if education is needed to transform an indigenous person into a citizen, it could be surmised that prior to this intervention they may not necessarily enjoy full citizenship. The children of rural women may therefore be able to obtain this citizenship through professionalisation and subsequent transformation, but their mothers may never fully be able to do so, illiterate and uneducated as many of them are.

From the perspective of the health centres, the professionalisation encouragement may also suggest a perception that people’s current way of life is not good enough. As one obstetra lectured a patient during a consultation:

Don’t you want your children to do better than you in life? Look at me, my mother worked in the market and my father worked in the chacra, but here I am, a professional. I went to University and now I’m doing better than my parents.

Wanting one’s children to achieve is not a problem necessarily. However, the suggestion that the current lifestyle is not good enough arguably has further implications beyond those on the surface. For example, the underlying narrative suggests that farming and animal herding (‘markets and chacras’, as the obstetra noted) are undesirable ways of life. However, working the land is much more than simply a job for many people, as the natural environment continues to hold spiritual significance for many people in Ayacucho and other parts of the Andes. It is a way of working life, but it is also a cosmology. The suggestion that the next generation need abandon this work not only addresses lifestyle and salary but can also be read to suggest an abandonment of beliefs about and relationship with the natural world, a core element of local indigenous realities.

Finally, the focus on professionalisation overlooks one glaring reality; even if an indigenous person were to migrate and educate themselves to become a ‘professional’, the existing structural barriers under the coloniality of power in Peru may prohibit them from ever truly achieving this goal that the discourse says that they should.

On this, Goldberg advances the theory of ‘postracialism’, a claim about the state of society in which we are living, or ought to be living, “outside of debilitating racial
reference…it presumes that effort, energy and inherent ability will determine individuals’ life prospects” (2015:2). Goldberg does not suggest that ‘race’ is over, but that the expressions of racism and ways of thinking about race are undergoing a process of change. It is now seen as being down to individual will, life choices, personal aspirations and hard work that people exist in certain ways in the world, not because of their ‘race’ and accompanying potential discriminations and prejudices, as the argument goes. However, as ‘race’ as we know it becomes increasingly invisible in public discourse, racism is encouraged to live on, “unmarked, even unrecognized, potentially for ever” (2015: 6). Under the coloniality of power, the imposition of racial hierarchies’ hinges upon the invented categorisations of racial inferiorities and superiorities, which are not so easily negotiated for all as ‘postracialism’ might suggest. Thus, although the health centre discourse might suggest that one can become whiter through biomedical associations, the underlying colonial power structures that govern in Latin America serve to maintain this ‘pigmentocracy’ (Telles, 2015). This is what renders it aspirational (Guerra Reyes, 2014), rather than necessarily achievable.

To return to the nutrition poster, then, as an example. Here we see no mention of race (thus deceptively hinting at ‘postracialism’ as Goldberg suggested). It does not enter the discussion- we are talking about malnutrition, which is supposedly a product of poverty and lack of access to resources. If parents make the wise decision to give their children supplements, their children will then become ‘great professionals’ and pull themselves out of poverty, it suggests. Yet clearly the poster-professionals are ethnically whiter than the indigenous target audience of the poster, and so race is addressed. However, as Goldberg suggests, it has become subtler, more unmarked, and perhaps therefore more pervasive. So, one could pose the question; what of the reality of this professionalisation?

Maribel, the daughter of a JUNTOS member, had come back to visit her natal village from Huamanga, where she now lived with her aunt. After her parents had struggled to purchase all the necessary school equipment and transport fees, they could finally send her daughter to live in the city and study administration in an educational institution. She came back to visit her family home during the holidays, where I met her, and as we lunched on fried fish she told me about her
life in the city. Her parents’ house was humble, an adobe building with a tin roof, running water and some electricity, built skilfully onto the slope of a hill-
 treacherous to climb when the raining season had turned the dirt to slush, but
typical of the villages. Maribel had seemingly escaped all of this, being sent away
to become a ‘professional’ in the big city. They spoke intermittently in Quechua
and Spanish, switching between the two when they sensed I was getting lost with
the Quechua. As I often passed through Huamanga, Maribel mentioned that I
should visit. She was now working in a pharmacy and could prepare a lunch in
her home when I came. I accepted her invitation.
The house in which Maribel shared with her aunt in Huamanga was not a
wooden-floored, high-rise apartment with an elevator and balcony in the centre
of town as city-living might suggest, but an adobe structure on a dusty hillside
well away from the plaza de armas. The neighbours were largely all campesinos
from around the department, she told me. ‘Allinllachu’ they greeted each other in
Quechua when passing on the street. Her place of work was a small, independently
owned pharmacy that stocked some food items as well as medicine, seemingly to make up the profit. It was not one of the nationally-franchised InkaFarma or MiFarma, with their distinctive neon-yellow and orange shop signs and accompanying jazzy uniforms. In fact, this life was not what I had expected to find at all when visiting a Vilquina who had achieved the dream of ‘professionalisation’. Indeed, Maribel’s current existence was quite similar to that which her parents lived in the village. She had not become an engineer or doctor as the poster promised, perhaps lacking the social and financial capital to pursue this particular dream even had she wanted it. Her living situation was not so very different from that which she had left- with one exception. She had left the village, and could now say she lived in the city, with all of the associated changes that this migration entailed. When I visited her, Maribel was visibly proud of her achievements and had previously emphasised the point to me that she now worked in a city pharmacy, juxtaposing this with one from her village that sold “the same pill for everything”. Here there was variety, including in the different people, according to Maribel. We discussed how she could now meet Ayacuchans who studied in the university and travelled between Huamanga and Lima, and importantly, who didn’t know her as a Vilquina, but a fellow Ayacuchana. This meant a great deal more of perceived freedom, such as the newfound ability to meet young men outside of the watchful eyes of the entire
village, the chance to spend her money on different items such as clothing, and the opportunity to explore different past-times such as hanging out on busy shopping streets\textsuperscript{50} with friends. When I asked her what this move meant to her, she responded that here in Huamanga nobody knew her, implying that this meant she had more freedom to formulate her own subjectivity of self (even if this was leaning towards ‘modern’ elements such as clothing, language, and job).

Yet, if the realities of professionalisation are not material, then they must be something else. Maribel was no longer a \textit{campesina} destined to a life of agriculture, but a ‘professional’ city girl. It didn’t matter that almost nothing had changed materially. In following the discourse of professionalisation, she could arguably now call herself a citizen of Peru in a way that her impoverished parents, working in the \textit{chacras} and receiving state welfare, could not.

Indeed, Barrig (2001) describes this very process of \textit{‘de-indigenisation’} that occurs to Andean women when they move to Lima to work as \textit{empleadas} (domestic workers) in the houses of white Peruvians:

\begin{quote}
“Domestic workers start their own path towards de-indigenisation. The sole act of moving to a big city to live in the house from which one can absorb elements of the urban life, including working in a job considered demeaning, implies a turn of social ascension in respect to one’s community of origin, and an escape (\textit{de huida}) from the predominant notions of Andean inferiority” (2001: 59).
\end{quote}

Even though indigenous women are given small, cramped living spaces, may face bad working conditions, and are underpaid (2001: 45), the very act of migrating away to a city begins a process of whitening, as Barrig notes, and arguably as Maribel also sought. This is not necessarily about increasing one’s wages or even living conditions – it is about \textit{a subjective racial transformation that can be sought through ‘escaping’ one’s Andean community.}

There is one final point to be discussed on this. As mentioned earlier, the move to professionalise may be read to be a move to \textit{de-agriculturalise} and \textit{de-indigenise}; the unmaking of a \textit{campesino}. Maribel’s reality supports this somewhat- all that really changed for her was an implicit racialised identity, rather than living conditions. Importantly, though, she is no longer working in the fields.

\textsuperscript{50} Huamanga has no cinemas, shopping malls, large discotheques or outdoor recreational facilities such as bike trails or boating lakes, although young people do often take the bus to the top of the valley gorge and skateboard back down to town at high speed.
It was suggested more than once, often under people’s breaths and in stolen whispers, that the Peruvian government wanted to get rid of rural people’s way of life. This would bring them into offices and modern cities, implying a whitening of the nation not through direct and violent termination of ethnic groups (as per the argument against the enforced sterilisations), but by mass-transformation-an ongoing project to address the ‘Indian problem’ as Garcia suggested (2005). This transformation could be through education, but also through FP and the encouragement of smaller families and the separation of children from their parents, as implied in the professionalisation through migration discourse. During my fieldwork, people in Vilcashuaman and across Ayacucho seemingly had real reasons to perceive that their agricultural livelihoods were under attack from the government.

In January 2018 the main highways in Ayacucho were all blocked by hundreds of protesting farmers. The only way to reach the villages throughout that month was to sneak in the back of ambulances- the people were not willing to risk their compatriots by disallowing medical care. These protests had come after the government decided to import pre-cooked potatoes from Holland. This was affecting the farmers ability to sell produce, which they insisted the state should buy from them instead (Reuters, 2018). Anyone familiar with the history of the potato, or Peru’s industries, will understand how ridiculous this sounded—potatoes originate from Peru and it is one of the main agricultural products, as well as a meal-staple across the country. La Papa es Peruana, as they say. Whether or not the government was actually attempting to draw people away from the chacras by destroying their livelihoods is anyone’s guess, however the concurrent encouragement of professionalisation alongside disadvantaging of agricultural industries set tongues wagging across the Ayacucho countryside. Professionalisation therefore not only implies a change in locality and work, but an active rejection of rural chacra work and therefore of a campesino identity. Garcia’s comments on this are a fitting conclusion to this section:

“Becoming a professional would somehow move you away from Indianness, a label that evoked...ascribed primordial qualities, such as a claim to territory, Indian ancestry, language, dress, and other markers of ‘authentic’ Indian identity” (2015: 135).

Financial Prioritisation
Before, in the Inca time the people used *ayni* and *minka*; when you didn’t have anything in your *chacra* you exchanged it. But now everything is with money...for that reason people eat so badly! If you go to people’s houses, they put noodles, rice with everything, and they think that this is the best food, but they don’t eat healthily. How can we support our children now that this is what we have? Now people need to take those *chispitas* from the post, now everyone must leave to go the city and work, it’s all about *el dinero* [money].

-Jhenny, Thirty-Nine, Michibamba

To return to Goldberg’s theory of postracialism and its focus on individual achievement rather than structural inequalities, one may have already noticed the implicit association with neoliberalism (as Goldberg indeed does). Under neoliberalism, “each individual is held responsible and accountable for his or her own actions and well-being” (Harvey, 2007: 65), and as such ‘the postracial individualizes responsibility” (Goldberg, 2015: 62). Importantly, neoliberalism necessitates the individual interacting with markets in a savvy manner- “individual success or failure [in the market] are interpreted in terms of entrepreneurial virtue or personal failings (such as not investing significantly enough in one’s own human capital through education) rather than being attributed to any systemic property (such as the class exclusions usually attributed to capitalism)” (Harvey, 2007:65-66). Neoliberalism presupposes, indeed demands, a market and financial fluency that indigenous mothers may never have previously experienced before their induction into the fold of welfare-FP and health centre discourse.

Further, it is important to note the crucial role that global capitalism and the neoliberal agenda play in the colonial matrix of power. As Mignolo notes, “modernity, capitalism and coloniality are aspects of the same package of control of economy and authority, of gender and sexuality of knowledge and subjectivity” (2013: 9). The neoliberal concept of personal achievement, and accompanying frameworks of income distribution, all play into Quijano’s concept of coloniality of power and how this operates through the control of work distribution and labour (Quijano, 2013: 25).

Finances and FP are mentioned time and time again in the health centres. All health workers mentioned financial considerations as a reason to limit childbearing in their interviews, and patients were consistently exposed to lecturing about their finances. In a JUNTOS meeting, where cash is the order of the day, this may be expected. However, in matters of FP and childbirth, where
health workers are charged with attending to a patient’s wellbeing and not their bank account, the existence of money-talk may be less relevant. Indeed, Peruvian family-planning historian Necochea Lopez explicitly points out that this assumption of financial prioritisation in relation to birth spacing must be questioned (2014:11).

Yet, the relationship between children, and specifically number of children, and finances was a topic of obsession, both directly in consultations, and indirectly, such as in the post-partum ward.

(Sarachongo, January 2018)
The maternity ward is unusually busy, with three new mothers busying themselves with their new-borns as their children and partners come and go from the room. The space is full and lively, as the usual post-partum entourage files in; a doctor, an obstetra, a nurse, a nutritionist, a technician, a CunaMas worker, all who begin rifling through forms and talking loudly and purposefully over the noise.

“Ay, to have children these days you’d have to be a millionaire!”, the tecnica laughs for her colleagues. The doctor responds offhandedly as he ticks some boxes on a form, “yes, every child will cost you S/360 (£80) each month to maintain”.

“You have to be rich to have children these days!”, another voice contests. The doctor turns to one of the mothers who was hitherto excluded from this conversation and has been minding her own business, to ask: “how many children do you have?”.

Six, she answers.

“Oh, you must be very rich then”, he states, deadpan.

Her jumper is dirty and a little ragged, and I notice that the soles of her shoes are peeling away. She certainly doesn’t look financially wealthy.

The nurse interjects, “ay no! I don’t think that I could have children! The cost is too much!”. The technician concurs, responding that with her one child she barely copes.

“How many do you have, doctor?” she asks.

“Me, none.”

The technician then asks the obstetra how many children she has. The answer is two.
“Ah yes, you’re rich then”, the doctor quips to the laughter of all.

For this woman, singled out in front of the entire room, her bed was already made. She already had six children, an outrage for the health workers, and so she was humiliated because of this. Furthermore, the workers compared her unfavourably to themselves, belittling her for not making the same decisions that they had personally made about family size. This is the consequence of not following health centre mandate, and criticisms were most often levelled at women who already had several children. Another Vilquina who had received a similar embarrassment lashed back at the health workers:

Who are they to treat us like this? They only work with health, they don’t pay anything, I pay my things, they shouldn’t get involved!

Although her outrage at maltreatment is justified, and health workers may not personally pay for the women, their employer, the state, does pay for women through their SIS. It is this welfare that arguably grants workers with the illusion of right to criticise women who ‘overspend’ through unrestrained reproduction. As Bridges (2011, 2017) suggests, the receipt of welfare strips women of privacy of family and personal choices, and health workers recognise this connection. For example, after she had given birth to her fifth child, one obstetra harshly criticised a new mother, going as far as to suggest that her children may now face health issues, and death, on account of her unrestrained fertility and lack of ability to pay the costs:

Who is going to pay for all of this? The state pays for your pregnancy, your CunaMas, your JUNTOS…and if your baby dies because of anaemia, who is going to pay? [for the funeral]. It’s yet another investment for the state.

Far from being just an attack on this woman’s responsibility, in this case the health worker was further suggesting that her multiple pregnancies are causing a financial burden on the state, and one more ‘investment’ that they potentially should not be making. A derogatory term and concept used for such women is ‘welfare queens’, as Bridges (2011) suggests. The stereotype is of a woman who sits back having untold numbers of children in order to collect the welfare pay-outs of the state; “she is uneducated yet informed enough to make lucrative
her reproductive capabilities. She is stupid, yet smart enough to shift to the
government the costs of maintain her” (2011: 211). She is also racialised.
Bridges’ research took place in the United States where the ‘welfare queen’ was
portrayed as black (2011: 212), a disadvantaged race in that context. In Peru,
the ethnic disadvantage arguably applies to those indigenous and non-
mestizo/white individuals; the poorer mothers of rural Vilcashuaman. However,
in this context it is expressed as women being interesadas; they only do things
for money.

One doctor believed that women should not receive any money from the state
as this makes them ‘lazy’ (or ‘facilistas’ - wanting the easy way (Gillespie, 2016:
76)) and in their opinion this has resulted in a situation where patients will not
do anything unless payment is received:

Women shouldn’t receive this money [JUNTOS], it needs to be reorganised because
they only come to meetings to get that money otherwise, they wouldn’t come. Before
people would work in the chacra and eat from the chacra. JUNTOS means that people
just rely on the state for money and don’t do anything for themselves. When there is a
meeting that doesn’t involve money, they don’t go. For example, the women were
supposed to meet at the school last week and only one went. It was because there was
no money involved. If you don’t pay them they won’t do anything, not even for their
children. Son bien interesadas. There was this thirty-seven-year-old woman who
wouldn’t come to her controls [at the health centre], because she said she had four
children already and knew what she was doing…but how could she not care about her
unborn baby like that?! She said, “es mi cuerpo, yo tomo mis decisiones” (“it’s my body,
I take the decisions”. They shouldn’t keep giving them money in JUNTOS.

Health workers can be harshly critical of women who rely on the state’s funds to
support their families, and this may play out in aggressive comments such as
those quoted above.
In fact, the funds received by JUNTOS, although helpful, may carry far less
significance for the recipients than assumed by this doctor and others, instead
the recipients value their own work (work that they may have missed in order to
attend the obligatory JUNTOS/MINSA parade discussed earlier, for example) as
far more financially important. For example, Gillespie found that:

“women did not find the payment insignificant enough to opt out of the programme,
however…it was a small fraction of what was needed to sustain their families, and rated
However, there is little acknowledgment of the real situation, nor the health centre’s position in creating it. For example, the doctor who lamented that people used to work in the fields and be content does not seem to acknowledge that the discourse of professionalisation, promoted by the health centre, actively encourages people to leave the chacras and move away. Nor did the obstetra who verbally attacked the new mother consider that if a woman’s babies keep dying of anaemia (which they might have in this case), then she may have prioritised grieving or trying for a new baby over worrying about modest funeral costs that were unlikely to have been paid by the government anyway. Again, we find the discourse of child limiting due to financial considerations with a moral value attached as it is the Peruvian state that is supposedly shouldering this burden.

Guerra Reyes also found that women who gave birth at home, against MINSA’s policy outlines, would be shamed with financial penalties, such as being ‘fined’ for all services given after the home-birth had been reported, and being charged for the petrol of the ambulance that came to collect the woman (2014: 216). Charges to patients for ambulance petrol were frequently observed in Vilcashuaman also as a form of penalty to women.

The concept of women who are increasingly interesada extends beyond the health centre and JUNTOS, however. After interviewing community members about their thoughts on the past sterilisations, for example, several people suggested that women were claiming to have been sterilised only because the state now offered financial compensation; women supposedly ‘played the victim’ because they are interesada. During an interview with the jungle Shaman (Ucayali) David, this theme once again emerged. When asked what were among the most common request of his clients, he did not need to think twice; to find a rich husband and stop working. Interesadas. Indeed, this concept of women’s increasing financial interest is also present in popular culture, however again there is a sinister undertone to this.
While travelling in *combis* throughout the region, one often hears one particular song being played on the radio that deals with this very theme. This music is a *huayno*; a genre typical of Ayacucho and across the highlands, that utilises common Andean instruments such as the *charango* (guitar), *zampoña* (panpipes), and Andean harp (Escalante Rodrigo, 2017). The *huayno* is important for another reason, however. *Huaynos* can be considered as a confluence between the indigenous, the *mestizo*, and the ‘modern’ (Mendivil, 2010). This is a music genre that expresses the intersection, or ‘transculturation’ (Escalante Rodrigo, 2017: 34) between *mestizo* and indigenous. The famous Peruvian (Ayacucho) author and anthropologist, Jose Maria Arguedas, has poetically described the music thus:

“The huayno is like the clear and meticulous footprint that the mestizos have been leaving behind in the path of salvation and creation they have been following…today the Indian and the mestizo still find the expression between their spirit and emotions in this music” (1977:7)

Lyrical waxing aside, this music can be said to explore popular themes that unite the realities of the city-dwelling mestizos and the rural *campesinos*. The lyrics to the song of interest, ‘*Dime quien*’ are sung in Spanish, the language of the urban/ ‘modern’/ Eurocentric-white, and discuss a woman⁵¹ who has become so interested in money that she purports to discard the love of a man:

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*Dime dime quien, quien*  
Quien te hizo cambiar  
Ya no eres la misma  
Ya no eres igual  
Eres interesada, te gusta el dinero  
El amor no se compra  
Algún día lo pagarás  
*Te gusta mucho el dinero*  
*Te gusta mucha la riqueza*  
*Yo te amé con gran ternura*  
*Dejaste…de amarme*

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 Tell me tell me who, who  
Who made you change  
Now you’re not the same  
Now you’re not as before  
You’re interesada, you like money  
You can’t buy love  
One day you’ll pay for this  
You really like money  
You really like to be rich  
I really loved you  
You stopped…loving me

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⁵¹ The lyrics use the feminine subject adjectives.
This could be read as nothing more than a love song; however, it is important to reiterate how *huaynos* are the confluence of *mestizo* and indigenous; of Spanish and Quechua; of town and countryside; of ‘professional’ and agriculturalist. When viewed in this context, the theme of a woman becoming increasingly *interesada* takes on more significance. The question, ‘who made you change?’ insinuates that previously the woman/ women in general did not covet money as she/ they does/ do now. It can be surmised, therefore, that it may be her intimacy with the *mestizo* world that has led to her transformation from uninterested in money, to *interesada*.

To say that a woman has changed to become more interested in money than love may carry the insinuation that she has migrated along the racialised continuum. It is *campesinos’* relationship with the *mestizo* world of the towns that encourages this change of perception. As the doctor lamented, people used to just work in the fields and eat the food that grew there- they did not need or covet money so much. Now, however, they apparently think of nothing else. The great irony in this was missed by that doctor. People need money because they are encouraged to desert the rural lifestyle of previous generations and send their children off to the cities to become ‘professionals’, a process that carries great financial cost. A place where the children will surely grow to covet money also. It could be said that it is the advancing associations with the towns and capitalist economy that drives this interest, associations which indigenous people are encouraged to make by the health centre, JUNTOS and others. Yet once women show an interest in this, they are lambasted.

It can also be argued that these perceptions may be based on the somewhat romanticised view of pre-colonial Andean exchange, expressed through the concepts of *ayni* and *minka*. *Ayni* is the exchange of comparable work or

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52 Whereas *ayni* involves reciprocal relationships between individual or collective parties, *minka* is a form of collective work that benefits the entire community and is ‘reciprocal’ in this sense (Enciso, 2011). For example, an *ayni* exchange may be that I help you to collect the maize from your *chacra*, and in return you help me. No money is exchanged. In *minka*, our whole community would collectively work (for free) to repair a section of road that was destroyed during heavy rains, for example. Whilst people in Vilcashuaman still refer to ‘*ayni*’ as an ongoing system of reciprocity, ‘*minka*’ was framed as belonging more to a pre-colonial past. Although communities do collectively work together in this fashion, for example during *Yaku Raymi*.
goods as part of an ongoing cycle of reciprocity’ (Porter: 2001:1), and whilst it does still form a core part of community organisation in Vilcashuaman this is no way excludes people from participation in the globalised capitalist economy. Often, Vilquinos use ayni for agricultural tasks, such as clearing debris from neighbour’s chacras or helping with the cosecha, rather than as a reciprocal exchange of goods, for which people use money.

Thus, it is important not to essentialise the Andean woman. They have long moved in the capitalist world and hold a particularly strong presence in the marketplace as entrepreneurs, for example (see Babb, 2018, 1998; Seligmann, 2004; Weismantel, 2001; Harris, 2000, 1995; Larson, 1995; Platt, 1995; De La Cadena, 1995). Quecha women’s interactions with ‘money’ are nothing new, and that is not the implicit suggestion here either. Instead this is to highlight the processes of perception that purports to paint them as interesadas, a negative trait that suggests that they are covetous with a moral implication attached. The suggestion here is that women are out to squeeze money from the state at any cost – even having an excess of children that they cannot care for and supposedly do not care about. It is a moral implication of power, as Guerra Reyes (2014) also suggests, whereby Vilquinas lose either way. If they accept the welfare finances they are portrayed as akin to ‘welfare queens’ (Bridges, 2011), but if they did not accept it then they may be unable to pursue the discourse of professionalisation for their children that is so promoted.

This may then have knock-on effects in the welfare policy and treatment in health centres if public narrative leans towards these unfavourable perspectives.

That said, this may be because the perceived relationship between Vilquinos and money does not follow that which is thought to be appropriate according to the neoliberal model. The receipt of state welfare, or resources from a spouse, negate the necessity of individualised market-participation. Meltzer (2013) argues that for women receiving state welfare in Peru to effectively participate in the market, they are supposed to follow the neoliberal ideals of individual risk

(Water festival) when communities collectively clear the acequias of debris so that water flows freely to all chacras, this was not referred to in name as ‘minka’.
management and asset accumulation, as promoted by the JUNTOS programme, amongst others. She calls this ‘good citizenship’. Good citizenship relies on a ‘fiscally responsible citizen’ (2013: 644) who develops specific habits and attitudes towards money, in particular the ability to save and manage individual risk (2013: 647). The antithesis to this, ‘bad citizenship’, could be a person who is financially illiterate and can neither make adequate financial projections (those who have more children without considering finances, for example), nor effectively accumulate assets or save (those who live hand to mouth, for example, as do many poor rural families). Furthermore, Meltzer notes that there is an underpinning assumption that ‘good citizenship’ ‘is defined by a capacity…to be able to independently mitigate social and economic risks’ (2013: 646), i.e. not rely on the government to bail one out of financial crisis. As successful management of finances is a prerequisite of ‘good citizenship’, those women/mothers who do not family-plan, and therefore do not attend to financial management, are bestowed with ‘bad citizenship’. In addition, this kind of citizenship is also racialised, as Meltzer argues:

“Discourses of ‘good citizenship’ are also racially encoded, reconfiguring longer standing narratives in which citizen ‘fitness’ is intertwined with racialized social hierarchies…Although indigenous populations are not explicitly targeted in contemporary cash transfer or savings program, they nevertheless continue to constitute the significant majority of extremely poor populations in Peru, and therefore make up the majority of economic conditions that could impact anyone in society, but are somehow rooted in a persistent backwardness” (2013: 649-650).

Therefore, poorer mothers who are also Quechua-indigenous, like those in Vilcashuaman, again have their status as full and desirable citizens made conditional- here on the ‘good’ neoliberal management of finances, but also on the condition that they develop certain kinds of reproductive behaviours and shepherd any existing children to a life of professionalisation; a life away from the agricultural, indigenous practices of their parents.

So, impoverished, ‘at risk’ mothers are considered morally irresponsible for becoming pregnant while poor (Bridges, 2011). Following from this, women are criticised for not having any money and having children. However, if they do seek and obtain finances from the state, they are criticised for doing so. Women are supposed to shepherd their children away from agricultural lifestyles so that they can become ‘professionals’ in the city, yet they are criticised for no longer
adhering to the ‘healthier’ agricultural lifestyle of the past. In short, they cannot win, as this discourse places them in a Catch-22 situation. Full citizenship for poor indigenous mothers is, in this view, an unobtainable goal. Their children may obtain this, but only through the calculated shedding of an identity shared with their parents, and the re-cloaking of a new one.

‘Good Fatherhood’

Finally, in contrast to the way that maternal responsibility is portrayed through maternal ‘altruism’ and importantly, child limiting in order to shepherd one’s children through from indigeneity to racialised ‘professional’, the paternal health campaign, ‘Tu Eres el Mejor Papa’ (‘You are the best father’) (Figure 6.3) suggests that whilst the values of ‘good fatherhood’ are not the same as those required of women, men may also be framed as ever-‘potential’ by MINSA.

The programme’s promotional materials are cleverly placed; knowing that men rarely enter inside the health posts, posters internal to the health establishments are accompanied by the public display of the campaign, painted onto village walls where men are sure to pass by and take notice (Figure 6.4). This is a colourful campaign, the word-filled splodges give men advice such as (left to right), “give your baby nutritional supplements”; “help with your baby’s alimentation”; “take your pregnant wife and your baby to monthly controls at the health centre”; “keep a garden, an improved kitchen and a clean toilet in your house”; and “play with your baby, make them toys with local materials”. With your ‘care’, it exclaims, you will have a happy family! To round off, a man is shown spoon-feeding a child that sits upon its mother’s lap, the picture of said aspirationally happy family. Yet, something is clearly missing here.

If we return to the concept of marianismo, introduced in the previous chapter, where a woman’s main role in life is expected to be motherhood (Stevens, 1973), such a discourse can be seen in the health centre’s FP discourse with its emphasis on the maternal role discussed throughout this chapter. In short, to be a ‘best mother’, a woman is supposed to use contraception and plan her family in order to spare her existing children from hardship and make them become ‘professionals’. To become a ‘best father’, however, there is zero mention of FP responsibilities.
Figure 6.3. ‘You are the best father’ campaign poster, Vilcashuaman.

Figure 6.4. ‘Tu Eres el Mejor Papa’ campaign painted onto village wall, Vilcashuaman
The above advice is all based upon actions a man should take once a child is already alive, or his wife is already pregnant. Such a campaign has herein missed the opportunity to address the male role in contraception and subsequent ‘care’ of his family through any ‘paternal altruism’. In the condom propaganda materials, mentioned in the previous chapter, women are encouraged to take responsibility and ‘demand’ use of the only male-led contraceptive method available in health centres. Here, in MINSA promotional materials cantered on paternal-responsibility, contraception use is not even mentioned. This insinuates to an extent that through the omissions, health-post FP and contraception has nothing to do with men – it is a female responsibility.

The ideas of machismo and male virility, discussed in the previous chapter, remain unchallenged here, as it is assumed that men will not use condoms without being demanded to, and do not have to consider FP and the avoidance of unwanted pregnancies because that is a woman’s job. The health centre here does a poor job in addressing gender inequalities, in fact, it appears to exacerbate them (concurrent with the coloniality of gender).

Yet, there is something else at play here that acts upon poor, indigenous men in a different way. Returning to the advice of the campaign, it is worth noting that to be a ‘good father’, you would need some access to finances. To build a garden, have an ‘improved’ kitchen and latrine requires money.

Marshall (2000) shows how state (NHS) pregnancy-literature in the UK excludes poorer parents from being ‘fit to reproduce’ by making preparatory suggestions based on middle-class economic assumptions. For example, in giving advice that expecting parents need prepare a child’s nursery beforehand assumes that a couple has a spare room in their dwelling in the first place, and then that they are able to purchase stimulating toys and equipment. As a result, poorer parents are presented as parenting failures because they cannot follow this advice, and this may affect their own subjectivity about their ability to be parent successfully.

Similarly, the ‘Tu Eres el Mejor Papa’ campaign suggests that to be fit-to-father, men must acquire certain things that may be out of economic reach for a lot of campesino men. Thus, consequently, they cannot hope to be a ‘good father’ according to the MINSA standards, unless they change features in their
dwellings. Things such as clean latrines and ‘improved’ kitchens are, perhaps unsurprisingly, aspirations of urbanity and modernity, a clear theme running through MINSA family-related discourse more generally. Men are not immune from these discourses either, although this is arguably a different kind of governmentality than that enacted on women; they are seemingly shamed after the act is already done, whereas biopower works upon women in the health posts to curb future pregnancies before they have occurred.

Finally, it is pertinent to notice how discourses around financial obligations in planning families work upon men and women in different but related ways. Poor Quechua women are portrayed as *interesadas* and it is insinuated that their actions are motivated by a desire to somehow ‘immorally’ seek money above all else. At the same time, they are encouraged to shepherd their indigenous children through to ‘professionalisation’ in an urban environment, and away from Quechua communities. Importantly, they are encouraged to make their children seek money whilst at the same time they are reprimanded for doing so themselves.

Conversely, men are told that to be a ‘good father’ in the state view, they must have the finances to do so. If they do not, they may not be considered adequate fathers by the state. As many *campesino* men likely cannot provide all those elements of good fatherhood described by the campaign above, they are framed as potentially not ‘good fathers’ – they too are always ‘potential’; a category reliant on them changing their status.

Thus, although the responsibility of FP falls disproportionately on women and requires further attention, it is also important to retain empathy for their male partners and their relationship with the state health care. For example, as the previous chapter discussed, some men are enthusiastic and willing about engaging with the health posts around issues of FP, asking for ‘talks’ and ‘training’, although this is not offered to them. Through MINSA propaganda, they are then positioned as unable to obtain ‘good fatherhood’ due to poverty. This suggests a rejection somewhat on the part of MINSA towards men/ fathers, who are seemingly chastised about their failures but also denied and excluded from health-worker-led events that could expand their knowledge and understanding on kinship-related health care (e.g. contraceptives). Although
further research is arguably needed on the relationship between state health and fatherhood in Peru, these findings hint at a contested relationship in which men, as well as women, are always unable to reach the promoted standards.

**Conclusion**

Despite the pervasive discourse, finances need only be one part of the story, even when discussing the desire to ‘professionalisation’ and the mechanisms by which to achieve this. For example, as part of the reparations afforded to the victims of the Shining Path violence, the children and grandchildren of those affected have access to funding and scholarships to help them attend higher education (*La Republica*, 2016). This is one way that people could access education without the high price tag so lamented by the health centre. In fact, if mothers were victims of the violence (which many people in Ayacucho were), then they could pass on these reparations to their children if they chose to. This is not mentioned at all by health workers, but people do know about it. I was first introduced to this scheme by a patient-father, for example, who elected to inform me that his daughter, a four-year-old he held in his arms, would be going to study in Lima when she was older, using this very scheme. One may wonder why health workers were reluctant to mention this as an alternative.

As another potential solution, Leinaweaver (2008a) writes that in Ayacucho families will also often ‘circulate’ children, sending them to live with relatives in other parts of the department as both a way to help the child receive an education not available in the village, and to help the relative receive the child’s help. This requires no financial inversion *per se*, although it is explicitly economic, Leinaweaver suggests. She has previously suggested child circulation as an alternative to the mass sterilisations (2008b: 13-14), however, less drastically, it could also be a solution to child limiting based on economic concerns alone. This is another consideration omitted in the health centre discourse. This suggests that the dominant financial narrative is favoured not purely because it is the only real concern – there are other very real alternatives, as discussed above. However, it is favoured because it accomplishes a specific end- money is the one thing that poor, indigenous women (and men) do not have. When they become mothers, they are brought into the world of state welfare where the government becomes immediately and invasively interested in their economic situation. But furthermore, it is a point of
entry where the state can manipulate their claim to citizenship through their
children and their ‘debt’ and duty to the government. (Poor) Motherhood makes
a woman visible through her newfound reliance on SIS health care and
JUNTOS, and as a previous chapter discussed, this visibility contributes
towards their disciplining.
As this chapter has argued, because apparently irresponsible decision making
led to women being pregnant while poor, they have their claim to full citizenship
thereby metaphorically revoked until the time in which they can successfully
deliver competent, professional children who are ethnically, culturally, and
racially superior to their indigent mother, in the state’s view. If one is poor and
indigenous in rural Ayacucho, one’s maternity makes citizenship conditional on
FP and contraceptive use and adherence to state subjectivities for children’s
futures.
Up until now, when speaking of ‘state health care’ the obstetras themselves
have been discussed as agents of state biopower. The following chapter, whilst
not contesting this, will focus on these health workers more closely, both to
further investigate the way that biopower and discipline works through them, as
well as to develop a comprehensive context of FP and health care in which the
indigenous women are operating.
Figure 7.1. A health worker checks a patient on a house visit.
“Why did you originally not want to become an obstetra?”, I posed to a health worker one afternoon after a long conversation about her current career trajectory choices. She had been working in this role for only a few months after finishing her five-year university degree in Huancavelica, a neighbouring department to Ayacucho. Fresh out of her studies, she had joined the small health post in Llamallaqta as a ‘Serumista’, a person undertaking their mandatory year of rural work, the SERUM year (Servicio Rural Mandatorio), that would qualify her to work in MINSA clinics upon successful completion. She was a native Quechua speaker and during her study years had spent her free time assisting her mother at the market. “I’m not ashamed to tell you that”, she once admitted, volunteering the information without my asking, the implication being that perhaps shame was an appropriate response to such an upbringing. Yet, obstetrics was not her first choice. She had been a brilliant biologist and had wanted to pursue that course. However, her family could not afford to send her away to another university that offered the training. And so, she became a reluctant obstetra as the consolation prize. To be sure, she enjoyed her job now, she confessed. But it was not what she had envisioned for herself. “Why not?” I probed again. “Porque todos nos crean las malas”, she sighed. “Because everyone thinks that we are the bad ones”.

When one glances at the literature or tunes in to patient and community comments alike, the perception of health workers as veritable boogeymen soon becomes apparent. It is important to unpack this representation and ask why health workers are negatively portrayed and conceived of in both literature and amongst the communities where they work. Furthermore, a contextualisation of their working conditions will help to understand instances of obstetric violence towards patients, and develop our comprehension of potential motivations behind mistreatment, thereby ultimately giving the opportunity to suggest recommendations for change.

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53 Health workers are sometimes considered as genuine Andean ‘boogeymen’, called pishtacos. See chapter eight for further discussion.
This negativity towards health workers has taken particular fervour regarding the enforced sterilisations, in which health workers are implemented and blamed for the tragedy. However, their hate-figure status extends beyond that event and into contemporary communities. Health workers in rural communities are painted as racist and regionalist, with the assumption being that their vastly differential status to their patients incites bad behaviour. For example, Guerra-Reyes (2013), studying the intercultural birthing policy in the highlands and commenting on the inability of MINSA workers to sympathise with Quechua beliefs (ethnomedical and otherwise), concludes:

“Health personnel, who are mostly urban professionals, identify as ‘white’ or ‘mestizo’ and middle class, assume that their view of the world is normal, desirable and correct. This persistent ethnocentric attitude, which is shared by many Peruvians, is replicated at all levels of policy and direct-care in health” (2013: 157).

This view is also shared by Ewig. She describes a Quechua woman’s experiences at a health centre, as she imagines they proceeded:

“At the health center she would face a white or mestizo doctor born and educated on the urban coast who would not comprehend her language or customs. He would likely call her mamacita (little mama) rather than by her name. Indigenous health concepts like pacha (sickness from the earth) would bewilder him, which in turn would frustrate her” (2010: 6).

The fact that health workers lack Quechua language skills was also suggested as a means through which they coerced women into sterilisations during the PNSRPF (Ewig, 2010; Rousseau, 2009). Therefore, when scanning the literature on health workers in Peru one is faced with what appears to be a definitive racial and classist distinction between obstetras and patients. This simplifies the understandings of coercion- of course white and mestizo doctors would treat indigenous patients badly if they have been educated by, and live in, a country with a “persistent ethnocentric attitude” (Guerra-Reyes, 2013: 157). However, what if health workers were native Quechua-speaking children of farmers and market sellers, educated in highland universities?

The obstetra mentioned above had a family that could not afford to send her to the coast. She already spoke Quechua and her family were not urban, white, or coastal. They may not have even considered themselves mestizo, but indigenous. Her situation is not unique.
In addition to the questionability of comments about language ability and ethnicity, nor is Ewig’s assertion that health workers might be ‘bewildered’ by concept such as *pacha* strictly true in all cases. The impression given in the literature is that health workers may never even have heard of ethnomedical illnesses, so we can fully discount their beliefs in them if that is the case. But it is not so in Vilcashuaman. For example, one *obstetra* not only acknowledges but has personally suffered from the *pacha* that Ewig suggests might have been bewildering to her:

> When I was little, I fell over and got really sick afterwards, every time I tried to eat in the night I vomited it back up again and my mum got really worried. Eventually they realised I had *pacha*, because I had fallen and hurt the earth, so we had to do a payment (*pagapu*) that we did with coca and after I got better.

This *obstetra* grew up in a village in the south of Vilcashuaman and had studied nursing at a technical college in Ayacucho. We had been talking about rituals performed by *curanderos* when I asked her about her beliefs in their effectiveness. Her story of childhood *pacha*, she recounted, was what made her believe, because it had worked. *Pacha* was as real to her as tuberculosis, she said.

That said, not all health workers across the region have the same beliefs or backgrounds, and a couple did come from Lima (although even one Limeño spent their free time learning Quechua and encouraged me to share our learning materials together for enhanced language acquisition – a far cry from the picture painted of the prejudiced whites from the coast). Thus, Vilcashuaman health network posts suggest a rather different scenario to that which has been presented in the literature. With this in mind, the fact that coercive and discriminatory activities *still* go on may actually seem more significant in the absence of simple binaries with which to analyse those behaviours. Here, it cannot simply be a case of white: indigenous, urban: rural, or professional: uneducated, etc, as has been previously suggested for other Peruvian locales. Instead, when health workers and patients are less dissimilar (in Vilcashuaman) than perhaps the literature would have one believe, a deeper analysis is required to understand discriminatory behaviours, which this chapter will address. And those behaviours *do* go on.
Bridges suggests that health worker animosity towards patients of similar backgrounds may be due to a desire to distance oneself: “the staff’s animosity…is intensified by a recognition of [their] own similarity to the patient’s profile and [their] desire to disavow the discursively disparaged patient as an abject version of [themselves]” (2011: 38), and that “at least some portion of the hostility…demonstrated toward…patients can be explained as an attempt to create distance between herself and them such that they could not, or no longer, be considered abject forms of herself” (2011: 39). Indeed, in Peru health workers and other state-employees, by virtue of their differential studies, may place them ‘above’ those with whom they grew up. Garcia, looking at intercultural education, comments that “even if teachers were from highland towns, their profession placed them in a higher social stratum that the Quechua farmers and herders” (2005: 118). Thus, health worker behaviours may be classist if not racist, or both. These attitudes reflect a common phenomenon in Peru called ‘choleandao’ (Bruce, 2007); when one group of Peruvians looks down on another, who looks down upon another still. Cabrera asserts that in Ayacucho, ‘choleando’ is rather prevalent (2017: 41), and the health worker’s attitudes of looking down on their indigenous patients (who may be similar to them) is ‘choleando’; other Peruvians may look down on those same health workers and so on.

There may also be other factors at work. Life as an obstetra is highly precarious, as the following paragraphs will discuss, and it is important to recognise this when approaching negative behaviours, particularly obstetric violence, as this dissertation does. In addition, workers are constantly aiming to fulfil targets, or metas, set out by their employers; an activity which both results in stressful working situations as at the same time it may incite coercive behaviours for which the staff are later personally blamed.

Paul Farmer had once advised that “You can’t sympathize with the staff too much, or you risk not sympathizing with the patients” (Kidder, 2011: 25), a suggestion that I too had subsumed and expressed in my PhD upgrade, and a comment which I now rescind.
In fact, it may not be possible to understand all the happenings, especially as they apply to reproductive health and FP, without addressing the situation of the health workers (albeit briefly in the case of this dissertation). The workers recognise their own precarity and the fact that they are unpopular. Coercive practices and discrimination do continue to occur, and this chapter is in no way an attempt to justify such behaviours, but to contextualise the realities of rural health work that structure and support them.

Therefore, this chapter will first address the local inequalities that take place within the health network amongst workers themselves, to show how these inequalities exert pressure and precarity on the obstetras. Next, the chapter will address the history of sterilisations and blame towards those working in MINSA, as well as contemporary goal setting and job security in which obstetras are themselves somewhat coerced. This situation, along with the excessive administrative duties, suggests that obstetra work is becoming a ‘bullshit job’ (Graeber, 2018); one which takes its toll on a person and renders what should be an incredibly diverse and important job, a waste of time.

It will then address the work undertaken by MINSA obstetras as it applies to, and supports, state biopower, through the administrative ‘census’ work inherent in their employment. Through this discussion it will be shown how government-employed health workers are contributing to a wider project of governmentality beyond that which they may perceive or personally support.

Finally, this chapter seeks to offer a complementary perspective on state disciplining of its employees, as well as patients, as they too suffer whilst also being highly criticised.

Indeed, as one obstetra pleaded to me after discussing how her working precarity brought her to tears: “Rebequita, defend us”.

**Local Inequalities within the Health Network**

Let us begin with the pertinent question: Why is it that workers in Vilcashuaman are not white, urban mestizos from the coast, as the literature claims they should be?

The local institutional organisation of the health centre has something, if not everything, to do with this.
In Vilcashuaman they follow the CLAS (Comités Locales de Administración en Salud) programme in the region. CLAS was implemented in 1994, around the same time as SaludBasica (Ewig, 2010: 99), the programme under which most enforced sterilisations were carried out. In SaludBasica, workers received short-term contracts that “would be renewed based upon productivity levels”, resulting in workers forgoing “job stability and benefits… contracts were extremely short…and productivity expectations were high” (2010: 100). Ewig argues that “with quotas to meet and jobs on the line, efficiency was successfully promoted, but there were no incentives to provide high-quality care” (2010: 101).

By 2007 SaludBasica no longer existed in name, although some networks do continue to rely upon certain elements to a greater or lesser extent. Vilcashuaman, although CLAS, relies upon the above-mentioned elements to a greater extent, although this shall be further addressed in the preceding section. Either way, the organisational structure of the region follows the CLAS model, whereby administration of health networks has been decentralised to a local board of community members (doctors and community leaders). This board remains dependent on MINSA (in the case of Vilcashuaman, mostly on the Ayacucho authority), although they can make decisions about spending, hiring and firing, and creating an annual community health plan (Ewig, 2010: 103). In theory, this system should encourage more equality if local boards have a degree of autonomy over health decisions in their own communities. However, this is not necessarily the case. Ewig says that “the effects of the CLAS program were highly dependent on context. In urban areas decentralized administration opened some space for leadership by mestiza women at the local level; in rural areas it reinforced exclusionary patterns that denied indigenous women leadership roles” (2010: 123). This suggests that the CLAS board members may be of a higher social status within the communities to begin with. Although potentially Quechua-speaking agriculturalists and the family of campesinos, this does not discount a social stratification within the region itself. As Gascon (2005) shows, in the Southern Peruvian Andes the introduction of new opportunities for the people, even though considered indigenous (Aymara and Quechua in that case), can deepen local inequalities, as some have more ability to take advantage of those opportunities than others. Boesten also discusses the regional and situational differentiations; “someone’s status and role depends on the context: an indigenous person can enjoy a high
status in their community but a low status in an urban mestizo environment” (2017: 298).

Therefore, when addressing the CLAS network in Vilcashuaman and similar provinces, it may be the case that those controlling the administration, although potentially Quechua(speaking)-indigenous, like their patients, enjoy a higher status within the community. This goes some way to addressing the incongruency between ethnic/racial and educational differences of health workers found in the literature, and highlights a significant point: in Quechua communities, there are local power hierarchies at play in health, in addition to those grander structures of the state.

When the Vilcashuaman CLAS board comes to hire health staff, they are apparently hiring people overwhelmingly from the region. This may be why staff are largely Quechua-speaking and local. This of course has its positives, as it helps them to understand and interact with the patients. However, it also indicates the ability of the board to be selective about who it hires, and why it hires them. When addressing obstetras, this is particularly precarious as they are almost all women, and across Peru, an estimated 97% of all obstetras are female. Directors and head of staff, however, are almost all male. As Ewig argues, “the CLAS programs in rural areas reinforced negative forms of recognition in indigenous communities by accepting male domination of the CLAS boards” (2010: 138).

Garcia studied rural teachers in Cusco, an employment situation that is comparable to that of rural health workers. Educators would be sent out to different locations depending on factors beyond procedure. It is noted that “if the teacher is a woman” she could receive an undesirable placement “because she didn’t sleep with the man in charge of placements” (2005: 117).

The trading of sexual favours for employment contracts and benefits is arguably rife in situations of gender inequality, especially when it is largely women being contracted by men, and Vilcashuaman was no exception.

For example, when a new contract became available for an obstetra to work in one of the posts as a nombrada, a number of the existing obstetras who had

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54 IX Congreso Internacional de Obstetras, “Salud Sexual y Salud Reproductiva: hacia el logro de los objetivos del Desarrollo sostenible”, May 2018, Lima, Perú
already been working within the health network for some time and had been overlooked for this more secure position had their thoughts as to why this new girl got the job. Fresh out of her SERUM year (and therefore not experienced), young and pretty – gossip abounded as to how she had managed to convince the (male) hiring team of her appropriateness for the position and subsequently beat the other more established obstetras to the post. On another occasion, one obstetra told me outright that the only reason that she had not been asked to have sexual relations with any male superiors was that they knew her husband and respected him (he was a surgeon in Huamanga). For those without such contacts they can rely upon for ‘protection’, this is highly precarious.

Martinez observed similar treatment of female health workers in a Venezuelan public hospital, leading her to suggest that in this setting although women may act authoritatively towards patients, when it comes to their male colleagues they hold “a common position of subalternity” (2018: 169). She argues that “in spite of their social positioning as professionals, women doctors may experience marginalization in relationship to the elite or core group of male doctors” (2018: 183). This, Martinez argues, is one in which women are regulated and ‘disciplined’ with public health structures.

Unequal gender relationships place the female obstetras in uncomfortable and precarious positions, especially as many of them are obligated to stay away from their home towns or villages during working days, and therefore do not have the protection of kin and friends against unwanted male attention. Yet, gender inequality is not only found in local CLAS boards and health posts but extends even to the medical education received by health staff. Recounting his anatomy classes at university, one doctor in Huamanga told me a ‘funny’ anecdote from his education:

> We were in the lab with cadavers, and that day the body we inspected was to be a ‘large-breasted’, attractive young woman. One of my bolder classmates thought it would be smart to comment how he would like to fuck this beautiful [dead] girl. “Ah!”, the teacher slapped him on the back, “we’ve found our first gynaecologist!”

55 Apparently, such dialogue is not uncommon within other medical schools. Konner (1994), commenting on medical school in the United States, says, “vulgar jokes about patients are a ubiquitous feature of medical social life, excused…as a ‘necessary defence mechanism’ in the
That the suggestion of necrophilia should be a joke within a classroom is problematic, demonstrating that even in death women are evidently unable to escape the sexualised male gaze. However, even more disturbing is the notion that a man’s libido and sexual attraction to women qualifies him to specialise in gynaecology; a job where, presumably, he can direct his lustful gaze at (living) women’s genitals with impunity. Perhaps proctology would have been a more appropriate specialisation as a punishment for that future doctor, yet the professor saw fit to suggest gynaecology. Furthermore, such ‘joking’ would arguably send a clear message to the female medical students, that in gender relations the medical gaze can also be sexual, and even deceased women are not immune. Martinez also observed male doctors openly sharing “sexual innuendos” and “sexually explicit jokes about women” (2018: 181), at times within the earshot of patients, suggesting that women, and even female co-workers, are not necessarily considered worthy of respect.

Troublingly, Bridges argues that the behaviours and perspectives of medical professors can get transmitted to their students, thus perpetuating a structural culture of prejudice (2011: 135-136). This can apply to race, as Bridges argues, but could also be applicable to gendered inequalities, as the above example addresses. She states that “it may be overly optimistic to think physicians’ extensive training in the biological sciences in some way cleanses them of the biases and prejudices that run rampant in the social milieu in which that training takes place” (2011: 111).

In this light, the gendered divisions and expectations of sexual transaction that occur in a local CLAS network may in fact be reflective of, and fed by, gendered divisions within the medical education system itself. This underscores a working environment of gender precarity for female obstetras; a situation that somewhat reflects the private struggles of their patients.

That said, the gender relationships between health workers are complicated by what appear to be rather prominent practices of “self-sexualisation” (Smolak, face of illness and death” (1994: 18), however he notes that whilst vulgarity may be excusable amongst students, in a “professor who stands on a platform from which he can influence the emotional response systems and the ethics of scores of future physicians, such remarks seemed inexcusable” (1994: 19).
2014) amongst obstetras, which can be observed predominantly through the
customisation and choices of work uniform, such as the use of high heels,
figure-hugging shirts and skirts (even if in the correct uniform colours), and
deerence to male colleagues.
Specific behaviours that have been identified as “putting on sexiness”, such as
wearing ‘sexy’ clothing (e.g. stiletto heels, tight fitting blouses) and personal
grooming (e.g. makeup and hairstyling) are indeed common amongst obstetras,
and even those working in more rural health posts where high heels may be
impractical for the terrain. This is not unique to Ayacucho. At the 2018
conference of the Peruvian Obstetrics College (Colegio de Obstetras de Peru),
a space where workers from across the country could meet and discuss current
concerns and developments within the industry, the majority of attendees had
personalised their burgundy uniforms with a thigh-length skirt or four-inch heel,
and many wore full makeup and presented highly-styled hair.
In Vilcashuaman, even given the weather and geographical extremes, many
obstetras would be adorned with high heeled shoes, fancy scarves and wear
full makeup. In fact, presentation of the self, especially using cosmetic make-up,
was highly valued amongst obstetras, and it was one distinguishing mark
between them and their patients who almost never wore make-up.
For example, once we were late to a presentation on sexual health in a local
school because the obstetra wanted to touch up her lipstick. When I urged her
about our lateness, she mentioned that she needed to be ‘presentable’ when
she was going to speak publicly. This was not for the benefit of ‘men’, however,
as the class she presented to were all teenagers, suggesting that their efforts
are not necessarily for the male gaze alone, but for all Vilquinos.

I also found my own presentation became policed by the obstetras. Whilst I
would usually wear make-up outside of the field setting, I had decided not to
wear any whilst conducting field work as I thought that it might distance me too
much from the Quechua women who do not wear it either. I only realised the
displeasure this fomented in the obstetras when I wore a coloured lip-balm one
day and was applauded for finally making ‘an effort’ with myself. After this I
decided to ‘compromise’ and purchased a tinted sunscreen. Two different
obstetras not only commented on this, but took it as their prerogative to go to
work on my face, ‘touching up’ my ‘make-up’ for me with wet wipes, all the while
trying to convince me that more cosmetics would make me look more 'professional'.

Appearance, therefore, is very important for obstetras in particular (other female health workers were less ‘glamorously’ presented), and at first glance it might appear to be a form of ‘self-sexualisation’, that may appear to play into the aforementioned denigration of women within the health network and education system. Indeed, feminist scholars have historically argued that a preoccupation with physical appearance is a mechanism of gender oppression. For example, referring to appearance in *The Second Sex*, “[Simone de] Beauvoir sees an obsession with meticulous self-presentation as one forced on women by well-heeled wifehood” (Church-Gibson, 2012). In *The Beauty Myth*, Wolf argues that beauty is “the last, best belief system that keeps male dominance intact” (1990: 12), and furthermore, is “the last, best training technique to create…a [female] work force” (26) that places men as superiors and shows respect and acceptance of repetitive and undervalued tasks as a result of this.

Observation of obstetra physical presentation and consideration of the negative effects of this gender imbalance on their working (and potentially private) lives, one might lean towards a conclusion that MINSA obstetras are playing into a system of patriarchal oppression that both disadvantages them and mirrors that of their patients' experiences. However, the social value of this kind of dress beyond gender troubles should be considered. Freeman’s (1998) study of ‘pink collar workers’ in Barbados discusses the phenomenon of high-fashion dressing amongst low-wage earning women in the service industry, to show how clothing and self-presentation becomes important not necessarily as a tool of gender relations, but of class consciousness. She reports that workers would often change their clothing from more informal wear to more glamorous high heels and skirts for the commute, in order to signal to their community a differential class status bestowed upon them through their jobs; “dress and appearance become central to the maintenance of ambiguous boundaries of class status” (1998: 250).

56 ‘Pink collar work’ refers to jobs that have historically been considered to be ‘women’s work’, e.g. care work, domestic work, service work, etc.
MINSA obstetras across the country are likely to encounter low-income patients using the SIS system; patients that may come from very similar backgrounds to the obstetras themselves, as is the case of Vilcashuaman. Therefore, the apparent ‘self-sexualisation’ (Smolak, 2014) of appearance may in fact be a class performance intended to differentiate workers from their patients. As Bridges had suggested, workers may treat patients of a similar background badly in order to create distance from the image of themselves they see in them (2011: 38-39). Sexualised appearances, therefore, may also be a mechanism of distance; high heels and makeup are a far cry from muddy flat shoes, plaits, and bowler hats, after all. Furthermore, as Freeman (1998) suggests, this kind of dressing can also be used to signify a person’s professionalism. Obstetras in Vilcashuaman are keen to play into the discourse of professionalisation, and associated de-indigenisation this entails, particularly as many of them could be seen as indigenous/Quechua themselves were they in another context, and they indeed mention ‘professionalism’ as a reason for using cosmetics (discussed above).

In fact, across the country at present, obstetras are desperately holding on to the desire to present a view of professionalisation due to a potential change in the law. If passed, this law would demote obstetras to ‘non-medical’ personnel, a position akin to a ‘technical’ career, that would remove a degree of respect and authority over patients from their jobs. There have been numerous manifestations and marches in protest against this change (e.g. see figure 7.2). However, this situation further underscores both the precarity in which they operate, and the belittlement that obstetras receive from the Peruvian government, and other workers within their own health networks.
Finally, it is important to note that due to the geographical location of rural health posts, many, if not all, obstetras are separated from their families and communities during working days. This arguably exposes them to potential abuse from (male) colleagues as they may be isolated literally and metaphorically and unable to avoid this or seek help. In addition, and importantly, several of them are mothers who are separated from their children for perhaps half of the month or more. Some have very young children who are left behind with grandparents or other family members while they work (this is common in Ayacucho and not restricted to MINSA workers). This means that the discourses on responsible and conscious mothering and FP that the obstetras impart to their patients daily may be something that they are unable to fulfil themselves due to work priorities. Although they can contribute financially to their children, a central tenet within the FP discourse, they are unable to

Figure 7.2. Call for Participation in Protest to MINSA, May 2018
‘Attention! All of the obstetricians to the ministry of health’
provide consistent or quality personal care to children when they are constantly absent for work. To again refer to Bridges’ (2011) assessment on patient mistreatment; in Ayacucho this may be a mechanism of distancing oneself from that which one is careful to avoid, but intimately close to, embodying.

In the end, it is also crucial to remember that the obstetras working as the face of the state whilst in uniform are not confined to that identity alone. Considering that many are Quechua-speaking, rural highland dwellers themselves, in other circumstances they too could be viewed as belonging to the identity group of ‘indigenous Quechua women’ that merits sensitivity and attention. Obstetras, however, by virtue of their differential working status, receive mostly derision. Nowhere has this been truer, or more concerning, than in the ongoing debate surrounding past sterilisations. Beyond the notion that this may have been an indigenous on indigenous affair in some situations, it is also important to acknowledge that the witch hunting for culpable health workers (imparted by politicians as well as feminist organisations and others) may result in the eventual condemnation of certain groups of women that the search for justice also seeks to avenge under other circumstances.

**Fulfilling Metas and the Blame Game**

We belong to a network that give us metas [goals] to reach every year. Like, we must cover two-hundred couples each per year. But you can’t obligate, no no no.

- Obstetra, Llamallaqta

Health workers are being blamed for the enforced sterilisations, and furthermore, these accusations are increasingly gunning for individual blood rather than collective punishment. In Vilcashuaman, specific names of workers who performed these sterilisations are identified, therefore this mounting tension may directly affect those obstetras in Vilcashuaman who were working at the time. Although there are those who argue that the Fujimori government

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57 Obstetras are not actually licensed to perform tubal ligation sterilisations. However, they have been directly mentioned in testimonies (see chapter three), and obstetras who were interviewed also speak about ‘sterilising’ women. This may mean that they either illegally performed the sterilisations themselves or accompanied and assisted the doctors and/or gynaecologists who were qualified to do so. Either event would render them culpable, although to varying degrees of legality and intent. Therefore, when the literature speaks of ‘doctors’ sterilising women, in regard to obstetras, they were arguably either acting the role of doctor, or directly supporting a doctor by rounding up and coercing patients (so the argument goes) and/or assisting the actual
is culpable, obligating health workers to sterilise certain numbers of people through enforced quotas, or *metas* (Ewig, 2010; Rousseau, 2007), the condemnation of individual health workers as acting alone operates as a counter to this.

For example, the daughter of Alberto Fujimori has recently weighed in on the blame game (to absolve her father of responsibility). Previously, Keiko Fujimori had denied the existence of ‘enforced’ sterilisations. This act led to her taking an unfavourable turn in the 2011 polls against Ollanta Humala, which then resulted in large numbers of female activists withdrawing their vote from her *Fuerza Popular* party candidature (Ewig, 2012). Ewig later argues that this may have been one of the criteria that led to her eventual defeat and loss of presidency (2014:65). Perhaps learning from her mistake, in the run up to the 2016 elections (which she also lost, this time to Pedro Pablo Kuczynsky), Keiko once again revisited the enforced sterilisations, speaking to a 2015 audience at Harvard University. She did not deny that sterilisations were ‘enforced’ this time. Yet, instead of taking responsibility for what happened under her father’s government, she opted instead to blame the doctors:

> “Now there have been various investigations about this and what they show are personal responsibilities of the doctors that did not respect protocols. I condemn the attitude of these irresponsible doctors, and as a woman and as a mother of girls, I am in solidarity with the women who suffered enforced sterilisations” (*La Republica*, 2015).

Whilst Keiko might have an agenda to deny the involvement of the Fujimori government in planning the sterilisations, others do not necessarily share this. In 2017, lawyer Maria Villegas released her (academic) expose, *La Verdad de una Mentira* (The truth about a lie), that aimed to highlight the responsibility of individual doctors in the enforced sterilisations, and absolve the Fujimori government of culpability, instead suggesting that the PNSRPF was undertaken as a form of national development (2017: 43), and that programmes aimed at bettering the life of the poor should be directed principally at the poor and therefore the majority rural-indigenous-poor recipients is justifiable (2017: 99), and that there does not exist sufficient official evidence to suggest that the enforced-element was part of a government-implemented programme

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surgery. As *obstetras* admit to having quotas, it can be concluded that at the very least they acted as the initial vehicle through which women were brought into the clinics for sterilisation.
(supported by policy)(2017: 36). The enforced sterilisations, she claims, are a myth, an ‘historia ficticia’, and one that has been used by various interested groups to achieve their political ends, including those that seek financial reimbursement (2017: 32)(see the previous chapter for discussion on concepts of interesada women). One of these groups that have capitalised on the ‘myth’, Villegas suggests, are the human rights and feminist groups that had previously lost their roles over defendants of sexual and reproductive rights in Peru (2017: 137).

Despite the book’s glowing references and introduction in which it is argued that Villegas has neither written a Fujimorista pamphlet or the opposite (2017: 15) (but, implicitly, the ‘truth’ of the title), for this work she has been accused of supporting Fujimorism and called a ‘Fujitroll’ in online political blogs (Grados, 2017). Ewig also attacked her work, accusing her of neo-Malthusian politics echoing Fujimori’s, that sees women as “instruments to obtain economic growth and poverty reduction” (2017). Ewig further suggests that Villegas’ work was not academically rigorous in her conclusion that a lack of written policy proves that this policy did not exist. Ewig comments that many other researchers working on this subject are aware that “written documents are not the only source of public policy, and these policies interacted with other policies and practices during their implementation” (2017), thereby highlighting the potential ulterior motives of Villegas.

Political intentions aside, what is clear is who Villegas seeks to blame - the medical professionals involved. She states that:

“In the case of the enforced sterilisations, it has been sought to demonstrate the responsibility of the highest members of the state, without signalling that of the doctors. The importance of this is based in the fact that to advance as a society, the crimes committed by the medical body during the implementation of a programme that looked to recognise the sexual and reproductive rights of the Peruvian women need to be necessarily sanctioned by the law” (2017:111).

And whilst Villegas has been criticised for her political stance, doctors are also personally blamed elsewhere, even when there is an acceptance that the policy was government-implemented. Gianella (2014) claims that owing to the mounting evidence released against the Colegio Medico de Peru (Peruvian Medical College), they were obligated to create their ‘own version of the story’ (2014: 80). This, he suggests, sought to portray medical staff as victims of a perverse system, just as the women who they were sterilising (2014: 81), and
blamed the structure of the Peruvian health system as opposed to individual will to sterilise without consent. However, Gianella concludes that if this were really the case, MINSA would be apologising for the past, when it does not (2014: 84). He goes on to opine, 'as a doctor himself', that he has never known a surgeon who did not enjoy his own authority (2014: 88), that if there had been a lack of medical will then thousands of efficiently performed sterilisations would not have been realised, and that no one resisted (2014: 89)(Villegas also makes this observation, 2017:109), and that Peruvian doctors have blamed other actors in society (e.g. MINSA or the government) for their own actions (2014: 86-87). Finally, he admits that “the Peruvian doctors who sterilised thousands of women…they did it convinced that they were doing what was medically correct” (2014: 89).

Health workers, and particularly female obstetras, are already in precarious situations in Vilcashuaman, and were somewhat disempowered during the PNSRPF regarding autonomy in the clinic, it could be argued. They were responding to the demands of the job, to save themselves and their own livelihoods. Not necessarily enough to exonerate a person from serious obstetric violence, but it is also necessary to hear their voices in order to better understand their motivations for doing so.

Perhaps understandably, health workers shied away from interviewing about the PNSRPF. It is not necessarily that workers feel guilty or deny that the sterilisations happened. Many workers maintain that women were not forced but convinced, and that they were obliged to reach certain goals as medical professionals, or they might lose their jobs. One obstetra put a figure to this: “they told us that we had to convince five women a month to have the ligadura”. Another elaborated a little more on their experience of working during this period:

Women who had up to three children was ok, but less than that, one or two, no. In the rural places it was more, those that worked in that time had a modality of contract in the SaludBasica programme, that ‘sí o sí’ you had to capture (captar), if you didn’t capture enough women, then you would lose your contract, so the staff, for fear of losing their jobs, had to complete their contracts however they could, even using force (a la fuerza). I was working in the city as SERUM so in my case it was less, but for those others ‘sí o sí’ they had to capture enough women. I didn’t see any violence, the idea was to convince
The ‘capture’ of patients refers to the targets given to workers. Rousseau writes that “the government’s prioritization of tubal ligation was…reflected in target quotas and incentives offered to medical personnel…quotas were pursued, notably, by holding ‘tubal ligation and vasectomy festivals’ organized by MINSA staff in various poor regions of Peru” (2007: 108). Ewig also concurs with the notion that jobs would be lost if targets were not met, “if quotas for sterilizations were not met then within this labor structure professionals risked losing their jobs” (2010: 152). However, because of these pressures, it was claimed that the workers “overstepped the norms in order to fulfil a quota and touched people who should not have been touched” (2010: 152).

Although workers in Vilcashuaman continue to express innocence and claim they were only following orders when sterilising, it should also be noted that the files containing medical information about the known sterilisation victims had ‘gone missing’ from the health posts when I tried to locate them, a fact that not one health worker tried to conceal from me, it should be noted. This, however, does not necessarily express guilt, but may highlight the unease produced in workers when they are singled out for ‘justice’, as discussed above. It is also worth reiterating that it is known who specifically participated in the sterilisations – rural health networks are small, and health workers are recognisable. For example, the women who gave sterilisation testimonies in Vilcashuaman, quoted earlier in this dissertation, whispered to me the full names of the staff who undertook the sterilisations. Therefore, the threat of denunciation constantly lingers over the workers.

Indeed, obstetras are fearful of being ‘denounced’ by patients, not only for past sterilisations but for contemporary maltreatment as well. For example, one obstetra told me that it was always important to ensure that the forms (discussed
below) were filled out correctly and that a patient had given their fingerprint as ‘consent’, otherwise the patients would ‘denunciar’ (denounce) them.

Although I had never actually heard of a case where a patient had successfully taken any health worker to court or ‘denounced’ them, the increasing focus on individualised ‘guilt’ for their sterilisations may heighten obstetras’ awareness of this possibility.

Obstetras often fretted over this possibility. For example, one day when I had returned from a visit to the UNSCH obstetrics department I asked one of the obstetras who I knew had studied there whether she considered that the classes prepared her for the realities of work:

OBSTETRA: In reality it’s difficult…it becomes difficult because of legal things (se hace difícil por las cosas legales).

RI: What do you mean cosas legales?

OBSTETRA: The patients can denounce you for everything, they want to denounce you, te quieren denunciar, it’s not easy working here for sure because of this.

She was not alone in her concern about being ‘denounced’. Another obstetra said that her work was difficult because often her patients would neglect their contraceptive method, or the method would inexplicably fail, and she would be blamed for their unwanted pregnancy:

If she becomes pregnant, it’s you who she will denounce, and why? Because now she has four children, and who is at fault? Because sometimes we say that a method is seguro (safe), but instead we should say that it is ‘highly effective’.

The fact that obstetras showed concern over a patient taking legal action does underscore one important thing – that patients are not entirely without agency in their interactions with health workers. Although it may prove legally complicated and expensive should a patient wish to officially report malpractice on the part of obstetras, the fact that the simple threat of this possibility is felt in the health posts suggests that Quechua patients may have a degree of agency and power within this situation, perhaps more than they are aware of.
That said, Quechua women were also being taught to denounce. For example, the focus of one JUNTOS meeting in Sarachongo centred around specific processes and avenues for denouncing husbands, partners and/or acquaintances that sexually violate the women and their children. Thus, Vilquinas may arguably be being trained to denounce malpractice, giving them further agency in both situations of domestic abuse (forwarded by JUNTOS), as well as against obstetric violence.

However, Vilquinas are also wary of being denounced by official workers in turn. As a Vilquina, quoted in chapter three, stated, women in the province were previously asked to sign paperwork that was used “to denounce us”, hence she no longer wanted to sign anything official nor respond to questions. Denouncement can be a weapon of agency on both sides, however both sides are suspicious of it – perhaps underscoring the shared cultural approach to certain mechanisms of state by indigenous workers and their patients.

Yet despite these concerns over potential legal problems with patients, obstetras did not necessarily cease certain behaviours. In all this, of vital importance and contemporary concern is the subject of quotas, or metas.

This subsection opened with a quote from the head obstetra at the health centre in the village of Llamallaqta. She admits that goals are given by ‘the network’, the MINSA network, that decided how many people health workers need ‘capture’, similarly to the Fujimori quotas. But this is not a quote from twenty years ago. This is happening right now.

Health workers, facing the mounting blame for the sterilisations when they claim they were responding to government-set quotas, quotas that they needed to reach or risk loss of work, are still being given quotas. Sterilisation as a specific target is off the table, the obstetra argued, yet in a bid to fulfil their mandated goals, coercion may still occur regarding other contraceptive methods (although she insisted that they could not obligate people). In fact, health workers are hushed somewhat about these contemporary targets as they are aware of the implications. One obstetra directly (and misleadingly) told me, “we don’t have targets because then we’d have to obligate, like in the time of Fujimori”. Her superiors said otherwise. Furthermore, the satisfaction of quotas and metas is also still implicated in one’s job security, expressed in the form of the evaluation.
Evaluations and Administration: An Obstetra’s World

Unless a worker has earned an appointed position\textsuperscript{58} after years of service, they will need to undergo an evaluation at the end of every contract period. Whether or not they have their contract extended or terminated will depend on the positivity of this evaluation.

In order to ‘pass’ the evaluation, a worker needs to prove that they are reaching the \textit{metas} that they have received. This is made possible through patient records that show how many people have been attended by each worker, and in a rural network such as Vilcashuaman with little technology, this is all done by hand.

Flicking through my first notebook of fieldnotes I find the phrase ‘the health centre is a paper mill’ jotted down and underlined in a margin as my initial impression of the institution. In time one learns that this excess of paperwork and administration is due to the evaluation that un-appointed (\textit{nombrada}) workers (who are the majority) must undergo every three to six months depending on their particular contract. No paper trail, no proof. No proof, no positive evaluation. No evaluation, no contract renewal.

I found one obstetra in the FP consultation room behind a stack of papers and forms when I came to interview her. Her contract was coming towards an end and with the evaluation looming, she was hurriedly trying to complete the necessary forms to prove that she had reached her \textit{metas} and should be kept on as an employee. Somewhat stressed by her imminent professional judgement day, she was keen to offload about the evaluation and contracts.

\begin{quote}
OBSTETRA: Look, when you have this kind of contract [short term, renewable] it’s not that stable, in any moment they can tell you that you have to go and look for another job…if they want to put someone else…it’s not stable. It’s estresante, it’s stressful. What papers you might have to prepare, maybe you need to study a bit more (actualizarte), so you are ready for the evaluación. If you don’t pass it, then hasta aquí chau (until here,
\end{quote}

\textsuperscript{58} To be appointed, or ‘nombrada’ grants a worker special privileges and permissions not available to those under contract and is usually granted after a minimum of ten years of service within one health institution; “Naming grants protection not only from termination, but also fewer work hours in a day” (Ewig, 2010: 105). Naming was a feature in the SaludBasica programme form, and although Ewig claims that it had now stopped (2010: 105), it does continue in Vilcashuaman health network. As mentioned previously, this CLAS network has absorbed many elements of SaludBasica that may have been discarded in other networks.
then goodbye). The modality of work is like that; they contract you; they evaluate you, then they contract you…

RI: What are the duties that you must fulfil in order to pass the evaluation and be contracted again?

OBSTETRA: It’s according to your ‘profile’ (perfil). Yes, you have to capture (captar) pregnant women (gestantes), yes you have to captar women for métodos (FP). If you achieve this according to your ‘profile’ then there’s no problem…In the case that you do not fulfil your profile, then yes, the superiors have the obligation to not contract you again.

RI: Do they give different ‘profiles’ to different workers depending on their experience or abilities?

OBSTETRA: It depends, it’s personal. If you are going well, then they will renovate your contract.

If, as this obstetra states, she and other health workers are still at risk of job loss lest they fulfil certain quotas and metas outlined in their contracts, then arguably those same impetuses that resulted in past coercive sterilisations continue to exist in some health networks. It is not hard to conclude that if an obstetra is given a goal of reaching say, two hundred people in a year for FP, and her job depends on successfully fulfilling that quota, then s/he may do so by whatever means possible. Including coercion. However, if such activities continue to exist as in the past, it should be questioned whether or not coercive behaviours and obstetric violence occur due to racism and discrimination, as suggested by Ewig (2010) and Guerra-Reyes (2013), or power-mad authority abuse and self-righteousness, as suggested by Gianella (2017: 88), or if in fact it may be due to institutional and structural conditions that obligate obstetras to pursue certain activities and behaviours on behalf of the state in order to keep their jobs.

Of course, it is tempting to suggest that they should just say no. However, realistically, losing one’s employment is unlikely to be an option for these workers who, without it, may be back to working in the chacras as their patients.

A further problem with this kind of system is that so concerned are workers to produce a positive evaluation, that they necessarily concentrate a large part of their working time to attending to the accompanying paperwork to prove they
have performed successfully. It cannot be overstated the sheer volume of the working day that can be observed competing paperwork and forms, in every single level of the health network. Workers will fill forms during lunch breaks, during consultations, and even on days off, for if they are incomplete the employee faces penalties. Indeed, paperwork administration is a feature of government offices across Peru and is not confined to MINSA. As Yrivarren suggests in his study of a Lima municipalities’ transition to an electronic system, for most public service workers “paper is king” (*papelito manda*) (2011: 22). Many sectors of the government, especially in rural areas, lack the resources to move to an electronic system, and all paperwork in Vilcashuaman MINSA network was just that- written on paper (that said, the EsSalud network within the same area had computers (so it was reported), and therefore paper-administration cannot necessarily be said to be absolute across all rural government institutions, but mainly those that serve the poorer populations).

This heavily reliance on paperwork also produces another effect; it turns the workers into administrators. There are obvious negative effects of this – more time spent filling forms means less time with patients. However, it also takes a toll on the workers themselves. Everyone always complained about the amount of paperwork required of them, and it is genuinely excessive.

The principal forms that must be completed for each patient are the FUA (*formato único de atención*) and the HIS (*historia*), along with other specific forms for the patient’s medical concerns (e.g. FP record, pregnancy record, etc). These are then filed away in a paper folder stored within the patient’s corresponding health centre. When they come for an appointment, patients must fetch this folder from the records room and *obstetras* will return it once the new paperwork is filed. The following section will address the political function of this paperwork itself, however for the time being it is instructive to examine how the workers relate to it.

It may be telling that the *serumistas*, who are new to the MINSA system, make jokes about it, both verbally and in the form of shared memes (see figures 7.3 and 7.4, shared on Facebook and in region-specific WhatsApp groups). For example, one meme shows a shocked ‘Lisa Simpson’ staring down at a FUA and reads “My face the first time that I saw the FUA and HIS [forms]” (figure 7.3). The
second shows a cross-armed, grumpy ‘Pingu the penguin’ and reads, “I want to fulfil my meta (quota/goal) but I don’t like to fill out FUA or HIS” (figure 7.4). Miller argues that memes are a way to reinforce norms, in this case, the begrudging acceptance of certain paperwork to reach one’s goal (and the importance of fulfilling metas) through humour:

“Memes circulate as a mode of moralising and humour; as such they are a way of reinforcing social norms…there seems to be a case for regarding memes more generally as a kind of ‘internet police’, attempting to assert moral control through social media” (2016: 172).

Thus, the sharing of discontent with MINSA paperwork through memes may be part of the process by which serumistas come to understand the gap between their studies at university and their actual roles within the health network; less patients and hands-on-health, more forms and tedium. Furthermore, the use of popular American television characters may hint at the supposed differential origins of serumistas to their patients (even if from within the same communities and mentioned above), as one would have needed to have grown up with television access to identify [with] these characters. However, serumistas are new to their roles, and after years of such tasks one’s humour may change. Obstetras would often lament how frustrated they felt with the situation. As an obstetra sighed, “Look, it’s all paperwork. Todo papeleo”.

Graeber discusses the rise of unsatisfactory work through the ‘phenomenon of bullshit jobs’ (2018); work which he defines as:

“a form of paid employment that is so completely pointless…that the employee cannot justify its existence even though, as part of the conditions of employment, the employee feels obliged to pretend that this is not the case” (2018: 9-10).

Now, neither I, nor Graeber, would ever suggest that the work of obstetras and other health workers is in any way pointless (he mentions nursing as the opposite of ‘bullshit’ for example) (2018: xix). However, the rise of the administrative sector, that behemoth that results in reels and reels of paperwork destined to nowhere, is highlighted as bullshit (2018: xv). A job that is vital in many aspects yet reduces itself to mindlessness through state-mandated necessity, could be seen as ‘partly bullshit’ (2018: 24).
Figure 7.3. Lisa Simpson FUA/HIS meme. Memes y Confesiones SERUMS (facebook.com/memesyconfesionesserums)

Figure 7.4 Pingu FUA/HIS meme. Memes y Confesiones SERUMS (facebook.com/memesyconfesionesserums)
What should be an active, engaging job such as obstetrics is arguably becoming pointless in the eyes of workers due to the endless march of paperwork and form-filling (and lack of patient interaction), the destinations of which are the bottom of a cabinet or dank records room. The tasks of filling the FUA and HIS are what Graeber calls ‘box-ticking’, which is often a form of government (2018: 46), and functions to “allow an organization to be able to claim it is doing something that, in fact, it is not doing” (2018: 45) (in order to satisfy MINSA metas, for example). The effect that this has on a person is far more serious than idle boredom, Graeber argues, and can be “soul destroying” (2018: 133). Humans, he suggests, are wired to produce a cause and effect (2018: 113), the lack of which can result in stress (2018: 117) (as indeed it has for one obstetra, as she mentioned in the interview quote above), and physical illness (2018: 119). Furthermore, the very act of forced pretence, of pretending that one is undertaking something meaningful whilst realising that this is untrue, can be particularly damaging. On this, health workers do realise that the paperwork is stopping them from spending any real time with patients but are forced to do it anyway for the evaluation. Graeber muses:

“It is hard to imagine anything more soul destroying than…being forced to commit acts of arbitrary bureaucratic cruelty against one’s will. To become the face of the machine that one despises. To become a monster. It has not escaped my notice that the most frightening monsters in popular fiction do not simply threaten to rend or torture or kill you but to turn you into a monster yourself: think here of vampires, zombies, werewolves. They terrify because they menace not just your body but also your soul” (2018: 113-134).

Following from Graeber’s rather haunting premonition, if obstetras’ jobs are becoming ‘partly bullshit’ through the (perpetuation of) administration-isation of medical care, yet they must continue to do so in order to satisfy the evaluations that will ensure the continuation of their employment, the evaluations that are based upon target-reaching that has historically led to mass-sterilisations and subsequent blame, whilst also enduring gender inequalities and absent community support, how can they be expected to offer optimum care to their patients? When addressing obstetric violence, therefore, this clearly needs to be taken into consideration.

Although health networks are set up to provide medical care, the aforementioned situation suggests that there may be other motives; paperwork
and form-filling data collection is being prioritised over patient primary care, it would seem. Thus, there may be an impetus and a motive for the forms beyond optimum care provision, one could surmise.

On this, it has been suggested that the very nature of paper-based forms and medical-reporting may have implications for the way that the health system and employee relations (with both patients and each other) are constructed, through the act of writing, that would be lost in an electronic system, thus supporting the continuation of paperwork. Berg (1996) argues that the patient record itself can be taken as a Latourian force that transforms the social interactions around it (1996: 501) and renders the patients ‘manageable’ (1996: 507); an important point which the following section will return to. Importantly, the use of paper administration made the earlier-mentioned disappearance of sterilisation records possible, thereby directly mediating relationships not only of health-patient interaction, but potentially of justice. As Yrivarren states “for many Peruvians, to be ‘papered’ (empapelado) means to be submitted to an unjust power” (2011: 22). Indeed, this issue of paperwork tying one to a power system is not inconsequential; it does exactly that, through the census.

**Data, Census, Discipline**

The paperwork that health workers must complete does not just contribute to patient care but is intimately related to the institution of the state and its power. Gathering and recording data on patients tells MINSA a great deal about the population with whom the contracted workers are dealing, information that is very important for the exaction of state biopower. When taken as such, the focus and importance placed upon data-gathering and record-keeping through staff (negative) incentives (i.e. complete the tasks or lose your job) becomes unpacked. Indeed, *metas* may be about encouraging contraception coverage by any means in order to control the fertility of a population, but they also ensure that health workers collect information from as many patients as they possibly can in order to pursue their work targets. Thus, the FUAs and the HISs are also agents of power, as this section will further discuss.

On the patient record, mentioned in the previous paragraph, Berg draws on Latour (1996: 501) to suggest that, “the medical record is one of the ways
power differences are materially constituted" (1996:513), as “the reality of a patient’s body is assessed and transformed through layers of paperwork” (1996: 511). Furthermore, Berg writes that the medical record is a ‘force’ in and of itself, “mediating the relations that act and work through it...social interaction is transformed through it” (1996: 501). The information recorded on these seemingly innocent sheets of paper does not and cannot reflect the reality or the truth, as this is highly subjective. The papers thus are records made by individual actors to interact with other actors, the content and consequential calls-to-action dictating the social interaction perpetuated by the papers. In Berg’s discussion, this is between those within the hospital network, yet, the relationship that is mediated by the medical forms may be much larger than that; it may be between the patient, the workers, the state (the global health communities with a vested interest in the state such as USAID in the case of Peru, if we consider the destinies of health statistics and their influence on donor programmes for example, and so on). From this, it thus further follows that medical records, in the present case the FUA and the HIS, be understood as actors within a human-nonhuman relationship and should be treated equally as agents of power (Latour, 2007).

In this view, the information on the MINSA forms does not just record a patient’s reality, but actively incites a transformation in that reality. Simply put, the data collected on the forms, data about children, fertility, contraceptives etc, is fed back to the state, which can then take steps towards its own goals for the population based upon this information – biopolitics. On this, Foucault says that governments perceive that they are “not simply dealing with subjects or even with a “people”, but with a “population”, with its specific phenomena” (1990a: 25), a population whose sex (reproduction) becomes a “thing one administered” (1990a: 24). A way to achieve this is through “analysis, stocktaking, classification, and...quantitative...studies” (1990a: 24), all of which culminate in the census - the ultimate way to analyses and take stock of a group of people (or a nation). To expand, Taylor writes:

“Biopower administers life rather than threatening to take it away. In order to administer life, it is important for the state to obtain forecasts and statistical estimates covering

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59 See chapter eight for more in-depth discussion of medical materialities in the MINSA clinics.
such demographic factors as fertility, natality...for this reason, an important moment in
the history of biopower is the development of the modern census” (2011: 46).

The administration of life is possible through governmentality, and Scott (1999)
suggests that the state needs to collect such comprehensive data on the
citizens in order to achieve this legibility to govern effectively. The census, an
“instrument of statecraft” (1999: 343), is the tool used. Scott outlines the aim
and scope of the census thus:

“State simplifications such as maps, censuses cadastral lists, and standard units of
measurement represent techniques for grasping a large and complex reality; in order
for officials to be able to comprehend aspects of the ensemble, that complex reality
must be reduced to schematic categories” (1999: 77).

In the dissertation’s introduction the state census’ re-introduction of indigenous
categories was presented as highlighting the Peruvian government’s re-
emerging interest in identification of these communities within the country
(Chirapaq, 2017; Telles, 2015). Thus, it follows that the FUA, HIS, and other
forms of data collection undertaken in MINSA are also a form of census taking
that eventually contributes to the whole.

In the case of these medical records, the term ‘census’ can be applied if one
considers the motivation and execution of the modern census and notes the
same manner of reductive statistical collection in the FUA and HIS. However, if
the national census can identify the ethnicity of communities in the county, then
the health census can identify bio-elements of the people within those ethnic
categories and ‘report back’. The work of MINSA can help to flesh out the reality
of the population’s health to make them ‘legible’ (Scott, 1999). Yet, it is arguably
not only about understanding them. The health data gathered can also help the
state to administer life (Foucault, 1990a) of these groups. For example, health
workers are careful to ask questions about a patient’s fertility, infant mortality,
use of contraception and reasons for discontinued use, number of partners, etc,
all of which is written down in the medical record. As seen in chapter four,
patients are often unable to resist questioning under the SIS system as it is a
condition upon which their health services are provided. Combined with the
national census’ information on ethnicity, one would now be able to infer the
relationship between, say, Quechua women’s fertility compared to the
Ashaninka (Amazon indigenous group), and therefore create more meticulously
targeted health programs based upon this new information (e.g. rather than
target ‘indigenous women’, as under the enforced sterilisations, state health
programs can specifically target each group using their new census data about
the bio-realities of each).
Finally, it must be considered that the gathering and tabulation of statistical data
about a ‘population’ is a constructive activity in itself:

“The measurement and quantification of population does not occur after the population
has been constructed; rather, population is constructed simultaneously with its
measurement and quantification” (Bridges: 2011: 148).

Hacking calls this ‘making up people’ (1990: 3). In order to count people (and
the characteristics of people), it must first be decided which categories will be
presented for which they may fall into. For example, indigenous-ethnic
categories must be reduced into quantifiable categories, thereby producing
those ethnic categories through the act of the census’ insistence on citizens
self-selecting of one. In terms of contraception and FP, the ambiguity with which
people may approach their own health decisions and kinship networks must be
deftly categorised. How many children one has, a seemingly simple question for
example, may become rather more complicated if one considers the fluid kin
relations prevalent in the Peruvian Andes (Leinaweaver, 2008a), for example.
Listing your contraceptive for the FUA may be made more difficult if you did not
consent to past contraceptives that you have had, or if you use natural methods
that do not feature as an acceptable biomedical census category. One risks
being a non-user statistic through the necessary rigidity of quantitative state
data collection. The census forces one to put a number on things that may be
complicated to quantify, thus inventing the categories “in which people could
conveniently fall in order to be counted” (Hacking, 1990:3). This not simply
counting, either. As Hacking argues, statistical inference and the census are
based upon an idea that through classification, “one can improve- control- a
deviant subpopulation” (1990: 3). The forms of data collection that make up
health workers’ days, then, are arguably themselves agents of state biopolitics.
In the light of the recent national census’ focus on ethnic, particularly
indigenous, categorisations, the mass collection of FP and contraception-use
data and statistics should not be brushed off as business as usual. The
Peruvian state seemingly wants to know ethnic and bio-realities of the Quechua
(and other) population, and the already-stretched and demonised health workers are apparently charged with this task.

**Conclusion**

Unlike Paul Farmer’s recommendation of limited sympathising with medical workers so as to focus on the patients (Kidder, 2009), instead it could be suggested that in order to sympathise with the patients, one also needs to sympathise with the obstetras that attend to them. Whilst there are complex and intertwining discourses that murky the picture, the fact remains; if one wishes to reduce health post coercion in contraception and beyond, then health workers will need to be relieved of their metas. Otherwise, they will continue to look for more patients to provide with contraceptives in order to save their own jobs. This is a truth that might not be pretty, but as this chapter has attempted to show, is somehow perhaps understandable. Yet, as the current national narratives continue to attack health workers for the past, this deflects from the over-arching structural powers that have the ability to incite such events which will therefore remain unchallenged. Furthermore, obstetras arguably need to have their authoritative positions vis a vis other health workers attended to, otherwise this will create increased job insecurity which may worsen coercion and negative behaviours within the FP services and beyond. More research is arguably needed to better understand and attend to this situation, including not only studies that focus on the precarity of health workers in varied positions (e.g. it is likely not only rural workers who may receive metas that compromise their morals), but especially amongst serumistas who are typically younger, new university graduates with less or no ability or experience to contest work-based authorities and therefore may potentially be more likely to (unintentionally) cause harm to patients.

This chapter has attempted to humanise those obstetras in order to better understand how and why obstetric violence occurs within the FP setting, and furthermore to challenge often-repeated and accepted wisdom about health workers in Peru – that they are all white – which suggests that violences are racially motivated on the part of the health workers. Indeed, this view may unintentionally absolve the state as it suggests that it is racist individuals who maltreat indigenous patients. Here it has been seen that in fact, health works
may be indigenous themselves, and it is the state structuring of MINSA working conditions that may (re)produce violences and inequalities, amongst other things (such as the health worker desire to distance themselves from their own communities that they may have come to see as inferior).

In the end, it serves to present as truthful a context as possible so that the reader can hold the humanity of obstetras in their mind when encountering such incidents.

This perspective will be particularly helpful as one moves into the following chapter, where the discussion shall be centred around the perceived cancer that Quechua women believe that health workers are contaminating them with and producing within them through clinic practice and biomedical contraceptives. This chapter will focus on the Quechua reaction to and perspectives on the contraceptives offered, to further elucidate local frameworks of understanding and explore the reactions of indigenous women to biomedical impositions within Vilcashuaman.
Figure 8.1. A Patient revises the cancer promotional materials on the table in the family planning consultation room.
EIGHT
CANCER

For six years I was using the injection, and when I went to Lima they detected a tumour in my breast, it hurt me, my breast became dry when my baby was still small. Then the doctor told me to have another baby so it could clean the milk. From my nipple it came out all coagulated, the milk was like cheese, so I had to stop using the injection to clean it. I had my baby for two years then, I was using the pill, but then I had a quiste, a cyst, in el ombligo ['belly'/stomach and/or uterus], so I always get checked now. Because I had so many hormones inside, how can I say it...for this reason it produced a tumour in my breast and a cyst in the ombligo. I never menstruated for those six years, but then my breast hurt so I went to go check it. I was crying, knowing that I was taking the pill and my sisters were pregnant, I was thinking how could I have another baby with all these problems. I would not use the injection again, nor the pill, as I don't trust them because of this. It still happens to some women I know. My baby is all healthy now, I have four children...but when this happened I had just two children only.
They [the obstetras] want to put another method in me now, the implant they say...I want it to cuidarme, to care of myself, but now it makes me scared.

- Angelica, Thirty-five, Willka Waman

Waiting in the health centre to be discharged after the birth of their fourth child, a couple from Willka Waman had been through a lot of troubles lately; two incidences of ‘cancer’ (breast, and later a cyst in Angelica’s ‘belly’) that involved them travelling to Lima, another pregnancy to dislodge the breast tumour, and a change of FP methods that made her afraid of hormones. They were now facing use of the implant, something that they both wanted as a way to avoid future pregnancies, albeit that the lady feared it. It had been with two different methods that two different instances of ‘cancerous’ tumour/cysts had appeared. Angelica’s partner wanted to be present in her interview and sat with his hand on top of hers throughout for support. He had seemingly agreed to the implant and nodded along when she stated her intention to use it; “this method would be good, el implante”, his tone repeats softly over the voice recording. The obstetras had already agreed to install the implant in her arm later that day. Angelica went ahead and left us alone to finish talking. Just before her husband pulled the door to a close, he turned nervously back to me, concern in his eyes,
Fear of cancer due to use of hormonal contraceptives is widespread in the Andes (Yon Leau, 2000: 28), and most people interviewed in Vilcashuaman made that connection, to varying degrees of severity, and whether they had experienced it personally or not. As the above testimony shows, this is directly related to the perceived high doses of hormones in the contraceptives. Although the use of hormonal contraceptives produces "a relatively small and temporary increase" (Westhoff, 2018:170) in breast cancer, combined oral contraceptives can produce protective effects on ovarian cancer risk (Cibula, 2010), and in Ayacucho the pill is always recommended for women who have ovarian cysts. There are also risks of cervical cancer following long-term use of hormonal contraceptives, although data is not definitive (Smith et al. 2003). Following a scientific, biomedical discourse, then, cancer is a genuine concern for users of hormonal contraceptives, but this may be weighed up against other health concerns, such as health-risks of multiple pregnancies and/or terminations. What is especially interesting in Vilcashuaman, as this chapter will discuss, is the conflation of biomedical discourse with Quechua understandings of the body and reproduction. The way that Quechua bodies function with hormonal contraceptives produces cancer in a very specific way.

From this, it serves to define what is ‘cancer’ in this context. Biomedically speaking, the British National Health Service (NHS) defines it as “a condition where cells in a specific part of the body grow and reproduce uncontrollably. The cancerous cells can invade and destroy surrounding healthy tissue, including organs” (NHS, 2019). Cancerous breast tumours, like that experienced above by the interviewee, can be defined as cancer using biomedical paradigms. However, when approaching cysts in the ovaries, more often than not they are common, non-cancerous, and go away by themselves (NHS Direct, 2019). Other ovarian tumours, such as teratomas, may be cancerous but are usually benign, although they need surgical removal (NHS, 2019). Therefore, according to the biomedical understanding of cancer and hormonal contraceptives, it is reasonable to exercise caution. That may be somewhat exacerbated when people are afraid and untrusting of biomedicine,
as previous chapters discussed. People’s embodied fear of biomedicine may heighten concerns over cancer, for example. Yet, there are other explanations beyond fear that highlight a Quechua aetiology of cancer that differs somewhat from the biomedical explanations. This point shall be returned to later.

It should be noted, that in Vilcashuaman, ‘cancer’ is also used to refer to diseases and medical concerns that would not be considered ‘cancer’ in biomedical discourse. For example, in a previous chapter, my informant Blanca’s aunt died of ‘cancer’ from a Copper-T, however, it is not clear whether this was ever medically diagnosed as ‘cancer’. Less ambiguously, during my field work another woman died of ‘cancer’ in Sarachongo. This happened right before Christmas, and I had joined the principal of the local school in a house-visit to offer my condolences and give small Christmas-gifts to the orphaned children. They were being cared for by their aunt, who told the story of her recently deceased sister.

Her leg had begun to rot, she said, and turned a strange colour with a foul smell. She had travelled to Lima for amputation but had died upon her return to the village. Biomedically speaking, this sounded like gangrene, but was discussed as a ‘cancer’ death. This is not to suggest that the family was mistaken in their understanding of this woman’s diagnosis, only to highlight that ‘cancer’, in these understandings, can refer to diseases/illnesses above and beyond those included in the biomedical discourse of the term, although those understandings do also include biomedical explanations as well. Henceforth, cancer shall no longer be referred to in inverted commas, but I trust that the reader understands that we will now be referring to a more encompassing definition of the word, and not simply the biomedical understanding.

This is an important point of entry when considered within a dissertation addressing coloniality, as Castro-Gomez (2010) points out that an effect of the coloniality of power has been the imposition of “a single way of knowing the world, the scientific-technical rationality of the Occident” (2010: 282), to the

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60 Although this case was not pursued, it is interesting to note that gangrene may be caused due to diabetes, which is a blood disease. Quechua aetiology of cancer also understands it as produced due to a problem with blood; therefore, it is logical that if this woman did suffer blood-disease, then she would indeed have died of ‘cancer’ in indigenous understandings. This area needs more research, however, that was not within the scope of this dissertation.
exclusion of other ways of knowing. Thus, whilst the ‘Western’ understanding of the theme will also need be discussed as this is the model of understanding employed by the state and the health workers, this is not the only valid framework, and when discussing Quechua views on cancer it is necessary to appreciate this aetiology as a different, but in no way inferiorly hierarchised, model to that of the biomedical clinics.

Mukherjee’s (2011) metaphor of cancer being like the crab from which it took its name; spreading out its gangly appendages into the body from a central rotten locus, is a tempting one to apply to Vilcashuaman; the health centre and biomedicine with outstretched pincers, reaching into the ovaries and breasts of Quechua women (both essential for reproduction and care of young), and afflicting them with cancer; the modern form of the sterilisation on this particular continuum of violence(s). However, Sontag warns against cancer metaphors; they “kill” (2009: 6). By viewing cancer as a stand-in for other societal ills, such as obstetric violence in rural Peruvian clinics, it demonises the disease which takes it beyond what it ‘is’ (for Sontag, a biological illness, full stop), and makes it shameful by association. However, here, cancer is not used as a metaphor for all other illnesses; in Quechua aetiology, it is cancer, even if biomedically, it is not. Or sometimes, biomedically it is.

The point is that here debating medical terms does not matter; it matters how it is ontologically understood for those people it affects. Principally, this applies to the question of ovarian cysts, the cancer that everyone fears and talks about (even if, biomedically, they are not related to cancer).

This chapter will first address the (in)visibilities of cancer within the health centre setting, to understand how it is presented in regard to contraception and therefore unpack why women may perceive the connection between the two in the way that they do. The conflation of obstetras with the pishtaco, an Andean monster that steals body tissue for personal gain, will then be explored to question how and why obstetras, and even indigenous obstetras, are labelled as such, and where people’s fears arise from. Finally, this chapter will investigate Quechua understandings of the reproductive body and the effect that hormonal pharmaceuticals have on the inner workings of menstruation, pregnancy, and cancer, to provide a complete picture as to the spectre of cancer within contraception and the health post, and how this could be
overcome so that Quechua women need not fear for their health as a consequence of FP.

**Cancer in the Clinic: (In)Visibilities**

It is little wonder that the threat of cancer is so often associated with contraception in Vilcashuaman, for everywhere they are presented together. A poster that hangs outside the FP consultation room, for example, squeezes both onto one space (figure 8.2); insinuating, at best, an ambiguous connection and at worst, a *causal* relationship between the two. This is not unreasonable from a biomedical perspective.

Barrier methods of contraception (and abstinence) can help protect against the human papillomavirus (HPV), which leads to cervical cancer. It is the *obstetra’s* job to undertake the Papanicolaou (smear test) as well, further tying contraception and cancer together in the posts. Indeed, during many a family-planning consultation a woman would be asked about timings of her last smear test, and it was an ideal time for *obstetras* to ‘capture’ more Papanicolaou patients for their evaluations too as they were already inside the consultation room. Indeed, none of this is unreasonable from a biomedical point of view; cervical cancer claims the second highest rate of cancer-related deaths in Peru (11%), behind stomach cancer (15%) (PAHO, 2018), and women in Vilcashuaman are recommended to undergo a yearly smear test. That said, screening for cervical cancer is generally low in the country with less than 43% of women attending their Papanicolaous within the recommended time (Winkler, 2008:10). JUNTOS has also incorporated compulsory smear tests as part of its conditional cash-transfers in order to obligate more women to take the test. Thus, the focus on cancer in the posts is hardly surprising from a public health perspective. That said, there are nevertheless important analytical points to be made on the particular kind of visibility given to cancer, and the invisibilities of other diseases compared to it.

As mentioned, cancer information materials are highly present within FP consultations; they are often presented and discussed side by side. Cancer is a rising issue in Peru, so this is reasonable. However, if one will momentarily
permit the diversion from a focus on contraception alone; there is another health issue that continues to plague Peru: Tuberculosis (TB). However, compared to cancer’s overt presence within posts, TB is relegated to invisibility. People are still tested for it on a regular basis, and sputum smear tests (phlegm tests) are often given alongside the pregnancy tests administered by health workers when on house-calls and during routine consultations. Yet, health workers lie to people about the nature of these phlegm tests, telling them that they are for *gripe* (flu) or other minor respiratory conditions, thus placing TB out of consciousness. It is also banished from sight within the health centre. If one remembers the geography of the large health centre in Willka Waman, previously discussed (see appendix 6.1); with the separate maternity building and main ‘children’s’/ ‘other’ building, a TB room did not feature in the main building(s). That is because it is out the back, all alone and hidden. On first
glace that makes perfect sense from an infection-control perspective - TB is highly contagious so patients should be isolated - were it not for the fact that to get to that location one would have to first walk through the entirety of the central hospital building, infecting everyone.

TB is an embarrassment, as one health worker told me, so people are in denial about it. In Peru, TB is a poor person’s disease, an indication of ‘backwardness’ and poverty (Farmer, 2000). This is especially salient when it is compared with images of cancer. Mukherjee writes that “we tend to think of cancer as a “modern” illness because its metaphors are so modern. It is a disease of overproduction, of fulminant growth – growth unstoppable, growth tipped into the abyss of no control”, whereas there is “another disease considered emblematic of another era: tuberculosis in the nineteenth century” (2011: 37); yet it is noted that “despite such parallels [between TB and cancer], tuberculosis belongs to another century...cancer, in contrast, is riddled with more contemporary images” (2011: 38). Cancer is a modern illness, for modern bodies. TB is a disease of a dark past, for bodies that are also 'stuck in the past'61. The (in)visibilities of disease in the health centre arguably suggest an image that is hoped to be projected. Here, people get cancer and so that’s what ‘we’ test on – modern bodies. Backwards, impoverished bodies get TB, and they must be relegated to invisibility and the past.

There is more. If cancer is a modern illness, it is also a white illness. Observe the images from the two cancer leaflets in Vilcashuaman, one for cervical cancer and the other for stomach cancer (Figures 8.3 & 8.4). Both show white, blonde people. These are the people that get cancer; modern, white people, it suggests.

61 Although cancer might be considered as a ‘modern’ illness in this context, this is not necessarily the case in all of Latin America. For example, Martinez refers to cervical cancer in Venezuela as a “third world cancer” (2018: 221), suggesting that it could be associated with poverty, as TB is in Peru. However, it is also worth noting that in Vilcashuaman, the ‘cancer’ that women fear is not specifically ‘cervical cancer’ in biomedical terms (even if this is what the pap tests are for), but may be more akin to an ‘ovarian cancer’ (see discussion below on blood accumulation). Furthermore, whereas in Venezuela (Martinez, 2018) and Brazil (Gregg, 2003), cervical cancer is related to STIs and morality, this was not the central discourse in Vilcashuaman.
¿Qué es la endoscopia?

• Este examen permite detectar la gastritis, úlceras y tumores cancerosos así como la bacteria Helicobacter Pylori que vive en el estómago.

• También facilita que el médico tome una biopsia, es decir, saque una pequeña parte de alguna zona sospechosa del estómago para su estudio en el laboratorio.

• Para realizar este examen se introduce a través de la boca del paciente un instrumento muy delgado que tiene una microcámara de televisión, que permite observar el interior del estómago.

• Este examen se desarrolla por indicación médica y no presenta mayores riesgos, si se hace con los equipos adecuados y en lugares de garantía.
Finally, cancer is associated with the urban. Namely, a cancer diagnosis necessitates a (sometimes one-way) trip to Lima. The provinces do not have the specialists or equipment to treat advanced cancers, and so this is the only option for biomedical treatment. The urban is also associated with whiteness and modernity; thus, cancer goes full circle as a racially subjective disease.

All that said, there is much controversy around smear tests, and women do not like to undergo them. One simple reason given for this is shame. Orr suggests that women often encounter “uncomfortable intimacies [of obstetric medicine]” (2012: 522), and may find the practices intrusive, or even invasive. Smear testing, where one must lie down with one’s legs spread and feet in stirrups, is one such example of an intrusive procedure. Patient maltreatment does not help; I once heard an obstetra admonish a patient as she left the consultation room following a pap-test⁶²:

You smell disgusting, you need to wash. *Hueles bien feo, tienes que lavarte. Are you sure you don’t have a casual [sexual] partner?*

Due to a lack of running water and the cold climate, it is common that women may not wash daily, so if this obstetra was so inclined to comment negatively on vaginal smell to this patient, she may be doing so to others who also lacked the means for maintain regular personal hygiene. The humiliation of patients constitutes a form of obstetric violence, to be sure (*Defensoria del pueblo*, 2016). In the above example, the obstetra also insinuated that the woman may be having casual sex which, as morally condemnable in Ayacucho, might be contributing to her malodourous genitals, i.e. she was inadvertently accusing her of having an STI, in public⁶³.

The relationship between cancer and STIs is rather interesting, in as much as this was barely mentioned as a factor. In other parts of Latin America, the opposite may be true. For example, Gregg (2003) found that in Brazil, women perceived their smear tests as a ‘test-all’ STI examination and further believed (incorrectly) that this procedure may remove any lingering infections from their

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⁶² I never observed a smear test, even if invited, to preserve patient privacy.

⁶³ See chapter five for further discussion on the link between physical and moral hygiene.
genitals and reproductive system. In contrast, in Vilcashuaman, the connection was never explicitly made during consultations. STIs are addressed (see chapter five), however, that cervical cancer might be produced as a result of HPV was far less visible – in fact, I never once heard an obstetra mention a link between sexually transmitted infections or even sexual intercourse itself and cancer. This may go some way towards explaining the mystery surrounding the cancer and contraception link, and the resultant application of Quechua reproductive-body aetiology understandings to solve the conundrum. That is not to say that people ‘misunderstand’; only that the biomedical link between the two is rather weakly presented within the health posts and thus leaves open the way for local interpretative discourse to fill in the blanks.

Even when women are not humiliated, they may feel too ashamed to attend cervical cancer screening. This is not isolated to Peru either, as plummeting test rates due to women’s ‘embarrassment’ have recently been reported in Britain as well, for example (The Guardian, 2019). Add to this some insults about genital odour, and smear-test avoidance in Vilcashuaman should not come as a shock. However, it is not just embarrassment that keeps women away. As one obstetra mentioned:

They [the patients] think that when we do the pap-test we contaminate them with cancer.

When asked why her patients thought that, the obstetra said that they didn’t trust them, they were desconfiada. However, there was one occasion where a patient commented specifically on why contamination was perceived. During an obligatory JUNTOS smear-test campaign, women were contaminated with infections, she charged, because the obstetras used the same pair of gloves on everyone:

There was a campaign, lots of women had gone, but as many had gone, they didn’t change their gloves [the obstetras], and until now I have an infection from that, still now I can’t do anything, I have like a ball inside, I have an infection too, I was healthy before, but just the next day this thing appeared. I asked why, because they didn’t change their gloves to do it quickly, because there were so many people, so many women. Well they obliged us, I haven’t told anyone else about this, in 2015, in that time it was really strong, now I have a small ball no mas.
Finally, if abnormal cells are detected then the treatment may be perceived as the final blow after cancer contamination. In Ayacucho⁶⁴, the method used is cryotherapy; a procedure that freezes cancer cells to kill them off. Cold is considered fatal for fertility in Quechua understandings of the reproductive body (La Riva Gonzales, 2017: 180). Hormonal contraceptives themselves may be perceived as ‘cold’, as one Vilquina gave the reason for her abandonment of health-centre contraceptives as due to them “making her bones cold”, further underscoring the relationship between cold and reproductive concerns. Thus, the direct application of ice to the womb could potentially be perceived as able to render someone sterile - a potential continuation of the continuum of violence discussed in chapter three, as a ‘cancer’ diagnosis may lead to a ‘cold’ treatment that renders one ligada. Scientifically, cryotherapy treatment itself is perfectly safe, and the method is explained to women in consultations where appropriate; however, following Quechua understandings of the body, could potentially be seen as damaging. If that were the case, there are alternative methods that use heat to sever unwanted cells, for example, ('hot') laser treatment that burns away abnormal cells. There is thus a potential line of enquiry as to whether women may avoid contraception in the health post because of this, although it requires further research that was not within the scope of this dissertation.

Health workers are not only accused of cancer-contamination due to smear tests, however. They are also accused of something much more sinister; they are accused of being human tissue stealing, self-interested barbaric gremlins. They are thought to be that most colonial, white horror of the Andes; pishtacos.

**The Pishtaco and the Speculum**

Whilst out on a campaign to undertake smear-tests in the village of Michibamba, a group of health workers encountered a problem. When they began to enter the plaza, the women gathered there refused to allow them near; “Pishtaco! Pishtaco!” they reproached and accused the bemused group of coming to steal their blood and body parts. After some investigating it came to

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⁶⁴ Localised cryotherapy can be undertaken in Ayacucho; any further treatments require treatment in Lima.
light that the village *curandero* had previously gone around warning the local women that these *obstetras* were going to take a piece of their uterus during the biopsy\(^{65}\), and sell it afterwards.

The *Pishtaco* is a fabled villain with a penchant for violently abusing the *campesino* body so that he may indulge his grisly (white, ‘modern’) ways (see figure 8.6). He is a ubiquitous feature of the Andean landscape, and can be found from Peru to Bolivia, from Quechua to Aymara communities. Weismantel (2001) defines them as a figure which:

> "evokes violence and fear – and *racial whiteness*...known in Peruvian Spanish as Pishtaco, in Quechua as the ñakaq, and in Aymara as the kharisiri. Under all these names, this creature attacks unsuspecting Indians and then drags them off unconscious to secret caves, where he hangs them upside down and extracts their body fat…he is said to be a foreigner, a *white man*" (xxvi) (emphasis added).

The *Pishtaco* legend is said to originate from colonial times, when the Spanish soldiers and/or *hacendados* (hacienda owners) were said to use the fat of the indigenous to salve their wounds and consume it so as to acquire some of the indigenous (superior) strength. However, it is a creature that “changes with the times” (Weismantel, 2001: 3), and nowadays has been represented as an engineer\(^{66}\), a soldier, a *senderista* (Isbell, 1997), a *sacajojos* (one who steals eyes) (Weismantel, 2001: 3), and medical doctor (Bastien, 1992). Indeed, there are features of the *pishtaco* that aligns him nicely with health workers in Ayacucho. For example, the creature has his “legal papers, identification cards, and training courses”, and these “certificates are logical extensions of the power vested in all whites” (Weismantel, 2001: 199). As addressed in chapter seven, ‘papers’ are an important, defining feature of the health worker too, and rural dwellers associate the reams of administrative FUAs and HIS with the post. In addition, Weismantel found that some view the process of becoming a *pishtaco* as involving a kind of formal education/training: “some tales even describe

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\(^{65}\) They would not have taken biopsies (where cells are cut away) at that point, this was a rumour. They would have completed a pap-test and used a brush to take minimal samples for testing.

\(^{66}\) This association with engineers is particularly interesting for Vilcashuaman too, as at present the province is experiencing an influx of them due to the roadworks. Oliver-Smith reflects that "in Ancash, the word ingeniero...was synonymous with pishtaco" (1969: 365) (quoted in Weismantel, 2014: 197). Engineers in Vilcashuaman are charged with a number of misdemeanours, including the murder of children to bury in the foundations of their constructions, based upon an Andean belief that the addition of live beings to the base of a building will ensure its success and durability.
becoming a ñakaq as a formal process like entering a profession, with its own
titles and organizations”, and recounts the stories of a “pishtaco club” in Cuzco
that required certification to join (2001: 197). Health workers too must undergo
special ‘training’ away from the villages, in big cities such as Huamanga or
Lima, to enter their profession. Furthermore, “the pishtaco is often an ally or
employee of the state” (2001: 198). It is easy to understand how one may arrive
at the conclusion that health workers are fishy characters.
On this, it is perhaps interesting to note divergences in the literature. Roberts
(2012b) suggests that the surgeon and the pishtacos are opposites, and one’s
race is produced through whichever one cuts you:

“The Pishtaco cuts out fat, a valued substance in the rural Andes…the surgeon cuts out
fat…it is who or what does the cutting that races the invaded woman. A white pishtaco’s
unwelcome invasion into a rural woman’s body with a fat-stealing knife produces an
Indian woman…A white physician’s expensive surgical cut produces a whiter urban
woman” (2012b: 229).

Roberts may see the surgeon and Pishtaco as diametrically opposed, but in
Vilcashuaman, they are one and the same. Here, we know that the women
accused the obstetras of being pishtacos, of coming to steal parts of their body
to sell. The sale of stolen body substance for personal gain is another feature of
the creature, and Weismantel further relates this to agents of the state:

“What the Ñakaq does with the fat of Indians is to sell it: he is moved by a lust for profit,
not for flesh… [he is] …the paid agent of a corrupt and violent state” (2001:208-209).

When the group of health workers had recounted their experiences of
accusations, they had scoffed over the notion of using biopsies to steal uterine
tissue, “what would we want with that?!”. However, it is not necessarily so
ludicrous a notion. For example, the story of Henrietta Lacks, a black woman
from the United States whose cancer cells ‘HeLa’ were taken without her
knowledge or family’s permission, underscores a real-world possibility of having
one’s uterus used and distributed without one’s knowledge. Lacks’ cells have
been studied, prodded, and manipulated around the world with much ensuing
debate around medical ethics and profit-related polemic, an important fact being
her status as a racial minority in the United States (Skloot, 2011). This is not to
suggest that the Peruvian health workers are genuinely intending to sell
Quechua
Figure 8.5. “The Pishtaco” (as interpreted by the Artist) – Javier Walter Mendoza, Escuela de Bellas Artes de Huamanga (used with permission).
women’s biopsies for financial gain, nor that people are aware of the Lacks’ story in the Andes; only that it is not a wholly unreasonable notion either.

What is particularly noteworthy in the *Pishtaco* accusations is the health workers themselves. As the previous chapter discussed, many workers are from the surrounding villages and provinces. However, in the literature, *Pishtaco* stories often name a foreigner, usually white, and male. *Obstetras* are often local, Peruvian (-Quechua), and women. If they don’t fit the profile, why are they being accused (apart from their obvious *pishtaco*-features)?

As to the gendered nature, my own *Pishtaco*-acccusations may help to illuminate this somewhat. Namely, in Vilcashuaman male *pishtacos* are sometimes accompanied by a female *Pishtaco*-partner.

The issue of my *Pishtaco* accusation was raised with Reyna, a woman who enjoyed prying into everyone’s affairs (and was sometimes referred to as a *chismosa*). Reyna had first told me about the village whispers pertaining to my potentially crafty nature. Were *pishtacos* not all men?67, I queried in confusion. No, she told me, they come walking around villages in pairs; much like the condemned spirits of the dead (*condenados*) in Vilcashuaman.68 Reyna, a whimsical sort, theatrically swept my scarf off from my lap where I had folded it and wrapped it around her head covering one eye. “The woman, she walks like this!”, she mused, mimicking a sneaky stride as best she could with the limp-injury on her leg only enhancing her performance. *Pishtacos* stalked the villages as a couple, I learned. Indeed, I stopped wearing the scarf after that story, although I had never actually covered my head or eye with it, nor walked around Vilcashuaman with a white male.

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67 Some female anthropologists working in the Andes claim that their dress and manner (e.g. wearing trousers, sitting cross-legged) designates them as socially-male (Allen, 2003: Isbell, 1997) Thus, if I were considered a ‘male’ for the same reasons, I could potentially be a common *pishtaco*. However, I was never spoken to or treated as a male and wore my waist-length black hair in plaits as the women, which may have countenanced this.

68 Andean male-female relationships are often thought of in pairs, for example, the man and woman ‘team’ are considered to work together in agricultural activities and compliment each other (although there is some debate around this issue of complementarity, see chapter five). As the pishtacos are considered mortal (similarly to the *condenados*, who were once human) (Weismantel, 2001: 199), it is not inconceivable that they would follow this behaviour of gender-pairing too.
Interestingly, Reyna’s description of the female *pishtaco* sounds very similar to the image of *la tapada Limeña*, the veiled woman of Lima; a colonial figure who used a black scarf to cover her head and one eye when out in public (a tradition thought to have been inherited from the moors of Spain) (figure 8.6). As the male *Pishtaco* story originates in the figure of colonial-era Spanish males (Weismantel, 2001), it is not inconceivable that he should be accompanied by a colonial-era woman (although he has moved with the times, in this story the female figure has not). Furthermore, as the creature is thought to be associated with the urban, and Lima (and its dwellers) are the epitome of this, it further supports the notion.

However, no other literature mentions this and so it may be specific to Vilcashuaman. Yet the example serves to underscore the possibility of female *pishtacos* in this context. Furthermore, the *obstetras* often make house-calls with other health staff members, often to include at least one male, so they may easily fit the image of the paired *pishtacos*.

As to the *obstetra*’s identities as *Vilquinas*, however, further examination as to their ‘implements’, here the speculum, may explain this identity incongruence.

Whereas a male doctor’s insertion of the speculum into a woman’s cervix has been analysed as a sexualised encounter in Venezuelan public health hospitals, “the penetrating penis” becoming “synonymous with the penetrating speculum” (Martinez, 2018: 163), in Vilcashuaman it was often female *obstetras* who used the speculum, and whose penetration of the vulva may be understood otherwise.

Thus, earlier the visibility of cancer in the clinic was discussed, however, there is one part of cancer that is invisible: the speculum and the brush.

When a woman is prescribed contraception in any health post or centre, she is able to see and touch that medication before it is inserted into her body (by herself, as with the pill, or the *obstetra*, with other methods). In larger posts, a woman will take her prescription from the *obstetra* to the dispense room where she will be handed whatever contraceptive she is using; it is familiar and visible.
to her. Although one may not be able to fully inspect the liquid-injection or small pills, there is nevertheless nothing hidden here at first inspection, and should she wish to the patient would be at liberty to privately examine the method before returning to the consultation room and handing it over to the obstetra. Sometimes women were asked to hold the injection in their hands to warm and melt the liquid, due to the freezing conditions in the mountains that caused medication to frequently solidify. They therefore also participate, to an extent, in the preparation of their contraceptives, affording them some reassurance that

Figure 8.6. *La Tapada Limeña*. PUCP Archives (used with permission)
they know what shall be done to their bodies (even if there are cancerous consequences from the hormones). Within the same consultation room, however, they are then abruptly denied contact with the papanicolau implements. The speculum and brushes are kept within locked drawers/cupboards and are only for the obstetra’s eyes. A woman may never even see what is being inserted into her vagina as she is asked to lay on her back with her feet on stirrups, blocking her view throughout the procedure. The sudden change from visible medicines to invisible implements is incongruous, and suspicious. Yet, it is the same obstetra that would perform the test – how would she go from someone trusted (enough to give an injection, at least), to a pishtaco?

The cold, prising, steel speculum, not so very dissimilar from the pishtaco’s sharpened, metallic knife, is the mediator in this transformation.

Berg (1996) argued that the medical record can act as a mediator of relationships. So too can the speculum, another medical artefact, mediate and transform social interaction. On the one hand, the speculum is the mediator that allows the penetrating Foucauldian ‘medical gaze’ of the obstetra; the ability to transverse the bounded, outer body to view the invisible depths of the inner reproductive system. Foucault describes this gaze as traveling “along a path that had not so far been opened to it: vertically from the symptomatic surface to the tissue surface; in depth, plunging from the manifest to the hidden… the gaze plunges into the space that it has given itself the task of transversing” (2003: 166) (emphasis added). This gaze has power, the power to bring that which is hidden to light; to know what is unknown (2003: xiv-xv). The obstetra alone, through the speculum’s mediation of the medical gaze, can see inside a woman’s intimate reproductive system. However, this explanation does not fully illuminate the accusations of pishtaco-ness, nor how the speculum is transformative in this role. For that, we shall now turn to actor-network-theory (ANT), and the speculum as object-actant.

The notion of the ‘pragmatogony’, a theme defined by Serres (1987) and later taken up by Latour (2001), makes some preliminary suggestions as to the object-actant within ANT. It has been described as:
“this situation where the human subject is no longer the sole creator and controller of
things and objects, but where the creative impact of the object or thing is shaping the
subject to what it is, becomes central” (1987: 6).

This pragmatogony sees an object, here a speculum, as central in the
relationship into which it is inserted. Here, the speculum would not simply be
seen as a tool that an obstetra uses to exert her power, but as an actant in
itself. Through its ability to prize open a vulva with its steel fingers and venture
deep within the intimate spaces of a woman’s body, making them open, visible
and vulnerable, it acts within and transforms the relationship between patient
and obstetra. Here, artefacts/tools are ‘us’ (Latour, 2001: 807), they are
mediators, swapping roles with humans. Furthermore, in the current case of the
speculum-mediator, it can be suggested that through its interaction with the
obstetra, a new entity is formed, the speculum being central in this process.
Latour (1999) introduces the example of the gunman-entity. Following from
Latourian theory, Dankert describes this idea as it relates to ANT enquiries:

“A man and a gun can form a new entity when they are connected in a third entity: the
gunman…a man cannot shoot someone all by himself. However, it cannot be said that
the gun is the cause of all problems…. the connection that ANT wants researchers to
focus on is the connection that brings the man and the gun together, and thus creates a
gunman. A gunman is different from both a man and a gun in the sense that a gunman
is able to shoot someone whereas both the man and the gun cannot do this alone. This
example also shows that ANT driven research can come up with unexpected
conclusions” (2001: 1).

To extrapolate from this; a speculum and an obstetra cannot (would not?) give
a woman cancer and/or steal a part of her body by themselves. A speculum
cannot harm you on its own, and an obstetra cannot extract body parts (or
introduce malignant cells) by herself. However, when they come together, the
new entity created is the pishtaco; this entity can, and does, inflict ill-will and
suffering. The pishtaco of legend is also produced through his tools; he is made
an entity through his “fat-stealing knife” (Roberts, 2012b: 228) or his ‘white’
governmental papers that give him power and freedom (Weismantel, 2001).
Here, the new entity produced is one of biomedical, and governmental,
associations. It does not just wield its speculum but its papers, its training
courses, and its new-found relationships with the urban and the modern. This is
where local Vilquinas are shut out, as they cannot gaze upon the cancer-
instrument, nor can they be fully assimilated into this world either.
It has been often mentioned in the literature that a *pishtaco* is a white male. This discussion has challenged that view; it can also be a Peruvian (indigenous) woman. That said, it has also been suggested that over time the *pishtaco* has come to represent the *criollo* (Kokotovic, 2000); the urban, often coastal, Peruvian. Those who moved away to study obstetrics may well be seen (locally) as more like *criollos* upon their return, supporting *pishtaco* suspicions.

Yet, it is not only the work of the health-post *pishtaco* that gives cancer. Based on a Quechua etiology and understanding of hormonal pharmaceuticals, the contraceptives *themselves* are perceived to produce internal problems within women’s reproductive bodies that lead to cancer.

**Hormonal Pharmaceuticals and Blood Accumulation**

“Sometimes us women, we get worried when there’s no blood coming down, you should have blood every month”, Karla commented to me in hushed tones over a hospital bed that we were using as a makeshift table in the quiet Llamallaqta health post. We were deep in a discussion about reasons why some women have problems with the contraceptives on offer in the health centre, and importantly, I had asked her why people may feel that the methods could cause you harm. A thirty-year-old woman with two children, and who desired one more, Karla herself had decided to discontinue use of the injection as she was dubious as to what it was really doing inside of her, and what effects this could have on her future ability to be healthy enough to bear another child. She had only come to the health post as her four-year-old was coughing and was seemingly avoiding the *obstetras* by agreeing to hide out with me to talk in an empty consultation room. Her concerns rotated specifically around the perceived accumulation of blood that she believed happened over the duration of the three-month injection, in which she did not see her period at all.

Explaining the dangerous effects of the contraceptives, Karla described these concerns: “they say that it forms a cyst, it forms cancer, *se acumula adentro*, it [blood] accumulates inside, it forms a small ball (*bolita*)”. Like many others in Vilcashuaman, Karla had heard it rumoured that contraceptives, and particularly the three-month-injection, were giving women cancer due to the accumulated menstrual blood that instead of being released monthly as it should, was stuck inside the uterus forming into a cancerous ball. Karla was not the only one who felt this way, as other women’s comments suggest:
With the injection, there was no blood, I had left the injection, and a lot of blood came, why would that be? Was it ‘accumulation’? (Maria-Jesus, Twenty-seven, Michibamba)

I used the injection, the blood didn’t come for many months, and later it came like clots (coagulaciones), they say that it’s cancer, tumorcitos (little tumours). (Noris, Thirty-eight, Pilpintumarca)

I didn’t see my blood with the injection, ¿a donde va esa sangre? Where does that blood go? (Flora, Twenty-two, Sarachongo)

Because my menstruation did not come, the blood was inside, sancochada (soaking), it became like gelatine inside. (Euologia, Forty-Eight, Willka Waman)

In the biomedical framework, contraceptives may be associated with cancer due to their hormonal content. Excess of hormones are a concern in Vilcashuaman, and they are thought to produce cancer (e.g. the opening testimony of the chapter).

The cancerous cysts/tumours that the women mentioned forming after using hormonal contraceptives, predominantly the injection, are a significant phenomenon in Vilcashuaman; there was not one interview where it was not at least mentioned in passing.

It is believed that hormones produce changes in the body that cause it to act in a certain way, with perceived disruptions caused to the normal menstrual cycle. Namely, with some hormonal contraceptives (injection and implant), menstruation can cease altogether, and this trapped blood is thought to coagulate inside the uterus (‘belly’) and develop into a cancerous cyst or tumour.

Blood is an extremely important substance in the Andes, a “dominant symbol” of “vitality” (Bastien, 2003: 173). It is the blood and fat of the indigenous person that the pishtaco so craves, his own being of lesser quality (Weismantel, 2001). Some consider blood a finite resource. Loss of blood can result in physical weakness, and for this reason pregnancy is considered a ‘temporary death’ in which the woman is physically vulnerable (La Riva Gonzales, 2017). That said,
menstrual/reproductive blood may also be considered renewable (Bastien, 2002: 180). However, it is not only blood loss that poses a problem; accumulation of blood is also problematic, as “body flows are of primary concern for wellbeing…impeded flow of essential substances (blood, bile, phlegm, urine, semen, feces, sweat, fat, air, water) are causes for bodily disorders” (Hammer, 2001: 244). When a Vilquina does not menstruate, this flow of blood is impeded and is thought to be accumulating inside instead of being expelled monthly, which would be the healthy cycle of blood. In biomedical understanding, the uterus lining will build up and thicken during a menstrual cycle in preparation for pregnancy. If an egg is not fertilised during this cycle, the lining will slough off as menstruation. The contraceptive injection can cause this uterus lining to cease building, hence the lack of menstrual blood as it has not been produced in the first place. However, this is not the dominant aetiology in Quechua understandings of the menstrual body. Hammer succinctly describes Quechua women’s views of menstrual regulation flows; views which closely reflect those of women in Vilcashuaman (although her population are Bolivian-Quechua), and deserves quoting at length:

“Women who are sexually active…become distressed about irregular and delayed menstrual periods. When menstruation fails to begin in a given month, women worry that the blood is stuck inside the abdomen. This is often attributed to contact with the cold environmental elements, usually water. Bathing, or placing the hands in water, is said to induce in the body the state of chiri…that can stop menstrual flow. It is believed that such contact causes the blood to coagulate into tight balls; then the abdomen becomes hard…women say that this blood becomes “like a baby” …while embryos are formed essentially of blood, lumps of cold blood or other growths that appear in the abdomen unrelated to male insemination are signs of danger to the woman’s well-being. Women use the borrowed Western terms, tumour and cancer, to describe severe, often terminal cases of menstrual malfunction identifies with the growth of masses in the belly” (2001: 245-246).

Hammer’s informants also used ‘cancer’ as an explanation for their hindered menstrual flows; however, there are important differences in this case and that of Vilcashuaman. Above, the menstrual flow is thought to be restricted by coldness; an idea expressed elsewhere in Peru as well, leading to an avoidance of showering whilst menstruating (Wallace, 2017: 63). In this example, cold sickness is the principal blame for abdominal pain, with no specific biomedical interventions named. Women in Vilcashuaman know a more definitive culprit; the hormonal contraceptives.
In accordance with Hammer’s informants, and following a humoral understanding of medicine, some women do perceive hormones [contraceptives] as ‘cold’ when in pharmaceutical form; “traiga frio”/”they bring coldness”, one woman had suggested. In the Latin American humoral system, biomedical pharmaceuticals are often considered ‘cold’ (Whyte, 2002: 11), and should be used with caution. That said, here the cause of cancer can be blamed on a specific villain; the health post, as opposed to one’s own behaviours alone, as in Hammer’s example (e.g. bathing in cold water). Biomedical injections in general are especially ambiguous, hence the cancer-accusations predominantly directed at the injection. One doctor mused that people preferred injections more generally as they went “straight into the blood”, unlike pills that would take longer to reach one’s system, and complaints about the health posts’ offering ‘only’ pills for medical concerns (reproductive and other) were often accompanied by admission that people prefer ‘cure-all’ injections from independent pharmacies. However, this could go two-ways. Whilst some medicines may be seen as beneficial in injection-form as they reach the blood quicker, contraceptives may be condemned for the same reason as they form cysts/tumours more rapidly than other methods.

Importantly, Hammer mentions women’s referencing ‘cancer’ and ‘tumour’ as ‘borrowed western terms’, i.e. they may not have meant ‘biomedical’ cancer but were using those words as references. However, here we are discussing hormonal contraceptives within a clinic context where cancer is ever present- it can be argued that Vilquinas are not ‘borrowing terms’- they are identifying a Quechua aetiology of cancer; they are told by obstetras that cancer is a real and omnipresent health risk; they see hormones as producing cancer in wider contexts, and so when they talk of cysts, tumours and cancer, they arguably mean biomedical (‘Western’) cancer (again, see Castro-Gomez (2010) on the decolonisation of knowledge and the colonial persistence to privilege Western-scientific knowledge and inferiorise other ways of understanding).

When using certain methods of contraception blood may not appear for up to three months at a time, and many women expressed concern about the lack of menstruation for such a long period as this is well beyond the timeframe of a ‘missed period’ and can indicate serious consequences; women wondered if the
blood had accumulated inside and was ‘stuck’ up there, rotting and fermenting away.

The three-month time frame and blood coagulation is significant within understandings of reproduction across the Andes. Until three months, it is thought that a foetus is not a living entity, but a coagulation of blood; a *trozo de sangre* (chunk of flesh) (Morgan, 1997:341). La Riva Gonzalez outlines the predominant theory of conception in the Peruvian Andes:

“conception is a “process of ‘cooking’ or ‘maturation’ of the masculine substance *(muhu)*, by the menstrual blood, the semen is considered metaphorically like alimentation that ‘grows’, that ‘cooks’ in the woman’s body, in her blood. The woman in this case is associated with the land that receives the seeds” (2017: 175).

Over time, this “foetus feeds on the maternal blood (liquid element) and the father gives…the solid part…the association of the female sex with the smooth, liquid element and the masculine sex with the solid element, seems to confirm the idea that the body of the foetus does not form at the same time…and *during those first months is purely blood* (yawarlla))(2017: 176) (emphasis added). It is suggested that this view is pan-Andean, also found in Aymara-Peru where the foetus is “plain blood”/*sangre plana”*/“*wila p’alt’a*” for the first four months (2017: 176), and the Ecuadorian Andes, where foetal “fermentation” can take between one and four months (Morgan, 1997). In all cases, there is a differentiation between the male and female foetus, as girls are thought to take longer to develop. In Morgan’s research, for example, females are fleshy entities with a single ‘chicken eye’ in the middle of a chunk of flesh for the first six months (1997: 341). The concept of a process of foetal ‘growing’ through maternal blood and male semen is also found elsewhere in Latin America. For example, the Amazonian Wari’ likewise perceive foetal development as a slow transformation made from the mixture of maternal blood and male semen (Conklin, 1996: 670), however in this context, multiple male partners may contribute semen during the gestational period, thereby have a claim to biological paternity through their contribution to the foetus (1996: 671).

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69 It has been suggested that this is based on (no longer widespread) Catholic teachings about the ‘ensoulment’ of the sexed foetus, whereby male foetuses will have ‘souls’ after 40 days; females after 80 days (Neuberger, 2005).
Thus, the process of blood coagulation resulting in a foetus must be understood as it relates to the process of blood coagulation resulting in a cancerous cyst or tumour. Both the development of life (foetus) and death (cancer) begin the exact same way; blood coagulates inside the uterus; however, its destined final product dictates the outcome for the woman.

Hammer noted that (cold) blood clots or growths in the abdomen that are unrelated to male insemination are dangerous (2001: 246). However, when contraception enters the equation it may not be so easy to tell the difference. Women are using hormonal contraception precisely because they are engaging in sexual intercourse, and thus there is a possibility of insemination. There is hardly one-hundred-percent faith in hormonal contraceptives; many women interviewed stated their reason for changing methods was because they had fallen pregnant whilst using another, and the obstetras were never observed suggesting that there was no definitive chance of pregnancy with contraceptive use (unless it was sterilisation).

Furthermore, the accumulation of blood can have other consequences besides cancer. In one case, a woman reported that a snake entered her vagina while she was pregnant, but still using the injection (it was unclear why she was still using contraception when expecting).

Eusebia and her daughter Laura were both wary of contraception because of this incident, and Laura refused to use any methods for fear that the same would happen to her as to her mother. At nineteen, she already had a two-year old, perhaps because of this. The family of three-generations all lived together in a relatively large adobe house in Michibamba, hidden behind a knot of trees and set back from the main road. I had met them whilst on a health visit with an obstetra, otherwise they might have been impossible to locate. When they had mentioned the snake then she had admonished them for talking nonsense. However, when I returned alone, they were more willing to talk about this event:

LAURA: While she was pregnant, mi mama was still using the injection while she was pregnant, but her belly really hurt. So, she went to the post, but while she was working

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Coincidentally, the lack of faith in hormonal contraceptives may also be a reason why high numbers of women do still opt for sterilisation, despite the past, although this needs more research.

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in the *chacra* a *culebra* (snake) had gone inside, because of the injection, the injection was inside but it was *sancochado* (soaking), the snake could get inside because of the injection, inside her uterus the blood was *empozada* (detained/trapped).

EUSEBIA: The blood didn’t come; I was thinking no me viene no me viene pe’ (it doesn’t come it doesn’t come). I was pregnant then, with her sister [Laura’s]. Inside, there was a *culebra*.

The snake did not harm the baby, and Laura’s sister was now a happy toddler. However, this story represents other dangers of blood accumulation due to hormonal pharmaceuticals. It further suggests that the blood that was supposed to go to the formation of the foetus may have been accumulating un-healthily due to Eusebia’s use of the injection whilst pregnant. Also, in the literature on menstrual beliefs, snakes are a recurring feature of threat. In Brazil, women “warn of the danger for a menstruating woman to cross a snake’s path, or go into the forest menstruating, lest a snake “smell” her” (Sanabria, 2016: 53). In Southern Peru, snakes are particularly sensitive to the smell of menstrual blood, “they want to go in [the vagina] and eat the blood”, the remedy for which is “to tie a piece of cheese outside of the vagina. The snake comes out to eat the cheese and can then be caught” (Larme, 1998: 1012). The accumulated blood perceived to be produced by the injection therefore increases health threats beyond cancer and can involve the literal invasion of another kind; a *snake*.

The line between blood coagulation that will lead to a healthy, living baby and blood coagulation that will result in a deadly cancerous tumour/cyst is thin. After all, the initial process of blood coagulation inside the abdomen is the same in both scenarios. Most often users are also engaging in sexual intercourse and therefore having contact with semen; what could develop is a foetus, were it not for the contraceptives. Yet, the formation of a ‘baby’ is not discounted with contraceptive use, as Eusebia’s example suggests. However, it is not a (future human) coagulation-entity that is formed when contraception is used, but a cancerous tumour/cyst.

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71 Menstrual-snakes have been analysed as a positive symbol outside of Latin America, see Knight, 1995; 1988, for discussion on aboriginal ‘rainbow snakes’.
72 Snake-metaphors abound, yet there is not the space here to do them justice. In regard to menstruation and vaginal-invasion, the snake has invariably been analysed as representative of the male penis, however snakes can also be read as the symbolic male-female due to its both phallic (tail) and yonic form (mouth) (Knight, 1988).
What is also being discussed here is an approach to, and understanding of, pharmaceuticals. Specifically, pharmaceuticals that use hormones to tinker with the reproductive body. Furthermore, the Quechua perception of contraceptive-cancer is at odds with other, more positive views, that are held towards hormonal contraceptives and their ability to suppress menstruation in other parts of Latin America.

Sanabria’s (2016) research into use of pharmaceutical-hormones and menstrual suppression in Brazil tells a very different perception of these contraceptives. She argues that in recent years, “menstrual suppression [via continuous contraceptive use] …has been reremarketed in a practice of pharmaceutical self-enhancement couched in neoliberal notions of choice and control” (2016: 5). In Bahia, contraceptives are presented and understood as a tool for the modern woman to free herself of bothersome menstruation, thereby allowing her to pursue other activities that might have been hindered by a few days bleeding each month (2016: 145). These practices, Sanabria notes, are tightly connected to race and class. Around reproductive health, this extends beyond menstrual suppression and into birthing. For example, caesarean birth is increasingly framed as a choice for the modern (white) woman in Brazil, not only due to the old adage ‘too posh to push’, but also because this maintains vaginal integrity (which is reconstructed via plastic surgery if necessary) (2011). In fact, C-sections have increasingly become framed as a woman’s ‘right’ in Brazil, becoming a ‘cultural phenomenon’ (De Mello E Souza, 2009). This is not isolated to Brazil but reaches the Andes too. Roberts argues that women specifically seek caesarean (birth) scars as ‘evidence’ of their relationship with the biomedical, and thus, the modern and the white (2012b). That said, this is a highly stratified phenomenon, as vaginal births remain perceived as the birthing style for the racialised poor, which in the Andes is “the peasant or indigenous woman, whose bodies are symbolically closer to nature” (Sanabria, 2016: 151). This does not indicate a lack of want, however, as the consumption practices surrounding biomedicalised reproduction entice all. Sanabria argues:

“In Brazil, to be urban and modern implies embracing various interventions, and although access to biomedical technologies or pharmaceutical regimes is unequal, the pace set by private sector consumption patterns incites desires that span across the class spectrum” (2016: 151).
In this context, all may be able to access certain interventions and feel entitled to them, as Edmonds (2010) argues for the poor’s widespread ability to seek low-cost plastic surgery and relate to the ‘modern’, for example. However, these are not equal relationships, and use of hormonal contraceptives for menstrual suppression is also unequal. Finally, Sanabria suggests that the use of hormones to influence the body suggests malleability, or ‘plastic bodies’; a subjective self that, through this plasticity, can renegotiate social hierarchies of class, race, or gender (2016: 41).

Such notions of plasticity are significantly present within the Andean context, where bodies are anything but bounded. Bodies function and reflect flows of the environment, the internal flows of a woman mimicking those flows of the rivers, with the ability to be directly, physically affected by changes in the natural world (Van Vleet, 2008; Bastien, 1985a, 1985b). People’s bodies are connected physically through non-physical connection, as Allen suggests, one can put food from one’s own stomach directly into the stomach of another over a distance (2003). The unbounded reproductive body is particularly important, and dangerous; after giving birth a woman’s permeability leaves her exposed to threats of mal aire and coldness that could result in death; a fear that is stemmed through the use of tight chumpi belts to bind her body once more (La Riva Gonzalez, 2017). The uterus may also wander throughout the body if it is not kept in place. Andean bodies were ‘plastic’ before hormonal intervention convinced them of this ability, yet, they fear those hormones and the possibility of cancer and interruption of correct bodily blood flows.

If the employment of hormonal pharmaceuticals changes one’s subjectivity into a white, modern individual, what does fear and/or rejection of those hormones suggest? Does this suggest that Vilquinas do not want those subjective associations?

Ecks has suggested that people’s relationships to pharmaceuticals (and manufacturers) be seen through the lens of ‘pharmaceutical citizenship’ (2008). He asks, “how does the actual taking of pharmaceuticals change a person’s status as a citizen?” (4). For Brazilians using hormones, Sanabria suggests that
“the regulation of bodies is closely assimilated to the regulation of the body of the nation. Patients are enjoined to fulfil their obligations as citizens” (2016: 132). Here, use of hormonal-pharmaceuticals enlists one into the fold of citizenship. In Peru also, women are expected to pursue their ever- ‘potential citizenship’ (Gillespie, 2016), through ‘patienthood’ (Biehl, 2004), and significantly, use of pharmaceuticals (Ecks, 2008). And women do use hormonal contraceptives, however, they are incompatible with a Quechua aetiology of the reproductive body, and cancer and hormonal-contraceptive use is sprinkled with tension; women want to avoid unwanted pregnancies, but they also want to avoid cancer, and those two goals are seemingly at odds in the biomedical health post.

That said, the suspicion and rejection of biomedical pharmaceuticals may speak to a larger rejection, a rejection of the discourse of modernity and whiteness promoted by MINSA. It is not only contraceptives that women reject, they also fear and loathe caesareans. Vilquinas are unlike Roberts’ Andean informants who proudly sought the abdominal scars (2012b); in Ayacucho, women feared these for the debilitating effect that they would have on their ability to work in the chacra and express terror at a botched-job, leading to a lifetime of problems. Those fears are not unreasonable, as the previous chapter discussed; past treatment of women under the sterilisations led to badly-performed operations leaving women immobile and hindering bodily capabilities, and health post reproductive care is widely suspected to destroy one’s ability to work in the fields.

That is not to say that women do not want to enjoy elements of contraceptive and FP discourse; for example, they may agree with the professionalisation of their children and cancer may be considered a reasonable trade-off when compared with multiple pregnancies, caesareans and/or episiotomies. However, this lack of conformity with discourses of pharmaceutical citizenship goes part of the way to keeping their citizenship potential and just that bit out-of-reach.

**Conclusion**

It is a tense position to be in; to want to use pharmaceuticals that one also believes may cause cancer, the choice comes in the balance of the consequences; cancer or (too many) children? It might be tempting to see
Quechua understandings of contraceptives and cancer as misunderstandings; the scientific understanding of the reproductive body suggests a different picture to that which local women envisage of themselves. However, perhaps it is the biomedical framework that misunderstands, imposing a system of technology that is incongruous with the patients and making no tangible efforts to negotiate or accommodate women’s fear. Take it or leave it.

Simple changes could be made to soothe people’s concerns a little. For example, a conscious effort to not conflate the two within the clinic setting might dampen the flames of fear, as might a quick show and tell of the speculum and brush to women before it is inserted into their intimate depths. That said, cancer concerns may reflect something a little more complicated than just a fear of a disease; a fear of the health posts and their intentions is also present here. Yet in addition, this is the first real area where women are able to use tangible evidence of concern to dispute the dominant discourse. If a woman is worried about cancer this is reasonable and ample ground to refuse contraceptive use.

Could women’s reactions be read as some form of resistance to the health post discourses surrounding FP and contraception? Thus far, the evidence presented has focused largely on the governmentality of this population with little (ability to) push-back from the women, apart from denouncing health workers for maltreatment through legal action, a recourse that women may only recently be starting to learn. Indeed, Vilquinas are made vulnerable by their poverty and health worker demands of their adherence to discourse if they wish to receive health care and/or welfare. Yet, as Martinez points out, women’s “vulnerability in the medical encounter should not be understood as surrendering their agency” (2018: 210). Furthermore, as Abu Lughod (1990) suggested, resistance to power may come in more opaque, smaller gestures, not immediately recognisable as a ‘resistance’ to the casual observer. She argued that one ought not to ‘romanticise resistance’, instead examining it as it is produced in the everyday.

Can the accusations of health-post cancer be seen as a form of resistance? It certainly is a discourse that gives women a get-out-card for refusing contraceptives that they might not want and opens up space for negotiation with
obstetras based upon this, a point that Abu Lughod also illumines. Spano argues that “the paradigm of negotiation, to which the Foucauldian idea of governmentality relates, depends precisely on this dialectic between subversion of norms and extension of their field of signification through creative appropriations, deliberate abuses, and conscious distortions” (2013: 192).

Every-day creative ways of influencing contraceptive use have certainly been documented elsewhere. For example, Hirsch (2008) discovered how Mexican Catholic women would employ creative strategies to employ religious discourse on FP to their favour (e.g. visiting different priests who are more lenient). In the central Peruvian Andes of Huancayo, in a previous work I similarly found that women would negotiate contraceptive use by timing administration of the injection with children’s routine check-ups, thus contracepting clandestinely (Irons, 2015). Yet again, using creative methods to hide contraceptive use from partners is as complex a situation to analyse as women spreading a cancer discourse to deny contraceptives – are these resistances or ‘weapons of the weak’ (Scott, 1987) that may contribute to one’s oppression in the end?

They may be seen as incidences of agency occurring within an already established structure of power, rather than as posited outside of it. As Mahmood (2004) has argued in regard to Egyptian women under the Islamic revival, agency and resistance actually might not be sufficient terms with which to understand women’s subjectivities and modalities within oppressive power structures. For Andean women, Babb concurs; their lives cannot be painted as simple cases of power or resistance (2018). Following Abu Lughod’s evocative question of Do Muslim Women Need Saving? (2013); an address to a ‘western’ view that Islam oppresses women who are in need of rescue, it is thus important to question with similar cynicism; Do Quechua women need saving? Feminists in Lima think that they do - they need saving not only from the patriarchal structures that oppress them but also from their own ‘backwardness’ and ‘Indigeneity’ that keeps them caged in poverty and ignorance (Babb, 2018). However, the discourse of cancer and contraceptives could be tentatively read as an interaction with agency; they do not simply allow an unquestioning dominance over their bodies but contest the undesirable effects too. It is complicated as disease-fears are negative reactions. However, following from Abu Lughod’s suggestion, there is the possibility to begin to see these
contestations as emergent forms of everyday resistance to a medical system that discards local aetiologies and attempts to impose a dominant discourse. That said, they may also be straight expressions of fear and mistrust. As Babb says, one must avoid seeing Andean women as one or the other (2018).
Figure 9.1. A woman plays with her son at the Puytoq in Willka Waman.
On the 30th September 2019, Peruvian president Martín Vizcarra staged an auto-coup by dissolving congress as a penalty for their not backing his anti-corruption reforms, throwing the country into political crisis (BBC, 2019). The people cheered for Vizcarra with joy and merrymaking to rival that of Carnival. Finally, all of the corrupt ‘ratas’ in congress were relieved of their positions, and new lawmakers could rise to take their place – such a simple solution, but one that the Peruvian nation revelled in.

They cheered on Fujimori for his own auto-coup too, once.

Now in the final chapter, this work comes to a close whilst a new period of Peruvian politics is being rapidly inked in the history books. On the constitutional crisis now in process, one of my Lima friends mused, “this will go down in la historia!!”. Yes, although what will be said about it remains to be seen. That is for future works to interrogate, but as this dissertation is concluded the contemporary crisis in government does suggest some points of relevance.

Vizcarra hoped to push through anti-corruption reforms, removing from office those officials who line their own pockets instead of focusing on the people. With them gone, could new congressmen and women who are more conscientious of the population, and perhaps of the indigenous plights, now take their places? That is impossible to say at this stage, but what can be said, in answer to an opening query stated in the introductory chapter, is that with so much drastic flux in parliament, ‘justice’ for sterilised women and others (including contemporary reproductive concerns) will likely have to wait. Again.

With no parliament to speak of until the new elections (proposed January 2020), the Peruvian state has been pushed into a position of liminality; betwixt and between as its fate is decided. For those vulnerable populations, such as the Quechua of Vilcashuaman, this may be an opportunity for positive change or the opposite, as was somewhat the case following Fujimori’s successful 1992 auto-coup.
Here it is important to be reminded of the state’s recent policies and approaches towards the indigenous, especially through the 2017 census.

The ‘new’ question of self-identified ethnicity hints at underlying dynamics of cultural change in the country. An increased state interest in who and where the indigenous peoples of the nation are is clear, but so also is a greater visibility and encouragement to recognise oneself as Quechua (or another ethnicity). This comes not long after the implementation of other Quechua-visibilising policies, such as the intercultural education policy that introduced Quechua-language into schools (Garcia, 2005). In reproductive health, this was seen through the intercultural birthing policy that aimed to attend to Quechua experiences of childbirth, seemingly valuing and visibilising the indigenous lifeways like never before (Guerra Reyes, 2013).

In regard to FP specifically, MINSA also stated rural, poor (indigenous) people as its primary targets for FP interventions not long ago (MINSA, 2015). Now that the state is liminal, the future of such interventions becomes more uncertain. However, let us be reminded that alongside Quechua-visibilising policies in health and education, Peru has also seen the continued popularity and celebration of a racialised television character, ‘La Paisana Jacinta’, whose role and effect is to render indigenous women ridiculous. Although international complaint was made about the release of the film it went ahead regardless, suggesting that Peru may be comfortable and even open to causing international uproar over derogatory indigenous representation – perhaps because it represents a position that some Peruvians, and particularly the state who did nothing to address Jacinta, continue to hold themselves.

What can be said on the matter of the current political crisis is that, according to the coloniality of power (Quijano, 2000), the power structures that govern Peru are unlikely to change in their post-colonial form, even if the people sitting in congress do alter. Although, hope can be held.

Quechua Reproductive Identity
When biopower is stratified (Bridges, 2012) and certain groups such as the Quechua are marginalised recipients of this, their reproductive identity becomes
entangled within these politics. However, it is not only the state, nor the other interested parties enacting reproductive governance (Morgan, 2012), that contribute towards these identities. One must also consider the further intersecting inequalities (Boesten, 2010a) that structure indigenous life in Peru; gender, race, indigeneity, coloniality, and agency. Thus, these multiple facets of the subjective self and the wider environment become enmeshed in tension by the persistence of structural and obstetric violences that mark daily life in the Andes.

This is not to completely deny indigenous women of reproductive agency. As the previous chapter has shown, agency and resistance can present in unlikely forms, such as cancer rumours and rejection of treatment backed up by (ethno)medical, Quechua aetiologies of the body. That said, it is also pertinent to remark that in the context of multiple violences, governances, and powers that play out a symbolic tug-of-war on the indigenous reproductive self, the Vilquina may become the fraying cords in the centre of the rope. In this sense, Quechua reproductive identity is a contested one, often based upon one’s realisation of certain conditions discussed in this dissertation: symbolic, ‘aspirational’ whitening; the professionalisation of children; the submission to biomedical interventions (including those perceived as harmful to the Quechua body) and to medical figures of authority; and the existence within an unequal gendered relationship, to name a few. Significantly, all of the conditions are united by one common thread: the rejection of one’s indigeneity in pursuit of appeasing the demands placed upon the subjective self by the state and others.

When Morgensen (2014) argued that global health initiatives are premised on the presumption that indigenous populations are weak and vulnerable to disease, he suggested that these assumptions rationalise “the biopolitical logic of settler colonialism, which presumes or seeks indigenous elimination” (191). When it comes to FP, however, there is often no explicit medical ‘disease’ that can be framed as an epidemic certain to wipe out the ‘vulnerable’ people in a population, as in the case of Morgensen’s argument. The result of this ‘elimination’ of which he speaks is death - of a physical, tangible indigenous genocide (193) enacted upon bodies ravaged by diseases that states and international agencies fail to adequately attend to. Although there are arguments for this being the case in regard to the sterilisations (see chapter
three), the same kind of indigenous corporeal elimination is arguably not being sought in the Andes under the FP programme. Even if they are subject to structural and obstetric violences, the people of Vilcashuaman are not being killed by obstetras or doctors. There is no literal elimination of the Quechua body here, as once was the case under colonialism and in other post-colonial contexts where the indigenous lives were/are disallowed until the point of death (e.g. sterilisations). However, this certainly does not mean that indigenous bodies (and consequently kinship in this case) are not subject to biopolitics, and one cannot exclude the concept of genocide as a possibility here either.

To explain – there may be no biomedical diseases present that are threatening to attack the Quechua’s reproductive bodies (bar perhaps cancer, which is increasingly presented as the up-and-coming threat to this population, as discussed in the previous chapter), yet nevertheless this does not exclude the possibility of their being treated with a logic of elimination by the state using the FP programme. It could be argued that where a demonstrable biomedical disease is absent in FP, the social factors involved in the way this programme is used are instead rendered as ‘diseased’ so that the logic of coloniality can continue. In this context, these ‘social diseases’ are presented as; inflated family size, a lack of resources or education, unequal gendered relationships, and a presumed ignorance on the part of the Quechua. Ultimately this entails a biomedicalisation of the social, following global trends that suggest the far-reach of this concept (Clarke, 2010; Inhorn, 2006). The social now rendered a biomedical concern, it becomes an area of intervention for the health centres.

This biomedicalisation of the social is not necessarily a concept new or unique to Peru, however there is something about this situation that specifically relates to racialised ethnic identity distinctive to the indigenous in this context.

For the Quechua, the ‘social’, as addressed by the health centres (e.g. rejection or non-compliance of biomedicine, application of ethnomedical understandings and aetiologies to biomedical concerns, and lifeway choices not deemed appropriate by the state) ties into subjective, racialised, indigenous identities, as this dissertation has explored in depth through the various chapters. In this light, if the ‘social’ is framed as diseased and in need of state (health centre)
intervention, so too may indigeneity be presented likewise, and in need of addressing by the state.

The Oxford Dictionary describes ‘disease’ as “a disorder of structure or function” (2018); the indigenous, those who are excluded from being the kind of ‘new Peruvian’ (Lossio, 2014) the state desires (and seems in the process of attempting to produce, as the discussion on Marca Peru suggested), themselves disorder the governmentally-aspired-to racialised structure of the nation, simply by existing. To seek order in this context, conditions are placed upon the Quechua pertaining not only to their reproductive lives, but to their wider involvement with kin, rurality, the land, and themselves. Essentially, they must aspire to be whiter (Guerra Reyes, 2013) and to therefore be less Quechua – not simply in skin, but in subjective self.

In the absence of killings, bodily harm, physical destruction, [explicit] birth prevention73, or forced child transference (UN Convention on the Prevention and Punishment of the Crime of Genocide, 1948), the current Peruvian FP programme and associated discourse is not tantamount to genocide - on paper. However, what this health programme does do is ask its Quechua users that they reject their indigeneity and pursue (social) whiteness instead – only then will they adequately contribute and belong to the nation, and only then will they therefore be considered worthy not only of health but Peruvianess. This rejection (or elimination) does not refer to the death of cells through disease – the physical colonisation of the body by virus or medical condition. Instead it refers to the self-erasure of the indigenous for the white – the colonisation of the subjective self; the coloniality of power in action. It could therefore be seen as a symbolic, racialised genocide inflicted against the self by the self; a subjective-auto-genocide, as a condition for acceptance to the nation.

To clarify this concept, in law, the term ‘auto-genocide’ refers to a government killing its own people (Stahn, 2018). Whilst there are undertones of elimination logic present in the Peruvian state’s treatment of the indigenous, the argument here is not for auto-genocide in the governmental, legal sense, but an auto-

73 Although the argument that coercive means may be used to ensure that women use contraceptives and therefore prevent births is not discounted here, however, this arguably has a different (legal) value than forcibly sterilising someone and removing their ability to reproduce indefinitely.
genocide of indigeneity perpetuated by the indigenous towards their own (racialised) subjective selves. What is 'killed' here is not the fleshy corpus, but an identity. As has been seen throughout this dissertation's pages, the Quechua are continuously encouraged to aspire to whiteness, in all of its manifestations beyond skin pigmentation alone, and even denied access to full citizenship and Peruvianess if they are not considered to be adhering to this discourse. Thus, they are arguably encouraged to exterminate their indigenous-selves through health centre discourse; not with weapons and blood-spill, but with a subjective shift to a whiter-self.

Furthermore, because this subjective-auto-genocide of the indigenous is encouraged through discourse and enacted against the self, by the self, it is not legally punishable nor possible to seek justice as so in tangible forms of genocide (i.e. where dead bodies are present), and thus may be harder to address and eradicate. It becomes elusive.

Family Planning, as a health programme that specifically addresses the future and has the ability to influence families and the reproduction of indigeneity, is excellently placed to promote this concept. However, this also indicates that it could be an equally excellent arena in which to promote the opposite; the conception and birth of Quechua children and expansion of Quechua families who are free to pursue lifeways with agency, and maintained indigeneity – whether that be working in a chacra and farming guinea-pigs, or migrating to Lima and pursuing higher education.

However, for that to occur, not only would changes within the health centres alone be required, but a national shift in understandings of racialised hierarchies and associated attitudes; a deconstruction of the coloniality of power; and thus ultimately, the forging of a ‘decolonised’ nation that can both look to pre-conquest society for reflection on what Peruvianess might have meant before European invasion, whilst also bearing in mind pertinent questions of contemporary identity concerns that would be excluded by a one-hundred-and-eighty-degree return to the pre-conquest Tawantinsuyu74 (such as the lack of recognition of gender fluidity, for example)(Horswell, 2003).

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74 Incan name for their empire pre-conquest.
All that said, the changes mentioned at the start of this chapter, both the current political crisis and the recent census’ focus on ethnicity, suggest a time of liminality for Peru. Following this, a return to ‘normalcy’ may offer the possibility of engendering a new social order. Hopefully, the concept of the ‘New Peruvian’ who is white and urban, as discussed by Lossio (2014), will not be the Peruvian of the new epoch into which the country may move at the conclusion of this defining moment, although hoping for a decolonised country at this stage is also highly unlikely due to the pervasive attitudes still held. These are thoughts over which a question mark will continue to remain as the power shifts within the country and the next stage of Peruvian politics plays out.

Towards a Decolonial Anthropology

It is often anti-climactic to conclude with hopes and humble suggestions for change when addressing structural and symbolic violences; violences so complex and colossal that their spectre may hang over us for a long time to come. However, less pessimistically, one may be able to effect some real change with one’s work, albeit on a micro level, through decolonial approaches to research and results.

Segato has suggested that the only way to appropriately and relevantly conduct anthropology in a post-colonial context is to conduct an anthropology ‘on demand’ (2015). She argues that anthropologists should carry out research consistent with the demand of the people studied; an anthropology that can ultimately help them to achieve a better understanding of their own problems and seek an improved wellbeing (2015: 13). Particularly so when it comes to medicine, as it has been argued that health research with indigenous women needs the anthropological perspective to develop a deeper understanding of the issues- and how to attend to them (Valeggia, 2016). However, one must take care not to reinforce colonial hierarchies when doing so.

Although it was not possible to undergo an anthropology demanded by the Quechua villagers in Vilcashuaman themselves, it was possible to do so in regard to the local MINSA Ayacucho directorate. It was they who suggested Vilcashuaman at the project’s inception (an area for which there existed little
data due to its relative isolation before the construction of the asphalt road). And, only fittingly, it was to them I returned at the conclusion of the research and once the bulk of the core dissertation data had been analysed and scribed.

In September 2019, before submitting this dissertation and in consideration of an anthropology on demand, I took the project back to MINSA – not to complete an authoritative presentation of what ‘I now knew that they did not’, but to engage in a discussion around the results and collaboratively suggest potential change that could be made to the FP and sexual health services on offer to indigenous women within their departmental mandate. Naturally, in a governmental ministry of health, the discussion and subsequent changes to policy and practice generated were public health focused, and we did not talk in depth about wider theoretical issues such as coloniality or race and subjectivity. However, it was fruitful to discuss my own public health-focused policy recommendations (Irons, 2019c) in light of their perspectives, and develop further suggestions collaboratively (although these were not exhaustive). The key recommendations produced were:

1) Implement training sessions for health staff to ensure that they do not misguidedly present cancer and contraceptives as cause and effect (e.g. remove suggestive posters or materials in posts, such as figure 8.2, and create new ones with clearer messages)\(^{75}\).

2) As per the intercultural birthing policy, suggest a new policy that allows men to accompany their wives when undergoing a Papanicolaou test - this would overcome the issue of suspicion surrounding practices that cannot be observed by the patient herself\(^{76}\).

\(^{75}\) The aim of this section is not necessarily to dispute the results of the MINSA-collaborative workshop but to present them as is and more to discuss a decolonial anthropology approach. However, it is worthwhile briefly putting the key recommendations into context and dialogue with the rest of the dissertation. This recommendation was made in the cancer chapter (see page 308). However, it is also important to mention this with an evaluation of the workload and strains placed upon health workers as it is (see chapter seven); otherwise this may add to their (already stretched) workload and cause further problems in a different sphere.

\(^{76}\) Again – a potentially important recommendation. However, there are currently some problems with the intercultural birthing policy (specifically allowing fathers to attend births) and real-world implication (e.g. see the case of Eloy and Erminda, page 191-192). Introducing another policy similar to this – albeit with good intentions - would only work if and when health establishments are willing to implement it. This in turn could only come to pass if and when health workers are
3) Encourage greater platforms for MINSA staff themselves to publish results of any studies they undertake, so that they can contribute their own knowledge to academia, from ample experiences working with the population.

Although a greater focus on health worker precarity was not possible as I had hoped, the last key recommendation given, and the discussion leading to it, is particularly telling. As health workers in Vilcashuaman are institutionally constrained, so too are those working at the directorate in Huamanga. Despite completing various public-health focused projects (often contracted by the MINSA central directorate), the results of these studies are ignored and overlooked, filed away somewhere and never taken into consideration. The MINSA Ayacucho staff considered that this was due to a lack of ‘publishing culture’ in Peru, however, it could reflect a wider problem. As elucidated in chapter seven, MINSA rural health workers are in positions of precarity, and this arguably needs to change if they are expected to provide optimum services to indigenous populations. However, it would also seem that those at the directorate in the Ayacucho capital also face certain precarities- their insights are ignored because they are unable to reach wider audiences with the project findings – thus suggesting little power to effect real change in their ministry or department.

![Figure 9.2. Discussing the project with the MINSA Directorate Ayacucho (photograph by Lorena Roca)](image)

given the necessary time and space to do so. See chapter seven for further discussion on the difficulties of this.
Thus, I would add another sentence to the third key recommendation we produced, and that which could take a decolonial approach a step further – for anthropologists and other interested academics working in rural Peru to collaborate directly with the MINSA staff on health-research projects, and for those scholars that have publication experience, support them to achieve published works of their own findings in the country. In this way, one would not be undertaking research to simply present back to them in the form of policy recommendations, but actively work collaboratively to produce those recommendations and support local research coming from rural Peru.

In regard to tracing colonial gendered histories, Morgensen had suggested that research on the topic could help give indigenous groups, and those interested in supporting the health of indigenous groups, a toolkit to help in doing so (2015: 1). Here, there is arguably potential for assisting Ayacucho health staff in developing their own portfolio of health research, allowing local public health issues to be addressed quicker but also allowing health workers to form working relationships with indigenous collaborators/participants in the field, which could then have the potential for extension and collaboration to Quechua communities in the future.

**Tupananchickama**

To bring this to a close then, in Quechua there is no ‘goodbye’, no final ending, in language nor in life. For the Quechua, humans inhabit three worlds, understood to rotate around a circular perspective of time: the kay pacha (present), uchu pacha (past) and hanan pacha (future), which are always co-existing with all others who have existed whether in the past, present or future (Huaman, 2008). Thus, to end this dissertation ‘Quechually’ there exists the word, tupananchickama (until we meet again); a sentiment that expresses hope that a relationship, or here a topic of study, will not be abandoned but continue into the future, for if this dissertation has achieved anything it may be that it has illuminated vastly more areas of study that are needed in order to address the unequal FP and reproductive health services currently offered to poor Quechua women in Peru today, and to other vulnerable women across Latin America. And so, I, along with interested readers perhaps, say to this work, and to those participants and friends that made it possible: ¡Tupananchickama!
Appendix 1.1

(Highlighting added)

Actualmente el MINSA ha ampliado la gama de métodos anticonceptivos con el condón femenino, inyectable mensual e implante.

La demanda insatisfecha de planificación familiar, ha disminuido poco en los últimos años, de 10.2 en el 2000 (ENDES 2000) a 8.6 en el 2014 (ENDES 2014).

Aunque en general, la demanda insatisfecha o necesidad no satisfecha ha disminuido como resultado del aumento en la oferta de métodos anticonceptivos y el uso correcto de los mismos, subsisten brechas en la población rural y la población del quintil más pobre.

Es por ello, que en los últimos años, el Ministerio de Salud ha realizado importantes esfuerzos para mejorar la oferta integral de servicios y satisfacer la demanda de la población en los diferentes aspectos de la salud sexual y reproductiva, asimismo, ha desarrollado estrategias para reducir la muerte materna y mejorar la calidad de vida y la salud de las personas, la que en gran medida está influenciada por sus conductas y comportamientos en la esfera de la sexualidad y la reproducción, por lo que se considera un elemento clave para la mejora, reforzar las actividades de salud sexual y reproductiva. En este sentido se cuenta con normatividad adecuada culturalmente, incremento de la gama de métodos anticonceptivos con la introducción del implante, inyectable mensual y condón femenino, que nos permitirá mejorar la calidad de atención a las usuarias/os de planificación familiar.

Es bien sabido que el uso eficaz de la anticoncepción contribuye a reducir el número de embarazos riesgosos, permitiendo particularmente a estas mujeres de diferir el embarazo hasta encontrarse en condiciones de salud que permitan asumirlo. Este criterio es también válido para mujeres adolescentes y jóvenes en edad fértil, las cuales pueden espaciar el nacimiento de su primer hijo a edades por encima de los 20 años, de aprender a establecer periodos intergenésicos de tres a cinco años y de reducir el número de embarazos no planificados.

Es necesario fomentar el ejercicio de una sexualidad responsable, basada en relaciones de igualdad y equidad entre los sexos y el pleno respeto de la integridad física del ser humano, en el marco de una política de reducción de la muerte materna. Por tal motivo se ha planteado la necesidad de reforzar las actividades de Planificación Familiar, orientadas a lograr que la población tenga un mayor acceso a los métodos anticonceptivos, garantizando la dotación de los mismos en todos los establecimientos de salud especialmente los de las zonas rurales.
Appendix 3.1

Promotional Materials for the Registry of Victims of Enforced Sterilisations, Ayacucho (MJDH) Front and back matter.

¡ Ministerio de Justicia y Derechos Humanos!

Dirección General de Defensa Pública y Acceso a la Justicia

REGISTRO DE VÍCTIMAS DE ESTERILIZACIONES FORZADAS (REVIESFO – AYACUCHO)

Ayacucho:
A partir del 18 de julio 2016

Lugar de Inscripción:
Dirección Distrital de Defensa Pública y Acceso a la Justicia de Ayacucho
Av. 26 de Enero N° 401 - 407
Huamanga - Ayacucho

Horario de Antención:
8:00 a.m. a 4:00 p.m.

LA INSCRIPCIÓN ES GRATUITA!!!

Para más información visita: minjus.gob.pe/defensapublica
Línea de orientación legal gratuita: 0800 - 15259
Si fuiste afectado (a) por una esterilización forzada, puedes inscribirte, de manera gratuita, en el registro a cargo del Ministerio de Justicia y Derechos Humanos.

¿QUÉ SE NECESITA PARA LA INSCRIPCIÓN?

- Llevar documento de identificación, (DNI o Liberta Electoral o Partida de Nacimiento o Partida de Bautizo, etc.)

- Ser una persona, mujer o varón, afectada por una esterilización forzada entre los años 1995 y 2001.

- Que la esterilización debió realizarse sin consentimiento o con ENGÁÑOS.

- Si se contara con algún documento que pruebe la esterilización, llevarlo al registro.

- Las personas que no saben leer o escribir el castellano, deben acercarse con alguien de su confianza, que sea mayor de edad, de preferencia familiar, que entienda, hable, lea y escriba el castellano.

Para más información visita: minjus.gob.pe/defensapublica
Línea de orientación legal gratuita: 0800 - 15259
Appendix 4.1

Contraceptives ‘Menu’ – Vilcashuaman. Front & Back Matter
Appendix 6.1.
Layout of Health Centre, Willka Waman
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