

**CHANGING BIRTH IN THE ANDES: SAFE
MOTHERHOOD, CULTURE AND POLICY IN
PERU**

by

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University of Pittsburgh, 2013

The present study analyzes the Peruvian Intercultural Birthing policy, which sought to provide culturally competent care to Andean women by changing health center birth care and incorporating elements of traditional Andean home birth. The proponents and supporters of this policy, assert that it facilitates a dialog of medical traditions on equal terms, promotes respect and cultural dialog, improves quality of care, establishes good relationships with indigenous communities, and ensures better maternal and child health. Furthermore, they contend that the use of *interculturalidad* as a framework for health will not only foster cultural competence but also contribute to engage indigenous communities with the state and enable the government to address longstanding inequalities in access to health and education.

This study analyzes and evaluates these assertions, and seeks to understand why the policy was created, what factors influenced health providers to implement it, and what impact it had on patients, health providers and the overall goal of promoting Safe Motherhood in Peru.

Using a comparative case study design, I contrast two sites of implementation of the Intercultural Birthing policy: the Flores micronetwork and the Kantu micronetwork. Data was collected through formal and informal interviews at national, regional and local levels, and observations of medical visits.

The results question the assertion that the intercultural birthing policy is providing improved birth care services for indigenous women. The democratizing ideas of *interculturalidad* are present only in discourse but not in the coercive and sometimes abusive birth care

practice.

Additionally, the persistence of a profoundly unequal health system structure penalizes health workers charged with policy implementation, restricting their professional development and marginalizing them because they serve rural communities.

I conclude that the framework of *interculturalidad* in its current iteration does not in fact change the status quo of birthing in the Andes, it does not promote intercultural dialogue, and does little to create culturally appropriate birth care. Rather it is an example of reification and appropriation of the concepts of ‘culture’ and ‘interculturality’ by state structures, which serves to sustain an already existing unequal health system and practice.

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PREFACE

Para Daniel, Adrián y Mateo.

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phase of this research I was very grateful to have field support from Maria Layme. She also welcomed me into her home and her family in Cusco, saving me from lonely hotel rooms during the brief sojourns in the city. In Cajamarca, the Niño de Guzmán family were a great support during my first time away from my boys. I am especially grateful to the men and women— health care workers, policy makers and community members in Lima, Cusco and Cajamarca— who took time out of their lives to share their ideas and experiences with me.

Mateo and Adrián were an integral part of this research, although they probably don't remember. Their presence put the— sometimes rarefied world of dissertation research and writing—in a whole new perspective and connected me to real life.

Finally, I am most humbled by the incredible love and support of my husband Daniel. His resolve, understanding, and sacrifice over long months of family separation make the completion of this study as much his accomplishment as it is mine.

1.0 INTRODUCTION

1.1 THE RESEARCH PROBLEM

The concept of interculturality (*interculturalidad*)¹ has come to dominate the rhetoric of provision of health care services to indigenous peoples in Latin America. This study explores the impact of a national policy of intercultural provision of birthing services for indigenous women on the service providers, the satisfaction of the clients and on the goal of safe motherhood in Peru.

Childbirth is a dangerous undertaking in the rural communities of the Peruvian Andes. Maternal mortality rates in these areas are consistently two to three times higher than in urban areas ([Abou Zahr and Wardlaw 2004](#); [Ronsmans and Graham 2006](#)). Several studies recognize the complex nature of the problem which compounds the structural limitations of the health and transportation systems with issues of poverty and discrimination ([Bravo 2003](#); [Gwatkin et al. 2007](#); [Physicians for Human Rights 2007](#)).

Over the years several strategies designed to reduce maternal mortality outcomes have been implemented by the Peruvian government with funding and guidance of international cooperation bodies. The most influential international organizations engaged in the reduction of maternal mortality in Peru have been those linked to the United Nations (UN) and the Safe Motherhood Initiative (SMI), especially the UN Population Fund (UNFPA) and the UN Children's Fund (UNICEF). These organizations supported maternal health policies in Peru from early on.

In the 1980's and early 1990's the preferred policies and interventions in Peru were based on training lay community health agents and traditional midwives in hygienic practices that

¹Throughout the text I use both words interchangeably.

would allow them to care for normal births more efficiently. Additionally, these community health agents were also trained in the identification of early problem signs of pregnancy which would facilitate the identification and treatment of common ailments like high blood pressure and dehydration.

Though these initial policies garnered community support, increased the number of women who sought prenatal controls in the health services, and succeeded in reducing maternal deaths, women in rural communities remained committed to home birthing and the number of births under the care of biomedical health personnel did not increase. This was seen as a problem from a public health perspective since the majority of maternal and fetal deaths occurred during home births. Thus from late 1990's onward the main concern of Peruvian policymakers and public health officials has been to increase the number of deliveries in medical facilities and under the care of biomedically trained personnel ([McQuestion and Velasquez 2006](#)). This new policy focus coincides with the expansion of government health services into previously under served rural areas, and is also aligned with changes in international maternal health policy recommendations.

In 2005 the Peruvian government enacted a policy of culturally adapted birth care, based on UNICEF pilots and recommendations. This policy was part of a package of suggested interventions to further reduce maternal deaths in rural areas and increase birthing in public health medical facilities. The Policy of Culturally Adapted Birth Care called on nurse midwives in rural health services to change the way in which they practiced deliveries by incorporating certain traditionally indigenous Andean birth practices including: adjusting the birthing position, allowing women to birth in their own clothes, allowing family members to accompany and participate in the process, eliminating prohibition against drinking hot beverages during labor, and providing the placenta for ritual disposal, among others ([Min. of Health Peru 2005c](#)).

The implementation of this policy, which changes biomedical birthing protocols to include traditional practices, and a related policy establishing the use of maternal waiting houses, have been reported to have profound effects on the birth care experience in rural Peru by providing high quality, and culturally respectful care, within a medically controlled environment, garnering community acceptance, increasing birthing in the health services,

and reducing maternal mortality ([Andina 2008](#); [Del Carpio Ancaya 2011](#)).

From an anthropological perspective the legitimization through policy of cultural aspects of Andean birth care which public health systems had previously derided ([Guerra-Reyes 2001](#)), presents itself as a possible example of the increasingly important role of cultural preferences in health care provision. In addition, if claims of its success were supported in reality, it could also represent an important example of the power of the framework of *interculturalidad* in transforming the relationship between indigenous populations and biomedical professionals in public health facilities.

The Peruvian Intercultural Birth policy can be seen as part of a larger movement towards inclusion of indigenous cultural values into health policy in Latin America ([Arnold et al. 2001](#); [Arnold and Yapita 2002](#); [Ramirez Hita 2006, 2009](#); [Fernandez Juarez 2010b](#); [Fernández Juarez 2011](#)). However, it differs from the experiences of other Andean countries in that it is not part of an indigenous political claim or a movement for culturally inclusive health care. It is a unilateral approach, advocated and piloted by international non-profit organizations, and accepted and replicated from the sphere of government to fulfill a perceived need in the community. As such questions of how the subjects/objects of policy respond to top-down attempts to define culturally competent birth care, and the effects of its implementation on the community members, and the health personnel charged with implementation constitute a new arena of inquiry in birth care from anthropological and public health policy perspectives. Further, the Peruvian effort should be understood in the context of the increasing importance of the Safe Motherhood initiative within the scope of the UN global health policy and the approaching 2015 deadline for the UN sponsored Millennium Development Goals (MDGs). Which loom large for those countries, like Peru, that are being continuously benchmarked on their progress.

In the present study I seek to understand the process of the creation of the intercultural birth care policy in Peru, and to analyze its effects on community members, on the goal of safe motherhood, and on the nurse-midwives charged with its final implementation. I additionally explore the contention that regional value placed on indigenous identity explains the variability across implementation areas and local support for the framework of interculturality.

In this dissertation I present the results of research and analysis of the Peruvian intercultural birthing policy in two Andean sites, and question its viability in providing improved birth care services. I contend that *interculturalidad* in birth care in its present iteration is devoid of transformational potential. It is present in the discourse of policy makers and nurse-midwives, where it is understood as acceptance, respect and mutual accommodation, but is not present in the coercive and sometimes abusive birth practice. Furthermore I will assert that interculturality in birth in Peru is in fact an additional tool of reproductive governance that seeks to normalize biomedical style birth care for indigenous populations as part of a longstanding implied modernization project, by inducing compliance and controlling their most intimate bodily practices at birth.

On the other side of the spectrum, I will also argue that the young female nurse-midwives who are in charge of the implementation of the policy are also negatively affected by the intercultural birth policy. Their professional and personal development is restricted by the structural inequalities in the health care system that employs them, and by the persistence of discrimination against indigenous people and those who serve them. They are pariahs of both the male dominated urban biomedical world, and of traditional Andean birthing customs. As a result they view the provision of intercultural birthing as an unrecognized personal sacrifice, which sets them at odds with both the indigenous population and the health system structure.

Further, I argue that for indigenous community members, the intercultural birth policy is merely one in a long line of imposed biomedical practices. Local indigenous leaders or community members were not directly involved in the policy implementation, and as such intercultural birthing is not requested, sought or defended by community members. Although, for some men and women the existence of intercultural birth does add to the elements they can use strategically when establishing relationships with health care personnel and when trying to mold existing care options to their preferences.

I conclude that the framework of *interculturalidad* in its current iteration does not in fact change the status quo of birthing in the Andes, it does not promote intercultural dialogue, and does little to create culturally appropriate birth care. Rather it can be understood as an instance of the reification and appropriation of the concepts of ‘culture’ and ‘interculturality’

by state structures, which serves to sustain an already existing unequal health system and practice. Furthermore the branding of certain aspects of traditional birth care as ‘andean culture’ serves to emphasize the idea that medical institutions, and biomedicine itself have no culture. A notion that serves to separate the ‘cultural other’ from those viewed as ‘normal’, stigmatizing people and practices in the process.

However, I believe that from a social science and public health policy perspective *interculturalidad* remains an interesting concept to think with and think about, particularly due to its popularity and use within public policy in Latin America. In Peru, the concept of *Interculturalidad* has become ubiquitous due to the creation of the Vice-Ministry of Interculturality, within the also recently created Ministry of Culture. As such I believe that much still remains to be said about its utility and effects as part of policy endeavors in health and other areas of governance.

In the following sections of this chapter I will describe the research areas, discuss methodological considerations, and the research strategy. Additionally, a final section will present a brief description of the organization of the present document.

1.2 THE RESEARCH AREA

The present study was undertaken in the Andean region of Peru. Peru is located in South America and limits with Chile, Bolivia, Ecuador, Colombia and the Pacific Ocean. As result of its particular location on the continent Peru can be broadly divided into three large ecological regions: the coastal arid plains, the Andean mountains and valleys, and the low-lying Amazon basin. This configuration makes it one of the most ecologically and ethnically diverse in the region.

The ecological differences also correspond to broad differences in economic, social and cultural configurations. Generally speaking the larger urban centers, large-scale agricultural industries, and manufacturing hubs are located in the coastal areas. The Andean region is less densely populated and its main sources of income are generated by large-scale mining extraction activities and small-scale agricultural production. A large part of the Andean

region is occupied by communal land parceled by the 16th century Spanish colonial administration, or as a result of a 20th century agrarian reform. Some of the communities that settle this area can trace their heritage back to pre-hispanic ethnic groups and clans, as a result in many areas pre-hispanic languages like Quechua and Aymara are still prevalent. The Amazonian region is also presumed to be sparsely settled, although this doesn't take into account the nomadic populations of the region. The Peruvian Amazon is home to many contacted and non contacted tribal groups who are commonly divided into at least 53 language groups, making it by far the most ethnically diverse region of the country. However, many of the settled areas are prominently populated by workers migrated from the Andes. The economy of this region relies heavily on income generated by legal and illegal extraction activities of natural gas, oil, gold and logging.



Figure 1: Peru Regions

Politically, Peru is divided into 25 regions and the province of Lima (See Figure 1). Each region constitutes a separate political entity; the regional president and his council are the highest level of policy making within the jurisdiction. As such they are charged with

implementing national and regional level policy directives, managing regional resources, and reporting to the national government. Internally each region is divided into provinces and municipalities. Regional, provincial and municipal authorities are all elected at the same time and govern for a four year period. As part of the ongoing decentralization reform, local governments at each of these levels have increasing influence on the way in which national policies are implemented at the local level.

The transfer of responsibilities and budget in health and education, from the central government to the regional administrations was completed in 2009. This endows the regional authorities with the administration and execution of all policies pertaining to these sectors. Previously, this was a centralized endeavor organized from ministries in the capital through subsidiary offices in each region. The new responsibilities allow regional policy makers to modify national level policies and allocate parts of their budget to specific programs. However, they are not independent from the central government. The bulk of each region's budget comes from the Ministry of Economy's central office in several forms, for example: taxes, region-specific levys on extraction activities, and the Regional Compensation Fund. Furthermore, the policy actions of each regional government are bound by a previously agreed upon Regional Plan, a development document that is negotiated and sanctioned by the central administration, and that sets desired benchmarks and goals to be achieved.

The new decentralized administration of health is specifically important for this study as it allows the regional and municipal governments, in consultation with each other, to formulate, implement and evaluate health policies, additionally allowing greater freedom in the allocation of budget and personnel. There are several major restrictions on these abilities, more importantly in the personnel situation. However, there is great potential for a more tailored response to the policy needs of a culturally varied population (see [Section 4.1](#) for more details on health system).

The research regions, Cusco and Cajamarca, are located in the Southern and Northern Andes respectively. These regions have a shared social, ethnic and economic history but have developed distinctly different regional identities and relationships with their respective indigenous populations, and with the Peruvian state.

Historically both have strong links to indigenous political struggles. They figure promi-

nently in the narrative of the grandeur of the prehispanic Inca empire and the debacle of the Spanish conquest, Cusco as the capital of the empire and Cajamarca as the site of the capture and execution of Athahualpa (the last Inca). In the late nineteenth and early twentieth centuries both areas were important sites of middle class pro-indigenous movements, which protested feudal conditions of laborers in local haciendas. As such they developed pro-indigenous art and political discourse that fed a political and social undercurrent that in part led to the land reform of 1968. Additionally, both areas have large rural populations which are considered indigenous for policy purposes, and who eke out a subsistence living based on small farming and animal husbandry.

Furthermore, rural populations in both areas share a pan-Andean view of body, health and illness, that draws heavily on humoral theory and the importance of holistic equilibrium. However, they currently vary on several key factors. The main language spoken in all public and personal interactions in Cajamarca is Spanish², probably as a result of the earlier influx of colonizers in the region. Conversely in Cusco, Spanish is the language of public discourse, official interactions, schools, and health care, whereas Quechua is, in the rural areas, most widely used for everyday life. A further important difference is the way in which the rural population refers to itself. In Cajamarca it is generally under the economic term *campesino* (peasant), whereas in Cusco this can alternate between that and the more ethnically rooted *runa*, a Quechua word which translates literally to man/person but that is more frequently used to designate a ‘like us’ group of Quechua speaking rural persons. Another more recently developed similarity is that both regions have experienced a strong renaissance of broad-based population movements rejecting government impositions regarding the allocation of mining and construction licenses, which in both cases threatened the water supply through mining in Cajamarca, and through the possible establishment of a hydroelectric generator in Cusco.

These characteristics provide a rich context in which to explore the implementation and results of the intercultural birth care policy in Peru. The following sections will provide a summary of the social and economic context for each of these regions and, within them, of the specific provinces and towns where the present study was conducted.

²An exception is the rural community of Chetilla.

1.2.1 The Cusco Region

Cusco is located in the southern Andes; at just under 72,000 km² it is the approximate size of West Virginia and the fourth largest region in Peru. It is home to over 1.2 million people and is divided into 13 provinces and 108 districts (INEI 2010a). The Cusco region spans several altitudes, from the Andes mountains into the Amazon forest, and is one of the most ecological and culturally diverse in the country. Approximately half (49.7%) of the region's population lives in a rural area (INEI 2009b:pp.20), a proportion that has been decreasing steadily over the past few years (INEI 2010a:pp.135), most likely due to migration to urban, rainforest, and coastal areas.

Approximately 45% of the region's population is between the ages of 15 and 44, making this a younger region. However, the population structure shows signs of a demographic transition. As fertility rates drop, the annual growth rate of population over the age of 60 (1.7%) is almost double that of the population under 19 (0.9%) (INEI 2009b).

The main economic activities of the region are agriculture, tourism related commerce and mining. Tourism directly or indirectly employs most of the urban population and is the second largest contributor to the regional economy. The largest contributor is mining, which includes gas and oil extraction from the rainforest province of Manu (INEI 2010a).

The capital city of Cusco is a well known tourist destination due to its link to Inca culture. The city itself houses several Inca monuments and ruins. Outside of Cusco the main touristic corridor spans northward through the Urubamba valley up to the Machu Pichu ruins. Cusco city and this corridor have been overtaken by mostly small and large businesses that cater to the tourism industry. All around the city center, and along the Urubamaba Valley, traditional houses are now used as shops, lodging and eateries. Although many residents work providing goods and services to the throngs of tourists, very few reside near the central areas, instead living on the outskirts in the chaotic growing urban brick and cement landscape.

Income generated by the main economic activities, tourism, commercial activities and mining remain mostly in the capital city and certain provincial urban areas. Other areas of the region are largely dependent on subsistence agriculture, animal husbandry, and seasonal employment in the large urban centers or touristic hubs. During my time in the region

one of the main topics of public discourse was the importance of safeguarding the touristic resource. The number of international visitors had recently suffered a severe downturn due to protests related to the hydroelectric licenses, due to the interruption of the tourist train to Machu Pichu, and the violent protests in the vicinity of the airport. As a result harsher police response to protesters, and a more hostile police presence on the streets were a fixture of life in the capital city and its outskirts.

1.2.1.1 Quispicanchi, Uraymarca and Kantu The Kantu micronetwork³ is located in the Province of Quispicanchi (see Figure 2), which is situated to the south of the capital Cusco. The provincial capital Urcos is located on the main highway that connects Cusco city and the neighboring Department of Puno; and can be easily reached after a bumpy 25 minute bus ride from Cusco city. Urcos itself functions as an unofficial travel hub of sorts as it is located at the beginning of the second section of the Interoceanic Highway, which connects the Andes and the tropical rainforest. As such it has become a central location for buses, passengers and goods traveling to and from highland Puno and Cusco, to Puerto Maldonado and Iñapari near the Peru-Brasil border.

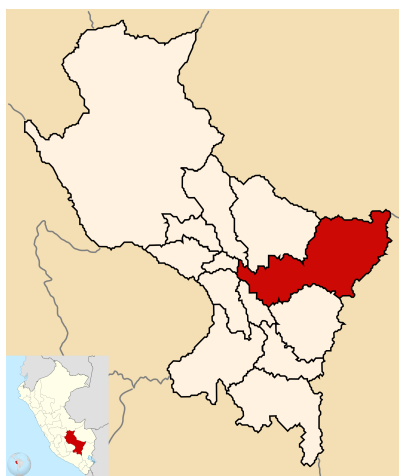


Figure 2: Quispicanchi, Cusco

The advent of the *Interoceanica* has spearheaded rapid change in Urcos and the surround-

³All micronetwork, district and health center names have been changed per IRB commitments

ing area. The construction project itself provided jobs for skilled and unskilled local men and women, injecting money into the local economy, increasing the number of televisions, refrigerators, radios and other consumer goods, and allowing community men and women to experience a different and wider world than their parents.

The reduction in travel time from the Andes to the rainforest, from two weeks riding on tanker trucks to a six to eight hour car ride, allows for a rapid flow of people and goods and has opened further opportunities for seasonal and long term migration. Especially for young men who go on to work in logging and informal gold mining operations in the rainforest. Many families in the Kantu micronetwork have a family member, mostly male, who work in the road building project or in gold mining, and it is a frequent topic of conversation. In fact, construction is the second most important economic activity after agriculture and animal husbandry in the province.

Quispicanchi is one of the most heavily indigenous Quechua areas of the Cusco region. In this province over 75% of the population over the age of three has Quechua as their mother tongue, much higher than the 52% at the regional level⁴. Almost half of Quispicanchi's population lives in rural areas; the majority of the population is dedicated to agriculture and large animal husbandry. Around 30 percent of the population is illiterate, with much higher rates for women; 36 percent of females over the age of 12 are illiterate, whereas only 9.7 percent of males are. Most of the illiterate population is over the age of 35, which indicates an improvement in educational attainment, although it is still the norm that more boys than girls finish secondary education (INEI 2009b). Approximately 78 percent of the population of this province is considered to be living in poverty or extreme poverty⁵, ranking seventh in poverty among the Cusco region's 13 provinces (INEI 2010b).

The District of Uraymarca is located in the mountains above Urcos, at an altitude of approximately 3600 meters over sea level (12,000 feet), and 32 kilometers (19 miles) along the Interoceanic Highway. It is reachable from Urcos by taxis that make the ascent once they have six to eight passengers crammed into a sedan or station wagon. The steep and

⁴Peruvian population statistics do not record ethnicity or race, however they use 'mother tongue' as a proxy for ethnic identity.

⁵Poverty defined as unable to afford the complete basic family basket comprised of food and other goods, extreme poverty means that the per capita spending is lower than the cost of the basic food basket.

winding ascent takes about a half hour now that the road has been paved. Before the road construction, this area was only reachable if you could hitch a ride on a tanker truck on its way to Puerto Maldonado or on foot. Tankers took almost four hours to reach Uraymarca and were notoriously dangerous⁶, several crosses mark makeshift memorials to the deceased.

The town of Uraymarca is located in the foothills of the Ausangate mountain, a regional *Apu* or mountain god; the snow capped peak is the scene of a yearly June peregrination established in the 18th century. This four day homage to the Lord of Q'oyllur R'itti brings together representatives from each of the communities in the various districts surrounding the mountain, Uraymarca included. They offer food, dances and traditional *pagus*, offerings of coca and other items. The festival symbolizes the reciprocal relationship between the mountain and the communities, which is renewed each year, people offer gifts and in turn could, in the past, take a block of ice from the mountain. This practice has been discontinued due to the dwindling glacier which has become a local rallying cause, and an example of the effects of global warming (Carey 2010). The Q'oyllur R'itti festival is one of the most important events for the Uraymarca community, and they also plan their own town craft and farm animal festival at the same time to take advantage of the main tourist event of the region.

Uraymarca and the surrounding districts were originally part of a large hacienda that was established in the 16th century under the Spanish reorganization of Inca territory. It was parceled under the terms of the Peruvian Agrarian Reform in the early seventies (Martinez 1962 in Laats 2000). According to local lore the town of Uraymarca grew on the basis of two neighboring communities that housed hacienda share croppers. Its proximity to a much used llama transport route encouraged commercial activities and drew people to the area. The boundaries of the district and communities were established when Uraymarca obtained legal recognition as a Municipality in 1825.

The town itself shows signs of unplanned growth and the effects of the boom years of the early 2000's when much of the town worked in, or provided services for, the road construction project. Traditional adobe houses survive alongside brick and cement houses

⁶In 2003, before the paving of the road, a tanker truck carrying gasoline to Puerto Maldonado overturned halfway to Uraymarca, a nurse-midwife returning to her health post and three local men died in the accident.

with tinted windows; there are several hostel signs and various unfinished brick and cement constructions on the main road. The 17th century adobe church and the municipal building are located on a paved plaza. The municipal building stands in contrast to most of the buildings in town; its grand facade and glass covered staircase are new additions to the old adobe structure as a result of donations by the road construction company. The plaza divides the upper and lower sides of town and is also used as occasional parking for the municipal vehicles and by street food vendors. An archway and clock close the plaza on one side and stores and the police station close the other side. The main street crosses the plaza in an east-west direction, running parallel to the highway and the river. The houses on this street are very big and include indoor courtyards, and several of them offer lodging.

The whole district has around 14,000 inhabitants, divided into 25 communities. More than 86% of the population lives in rural communities and approximately 95% have Quechua as a mother tongue. Approximately 31% of the population is illiterate, 70% of whom are women ([INEI 2009b](#)). The main economic activities for the district are agriculture, hunting and animal husbandry, construction, and commerce. The construction efforts and the jobs it creates are directly related to the ongoing expansion of the *interoceanica* highway, and the maintenance of the existing segments.

Uraymarca, is very accessible due to its location on the highway. This prime location also comes with extremely good cell phone service both in the town and in the nearby communities. As such it has become the preferred form of communication it seems all families have at least one member who owns a cell phone. Furthermore, it is possible to obtain computer services and internet at the nearby market town of Kusipata.

1.2.1.2 The Kantu Micronetwork The Kantu micronetwork located in Uraymarca, consists of a health center, called the micronetwork head, two MoH health posts, and two unrecognized municipal health posts. This micronetwork reports to the Cusco South Network, whose administrative offices are located on the outskirts of Cusco city.

The Kantu health center is located in a recently built two story, modern cement structure that was financed in part by international cooperation aid. It is located four blocks from the town center on the main road and was first used in 2009. The old health center, located just

one block off the main plaza, was still being used by health care personnel as lodging for some of the contract personnel and for university interns. It also housed the storage facilities for the national food program, managed by the nutritional coordinator of the health center. The Mama Wasi or maternal waiting house was also located in the building.

The style of the new health center has a mostly open floor plan which means that most first and second floor medical offices was exposed to air. The hospitalization area is closed as is the lodging area where most of the medical professionals live (lower ranking technicians reside in the old health center). In addition to the open floor plan the cement and tile construction is very inadequate in the cold Andean climates where locals favor warmer adobe and wood constructions. The only exception was the labor and birthing areas. The two rooms constructed especially to accommodate the intercultural birthing changes are the only ones with wooden floors that help keep the room warm.

The Kantu health center is jointly managed by the community and the MoH, the Local Health Administration Committee (*CLAS-Comité local de administración de salud*) formed by elected community members and physicians make most of the health management decisions. CLAS managed centers are early attempts at establishing community participation in management and decentralized decision-making in health. The CLAS board has the authority and responsibility to oversee and approve the annual program elaborated by the health center personnel, it can engage some contracts and regulates overtime; and is charged with all maintenance and decisions related to infrastructure and equipment and also oversees support for indigent patients. However, a CLAS is still part of the MoH structure and receives basic funding from the central and regional governments.

The Kantu health center is the head of the micronetwork of the same name. This facility employs more than 15 people, both medical professionals and back-up staff: three male physicians, four nurse-midwives, four nurses, one lab technician and at least four nurse aides. The health center is considered a Level 2 facility, it included a small operating room and had in-patient facilities⁷. Additionally, it was used as an internship center for two classes of the San Antonio University medical program: a first year Introduction to Community Health Care course which sent in students for three week stays; and an Advanced Practicum course

⁷See Table 3 in Chapter 4 for complete explanation of health facility levels.

in which two medical students spent one semester as interns at the center.

Of the medical professionals only three were under tenured positions: one nurse-midwife, one nurse and one nurse technician. Other professional personnel in the center were on short term contracts with diverse level of benefits, contract time, and funding sources. The diversity in payment levels and job security was a frequent source of uneasiness among health workers since some lines of funding were secure whereas others were dwindling, resulting in missed payments for some personnel.

In addition to a new building, the health center had one ambulance, and also two relatively high-tech pieces of equipment related to birthing services: a sonogram machine which was operated by a recently trained physician, and a ‘Servo-crib’ machine which served as reception and checkup area for newborns, which was in use in the birthing room.

The Kantu health center has two subsidiary health posts that complete the micronetwork. These posts are basic Level 1 facilities, located further along the Cusco- Puerto Maldonado Road. Each of them employed a medical doctor, a nurse-midwife, and a nurse or nurse technician. However given their low complexity level they were restricted in their actions; for example, they were prohibited from birthing at their center and were supposed to refer all women who came there to the micronetwork head center for birth.

1.2.2 The Cajamarca Region

The Cajamarca Region is located in the Northern Andes; it has an area of around 33,000km² and is the approximate size of the state of Maryland. It has a population of just over one million people and is divided into 13 provinces and 127 districts. This area of the Andes is mostly Spanish speaking; although pockets of Quechua speakers remain they constitute less than one percent of the region’s population. Approximately 27% of the region’s population was illiterate; however, following trends in the rest of the Andes these levels were much higher among women, 39% of the female population of the region is illiterate while only 14.7% of the males ([INEI 2009a](#)).

Around 75% of the population of the region lives in a rural area, and the activities that engage most of the economically active population over the age of 15, mining, commerce

and manufacture, are also important for the regional economy. Cajamarca is the site of Yanacocha, the largest gold mine in Peru, and several other smaller mines which produce copper, zinc and mixed minerals. Income influx from mining operations has transformed the region. From the 1990's onward the city of Cajamarca, has grown enormously. Large modern department stores, supermarkets and commercial areas have replaced the small outdoor markets, and provide a broader array of goods and entertainment for the growing urban population. On the other hand, episodes of land and water contamination due to mining operations have given rise to anti-mining and environmental groups, which have been increasing in influence.

Tourism is not a large part of the regional economy, although the hot spring baths where the last Inca was captured are still standing, as is the supposed rescue room, where Atahualpa was held. However, there are no other monuments of Inca occupation. In accordance to the region's highlighting of a mestizo or Spanish identity the most important regional and touristic celebration is the February Carnival modeled on Spanish festivities.

1.2.2.1 San Marcos, Picos and Flores The Flores micronetwork is located in Picos district in the province of San Marcos (see Figure 3), which is situated 64km southeast of the city of Cajamarca. The transport route from the city is serviced by several small public transportation companies; the trip lasts approximately one hour and is fairly comfortable.

San Marcos has a population of 51,000 and approximately 77% of them live in rural areas and are dedicated to subsistence agriculture. The province has seven districts which vary in altitude and climate.

The capital city of the same name is in a low-lying valley at only 2300 meters (approximately 7500 feet) meters above sea level; however, Picos and other districts are located over 3600 meters (approximately 11000 feet) above sea level. This creates a division between those who live in the valley and those that live in the *jalca* or highlands. Although both groups are very similar in ethnic background and educational attainment, they differ markedly in their economic activities. People living in the highland areas, which are colder, are more reliant on cattle and sheep products, and there is very little agriculture. People in the low-lying areas have irrigation, the possibility of farming larger plots and easier trade

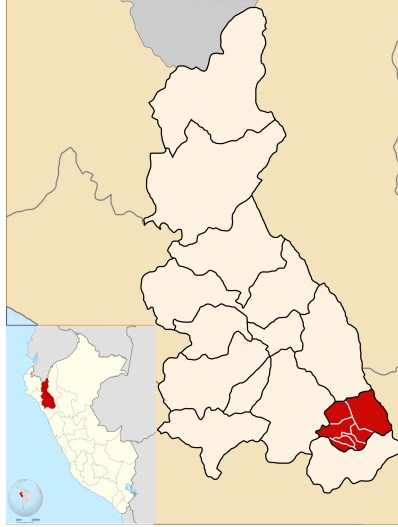


Figure 3: San Marcos, Cajamarca

connections. Locally these differences also translate into perceived differences in ethnicity, and education; it is common to hear those in low-lying areas refer to their highland neighbors as ‘uneducated’, and ‘indians’, whereas they class themselves as ‘educated’, and ‘mestizo’. As such those living in the highlands are the local focus of discrimination, even though many of the inhabitants of low-lying areas are migrants from the highland areas or have family connections there.

A paved road passes through San Marcos, and extends into the nearby provinces. However, most of the road network to the smaller districts and communities is unpaved. The Picos district, the largest of the province, is reachable from San Marcos by two routes. Route one is approximately 65 km (40 miles) long, and in normal circumstances and with dry weather, the trip takes around two and half to three hours. The second route is shorter, at only 45km (28 miles), and takes less than two hours; however, its steeper slope is not suited for many vehicles, and renders it almost useless in rainy season.

Both routes are dangerous, accidents are frequent and only two vans make the trip three times a week, departing from Flores at four in the morning. It is possible to pay a taxi for a scheduled pick-up; however, at over 100 Nuevo Sol (approx US\$30) per way it is not a

popular option. A final possible method of transportation, for those with no other means, is to ride on the milk truck that goes to San Marcos every day. However, since it stops to pick up the milk produce frequently, it takes much longer than three hours to make the trip.

The Picos district was officially established relatively recently, in 1984. Before that it existed for more than a century as a small town on the outskirts of a large *hacienda*. In fact, one of the peripheral health posts of the Flores micronetwork is located in one of the three surviving *hacienda* houses.

Flores, the capital of the Picos district, is located at 3,200 meters (approx 10,000 feet) above sea level. Most of the district is located at altitudes higher than 3,000 meters. However, one of its seven communities borders with Marañon River and is located at an entrance to the Amazonian Rainforest Basin. Almost 98% of the population of the district lives in a rural area, and the main occupations are agriculture, and animal husbandry. A prominent cooperative that keeps cattle and processes cheese and milk sweets has been established in the lower lying and well-irrigated land that belonged to the *hacienda*.

Flores, the district capital, houses the only secondary school in the areas, the municipal building, the radio station and the health center. However, it is much smaller than nearby community of El Yuyo, only 20 minutes away on foot. During the day Flores has very little movement, whereas in El Yuyo, stores and the local market are open. Furthermore, the weekly market is held in El Yuyo since it has a wider road and is located on a comparatively flatter area, which makes truck access easier. Furthermore, El Yuyo houses several small shops and restaurants, one gas pump (located in the middle of the pavement), one dental care office and two pharmacies (drugstores). The drugstores open on the weekends, and offer injections, diagnostic services and treatments. Flores on the other hand has only one restaurant which serves only those who are pensioned and pay in advance, such as school teachers, health care workers, the Juntos team and the odd anthropologist.

The one area of Flores that was constantly visited was the sole internet service cabin provided by the government through a rural satellite program. Also, the area near the internet was the only location in all the town where one could obtain a meager hint of cell phone service. Although many people had cell phones, these were not reliable and could generally not be used for voice communication within the town limits. Many younger people

and those needing to make calls regularly took long motorbike or bicycle rides to the best cell phone access point, which was at least 10 kilometers away. The main forms of communication throughout the district were the public paid satellite phones, word of mouth, the local radio station, and CB radio.

1.2.2.2 The Flores Micronetwork The Flores health center is the head center of the Flores micronetwork. In addition to the Flores center the micronetwork also consists of three MoH established health posts in peripheral districts and another three satellite posts which are financed by the Municipal Authority. The Flores micronetwork belongs and reports to the San Marcos network whose offices are located in the San Marcos health center.

The main problem that the micronetwork faces is the lack of stable staffing. At the time of research the only two medical doctors in the whole micronetwork were recent graduates who were serving their community service year (SERUMS). Although a permanent medical position was open in the main center no candidates had applied to fill it. The remoteness, difficulty of access, lack of means of communication, and low wages discouraged qualified applicants. At the time of research the health center had only seven permanent staff: one nurse midwife, two nurses, two nurse-aides, one lab/pharmacy technician, and one driver. The sole nurse midwife had assumed the role of center head and network coordinator due to the resignation of a physician. It was assumed that once the post was filled the incoming doctor would assume that role.

The Flores health center is a small cement structure; it has an open floor plan, with rooms converging on a open air corridor. Although the center has cement floors throughout, the consultation rooms have wooden floors because of the cold and humid climate. The health center connects to the maternal waiting house through a small door. That house is built of the traditional adobe and wood. The birthing room is cement and tile and has two large windows, making it much colder than the rest of the building. Additionally it is located in a very public place, near the entrance and triage area. As such, anything that happens there is easily known in the community.

The most recent acquisition by center is the sonogram machine, which is managed by the SERUMS doctor who is the only one trained in its use. However, given the very superficial

training and relative inexperience of the doctor it is generally used only to ascertain fetal position. The health center also has an ambulance, which has adapted from an all wheel drive pick-up truck. Nevertheless, no current health personnel know how to drive it, making them dependent on a hired driver from the community.

1.2.3 Kantu and Flores: Similarities and Differences

The chosen research micronetworks share some characteristics, and also have some important differences.

Both rural micronetwork sites, Kantu and Flores, are part of a larger provincial health network, which itself combines urban, peri-urban and rural populations. Each micronetwork consists of a central health service, also called the head of the micronetwork, that is located in the capital of a district, and which supervises related peripheral health posts of lower hierarchy located in surrounding communities. The geographical area covered by the health center and its related health posts constitutes the catchment area of a specific micronetwork.

The provinces where they are located are relatively close the departmental capitals, both San Marcos and Quispicanchis are located approximately one hour by car from the Cajamarca and Cusco capitals. However accessibility to the districts themselves differs markedly. It is much easier to reach Uraymarca, in Quispicanchis there is a paved road and reliably frequent transportation. Reaching Picos, in San Marcos on the other hand, requires a three hour jaunt in unreliable transport over mud caked roads.

Additionally both districts have a history of high maternal mortality rates ([Oficina General de Epidemiologia- MoH Peru 2003](#)); a majority of their population is considered indigenous for policy purposes, and both their economies are largely based on the returns from, mostly male, seasonal migration, farming and animal husbandry.

Both areas also share similar conceptions of the body, of illness and health, and have demonstrated a historical preference for home birth in the care of traditional birth attendants or family members. Furthermore, the two micronetworks have also been part of previous interventions directed at reducing maternal mortality, specifically the previous iteration of the Safe Motherhood Initiative policy recommendations that focused on the training of

traditional birth attendants.

1.3 THE RESEARCH STRATEGY

The original research design considered the following goals: 1) to examine and understand the impact of the government discourse of interculturality on the childbirth services available to rural women in the Andes; and 2) to understand the role of nurse-midwives in the process of implementation of the intercultural birth policy.

The specific objectives of this study were:

1. To analyze the relationship between the expressions of regional identity and the implementation of the Peruvian birth care policy;
2. To explain how ideas of culture and indigeneity are perceived by nurse-midwives;
3. To describe the effects of these perceptions on birth care services;
4. To assess the opinions of traditional midwives, health care agents, local leaders and community women and men on the accessibility and quality of birth care; and
5. To explore if implementation of the policy has contributed to the goal of safe motherhood.

Though the present dissertation certainly reflects these initial objectives, fieldwork results and the analysis they prompted also encompassed a much broader reflection of the intercultural birth policy in Peru than initially suggested by these objectives.

I used a comparative case study methodology. This approach allows the researcher to understand and explain complex phenomena within their specific contexts, and also to use contrasting elements of the particular case narratives to identify broader issues, effects and problems within a larger geographical and theoretical scope ([Yin 1994](#)).

This methodology is especially suited to policy research, where results are measured at the regional or national levels, but are dependent on local implementation that is rarely studied. Furthermore it is also useful in approaching research that attempts to include multiple levels of inquiry and actors.

This dissertation compares two field sites in separate geographic locations within the Peruvian Andes. Each site represents one case of implementation of the Intercultural Birth Policy. The chosen sites represent critical contrasts in the implementation of the policy that allow the identification and comprehensive understanding of the important factors involved in the process of transforming policy into practice.

A case specific narrative regarding intercultural policy implementation was constructed for each site using a variety of data collection techniques, deployed at different levels of the geographic and ministry of health organizational hierarchy.

The analysis of each case narrative has provided important results regarding the impacts and challenges of implementation at the local and regional levels. A final analysis contrasting both cases provides a broader perspective and critique of the concept of interculturality in health policy and its relevance in the wider scheme of health care in Peru and its relationship to international forces.

1.3.1 Data Collection

Data collection was undertaken during a twelve month stay in Peru in 2010, in addition to a three month preliminary research trip in 2007. Data collection was organized to coincide with different levels of inquiry, which also loosely reflect the organizational hierarchy of the Ministry of Health and Peruvian socio-political organization. As such I conducted interviews at the national, regional, health service and community levels.

The techniques used were qualitative in nature, specifically semi-structured interviews, informal conversations, observation of patient-provider interactions inside and outside of the medical consult, observation of births in the health center, and participant observation of district life.

Additionally I also collected secondary sources, such as government publications, maternal health reports, presentations and relevant statistical information at national, regional, district and health service levels.

Authorization to conduct the study was obtained at the Regional Health Directions in both Cusco and Cajamarca. Likewise, I presented the project and obtained written

authorizations from network and micronetwork administrators.

I initially intended to conduct this study mainly at network or regional level in both of the chosen provinces, focusing on health centers with a broader population base and higher level resolution capacity. However, it became clear that intercultural birth care was being offered only in some of the smaller micronetworks, and not in the provincial capitals or other urban areas. This led to the choice of different sites, and added an extra level of inquiry to the original proposal.

An unexpected consequence of this change of sites was the difference in the number of nurse midwives available for interviews in each of the micronetworks, four in Kantu and only one in Flores. I had originally anticipated encountering six to eight nurse-midwives given the larger scope of the network. The reduced number of midwives available also precluded the use of focus groups as part of the data collection techniques.

1.3.2 Levels of Inquiry

A key element for understanding implementation of the intercultural birth care policy, its impact and the role of nurse-midwives, lies in the attitudes and opinions of diverse actors situated at different sociopolitical and organizational levels. At each level the opinions and attitudes of elected and appointed officials, local intelligentsia, NGO representatives, community health agents, and other men and women mold the policy with differential impact.

1. At the national level I interviewed policymakers and others involved in the proposal, implementation and supervision of the Ministry of Health's maternal health policies.
2. At the regional level I interviewed policymakers and NGO representatives involved in enacting and supervising maternal health policies.
3. At the district level I interviewed elected officials and community leaders, traditional birth attendants and other health agents, and conducted participant observation into village life.
4. At the health service level I interviewed administrators, conducted informal conversations with diverse health personnel, and conducted observation of patient provider interactions inside and out of the medical consultation.

5. At the individual level I conducted in-depth interviews with nurse-midwives, and in one case a group interview, in addition to informal conversations. I have also conducted informal conversations and in-depth interviews with local women and their male partners to collect ideas and opinions about birth care in the area.

1.3.3 Recruiting Strategies

At each of these levels I employed diverse strategies to identify relevant actors and obtain interviews. At the beginning of the research tenure I presented the research proposal to the Universidad Cayetano Heredia (UPCH) and obtained the approval of its Ethics Committee (the only IRB board in Lima). This allowed me to obtain a letter from the Public Health Department at this university, presenting my research to national functionaries, NGO representatives and higher level officials in the Regional Health Directions. Previous contacts within the health care framework and in another local university, the Pontificia Universidad Catolica, also helped in the identification of relevant actors.

At the district level official letters of introduction from the UPCH aided in obtaining interviews with elected official, while local contacts developed during prior visits were useful in identifying traditional birth attendants, community leaders and other community health agents. At the health center levels the letters from the UPCH and written approval from the relevant Regional Health Direction opened doors to administrators and other health personnel.

Identification of possible interviewees among community members was achieved using referrals. Asking each interviewee for the names of any women who had birthed in the past four years either at the health center or in their homes and then visiting each of those homes, explaining the research and requesting an interview, and repeating the process.

1.3.4 Data Collection Techniques

1.3.4.1 Semi-structured interviews I conducted interviews with a wide variety of relevant people for this study, most were carried out in an area chosen by the interviewee.

In the case of MoH officials and NGO representatives this generally meant their places of work; others were interviewed in restaurants, other public places or their homes.

The interviews with community men and women and community health agents were mostly conducted in their homes. I used a referral technique, contacting the first interviewees in the health service and asking for permission to visit them in their homes to talk. At each of those interviews I retrieved a list of names and approximate locations of potential interviewees and repeated the process at subsequent interviews, asking specifically about traditional birth attendants and families who had children under the age of three. This successive effort allowed interviews with men and women representative of the communities that are in the vicinity of the health center. I conducted two waves of interviews in each site; wave one was geared towards obtaining general opinions and impressions, it was followed by another round of interviews which identified and recorded specific cases.

Community interviews in the Uraymarca district were conducted with the aid of local field assistant Maria Layme. Although community men mostly spoke a mixture of Spanish and Quechua, several were uneasy talking about these matters in Spanish, and women were for the most part monolingual Quechua speakers. In these cases Maria's presence helped in obtaining interviews and put interviewees at ease. All interviews were recorded and transcribed in Spanish. Once an interview transcription was completed both Maria and I would listen to the recording, while checking transcriptions and notes to make sure the information was accurately portrayed.

Interviews with health care providers, administrators, nurse midwives and other providers were conducted in the health center itself. I had initially planned to conduct them elsewhere but was surprised to find that this was the preferred place by all these interviewees. This unusual arrangement was a consequence of the work regime of rural health care workers, who spend most of their downtime in the health center; in Kantu some even lodged in rooms located within the health center building itself. During this time they would work on their case histories and other reporting and on their free days leave to visit their families.

Over all more than 100 formal and informal interviews were recorded, approximately 50 patient-provider interactions in office visits were observed in addition to 10 birth processes.

1.3.4.2 Observations Observations focused on the description of birth care practice and patient-provider interaction, specifically: salutations, tone of interaction, direction of talk, attitude of patient, and attitude of health care provider.

Observations of patient-provider interactions were conducted at the district Health Center (CS Flores, CS Kantu) and at one peripheral health post in each micronetwork (PS Sub Flores, PS Sub Kantu). Verbal permission was obtained from incoming patients to allow my presence during their consultation.

I conducted two days of observations in the peripheral health posts and one full week of consultations in the health centers. The total number of observations was higher in the Uraymarca district, given the higher work load. Observations included consultations for family planning, pregnancy and postpartum.

I additionally observed births in both Kantu and Flores health centers and also patient-provider interactions outside of the consultation both in the health center and the community at large. Permission for my presence during birth processes was requested to the family members of women in labor, as they arrived in the health centers. I specifically stressed that I was not a health care provider but that I wanted to learn about birth in the area. Verbal agreements were obtained in all cases. I observed 10 birth processes, some of which did not finish at the site due to complications.

1.3.4.3 Secondary data and statistics General statistical information describing the field sites was obtained at the Peruvian National Statistical Institute, university libraries in Lima and through official online databases. Additionally, published reports from the MoH related to maternal health, and recent tendencies in maternal mortality were also obtained.

Although births performed with intercultural adaptation are reported to the MoH statistical system (as vertical births), there are no official published documents that present or analyze this information. Data collected in relation to number of births in the health center, home births and vertical births, were obtained directly through the policymakers in the regional health directions, provincial health networks and nurse midwives at each health center.

1.3.5 Analysis Process

The analysis process consisted of the following steps:

1. Literal transcription of information collected through data collection methods;
2. Coding of narrative material;
3. Construction of case narratives;
4. Intra-case analysis; and
5. Cross-case comparison

Interviews were recorded digitally and transcribed in a word processing program. All interviews were uploaded and analyzed using the software Atlas.ti, which allows the identification and coding of segments of text. Codes can then be recalled and segments reread and contrasted. Observation narratives and field notes were also included in this analysis.

The coding procedure was conducted in three phases: 1. identification of broad recurring topics; 2. selection of specific qualifiers and ideas; and 3. selection of important quotes. Initial codes were created by the researcher a-priori on the basis of preliminary research and new codes that identified ideas and themes that emerge from the data were developed and assigned during the coding process.

Coding procedures made the identification of similarities and differences between the narratives of interviewees at different levels of policy more evident and allowed a clearer picture of the expectations, commitments and challenges of intercultural birthing to emerge.

1.4 DESCRIPTION OF CHAPTERS

The present document is organized into eight chapters. The current chapter has provided the introduction to the research problem, study area and field research strategy.

Chapters two and three describe a broad theoretical, historical and policy background which provides context to the implementation of the intercultural birthing policy in Peru.

The making of the policy in relation to the Peruvian public health system, the presentation of the policy text, and the description of the implementation and results in the

research sites are discussed in chapter four. In chapter four I also discuss the current role for traditional birth attendants in reproductive care in the implementation sites.

Chapter five presents the findings regarding the multiple meanings of interculturalidad in the research areas, and it also explores the idea that regional interest in a traditional Andean based identity may have influenced the implementation of policy in some areas.

Chapter six follows the supposed construction of interculturality in the process of pregnancy, birth and postpartum care through the analysis of observations and case stories of prenatal and normal birth care and also the change in care practice under the strain of difficult or home births.

Chapter seven then explores the perceptions of the main actors in the implementation of the intercultural birthing policy: community members, and nurse midwives.

Chapter eight, the final one, discusses the results presented in the preceding chapters in relation to three related issues: an analysis of the use of the concept of interculturalidad in Peruvian birth care; a description of the case of intercultural birthing as a practice of reproductive governance; and the multilevel effects of the implementation of the policy in Peru.

2.0 THE THEORETICAL BACKGROUND

This dissertation inserts itself in the broader scholarly production of medical anthropology, specifically within the theoretical scope of the anthropology of birth and reproduction. However,,,, it is also one of a growing number of studies of policy from an anthropological perspective, specifically undertaking the study of how policy manages cultural diversity.

The present chapter presents an overview of the study of birth and reproduction in the anthropological tradition, and outlines the relevant contributions to this study from the perspectives of anthropology of policy and critical medical anthropology.

Additionally it presents the concept of interculturality or *interculturalidad* which is central to the analysis of the role of culture in health policy in Latin America in general, and more specifically to the analysis of birth care policy in Peru.

2.1 ANTHROPOLOGY OF BIRTH AND REPRODUCTION

The earliest ethnographies of birth and reproduction were snippets within larger cultural and social descriptions of non-western groups. These first descriptions were generally restricted to some of the ritual aspects of the process that were readily observable in daily behavior by the mostly male anthropologists ([Browner and Press 1996b](#); [Sargent 2004](#)). Research on human reproduction from other disciplines, particularly medicine and psychology, was generally geared towards identifying and solving reproductive problems and focused on the issues of reproductive physiology and fertility and on the psychological and psychiatric implications of the process such as infertility and depression ([Browner 1982](#)).

However, in the 1960's and 70's there was a palpable shift in anthropological studies of

human reproduction towards a consideration of the social and cultural contexts in which pregnancy and birth are enacted ([Browner and Press 1996b](#); [Sargent 2004](#)). The work of Margaret Mead and Niles Newton on the cultural patterning of perinatal behavior ([Mead and Newton 1967](#)), and several books and articles by Sheila Kitzinger, Dana Raphael and Sheila Cosminsky, contributed greatly to the cooperative endeavor of describing and understanding, reproduction and birth, as a cultural system ([Davis-Floyd and Sargent 1997](#)).

These early studies and the ones that followed them in the 1980's branched out into two related areas. The first group, studies of non-western birth systems, produced detailed ethnographies of traditional midwifery, birth rituals and birth processes. These ethnographies served as a way to situate the birth process as a system unto itself and as a functional part of the total social system within specific societies or cultures. They also registered the variation in the characteristics and types of individuals who were allowed to attend a birth and offer specialized assistance to the birthing woman. Thus in addition to the description of the birth process itself they explained the different forms of recruitment for this accompanying role, the mode of acquisition of said role, the acquisition of the knowledge base, the status within the social group, and the role of this individual in prenatal care, delivery and postpartum ([Sargent 2004](#)). Carolyn Sargent's work in Benin ([Sargent 1982](#)) and Carol Laderman's research in Malaysia ([Laderman 1987](#)) exemplify this type of research and the multiple qualitative and quantitative methods used.

The second group of studies moves beyond the in-depth description of a single birthing system towards cross-cultural comparisons. These generally sought to compare local non-western systems as they faced western biomedical traditions and attempted to isolate certain generalized features that can be compared across cultures.

Jordan's Birth in Four Cultures ([1978](#)) is a pioneer in this type of study. Although she is not the first to conduct this kind of cross-cultural study, she is the first to engage in the comparison from a bio-social perspective ([Davis-Floyd and Sargent 1997](#); [Van Hollen 1994](#)). She compares four regions, Yucatan, Holland, Sweden and the United States, focusing specifically on seven previously identified bio-social factors:

1. The cultural definition of birth, and within it the issue of pain and pain management;
2. Preparation for birth;

3. The attendants, with consideration of their level of specialization and the nature of the interaction, and also the woman's support system;
4. The birth territory;
5. The use of medication;
6. The technology of birth; and
7. The locus of decision making.

Jordan presents a detailed ethnographic account of the Mayan system of birth in Yucatan, with specific focus on the recruitment and role of the Mayan midwife. This part of her book follows a similar structure to the early descriptive studies of the birth process. However, she takes it one step further in comparing each of the seven bio-social factors identified across the birthing system of each specific area of her study. Based on her ethnographic work she argues that each culture has its own conceptualization of birth and that within a culture all aspects of birth events are mutually dependent and internally consistent. Each of the seven bio-social factors she compares differs across cultures, and she contends they correspond directly to the way in which each culture conceptualizes birth. In the US, for example, it is viewed as a medical procedure, thus the main actor is the doctor not the woman, whereas in Sweden it is seen as a personal and fulfilling achievement, and thus it is less medicalized. Furthermore, in Yucatan it is seen as an important family event and the midwife becomes the representative of the community ([Jordan 1978](#)).

In this comparison Jordan is successful in substantiating that birth is culturally constructed and patterned, and that within each culture this patterning constitutes a system within which the rest of the bio-social features make sense. This idea is important in the consideration of the cultural context of birth as a part of later studies of childbirth. Also, it sets the scene for the later development of the concept of authoritative knowledge. In addition it provides non-western knowledge, in this case of midwifery, a certain claim to legitimacy that allows traditional midwives to attempt a negotiation in the face of advancing biomedical frameworks of health care.

Jordan's proposes that the way in which cultures conceptualize birth and the role of the birth attendant has specific consequences for the type of interaction the attendant has with the birthing mother. As such, cultures where birth is seen as an empowering female process

the role of the attendant tends to focus on support and company, whereas in a culture where birth is viewed as a result of medical intervention the attendant role will be seen as more important than the mother herself.

The last two important bio-social features identified by Jordan, which have sparked further studies, are the use of medication and technology, epidural anesthesia, fetal monitoring, IV-fluids among others. In this respect Jordan's perspective is that even though there are many unwarranted medical interventions in western childbirth, there is also danger of complications in low-technology birth settings. She does not advocate hi-tech or low-tech over the other but is critical of the imposition of unneeded interventions in third world countries. Further studies have been written on both sides of this debate, and it is still a contentious issue both in western developed countries and in developing countries. Ultimately Jordan seems to advocate not for or against technology per se, but rather that when available the decision of using specific technology or medication should be based on the birthing woman's decision.

Carol Mac Cormack's edited volume, Ethnography of Fertility and Birth (1982) and Margarita A. Kay's Anthropology of Human Birth (1982) both build on Jordan's 1978 book. The two books feature several classical descriptive ethnographies of childbearing, which provide a broad view of the many similarities among disparate birthing cultures across several continents and thus lend credence to the idea of the universality of traditional birthing systems. Kay's compendium also features several studies that herald new lines of research such as new forms of birth practice in the United States (Henderson and Henderson 1982; Hubbell 1982) and technologically mediated conceptions (Goleman Wolf 1982), whereas Mac Cormack's volume provides more information on cross-cultural comparisons (Cosminsky 1982; Homans 1982; Kitzinger 1982).

The editors of both collections also begin their volumes by providing an overview of their theoretical stand point relative to the nascent study of the anthropology of birth. For Mac Cormack birth is a biological universal that is culturally patterned in response to social and environmental stresses. Thus particular birth customs around the world are a result of adaptive survival strategies of specific populations in given environments. It is her contention that descriptive studies of birth customs and descriptive studies of biological

studies fail to take into account the rich intersection of culture and biology that is evident in the birth process. In this sense she proposes that the collected articles in her volume are an attempt to bridge this gap, taking a bio-social perspective similar to Jordan's but giving more relevance to the cultural adaptation to biology.

Kay's perspective differs from that of the two previous authors; she attempts to generate universal categories that will allow cross-cultural comparison of birthing systems using the paradigm of humoral medicine. She asserts that this paradigm was diffused from Babylonia to the rest of the world and is at the core of most non-western obstetric cultures and identifies six extrinsic factors taken from the realm of humoral medicine which she believes to be at the core of folk management of childbirth across cultures. These elements are air and water; food and drink; sleep and wakefulness; movement, exercise and rest; evacuation and retention; and spiritual passions and emotion. Thus she proposes that for ease of cross-cultural comparison when 'writing the anthropology of birth' ethnographers could use the stages of the process identified as Emic to western medical culture (pregnancy, labor, delivery, postpartum and newborn) and within each one describe the behaviors relative to six extrinsic factors indicated before.

This use of humoral theory is questionable, even though behaviors surrounding many of these 'humors' are specifically regulated during the reproductive process in many different and disparate cultures, this medical paradigm does not carry the same meanings across cultures. Furthermore, as Browner ([1982:pg.10](#)) points out in a contemporary review, it also '*overlooks the role of indigenous practices that have syncretically mixed with colonial systems*' in the new world.

Kay also supports the idea that the birth process is a system that is part of total society. However, she moves a step ahead in proposing that the study of the dynamics and definitions of childbirth provides access to understanding where the locus of power lies in a specific society. In this sense she advocates situating the description of the birth process in its relationships within the other systems of culture, such as social structure, social organization, economy, religion, history, politics and physical environment. This call for profound contextualization is not as vehement in the writings of previous researchers and will later be expanded on to include considerations of global-local connections and their relation to

changes in the birth systems by proponents of the critical medical anthropology and feminist approach.

Within these studies of traditional birth the research conducted by Kitzinger and Cosminsky are particularly note worthy as they tackle cross-cultural, comparative and critical perspectives. Kitzinger undertakes the cross-cultural comparison of social contexts of birth in Jamaica and Britain ([Kitzinger 1982](#)) which in a way parallels Jordan's work in Yucatan and the USA, yet she expands her analysis to include a discussion of the symbolic value and meaning of birth and the role of the midwife as well as a discussion of concepts of sickness and health. The author contends that in a rapidly changing culture there is a need to explore the relation between the social structures, values and biological variables of birth. In this sense she moves away from the mutual translation paradigm advocated by Jordan and heralds later studies of meaning and power in the study of reproduction.

Cosminsky ([1982](#)) analyzes the change in Guatemalan birthing practices, and contends that in the process of change brought on by the spread of western medicine there is a loss of the sacred rituals of birth and an attenuation of the role of the midwife. In the face of progressive secularization of birth, she sees the role of the midwife as ambiguous. The traditional midwife is at the same time the repository of traditional knowledge and in the same way has become an agent of change by her contact with western medical frameworks and the incorporation of some of their technologies. The role of midwives as a source of cultural change and as key actors in the modernization of maternal and child health care was very important in the community health movement of the 1980's. Cosminsky's article seems to be situated at the beginning of this process.

The aggregate result of these collected studies was that the idea that childbirth is culturally and socially constructed became mainstream within anthropology; they encouraged scholarship around and study of childbirth and reproduction; they also demonstrated the existence of alternative and coherent systems of birth care that are adapt to different cultures and environments; and lastly contributed to the nascent theoretical framework for the analysis of birth.

However, as Van Hollen ([1994](#)) points out, Jordan and others cited here have tended to present a romanticized view of indigenous birthing cultures and have paid little attention

to the variation in, and contestation of beliefs and practices associated with birth within a given culture. Thus issues of unequal power relations as a result of class and gender are not considered part of their analysis at this early stage. The advent of more critical concepts necessary to understand the reality of inequality among birthing systems and within the birthing process itself was later explored by Jordan and others through the concept of authoritative knowledge.

2.1.1 Authoritative knowledge and cultural construction of childbirth

In the early 1990's there was a change in anthropological theories of childbirth which has been adequately termed as a move from function to authority ([Van Hollen 1994](#)). This change moves away from merely descriptive system based theories to incorporate some notion of inequality and power through the concept of authoritative knowledge (AK). This concept was incorporated as an update to Jordan's Birth in Four Cultures in the 1994 edition. In this update Jordan exposes how the hierarchical, institutionalized and technology laden knowledge of biomedicine is constructed as 'authoritative', and therefore more valuable than the lay knowledge wielded by non-medical personnel. Thus in the US, for example, the knowledge of the birthing woman about her body and its functions is dismissed in favor of machine mediated readouts, and medical personnel's own experience. In the same way in Yucatan, traditional Mayan midwives are 'enlightened' with biomedical knowledge of birthing processes through the safe motherhood training courses that are aimed at inducting them into the biomedical health care system and which erode, and sometimes contradict traditional knowledge and practice([Jordan and Davis-Floyd 1994](#)).

In a [1997](#) edited volume on childbirth and authoritative knowledge Jordan and other scholars develop this concept further. Here Jordan asserts that authoritative knowledge is the knowledge that "*participants agree counts in a particular situation, which they see as consequential, on the basis of which they make decisions and provide justification for courses of action*" ([Jordan 1997:58](#)). Thus AK is created within the social interaction, and does not necessarily belong only to the persons in authority, although these authority figures may represent this knowledge to the extent that they are part of the community that produces

it.

Jordan contends that in hospital birth the ownership of the material technology “*simultaneously defines and displays who should be seen as possessing the authoritative knowledge and consequently as holding legitimate decision making power*” (Jordan 1997:61). Her example shows clearly that in the ritual space of the hospital the woman’s perceptions of her own body are secondary to what the machines say about it and she is in turn the absolute lowest person in the hierarchy of relevant actors in the drama of birth, coming even behind the child itself. For Jordan, this is further proof that biomedical authoritative knowledge imposes itself hierarchically over others and thus illustrates the importance of uncovering the inflexibility of biomedical AK and the possible health or psychological consequences it may cause.

Sargent and Bascope (1997) also analyze the production of AK in biomedical health care systems and conclude that the achievement of AK is not only a result of technology mediated knowledge, but it is also due to the social position of medical practitioners, the legitimacy of their profession and its claims to control over the birth process. They suggest that in highly hierarchical societies where class and race are intertwined with ‘professional’ knowledge, the control of biomedicine in the birth process is socially legitimized and almost complete.

Sargent and Bascope advocate for an active resistance to the monopoly of technology mediated knowledge. As such their recommendations are similar to those from critical ethnographies of western that propose granting legitimacy to different types of birth knowledge; for example knowledge created through home birthing practice (Szurek 1997) and female intuition based knowledge (Davis-Floyd and Davis 1996), which seek to engage with the embodied experience of the birthing mother as part of a holistic female centered spiritual connection among birthing women and their female attendants.

These portrayals of the authoritative nature of biomedicine can be interpreted as supporting the notion of the patient as a powerless subject under the grip of hierarchical pressures. However, Browner and Press (1996a) lead us to reconsider this idea by identifying patients as avid re-interpreters of medical information, contrasting and comparing with their own experience based embodied knowledge, and using and discarding advice according to internal constraints and considerations. In the same way Ketler (2000) finds that childbirth educa-

tion classes in Italy are most effective because they allow transmission of knowledge from woman to woman and do not in fact have a totalizing effect of inducting mothers into the biomedical realm. In this sense her research seems to indicate a different pathway to outright resistance which could be termed as critical compliance. Nevertheless it is important to note that both these articles refer to prenatal care and perhaps may not be applicable to the decision making needs and particular power interactions that are in play during the birthing process.

However, this more accommodating argument an extension of the concept of authoritative knowledge which considers possibility of establishing a productive dialog between biomedical practitioners and traditional birth attendants. Thus Sesia (1996) advocates for the importance of biomedical training of existing traditional midwives. This endeavor, which was part of the reevaluation of the safe motherhood strategies of the early 1990's, did not attempt to fully convert traditional midwives into biomedical personnel but rather sought an accommodation in the face of rising maternal deaths and reduced health care provision. Traditional midwives would be trained in early pregnancy risk detection, and hygienic practices to reduce sepsis and in some cases were provided with birth kits to aid them. This training allowed certified midwives to assist normal pregnancies in their area combining their own authoritative knowledge with the newly acquired biomedical notions. This arrangement also permitted certified midwives to maintain status within the community and built collaborative relationships between health care providers and the local community.

Despite an initial boom in articles using the concept of authoritative knowledge to explain inequalities in power and decision making abilities, its use is scant in the later literature. This may be a result of the difficulty of using the idea of authority to present a more nuanced explanation of the power relationships at play in patient provider interactions, between health systems, and among developed and less developed countries. Thus in many of the articles cited here it is difficult to escape the 'indigenous-is-good' and 'western-is-bad' dichotomy that seems to be inherent the notion of authoritative knowledge.

2.1.2 Critiques of childbirth in western settings

The comparison of birthing systems among across several regions of the world spurred research on western systems of birthing informed by political economy analyses. This western-based research occurs concurrently with the research using the concept of authoritative knowledge in non-western settings and attempt to provide a clearer description of power relationships within the western birthing systems which are prevalent in urban settings in North America and around the world.

Emily Martin's The Woman in The Body (2001), originally published in 1987, heralds this new perspective presenting a critical view of the underlying assumptions that biomedicine makes about reproduction, women and their bodies. Martin's achievement is to unveil biomedicine as a cultural system, akin and comparable to other cultural explanations of health and illness. Martin embarks on a critical view of the underlying assumptions that biomedicine makes about reproduction, women and their bodies. She states that women's bodies are a political battleground where men attempt to control the power of sexuality and reproduction. In her analysis of biomedical texts she consistently proves that the language used to describe the female reproductive processes is imbued in the woman-as-machine metaphor.

In this sense she asserts that during the birth process women are viewed as a productive machine, where the focus is on obtaining a good product, that is, a good baby. In this argument we can see evident connections to the idea of women's labor being alienated from them much in the same way Marxist theory explains the alienation of the production from the manual workers by the industrial revolution. Following along with this metaphor Martin argues that women are not a participant in the birth but an object that needs to be delivered by a doctor to add value to the product. However, in the face of increased medicalization Martin recognizes a burgeoning culture of resistance among pregnant women who deliberately delay going to the hospital to reduce the number of interventions to which they are submitted, or who try to circumvent the whole hospital birth experience.

It is at this juncture that Davis-Floyd (1992; 1994; 2001) picks up on the ethnography of western birth. Where Martin attempted a 'cultural analysis of reproduction' as whole,

Davis-Floyd is very much situated within the pregnancy, birth and postpartum process. She frames this process as a year-long rite of passage that is initiated with the medical confirmation of pregnancy and that culminates at birth with the full incorporation of the woman into a technocratic (or biomedical) model of birth. This is achieved through symbolic messages conveyed to the woman by the rituals of hospital birth. In this sense she contends that women's supposed free choices for birth technology, such as fetal monitoring, use of epidural, acceptance of induction, and elective cesarean sections, are embedded in a hegemonic model that is constantly presented as the only option through the most basic cultural rituals expected in this process.

In her ethnographic research Davis-Floyd (1992; 1994) identifies two models or paradigms of birth: the Technocratic and the Holistic. The Technocratic is the biomedical model, which stresses mind-body separation and sees body as machine; the Holistic is female centered and draws on the metaphors of the human body as a living organism with its own innate wisdom and energy field connected to the rest of the living world; it favors a non-interventionist approach to the birth process and allows women to choose their own place and position for birth. She finds that those women whose self and body image corresponds to that of the body as machine metaphor accept and welcome the incursion of technology in their bodies, whereas women who view the birth process as natural and holistic feel violated by technology. In a later revision (Davis-Floyd 2001) she adds a third paradigm which is a result of division of the previous holistic paradigm. This model, called Humanistic, emphasizes the body-mind connection and defines the body as organism. In turn the renewed definition of the Holistic model purports a connection of body, mind and spirit, and sees the body as an energy field in interaction with the energy of other living things.

Davis-Floyd's focus on meanings and on women's voices lends a much needed light into the study of childbirth for middle class women in the United States. Her study conveys the complexities faced by these women in their negotiations with the biomedical system and its definitions of normal birth. She also continues in Martin's footsteps in chronicling the many ways in which the idea these women resist biomedical establishment in search of the ideal of a natural birth.

Both studies are foundational works on the study of the totalizing effect of the medical-

ization of the birth experience. Implicit in the idea of the female body as machine is the idea that body, mind and emotion are not only perceived as separate by biomedicine but that women are progressively indoctrinated to perceive themselves as machines in their everyday encounters with the biomedical establishment and also through their very existence in a social world which is imbued with this discourse. However, both studies fall into the trap of binary distinctions that equate natural and female. In doing this they openly advocate for a return to the naturalness of birth, viewing the female body as the natural and knowing subject of birth and rejecting the unnatural medically mediated body of technological birth.

This stance has gained a wide acceptance among some middle class Americans, sparking one of many so-called ‘mommy wars’, drawing cultural and political boundaries that pit pro-natural, non-interventionist mothers against supposed medicalized, pro-interventionists ones, and where each band accuses the other of outrageous, selfish and irresponsible choices ([Monto 1997](#)). Thus the woman and her body seem to have only one choice medicalized or non-medicalized. However, as often happens, many women situate themselves among the many possible shades of grey, a little medicalized or a little natural, or everything in between. In turn, the response of the biomedical establishment to these changing consumer desires seems to have rendered this dichotomy obsolete. They incorporated elements identified with natural birth, touting female centered care, the possibility to deny medication, customized home like birthing rooms ([Fannin 2003](#)) and possibility of variations in birth positions achieved through redesigned birthing beds, thus re-elaborating the concept of ‘natural birth’ and giving rise to the possibility of having a natural-medical birth .

However, as Cosans ([2001](#)) asserts, the dichotomy stands. From his own biomedical perspective he proposes that physicians’ training emphasizes the image of the body as an unambiguous and passive object that makes it difficult to appreciate each patient as a unique embodied person. He contends that although there is lip service paid to encouraging a view of the human body as more than a collection of parts, the way the training is organized leaves the doctors’ own bodies too exhausted to reason past the readouts of diagnostic machines which in reality ‘stand in’ and ‘embody’ the patient ([Cosans 2001](#)).

Birthing women continue to situate themselves in the grey area between natural and medicalized, in a sense positioning their bodies and selves in the most advantageous position

amidst the rhetoric of risk. They negotiate the grey area as savvy consumers, for example using seemingly non-natural methods to proactively induce labor to avoid medical definitions and further technology as a result of ‘overdue’ pregnancy (Westfall and Benoit 2004). This construction, negotiation and experience of a self defined natural childbirth “*reflects and promotes a shift away from fixed and essentialized understandings of the natural female body and childbirth*” (Macdonald 2006:236). This renewed version of natural birth allows leeway for the practical choices, rather than a clear cut option for or against medicalization; patient satisfaction resides in being part of the locus of decision making. In this context then women reject set notions of natural birth because they fix nature against culture and against the female birthing body itself.

This reworking of the dichotomy of natural/medical may also reflect a growing comfort with the omnipresence of technology. This may imply that western medicine was successful in establishing the dichotomy between body/mind in the embodied experience of the birthing woman themselves.

However, Akrich and Pasveer (2004) assert that although it is true that a dichotomy is produced, it is not one of body/mind. Rather the second term (mind) corresponds to an embodied self, not an abstract notion, constructed in the interactions of the different actors present: the woman, the professionals and even through the implementation of specific mediations which may be technical. Thus rather than being pro-natural or pro-medical, the various configurations of obstetrical organization result in different experiences, in which the particular interventions of the birthing professionals (doctors or midwives) mediate between the body-in-labor and the embodied self and also allow the joint transformations to occur.

Although Akrich and Pasveer state that this does not imply that the medical birth experience always results in satisfaction for women, it does provide the scholar with an alternative and critical view of the process that does not focus on fixed dichotomies. As such it may be closer to the actual lived experience of women who do not choose sides but seek to negotiate the middle ground.

2.1.3 From Birth to Reproduction

Feminist perspectives on gender and women's health permeate much of the research in the realm of childbirth. However, feminist theories view birth only as a small part of the larger realm of reproduction, which includes all biological and social attributions of the female body. As such the feminist perspective of reproduction applies a political economy approach to the analysis of gendered power relationships and seeks to understand how gender inequality is embodied and negotiated at the individual level and how it relates to broader power structures.

The move towards theorizing about reproduction as a complex entity responds on the one hand to the recognition of the importance of the whole female experience over the life course and the multiple interrelated issues that are encountered at different moments. On the other hand it is also a concerted effort to situate women at the center of all discourse and policies that relate to decisions over their bodies. The feminist agenda sought to counterbalance years of neglect by policymakers and academics who theorized for and about women but without active female participation. In this sense all feminist research seeks to be transformative and is viewed as a tool for achieving female empowerment and self determination.

Rapp (2001) argues that feminist attention to the embodied inequalities of gender helped reproduction become a focus of investigation and funding and allowed it to move to the center of social theory. In her view, the feminist critique of the 'politics of the body' permitted the female body to be conceptualized as the material site of political struggle, thus linking the individual female body with the body politic. As such, the feminist agenda sought to subvert the body/mind, nature/culture, irrational/rational dichotomies, which were identified as expressions of the same Cartesian dualism that equated the female body with nature over culture, body over mind, and innate irrationality over masculine reason (Rapp 2001). In analyzing the political, historical and social moorings of this view of the female body the feminist movement prompted critical studies that dissected the concept of nature and uncovered the tangible consequences for women. In order to achieve a nuanced and detailed analysis this approach turns to the qualitative methods of anthropology for the production of feminist ethnographies. This approach engages with a critical trend within historical re-

search; this 'history from below' focused on the ways in which the political and social climates were expressed in the lives of ordinary people and also sought to subvert the public/private and culture/nature divides ([Stern 1997](#)).

Many feminist ethnographies sought to produce accounts that gave women's voices center stage and attempted to provide human context to the broad generalizing trends of earlier demographic and sociological research. Their approach is grounded on multiple instances of micro level data collection and macro level analysis. In this sense they find interesting similarities among female experiences across disparate cultures which solidify gender as one of the key explanatory variables for inequality.

One such group of ethnographies was promoted by the International Reproductive Rights Research Action Group (IRRRAG)([Petchesky et al. 1998](#); [Petchesky 2001](#)) and was conducted among poor women in seven different countries: USA, Brazil, Mexico, Malaysia, Egypt, Nigeria and the Philippines. This project labored to uncover women's ideas of their rights and entitlements to reproductive and sexual self determination through qualitative in-depth research. They find striking coincidences and commonalities among diverse participants, for example a shared sense of agency and power among women in the different project sites. Even in cases of seemingly total restriction women do not conceive themselves as victims but rather engage in complex processes of negotiation to carve out small areas where they can exercise control over their reproductive and sexual lives ([Petchesky 2001](#)).

Furthermore, they identify that motherhood is wielded by many women as a justification for sexual and reproductive entitlement, thus the pain and burdens of childbearing and child rearing represent a kind of currency they pay out of their bodies to gain reproductive authority to decide about their bodies and lives ([Petchesky 2001](#)). In addition, the project results uncover a practical morality, even in orthodox religious settings, where women are negotiating with religion in the same way they negotiate with partners and families, achieving a personal accommodation with regard to theologically forbidden practices such as contraceptive use and abortion. These collected testimonies provide texture and nuance to the policy debates and the feminist agenda, and counter the conception of poor women as unempowered victims.

The advent of the International Conference of Population and Development (ICPD) in

Cairo in 1994, and the Fourth World Conference for Women (FWCW) in Beijing in 1995 consolidated the study of reproduction, conceptualized as a holistic complex multilayered issue along similar lines as those proposed by feminist researchers. Previous UN population conferences (Bucharest 1974 and Mexico 1984) had focused on the issues of overpopulation, fertility control and the mother-child dyad, and were marred by conflict between pro-natalist and anti-natalist groups that viewed women as passive subjects of policy ([Petchesky 1995](#)).

The program of action of the ICPD Cairo demonstrated a clear change in thinking: it deliberately rejects the view of women's equality as a means for fertility reduction, is committed to female empowerment through the change of existing power relations, recognizes the similar conditions of poor women in developed and undeveloped countries, and states that the elimination of discrimination against women is a prerequisite to the elimination of poverty. It also adopts the broad definition of reproductive health that encompasses sexual health and physical, mental and social well-being ([Petchesky 1995](#)).

The Platform of Action of the 1995 Women's Conference in Beijing furthers this approach to reproductive and sexual health stating that the reproductive rights stated in the ICPD are in fact basic human rights and that women have the right to have control over and decide freely and responsibly in matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence ([Petchesky 1995:155](#)). More than ten years after these conferences these agreements have triggered many changes in the rhetoric and practice of policy and research, and have also been part of the later pronouncements of international regulating bodies.

The shift from the description of birth practices to the analysis of power relationships at play in reproduction also responds to the desire to break with the idea that childbearing is the most important role of a female in society. Thus feminist ethnographies have expanded the realm of study beyond childbirth towards issues that are intimately related such as decision making processes within the context of global reproductive politics, the spread of biomedicine and its hierarchical power structures, female resistance to hegemonic structures, and the gendered power struggles behind the use of new reproductive technologies.

2.1.4 Reproductive Politics to Reproductive Governance

The contextualization of female reproductive decisions within national and international politics of reproduction is a result of the confluence of a critical approach to medical anthropology with feminist oriented research on gender and power. During the latter part of the 1980's and into the 1990's there was an increasing awareness of multiple ways in which seemingly distant power relations influence local reproductive experiences, and conversely that local reproductive experiences respond differently to the relationship with external power structures (Ginsburg and Rapp 1991, 1995).

Ginsburg and Rapp propose the concept of 'politics of reproduction' which synthesizes the local and global perspectives. They propose that anthropology is uniquely positioned to deal with both dimensions. In this context the task of anthropology is to identify and comprehend the transnational inequalities on which reproductive practices, policies and politics depend (Ginsburg and Rapp 1995). Their 1991 review presents the framework of the politics of reproduction as a reflexive endeavor which reveals the ways discursive practices and biological constraints are shaped by political-economic history (Ginsburg and Rapp 1991).

In their edited volume Conceiving a new world order: The global politics of reproduction (1995) Ginsburg and Rapp also consider historical and inter-generational contexts in addition to the life course perspective in the study of reproduction. In this sense they seek to shift from a traditional anthropological focus of how reproduction is structured within a culture to consider the structures across social and cultural boundaries. They utilize the concept of 'stratified reproduction' as a way to describe *power relations by which some categories of people are empowered to reproduce and nurture while others are disempowered* (Ginsburg and Rapp 1995:3). Thus it enables a broader look at the underlying hierarchies of power that through covert or overt policies try to mold reproductive actions.

Studies linking the global and local, and the internal power struggles within communities have been particularly fruitful in the realm of fertility related research. Several studies have analyzed the relationship of fertility and nation making, which links women's bodies to the production of specific kinds of wanted and unwanted citizens (Anagnost 1995; Greenhalgh 2008). Others have analyzed the relatively recent and expanding realm of new reproduc-

tive technologies ([Inhorn and Birenbaum-Carmeli 2008](#); [Rapp 2000](#)) and assisted fertility ([Franklin 1995](#); [Davis-Floyd 1998](#); [Morgan and Michaels 1999](#); [Lay 2000](#); [Birenbaum-Carmeli 2004](#); [Levine 2008](#)).

Overall these studies uncover the multiple interrelated power structures that interact and influence decision making in reproductive health. However, the focus on fertility politics obscures other unexplored areas of policy and politics related to the reproductive cycle that can benefit from analyzing power relationships at different levels and their effect on women's decisions.

The concept of 'reproductive governance' proposed by Morgan and Roberts ([2012](#)) bridges this gap and provides a useful analytical tool to understand the politics of reproduction in relation to policy and the emergence of the sexual and reproductive rights framework in Latin America.

This concept is shaped by Foucault's idea of biopower, which is *different from sovereign power or explicit force, as one of the forms in which governance is enacted by the subjects of power unto themselves* ([Morgan and Roberts 2012:243](#)), as such the subject of power self regulates to conform to an externally defined ideal, rule or prescription. Thus Morgan and Roberts propose that reproductive governance refers specifically to the way in which policy mechanisms become an instance of biopower. Reproductive governance is:

[a group of] mechanisms through which the different historical configurations of actors, such as state institutions, churches, donor agencies, non governmental organizations- use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviors and practices ([Morgan and Roberts 2012:243](#))

In essence reproductive governance is the way in which certain ideas of morality are embedded in the subjects of power and which normalize or condemn certain reproductive activities or behaviors. The authors call diverse morality positions 'moral regimes' which can be used to guide intimate behaviors, ethical judgements and public manifestations. Moral regimes are valued in opposition to supposedly immoral and irrational activities, thus the coexistence of diverse positions are not tenable, as a result any moral regime that is not compatible with that of the governance apparatus, for example home-birth, non-use of contraception, or premarital sex is derided.

In this context the concept of reproductive governance is useful to understand how international policies intersect with national level policies and create subjects of power, or rights and of policy. As an example Morgan and Roberts propose that in Latin America, competing factions of conservatives and progressives use the rhetoric of rights to establish opposing moral regimes of reproduction and creating different rational and irrational citizens. As such they propose that viewing the Latin American process through the prism of the concept of reproductive governance can be useful to understand the links between embodied moral regimes, national political strategies and global economic logics, by situating the governance of bodies within world governance ([Morgan and Roberts 2012](#)).

This concept is particularly relevant for the analysis of the intercultural birth care policy in Peru as it was developed specifically in reference to common Latin American historical developments. Reproductive governance also incorporates the examination of the power relationships expressed in the links between the local and the global politics of health and reproduction. Understanding these connections in policy has also been the focus of two other perspectives which also inform the present study: critical medical anthropology and anthropology of policy. In the following sections I briefly present both perspectives.

2.2 THE CRITICAL MEDICAL ANTHROPOLOGY PERSPECTIVE

The critical medical anthropology (CMA) perspective emerged in the late 1970's as criticism of the role of medical anthropology in the expansion of western medical hegemony in the third world mounted. CMA readily engaged with political economic theories that led to a broader understanding of the social causes of disease, specifically the way in which the supposedly objective 'macro' level institutions and policies caused ripple effects across continents, cultures and class lines. In this perspective biomedicine is viewed as a socially constructed system, which is part of an economic world system that seeks to expand a capitalist hegemonic ideology to the detriment of local systems of belief ([Baer et al. 1986](#)).

This perspective advocates for research with a critical gaze, questioning the locus of power, the economic, social and ideological consequences of power relations and the identifi-

cation of contradictions and struggles within the system (Singer and Baer 1995; Baer et al. 2003). In this sense the theoretical model proposed by Singer and Baer (1986; 1995) proposes a systems approach to research design. This approach allows the researcher to tease out links and conflicts between structures of the system. Furthermore, it also proposes using a model of levels of health care and health care related behavior in order to better conceptualize the complex links between individual experiences and the structures of biomedicine, while also incorporating the larger social environment (Baer et al. 1986; Singer and Baer 1995).

In the anthropological research of reproduction this model has been fruitful in providing a systemic approach to understanding the effects of globalized health endeavors and policies on issues of fertility, reproductive choice (Ginsburg and Rapp 1995; Davis-Floyd and Sargent 1997; Lock and Kaufert 1998; Van Hollen 2003), and the societal impacts of new reproductive technologies (Inhorn and Birenbaum-Carmeli 2008).

A discussion of some of this literature is provided in a previous section (see subsection 2.1.4). It has also been expanded upon in the realm of health policy research (Castro and Singer 2004) and used in the analysis of the relationship between Anthropology and Global Health (Pfeiffer and Nichter 2008; Nichter 2008; Janes and Corbett 2009).

Similarly, the present study uses the structural divisions of the Peruvian government and the Ministry of Health to define multiple levels of inquiry and analysis with regards to the Intercultural Birth Policy and its impacts. This conceptual model allows identification of the links between the multiple layers of policy, from the birth care choices and experiences of women and their partners in remote Andean villages, to the supra governmental tasks of global health endeavors. As such it offers a complex understanding of the power relationships in which policy changes are negotiated from the Ministry offices in Lima, to the day-to-day obstetrical encounters in the Andes.

2.3 ANTHROPOLOGY OF POLICY

The anthropology of policy as proposed by Shore and Wright (1997) questions the dominant perception that processes of policy are objective, quasi-scientific endeavors. They propose that they are not only embedded in particular social and cultural worlds, but also that policies create and recreate those worlds (Shore et al. 2011). Thus a policy creates new social and semantic spaces, new sets of relations, new political subjects and new webs of meaning.

This view of policy allows researchers to conceptualize policy as a cultural creation. In this sense the analysis of policy discourse and process becomes a rich terrain in which to study and understand the governing culture and the response to it in various areas of the social world.

Understood from this perspective health policy, which is commonly presented as based on neutral empirical evidence, it is also a vehicle for a specific way of understanding health, healing and the governing of bodies (Manderson and Whiteford 2000). Furthermore, maternal health policy can then be viewed as an attempt to foster the reproduction of a specific kind of social body and social structure.

In this context the analysis of the intercultural birth care policy in Peru also provides a prism through which to identify contested areas in the relationship of the state and the Andean indigenous populations and the role of culture in enacting governance in Peru.

Other Peruvian policy endeavors have been the focus of previous research. Ewig (2010) analyses how in practice the neoliberal health reforms of the 1990's, which included gender equality as a goal, had a negative effect on women, on indigenous populations and the poor. Similarly Boesten (2010) focuses on the role of women's organizations after the neoliberal market reforms, providing a complex picture of how the intersections between race, gender and class produce differential outcomes for diverse constituents.

Both studies touch on important issues in health care delivery, but these are cast into the broad net of the market reforms of the 1990's. In the wake of these reforms policy discourse in health has expanded to include issues of human rights and cultural competency. Additionally the evolution of the decentralization process allows for a much closer relationship between

policy makers and subjects of policy. This has been touted as an advance in the realm of health care and education as it supposedly permits a socially, culturally and geographically tailored approach. The present study provides a more detailed understanding of the role of this renewed policy discourse on the current praxis and experience of maternal health policy in Peru.

2.4 THE CONCEPT OF *INTERCULTURALIDAD*

Interculturality or *interculturalidad*¹ is not a new concept in social theory or politics as in essence it pertains to how previously separated social and cultural groups interact when thrown together by force or fortune. From a historical perspective researchers situate the birth of modern preoccupations with multiculturalism in the mid XXth century, more specifically as a result of the post world war II reconstruction period (Dietz 2009; Mateos Cortés 2010). During this time much of the world was attempting to come to terms with ethnic reconfigurations, a product of the mass refugee migrations due to the war, and the independence struggles in several former European colonies. The emergence of large diverse groups of people in somewhat established societies prompted reflection on issues of assimilation, homogenization and respect for cultural difference. These form the basis of ideas, and later, policies regarding multiculturalism, specifically the idea of tolerance of diversity, which for some researchers constitutes the first instance of the development of the ideas of interculturality (Dietz 2001, 2005).

Researchers who view multiculturality and interculturality as points on the same arc of meaning, identify different continental and regional ‘accents’ (Dietz 2009; Mateos Cortés 2010; Antolínez Domínguez 2011) created by the specific actors who are involved in their use, their broad philosophical underpinnings, their particular political context and the nature of the claims they make.

Antolinez (2011) traces three broad schools of thought in relation to multiculturalism and interculturality: the North American, European and Latin American. According to this

¹I will use both terms as synonyms throughout the text.

author, the North American school has roots in the postwar European exodus; it was revitalized by the civil rights movements of the 1960's and finally crystallized in the affirmative action policies and recognition of the right to difference in the 70's and 80's. The European development of interculturality was likewise impacted by large immigrant populations and gathered strength in the language and educational policies of the 1980's. The Latin American developments came with the increasing recognition of the internal diversity, specifically a renewed interest in the indigenous populations and also first focused on education.

Mateos (2010) also recognizes that the North American construction of multiculturalism is related to that of interculturality in Europe and Latin America, but points out that in its development it has been embraced as a recognition of difference broadly understood as going beyond ethnicity to include gender, age, and sexual orientation. In contrast, the intercultural discourse in Europe and Latin America is undeniably related to ethnic difference. This may be due to the transnational migration of the 'web of meaning' of interculturality that flows from Europe to Latin America, and within the latter region, through the channels created by international cooperation agencies (Mateos Cortés 2010). However, once in Latin America, the concept becomes re-signified once more as a result of the different constituencies involved.

From a Latin American perspective the concept of *interculturalidad* can be seen as both a radical philosophical construct and as a more pragmatic political discourse. Nonetheless, in both cases, it is closely connected to the realm of governance and nation making. Several researchers in the region have sought to distance Latin American understandings of interculturality from liberal multiculturalism (Zuñiga and Ansión 1997; Degregori 1999; Tubino 2002, 2005; Walsh 2006; De la Cadena 2006). They posit that the North American ideas of multiculturalism, based on the principles of tolerance and political liberalism, are not applicable to Latin America (Degregori 1999; Tubino 2002). The authors counter that multiculturalism views minorities as defined groups which despite contextual inequities, can be aided through positive discrimination to achieve the level of development of the majority. They argue in turn that this view of reality obscures salient issues such as the history of colonization and exploitation, and the power inequities of the present.

Thus these authors propose that a true intercultural approach is the only one that makes sense in Latin America where being intercultural is already a part, although little recognized,

of the fabric of society. As Degregori puts it the ‘We’ in the majority *exists through and only because of the existence of the Other and by means of a mutual gaze* (Degregori 1999:2). Thus interculturality represents a path to the radical recognition of ourselves in the other, and as a way to subvert existing power structures. In this sense the authors argue that multiculturalism represents a first important recognition of difference but is not a sufficiently powerful concept to encompass the needed changes in Latin America.

Viewed from this perspective *interculturalidad* questions the post-colonial efforts of nation building in the region, specifically the tenet of a sole national identity, which led to a push for the homogenization of indigenous populations (Moya 2009). In Peru, and in other areas of the region, indigenous groups were seen as impeding the development of modern society. This was framed as the ‘problem of the indian’ which was to be overcome by creating citizens through teaching Spanish and overtly discriminating against all things indigenous.

Historically this has meant a persistent stigmatization of indian identity and the self-identification of indigenous peoples in economic terms as *campesinos* or farmers, something that has also been promoted by academic researchers and development agencies, sometimes purposefully (De la Cadena 2008; Moya 2009).

As such many see interculturality as the expression of a political shift necessary to produce nation states that include and recognize historically marginalized peoples while still maintaining diversity. Allowing society to address historically engendered inequalities in the power structure and to reestablish the post colonial social contract in new terms that would allow the full and equal practice of citizenship amid diversity (Hornberger 2000; Walsh 2002; Fuller 2002; Alarcon et al. 2003; O’Neill J., John and Bartlett, Judith and Mignone, Javier 2006; De la Cadena 2006; Ansión 2007).

However, this radical philosophical iteration of interculturality is only one of several managed in the region, other actors such as governments, multilateral governance bodies (e.g. IMF, OAS), some development agencies and non profit organizations, manage an applied concept which favors the notion of intercultural dialog and mutual accommodation of cultural preferences. This has been labeled as conservative (Viaña Uzieda et al. 2010) or cosmetic interculturality, which allows subjects of government the freedom to express their cultures insofar as they do not impinge on the hegemonic structures of power (Tubino 2005;

Walsh 2009). In this sense the incorporation of culture into policy can become a political device designed to pay lip service to the demands of indigenous movements but brings no radical transformation (Ruiz 2006).

Some researchers counter that this lack of a common definition renders the transformative potential of intercultural concepts in policy useless, as each constituency projects its own meanings and desires onto it (Walsh 2006). Mignolo (2005) for example, refers to the reluctance of states to recognize the existence of a different but equal logic which is required to establish a dialogue. Thus states promote a multicultural view in which the *hegemonic principles of knowledge, education, the concept of the state and government, political economy, morality, etc., are controlled by the state* (Mignolo 2005:117-118), while still calling it *interculturalidad*.

Furthermore, the concept of *interculturalidad* as accommodation, assumes the existence of those ‘with-culture’ who need to be catered to by those who are modern and without culture, thus making culture a barrier and further reducing intercultural changes to something needed only for ‘indians and migrants’ (Flores Martos 2011; Fernández Juárez 2011). As such it only serves to support and perpetuate the social system that others believe it could subvert.

Nevertheless, interculturality in all its diversity has become a central tenet of policy discourse at all levels in Latin America; it is part of the broad call for recognition of the basic Economic, Social and Cultural Rights (ESCR) promoted by the UN under the spectrum of human rights (Hopenhayn 2007), and it is also mentioned in Agreement 169 of the International Labor Organization as part of the rights of indigenous peoples (Stavenhagen 2003; Organización Internacional del Trabajo 1989). Both documents have been ratified by all Latin American countries. At the international policy level, at the UN related organizations and other international organizations, *interculturalidad* is part of the framework of all projects and policies related to the indigenous populations in the Latin America. Furthermore the right to cultural practice and promotion of *interculturalidad* has also been included in the constitutions of several countries in the region (Walsh 2002, 2009).

Intercultural discourse and policy interventions in Latin America began initially in the realm of education, with the development of diverse interventions in bilingual intercultural

education in the region in the late 1970's and into the 1990's (López and Küper 2000; López 2009). From the realm of education the focus on culture and the need for recognition of indigenous rights shifted to the realm of health care (Del Cid Lucero 2008). In this context *interculturalidad* has been perceived as a way to bridge the gaps and as a useful concept to induce change in the public health system, which would allow nations to overcome long-standing problems of discrimination against indigenous populations and their health related beliefs and practices (Albó 2004; Camacho et al. 2006). The following section briefly details the path that interculturality in health has taken in Latin America, and in Peru.

2.4.1 *Interculturalidad* in Health

The use of the idea of interculturality in health was proposed more than 50 years ago by Aguirre Beltrán, who published Programs of Intercultural Health in Mexico in 1955 (Campos Navarro 2010). However, its use was very restricted and as a whole focused basically on promoting the recognition of the usefulness of traditional herbs and the existence of traditional medical systems (Salaverry 2010; Campos Navarro 2010). It was reintroduced through international policy bodies and development cooperation agencies in the 1990's and became ubiquitous in all indigenous health related discourse, from indigenous groups to policymakers, in the 2000's (Fernandez Juarez 2010b).

The commemoration of the 500 years of the arrival of the Columbus expedition in the Americas signaled a symbolic moment of renewed interest in the plight of the indigenous populations in the region. The nascent use of the concept of *interculturalidad* in health policy recommendations at the international level can be traced back to the meetings that followed the commemoration. In 1993 representatives of indigenous groups met for the first time with representatives from development agencies, non-profit organisms and the Panamerican Health Organization (PAHO) to discuss the health problems of indigenous populations in the Americas in a UN sponsored workshop. The conclusions of this meeting note the perilous problems of poverty and the correlates of early deaths and ill health that plague native groups, their exclusion from the national health systems, and the discrimination against their belief systems that were all brought on through a long history of injustice due to

invasion and colonization. As such their recommendations for health policy called for a broad encompassing acknowledgement of intercultural factors in health, for example equality in access to health, respect for the indigenous world view of health, recognition of traditional healers and health systems, and more participation in the development of policies that affect native groups (PAHO 1993).

This workshop led to the creation of the Health Initiative for Indigenous Peoples (PAHO 1993), which outlined guidelines for the improvement of health indicators and access to health services. One of the first regional implementations of the initiative was undertaken with the Mapuche groups of Chile. The presentation of results and evaluation of this project cited the need for a national policy of intercultural health (PAHO et al. 1998) a term which appears throughout the document, although it received no clear definition.

At the first evaluation of the initiative, in late 1997 (PAHO 1998), the PAHO working group on indigenous health recognized that *interculturalidad* should be a central tenet of any intervention in the region. However, participants in the evaluation conceived ‘interculturality in health’ from different perspectives: as the acceptance of and respect for different cultures; as a dynamic process of mutual instruction, the implementation of which requires political will; or as the capacity to understand and respect different sociocultural contexts in order to provide holistic care to individuals and the community. Thus the inability of asserting a common definition meant that, although *interculturalidad* is mentioned in the official document, it was replaced by the term ‘cross-cultural’ (PAHO 1998) in the recommendations.

Nevertheless, later that same year PAHO proposed a framework for the incorporation of an intercultural perspective in the training of human resources for health care. In this document PAHO defined interculturality as:

interactive social process of recognition and respect for the differences within and between cultures in a given area, indispensable to building a just society within a political, economical, societal, cultural, linguistic, gender, and generational scope (PAHO 1998:vii).

Additionally the necessary conditions for the achievement of interculturality in health according to PAHO are: dialog based on mutual respect; tolerance for contradiction which leads to solidarity; cultural democracy; representation and participation in decision making and a consensus on common objectives. The practice of interculturality in health should

therefore defy asymmetric, discriminatory and excluding relationships; achieve equitable relationships between different peoples, cultures and ethnicities; revalue cultural difference to eliminate racism; and create new forms of shared power in which all actors participate in the social dynamic ([PAHO 1998](#)).

The incorporation of the ideas of interculturality in health at PAHO from 1998 onwards was generated by, and in turn spurred projects that used the concept in designing interventions as part of state-sponsored policies and non-profit development projects. These projects and policies engaged with an already standing claim from organizations representing indigenous groups whose influence and power were growing in the region ([Fernández Juárez 2011](#)). However the concept of 'interculturality in health' has inherited the same problems faced by *interculturalidad* more generally, a lack of common definition, which has multiplied with the range of actors, projects and proposals; it has been identified as solely of concern to the indigenous groups, perpetuating public health sector's static and homogeneous understanding of 'indigenous' and the evolutionary views of biomedicine as the gold standard ([Menéndez 2006](#); [Fernandez Juárez 2010b](#); [Fernández Juárez 2011](#)).

Nevertheless, PAHO's Indigenous Initiative has achieved top level policy commitments in the region. The Andean Commission for Health and the Andean Health Agency implemented the Andean Plan for Intercultural Health in 2008, with the support of the Spanish Development and Cooperation Agency (AECI) ([Lagos 2010](#)). This plan vowed to support national initiatives in intercultural health in member countries (Chile, Bolivia, Venezuela, Ecuador, Colombia and Peru) by: generating epidemiological data for health interventions on native populations, to developing and strengthening competencies in intercultural health care, promoting the incorporation of traditional medicine and cultural adaptation in the health services, formulating and developing intercultural health policies, and establishing an evaluation and monitoring plan ([Lagos 2010](#); [Organismo Andino de Salud-Comisión de Salud Intercultural 2008](#)).

Additionally, UNFPA implemented the Intercultural Sexual and Reproductive Health Initiative for Indigenous Women ([UNFPA 2005](#); [UNFPA and AECID 2008](#)), also with the support from AECI, in Bolivia, Ecuador, Guatemala and Peru. This initiative aims at fostering and incorporating maternal health care models that respond to the human rights

and interculturality frameworks in public policies in the selected countries. Results from interventions and policy advances of this initiative were presented in 2009 ([Fernandez Juarez 2010b](#)), and in 2011 health ministers from the selected countries affirmed their resolve to ensure and advance the intercultural adaptation of reproductive health services or indigenous populations in their territories ([UNFPA 2011](#)).

There has been a surge in publications related to interculturality in health since the beginning of the Indigenous Health Initiative. The diversity of the publications can be organized in three major interrelated groups ([Ramirez Hita 2010](#)): government generated documents, conceptual declarations and policies; reports from international development agencies and projects, some of which are co-sponsored by national governments ([Luca Citarella Menardi et al. 2010](#); [Bazán 2008](#); [UNFPA 2010](#); [Gabrysch et al. 2009](#)); and critical socio-anthropological research on topics of ethnomedicine, alternative medical systems and critical analysis ([Ramirez Hita 2010, 2009, 2006](#); [Knipper 2006, 2010](#); [Menéndez 2006](#); [Albó 2004](#); [Fernandez Juarez 2006](#); [Arnold et al. 2001](#); [Arnold and Yapita 2002](#); [Bradby and Murphy-Lawless 2002](#)). Additionally, there are various first forays into research generated by health providers enrolled in Master Degrees and Diplomas in interculturality in the region ([Proyecto Amares 2005](#)).

However, each of these groups manages its particular take on interculturality in health, with the public and development sectors favoring what they label as ‘applied notions’ which can be quite removed from the anthropological and academic meanings ([Ramirez Hita 2009](#)). These are generally unproblematic definitions that do not question the status quo of the biomedical hegemony in health care or the social and economic factors that led to current exclusion of indigenous peoples from full citizenship ([Flores Martos 2011](#)). As such, they tend to dismiss discussions surrounding the meaning, scope and applicability of interculturality in health as unnecessary and cumbersome for implementing care ([Salaverry 2010](#); [Nureña 2009](#)); thus reducing conceptual discussions to a general idea of accommodation of the health care services, the need to speak the language, or at the most radical a coexistence of medical traditions ([Flores Martos 2011](#)).

Furthermore, applied notions tend to aggregate diverse cultural practices of health care into a homogenized ‘traditional system’ which can be reduced to list of practices summarized,

defined and studied by the medical profession ([Ramirez Hita 2006](#)). In this sense, applied interculturality is more akin to a narrow conception of cultural competence, a temporary change in the form of health service care for minority groups, but with the expectation of future biomedical assimilation ([Fernandez Juarez 2010b](#)).

Amid the diversity of conceptions, Andean countries have implemented various types of intercultural provisions for health care services ([Del Cid Lucero 2008](#)), including adding practitioners of traditional medicine in the public health centers ([Baixeras Divar 2006](#); [Campos Navarro 2004](#); [Abad Gonzalez 2004](#); [Menardi 2010](#)), setting up intercultural models of primary care ([Tejerina Silva et al. 2009](#)), and incorporating it as a transverse policy in all health care policies ([Min. of Health Peru 2006b](#)).

Maternal health is the one area where most countries in the region are united in implementing interculturality, partly as a result of the UNFPA's intercultural reproductive health initiative ([UNFPA 2005](#)), and also as due to previous local processes ([Paz et al. 2010](#)). Some of the relevant policies and changes were already in effect before the UNFPA initiative officially began, which may account for differences in the extent of policy changes and the scope of implementation. Another key difference between proposed changes at the Latin American state levels is the existence, strength and national political representation of indigenous peoples. Earlier implementations of changes in birth care services in Peru and Chile were government-developed-and-designed, health-provider-centered, were limited to birth care and had limited participation of traditional health practitioners ([Alarcon et al. 2003](#); [Nureña 2009](#); [Salaverry 2010](#)). In contrast proposed changes in Bolivia and Ecuador, were backed by an established indigenous movement, and sought a broader change in the recognition and status of all practitioners of the traditional systems of care, thus providing a more established role for '*parteras*' in birth care ([Del Cid Lucero 2008](#)).

Despite the differences all intercultural maternal health policies share a general approach which includes the training of health care personnel; changing the environment for birth care; and modifying birth care protocols to allow indigenous women more freedom to move, have more company from family members and adopt their desired birthing positions ([Campos Navarro 2010](#); [Sáez Salgado 2010](#); [Tavera 2010](#); [Yaksic Prudencio 2010](#); [Paz et al. 2010](#); [Laspina 2010](#); [Hermida et al. 2010](#)). The results and continuity of the diverse intercultural

policy implementations in the region differ; for example, Chile's seems to be experiencing a resurgence after a lull in the process ([Sáez Salgado 2010](#)), while the intercultural birth centers of Bolivia have received criticism for the uneven quality of care ([Ramirez Hita 2010](#)). However, the overall consensus among government policy makers is that adapting birth care services is central to the reduction of maternal and infant mortality and to achieving desired MDG commitments ([Paz et al. 2010](#)).

2.4.2 *Interculturalidad* in Health in Peru

In Peru the notion of '*interculturalidad*' in health developed in the late 1990's influenced by the PAHO's Indigenous Peoples Initiative meetings in Chile and Washington DC ([PAHO et al. 1998](#); [PAHO 1998](#)). Although there was no official Peruvian participation in these meetings both documents circulated among government and non-profit policy persons through the peruvian PAHO office. At this time, however, *interculturalidad* was still on the fringes of health care policy ideas in Peru. It was seen as pertaining mostly to tribal Amazonian groups or related to traditional medical systems. As such *interculturalidad* became the area of expertise of the *Centro Nacional de Salud Intercultural* (National Centre for Intercultural Health, CENSI).

The CENSI, created in 2002, had previously been called the National Institute of Traditional Medicine (INMETRA) and was charged with research and regulation of traditional herbal medicine. In becoming CENSI it was also formally charged with the formulation and proposal of policies for intercultural health. In 2004 it also took on the National Sanitary Strategy for Indigenous Peoples' Health. However, its scope of influence within the MoH was limited. As part of the National Institute of Health (INS), a semi-independent research based organism, and housed in a distant INS location, its staff had little engagement with central MoH policy makers.

At the regional level the CENSI was able to elicit commitments in favor of improving health for indigenous peoples from certain regional governments. However, these apply only to the areas in which Amazonian tribes live in that particular region ([Min. of Health Peru 2008b](#)). In the year 2008 the CENSI formed the National Observatory of Interculturality

and Health Rights of Indigenous Peoples and Afroperuvians ([Instituto Nacional de Salud 2011](#)), expanding its efforts to include other cultural minorities by establishing focal points of observation in several areas of the country. The staff of the observatory compiles reports of violations and generates information about situations that may infringe the rights to health of all cultural minorities. However, the reduced number of available reports that actually concern problems with access to health care, question the efficacy of the observatory in promoting and safeguarding intercultural health. Furthermore, in spite of attempts to expand its reach CENSI's continued focus on the native Amazonian region effectively contributes to an overall equivalence of interculturality as special accommodations for 'exotic' others.

On the whole CENSI remained on the fringes of the development of intercultural policy in Peru. Despite the center's mandate it has not been credited with any official publication or document relating to interculturality in health except those directly related to the Sanitary Strategy under its care. The extensive incorporation of interculturality into official health policy came through a parallel process at the central ministry headquarters, through the areas of health promotion and reproductive health, which was aided by the pro-indigenous rhetoric of the early years of the Toledo government².

In 2003 the European Commission funded Amares Project, whose objective was to support the modernization of the health sector, published a report supporting the need for and viability of an intercultural approach in health care provision ([Camino Diez Canseco et al. 2003](#)). The document lists several points of disconnection between health care providers and community members and implies that the need for intercultural care begins with training health personnel. As a follow up to this report, Amares and the MoH implemented the first Diploma in Intercultural Health in the University of Huamanga, located in the Andean department of Ayacucho. This endeavor produced several brief research papers on interculturality in health and increased the visibility of the ideas of interculturality in health at the regional levels ([Proyecto Amares 2005, 2006](#)). At the central MoH interculturality remained on the agenda. In 2005 the Direction of Health Promotion was charged with implementing the mainstreaming of the Human Rights, Gender Equity and Interculturality frameworks

²Toledo, who governed from 2001-2006, ran on a platform of revaluing his and the country's indigenous heritage which permeated several of his government policies

across the MoH. In 2006 it created the Technical Unit of Human Rights, Gender Equity and Interculturality in Health which was charged with proposing the normative and conceptual foundation, technical support and supervision of the mainstreaming process to other MoH areas ([Min. of Health Peru 2006b](#)).

Its conceptual framework and normative documents, presented officially in 2006 ([Min. of Health Peru 2006a,b](#)), were reviewed and validated by a broad spectrum of actors that included MoH representatives from various areas (including CENSI), international cooperation organizations, universities, and other civil society organizations engaged in health policy projects. The documents define the concepts related to human rights, gender equity and interculturality in health, and the procedures for them to be included in the planning and execution of MoH policies. As such these constitute the official MoH definitions on the subject of interculturality in health.

The conceptual document ([Min. of Health Peru 2006a](#)) officially distinguishes between interculturality and multiculturalism. It poses that interculturality overcomes the shortcomings of multiculturalism in that it seeks to go beyond right to difference, to establish connections and resolve tensions among groups by actively pursuing a horizontal relationship of mutual respect, recognition and understanding ([Min. of Health Peru 2006a](#)). *Interculturalidad* is presented as a path to confront discriminatory visions and support the construction of an integrated and tolerant society :

Interculturalidad recognizes the right to being diverse, of the different rationalities and cultural perspectives of the different peoples, expressed in diverse forms of organization, relationships and world views. It implies recognition and appreciation of the other. It proposes the interrelationship, communication and permanent dialogue to foster conviviality between cultures, guaranteeing each one a space to develop autonomously and promote their integration into citizenship, in the broad framework of a pluricultural, multiethnic and multilingual society. ([Min. of Health Peru 2006b:27](#))

Following the path to creating this inclusive society the documents argue that 'interculturality in health' *implies the construction of participatory strategies to confront the health needs of the different cultures that live in the country* ([Min. of Health Peru 2006a:35](#)).

Thus the MoH recognizes the existence and validity of the practice of traditional medicine and the detrimental effects of the uneven relationship between the traditional and the official health systems on traditional practitioners and the people they serve.

Interculturalidad in health from the MoH perspective should address these problems by:

1. Promoting attitudes of respect of difference and diversity, and recognition and appreciation of traditional medicines among health providers of biomedicine in the health system;
2. Ensuring interactions between agents of different health systems to promote complementarity and mutual enrichment; and
3. Incorporating strategies for the identification of individual, collective social and cultural protective factors that may potentially contribute to increasing favorable conditions for health among the members of ethnic cultural communities.(Min. of Health Peru 2006b:p.25)

Finally, according to the same normative document the incorporation of interculturality in health and the *recognition of the difference and specific requirements of women and ethnic-cultural minority groups should not mean the creation of new inequities -through partial and stigmatizing policies- rather it should lead to a reduction of existing inequalities without eliminating or dismissing the differences* (Min. of Health Peru 2006b:p.25).

With these definitions at its core the MoH, through the Technical Unit, mandated the creation of administrative and organizational changes at the central and regional MoH facilities. These included creating a regional overseer of the mainstreaming effort; changing in hiring practices and generally the organizational culture to make it more equitable for women and cultural minorities; sensitizing higher level personnel on the importance of the new approaches; training health care personnel in interculturality; and promoting policies that incorporate or work towards the achievement of interculturality, gender equity and human rights in the health care system (Min. of Health Peru 2006b).

Overall the official discourse from the MoH regarding the inclusion of interculturality in health was comprehensive, identifying several of the organizational constraints to its implementation. However, on the operational side the normative document fails to identify clear avenues through which to establish the respectful horizontal relationship that it purports to seek through the mainstreaming of interculturality in health. In practice the changes in relation to interculturality were basically reduced to language requirements, sensitization and training, and little was promoted or achieved in the recognition of, or relationship with other medical traditions.

Furthermore, the Technical Unit itself struggled to maintain relevance. The main inter-

cultural policy promoted by the MoH, the Intercultural Birth Policy subject of this dissertation, was enacted by the Sexual and Reproductive Health Strategy (SRHS) a year before the Technical Unit was established. Changes in top level officials due to elections in 2006 also diluted the role of the Technical Unit within the MoH because the new government was not as interested in pursuing the interculturality agenda further.

Additionally some of the main actors involved in the development of the process towards interculturality in health did not agree with the MoH perspective. Medical doctors were particularly resistant to the intercultural discourse, which they perceived as unscientific and of limited use. As such some of them argued that it was unfair to ask health professionals to act in a way completely opposed to that in which they have been taught, highlighting the need for a deeper paradigm shift in the education of human resources for health ([Salaverry 2010](#)).

On the other hand, the government proposed processes were perceived as thoroughly one-sided since a broad indigenous claim for the implementation of culturally appropriate health care services was not apparent at the national level. It had been a small part of electoral discourse in the Andes regionally during the 2006 election but did not remain significant after the process. Generally there are few ethnically identified movements in the Andes, and few of these considered intercultural health as part of their agendas, focusing more specifically on environmental and economic issues. However, the claim for cultural appropriate care was present in the Amazonian areas, where the indigenous movement represented by the Interethnic Association for the Development of the Peruvian Jungle (AIDESEP) has included culturally appropriate services as part of their agenda for several years, though they lacked national recognition. Additionally given its area of influence AIDESEP mostly liaised with CENSI, and with the strategy for indigenous peoples, and struggled to make their petitions known outside of these organisms. Thus they also unwittingly supported the idea that cultural consideration in health were only sought by, and needed for Amazonian natives.

Despite a lull in official promotion of interculturality in health, the topic was kept at the forefront of policy making by proponents of interculturality in health, mostly from PAHO, UNFPA and non profit organizations funded by international cooperation agencies, who

were able to maintain and extend the visibility of intercultural health through partnerships with the Regional Health Directions. These endeavors mostly focused on maternal health (Gabrysch et al. 2009) and the training of existing and future health care workers in interculturality (Verástegui Sánchez and Fallaque Solí 2011; Cueva Maza and Roca Gonzles 2011; Rojas 2011; Frisancho et al. 2011).

At the official MoH level, the intercultural approach to health care remained central to the area of Sexual and Reproductive Health. In addition to the policy of Vertical Birth with Intercultural Adaptation (Min. of Health Peru 2005c), the SRH strategy produced a guide to cultural adaptation in counseling on sexual and reproductive health in primary care (Min. of Health Peru 2008a), and with the renewed support of UNFPA's reproductive health unit they also developed a conceptual document to guide the inclusion of the human rights, gender and interculturality frameworks in maternal and neonatal care (Min. of Health Peru 2010). Additionally, *interculturalidad* figures prominently in the current Maternal Mortality Reduction Plan (Min. of Health Peru 2009b).

A review of the relevant documents shows that the conception of interculturality in health at the SSRH has changed from a general idea of 'mutual accomodation'³ in the 2005 birth policy (Min. of Health Peru 2005c), to viewing it in the 2010 guide as a *process of mutual recognition and respect, which implies dialogue, exchange of opinions and knowledges without imposition or prejudice [which promotes] a respectful, plural and democratic conviviality which will lead to mutual enrichment*(Min. of Health Peru 2010:8). As such from 2009 onwards the SRH strategy has promoted a 'package' of changes to enhance gender equity and intercultural respect in sexual and reproductive health care services at the primary level. It includes :

1. Promoting and respecting human rights through training and educating health personnel and fostering operational research into the customs of the surrounding population
2. Intercultural adaptation of birth services through vertical birth;
3. Promoting participation of husbands and other family members in the birth care process;
4. Creating maternal waiting houses for women who live in remote location and high risk cases;

³See full definition in section 4.3

5. Improving counseling skills;
6. Improving the provision of information of treatment and personnel in charge to patients in their own language;
7. Improving confidentiality and privacy;
8. Improving and maintaining proper treatment or *buen trato*, avoiding long waits; limiting information, insults, and deceitful or coercive practices regarding the patients rights to government sponsored programs and avoiding undue charges to force women to give birth in health centers, among other markers of mistreatment; and
9. Promoting a regional contest of ‘Maternal and Neonatal Deaths Avoided’. ([Min. of Health Peru 2010](#))

Despite a comprehensive approach on paper the reality of implementation of the package differs widely, especially in light of the changes brought on by reform and decentralization efforts, and a persistent culture of discrimination and exclusion. Both issues are discussed in detail further in this text.

Internationally the efforts of the MoH and the SRH strategy in particular have been lauded as worthwhile and consistent. However, a UNFPA-sponsored report has also identified the main problem of the process, specifically that normative documents lack concrete steps to establish intercultural dialog and increase participation of indigenous members of society (beyond that of community health workers)([Family Care International 2010](#)). In this sense, despite sustained official interest in intercultural health and a robust production of normative and conceptual documents, the process of developing ‘interculturality in health’ in Peru is much less widespread and effective than in other Andean countries.

The recent⁴ change of central and regional governments have given the the intercultural framework a boost, extending it beyond the realms of education and health into broader measures of participation in decision making, through the establishment of the Viceministry of Interculturality and the recent establishment of a law mandating consultation with indigenous peoples prior to extraction activities in their land ([Congreso de la República Perú 2012](#)). However, it remains to be seen how this new institution may affect the process of ‘interculturalizing’ health and the overall health issues of poor and indigenous Andean and

⁴Elections for Regional Governments were held in 2010 and General Elections were held in 2011.

Amazonian populations. Furthermore the production of norms without actual monitoring and evaluation of changes, may also indicate a savvy political use of an internationally favored framework but a lack of concrete will to see through the changes it requires.

2.5 CONCLUSION

This chapter has presented a review of the broad scholarly production which this dissertation engages, specifically the anthropology of birth and reproduction, critical medical anthropology and the anthropology of policy. It also presented the concept of ‘Interculturalidad’ and its application in health in Latin American and Peru.

The anthropological study of birth and reproduction has expanded over the years from descriptive endeavors to complex multi-sited and multilevel studies in which politics, power and the role of gender are central to analysis. Rapid technological advances in the realm of reproduction have opened new complicated areas of inquiry, like the consequences of assisted reproductive technologies, alternative families, genetics, genomics, and the implications of power and poverty in the availability and use of reproductive technology. The ethnographic study of the birth process itself seems to have halted at an apparent conflict where traditional forms of birth care are set in sharp contrast to the biomedical model: one is labeled as desirable and culturally appropriate, and the other as homogenizing and unwanted.

This stark differentiation has led some to view non-western birth practices as akin to home birth in developed countries, lending them an aura of romanticism. This line of thinking fails to recognize that traditional birth practices have organically incorporated some of the tools and concepts of biomedical practice. In addition it fails to take into account that in many non-western settings lay midwives are disappearing and maternal mortality is still an important problem. Furthermore, this view sets the field of studies of reproduction in an apparent timelessness that fails to capture the dynamic changes of modern life for indigenous women and their active reinterpretation and management of multiple systems of birth care. In this sense it is important to transcend the traditional vs. biomedical dichotomy and look to more inclusive paradigms to birth care research.

The re-emergence of the concept of *interculturalidad* in Latin America, and its use as a basis for social policies provide a framework that can serve to reassess previous research on birth care services and preferences among cultural minorities. Additionally Latin American birth care policies can serve as a backdrop to evaluate the capacity of an intercultural view to bridge the biomedical-traditional divide. In this context further research is needed to understand what indigenous patients desire for birth care, what is the impact of these policies on maternal health problems in the region, what health care providers in rural areas think of these policies and their outcomes, and what effect these have on their attitudes and perceptions of indigenous peoples and culture. Furthermore, it is important to consider the broader political changes that have resulted from a surge of pride in pre-colonial heritage and identities in many indigenous areas and the differential impact these may have on health care professionals and the willingness to implement new policies. The present research proposes that an analysis of Peruvian birth care processes, viewed through the prisms of critical medical anthropology and anthropology of policy, will provide insights into the role of intercultural ideas in policy and how regional identity processes impact the way health care professionals relate to and enact the policy. Using a multilevel comparative methodology it also provides further understanding of the effects of the proposed changes for the health care providers and the women they serve, and a first evaluation of the policy implementation process and its effects for maternal health in Peru.

3.0 MATERNAL MORTALITY AND SAFE MOTHERHOOD

This chapter provides an overview of the international policy initiatives concerning maternal mortality. The first section presents an overview of the state of maternal health indicators worldwide. The second and third sections detail the evolution of the UN stance on maternal health and provide a general historical overview of the safe motherhood policies over the past 30 years. These policy pathways have been the guide for previous programs and projects in the Andes; as such they constitute an intervention history against which newer programs and projects are evaluated. Additionally they represent an evolving understanding of the role of lay practitioners in birth care.

3.1 MATERNAL MORTALITY: AN OVERVIEW

A maternal death is defined as the death of a woman as a result of the process of pregnancy, from the first stages of gestation or within 42 days of the termination of pregnancy, irrespective of duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management ([WHO 1992](#)).

Maternal deaths are divided into two groups for registration purposes: Direct obstetric deaths result from obstetric complications of the pregnancy, labor and puerperium, from interventions, omissions, incorrect treatment or a combination of the above, and Indirect obstetric deaths result from previously existing conditions that were aggravated by the physiological effects of pregnancy.

Approximately 70% of maternal deaths worldwide are caused by hemorrhage, eclampsia, obstructed labor, sepsis or unsafe abortion. Additionally, in areas where there is a high

prevalence of co-incidence of pregnancy with infectious diseases like HIV, tuberculosis or malaria, maternal deaths are increasing ([Donnay 2000](#); [WHO 2006](#); [Gil-Gonzalez et al. 2006](#); [Khan et al. 2006](#)).

Around 99% of maternal deaths occur in the developing world. In some impoverished areas a woman is 140 times more likely to die of preventable pregnancy-related causes than in a developed region ([Donnay 2000](#); [Harvey et al. 2004](#); [WHO 2006](#)). Worldwide the highest rates of maternal deaths are seen in Sub-Saharan Africa and south Asia. Sub-Saharan Africa shows an average rate of approximately 900 deaths per 100,000 live births. Individual country rates range from 75 deaths per 100,000 live births in Cape Verde to 1570 in the Central African Republic. In south Asia the highest rates occur in Afghanistan (1575 deaths per 100,000 live births). As a comparison, the rate in North America in 2008 was 17 deaths per 100,000 live births, and only four in Italy ([Hogan et al. 2010](#)).

In Latin America maternal mortality rates are highly variable, ranging from 21 deaths per 100,000 live births in Chile to 180 in Bolivia. Although the Andean region has consistently had higher maternal death rates than other regions in the continent, the overall trend seems to be a progressive reduction of maternal mortality ([Hill et al. 2007](#); [Hogan et al. 2010](#)). In the case of Peru, maternal mortality rates have decreased from 250 in 1990 to 98 per 100,000 live births in 2008, according to UN estimates ([WHO 2010](#)). However, national level estimates can mask broad internal differences between regions. In Peru, for example, maternal deaths occur in larger proportion in rural areas, in regions with a high percentage of indigenous population and among women with lower levels of income and education ([Min. of Health Peru 2009b](#); [Direccion General de Epidemiologia 2011](#); [Seinfeld 2011](#); [Del Carpio Ancaya 2011](#)).

In 2007 the country level maternal mortality rate was 173 deaths per 100,000 live births; however, the regional rates varied from 315 in the highland department of Puno to 71 in the Department of Lima ([INEI et al. 2009](#)).

The main problem with assessing maternal mortality indicators is the availability of data and problems with current forms of registration and measurement of maternal mortality in many developing countries ([Hill et al. 2007](#); [Shah and Say 2007](#); [Gil-Gonzalez et al. 2006](#); [Boerma et al. 2007](#); [Betran et al. 2005](#)). These shortcomings make overall evaluations of

the regional and global trends difficult and have subsequently become a major source of contention. Recent modeled estimates presented by Hogan et al. (2010), for example, present an optimistic picture of global indicators, a reduction of almost half the total number of deaths from 1980 to 2008, which contradicts earlier reports based on UN reporting data (Hill et al. 2007). Several researchers have criticized these findings due to the large uncertainty estimates which accompany the report and have cautioned against using this data to evaluate individual country progress (Graham et al. 2010; Meda et al. 2010).

Other critics assert that the high level of mathematical knowledge needed to fully comprehend the scope and limitations of the methodology used by Hogan et al. may lead to incorrect readings of the data and could confuse policy makers and which may result in reduction in funding and the political commitment needed to maintain gains in death reduction (Frisancho 2010; Melgar and Melgar 2010; Althabe et al. 2010).

The resulting confusion, generated by the debate about estimates and data, has been heralded as a call to action to develop more consistent estimates and collect more data among diverse development agencies (Horton 2010). This information is important as countries are voluntarily benchmarked on their progress towards the Millennium Development Goals (MDG's) by the UN. Countries that do not make progress towards these goals may face close scrutiny and possible censure of their policies and of their use of international aid forwarded for this purpose.

Nonetheless there seems to be some global consensus that poverty, lack of education for women and girls and HIV are important issues to consider in the reduction of maternal deaths (Shah and Say 2007; Freedman et al. 2007). Going beyond the numbers, it is important to consider that in all regions the overall burden of death and disability its impact into all aspects of the family's life. It may mean economic problems and stresses for the family and the remaining children in case of death. In the case of the so called near-misses, where maternal and fetal deaths have been avoided albeit with possible physical consequences, it may mean lifelong disabilities that can bring social and economic problems due to the increased need for specialized care and/or the inability of the affected women to participate in economic activities of the household (Filippi et al. 2006; Ronsmans and Graham 2006).

The global effort to reduce maternal mortality has been translated into supra national

recommendations and policy guidelines. The most important and broadest reaching are the Safe Motherhood Initiative and the related UN development conferences. The following section describes these endeavors and the relationship of the maternal mortality reduction effort to the Millennium Development Goals.

3.2 U.N. CONFERENCES AND MATERNAL HEALTH POLICY

The United Nations is the most important international policy body for topics related to international development. As such it has set the agenda for global policies related to many problematic health issues like malnutrition and maternal mortality. Its several organisms host recurring conferences on selected issues. At these meetings researchers, policy makers, and others present and discuss recent findings and agree on a set of common goals that aim to be incorporated into national policies. In the related areas of maternal mortality, fertility and maternal health it has convened eight such conferences over 30 years.

The first international United Nations led conference that directly tackled the issue of maternal mortality was the International Safe Motherhood Conference held in Nairobi in 1987 (WHO 1999; Rasch 2007). The agreements reached at this conference called for a 50% reduction in levels of maternal mortality by the year 2000. Additionally it led to the establishment of the Inter Agency Group (IAG) on Safe Motherhood, and the Safe Motherhood Initiative (Thompson 2005; AbouZahr 2003b). The IAG was formed by the World Health Organization (WHO), the World Bank, the United Nations Population Fund (UNFPA), United Nations Development Program (UNDP), United Nations Children’s Fund (UNICEF), the International Planned Parenthood Federation (IPPF) and Population Council.

Some years later, in 1994 at the International Conference on Population and Development (ICPD), this goal was reiterated and another target of a further 50% reduction by 2015 was added. The International Conference on Population and Development (Cairo, 1994), the Fourth World Conference on Women (Beijing, 1995) and the Safe Motherhood Technical Consultation (Colombo, 1997) have all helped to focus the attention of the international community on the need for accelerated action to achieve the goal of reducing maternal

mortality by half.

The Colombo 1997 meeting marked ten years of the initiative and was also the culmination of an intense program by the relevant agencies to bring renewed focus on the issue. It revitalized efforts in engaging policy makers to commit to reduction of maternal mortality by placing it in the context of human rights, urging governments to use their political, legal, and health systems to fulfill the obligations imposed by their endorsement of various international human rights instruments ([AbouZahr 2003b](#)). Experts from WHO, UNFPA, UNICEF, the World Bank, the Population Council, the International Planned Parenthood Federation, and other agencies concerned with safe motherhood reviewed progress and concluded that it is possible to reduce maternal mortality significantly with effective program and policy interventions.

However, it also recognized the scant progress made over the last decade and the need to continued advocacy for the reduction of maternal mortality at the highest levels of policy making. The previous United Nations sponsored conferences led to the adoption and signature of policy binding documents by representatives of developing countries worldwide. However, both in Cairo and Beijing the problems of maternal mortality had been lost among the issues of reproductive health. At the same time other UN conferences which analyzed the plight of women, other health issues and general issues of poverty and development also their own had specific agreements and goals. Leading to a multiplication of efforts and funding.

In the year 2000 the United Nations convened a new meeting in which to analyze the progress on several issues related to promoting international development. The declaration produced by the end of this meeting described in eight chapters the consensus opinion of the basic targets that should be attained to ensure equality and development around the world. The MDGs are a response to the overlapping targets of many of the previous agreements and also to the lack of accountability in the achievement of the policy targets. In this sense they have set specific indicators that are tracked on a country basis to measure the progress made in achieving eight broad encompassing goals:

1. Eradicate extreme poverty and hunger;
2. Achieve universal primary education;
3. Promote gender equality and empower women;

4. Reduce child mortality;
5. Improve maternal health;
6. Combat HIV/AIDS, Malaria and other diseases;
7. Ensure environmental sustainability; and
8. Develop a global partnership for development.

Within this new policy framework maternal health features once again as one of the main global health challenges. The reduction of maternal mortality ratio by three quarters by 2015 is one of the sub goals of MDG 5, and its measurable indicators are national maternal mortality ratios (MMR) and the proportion of births under the care of skilled birth attendants.

Achieving a reduction in maternal mortality and the other indicators of the MDGs is in large part a moral commitment on the part of developing countries. Although there is a clear goal and deadline there are no sanctions if a goal is not reached. However, countries whose legislature has ratified the Final Document of the Millennium Conference have made a declaration that they consider the goals morally just, and legally made a commitment to their own constituents that national policies will work towards achieving those goals. In this sense the drive to reach these goals is as much a matter of national pride as it is a need to respond to internal demands.

The intercultural birth care policy, which is the central focus of this study, is part of the various policies enacted by the Peruvian Government to reach Goal 5 of the millennium agreement. However, it is also a continuation of a much longer process of attempting to reduce maternal mortality. The following section provides a brief review of the interventions undertaken globally under the Safe Motherhood initiative over the past three decades.

3.3 THE SAFE MOTHERHOOD INTERVENTIONS

The issue of safe motherhood in less developed nations has been a focus of several international policy bodies since the establishment of the IAG on Safe Motherhood, which was

formed in 1987 with the participation of WHO, the World Bank, UNFPA, UNDP, UNICEF, IPPF and Population Council.

The special interest of these international agencies in the issue of safe motherhood demonstrates the important influence of demography, family planning, community development and access to health care on maternal outcomes. Thus in the 80's and 90's much of the initial research and interventions focused on these issues, especially the introduction of modern family planning methods (e.g. the pill, condom, and IUD) in underdeveloped countries.

This specific convergence of agencies also explains the surge of the mother-child dyad as the target of interventions. In many cases the construction of mother and child as one led to seeing the improvement of women's health not valuable in and of itself but only as a way to improve the child's health ([AbouZahr 2003b](#)). However, a change in perspective and focus from Maternal and Child Health to Reproductive Health resulted from the international conferences of the mid 1990's, the ICPD Cairo in 1994, the Fourth World Conference for Women (FWCW) in Beijing in 1995, and the Social Summit in Copenhagen in 1995. Within this renewed context safe motherhood is seen as a basic human right and the focus of research and interventions were centered on the social, cultural and gender-based determinants of health and development ([AbouZahr 2003a](#)). This focus on the broader framework that affects woman's health allows policy makers to rethink maternal health within a social-ecological model from a public health perspective and also helps to identify new areas for possible interventions.

In the 20 years since the beginning of the Safe Motherhood Initiative there has been a significant reduction of maternal deaths worldwide ([Donnay 2000](#); [Shah and Say 2007](#)). This has been achieved by multiple-level strategies that have evolved over time in accordance with the changing nature of the problem and the specific needs of different developing countries.

Several studies ([AbouZahr 2003b](#); [Thompson 2005](#); [Freedman et al. 2007](#)) agree that the most success in reducing maternal mortality is attained when interventions are combined to create a synergistic effect. They assert that interventions on the policy, community and organizational levels that go further than just health care provision have been shown to be effective. Some of the interventions they advocate are universal education, universal access to basic health services and nutrition before, during and after childbirth, access to

affordable family planning services, attendance at birth by skilled professionals, access to quality obstetrical emergency care, and policies and projects that raise women's social and economic status thus empowering them. Another issue under consideration is the toll of unsafe abortion and therefore, the provision of safe abortion services to these populations as a way to curb maternal mortality ([Chowdhury et al. 2007](#)). However, due to the fraught political nature of this topic in various countries it is seldom at the forefront of policy suggestions.

The following sections summarize some of the safe motherhood based policies and programs which have been organized loosely by intervention level. This will provide a broader view of the types of interventions generated by the initiative which serve as background for the establishment of the Peruvian intercultural birth care policy.

3.3.1 Community Level Interventions

The community level was the initial focus of the safe motherhood campaigns, and at this level there are many examples of interventions. Several of them have dealt with the Traditional Birth Attendant (TBA).

In the late 1980's and early 1990's training for TBAs was the most prevalent form of intervention in the search for safe motherhood. This occurred largely because the health infrastructure in many developing countries did not provide access to most of the population. In this context the TBA became the first line of defense against maternal mortality. These early interventions, designed to improve management of labor and delivery, were based on the belief that providing training on hygienic delivery and life-saving techniques to TBA already attending births in underserved areas would provide the most far-reaching and cost-effective strategy for increasing maternal survival ([Ray and Salihu 2004](#)). The underlying assumption was that given the knowledge, skill set and tools of biomedicine in conjunction with their own personal experience TBAs could safely perform normal, low-risk deliveries in the woman's home or in a community setting and identify high risk pregnancies to be referred to health centers ([Bergström and Goodburn 2001](#)).

These interventions were received with varying degrees of adaptation to the diverse geo-

graphical and cultural areas in which they were implemented. As a general rule they mostly involved the training of birth attendants with the support of health care service staff and the provision of clean birth kits and other materials to newly certified TBAs. This pattern of incorporation of TBAs into the area of influence and collaboration of government health care services was initially deemed successful as they aided in the reduction of neonatal death due to sepsis. Nevertheless, they were difficult to follow up and maintain, and in the long run maternal mortality outcomes did not seem to improve significantly ([Ray and Salihu 2004](#)). In the mid 1990's several studies started to question the effect of these interventions on maternal mortality and morbidity and also raised concerns on the problems of uneven training and lack of use of biomedical knowledge and skills ([Fleming 1994](#); [Rozario 1995](#)).

Other interventions at the community level later focused on maintaining the continuum of care for pregnancy, delivery and postpartum including the household as part of that continuum. Portela and Santarelli ([2003](#)) base their approach on a social interactionist theory, which:

[E]mphasizes that the central element in intellectual and psychological development and the learning process is the 'zone of proximal development'. This zone is defined as the distance between the level of current development and the more advanced level of potential development that comes into existence in interactions between more and less capable participants. ([Portela and Santarelli 2003:67](#))

Thus a key principle for the design of health education processes lies in the effective use of the zone of proximal development, and the identification of existing knowledge and capacities. It recognizes that cognitive development is more efficient in a situation of social interaction. Thus it seeks to distance itself from the perception that development problems and poor health care choices are based on lack of knowledge and rather seeks to engage individuals and communities in meaningful horizontal interactions where local knowledge and medical knowledge can be shared on the same value terms. The idea is that this form of interaction will result in a negotiated course of action that will empower the individual and the community and allow ownership of medical knowledge that will lead to behavior change.

Portela and Santarelli (2003) identify four priority areas for intervention strategies based on this theoretical approach:

1. Developing capacities of women, families and communities to stay healthy, make healthy

- decisions and respond to obstetric and neonatal emergencies;
2. Increasing awareness of women, families and communities about their sexual and reproductive rights, and of the needs and potential problems related to maternal and newborn health;
 3. Strengthening linkages for social support between women, men, families and communities and with the health care delivery system; and
 4. Improving quality of care, health services and health provider interactions with women, men, families and communities.

This approach to health education seems promising and can allow the health care provider or educator to engage with the community in more constructive ways than the vertical paradigm of expert versus lay person.

3.3.2 Interventions in Policy and Planning

At the general policy and planning level there are three large partnership based initiatives that designed policy level planning and intervention strategies at the multinational level.

The first is the Skilled Attendance for Everyone (SAFE) toolkit, which was developed by the Dugal Baird Centre for Research on Women's Health at the University of Aberdeen through an operational research endeavor as part of international collaborative inter-agency and multidisciplinary network in five collaborating countries: Bangladesh, Ghana, Jamaica, Malawi, and Mexico ([Bell et al. 2003](#)).

This group has created a strategy and intervention development tool geared towards program managers and high to mid level policy makers. It consists of a series of modules that aid in the identification of problems and the formulation of tailored strategic responses. The toolkit was tested in the five collaborating countries at the regional and district levels. According to Bell et al. (2003) the methods employed were to be a feasible in diverse cultural and organizational settings and produced evidence that they will be useful in the formulation of strategies.

The second partnership-based initiative is the initiative from the International Federation of Obstetricians and Gynecologists (FIGO) which in 1997 started a plan through its

affiliated societies to help change the ability of women in developing countries to obtain skilled attendance at birth. FIGO intervened in five areas with high maternal mortality: Central America (Guatemala, Honduras, Nicaragua and El Salvador), Ethiopia, Mozambique, Pakistan, and Uganda. They based their interventions on achieving four key goals for the reduction of maternal mortality: skilled attendance for all women during pregnancy and delivery, availability of emergency obstetric care services, existence at the regional level of comprehensive obstetric services and an ability to rapidly transport any woman in need ([Benagiano and Thomas 2003](#)).

Each partner country underwent a needs assessment analysis, and customized projects were developed to address the areas in which there were deficiencies. There was care in ensuring that all interventions and activities were low cost, replicable and sustainable without international help. In some cases this meant the incorporation of local traditional specialists, in others the focus was on improving skills of the medical crews. The results seem to have been largely positive when coupled with increased investment in health systems and an efficient referral system.

Much in the same arena the Averting Maternal death and Disability (AMDD) initiative developed at the Mailman School of Public Health, Columbia University also developed a framework to understand some of the social and organizational causes of maternal deaths and identify tailored strategies to address them. This program is a global endeavor of research advocacy and policy analysis mainly focused on tackling the issue of obstetrical emergencies through policy interventions at regional and district level and interventions in the health care setting. The basis of their interventions is the Three Delay Model, which identifies the three main causes for delay in seeking health care attention for an obstetrical emergency ([Thaddeus and Maine 1994](#); [Stekelenburg et al. 2004](#)):

1. Delay in the decision to seek care, which could be due to an inability to recognize complications, a fatalistic acceptance of maternal death, or other socio-cultural barriers;
2. Delay in reaching appropriate medical care, due to for example poor or absent roads, rugged terrain, lack of a transportation system; and
3. Delay in obtaining effective medical care, which could be due to user fees, or poorly staffed and ill-equipped institutions with poorly skilled personnel.

The AMDD group has partnered with several funding and research agencies and international NGOs and through them has been implementing interventions in around 50 countries. One of the partner organizations in this endeavor has been CARE, and through it this program was implemented in the Peruvian region of Ayacucho ([Kayongo et al. 2006](#)). In this area the project targeted five health care facilities and provided a package of interventions designed to improve capacity of services to provide quality Emergency Obstetrical Care (EmOC) services and to promote a human rights approach. The activities included improvements in infrastructure, skill training for human resources through rotating internships, and the development of technical protocols, standards, and activities to promote quality of care. The intervention in Ayacucho engaged regional health officials, practicing doctors, midwives and nurses, as well as communal participation; it created six functioning EmOC care facilities that were able to provide 24/7 care and increase the met need for EmOC from 30% to 85% at the end of the intervention.

All three of these multinational initiatives can and have been used in conjunction as some are more useful for addressing broader policy level issues and others for facility level interventions.

Another multiple level approach has been proposed by Lewis ([2003](#)). It is called Beyond the Numbers, and its main objective is to produce reliable and useful information that can serve as a complement to the existing data which focuses on achieving rates represented only by numbers. Lewis argues that his approach will enable policy makers to better understand the scope of the problem of maternal mortality and to take specific corrective actions in their programs. This approach can be used at different levels from the national level to the local and in health services and small communities.

At the community level maternal death reviews (MDR), also called verbal autopsies, serve as a method of finding out the medical causes of death and determining the personal, family or community factors that may have contributed to the deaths in women who died outside of a medical facility

At the health care facility level, the MDR are a qualitative, in-depth investigation of the causes of and circumstances surrounding maternal deaths that occur there. These may be expanded to identify the combination of factors at the facility and in the community

that contributed to the death, to be able to evaluate which deaths were avoidable. At a local or regional level maternal death reviews are called confidential inquiries into maternal deaths, and should be a systematic multi-disciplinary anonymous investigation of all or a representative sample of maternal deaths occurring at an area, regional or national level. They can identify the numbers, causes and avoidable or remediable factors associated with them.

Additionally, the Beyond the Numbers initiative also proposes a review of the morbidity caused by near death situations which may result in ongoing obstetrical or other impairments. This type of review can be developed at any of the above mentioned levels.

Both the morbidity review and the death review can be seen as part of a quality improvement process that seeks to improve patient care and outcomes through a systematic examination of specific cases.

Overall the initial Safe Motherhood interventions focused in the community and in later iterations in promoting changes at the level of policy. The multilevel interventions are not frequent due to their need for large scale commitment and funding, and also because in many cases they require major changes in the organizational culture at all levels of health care delivery. The most widespread of these types of interventions to date has been the work with traditional birth attendants and lay community women. As such the change in policy model at the UN agencies and the Safe Motherhood Initiative, which veered away from this initial model signaled a major change in the way policy and funding priorities would be considered and also brought repercussions at the community level. The following section details this change and reviews implications for birth care.

3.3.3 The Change to Skilled Birth Attendant (SBA) Model of Care

Traditional birth attendants (TBA) held a privileged place in early interventions to promote safe motherhood, which were geared towards providing TBAs with knowledge about hygiene, basic medical concepts and clean birth kits. The underlying assumption was that given the knowledge, skill set and tools, TBAs could safely perform normal low risk deliveries in the woman's home or in a community setting and identify high risk pregnancies. Some gains such

as the reduction of neonatal death due to sepsis were attributed to the TBA interventions but overall maternal mortality outcomes did not seem to improve ([Ray and Salihu 2004](#)).

In the mid 1990's, more than 10 years after the initial work with TBAs started, several studies started to question the effect of the interventions on maternal mortality and morbidity, specifically referring to issues of uneven training and the problems of different social status as barriers to their expected effects ([Fleming 1994](#); [Rozario 1995](#)).

Although training and inclusion of TBAs were still seen as important for the Safe Motherhood Initiative ([Koblinsky et al. 1994](#)) there was considerable discussion as to their merits. Those in favor of maintaining the TBAs within the scope of the health system argued that national and international policy bodies were not really focusing on women's health with some of the earlier interventions but rather were more interested in the child's health, thus the emphasis on hygiene, and asepsia in handling and cutting the umbilical cord ([AbouZahr 2003b](#)). Furthermore, they pointed out that TBAs could not be expected to affect any type of behavior or attitudinal change in the community when there was no health care infrastructure to support that change. Additionally, studies ([Kebe 1994](#); [Chowdhury 1998](#)) demonstrated that TBAs could be extremely efficient when coupled with consistent prenatal and postnatal care in health care services.

However there were many opposing this view. De Brouwere et al. ([1998](#)) pointed out that TBA training was not significantly associated with a reduction in maternal mortality, a claim that has been corroborated by other studies ([Sibley et al. 2007](#)) Furthermore they observe that several elements of TBA training had been underestimated: the variability in knowledge and training, the need for constant and costly supervision, lack of consensus about what TBAs should be taught, and finally that trying to mold them into the image of a health care provider may destabilize the TBA and detach her from [her] traditional body of knowledge ([De Brouwere et al. 1998:778](#)). Consequently they stated that TBA training is by definition uneven and thus effects are also ambiguous.

A similar perspective is put forth by Maclean ([2003](#)), who analyzes the role of the TBA identifying the needs in a birth attendant and agrees with De Brouwere et al. ([1998](#)), that both for education and environment for birth, investing in a nurse midwife makes more sense than training a lay person.

However, Maclean also considers that TBAs can still have a positive role in the overall result of maternal health policy when they are part of an effective system.

As a result of these and later studies that support the importance of a skilled birth attendant at the time of birth, there was a palpable policy shift, which declared that a TBA is never an acceptable substitute for a Skilled Birth Attendant ([Cook 2002](#); [De Bernis et al. 2003](#)), especially in crisis situations when equipment and biomedical knowledge are paramount. As such the focus changed to defining and training SBAs in health care services.

The WHO defines an SBA as someone trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer obstetric complications ([Harvey et al. 2004](#)).

An SBA should be able to perform the following functions ([Carlough and McCall 2005](#)):

1. Safely conduct a normal delivery using aseptic technique;
2. Active management of the third stage of labor;
3. Provide immediate care of the newborn, including resuscitation;
4. Manage most postpartum hemorrhage through use of parenteral oxytocics and abdominal massage;
5. Manually remove the placenta;
6. Manage eclampsia through provision of parenteral anti hypertensives;
7. Recognize and manage postpartum infection through use of parenteral antibiotics;
8. Perform assisted vaginal delivery through the use of a vacuum extractor;
9. Manage incomplete abortions with manual vacuum aspiration (MVA); and
10. Know how to refer women to the next level of care and stabilize them for their journey.

However, some studies question the level of skills that mid-level professionals have in different settings and the lack of homogeneity in training across the large urban areas and rural areas, and also between different generations of health care providers. Harvey ([2004](#)) evaluated a sample of health care providers in four international settings, Ecuador, Jamaica, Benin and Rwanda, to gauge their level of knowledge and practical skills related to pregnancy and delivery. They concluded that if their data accurately reflected the reality of provider

competence there would be cause for concern, because their results show a wide gap between evidence based standards and current levels of knowledge and skill.

A similar study in Bangladesh ([Bhuiyan et al. 2005](#)) reported similar results prompting the researchers to assert that it is not only important to improve SBA competence to manage and resolve obstetrical emergencies but it is also important to improve the image and acceptance of SBAs in the community.

Furthermore, the presence of a skilled SBA is not enough to tackle the issue of maternal mortality and disability. These professionals, even the most skilled ones, also have structural and economic limitations to the interventions they can provide and unless they are also part of an efficient referral system the presence of an SBA alone cannot ensure a woman's survival in the event of an obstetrical emergency.

In addition, although TBAs have been displaced from the locus of policy some studies have suggested it may be counterproductive to leave them outside the health service structure, especially in those areas where access to health services is limited and where they are more likely to have an important social and cultural role ([Kruske and Barclay 2004](#)). In some traditional and rural areas there are still many barriers to the reassignment of delivery care to a SBAs ([Cotter et al. 2006](#)), and TBAs can still be a cost effective way to curb maternal mortality ([Sibley et al. 2004](#); [Sibley and Sipe 2006](#)).

There is some evidence that links trained TBAs with a decrease in newborn deaths when combined with access to health services ([Sibley et al. 2007](#)). Therefore there may be some support for the involvement of TBAs in achieving optimal maternal and child outcomes, and for maintaining and strengthening the link between the TBAs and the health care services. Furthermore in some areas TBAs still hold special places in the community and are the de-facto primary provider for pregnancy related ailments; alienating them from collaboration with public health services would be counterproductive to the overall cause of safe motherhood.

Paradoxically the diminishing role of traditional birth attendants in global Safe Motherhood interventions coincides with the increase in mainstreaming home birth options and of the ideals of a return to 'the natural birth' for some women in more developed nations. Thus it could be argued that while birth care options for the developing world were being

reduced through global policy, in the developed areas the array of choices is growing.

The shift to an SBA model also coincides with increasing interest in the role of cultural preferences in birth care choice at biomedical institutions, and could yet still lead to better birthing options. The following section presents a summary of the evolving relationship of biomedicine and cultural preference in birth care.

3.4 CULTURE IN BIRTH CARE

For more than three decades national governments and international cooperation agencies have collaborated to promote access to adequate health care services around the world. In the latter part of the 20th century the proposed solutions were the modernization of health care systems and the expansion of biomedical services. However, these were not as successful as expected in bridging the access gap and curbing the problems of maternal and infant mortality. In many countries the initial response of the biomedical community was to consider traditional practices of health and birth care as the main barrier. In this sense many early interventions sought to change cultural beliefs that were seen as impeding the advance of modernization through education and training campaigns ([Shaw 2005](#)).

The underlying assumption for these Information, Education and Change (IEC) programs was that cultural preference stems from a basic lack of awareness of options, and inaccurate perceptions of bodily functions and risk. As such the expectation was that the communication of this information would induce a rational change of behavior. This endeavor also highlighted the importance of understanding beliefs and behaviors to allow effective tailoring of communication messages. To this end a vast amount of Knowledge Attitudes and Practice (KAP) studies also accompanied IEC. In the realm of birth care KAPs were widespread and IEC mostly focused on communicating with the TBAs. Thus TBA training modules of the early years were geared towards explaining biomedical views of the birth process and the related risks ([Jordan and Davis-Floyd 1994](#); [Davidson 1983a](#); [Griffiths et al. 1991](#)). It was expected that once presented with ‘correct’ knowledge TBAs would change their attitudes towards birth care, identify biomedical risks with greater ease, recommend

biomedical care to some women and in doing so produce broader behavior change.

However, the continued failure of these strategies to change behaviors, even in the event that biomedical knowledge had been communicated effectively, and the meager reductions in maternal deaths led some to change the way culture was seen from the perspective of health care, from problem to solution ([Santiago-Irizarry 1996](#)). As a result, in the late 1990's there was a surge in cultural sensitivity, and cultural competence training for health care and other service providers in many developed countries. This was especially true for those that were receiving large numbers of refugee or immigrant populations like the US, Sweden, Norway and Canada.

Cross cultural training for birth care providers catering to non-native populations in these countries faced problems in the multiplicity of beliefs and preferences for birth care among the diverse immigrant and refugee groups. In this sense, rather than train personnel to become experts on one culture they promoted awareness and respect for the patient, and focused on six areas interest: communication, social organization, space and touch, concept and management of time, control of environment and biological variation ([Ottani 2002](#)). One approach, for example, suggests that health provider could use the acronym COST, which stands for Communication, Organization, Space and Time, to quickly remember to be aware of cultural differences in these areas, allowing them to effectively tailor communication messages to women and families, to remember that different concepts of family may mean that many people accompany the birthing woman, to take into account that time may be conceptualized in different ways, and to be mindful of differing concepts of personal space and gender among their patients.

However, even the advent of greatly improved cultural awareness and provision of cross cultural training was not necessarily a guarantee of improved experiences for birthing women. The case of Somali refugees in several developed countries is particularly enlightening in this sense. There has been a lot written on the problems of Somali women in western biomedical settings. This literature focuses almost exclusively on childbirth because Somali women practice the most extensive form of genital cutting called infibulation, a procedure which covers the opening of the vagina with scar tissue leaving only a small opening for the passing of menses, and that creates special circumstances for vaginal childbirth, such as the need for

surgical defibulation and an increase in pain during labor (McCleary 1994).

Clinical studies (Johnson et al. 2005; Vangen et al. 2002) have suggested that women of Somali origin are more likely to suffer from premature labor, failed induction, fetal distress and need for an emergency cesarean section. In light of this information Scandinavian countries adopted a proactive policy of training health care personnel for the particular problematic of infibulated women, providing cultural sensitivity training and modifying some aspects of birth care protocol. However, this approach presented some unforeseen problems. Johansen's (2006) study on birth care for infibulated women in Norway suggests that the problems go beyond mere cultural misunderstandings and provides a complex panorama in which lack of technical know how, increased cultural sensitivity and diverse interpretations of gender, nature, health and gender equity interact and result in inadequate care.

Johansen posits that the Norwegian birth philosophy that champions 'natural childbirth' does not provide an adequate framework for health care professionals to treat women whom they consider more natural because they come from less developed areas, but who in reality are less natural because of infibulation.

A key finding of her analysis is that many times well-meaning culturally sensitive health professionals over-culturize their patients, assuming for example that infibulation was done against the woman's will, that she is in a position of extreme subordination, and that she would rather not break the infibulation seal because of fear of family repercussions. Johansen points out that in many cases this leads to a staunch silence by health care professionals on the subject of infibulation; thus they do not learn from the women themselves the expected way to give birth under this circumstance. This may lead in turn to reticence to open the seal surgically, prolonged labor, increased pain during childbirth, fetal distress and unwanted cesarean sections. She argues that essentialization of Somali women has led progressive minded, culturally aware personnel to distance themselves from the birthing mother, not considering her as a right-bearing individual, and thus providing a substandard quality of care.

In a similar manner Bradby (1999) demonstrates that essentialization and preconceived ideas of health care personnel about birthing women in Bolivia lead to problems in health care and relationships with the community. She argues that health care policy and health

care providers view women as either modern or indigenous, and as passive receptors of care. In this sense they fail to acknowledge that in their daily lives many migrant women use their cultural knowledge to negotiate traditional and modern systems of birth care and are proficient in the use of overt and covert strategies in their relationship with the official health care system. She downplays the idea of women as victims and shows them as agents who develop passive and active cultural strategies that enable them to obtain what they want from the hospital birth experience.

The recent growth in political and government participation of indigenous majorities has brought a renewed focus on the importance of cultural preferences in health. In turn policies have attempted to move beyond essentialization to a new view of mutual collaboration and interculturality (see [2.4](#)). Several countries in Latin America have incorporated traditional birth care practices into their health care systems. Chile, Peru, Ecuador and Bolivia have enacted intercultural policies for birth.

In Chile these have focused specifically on the Mapuche population and have involved creating culture specific services that, although important, some also view as somewhat essentializing and indicative of the diminished status of the Mapuches in contemporary Chilean society ([Alarcón et al. 2004](#)).

On the other side of the spectrum, initiatives in Ecuador and Bolivia build on the strength of indigenous movements and many years of projects conducted by international aid and development organizations in alliance with indigenous organizations, traditional healers and others in maternal health ([Fernandez Juarez 2004, 2006, 2010a](#); [Arnold et al. 2001](#); [Arnold and Yapita 2002](#); [Bradby and Murphy-Lawless 2002](#)). Although these attempts do not escape criticism ([Ramirez Hita 2010](#)), the interest in, and participation from the intended subject population in Ecuador and Bolivia is a hopeful sign of continuing support for the intercultural agenda. The Peruvian proposal of culturally adapted birth care was born under a much different set of circumstances, a top down approach with almost no participation of the intended subjects of policy.

Nonetheless, at a broad Latin American level, the creation and implementation of intercultural birth care is seen as a key step to reduce maternal mortality. In 2011 health ministers from six countries (Peru, Ecuador, Colombia, Chile, Bolivia and Venezuela) met

in Lima and issued a declaration of support to the continued promotion of participatory intercultural processes to improve maternal health and reduce maternal mortality among indigenous populations in their jurisdictions (UNFPA 2011). This public declaration of support for the framework of *interculturalidad* from leading health policy makers increases the importance of analyzing and evaluating existing policies which will inform possible future implementations.

3.5 BIRTH AND SAFE MOTHERHOOD IN PERU

Peru has been part of international efforts to reduce maternal mortality and improve the health indicators of mothers and children for more than 50 years. However, the country's political and social changes over these years have impacted both the type and scope of policies, and their results. Furthermore, maternal policies are enacted in the context of an already existing traditional birth care system and a certain local version of biomedical birth care. The present chapter discusses the evolution of maternal health indicators in Peru. I also describe the traditional and biomedical systems of birth care, and delineate how global Safe Motherhood policies have been implemented in the country.

On the whole maternal health indicators in Peru have improved remarkably in the last 15 to 20 years. The key variable observed has been the Maternal Mortality Ratio (MMR) which has seen a national reduction from approximately 318 deaths per 100,000 live born in the 1980's to 98 deaths in 2010 (see Figure 4).

However, Peru still has a lot of work ahead if it is going to achieve the goal of reducing the MMR to 66.5 deaths per 100,000 live births, which is the Peruvian goal for the MDG initiative. Much of that effort will be directed at lowering regional death tolls.

Regional maternal mortality ratios, last calculated by the National Statistics Institute (INEI) for the year 2007, show stark differences in the levels of maternal deaths (see Figure 5). The more urban, coastal and more industrialized regions, like Lima, Ica, and Tacna had levels below 90 deaths per 100,000 live births, considerably lower than the country level of 173.5 for that year.

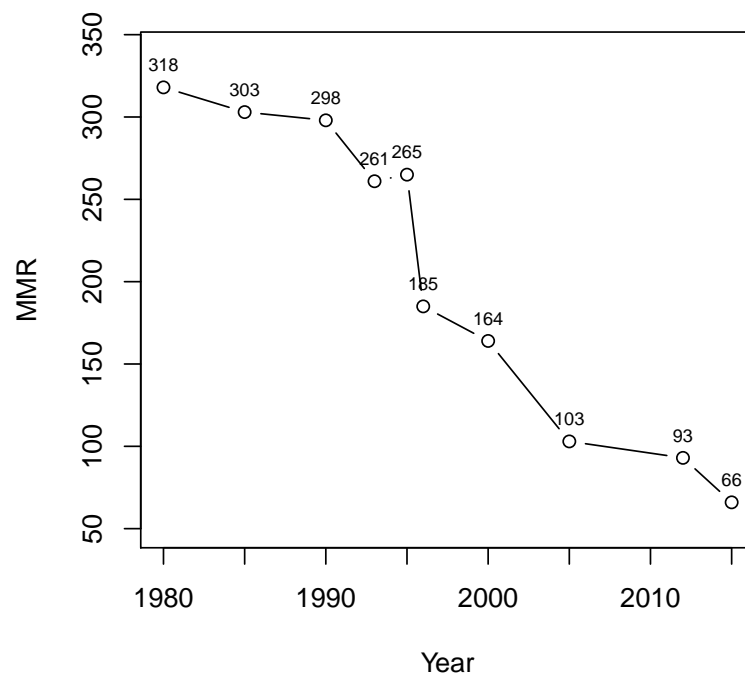


Figure 4: PERU: Evolution of Maternal Mortality Ratios 1980-2010

On the other side of the spectrum the highland, more rural and largely agrarian and mining regions of Cusco, Cajamarca, Huancavelica, Ayacucho and Puno had levels between 271 to 315 deaths per 100,000 live births ([Centro de Investigación y Desarrollo-INEI 2009](#); [Oficina General de Epidemiología- MoH Peru 2003](#)). Furthermore, Amazonian departments such as Loreto, Madre de Dios and Amazonas also show much higher levels of deaths than the national average.

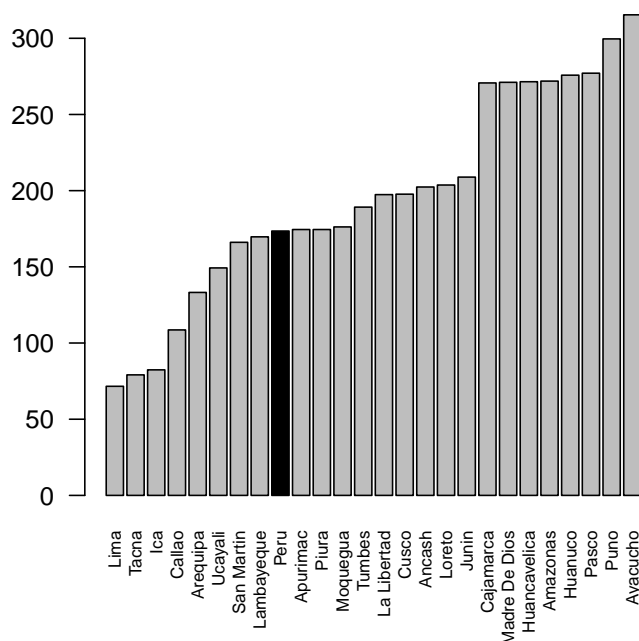


Figure 5: PERU: Regional Maternal Mortality Ratios 2007

More recent data available from the MoH Direction of Epidemiology (DGE) show a decreasing ten year trend in the number of deaths across high mortality regions, but they provide only absolute numbers ([Oficina General de Epidemiología-MINSA Peru 2012](#)). Certainly in the two regions central to the present study, Cajamarca and Cusco, MMRs calculated by the DIRESAS using their epidemiological surveillance data show remarkable reductions.

Maternal mortality ratios for Cajamarca were calculated at 281 deaths per 100,000 live

births in 2002, and at 159 in 2010 ([Oficina General de Epidemiología-Dirección Regional de Salud Cajamarca 2010](#)); and Cusco's levels fell from 271 per 100,000 live births, to 105 in 2007 ([Gobierno Regional-Dirección Regional de Salud Cusco 2008](#)).

However, even with these reductions in place 72% of all deaths in Peru in 2011 occurred in the highlands and Amazonian regions ([Oficinal General de Epidemiología-MINSA Peru 2012](#)).

Despite the disparate improvements in MMRs there is consensus that an overall reduction in the number of deaths has been achieved. This reduction is due in part, to policies targeted at maternal mortality, like improving training for health personnel, increasing prenatal controls, and promoting birthing in the health services.

The 2010 Demographic and Health Survey (DHS) report shows that in 20 of Peru's 24 regions, 90% or more of pregnant women attended least one prenatal control or visit with a biomedical health provider in the last five years. Additionally rural prenatal control levels have increased to 87.9% from 73.2% in the year 2000 ([INEI 2011](#), [2001](#)).

Furthermore, as Table 1 shows, birthing in health care facilities has risen. Nationally birth in health care facilities increased to 84.4% in 2010 from only 57.9% in the year 2000. Although the increase is impressive, differences between rural and urban areas are still very large, with only 63.7% of all rural births in the previous five years occurring in the health services.

Table 1: Percentage of Births in Health Facilities by Selected Geographic Areas

	DHS 2000	DHS 2010
Peru-National	57.9%	84.4%
Urban	82%	95%
Rural	23.8%	63.7%
Cusco	39.5%	85%
Cajamarca	22.2%	61%

Source: INEI Demographic and Health Surveys 2000 and 2010

Notably, the Cusco and Cajamarca regions have seen dramatic increases in births in the health care facilities. However, Cusco's levels are higher than the rural and national averages whereas Cajamarca, at only 61% of birth in the health services in the past five years, comes

in below both averages. A more detailed review of indicators for these specific regions will be presented in a later chapter, but they are introduced here to provide a broader perspective on the national level indicators.

The reduction in maternal deaths is also part of the aggregate effect of a significant reduction in fertility levels, especially in rural areas. In the year 2000 the total fertility rate for women in the rural areas was 4.3 births per woman, and in 2010 it was 3.5 births per woman. In the Cusco region birth rates were reduced from 4 to 2.9 births per woman. and in Cajamarca birth rates were reduced to 3 per woman. Rural areas in both regions registered reductions in fertility; however, in both areas the birth rate remained significantly higher than in urban areas (see Table 2) (INEI 2011).

Table 2: Number of Births Per Woman by Selected Geographic Areas

	DHS 2000	DHS 2010
PERU	2.9	2.5
Urban	2.2	2.2
Rural	4.3	3.5
CUSCO	4	2.9
Urban	2.6	1.8
Rural	5	4
CAJAMARCA	3.5	3
Urban	2.2	2.2
Rural	4	3.4

Source: INEI Demographic and Health Surveys 2000 and 2010

Overall these indicators support the notion that although maternal deaths are decreasing on the national scale, women in the rural areas are more at risk for maternal deaths than their urban counterparts due to their higher fertility and lower levels of prenatal controls and of birth in the health services. Other elements such as income, level of education and distance from health services with basic obstetrical emergency resolution capacity (INEI

2011; [Min. of Health Peru 2009b](#)) also contribute to this conclusion. Successive Peruvian governments have sought to reduce this risk through various policy initiatives designed to influence both the public health system and the population. However, these policies operate in an already existing cosmos of beliefs and customs regarding birth and birth care. In the following sections I present an overview of these belief systems, and of the policies undertaken to improve maternal health and reduce maternal mortality in Peru.

3.6 PERUVIAN BIRTH CARE SYSTEMS

The quest to achieve lower levels of maternal mortality in Peru through public policy could be characterized as a struggle between tradition and modernity, pitting on one side a relatively robust realm of traditional birth practices that has evolved over generations and has been the default system of care; and on the other a biomedical practice of birth provided and promoted by the advent of public sanitation systems. However, this view obscures the fact that both traditional and biomedical practices have an interrelated history globally and in Peru. Modern medical practices developed on the basis of midwifery knowledge, and the traditional systems have incorporated instruments and knowledge from biomedicine.

Furthermore, there is no one traditional or biomedical system in Peru. Andean area practices share some key elements that extend across countries, but these differ somewhat from those of Amazonian regions, thus providing myriad different so-called traditional practices. Likewise the type of care a woman can expect at a biomedical facility in an urban setting is not the same as that available in the rural areas of the Andes at a similarly rated health center.

Although both types of systems are constantly evolving, certain unique elements characterize each one, and are at the core of policy interventions. In the following sections I present a brief description of these elements in the Peruvian Andes and an overview of the maternal health policies implemented by the Peruvian Government.

3.6.1 Traditional Birth in the Andes

One of the central tenets of an Andean view of the world is that humans and their environment are inherently interconnected. In this sense a healthy body is one that achieves equilibrium between the human world, spiritual world and the environment that surrounds them (Cooley 2008). In practical terms this is a result of careful daily practice of balancing hot and cold bodily humors (Bastien 1989). This form of conceptualizing health and the body is not exclusive to the Andes, it is regarded as one of the oldest forms of diagnosis and treatment of disease and is prevalent in other areas of Latin America and the world (Foster 1994).

The Andean humoral theory extends to the whole environment. Food and drink are classified as hot or cold despite their actual temperature. For example rice, potatoes, eggs and milk are considered cold, whereas beans, corn, and beef are considered hot (Finerman 1989). Balance is adjusted by combining hot and cold foods, and also by adding medicinal herbs as needed (Finerman 1989). In the same manner features of the landscape are considered hot or cold; for example areas of pre-hispanic ruins and burials are regarded as hot and dangerous (Larme and Leatherman 2003) as are certain areas near the peaks of well-known *Apus* or mountain deities. Thus all daily activities of an Andean man and woman are seen as either contributing to or endangering overall health.

A woman's reproductive potential means that she is equal to the *Pachamama* (mother earth), something which puts her in danger and also makes her particularly dangerous (Larme 1998). Her body is considered to be weaker due to the existence of an extra orifice which can increase the threat of humoral imbalance. Consequently, female reproductive processes - menstruation, pregnancy, birth and postpartum- receive particular attention. For example, concerns over menstrual blood focus on the nature of the flow, consistency and quantity. When the blood fails to show, in the absence of pregnancy, it is attributed to the action of cold elements (air, water, foods) that cause the blood to harden in the abdomen and produce aches and lumps which are considered very dangerous for the health of the woman (Hammer 2001). In some cases they are equated to the modern ideas of tumors and cancers, thought to lead to chronic weakness of the body, and are treated using 'hot' herbs which are

considered emmenagogues or menstrual regulators ([Hammer 2001](#)).

Similarly one of the main health concerns regarding childbirth is the effect of ‘cold’ elements. Birth is considered a hot occurrence. In the same way in which a hot substance is needed to regulate the menstrual flow a hot environment is needed to ensure a speedy and healthy birth outcome. Therefore the preferred area for birth in an Andean adobe house is the kitchen or the area where the hearth is located, or the windowless main room. The woman is administered hot herbal beverages to aid dilation during labor; abdominal massages with herbs and warm animal fat or oil are also used to promote a quicker birth ([Bradby 2002](#); [Bradby and Murphy-Lawless 2002](#)). Some TBAs may apply oxytocin¹ to increase uterine contraction and aid slow births. However, in general the dilation period is aided only by herbal beverages that have this same effect. The birth attendant will ask the woman if she feels the urge to push and will ask her to wipe her genital area with a clean white cloth to check for signs of blood that may indicate an impending birth ([Guerra-Reyes 2001](#)).

The preferred position for birth is vertical, supported on a shallow stool, bed or chair by the husband, father or midwife. The woman is generally fully clothed, using several of her daily use wool or cotton underskirts, this way her genitals remain covered from the dangerous air ([Bradby and Murphy-Lawless 2002](#)). The child is born onto a black sheep or llama hide (in recent times a dark colored wool cloth is also used); this color is considered hot and will keep the child from harm while the placenta is tied off.

During the birth process, the main focus of the activity is the mother; thus, in many cases the child may remain on the mat or floor until all interventions on the mother have ceased or until someone who is eligible can pick her up ([Bradby and Murphy-Lawless 2002](#)). It is generally supposed that someone other than direct family members should collect the child from where it lies after birth, wash and clothe it. This is a ritual act that creates the fictive kin relationship of *compadrazgo*, which creates internal community links and establishes a lifelong relationship of respect and responsibilities between families. There are mutual benefits to the creation of a *compadrazgo* through birth, a TBA serving a specific

¹The synthetic version of oxytocin called pitocin is available to some TBAs through health centers or pharmacies.

community can increase her standing and influence by being *madrina* or godparent to several generations of community members, and the child's family benefits by being privy to health related advice of a knowledgeable person ([Guerra-Reyes 2001](#)).

Once the child is birthed, the placenta becomes the focus of care. The placenta is considered to be linked to the health of the mother and child; it is sometimes called the *madre* or mother, and is said to sleep next to the child during pregnancy ([Davidson 1983b](#)). In its role of mother the placenta provides teats for the child to suckle on and feed while in the womb ([Bradby and Murphy-Lawless 2002](#)). Because of the strong link between child and placenta it is important to dispose of it correctly so as to prevent cold-hot imbalance in the body of the child; this is generally achieved by burying the placenta deep in a field. Within the Andean belief system this mode of disposal allows the womb mother to return to the earth mother (*pachamama*) and nourishes the family field ([Bradby and Murphy-Lawless 2002](#); [Guerra-Reyes 2001](#)).

After birth the body of the woman is considered to be more 'open' and liable to suffer humoral imbalance. Immediately after birth her hips are bound with a strong broad cotton or wool cinch which aids in closing the body. Additionally it is generally recommended that she rest during 30 or 40 days from her usual duties. During this time she should avoid cold air drafts, coming out of the house only when sunny and protected, she should eat only warm food and should not do any washing or cooking. The effect of a humoral imbalance during this period can lead to *sobrepardo*, which is caused by cold air and is locally understood to be a result of the coagulation of birth blood inside the abdomen ([Larme and Leatherman 2003](#)).

Sobrepardo is a sometimes fatal illness that presents as fever and abdominal pain, some scholars have associated it with puerperal fever ([Larme and Leatherman 2003](#); [Bradby and Murphy-Lawless 2002](#); [Hammer 2001](#)). However, it can also occur months and years after the birth ([Larme and Leatherman 2003](#)) and is also associated with the female cultural illness called *debilidad* or 'weakness' ([Oths 1999](#)). Scholarly analysis of these ailments have proposed that they are embodied cultural responses to years of productive and reproductive labor in a male dominated hierarchical society ([Larme and Leatherman 2003](#); [Cooley 2008](#)), as such they occur because they may bring a respite from female responsibilities in the

home and in the fields. The work of women in the Andes extends from all home and child care to small animal husbandry and vegetable production and into seeding, weeding and sowing crops along their male counterparts (Bourque and Warren 1981). When a woman is diagnosed with *sobrepardo* this work may be then undertaken by other female members of the family, generally daughters. A woman who has no daughters is pitied as she has no one to alleviate this burden, and is then more prone to illness (Crandon-Malamud 1991).

Given the pivotal role of the woman in the well-being of the family, and the intrinsically dangerous nature of the reproductive process, the type of care sought during pregnancy and birth is subject to much thought and discussion. Particular circumstances like number of pregnancies, previous personal experiences, availability of different types of care, family input, the woman's age, the type of family livelihood, and other people's experiences can augment or reduce the focus on humoral balance and guide the final decisions. In practice multiple paths to obtain preferred care patterns are available, these paths may mix several different types of care both traditional and biomedical (Guerra-Reyes 2001). Though in many cases the chosen path may include biomedical care it is important to note that the type of medical care and practices also differ widely and are the subject of complaints. In the following section I will describe a typical biomedical care practice in rural Peru.

3.6.2 Biomedical Birth in the Andes

Although formally birth care practice in a public health center follows the same directives of care anywhere in the country, the particulars of the Andean rural environment and the likely absence of other biomedical options or support make providing birth care particularly challenging. Structural constraints of the health system itself can influence the type, experience and readiness of the personnel, the availability of needed supplies, and possibility of evacuation in case of emergency. In addition to this the pressures posed by undependable electricity, water and sewage services, incomplete or non-existent access roads, and the alternating very cold and very wet highland weather all unite to create a problematic arena of care.

The following description of a typical birth practice in a rural health center is based on

my own experience and observations in the Andes and on descriptions in Reyes (2007) in the coastal and highland facilities of a rural micronetwork.

Public health centers are constructed using a similar pattern which favors cement walls and floors and a ceramic-tiled birthing room. Sometimes wooden floors are used in office spaces as a concession to the cold Andean climate. On arrival the woman is directed to a dilation bed, generally located on one side of the birthing area. In this room she must change into a regular hospital gown. Once she enters this area she is generally not allowed to be accompanied by any family members and nurses or nurses' aides act as go-betweens while the family waits outside. Sometimes one person may be allowed to enter, but this is at the discretion of the attending personnel, and this permission can be revoked at any time. Once in a hospital gown she will generally be shaved and washed and, an IV line will be inserted in her arm. In this area food is not allowed and drink is restricted by the health personnel. The woman is encouraged to walk but cannot exit the room.

During her time in the dilation room one or more of the professionals in the health center will check her progress by inserting their fingers into her cervix. Protocols state this may be done up to once every hour. Sometimes this requires her getting into a gynecological stretcher equipped with stirrups. During these procedures the genitals are left uncovered. These and other procedures are not negotiable, nor is the woman consulted, and are seldom announced (Reyes 2007).

Once dilation is complete the woman is moved to the birthing room and laid down on a stretcher, her feet up in the stirrups. During the pushing phase only the woman and health care providers are present. Medical personnel will coach her and often yell or bark orders. No pain medication is given, and women who yell and scream are seen as a nuisance. Interactions and conversations about the process occur between the professionals but will generally not include the birthing mother.

Sometimes an episiotomy (a cut to widen the vaginal orifice to avoid tears) may be performed using a topical anesthetic. Although it is not deemed a routine procedure in the current birth care protocol, many older professionals still believe it is necessary, especially with first-time mothers (Reyes 2007).

Once the child is born the focus, is mostly on her. After being examined and cleaned the

child will be clothed and swaddled. During this time the mother is still in the stretcher and stirrups awaiting the birth of the placenta. Sometimes she will be administered oxytocin to aid in the afterbirth process.

Once the placenta births it is checked and thrown in a plastic bag, which is then taken to the center trash area together with other biological material. Sometimes this material is incinerated in a hearth onsite.

If an episiotomy was performed or a tear occurred, some time will be dedicated to sewing up the layers of affected tissue. Once this process is complete the woman and child may be moved to the ward, and one family member may be allowed inside.

Faced with this form of biomedical birth that deviates so strongly from cultural expectations, it is not surprising that many Andean women forgo the health center for birth. However, death as a possible outcome of birth is also recognized and evidenced by the recurring use of the phrase *salvar con bien* which literally translates as ‘to save well’, which is used by women when referring to their expectations prior to their deliveries, positive delivery outcomes and when commenting on other women’s experiences. Women thus recognize that biomedical options may be necessary to save their life and develop personal strategies to prepare themselves for such an outcome and to try to obtain certain accommodations of the strict protocol, for example, establishing sympathetic relationships with the nurse-midwives and formally complying with all prenatal requirements ([Guerra-Reyes 2001](#)).

On the government side other strategies have been attempted with varying results to bridge the ‘birth divide’ and increase the number of women who birth under the care of medical personnel. In the following sections i provide a summary of those efforts and describe current policy strategies.

3.7 SAFE MOTHERHOOD POLICIES IN PERU

The situation of motherhood in Peru was an early preoccupation of the sanitation efforts of the early twentieth century. However, at this time the focus was on rearing practices rather than maternal health ([Mannarelli 1999](#)). Mid-century the global spotlight on the

relationship between population control, social development and economic growth brought more interest in reproductive patterns and practices, including birthing, to Latin America.

Between the late 1960's and the early 1980's the focus of policy was on implementing and expanding health care access under the framework of the Alma Ata (1978) declaration which prioritized primary health care for all ([Min. of Health Peru 2009b](#)). Traditional birth attendants and other community health workers (CHW) were trained to become liaisons with the health system and were given central roles in identifying high risk pregnancies and promoting family planning ([Verderese and Turnbull 1975](#); [Simons and Maglacas 1986](#); [Leedam 1985](#)). The specific scope of these efforts in Peru varied as different development agencies (e.g. UNICEF, CARE, USAID, Population Council) funded and sometimes directly undertook interventions in diverse geographical areas in coordination with the MoH. The results differed and data was difficult to collect ([Gomez 1988](#); [Iguñiz and Palomino 2012](#)). Public health facilities were scarce, and the existing ones were understaffed and under-equipped; and professionals at all levels of care were chronically under-trained in responding to obstetrical emergencies. These issues, coupled with the international focus on population reduction ([Stycos 1965](#); [Verderese and Turnbull 1975](#)), meant this early initiative focused more on family planning and child survival rather than on direct prevention of maternal deaths.

When the Safe Motherhood Initiative emerged from the Nairobi Conference (1987) Peru was in the midst of an internal armed conflict and a severe economic crisis that had undone much of the earlier policy effort. All infrastructure of governance, including health care was lost; in many hard-hit rural areas and even in urban centers maintaining necessary health services and personnel became very difficult. The coalescence of both situations resulted in a near collapse of the system. As such, the role of community health agents and TBAs grew. The spaces left vacant by the government were filled by non-profit and development agencies, which largely managed emergency food aid and primary health projects with lay agents ([Davison and Stein 1988](#)).

In 1993 the Safe Motherhood initiative in Peru received a major boost with the beginning of the Project 2000, a joint USAID and MoH endeavor whose main objective was to increase the utilization of priority maternal and child health interventions in the public health system

([USAID 1993](#)). Over the following ten years this project focused on improving the quality of medical attention for maternal and perinatal complications. It promoted a standardization of birth care practice and increased levels of prenatal care. Additionally, the project developed an ongoing training program in management of obstetric emergencies and established a case reporting system ([USAID 2003](#)).

Under the auspices of Project 2000 the MoH trained a network of community health workers and increased their links with the expanding public health services. Traditional birth attendants were officially named lay health workers and were incorporated into a referral and counter-referral system. TBAs in rural communities were essentially charged with the observation of all pregnant women in their community, visiting them and identifying early signs of danger. Using the projects referral forms (most of which were pictorial) TBAs could then send women on to the health services for treatment. Once treated in the health service women could continue their care with the TBA who was also in charge of supervising medication and reporting any problems to health personnel ([Alcalde et al. 1995](#); [APRIS-ABAC 1999](#); [Benavides 2002](#); [Min. of Health Peru and USAID 1994](#); [Min. of Health Peru and UNICEF 1994](#)).

The community health agent model evolved in scope and remained important into the first years of the millennium. Community health agents, included traditional midwives and lay healers who were elected by their community to be liaisons between them and the health care workers. As such they were trained in basic care of common illnesses and in the recognition of potential serious health issues which occurred in different times of the year. They functioned specifically as sentinels or lookouts of diseases, and as replicators of health messages. This system worked well in areas where a respected lay healers or *curiosos* were also the health agent. However given the intensive commitment required by the health services, the multiplicity of programs they were supposed to support and the perceived submission to the health system's biomedical stance, many lay healers did not want this relationship. Traditional midwives, on the other hand, continued participating in large numbers and seemingly held a more favorable view of the relationship with the public health system.

TBA training under Project 2000 was intensive and focused more specifically on identifi-

cation of danger signs and hygiene. The MoH provided certificates for those who completed training. This tacitly, and sometimes explicitly, allowed them to continue providing birth care for women in their communities and provided them with legitimacy. However, it also created a divide between and competition among ‘certified’ and ‘uncertified’ midwives in rural areas. Health personnel only recognized births by certified TBAs as legitimate and campaigned against those that were not. Certified TBAs received clean birth kits with the necessary implements and basic medication for a hygienic home birth. In some cases they were also allowed to buy restricted medications like oxytocin, which they sometimes used to treat post-partum hemorrhages (Guerra-Reyes 2001). The training, important role and increasing links with the community were touted as some of the better results of the Project 2000 decade.

Once Project 2000 came to an end in 2003, the newly created National Sexual and Reproductive Health Strategy (SRHS) took a leadership role. This new policy body began working after a politically volatile period which ended with new general elections. However, the human rights violations² of the previous regime brought a broad revision of existing health policy at all levels.

In the realm of birth care one of the major changes which was also a result of changing views at the global level, led to a reduction in the MoH work with TBAs and a promotion of birth in the care of an SBA. All TBA training activities were suspended. In general, the reliance on the extended network of community agents grew progressively unnecessary as the public health system extended. Furthermore, stories of conflicts over area of expertise and health agents overstepping their allotted scope of action were frequent among rural health professionals. This was especially true in the realm of birth care as the work with the TBAs from a policy perspective was seen as stopgap care which should cede space to the health system.

Additionally, Project 2000’s investment in training and improving standards of obstetrical care in the health services was not achieving the desired results as personnel were not able to access the population which they sought to serve. Policies that followed the creation of

²I am specifically referring to the coercive program of sterilization which was part of an overhaul of family planning efforts during the Fujimori years.

the Sexual and Reproductive Health Strategy focused mainly on increasing the relationship of women to the health services. In practice this meant that women were discouraged from using TBAs for birth care, covertly by delaying certificate of live births to home birthing women and overtly by threatening both home birthing women and TBAs with prosecution (Defensoría del Pueblo Peru 2008).

The first National Plan to Reduce Maternal and Perinatal deaths was produced by the SHR strategy in 2004 (Min. of Health Peru and Direccion General de Salud de las Personas 2004). The main policy initiatives of the following years were all present in this plan and continue to this day with minor modifications. Officially the problem of maternal mortality was conceived under the explanatory framework of the four delay model (Thaddeus and Maine 1994), which postulates that delays in recognizing the seriousness of a pregnancy complication, deciding to seek outside medical help, transporting the woman to treatment center and then providing the adequate treatment once there, are the main nodes of possible interventions to reduce maternal deaths. The delay model was also complemented with the barriers of access to health care model, which postulates that economic, geographic and cultural barriers limit access to services, which was popular at the time in other areas of health care service provision in the MoH (see Subsection 4.2.1). Thus policies sought to overcome or ameliorate either a barrier or a delay.

More specifically policy strategies on the supply side focused on the fourth delay, adequate treatment once in a health facility. They re-enforced and expanded training in dealing with obstetrical emergencies (Kayongo et al. 2006; Min. of Health Peru 2009a), increased equipment in the health services and created an emergency response evaluation system that guides and limits the interventions that specific centers are able to treat (Min. of Health Peru 2005a; Min. of Health Peru and Direccion General de Salud de las Personas 2004).

Increasing the level of prenatal controls with the help of community surveillance groups that identify pregnant women and increased emphasis on the signs of complications during prenatal consultations were used to counteract the first and second delays, recognizing and acting. (Min. of Health Peru and Direccion General de Salud de las Personas 2004; Del Carpio Ancaya 2011).

Community groups for maternal mortality surveillance (*Comités locales de mortalidad*

materna) were initially implemented to deal with transportation delays and geographic barriers; these committees coexisted and were later replaced with the maternal waiting houses.

Further policy efforts on the demand side focused on increasing levels of family planning use, especially modern methods, which linked women of reproductive age more closely with the health services and also lowered the number of women at risk for birth-related deaths (Min. of Health Peru and Direccion General de Salud de las Personas 2004).

The issue of economic access to the health services was tackled by the Maternal and Child Insurance implemented by the MoH in those years, which was purportedly a way to allow low and lowest income groups to use medical care free of charge (Min. of Health Peru and Direccion General de Salud de las Personas 2004).

Among these policies is a first mention of the strategy of providing intercultural birth care in the health services. At this time providing culturally appropriate measures in birth care was part of growing trend in Latin America (Richardson and Birn 2011), and the notion that culture was a significant barrier to decrease maternal deaths became mainstream in the MoH. The specifics of the background and development of this policy are detailed in the following section. It is important to note that intercultural birth remains a key element of the updated maternal death reduction strategy into the year 2015 (Min. of Health Peru 2009b; Del Carpio Ancaya 2011).

This new plan, which covers 2009-2015, still looks to the four delay model for guidance but makes a greater emphasis on human rights, gender equity and interculturality frameworks to achieve the goal of voluntary, healthy and safe motherhood. As such there is more focus on the gaps in access to care among women by education and income level and less focus on only rural groups (Min. of Health Peru 2009b). Additionally there is a renewed interest in reducing the number of births among adolescents and a deference to the growing power of the regions to define their own priorities.

In the following years the two main challenges faced from the policy perspective in regards to maternal mortality are the availability and the opportune use of data to make policy decisions (Iguiniz and Palomino 2012) and maintaining gains achieved in the new decentralized policy structure.

Data collection for maternal deaths has improved since the General Direction of Epi-

demography at the MoH began centralizing information on deaths in 2006, through the MoH networks and micronetworks. However, some measure of sub-reporting still occurs, especially among the most vulnerable populations. Furthermore, since the National Statistics Institute does not provide official MMR at regional levels, some newly minted authorities in the new decentralized health system doubt the MoH figures. Additionally, data are not available in an intelligible format for policy makers at local and regional levels ([Iguñiz and Palomino 2012](#)).

Another challenge brought on by the changing administration of the health policy is the need to maintain the achieved gains in death reduction through the new structure. As it currently stands, the SRHS is still the main policy body, but its role has changed from being directly in charge of implementation, benchmarking and oversight, to a less involved role of policy advocacy and supervision, thus leaving the concrete policy and implementation decisions to the Regional Health Directions (DIREAS). A more detailed explanation of the recent changes in health care provision in Peru, and the impact on policy making in the public health sector is discussed in the following chapter. However, it is important to note that although there are clear benefits to this new structure, it also creates the need for an overarching agreement and constant surveillance of regional decisions that tax the already stretched personnel at the national level.

3.8 SUMMARY

The Peruvian implementation of international policy recommendations and strategies on the eve of the birth of the Safe Motherhood Initiative were initially adversely affected by a complicated social and political climate. However, the policies enacted with international aid from the mid 90's onward have achieved significant reductions in maternal deaths. Even so, internal differences in the reductions achieved signal that deaths are occurring mostly among rural, low-income and indigenous women. Among these populations reductions have also been significant but maternal death rates are still two to three times higher than in urban areas. Additionally, these populations use less birth control and have more children.

Furthermore, they have weak relationships with the health services, mostly due to remote location, and sometimes conflict situations.

Early causal evaluations of maternal deaths used the four delay and barriers of access to health care model to guide policy interventions. Although the policy strategies have remained mostly the same since 2004 the explanatory models have been re-imagined within the frameworks of health, gender equity and interculturality. As such issues like the right to health care, the impact of gender inequality on women's access to care and the need for respect of women's culture and traditions are now also considered part of maternal health policy. This marks a closer relationship to the explanatory framework of social determinants of health that is now mainstream in the MoH.

The relationship of the official public health system and the pre-existing birth care system and traditional birth attendants has followed a rocky path, which has changed from initial disinterest, to tolerance and training of practitioners, to active incorporation into referral systems, to finally cooling connections and incorporating certain aspects of the traditional practice into some health service birth care. The changes of this relationship over time also go hand in hand with the evolving perceptions of indigenous Andean birth culture and interculturality at the MoH. Paradoxically, a greater acceptance of and emphasis on the importance of respecting indigenous cultures have been accompanied with the wholesale rupture of any official links to the traditional practitioners and with a desire to stamp out their practice.

This inevitably leads to questions as to the sincerity of MoH officials in espousing intercultural care and to the real desire for understanding and respecting birth care needs of indigenous populations. This is one of the many contradictions in health care provision with regards to culture.

In the following chapter I present an overview of the context and development of the intercultural birth policy, which was created with help from traditional birth attendants. As such understanding how health care personnel and also traditional practitioners view this relationship, and the attendant policy, has been an important part of this research. Further chapters explore this relationship on the ground in the study sites and analyze the possible effects on policy implementation and acceptance of care among rural women.

4.0 THE INTERCULTURAL BIRTH POLICY

The Peruvian Intercultural Birth policy can be seen as part of the movement towards inclusion of indigenous cultural values into policy (see [3.4](#)). However, it differs fundamentally from policies of other Andean countries in that its creation was not in response to requests from indigenous organizations, but rather a top down approach born out of the need to overcome the reticence to birth in the health facilities.

This chapter introduces the Intercultural Birth Care policy and the institutional context in which it was produced. In the following sections I provide a description of the Peruvian health care system and of the two important changes that influenced health policy making in Peru during the first decade of the new millennium.

In a further section I describe the conceptual model of barriers of access that led to the development of several health care policies, including intercultural birth care and will detail its path from institutional project to official policy. A final section highlights specific aspects of the policy text that are relevant to later analyses.

4.1 HEALTH CARE SERVICES IN PERU

The Peruvian health care system is comprised of two large sub-systems: a private system and one managed by public institutions.

The private health system is a fragmented collection of for-profit and non-profit organizations which, cover approximately 10% of the population ([WHO 2007a](#)). A large part of this group is covered by *Entidades Prestadoras de Salud* (EPS) or Health Providing Institutions, which are offered in a partnership between private insurers and organizations of more than

30 workers. They offer a multi-tiered coverage in addition to the social security system, and paid for jointly by the employer and employee. These formal employees, often white collar professionals, do not use the social security system for health care in spite of contributing to it.

For those who are not able to use the EPS, for example free-lance professionals, small organizations, and small businesses there is the option of private insurance. However, due to its high cost it is mainly available to the highest income segment of the population. Nonetheless, for those who cannot afford insurance there are myriad private for-profit clinics and medical practices in urban and peri-urban areas which cater to all income levels. Additionally, they can seek the services of traditional practitioners of diverse experience, specialty and pay range, who are also considered part of the private system.

The public sub-system is comprised of sector specific organizations: the Social Security Health System, the Armed Forces Health System and the Public Health System. Each is managed by different ministries according to the corresponding population segment.

The Social Security system or *Seguro Social de Salud* (ESSALUD) was established in the early 20th century and is managed by the Ministry of Labor. In the beginning it catered to formal blue and white collar workers, mainly those in government and educational institutions, financial services and textile and manufacturing industry. In the mid 1990's it began to allow self-employed persons and small businesses to participate. The social security network manages a series of high-to-mid-level facilities in Lima and provincial cities. It does not have any facilities in rural areas. It works with compulsory deductions from the pay checks of all formally employed workers. According to WHO data it covered approximately 25.1% of the total population in 2006 ([WHO 2007a](#)) .

The Armed Forces have a similar deduction scheme, which supports health care networks specific to each branch of the military. These are managed by the Ministry of Defense. The Police Forces also have a particular network of health service facilities that is managed by the Ministry of the Interior. Overall, health care services for the military and the police cover around 3% of Peruvian population ([WHO 2007a](#)).

The Public Health System (PHS) is the largest of all and is managed by the Ministry of Health. It is organized into regional networks and micronetworks which link health posts,

health centers and hospitals. This system caters mostly to rural poor and extreme poor populations, many of whom are viewed as indigenous from a policy standpoint. In many isolated areas it is the only available access to biomedical treatments. The PHS has additional mandate over other issues related to public health, such as preventing epidemics and supervising sanitation and environmental care in rural areas.

Public health facilities offer services for up-front payment and at different levels of subsidies. Certain high risk population groups, such as pregnant women, children under age five, school aged children and the elderly can access ‘focalized’ care packages which are subject to higher subsidies. Most of the care seekers tend to be female given that males between the approximate ages of 18 to 65 are not considered high risk.

In 2010 the Public Health Insurance which initially covered only those below the poverty line and children under age 18 expanded to include all uninsured individuals and became a Comprehensive Health Insurance or *Seguro Integral de Salud* (SIS). This expansion increased the client base of the PHS and established new pay scales for insurance coverage. As a result the newly created SIS reportedly now covers a little over 12.7 million people or approximately 43.6% of the population (SIS 2011)¹.

4.1.1 The Public Health System (PHS)

Viewed as a whole the Peruvian health system is segmented by income and location. Rural and isolated populations have few options for health care. Conversely, urban formal workers have ready access to several care options. This class/race differentiation of the system can be traced to the eugenic influences in the foundational processes of Peruvian public medicine in 19th and early 20th centuries (Ewig 2010). This is especially evident in the Public Health System which was created in the early 1930’s, a time when the indigenous population was seen as the main hindrance to nation building and development. The hygienists and doctors who promoted the creation of the PHS, saw it as a medium through which they could improve the native indigenous population. This accounts in some part for the early focus on mothering, reproduction and hygiene education, and for the persistent feminization of the

¹Calculated using the 2011 population estimate of 29,248,943

system in terms of patients and direct care labor force. On the other hand, authorities and decision makers remained overwhelmingly male ([Mannarelli 1999](#))².

The legacy of this segmentation underscores the complex relationship established between the indigenous population and the health services. For much of its history and into present day Peru, public health facilities have been seen as a mixture of desired social service and unwelcome intrusion. The latter being mostly the result of recurring behavior change campaigns which made feeble or no attempts at concealing health professionals' aversion to the customs of their patients ([Mannarelli 1999](#)).

In the past three decades the PHS has increased its attention to improving health indicators in rural areas and has made structural changes to address past shortcomings. The most important, in terms of impact, in recent years, have been the creation of a Comprehensive Insurance Program (SIS) and the economic and political decentralization. Both have spearheaded changes in the way the health services work and how policies are implemented.

4.1.2 Decentralization

Economic and political decentralization changed the way in which policies and policy goals were set at a regional level, allowing regional authorities to exert more influence and input. This is the second decentralization project attempted in the country. It came on the heels of the turbulent political landscape left by the Fujimori regime's downfall in the year 2000.

In an attempt to coalesce the divergent political forces, the interim government called upon political parties, and religious and civil society organizations to produce a national consensus that would act as the basis for the democratic transition and consolidation, and provide a shared vision for the country's future. Two of the 29 agreements detailed in the subsequent National Agreement (*Acuerdo Nacional*) referred specifically to health policies that were to be partly implemented through the Ministry of Health: the commitment to universal access to health services and the promotion of food safety and nutrition. These in turn are reflected in the health sector specific guidelines and objectives which include health promotion, prevention of chronic and degenerative diseases, health education, comprehensive

²A detailed historical explanation of the development of the different sectors of the Peruvian Health System and its implications can be found in [Ewig \(2010\)](#).

health insurance, reduction of child and maternal morbidity and mortality, expanded access to and rational use of drugs, and decentralization (WHO 2007b).

The Basic Decentralization Law was passed in 2002, creating 25 regions, one in each of the 24 Departments and creating a special region in the port city of Callao. It also created the National Decentralization Council as the overseer of the process. In January 2003 the newly elected regional governments began functioning with limited responsibilities, and in 2005 the Ministry of Health began transferring certain responsibilities from centrally managed field offices to regional governments. A key part of this process was the development of regional human resources which could lead, direct, and manage health services following the complete transfer of responsibilities (WHO 2007b).

In 2009-2010 the central government finally completed the transfer of all health care related responsibilities to the regional bodies. Each Regional Health Direction (DIRESA), depending on its size, is subdivided into networks (*red*); these in turn are divided into micronetworks (*microred*) as shown in Figure 6.

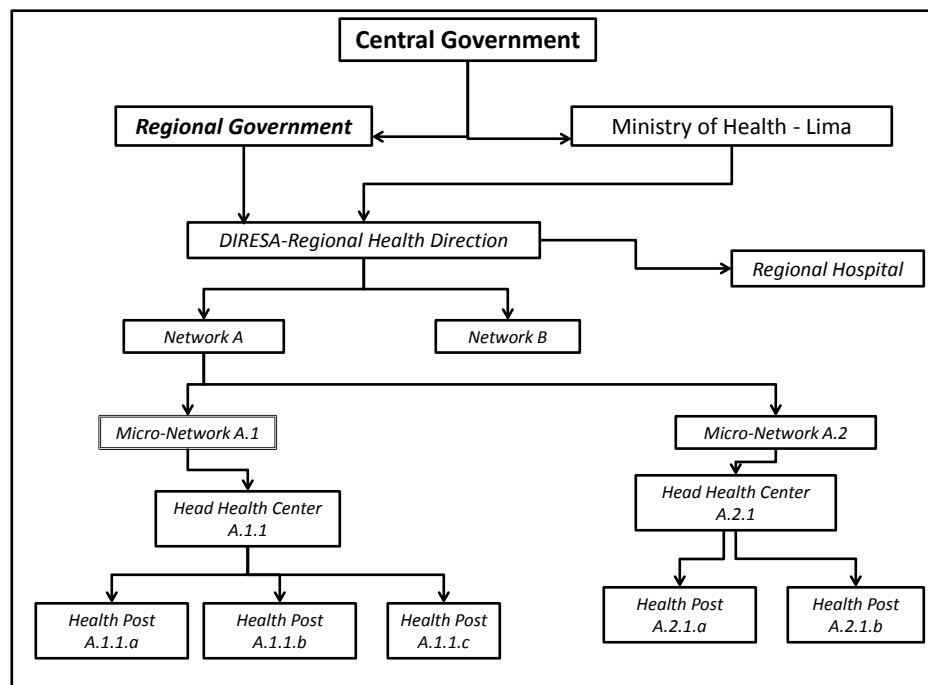


Figure 6: PERU: Organization of Public Health System

National policies thus generate, regional policies which in turn translate into sub-regional directives which are implemented through the networks and micronetworks.

Each network has a team that replicates the organizational complexity of the DIRESA: a director and specialists in charge of supervising each of the regionally applicable national health programs. The core group of programs that is generally found at any DIRESA includes prevention of vector borne diseases, prevention of sexually transmitted diseases, sexual and reproductive health, immunizations, zoonoses, family health and mental health.

Each network includes a collection of health centers (HC) and health posts (HP) organized geographically. Additionally, each of the facilities is classified into one of eight categories according to the complexity of the conditions they can treat, the type of personnel, and the existing services and infrastructure (see Table 3).

Table 3: Peruvian Health System Classification

Categories	Type of Facility	Personnel and Services
I-1	Health Post	Nurse's aid or nurse or nurse-midwife
I-2	Health Post w/MD	General Physician or Surgeon + One of the above
I-3	Health Center	All of the above + dentist, lab technician, pharmacy technician and statistical technician
I-4	Health Center w/in patient facilities	All of the above + Specialist Physician and professional Chemist
II-1	Level 1 Hospital (i.e. Provincial Mini-Hospital)	All primary care personnel, diverse specialists, administrative personnel and full size pharmacy
II-2	Level 2 Hospital (i.e. Regional Hospital)	All of the above and advanced imaging and pathology services
III-1	Level 3 Hospital (i.e. Hospitals in Lima)	All of the above, latest imaging and diagnostic facilities, and all sub-specialties
III-2	Specialized Institute (i.e. National Cancer Institute, National Visual Health Institute, etc.)	Only services and personnel specific to the institute's focus

The micronetwork is the basic management unit of health services. Administrators at this level are responsible for the planning, organizing, coordinating, controlling, supervising and evaluating all health activities in their territory. They also manage all other health services in their territory and all resources allocated by their health network ([Bardález 2007](#)).

The micronetwork consists of a ‘head’ health center and several health posts. Each of the minor posts report to the higher ranking ‘head’ center and they, in turn, report to the network direction, which similarly has to respond to regional level scrutiny for each of the programs it manages.

The decentralization of the system has also allowed tighter control of the classification system, more specifically of the approved interventions at each of the levels of care, which is now tightly enforced. Additionally it has allowed the regional bodies to create and manage diverse funding and staffing strategies, for example hiring personnel using insurance allocations, sharing staffing costs with local municipalities and also promoting more efficient shared community management of certain health services through the Local Health Administration Committees or CLAS. Though these strategies make reaching staffing levels, and as a result improving in the classifications much easier, they have also created differential status for health providers, generating diverse levels of compensation and differences in benefits that create tension among colleagues.

4.1.3 The Comprehensive Health Insurance-SIS

The advent of a Comprehensive Health Insurance program or *Seguro Integral de Salud-SIS* has permitted a growing number of families to access public health facilities and services at reduced out-of-pocket cost. It broadened the pool of health care seekers and reduced the economic barrier to health.

The seed of what would become the SIS began in 1997 as limited insurance for school children enrolled in the public education system. It was expanded to include pregnant women and infants in 2001, and to very low income populations in 2005. In 2006 the public insurance plan covered approximately 27.8% of the population ([WHO 2007a](#)).

In 2009 the Peruvian government enacted the Universal Health Care Law which reformed

the plan and expanded it to previously excluded populations. This reform was enacted partly in response to internal and international assessments that pinpointed high cost as one of the major barriers to health care seeking in the country ([Castro 2009](#); [Dammert and Consorcio de Investigación Económica y Social 2001](#)).

The expansion was heavily publicized in the national and provincial media ([Wilson et al. 2009](#); [Andina 2012](#)), and the percentage of insured increased tremendously. It is now the largest health insurance provider in the country, covering around 43% of the population ([SIS 2011](#)). The fully subsidized program caters to populations that were previously not covered under any health insurance plan and targets the lowest income populations. For a one-time payment of one Nuevo Sol (NS) a family can become affiliated at the point of service for a 12 month period. This entitles each of them to other services in addition to primary health care coverage up to an annual total amount of 9000 NS (approx US 3,370)³.

This effort has made strides in increasing awareness of the availability of health services to rural populations, thus increasing demand, and contributing somewhat to closing the access gap due to economic considerations ([Bitrán and Prieto 2010](#)). However, many of the covered services have already been available to the same poor populations for free or were already heavily subsidized as part of the ‘focalized’ primary care package. Furthermore, very few non-primary care problems are covered. Additionally, given the strong emphasis on prevention, the program covers only a small group of generic medicines, which can be purchased only at the specific health center pharmacy. In practice, this means that families may still have to spend sizeable out-of-pocket amounts in extra services, medicines and other related expenses like transportation. Paradoxically these limitations may also make it a less desirable alternative for the extreme poor.

The requirement of the national identity document (commonly referred to as *DNI*) for affiliation represents an additional barrier for the extreme poor, especially in rural areas, mainly due to the cost of traveling to obtain the document and the need for other paperwork (e.g. utility bills, birth certificates, and proof of residence) that is not readily available. Additionally, complicated bureaucratic processes and inconsistent or incomplete information regarding coverage and responsibilities have been carried over from the initial merger of the

³Calculated using average exchange value for December 2011

School and Maternal insurance programs ([Asencios-Angulo 2008](#)), and have complicated understanding and use of the system.

Despite shortcomings, the rising number of affiliations demonstrates that the renewed program fills a latent demand from population on the lower end of the income scale. It has also reduced the out of pocket expenses and is positively correlated with increased immunizations and timely treatments to intestinal and pulmonary illnesses in children ([Bitrán and Prieto 2010](#)).

4.1.4 Policy Pathways in the Public Health System

Policy making within the PHS has changed with decentralization. The Regional Health Direction (DIRESA) has become an additional instance of decision making which mediates between national policy making and local implementation. The DIRESA staff's closer knowledge of the local issues should allow a better management and tailoring of policies to specific realities. However, the creation of an extra layer of policy making has also diluted the power of the Central MoH, and specifically of the Sexual and Reproductive Health strategy, to control the quality of policy implementation.

Currently, the highest ranking policy and administrative body in any given region is the Regional Health Direction. Central authorities in Lima maintain certain arenas of direct decision making but are mostly concerned with providing national guidelines, training and monitoring progress.

In collaboration with the central government each region agrees upon a set of benchmarks that are in line with local needs and national policies, and which in theory respond to the National Health Plan (*Plan Nacional de Salud*). Regions are evaluated on their indicators at biannual national meetings in Lima. The data presented at these meetings and explanations for any shortcomings are the result of similar evaluations which work their way up the system beginning with the micronetworks.

Some national policies are mandatory and are subject to the highest level of control and scrutiny from the central authorities. Immunization policy is a good example of this. Other national policies are only guidelines for action. These are not mandatory but are

recommended to achieve a compulsory national goal. The scrutiny thus is not on the implementation of the policy itself but rather on the contribution (positive or negative) that each region makes toward the national goal. These policies internally labeled ‘Standards’, are soft policies. Central MoH personnel will provide guidelines and training at the request of the Regional Health Directions. Although technically all implementation will follow the printed guidelines, the final details of location, personnel and level of oversight are decided at the regional level.

Intercultural Birth Care is an example of a soft policy, implemented at the request and expense of the interested regions. It is part of a package of recommended policy changes that aim to improve maternal health, reducing the maternal mortality ratio by three quarters by 2015⁴. As such it is not subjected to the same level of oversight from central MoH personnel. This may mean that policy implementation can be tailored to respond more closely to local idiosyncrasies, but it can also lead to poor execution.

The MoH’s Sexual and Reproductive Health Strategy (SRHS) is in charge of providing training and guidelines to regions on all policies that relate to family planning and maternal and perinatal health. Representatives of the SRHS at the regional and network levels serve as replicators of training provided by central SRHS personnel and are also the main source of information for the central MoH personnel. The Intercultural Birth care policy is one of their more recent and most promoted policies. Although it is not compulsory, it is very strongly recommended for regions that have a history of high maternal mortality and a sizeable indigenous population. The SRHS has also established certain areas of implementation as models, where other MoH personnel and foreign visitors can see the policy at work and its results.

The following section describes the process that culminated in the intercultural birth policy and details the terms of the policy itself.

⁴As pledged by the Peruvian Government in ratifying the Millennium Development Goals

4.2 THE MAKING OF THE INTERCULTURAL BIRTH POLICY

During the 1990's the MoH directed a major expansion of the health care services into previously underserved areas. Access to health care was severely restricted during most of the 1980's due to hyperinflation and economic hardship, and was exacerbated by internal armed conflict. This led officials to expect a high demand and intensive use of the new facilities due to a repressed demand. Although this was true for acute infections and some childhood diseases, many services were underutilized. At the same time health personnel were recording high levels of maternal and child mortality, many of them from preventable causes.

Several studies in the late 90's and early 2000's attempted to provide a framework to understand and provide recommendations to resolve this issue ([Lama 2000](#); [Llanos Zavalaga et al. 2004](#); [Dammert and Consorcio de Investigación Económica y Social 2001](#); [Petrera and Cordero 2001](#); [Valdivia 2002](#)). These studies recommended more investment in infrastructure and personnel in rural areas and also pinpointed several other problems which they contended directly affected access to health services. The identified barriers were economic, geographic and cultural. According to these studies these barriers interacted in diverse ways to influence the demand for services. As a result efforts to improve access to health care services provided by the MoH focused on overcoming them, and popularized the barriers to accessibility model at all levels of the health administration.

The expansion of the SIS and increase in new health posts, health centers and micronetworks were effected in part to respond to the combined problems of economic and geographic accessibility. The issues of cultural barriers became then one of the prominent explanations for lack of access to health care services and the subject of several studies and pilot projects.

4.2.1 Barriers to Accessibility for Birth Care

One of the most problematic areas of service from the MoH administration perspective was birth care. Studies identified a seeming paradox in the use of reproductive health services, specifically noting that levels of prenatal controls were high but actual birth in the health

service was very low. This was especially true for the rural Andes and the Amazonian regions.

Following the congressional ratification of the Millennium Development Goals there was a sense of urgency in government circles to find and fix the root causes of maternal deaths (Tavera 2007). Following the barriers to access model, which was also used to diagnose the wider system, the SRHS commissioned studies to research the barriers to birth service utilization. The studies conducted by medical professionals from NGO's and aid agencies, such as UNICEF and Pathfinder, identified three main barriers: (1) the cost of birthing in the health service and the need to pay in cash; (2) the long distances between rural hamlets and appropriate health centers and the lack of transportation; and (3) cultural factors, such as the need to have a warm birthing environment, enable various laboring positions, and dispose properly of the placenta (Gutierrez 2007).

Prenatal and birth care were the first services to be fully covered at public health services for the poor and extreme poor under the wider structural plan of abating the economic barriers. This constituted the first expansion of government sponsored health insurance that previously covered only pupils in public schools. The program, which began in 2004, paid for a package of prenatal and normal birth expenses in public health services. The amelioration of costs directly addressed the economic barrier to birth care, although it did not help with the costs of transportation and others associated with complicated birth processes occurring outside of the local services.

The geographic accessibility barriers generated a three pronged response which resulted from site specific evaluations of service access. The first policy response was to fast-track the expansion of existing micronetworks with health posts in remote areas. The DIRESAs and networks promoted community engagement and in many cases partnered with communal organizations to build health posts to expand their reach and funnel users to facilities with higher complexity levels. However, staffing became a problem with these remote posts, an issue that has partly been overcome in recent years through the decentralization of human resource management. This allowed local municipalities to hire personnel vetted by the DIRESA.

The second policy response to the distance problem also relied on community engage-

ment; personnel from micronetworks lobbied communal organizations and created Local Maternal Mortality Prevention Committees or *Comités Locales de Mortalidad Materna* (CLMMs) in many hamlets. These articulated with the existing Maternal and Perinatal Mortality Prevention Committees which were created in 2006, at all administrative levels of the MoH structure, from the micronetwork to the national level ([Min. of Health Peru 2006c](#)). Following a long tradition of state-sponsored communal organizations, in the vein of the health promoters and other community health agents, they appointed a president and secretary and the group was incorporated into the existing organization. This group of people, which generally included the community health agent, was tasked with checking on known pregnant women in their vicinity and organizing means to either transport them to the health service when in labor, or to relay the message of impending birth to the health providers. The effectiveness and contribution of this strategy to aid in overcoming maternal deaths were questionable. Lack of commitment and efficient response have been problematic in implementing this strategy ([Gutierrez 2007](#)).

The third policy response to the geographic barrier attempted to address the shortcomings of the CLMMs by bringing women to the health services before the onset of labor. The MoH proposed and implemented Maternal Waiting Houses ([Min. of Health Peru 2006d](#)) that were located near health centers. These centers theoretically provide a home-like environment where women can wait until the onset of labor. Some are located adjacent to the health center and others in a community house. Implementations vary because of local administration, which also allows for differences to make them more akin to typical local settings. As a general rule women are under the care of a non-professional health care person (a nurse's aide, for example) and receive some food and fuel from the health center managed Nutritional Assistance Program. However, community acceptance of this policy is spotty, and its effectiveness in overcoming distance problems is compromised. There are reports of coercion, restriction of movement and of women's abhorrence of being absent from household duties to their husbands, animals, crops and other children ([Summer 2008](#); [Flores Valdivia et al. 2010](#)). The maternal waiting house strategy is also considered a type of intercultural care by the MoH personnel, and perceptions of it are inextricably linked to those of birth care in general. As such these issues will be explored in more depth in later chapters.

On the whole the combined effect of the economic and geographic barrier amelioration policies certainly affected birth care in many areas, mainly increasing demand. However, much of this increase was located in peri-urban areas or engaged people who had already decided to go to the health services for birth care or who had a high probability of doing so, for example those who had previous urban experience or previous health concerns ([Tavera 2007](#); [Gutierrez 2007](#)). Much of the remaining core population of rural or remote Andean villages where most maternal or perinatal deaths were reported, especially among the extreme poor, were still largely birthing at home. MoH reports, articles and interviews with health care personnel attributed this to cultural barriers, namely the clash between desired birth care practice and that experienced or expected at the health service. The intercultural birthing policy was touted as a tool to overcome this barrier.

4.2.2 Background, pilots and policy making

The supposed problems posed by indigenous cultures' views on health and care seeking have been a focus of public attention for a long time. Historically the objective of the many and diverse public health education campaigns implemented in the Andes, and elsewhere, has been to change local custom and behaviors. In the early days of Peruvian public health the traditional Andean world view and its health related beliefs were seen as hindering the advances of biomedicine. This view was somewhat ameliorated with the rapid adoption of some aspects of biomedical care, like antibiotics and to a lesser degree immunizations. Nonetheless, traditional birth care beliefs and practices remained strong and ever present over time ([Yamin 2003](#)).

Several core differences between biomedical and traditional birth care in the Andes have been detailed previously in section [3.6.1](#) as have the programs and policies which sought to change the preference for home birth over health service births (see section [3.7](#)). The general strategy of these and other programs was centered primarily in changing perceptions in the population and creating ways to attract or funnel women into the health services for birth. The 2005 Intercultural Birth Policy marked a change of focus in the MoH programs by promoting changes in the health services themselves.

The broad policy strategy was introduced for the first time as intercultural adaptation of birth services in the first Maternal and Perinatal Death Reduction Plan produced by the Sexual and Reproductive Health Strategy in 2004 ([Min. of Health Peru 2004](#)). This document specifically stated that it was important for women to be able to freely choose their preferred form of birthing in a climate of respect for their traditions and customs ([Min. of Health Peru 2004](#)). As such, the 2004 document proposed conducting studies to identify the best way to implement this idea in the short term. At this time, pilot projects were already underway with MoH support and it was supposed that, depending on their results, one or more of their changes and recommendation would be incorporated into the final policy.

The final policy itself was based on regional projects undertaken by the UNICEF under the terms of its 2001-2005 cooperation agreement with the Peruvian government. The Peruvian chapter of this organization started working in the year 2000 on a program for Safe Motherhood in areas of high maternal mortality, as part of its overall mission to promote maternal and child health ([UNICEF 2004](#)). An analysis of existing data from its regional partners, the DIRESAs of Cajamarca, Cusco, and Apurimac, revealed a four-fold increase in prenatal controls but no concurrent increase in births. They hypothesized that given that prenatal controls had no traditional equivalent in the Andean world they had been accepted by the target populations. Birth care, on the other hand, had a long running and respected tradition and was amply preferred than the institutional option. They concluded it was important to focus on pinpointing the undesirable aspects of biomedical birth to make it more appealing and to close the so called ‘prenatal-birth gap’, that is the large difference between the proportion of prenatal care visits and the proportion of pregnancies that ended as births in public health facilities ([Tavera 2007](#)).

The UNICEF project conducted regional fact finding studies in its chosen intervention areas. Project personnel and MoH providers conducted interviews and focus groups which asked community women and traditional birth practitioners what problems they saw with birth in the health service and what would need to change for them to go there ([Tavera 2007](#)). Based on the answers received the project personnel identified ten barriers to health service birth that were directly related to the birthing services and environment:

1. Fear of exposure to cold temperatures which among other things causes a coagulation of

the blood commonly known as *sobreparto* which can lead to death or lifelong weakness;

2. Fear of cutting (episiotomy and C-section);
3. Discomfort with repeated exposure of the genital area as part of labor due to modesty or *pudor*;
4. Fear of high and narrow hospital stretchers;
5. Fear of soiling clean, white hospital sheets;
6. Discomfort with the lithotomic (flat on back) birthing position;
7. Mistreatment and discrimination from health service personnel;
8. Inability to understand health care personnel due to the use of technical language;
9. Anxiety over the disposal of the placenta, which is perceived as connected to health of mother and child after birth, causing sickness if not treated properly; and
10. Fear of being alone because regulations prohibited companions during the birth.

UNICEF (2004) proposed changing the environment and the practice of birth care in the health services by:

1. Reducing discomfort with exposure by designing and using a warm and full covering hospital gown and reducing the number of dilation checks;
2. Maintaining a warm environment by using small electric stoves to heat labor and delivery rooms;
3. Swapping the metal frame bed for low wooden ones and changing white bed sheets to preferred darker colors;
4. Allowing vertical birth positions for normal deliveries;
5. Giving permission for someone to accompany the laboring woman and participate in the birth process;
6. Allowing food and drink, including certain traditional labor-inducing herbs;
7. Giving the family the placenta for its culturally appropriate disposal; and
8. Sensitizing health care personnel to the ‘cultural needs’ of patients in their care.

Three pilot intervention areas were selected, one micronetwork with high maternal mortality and low health service birthing in each of their partner regional health directions, Cajamarca, Apurimac and Cusco. Reception of the proposed changes varied greatly among

medical professionals. Nurse midwives (NMs) were mostly in favor of the changes, but medical doctors felt it was catering to traditional methods that were ‘going backwards’ (Tavera 2007; Gutierrez 2007). Lobbying with the medical profession in general became a large part of the work undertaken by the project. This led to much of the effort being focused on the benefits of the change in position:

Finally for the doctor and the nurse-midwife it all came down to the [vertical] position, it was shall we say the spearhead. [...] first we had to get the academics [on our side] I started going to medical meetings and to the Gynecology and Obstetrics Congress to present research that came from the North but that revalued traditions in the South ⁵. I did presentations on what I had read on the evolution of bipedalism, the need for bigger brains, the vertical position as the best physiological way for birth. [I also had] a lot of images that I collected from historical sources [Peruvian, African, American Indian, European, and from other areas] that showed traditional [vertical] birthing techniques.[...] That started to change some of the perceptions. [However,] in the end nurse-midwives were [most] central to the process, it was them and not the doctors who moved the changes along. It was a luxury to have them in Peru and there were more than 5 thousand supporting us (Tavera, 2007).

Other medical advantages from the change in position, such as the reduction in vaginal tears and the less need for the use of episiotomy were also touted as a way to obtain support from influential medical professionals and others in the higher echelons of the health administration nationally and regionally.

When the pilot project areas demonstrated gains in birth care coverage, those experiences were promoted and sometimes replicated at the network and regional levels. On the whole, the improvements in coverage of birth care in the health centers generated considerable prestige for the Regional Health Directions and proved to be a political asset for regional governments.

The good results and support garnered in the intervention areas added to lobbying on the part of key academics and UNICEF officials, and were met with a particularly positive political environment at the central MoH administration in Lima. The MoH had recently begun a focus on bringing the agenda of human rights into health policy, specifically in regards to reproductive health and gender equity. Several important gains in reproductive rights, sex education and others were achieved during the tenure of then minister Pilar

⁵Refers to the Northern and Southern Hemispheres

Mazetti (2004-2006). This marked an important change of attitude in the MoH which had previously been under heavy criticism for its restricted actions on these issues ([Gutierrez 2007](#)).

The fortunate confluence of positive results and favorable political environment garnered a lot of interest in the pilot projects, including similar non-UNICEF sponsored projects in the Departments of Ayacucho, Huanuco, Amazonas and San Martin. Interest led to a series of meetings with regional teams from each intervention site, SHRS officials, representatives from medical professional organizations (College of Obstetricians and Gynecologists, College of Nurse Midwives) and other key actors. At these meetings the pilot process and results were presented and analyzed. The final policy document, based on the meetings, was produced by the SRHS team.

Although previous presentations and enthusiastic media reports had already produced support and interest for the policy, there was still a lot criticism from stalwart groups of medical professionals who voiced concerns about the efficacy and pertinence of these changes at higher complexity facilities. They specifically cited the lack of training and experience of health care personnel, the cost of retraining and the absence of ‘cultural need’ at these higher levels:

They [critics] basically said that hospitals and clinics were focused on more complex issues, their levels of normal births were low and their population was urban and modern and therefore found no need to implement any of these changes. And their personnel had to be trained, right? You know, in the end it’s not the way they know, it’s a change of status quo, an idea of a ‘progressive’ group of academics [they don’t agree with] ([Gutierrez 2007](#))

As a result the policy was promoted as a non-compulsory guide for rural low complexity facilities, for example, areas that were seeing very few health service births or had a large indigenous populations in their coverage area.

These restrictions on the mandate to only indigenous or rural areas was met with some criticism, especially by academic and non profit supporters, whose intent was to expand birthing options for all women in the public sector. However, those directly involved chose to view the policy as it was released as the first step on the road to achieving this goal. From the public health perspective the Ministry officials and medical professionals not directly involved in the pilots viewed policy measures as a low-cost, efficient way to increase coverage

and reduce maternal mortality. As such it generated a lot of interest at all levels of care in the public health system. It also produced a lot of attention in the national and international media where it was widely publicized ([Andina 2004, 2006a,b, 2007, 2008](#); [Fraser 2008](#); [Palomino 2008](#)), and touted as an exemplar way to change health care provision by making birth care culturally sensitive and accessible ([Diaz and Diario La República 2008](#); [Cavero 2008](#); [Diario El Comercio 2008](#)).

4.3 POLICY TEXT HIGHLIGHTS: *INTERCULTURALIDAD* AND VERTICAL BIRTH

The final document of the policy titled ‘Vertical Birth Standard with Intercultural Adaptation’, was approved and published in August of 2005 ([Min. of Health Peru 2005c](#)). The publication was sponsored by the UNFPA and it is still available through its Peruvian website. A number of English language copies were also produced in anticipation of international attention and due to the interest of MoH officials to publicize it abroad.

The cover (see [Figure 7](#)) features an ancient ceramic vessel from the Moche culture depicting birth in a vertical position. This figure is part of a widely circulated presentation compiled by UNICEF to promote policy adoption, and was chosen to symbolize the connection with tradition that the policy purported to recreate (Interview with [Hurtado \(2007\)](#)).

The policy document presents a brief historical review that describes biomedicine’s role in the change from traditional vertical birth positions. Additional background information describes the positive physiological aspects of the vertical position in comparison to the lithotomic (horizontal) position. The conceptual framework presents definitions for *interculturalidad*, vertical birth and birth plan.

The bulk of the document is dedicated to listing the human resources, environment changes and supplies required to implement the policy. Additionally, it also provides a detailed description of the specifics for management of labor at each phase with special emphasis on the changes encountered in the vertical position.



Figure 7: Cover of the Policy Document

Source: Ministry of Health and UNFPA, 2005

The concept of *interculturalidad* is given little prominence in the policy text, in contrast with the increased focus it received in later press reports and presentations. The definition itself is a brief verbatim quote from the First Chilean Indigenous Health Conference, sponsored and published by PAHO (1998). It has been taken from one of the presentations at the conference, and is not specifically the one that PAHO cites in the rest of its documents⁶.

In the policy text *interculturalidad* is defined as a:

[...] relationship between several different cultures that takes place with respect and horizontality, where none of them, is above or below the other. The intercultural relationship aims at favoring mutual understanding between persons from different cultures, becoming aware of the way the others perceive the reality and the world of the other, thus enabling openness and mutual enrichment [...] Interculturality is based on dialogue, where both parts listen to each other, where both parts talk to each other and where each part takes what may be taken from the other part, or simply respects the others' particularities and individualities. It is not a question of imposition or subjugation but of concerting (Min. of Health Peru 2005c:16).

⁶See 2.4 for a broader discussion of the concept

This definition emphasizes dialogue and consensus building; in this it follows the general essence of the PAHO definition (see Subsection 2.4.1). However, it makes no mention of *interculturalidad* as a means to create a more equitable society, something that is highlighted in the official PAHO definition (PAHO 1998). Nonetheless, this is the definition adopted by the Sexual and Reproductive Health Strategy (SRHS), and it is repeated in several other related SRH policy documents. It has also been copied in all related digital presentations that circulate widely at all levels of the public health system, thus ensuring that a large section of the birth care providers in the system is, at the very least, broadly familiar with the concept.

Although this was the first policy to directly reference *interculturalidad* in health, the MoH was already in the process of establishing *interculturalidad*, human rights and gender equity as transverse principles for all health care policy in Peru. This started with the creation, in January of 2005, of a technical unit which was in charge of proposing the guidelines for the incorporation of these concepts into health policy and of providing assistance in these efforts to all policy processes within the MoH (Movimiento Manuela Ramos 2005).

Noticeably, the definition of *interculturalidad* in the documents produced by this unit is more complex and differ from the one in the intercultural birth policy text. The fact that no representative from this technical unit seems to have participated in the elaboration of the final document for the intercultural birth care policy hints at internal division and compartmentalizing among MoH officials.

As such, the intercultural birth policy document presents a highly simplified idea of culture, and fundamentally equates the change in birthing position with intercultural care. It is this specific equivalence, not the idea of *interculturalidad* broadly understood, that is readily propagated by policy training, and which creates a dissociation with the other understandings of the intercultural agenda within the MoH and the government in general.

4.4 INTERCULTURAL BIRTHS IN CAJAMARCA AND CUSCO

Initial UNICEF pilot implementation sites of the intercultural birth policy were located in both Cajamarca and Cusco, but not specifically in the Kantu and Flores micronetworks. Implementation in both Kantu and Flores were part of the early replicas of successful pilots in nearby micronetworks. The initial implementation at the sites of the present study required the collaboration and participation of the existing traditional midwives, and also an accommodation of the TBAs role in relation to the health service. The following sections will describe the role of traditional birth attendants (TBAs) and the implementation and results of the policy text at the research areas.

4.4.1 Role of traditional birth attendants

In Cajamarca and Cusco, traditional birth attendants had been working under the auspices of the MoH since the early 1990's. Training manuals and official guidelines for the work with *parteras* were produced as part of the Project 2000 and funded by USAID, UNICEF and other non-profits ([USAID 1993, 2003](#); [Griffiths et al. 1991](#)).

According to the official training guidelines published in the year 2000, traditional birth attendants (*parteras*) were necessary due to the reduced number of institutional births and to ensure that women birthing at home were properly cared for.

In both research provinces, Quispicanchis and San Marcos, UNICEF had engaged traditional midwives to become part of the network of community health agents, through training and by providing 'clean birth kits' well into the 1990's. Additionally, in San Marcos, Aprisabac, a non-profit working with financing from the government of The Netherlands, continued training of midwives using similar strategies as UNICEF until the year 2000.

Throughout these years traditional midwives held a privileged place among community health workers. At the onset of the collaboration the training sessions were seen as a way for the health care service personnel to regulate existing TBAs, to ensure normal births were catered to with optimal hygiene, to extend the eyes and ears of the health care services to underserved remote communities, to identify possible complications, and to attract mothers

and their children to health service care.

However, there were issues in establishing and maintaining the relationship with the *parteras*. There were few incentives for established *parteras* to enter into health service training since the trade-off for being certified by health personnel and receiving materials was closer scrutiny from the health services. On the part of health personnel it meant additional responsibilities in regulating, supervising and training women and men with little medical background and who had few incentives to comply with health service regulations.

As the health care system expanded and more professional nurse-midwives entered the job market⁷ there was less support for the special relationship afforded traditional midwives. Additionally maternal deaths had not reduced as expected. MoH policy makers supported the change in international policy which steered away from the TBA training model and called for re-orienting the Safe Motherhood effort and investment on medically trained professionals.

In this context UNICEF's Intercultural Birthing project proposal to the MoH was welcomed as a way to channel existing international aid to apply the new policy recommendations. In Quispicanchis and San Marcos, pilot UNICEF projects and replicas involved the participation of TBAs, who served almost as consultants, sharing their knowledge and coaching NMs in the vertical birthing process.

The process implementation in Flores, for example, began with meetings between the community health agents, local *parteras* and nurse midwives. In interviews with Zoila and Maria, both traditional birth attendants in Flores and El Yuyo respectively, they describe how all community health agents participated in meetings with NMs who wanted to share experiences of home birth, learn practice of vertical birth and be informed on the uses and types of herbal medicine. Participating TBAs were accustomed to being called on for training workshops and assumed this was more of the same:

We were sitting in a circle and the *señoritas* asked us how we did things at home, they said they wanted to learn and understand. I told them about the pulse, when it becomes fast-fast then it is time to push, but they only knew about putting their fingers into the

⁷In the mid 1990's there was a sharp increase in the number of professional midwifery programs created in existing and recently established universities, especially in regional capitals. These programs were part of a large-scale professionalization effort which catered to the children of internally displaced migrants who settled in urban and peri-urban areas.

women. I told them the women here don't like that, you shouldn't do it! Then I told them about the herbs, and keeping everything warm, and that then we just wait for the child's time to come. I think they really don't know much because in the *posta* they make them push before it is time and then the woman suffers, her parts swell and then they have to take her to cut the baby out! Nobody wants that to happen to them! *Ay! cati, pa feo* (it is horrible)! (Maria, TBA, Flores)

Shortly after this meeting, Maria, Zoila and the other TBAs were told they would not be allowed to provide home births. From their perspective they were being marginalized due to the insecurities of the health personnel, who were intimidated by their skills and experience:

you know, they saw we were better, we knew how to do it with the pulse and how to treat the women right. Nobody wanted to go to the center. 'why go?' they said, 'if I can stay with you!' They [nurse midwives] are young and really don't know much, they don't even have children you know! So how can they tell someone how to do something if they haven't done it themselves! (Zoila, TBA, Flores)

TBAs in both Flores and Kantu were expressly prohibited from performing births as they had done before. They were also threatened with legal sanctions and jail. These threats were important enough that *parteras* in both areas ceased to be open about their practice and stopped aiding home-birthing women. This however, did not mean that they completely ceased to provide some services, and sometimes could still be coaxed by family members or close friends to be there for a home birth. On these rare occasions their participation was kept hidden from health personnel.

Paradoxically, continuing to offer some services covertly was possible because the quick turnover of health personnel, and the break in TBA connections with the health facilities meant new NMs did not know who was a TBA and were unable to enforce their ban. Sometimes TBAs passed for aunts, or other relatives, and accompanied women to the health facilities unbeknownst to health providers. In this manner they continued to offer women some measure of support and reassurance even when officially banned from practice.

On a larger scale the ban on TBA activities symbolized the loss of mutual respect which had been the bedrock of the relationship between the traditional practitioners and nurse midwives. In both research sites the end of this relationship was acrimonious. In Flores, health personnel who had previously worked alongside TBAs were rude, blunt and insulting to them and barred them from just showing up at the health facilities when a birth was in

progress. In Kantu, the shift in policy also created a discourse of denial in relation to the TBAs. The head NM in Kantu denied them any recognition of either worthwhile experience or even existence, she stated that *‘there is no such thing as a traditional attendant, because birth is physiological event and what they do is just waiting around and cutting the cord, and wrapping the baby. There is no skill in that, no knowledge’*. In denying the existence of TBAs she justified the increase in births at the facility, not as a result of banning TBA practice, but as the result of an education process with community women who had finally understood the risks involved in home birthing and were now voluntarily going to the *posta*. Furthermore, she denied the very existence of a cultural preference for a TBA assisted birth, which might deter women from birthing in her facility, stating that if community women did not go to the health facility for birth it was because they were stubborn.

Despite health providers’ assertions that TBAs in Flores and Kantu did not exist, or did not play any role in pregnancy and birth care, interviews with women and men in the community demonstrated that TBAs were very important in community life. They were often the first consulted when a period was missed and when there were any abnormal pregnancy symptoms. Furthermore, TBAs were still the primary providers of culturally appropriate prenatal care, providing herbs, advice, and adjusting the fetus to a head down position using massages called *acomodo* in Flores and *suysusk’a* in Kantu.

The inability of health care workers to recognize the continuing presence of TBAs in community life and the importance of engaging them have negative effects for how institutional birth is viewed by community members, and for how effective and respectful intercultural birth care can be.

4.4.2 Kantu and Flores: Implementation and Results

In Kantu and Flores the implementation of the intercultural birthing policy began in 2003 and 2004 respectively, before the publication of the normative document. However, in both cases the Regional Health Direction had produced internal documents systematizing the pilot experience which served as a guide to the replicating implementation sites.

In Kantu the implementation began in the old health center, with the conversion of the tiled covered birthing room with the addition of low wooden furniture and textiles. When the new health center was built, with the help of funding from an international aid agency, wooden floors were incorporated to all brick and cement design to make the birthing area warmer and more culturally appropriate.

The birthing room is small, has wooden floors and a low wooden bed which is shielded from view by a room divider that is covered by colorful local textiles. A small space heater is located next to the bed. To one side of the small room there is a gynecological stretcher and a small medicine cupboard. The Servo-Crib, which is used to warm and weigh the newborn, a small stool and the IV stand occupy the rest of the room.

A woman in labor accompanied by family members, coming from home or from the maternal waiting house would be received by the nurse midwife in service that day. The woman would be taken to the birthing room, checked for dilation, an IV line placed in her arm and depending on dilation left with family members and checked periodically. Following the policy document guidelines dilation checks were kept at the minimum possible given the evolution of the process. Birthing position is left to the decision of the woman, although NMs may be forceful in their suggestions if dilation and expulsion are taking longer than the time allotted for them. Once the child is born the placenta is birthed and handed to the family if they choose. The woman is cleaned with a damp cloth and then left to be cared for by family.

The Kantu health center has seen a remarkable increase in the number of births in the health center. According to its own data in the year 2001 only 28.6% of all recorded births in the area were completed in the center, that percentage was already increasing steadily but had only reached 35.6% in the year 2003. Once the changes were implemented the rate of institutional births jumped to 50.8% in 2005 and had reached 93.2% of registered births in 2009. It is interesting to note that the percentage of pregnant women who complete at least three prenatal controls (the MoH category of *gestante controlada*) has fluctuated between 65 and 75% in that same period, meaning that women who had received little or no prenatal care also birthed in the health service.

In Flores the health center is located on the main plaza, the intercultural birthing room originally conceived to double as a minor operating room is all tile and cement. Though this type of construction is terribly cold for the area, in the 1990's when it was renovated it was considered more hygienic and easier to clean than the original wooden floor structure. However, it does not suit the implementation of the intercultural birth policy well, since it is a large room, with two large windows and it is very difficult to keep warm. Because of this a big wooden dresser has been placed on one side of the room dividing the bed area and creating a smaller more sheltered space which can be kept warm with the help of a small space heater. The bed is low and made of wood, and next to it there is small metal receiving table with a heat lamp designed to warm the new born. On one side of the room there is an IV stand and a gynecological stretcher.

The birth process is similar to that in Kantu, the only exception being that due to the reduced number of personnel there is more involvement from non-professional staff, like nurse's aides (*técnicas*), and other non- obstetric personnel, in the birthing process. The placenta is given to the family if they ask for it, and the woman is kept in the health center from 24 to 48 hours after birth.

The rate of institutional births at Flores was 89% in 2009 and the number of controlled pregnancies (*gestantes controladas*) has ranged from 75 to a 100% since 2005. Immediately after the implementation of the intercultural policy in the micronetwork in 2004 institutional births jumped to 64% and remained thereabouts for the next two years. A new surge in the proportion of births in the center came after the beginning of the Juntos cash transfer program, in 2007 when births at the Flores health center totaled 89% of all births in the area. This increase was probably an effect of the confluence of the institutional birth requirement of the Juntos program and increased pressure on the part of the health personnel. Interestingly births by traditional birth attendants have remained between 10 to 20% of all registered births throughout the past decade.

The number of maternal deaths in the Flores micronetwork has also seen a reduction. In the year 2005 there were three deaths in the micronetwork; however, in the whole five years until 2010 the total number deaths was only three⁸. One of those was due to a placental

⁸Regrettably the epidemiological surveillance system shows that in the year 2012 two deaths had occurred

retention occurring during a home birth, and the other two were caused by high blood pressure and pre-eclampsia. The deaths occurred in the third trimester, and the women who died resided more than four hours on foot from the health service. These prompted the San Marcos network administrator to issue a warning to the Flores center and required more community visits. However, given the staffing restrictions, the problems in obtaining transportation and the large distances, complying with regular care hours and community visits was enormously difficult and increasing community time remained an unlikely undertaking.

It is interesting to note that given the transportation difficulties the personnel at the Flores Health center did not enforce the referral rule for women in labor arriving to peripheral health posts⁹. This was not done openly, since it was against MoH policy, however, in practice it was accepted that the peripheral health post would contact the center by short wave radio after initial evaluation to put them on alert about possible complications. Only those situations which were deemed too risky to continue at the peripheral posts were referred to Flores; for example, low fetal heartbeats, symptoms of high blood pressure or pre-eclampsia. Sometimes these were referred directly to the San Marcos Health center without passing through Flores. Normal births conducted in the peripheral health posts were registered as imminent by health personnel, meaning that the woman arrived so far along in the labor process that there was no time to refer her to a higher complexity facility. Although some of these births were really cases of imminent birth, most were not. Micronetwork personnel used this strategy knowing that community members who had already made a big effort just to come to the health post would not be convinced to go on to the Flores health center, especially if there was no emergency. In some cases, such as the outlying health post at Tinyacongá, a low lying district which borders the Marañón river distant seven to eight by foot and vehicle transports, the trip to Flores was not even considered and option for a normal birth process since it could be detrimental to the health of woman and child.

On the whole the results of policy implementation in both areas have been noticeable

in this micronetwork. No more information is available as to the specific causes since all other data is aggregated at the regional level. However, the overall death toll for the region has increased, prompting a 'red alert' and warning of severe consequences for health personnel who do not comply with regulations of care.

⁹Regulations state that health posts (Level I-1 and I-2) must refer all women in labor to a health center (Level I-3 or higher) unless the birth is imminent.

in increases in the proportion of births in the health facilities. However, in Kantu it is not apparent if it is a result of more acceptance of health service care, or of the creation of a system of punitive consequences for not birthing there. In Flores the increase in births in the health services immediately following the implementation was not as steep and the further gains of recent years seem to be more related to the district's participation in the Juntos program. Despite these increases in both areas there is still a proportion of births that occur at home.

4.5 CONCLUSION

The Peruvian intercultural birthing policy was part of a group of policies that sought to overhaul governing in the wake of the destabilization of the Fujimori years. This drove issues of human rights and culture to the center of policy making in the country. In the realm of health care this resulted in the incorporation of human rights, gender equality and *interculturalidad* as transverse elements of policy. Furthermore, the renewal of the decentralization efforts and the increasing awareness of the different health needs of culturally diverse populations gave more power to regional governments to effectively tailor regional policy.

In this context the intercultural birth care policy became the first to openly mention the need for respect and dialogue with other cultures, and to promote a tailoring of the birth care to accommodate non-biomedical needs. However, the inclusion of the concept of *interculturalidad* in the policy document seems almost an afterthought. The presentation of the concept is restricted to one quote, that is left unexplained and its complexity is lost. Additionally there is no mention of the transformative aspect of the intercultural agenda which is part of the documents produced by the MoH unit overseeing the inclusion of this and other concepts into policy. This serves to highlight internal division in the MoH, especially between the two major directions at the time Health Promotion, where the Human Rights, Gender Equity and *interculturalidad* Unit was located, and the General Health Direction, home of the Sexual and Reproductive Health Strategy. The latter did not recognize the

former's expertise or authority in the production of their 'technical' policy document.

Furthermore, the need to justify the change in position in biomedical terms and the scant explanation of the reason for the cultural preferences, make vertical birth the central theme of the policy. In emphasizing the birth position policy proponents sought openly to court medical favor and attempted to establish vertical birthing as one more option within public health birth care. However, strong resistance to change posed by the medical profession and the perception of the changes as too indigenous for 'high level' biomedical settings weakened the policy mandate and restricted its offering to the upper tier of primary care facilities, specifically classifications I-3 Health Center and I-4 Health Center with in patient facilities¹⁰.

In these settings the proposed changes are voluntarily enacted and depend largely on the understandings, skill and willingness of the health provider and their immediate superiors. At these levels it falls to the nurse-midwives to propose and implement policy recommendations. As a group nurse-midwives seem to have welcomed proposed policy changes. A further restriction on the implementation of the policy is the idea of 'cultural need', specifically the perception that it is only non-urbanized indigenous populations who possess it. This circumscribes the implementation areas to ever remote locations and conversely restricts options in rapidly urbanizing areas.

Implementation of the policy in Kantu and Flores was enacted with the initial help and transmission of knowledge from the local traditional birth attendants. However, in both areas once the policy was in effect in the health center they were prohibited from practicing the very things that previous health service projects had trained them to perform, prenatal care, and birth care, and also identification of danger signs. This disconnect with the health care services is such that their expertise in the arena of birth care is no longer recognized, and they themselves have become invisible to health care personnel due to personnel changes. By losing the connection with the TBAs health services are neglecting an important ally in the community, one that, despite reduction in birthing practice, still plays an important role as advisor and pregnancy and postpartum care specialist.

¹⁰As per the Regulation of Neonatal and Obstetric Functions ([Min. of Health Peru 2005b](#)) health services in levels I-1 and I-2 can only provide primary evaluations and must refer all births to health centers with higher complexity.

Although implementation results indicate a welcome reduction in maternal deaths, it is important to note that this is not the only expected outcome of the intercultural birth policy on paper, although it is often treated as such. This policy is also supposed to provide better quality of care by encouraging a respectful and culturally appropriate care environment. There are indications in the research areas that punishment for not birthing in the health centers may be the driving force behind the positive results. Furthermore, although the number of maternal deaths has been reduced and the number of births in the health centers has increased, the quality of care and respect of the rights of patients and their families is lacking. Thus questions remain as to the influence of perceptions of *interculturalidad* among health personnel and their application of intercultural discourse in daily care practices.

The following chapters explore the meanings of *interculturalidad* for health professionals at different levels of the MoH organizational hierarchy and analyze the supposed application of the intercultural framework to the birth care processes in Kantu and Flores, and describe the perceptions and strategies of community members and nurse midwives related to intercultural birth care.

5.0 THE MULTIPLE MEANINGS OF *INTERCULTURALIDAD* IN BIRTH CARE

Previous research experience in birth care in Peru from public health and anthropological perspectives (Burgos Langan 1995; Guerra-Reyes 2001; Evans 2013; Camacho et al. 2006) highlighted the role of cultural preferences for traditional home birth as one of the elements keeping women from going to the health service. These and other considerations led to pilot programs and ultimately to the formulation of the Intercultural Birth Policy (Niño de Guzmán 2007; Nureña 2009; Gabrysch et al. 2009), which showed great promise for both increasing in-center births and providing a more agreeable birth experience. The Peruvian MoH and the non-profits involved in its inception publicized it widely and set to promote it as a model for the Andean region. However, by 2007, the year I conducted preliminary interviews, the uptake of policy recommendations by regional governments was limited, and some pilot areas had stopped the program.

During that visit Jessica, a nurse midwife who worked with UNICEF in the initial successful pilot program in Cajamarca, promptly told me that they had stopped offering this type of care at her center because the *‘women in the area did not need it.’* She went on to explain that in the urban and semi-rural areas surrounding the health center, women *‘had a different mentality of what birth is, so they mostly give birth in a gynecological position, the women who are far away and higher (más lejos, más arriba) like Jose Sabogal or La Chira or from those areas who migrate [here]are the ones who do birth vertically and if they want it we do it.’*

What Jessica, her colleagues and some local residents who reiterated this idea, meant is that ‘having culture’ is something viewed as exclusive to those non-urban groups who live in the mountains, a euphemism for *indios* or indigenous. In this particular health service

this meant that medical professionals did not believe women in their area needed or wanted adapted birth care, and did not offer it, despite the existence of all needed materials (birthing stool, full coverage gowns, and herbs which I was shown), despite the expertise and training of at least one nurse-midwife and despite very little change in the demography of the area since UNICEF's pilot intervention. At that time I considered that it was likely that in an area where being indigenous brings stigma, women who view themselves as urban may balk at the notion of receiving a type of care associated with discriminated groups, thus reinforcing medical views and stereotypes. However, community women with who I talked reiterated the desire for a more home-like birth care practice, lamenting the disappearance and aging of traditional midwives and with some resignation accepted that it was now their fate (*'nuestra suerte'*) to go to the health center and submit to its practice. They were completely unaware that adapted birth care was an option.

This experience led me to ask how does the degree to which local groups recognize or value Andean cultural elements as part of their identity influence both policy implementation and acceptance?, Does a larger regional consideration of Andean elements in public life lead to stronger claims for cultural preference on the part of the patients? Does this then lead to more sites of implementation? and What does *interculturalidad* mean for the people involved in its implementation and practice in the case of birth care? These questions are considered and discussed in the following sections. The results presented here are based on interviews and informal conversations at three levels of health care provision (regional, network and micronetwork), as well as review of documents, and observations at those same levels.

5.1 INDIGENOUS CULTURE AND *INTERCULTURALIDAD*

Despite the recent formalization of interculturality as part of mainstream governmental discourse through the creation of the Ministry of Culture and Vice-Ministry of Interculturality, on the whole Peru lags behind other Andean neighbors in the official recognition of indigenous heritage and rights. There are no large scale indigenous movements, like those that occurred in Ecuador and Bolivia, which could trigger a national conversation and reevaluation of the

relationship between the state and the indigenous majorities.

There is one organization that represents a large portion of the indigenous populations in the Amazonian region, the Interethnic Association for the Development of the Peruvian Jungle (AIDSEP) which has included petitions for *interculturalidad* in health as part of their political platform. However, in the Andes, regional groups form and dissolve without coalescing into larger multi-regional movements. Some researchers have attributed this to the effects of the years of internal conflict, during which both Sendero and government forces targeted Andean organizations and leaders (Albó 2008). A large number of leaders perished and the traditional communal organizations were left in disarray. Others point to the effects of the modernizing push to transform the stigmatized *indios* into *campesinos*, going from ethnic to economic persona through state sponsored programs (Quijano 2005). Still others propose that pervasive racial discrimination leads to desire the ‘whitening’ effects which come with the definition of identity in economic rather than ethnic terms (De la Cadena 2000; García 2005; Weismantel 2001). A complete explanation would probably include all of these and other reasons as well. However, it is clear that the weak ethnic-based identity of Peruvian popular movements in the latter 20th century and to the present day have precluded a wider national discussion of *interculturalidad*. This in effect limits the possibility of negotiating interculturality and its meaning and scope at the national level.

Nevertheless, recent advances in political decentralization have provided space for discussions of culture and ethnicity to emerge as part of regional policy. Three related elements have led to this outcome: first, the need to court local voters for regional government elections, especially in areas of historically embedded distrust of the white or *mestizo* national government; second, the economic importance of tourism and the need for regions to brand themselves differently to appeal to diverse niches in the industry; finally, the increasing number of conflicts created by the extraction activities of multinational companies, which have galvanized disparate groups into politically oriented movements.

Despite growing prominence of cultural-related discourse, the existing Andean regional demand groups form around economic and environmental issues, such as rejection of mining or oil extraction, denunciation of contamination, and defense of local agriculture. Though many of these groups use the idea of cultural rights as part of their rhetorical strategy (one

example are the coca growers in [Canessa \(2012\)](#)), their demands and overall ethos are firmly economic. As a result recent discussions of interculturality on the national stage have almost entirely centered on the economic and environmental problems posed by extraction activities on native lands.

Cajamarca and Cusco are both part of this trend towards a regionalist discourse, but are on opposite sides of the spectrum in regards to their appeal to indigenous elements. Cusco's prehispanic role as center of the Incan empire has been the source of a longstanding array of activities which seem to lead towards an increasing revaluation of indigeneity as part of the regional identity ([Pacheco 2007](#)). Furthermore, Inca past is the bedrock of tourism, the second largest economic activity in the region, and the first for urban areas and the northern Urubamba Valley ([INEI 2010a](#)).

The use of traditional Andean and Inca symbols is mainstream in Cusco City, and is an important part of the region's social and political life. Civic celebrations, like the anniversary of the foundation of the university, or a local school, or the weekly Sunday gathering to raise the national flag in the main square, are always accompanied by groups performing traditional dances, and other characters inspired in Andean tradition like the mischievous *sagras*, a demon-like creature who chastises passersby and chases them with a whip. Civilian authorities brandish Andean symbols of political power like the traditional *varas* (batons), or symbols that link them to the Incas in general, like the large golden sun-shaped medallion worn by the city mayor and his council. Politicians, and public leaders in general, emphasize their 'indianness', wearing multicolored *ponchos* and hats, using Quechua words and phrases in their public speeches, calling on healers or *chamanes* and coca diviners, and making payments (*paqus*) to the mountain and earth deities (*apus* and *pachamama*). Quechua is routinely spoken even in urban areas, although most official business is conducted in Spanish. In the 2010 regional elections all but one of the seven political movements vying for the Regional and Local government seats used Quechua words (*ayllu*, *apu* and *tawantinsuyo*) or symbolic Andean images (potato, llama, mountains, and multicolored flag) in their group logos ([EleccionesPeru.com 2010](#)). Some of these groups also espoused fiery Quechua nativist rhetoric, criticizing non-indigenous politicians and, what they called the national *mestizo* and white establishment.

Cajamarca, on the other hand, tends towards the projection of a *mestizo* identity which seeks to separate itself from the Quechua speaking indians. Spanish is spoken by almost all the population in urban and rural areas. Only some communities, like Porcón and Chetilla, maintain Quechua as the language of daily life. Within the region they symbolize the stigmatized indian others ([Coombs and Coombs 2011](#))¹.

Historically linked to the downfall of the Inca empire, Cajamarca was populated by conquering Spaniards very early in the colonial period. As a result a considerable portion of the population expresses genetic traits linked to European ancestry, like pale skin tones and lighter eye color. These traits are exalted in colloquial conversation and valued over the darker coloring of most Andean Peruvians. The 2010 election cycle in Cajamarca brought few public discussions of culture and ethnicity. The campaign symbols referenced economic activities and farmer or *campesino* identity, like the machete, hoe, and the typical straw hat, as well as the implied ecological problems of mining activities for other economic activities like animal husbandry (a bull) and agriculture (a tree) which was the most contentious issue of the campaign ([EleccionesPeru.Com 2010](#)).

It would appear that the overt differences in reference to ethnicity and current use of indigenous related symbols in the public discourse should mean that there is a more horizontal acceptance of indigeneity as part of the regional identity in Cusco than in Cajamarca, thus making regional and local government officials more supportive of ideas of '*interculturalidad*' and intercultural programs in health.

However, during my research there was no indication that the word '*interculturalidad*' was relevant in public circles beyond the Ministry of Health and related academic and non-profit sectors. The main difference between the sites was that there was more public preoccupation with culture in Cusco. However, for all its overt indianness the Cusquenian reality is that it lauds the Incan imperial past and discriminates and stigmatizes its indian present ([Pacheco 2007](#); [Planas and Valdivia 2007](#); ?). Public references to indigenous groups in the present exalt only those elements that make certain areas of rural Cusco appealing in touristic, and therefore economic, terms. Conversely there is an almost constant hostile charge in relation to

¹Although both communities have been able to translate their unique traits into tourism opportunities for the region, their members are still discriminated against when outside their areas.

most other areas of indian life. In Cusco City discrimination is present in daily exchanges and insults and is equally or more contentious than the overt rejection of indianness experienced in Cajamarca.

Furthermore, though regional and municipal elections, which were in full swing during my fieldwork months, meant that there was an explicit interest in appealing to the indigenous or *campesino* vote, traditional healing and care practices did not figure into political or campaign discourse².

Nevertheless, it was clear that there were more sites of implementation of intercultural birthing in Cusco than in Cajamarca. Given the overt and covert rejection of current indigeneity as part of the regional identity construction in both regions, it seems implausible that the proliferation of adapted birth care responded to popular support for indigenous peoples and their cultural needs, thus raising the question of why intercultural birthing was implemented or viewed as necessary at the regional level.

5.2 REGIONAL INTEREST IN *INTERCULTURALIDAD*

Nationally the interest for interculturally adapted birth care grew because it was considered a solution to the reduced number of births which occurred in public health facilities, and to perceived cultural barriers to health care (See Section 4.2). However, the proposal and success of implementation depends on interest and engagement at regional policy levels.

Interviews with top health policy makers in the regional government, regional health directions and at the network level in both sites uncovered a broad interest for the possibilities of intercultural birth care as part of a larger package of maternal health reduction programs. However, there were no concrete actions to support health services implementing intercultural birth logistically or economically, and no future plans to extend implementation sites.

In Cajamarca the regional health director, a youngish doctor with an executive demeanor, was more interested in highlighting the importance of infrastructure and the direct cash

²Health and healing did figure in the electoral discourse of Amazonian regions promoted by AIDSEP.

transfer program called JUNTOS, than the possibilities of *interculturalidad* in improving care:

As I see it, it is something that helps, right? But there are other elements that are more important, for example roads and communication, a better implementation of the health services with equipment, personnel and medicine, creating new posts and improving others, and of course JUNTOS that has become a hook bringing the population to us so that we can offer our services(Freddy, Regional Health Director Cajamarca).

In Cusco, the regional director, who finally agreed to meet with me for five minutes after I waited outside his office for several hours, could muster only a meager interest in the idea of *interculturalidad*: *yes sure, we have been doing this for a while, it isn't new and rather it is more important to train our personnel I think, and that is what my administration is doing* (Daniel, Regional Health Director Cusco). He speedily referred me to the person in charge of approving external research in the area, who would not comment on anything related to the program, referring me again to a different official.

Nevertheless, the reduction of maternal deaths was a central preoccupation of top policy officials of both regions. However, the importance ascribed to implementation of intercultural birthing in each region varied.

In both Cajamarca and Cusco it was viewed as part of the 'maternal death reduction' package which also includes implementation of maternal waiting houses, expansion of prenatal controls to include labs and ultrasounds, and community level monitoring of pregnant women. However, there was more interest in making *interculturalidad* part of this package among mid-level policy officials in the Cusco region and the Cusco South network than in the San Marcos Network in Cajamarca.

Constantina at Cusco South was very proud of the overall reduction of maternal deaths in her area, but referred to the effort as an ongoing battle in which culturally competent care comes in at almost the last stage:

we must not let our guard down, we must keep our prenatal controls up, we must go to the community to seek out women who don't come to the services, we must expand our ultrasound coverage to nip problems in the bud, we can't let up, this is constant. Now once they come to birth we must strive to be competent and sensitive but that in and of itself is not going to reduce the risk of death (Constantina, Director Cusco South network).

However, for Manuela, the head of the San Marcos network, the most pressing issue was

the loss of trained personnel to the mining industry:

with our salary we just can't keep up with the amount of money they pay, and we have no medical doctors willing to come, so who is going to do the ultrasounds, who is going to manage the difficult births, we can't have maternal death prevention like this! At this time that is more problematic for our maternal care than other things (Manuela, Director San Marcos network).

In this sense, as policy official she was on the whole supportive of the strategy of intercultural adaptation for birth but was overall more pressed by the staffing issue to consider *interculturalidad* a priority in her network.

Despite meager interest from top-level policy officials in the continued implementation of *interculturalidad* for birth, there were existing implementation sites under their jurisdiction, as such it is important to understand the context of the implementation at these sites and the support they receive.

In Cusco, interculturality and changes in birth care protocol were seen as the measures needed for the emergency of 1997 and 1998 when an MMR of over 400 deaths made them the area with most deaths in the country. Cynthia, the highest level policy person in Sexual and Reproductive Health (SRH) at the DIRESA, tells of the sense of urgency that the MMR rate and the attendant political questioning brought:

It was terrible, they gathered like a group that reviewed all death cases and saw they were all in the periphery [areas outside urban centers] right? and they began to question colleagues, what happened to this woman and this other woman. Did they have their controls? like that. In the end it was concluded that most occurred in the home and could have been prevented. So that's how they began to look for ways to convince women towards the health centers right? To look at their customs, they built the maternal houses, and the awareness training (sensibilización) in interculturalidad...Thankfully though, we are not there anymore (Cynthia, SRH Cusco).

The emergency period not only brought action and change to the maternal health strategy, it prompted the Regional Health Direction, and now the Regional Government, to consider reduction of maternal deaths a priority. This means that maternal deaths are closely monitored and that death reduction has become a measure of pride for the corresponding government officials. Furthermore, the emergency period also cemented the use of the maternal death review (MDR) boards as fact finding and disciplinary measures, vaguely reminiscent of a trial, which is often mentioned and feared among nurse-midwives (NMs)

and other health personnel.

However, as Cynthia pointed out, the region's maternal death toll has steadily declined; currently the MMR borders on the 200 deaths per 100,000 live births, and more than ten years after the emergency it is evident that the role of cultural adaptation has diminished in prominence for maternal health policy officials. As such it was seen only as central to those areas where there are either still emergency level death rates, or those in which health providers believe they cannot convince women to go to the health service by other means.

In the terms of the barriers-of-access model that is prevalent at the MoH (See section 4.2) interculturality and maternal waiting houses in Cusco were perceived as an effective duo against interrelated elements of cultural and geographic barriers, especially with populations that officials felt were 'very entrenched in their customs', or those that were 'resistant' and were described as:

Those that come right up and tell you I don't go [to the center] because you're going to force me onto your stretcher and you're going to force me to be in this manner [makes horizontal hand motion] and I can't, I don't give [birth] that way, because my first child I birthed like this with my husband's help'. So, very chúcaros [contentious] and resistant to any progress as you can see (Cynthia,SRH Cusco).

Although one could also characterize these potential patients as outspoken about their cultural preferences and empowered, they are viewed as presenting a barrier to the efficacy of the health service in the area. Areas with low levels of institutional births in Cusco are often viewed as those 'where people are ingrained in their customs', thus they are areas where the policy is being or should be implemented from the policy officials' point of view.

On the whole interculturality and adapted birth care were still considered relevant strategies in the maternal death reduction package in Cusco, ranking third or fourth in importance, after staffing, equipment, training and sometimes waiting houses. However, the general understanding of Cusco officials was that the places that needed adapted birth care probably already had it, since it was those areas that were central to the effort of the emergency strategy of the early 2000's. As such there were no concrete actions in support of or expansion for the policy at the time of research.

In the case of Cajamarca *interculturalidad* did not appear as central for policy level interviewees, perhaps because they saw it as pertaining to a fairly contained and small area

of the region, those ‘higher up and far away’. As Freddy, the Regional Health Director, pointed out when referring to the intercultural strategy:

It's not big in terms of proportionality but there are three or four provinces that practice it, and then in some districts in those provinces more than others[...]Like in those areas where if you don't do it then you don't attend anybody. For example Chetilla is one of those [...] it is populated by native people, specifically natives, some say it was a place where the Incas punished people from Ecuador or the Tahuantinsuyo[...] it's an area like with a [pauses] more entrenched in the ancestral, into the culture, in this case, more of our Andean, ancestral, traditional world, no? where they still speak Quechua and dress in native clothes. There, for example, the doctor told me 100% of his births were vertical (Freddy, Regional Health Director Cajamarca).

Interculturality ranked low in terms of the overall maternal death reduction strategy for all policy makers interviewed in Cajamarca. Although Cajamarca at an MMR of 270 currently has a much higher rate of maternal deaths than Cusco, there was no sense of that constituting an emergency. The Regional Government had upheld the reduction of maternal deaths as one of its main concerns. However, it viewed its role mainly as supportive of the interventions originating in the regional health direction. The health direction was focusing on staffing as the main problem for all strategies and in that sense efforts were not focused on the reduction of maternal deaths specifically, creating somewhat of a rift with the regional government.

From the perspective of the regional health director, appropriate staffing of the health services would ensure a reduction of maternal deaths as well as support other regional governmental efforts. There was a particular poignancy to the personnel problems in Cajamarca, which differed from the regular issues of expanding facilities and recruiting extra personnel, specifically because they were unable to recruit professionals into existing jobs that already had allocated funds. As a result health posts were unmanned, health services were losing accreditation due to the lack of physicians or other higher skilled professionals, there was the risk of losing funding for existing positions, and public health care quality and accessibility suffered. The main reason for the shortage was the availability of better options for medical professionals. The region's large mining complexes pay three to four times as much as the MoH and were actively recruiting health workers with rural experience. Furthermore, the influx of mine-related money into the major cities of the region had increased demand for pri-

vate medical care³, creating lucrative opportunities for private practice which was siphoning away medical professionals from the MoH.

From the regional health director's perspective the most important element in the maternal death reduction arsenal was the JUNTOS program. JUNTOS, the Peruvian direct cash transfer program, is focused on the poorest rural areas, which are also the most indigenous, and it brought funds that could be used to cover payment to health providers in those areas. Additionally, the program requires its beneficiaries to comply with a set of educational, identity and medical responsibilities in exchange for the monthly 100 nuevos soles (approx. US\$39). One of the medical benchmarks is birthing in the health centers, and completing all prenatal, puerperal and well-child visits. The director called these requirements 'the hook' (*un gancho*), which could bring people into the scope of health service care and retain them there, neatly bypassing the issue of culture by mandating general compliance.

Although the other policy makers in Cajamarca, all midwives who were directly involved in the SRH strategy, were more enthusiastic in relation to the possibilities of intercultural birth care, they also believed the best way to ensure better maternal care was to improve the 'offering' of health services (*la oferta*), that is improving staffing, remunerations, training and equipment.

Rocío, chief social development official at the regional government and previous regional coordinator of the SRH strategy, summed this up:

We want the mother to feel good, with the attention, so she can come back and so that she can talk with the other people about it and say 'yes they're treating me [well]' this is cultural adaptation right? But I see it as a system right? So if something goes wrong cultural adaptation is only that! So we cannot intervene maternal mortality with cultural adaptation alone. If my services are closed, there's no technical competence, we have no resolution capacity, she's going to die anyway despite any good work I do in cultural adaptation (Rocío, Social Development Official at the Cajamarca regional government).

In this context of near labor crisis, expansion of the areas offering adapted birth care was quite evidently not a central part of their official strategy.

³As in other parts of Latin America private medical care is seen from a symbolic and practical perspective as better and more efficacious than public services. The ability to procure private care situates the patient in a perceived middle class, symbolically 'whitening' by cementing racial and class differences. Furthermore given the bureaucracy, lack of staff and persistent shortages of supplies at public medical facilities private sector medicine is often an effective and efficient use of time and resources for those who can afford it.

In both Cusco and Cajamarca the involvement of the regional health directions (DIRE-SAS) in the expansion and support for the intercultural strategy was almost non-existent. Both regions possessed networks that had been included in the original UNICEF pilots and were also subject to early replicas of the programs before the official policy change. All equipment needed for adapted birth care (stools, low wooden beds, darker colored sheets, and space heaters) had been provided by UNICEF or other non-profits working in the intervened areas. The general view was that all that was needed was already in place.

Ketty, the South Network SRH official in Cusco told me frankly, *“I don’t see any indication of expansion of the implementation, and to say that we at the DIRESA are buying any materials, beds or anything specially for this, no, we are not. Now I don’t know if la norma [the policy document] lists or requires any materials but we are not monitoring who has it or not.”* The issue of what is being monitored is relevant because it signifies the importance given to any part of the health strategy and it means that materials will be replaced by the MoH once they are spent. In essence the closer the monitoring the more importance ascribed to the program. As Ketty mentions the areas for implementation of adapted birth care are not subject to any extra monitoring on the part of the regional health department. The procurement and maintenance of any existing or necessary materials to ensure adapted care are the responsibility of the health center itself.

Existing implementation areas in both regions were closing down without much intervention from the regional health direction. Most of these were related to staffing problems, specifically due to the high level of attrition of personnel that had been trained in cultural awareness and on intercultural changes during non-profit interventions. There was no established system or policy that provided training in vertical birthing or on the changes of adapted birth care to incoming personnel from the Regional policy level. In this sense the continuation of vertical or intercultural birthing was entirely dependent on the disposition of the new person and immediate superiors in the rural health centers.

Furthermore there was little that regional policy officials were willing, or perhaps capable, of doing when a center decided to discontinue adapted birth care. When discussing research areas with officials in Cusco I asked about Quiquijana, an intervention area that had been mentioned to me as very successful and continuing, Cynthia from the SRH strategy hesitated

and after a lengthy pause finally admitted that the implementation there had fizzled:

Humm! I'd have to go and look at Quiquijana, there's not much going on there right now, before there was a colleague that managed things well, now....well you know it all depends on the personnel. [...] You know not everybody is on board like its not their vision[...]so it depends in what context you get them into right? so for example the new colleague is from the city, from Lima.. so you see not much we can do [makes apologetic hand gesture](Cynthia, regional SRH official).

Her laissez faire attitude about the continuation of the policy changes highlights two important themes that emerged from my discussions with policy officials. First, more than a policy, adapted birth care was treated as an issue of personal and professional commitment on the part of the health personnel. Second, that while the numbers were good, that is that while the levels of institutional births were high and maternal mortalities low, there was very little oversight into the activities of any particular health service.

Additionally, the murky issues of who could politically claim positive results and who was responsible for funding and supervision created by the recent decentralization also contributed to the waning interest in expanding intercultural birth at higher policy levels. Regional health directions (DIREAS) became part of regional governments in an effort to integrate decision making and oversight. However, the regional governments do not fully control the programs nor the funding, but are liable for the adverse health results.

On the other hand municipal governments receive some direct funding from the central government to support health care in their jurisdictions. However, there is very little oversight on the allocation of these funds, as the oversight is not part of the responsibilities of the region. On the one hand this could allow for a more comprehensive and locally adapted health services, where urgent local health needs are catered to with little delay by the municipality. However, it also means that direct health care money can be used for political gain or misappropriated. Additionally, it can also lead municipal authorities to misappropriate health related successes to themselves, much to the chagrin of the regional governments, who get questioned by central authorities when things go bad, and the health services workers, who do not feel appreciated for their efforts. For example, in the research districts of Kantu and Flores the mayors used the direct funds to support payment of two *técnicas* or nurses' aides. In Kantu one of them worked supporting the women who were living in the maternal

waiting house. The mayor took this circumstance to present the maternal house experience himself in a national meeting of mayors, garnering widespread attention as the champion of *interculturalidad*, effectively usurping the success of others involved in the venture.

In sum, although regional interest in intercultural adaptation of birth persists, the policy is viewed from a regional perspective as something pertaining only to what policy makers in both regions called the ‘resistant indigenous population.’ This perception and the aftermath of the maternal death emergency period in Cusco have led this region to have more sites of implementation of interculturally adapted birth care than Cajamarca. Paradoxically, *interculturalidad* is more accepted and used in Cusco because a larger part of the population is seen as a barrier from a policy perspective, and not because there is a deeper commitment to cultural respect or to providing culturally appropriate care.

Support for interculturality, and intercultural adapted birth care, is merely theoretical. In practice there is no evidence of material support or further training from the regional policy levels. Furthermore, there is no evidence of efforts on the part of regional officials to nurture and maintain the existing sites of implementation or to expand to other areas. However, there is a lot of ‘intercultural’ related discourse, which leads me to ask, what does *interculturalidad* mean for policy makers and health care providers?

Regional policy officials’ attitudes towards policy implementation provide some ideas to answer this question. In the following sections I explore the diverse meanings of *interculturalidad* at the different levels of policy making and also in the health care settings themselves.

5.3 UNDERSTANDING *INTERCULTURALIDAD* ON THE GROUND

Understandings or meanings of *interculturalidad* among MoH personnel are multiple. Interviewees at different levels of the implementation varied in their approach to the concept. Broadly speaking personnel who were directly in charge of providing intercultural birth care to indigenous women provided more concrete definitions of the idea, whereas those removed from actual care mostly gave by-the-book or broader philosophical answers. However, at all levels of policy making and implementation there was a clear division between a theoretical

or formal definition and perception of the concept, and an applied informal perspective. In some cases the applied perspective contradicted the theoretical one, although in practice it did not appear so to health personnel.

5.3.1 Policy Makers' Understandings of *Interculturalidad*

At a national policy level *interculturalidad* is one of the cross policy frameworks that supports the Sexual and Reproductive Health strategy, the others are gender equality and human rights. It was one part of a larger strategy and as such the framework of interculturality was seen by national policy officials as necessary but not sufficient to improve health care for rural or indigenous populations: *What we seek is reproductive health within the rights framework with focus on interculturality and gender, and all of **that** will allow us to reduce maternal mortality and improve outcomes [reduce deaths]* (Lucy, SRH Strategy Director Lima).

The understandings of the concept itself were closely related to later MoH documents (Min. of Health Peru 2009b, 2010), which present a more complex panorama than the scaled-down definition presented in the original policy document (see 4.3). More specifically interviewees mentioned the importance of receiving respectful care that part of the Peruvian Health Care Law (Gobierno del Perú 1997) and also article 24 of the UN Declaration of Indigenous Rights (UN General Assembly 2008). In this context *interculturalidad* viewed under the umbrella of human rights was a tool through which policy could ensure access to health care.

The implication was that *interculturalidad* could foster a more respectful and comprehensive approach to health care among direct-care personnel, and that this was desirable. However, in a practical sense, *interculturalidad* served to ensure results. After a lengthy discussion with the highest official of the SRH strategy in the country on the impacts of the policy, measurements of success and possible rejection on the part of the intended user group, she told me: *In the end the thing that matters are the numbers [of maternal deaths] if the numbers are low then interculturality or no interculturality, accepted or not, it doesn't matter as long as the number is good.* In this more applied sense interculturality became an issue of numbers.

Among regional policy makers there was also a split between theoretical and practical notions of *interculturalidad*. As an ideal notion interculturality in birth care was viewed as an expansion of options and an issue of rights, more specifically giving the woman the *right to choose whatever form of birth makes her more comfortable* (Manuela, SRH and San Marcos Network Director Cajamarca). In this sense *interculturalidad* was equated with respect and care which includes a larger attitudinal change. For example, Ketty at the SRH strategy in the Cusco South network mentioned:

When we talk of interculturalidad a health center can tell you that they are doing interculturalidad or I could say that I talk of interculturalidad because I am already doing vertical birth, but in reality it is the whole process of care be it a pregnant woman, a child or an adult, it should pass through seeing all the cultural context for the care, not centering all of it only on birth (Ketty, SHR Cusco South 2010).

This idea of *interculturalidad* as an attitudinal change in the approach to health care coincides with the view that implementation of intercultural birthing is mostly part of a personal commitment from ‘good’ health providers, thus desire from health personnel to provide caring service would lead him or her to attitudinal change, to view the patient as a whole person and to *‘empathize with the population, really connect, then you get to know the people and they you, you understand their customs and it allows for better care all around’* (Constantina, Director South network 2011). However, from this perspective the responsibility for ensuring culturally appropriate care falls squarely on the shoulders of the direct-care provider. It becomes an issue of professional adequacy and moral choice that liberates the broader policy echelons of the regions from accountability, and in essence moves the issue of culturally appropriate care away from the scope of the human rights discourse; it ceases to be a right of the patient and becomes a sign of the commitment or failure to commit from the provider.

Likewise the applied understandings of *interculturalidad* at the regional level, as education and a position, reinforce the notion of personal responsibility. Interviewees highlighted the resistance of some personnel to policy implementation. As one of the policy officials put it, *‘there was much discussion among colleagues to see if interculturality meant we were going backwards’* (Rocio, Cajamarca).

In this context cultural awareness workshops were organized for policy officials and direct-care personnel, as a result interviewees rapidly equated *interculturalidad* with educating in cultural awareness and tolerance:

So during sensitization [cultural awareness training] we tried to make them [health care workers] to understand the context of where they [indigenous population] live, you know that we are intruders right? We don't speak Quechua and even when I do my tone right? is not you know good...and we had groups talking about their rural experiences and we put the video [vertical birthing video prepared by Unicef and MoH] [...] but there was a lot of talk and resistance on the part of the personnel and if you come talking about traditional medicine, and their herbs and their rituals it's not what they know you know? (Cynthia, SRH Cusco 2010).

The cultural awareness process was focused on producing a change in the perception of direct-care providers towards cultural preferences that were previously deemed unimportant or retrograde, and provided a scaled down version of what policy makers termed Andean (in Cusco) or rural (in Cajamarca) traditions:

We learned about the problem of the cold, how they keep that room so warm that it should have no air coming in to keep the bad blood flowing, and how they leave the child on the woolen hide waiting until somebody who is not a blood relative can come to pick her up so they can be comadre, there was also something about the link between the placenta and the child and if they don't put it in the right place then the child might get sick (Manuela, SRH San Marcos 2010).

On the whole however, the process of educating health care providers in the MoH's view of *interculturalidad* was largely centered on the vertical birthing position, which was a somewhat contentious topic. Vertical birth, or birthing in a squatting or semi-squatting position, was not something most health providers had trained for, it was seen as outdated, and it was a complete change of perspective for the medical professional. However, it was also the most scientifically supported of the changes involved in adapted birth care. Although there are biomedical studies that emphasize the importance of family support during labor in obtaining a good outcome ([Chalmers and Wolman 1993](#)), as well as those that study the oxytocic and relaxing properties of some herbs during labor ([Westfall 2001](#)), the literature on birthing position is more extensive and has generated more support from physicians ([Zwelling 2010](#)). The cultural awareness training process focused on the positive aspects of vertical birth, because MoH and UNICEF support officials believed an evidence-based-scientific approach

would be useful in convincing health personnel and would pave the way for the acceptance of other elements of the intercultural birthing policy (see Subsection 4.2.2). A result of the emphasis on position change is that interviewees, and others, at policy and direct-care levels first identified interculturality as a change in position. Janet, for example mentions a poster and a calendar that ‘*show interculturalidad, right there with photos and everything*’. Similarly, when asked more generally about the status of the strategy, interviewees equated vertical position and interculturality, for example saying ‘*so almost 50% of births at that center [Santo Tomás] are intercultural you know in vertical position*’ (Constantina, Director Cusco South network). These quotes demonstrate that in the practical sense, the elements of cultural encounter and respect for human rights which are at the center of the theoretical notion of *interculturalidad* became almost an afterthought.

A contributing factor to the equivalence between interculturality and vertical birth, is that health personnel are required to register if a birth was ‘vertical’ in the Health Monitoring System, as such this number has become a proxy for establishing if a health facility or micronetwork is currently offering intercultural birthing services.

In sum, from the perspective of policy makers at all levels *interculturalidad* has a theoretical or discursive meaning and another more practical and applied. From a discursive perspective *interculturalidad* is part of a rights framework, a tool to aid in providing the right to access health care and the right to respectful care. However, from an applied perspective, *interculturalidad* is viewed as particularly useful approach to increasing institutional births and reducing maternal deaths. Although MoH documents and officials present interculturality as a path toward equity in care, the policies that invoke interculturality are geared principally to improving the numbers, that is increasing births in the health facilities and reducing deaths, if while doing this they also led to a more respectful relationship between indigenous communities and health providers then it was good, but that was not the main objective. On the whole, there is a distinct feeling that were these groups not viewed as ‘resistant’ to birthing in health facilities the trope of respect for customs would not be present in the official discourse. Additionally from the higher echelons of health policy *interculturalidad* has become somewhat synonymous with personal and professional commitment, a measure of the positive attitudinal change among health care providers, that abounds in

stories of non-trained personnel who sacrifice technical knowledge to better serve indigenous populations. Furthermore, at the regional levels of care interculturality has become equated with vertical birth. Although interviewees frequently assert the contrary, mentioning mutual respect and an ethos of service and sacrifice as part of their idea of interculturality, the number of vertical births is the way in which they value and evaluate existing policy implementation.

Finally, it is important to mention one glaring absence in policy makers' understandings of *interculturalidad*. Though some interviewees mentioned the idea of cultural encounter as part of the ideal of interculturality, the implication of their practical definitions, which emphasize accommodation, is that only those indigenous rural people who have to be convinced to go to public health facilities have 'culture'. There is no recognition that western medicine is itself a cultural construct. Furthermore health personnel, whom 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.

5.3.2 Primary Care Providers' Understandings of *Interculturalidad*

When discussing the meaning of *interculturalidad* and its application in health with nurse-midwives (NMs) at research sites, I encountered similar distinctions between theoretical and applied meanings of interculturality. The difference was clearer among health personnel in the Kantu micronetwork than in Flores. Overall in the Flores center there were no spontaneous mention of *interculturalidad* as a concept among personnel other than Sara, the nurse-midwife who had been involved in a training workshop. Other personnel involved in birth care at the center, the SERUMS doctor and the nurse's aide had never heard the concept mentioned before.

There were several reasons for this divergence. First talk, of culture and resistant populations was much more prevalent in Cusco than in Cajamarca as a whole, due in part to its very large monolingual Quechua population and the particular interest in reducing maternal deaths. Furthermore, Kantu had been designated as an internship center (*centro*

de pasantía) for people interested in learning more, and possibly replicating interculturally adapted birth care. Visitors came to the center at a rate of one or two groups a month and received a presentation on *interculturalidad* and adapted birth care. The workshop was conducted by the only tenured nurse-midwife, Gloria, but any of the other three NMs that were on duty also participated, ensuring their continued exposure to the concept.

The Kantu visitor's workshop was structured in three parts: first, a medical-physiological explanation of the advantages of vertical birth versus supine position; second, the presentation of *interculturalidad* and cultural adaptation; and third, evaluation of things learned. The whole process lasted around one hour, and the section dedicated to defining and discussing the concept of *interculturalidad* was the shortest segment. During the workshop I attended the definition that was presented and read by one of the NMs was *interculturalidad recognizes the right to cultural differences of groups and of their customs its is not an imposition but an agreement (concertar)*.

It was then followed by an explanation from Gloria, who was conducting the meeting:

So the key word there is concertar or negotiating right? so to value the other, absolutely nobody is above anybody, each one has their customs, different cultures, so interculturalidad is that, to respect one another and the fact of exchanging situations and negotiating so that things work out well, it's not about imposing, it's not about [mimics loud exasperated tone]'give you this injection because I know more than you, I have studied you don't know anything, I am the doctor I call the shots here, or I am the nurse-midwife [obstetriz], have you studied at the university? [acaso has estudiado en la universidad?] I treat you like I want' [returns to normal tone] It's not that right? but it also isn't that the patient comes and tells me [changes tone again]'no I don't want this I've never had it before so I'm not having it now!' [normal voice] Tampoco! [interjection and laughs] It's not about that either, the patient will also have to yield a little with knowledge [conocimiento]. (Gloria, Kantu)

There are some interesting elements to this definition and consequent explanation of *interculturalidad*. There is a brief but present mention of the issue of rights, and in this case specifically the right to cultural difference which is how the MoH is currently presenting the advocacy for intercultural adaptation. The mention also demonstrates that there is some understanding that there is such a thing as cultural rights or rights to cultural difference. However, in Gloria's explanation of the concept, and in follow-up conversations with her on the issue, the rights framework was not invoked. Rather the central point becomes *concertación*, which implies a process of presentation of divergent points of view, negotiation

and agreement.

Gloria emphasizes the issue of knowledge; first she implies that knowing or studying does not give one the right to decide treatment unilaterally, but at the same time she presents the opposition of knowledge and customs implying that one is indeed better than the other.

The presentation of the concept in the workshop sets up *interculturalidad* as a dialogical situation, very much in line with the formal definition found in MoH documents; but we get no concrete sense of how this dialog is enacted or how it may take place. Additionally Gloria mimics quite closely the dismissive attitude of medical professionals towards patients, garnering knowing smiles from the group. However, it was her interjection regarding the patient's participation that drew the most laughter. It underscored that although interculturality is supposed to be dialogical, there are limits to dialog, and that even among seemingly progressive minded professionals changes in patient attitudes remain so subversive they are funny.

Following on Gloria's definition the formal answers to my questions about the meaning of *interculturalidad* from all the NMs at Kantu touched significantly on the three elements related to achieving a joint agreement: respect, negotiation and yielding. More specifically they viewed *interculturalidad* from a practical perspective as mutual accommodation:

What interculturalidad is, is cultural exchange so you adapt and also imparting your own stuff, everything for the good of the patient, so I have learnt things and they a little bit, maybe a very little bit they learn also [...] for example they like for the moment of the placenta to put pillows a lot of pillows underneath so the woman is half seated, but all the literature and the policy (la norma) says you don't do that because the head is high there is more blood, that the woman has to be horizontal like flat, so when the baby comes out they say sauna, they call this sauna, and I say "Do you want your wife to die of hemorrhage (acaso quieres que tu mujer se muera de una hemorragia), that's not how you do it no pillows". So they say oh a hemorrhage, no! oh right? ya! señorita [...] and I also learn some things for example the force that the man has to apply [during the birth when serving as support] and also when they produce spasms (arcada) using the handle of a wooden spoon in the woman's mouth like to help with the expulsion of the placenta. So it is an exchange in cultures (Claudia, Kantu).

In Claudia's description we can identify the elements of the broader theoretical ideas of *interculturalidad* from Gloria's workshop definition, the idea that separate cultures learn from each other. However, the key element of her definition is the consideration of what is good for the patient, and it is clear that it is she (or the biomedical establishment) who

decides what that entails. Furthermore, although she speaks of a dialogical experience her example of providing learning or knowledge to the family members is aggressive, dismissive and humiliating.

From the perspective of the health personnel the intercultural dialog does not actually occur in the birth process itself but rather in the preparation for the birth event, and more specifically when, during the first prenatal visit, health providers ask the woman ‘how do you wish to give birth?’. I will describe prenatal control visits in more detail in the next chapter however, it is important to note that at this time they ask about preferred place of birth, accompanying person, and position.

During labor NMs only inquire about position, there is very little explanation of procedure and almost no talk of preferences, although it is all understood as accommodation:

It is a mutual accommodation, right? We as health personnel cede a little and they [patients] also have to compromise. So for example we allow them to give birth in a vertical position, we allow them to take hot beverages and we allow them to have their family there with them, and we don't make them change clothes, etcetera, etcetera. Even though those things can be a problem for us, the position is uncomfortable and family can be intrusive and problematic, but we make that compromise, see? However, there are some things that are not negotiable for us, the IV line for example⁴ and vaginal dilation checks also and they have to accept those. If not then we are going to have problems! (Susana, Kantu)

From these descriptions I glean that from the NM perspective the respect for culture and the dialog occur not on a person to person basis but on a more diffuse level. It's rather like they feel the dialog occurred at some point in the past, and that in the present they already knew what the women of the community wanted for birth and as such permitted those things they know to be medically harmless or perhaps helpful. Far from being respectful this attitude towards intercultural birthing felt more like a favor than the result of a negotiation.

Another prevalent understanding of *interculturalidad* from the NMs perspective at both research sites was that it mainly implied affection or warmth and a positive or flexible attitude towards the patients. Sara, the NM in Flores, proposed said that to her *interculturalidad* was an open and honest attitude:

I talk very frankly with the ladies that come here, I try to listen and to explain things clearly

⁴Placement of an IV is compulsory because it is used as a way to administer medication easily, it is most often used for the administration of pitocin to enhance contractions and to aid in the expulsion of the placenta.

and make sure they understand the consequences, and of course there are those that don't want to come to the center for birth, and I tell them please just let me know if you're in labor and at the very least I come to you right! If I was indifferent or mala as I know other colleagues have been then the ladies would not trust me. So to me it is more an attitude(Sara, Flores)

. Similarly, in Kantu Yuli was recounting the experience of referring a woman in active labor with a prolapsed cord to the regional hospital and reflecting on what the absence of an intercultural approach meant for her:

In the hospital they are cold, at least here we still have that little bit of sensibility of warmth to the mothers of having (sic) so much patience. For example with the patient I took to the hospital yesterday we arrived straight to the sonogram and then immediately the doctor shouted 'to the OR' and in the hallway they were taking her clothes off and you see her mother shouting, running behind 'chiri! chiri!' [cold in Quechua⁵] and she almost fainted, and nothing from the doctors, no chiri nothing (que chiri, ni que nada) they threw her out! [laughs] (Yuli, Kantu).

A different view of *interculturalidad*, from the perspective of Gloria and Sara, the oldest and most experienced NMs at both research micronetworks was that viewed in the long-term *interculturalidad* was possibly a passing fad. Although no one said this directly, it was clearly implied in the way in which both NMs recounted in different ways that they felt at times overwhelmed by the number of requirements from their respective regional officials and how over the course of their 20 or so years of work these had changed from the focus on gender, to the focus on family planning to the focus on maternal health and *interculturalidad*. Sara likened it to feeling like a 'fireman, always putting out fires here and there, and there is always some new training session or some new workshop that we have to replicate or implement on top of our regular work'.

Furthermore, the general perception among health personnel that a rural generational change would bring urbanization, progress and a change of attitudes toward birth care also added to the overall feeling that *interculturalidad* in birth was a temporary solution. At the Flores center, Gracia the SERUMS⁶ physician, explained how urbanization and experience of city life may prompt people in the area to go to the health service for birth care:

⁵The mother was trying to keep her daughter from catching cold which could imbalance her humors and put her life at risk see Subsection 3.6.1 for a more detailed explanation.

⁶The Rural and Urban-Periphery Health Service (*Servicio Rural Urbano Marginal de Salud*) is required for recent medical graduates of all specialties who seek to work in the MoH.

If you see the women here who have family in Cajamarca or in Lima, or other parts of the coast, or some who have worked there, it's like they already know how things are, and they even want to come to the birth center because they know in the city it is much much worse and at least here they have their family near and that, so it's like they are more learned (Gracia, Flores).

In this sense, NMs viewed induction into city life as a way to normalize a medicalized urban-like birth practice, which in turn would make adapted birth care more attractive in the short term and may, over time lead to complete acceptance of 'regular' health service birth. Similarly in Kantu Susana was telling me of how she encountered culturally adapted birth care in a health post as a recent graduate:

I was really new and the nurse's aide (técnica) was the only one with me and I was alone. So the very first time [I had a birth] I sweet talked the lady into letting me make her lie down and that was relatively easy because the woman was younger and had been in Cusco working, she was back in her community but she already knew. So that was great! But after that all the other times it was only vertical and nothing else. I had to learn on the job right? It's the same I see here [in Kantu] so when we have ladies who have lived outside or are younger they are more, hummm, receptive let's say! So maybe the younger ones than them with more knowledge it won't be like it is now (Susana, Kantu).

In sum, among the primary care providers interviewed there were also theoretical and applied notions of interculturality. However, in the case of direct-care personnel the applied meanings were constructed and replicated in daily practice and exchanges with patients and other health personnel. The applied understandings of *interculturalidad* which they espoused were very different from the those present in the MoH documents, they describe an intercultural practice devoid of any concrete dialogue and that perpetuates power divisions and distance between health personnel, patient and patient's family under the guise of mutual accommodation. Among health providers there was a sense that interculturality was a temporal framework which be rendered unnecessary by urbanization or generational change that would change community birth care preferences and practice.

5.3.3 *Interculturalidad* in Community Expectations

A key component to the success of any policy effort is responding to a demand or need of a constituency. In the case of the Peruvian intercultural birth care policy, there was no organized political constituency, indigenous or other grassroots movement that demanded

changes in health care provision to its members. The motivations for policy changes came from an evaluation of shortcomings and some sense of unmet needs on the part of the MoH.

In this sense the concept of '*interculturalidad*' was not at all part of the vocabulary of the communities where the interventions took place. However, the work of health care providers to promote the adapted birth care with the help of the community health workers did manage to convey to some community members the essence of early slogans; 'We treat you like in your home' in Cajamarca (see Figure 8), and 'We take care of your health and respect your customs' in Cusco (see Figure 9).



Figure 8: We treat you like in your home

In this sense although community members in the Picos and Uraymarca districts had not heard of the word *interculturalidad* or knew anything about the concept, there was a sense that something was changing in the health services and that this could mean an improvement in health center birth care.



Figure 9: We take care of your health and respect your customs

When discussing overall birth care arrangements with women in the Picos district, where the Flores micronetwork is located, the recurring view was that independent of location the goal of birth care was '*salvar con bien*'. This literally translates as 'to save well' and alludes to the danger of death in childbirth but also describes a broader sense of well being: '*when you save well ('salvas con bien') it means the birth was quick, the baby came out nice and easy ('salió bonito') and then your body is warm and closing well so you don't have problems later in life, you need to keep warm*' (Santos, Flores). Although there was consensus on the expectation of a 'good birth', women interviewed differed on whether the health care service was the place where *salvar con bien* could be accomplished.

Female interviewees in Picos were at the same time cognizant and doubtful of the policy changes. Reinaldina, a 35 year old mother of two, had birthed her younger child, now an 18 month old toddler, at home. She lived only 10 minutes walking distance from the health center, knew of the adapted birth care but did not want to go to the center:

They say that they treat you like in your home, but who knows? Cati! it can never be like in your house, it's their center and you have to do what they say [...] but if I call them to come to my house then they can be here with me in case something happens, we are very close to the center so if something bad happens then the ambulance can take me, but nothing happened no? (Reinaldina, Picos).

Reinaldina emphasizes two recurrent views among the women I interviewed in Picos, first a persistent doubt that health care workers would actually abide by their statement of treating you like in your house; and second, that the loss of control of the location also meant a loss of decision making ability. In the case of Reinaldina the fact that she lived so near the health center, was fairly well off by community standards and was well liked by health care professionals gave her many more options than other interviewees, she was able to have health professionals by her side in her house and these acted as a safeguard to possible problems.

I later found that a home birth with the support and company of family and health personnel was viewed by several interviewees in Picos as the ideal type of birth. However, as Reinaldina's case shows it is not available to most. The poorest, and those that lived far away from the health service could not be offered these perks. Women from households that were considered poor or extremely-poor were more likely to belong to JUNTOS and were restricted

by the fact that birthing in the health service was part of their agreement with the program. A home birth would be viewed as non-compliance and that meant temporary suspension of benefits. Women who lived farther away from the health facility faced additional problems which limited their ability to go to the health center, no cars, waterlogged dirt roads, and an area prone to landslides; because of these difficulties they were pressured to come early to and stay at the Maternal Waiting House. As such the tendency among interviewees in Flores was that women who were part of the JUNTOS program, and those that had previous urban experience, little family support, or previous history of complicated births viewed birthing in the health facility as the default option.

The distrust of health care providers was echoed by other interviewees; for them the mere consideration of going to the health center for birth care depended on knowing who was on call. Certain providers were seen as *buenas* or *buena gentes* (good or good people), amenable to negotiation and less likely to mistreat. They were preferred over those seen as more rigid. Given the high rate of rotation of personnel in the Flores health center, where an average length of employment was one year or less, interviewees could not depend only on personal birth care experience to ascertain the perceived adequacy of a health provider. Thus community members relied on experiences in prenatal care and word of mouth to form an idea of the character of the medical professionals. During my stay the current head of center, also the only nurse-midwife, was viewed largely as a good person. Sara, did effectively try very hard during prenatal controls to convey a calm and approachable persona. Furthermore it was not uncommon for her to tell pregnant women living in the immediate vicinity of the center the family could call her at the start of labor to accompany them in their home and to be on guard for complications. However, previous personnel who had originally implemented the policy, had a very different practices, which included the application of fines for birthing at home and also had a more severe way of treating the patients.

Saturnino, a young recent father and one of the only men in Cajamarca who had no qualms discussing ‘women’s issues’ with me, told me of his and his partners’ experiences with the previous NM. His now common law wife was only 16 at the time they got together, he was 18. A pairing at such a young age was not uncommon for the area; some interviewees had ‘gone off with the people’ (*se fue con la gente*), a euphemism for leaving home and

starting a sexual relationship at 14 or 15 years of age. These pairings often result in very early pregnancies which can be more complicated due to the young age of the mother. However, Saturnino, a carpenter's apprentice with migration experience in the coastal city of Chiclayo and no land or animals to his name, had internalized the idea of waiting to have children until he could afford them. So they had gone to the health service a few weeks after moving in together at his behest to get birth control. The previous nurse-midwife, Monica, had been very negative and threatened him with reporting to the police and with jail for statutory rape if he continued to live with Valeria. They felt judged and left; later Valeria visited the San Marcos health center on her own and obtained a Depo-Provera injection. Valeria became pregnant three years later at 19 and they were skeptical of the treatment of the health center:

'like we didn't want that señorita to be the one who was going to take care of us, so we went to Valeria's grandma, who is a partera and she said that she had other women tell her that Sara [the current NM] was a good person and that the other one had left! They said she had been reported and got changed centers. That's the only reason we went to the center for the controls and la señorita Sara was really good. For the birth she came down and was with us here at the house and then I took the baby with her to get her checked out at the center and Valeria only had to go a week later for her control' (Saturnino, Picos).

Coercive and strong armed tactics like those experienced by Saturnino and Valeria were frequently mentioned and generated considerable ill feeling in the community. Thus, it is not surprising that the main issue mentioned in expectation for birth care was 'good treatment'. In this large category interviewees included the general expectations which could be classed under cultural preferences like caring that the room was not cold or that the woman be adequately covered, and receptiveness to family presence and participation:

'[..]That they help us nice and talk to us nicely, that they let my mother and my husband in with me and that they let them give me my 'caldo de cabeza' for the strength Cati! or if not that they tell my husband what's going on! in sum that they help us well right? if they say like in your home then that they make it like that'

(Veronica, Flores) Other notable issues mentioned by Veronica and other interviewees are the general expectation of being treated respectfully and keeping family members advised of the process and interventions.

In sum, although cultural adaptation for care was known to the people of the Picos

district where the Flores micronetwork operated, the possibility of mistreatment and lack of respectful care kept interviewees away from health service care. In this sense the most important changes that the strategy of cultural adaptation was a more open attitude towards local customs which was brought by Sara. In her position as the head of the center she required that all personnel followed these guidelines, although this was not always heeded in her absence. These findings are similar to those encountered by [Niño de Guzmán \(2007\)](#) who surveyed men and women in the same province of Cajamarca to ascertain their expectations for birth care. Her study was conducted at the time when adapted birth care was being piloted in the area and shows that good treatment and active communication were two of the most valued traits in the new adapted birth care changes.

Though home birthing was officially prohibited, women and men interviewed in the Picos district still considered it an available option. In the Uraymarca district, where the Kantu micronetwork was located, interviewees were much less optimistic about their possibilities for home birthing. Although home births did occur it was generally understood that if you did not birth in the health center you would be liable for a penalty either to the communal organization or the municipal authority (see section 6.5). This meant that almost all interviewees in the Uraymarca district did not openly allow for the possibility of a home-birth unless it was an accident, thus the standard answer to my questions regarding non-health facility birthing options was ‘it is not allowed’.

Interviewees in Uraymarca also mentioned being treated well (*buen trato*) as the most important element needed for birth care. However, many saw the abusive language and general disrespect towards the patient as part and parcel of public health care, as Juana mentions when talking about the NMs at the Kantu center ‘*they come and go, some are good, some are bad tempered (aburridas) like any mortal. At first contact you know (a la vista se sabe) if she’s nice during the control doesn’t make you wait while she’s doing nothing or chatting away like some do then maybe she’s not so bad*’ (Juana, Uraymarca district).

For interviewees in Uraymarca good treatment did not necessarily entail respect, as they seldom expected it, but rather a good care of the body during and after birth. This meant that many of the claims of mistreatment implied critiques of current adapted protocol and also of the level of professional knowledge of personnel that was permitted to attend births

at the center.

The main problem that community interviewees from Uraymarca mentioned when talking about the need for good care of the body was the problem of cold (*chiri*) and the long term negative consequences of the cold air for the female body. Sebastian, a local man whose wife had had four children, two in the home with him, and two in the health service, viewed the relationship with the health services as an uneven endeavor that undermined the health of local women. After the birth of the second child at home Sebastián called the Kantu health center to let them know and they came with an ambulance to take her and the child to the center for a checkup. He was forced then to pay the health service the equivalent of two gallons of gasoline (around 25 soles or 10 dollars at the time) for the ambulance trip even though it was a short distance and the cost exceeded the market price of gasoline at the time. Because of the ambulance charge, when time came for the birth of the third child, they went to the health center willingly for the first time. After the birth, he was shocked to see that his wife was sent home very soon after birth, and from his perspective this constituted a grave mistreatment (*mal trato*). Although he believed that his wife didn't develop medical problems or *sobrepardo* because of his care, he views the declining resilience of other women's bodies in the community as the result of the health professional's disdain for proper care:

My first two they were born in my house. I cared [for her], fed her well and kept her warm [...] I know how to attend births and to bind the body very well, and then she gets up after a month, to wash her hands, mouth and head with boiled rosemary water. [...] But in the health center they threw her out after two days [...] we want women to be cared for five or six days that's what we want. I tell you Miss would you like to be put in a car after your birth, it shakes and damages us (maltrata), this makes us very very very ill[...] here in the country (campo) we work husband and wife together and we need more energy. In the city it's not like that with the women [...] now the señoras who birthed in the health center, they look like chickens with distemper (moquillo)[meaning frail], they feel everything, everything hurts, the teeth and neck (las muelas), the back, the head... (Sebastian, Kantu)

Another point related to the bad treatment or deficient care that was mentioned repeatedly in Uraymarca, is the perception that health professionals who care for them are students or apprentices and therefore less knowledgeable. From the community members perspective the fact that most of the NMs in Kantu were young, and more importantly childless, made it difficult to think of them as respected professionals despite their training.

During a leisurely conversation about the NMs at the center and their services, Carmela the wife of our landlord, a no nonsense business woman with ample migration experience, commented laughingly:

You know I was bad patient, chúcara! with the pain I thought my head was going to split and I know I shouted a lot and señorita Yuli was telling me ‘come on! hold back your pain!(aguanta tu dolor!)’ and I thought what does she know of the pain, you can’t learn that in her books, and they don’t know how to help you control [...] and I was desperate with the pain in the end my mother gave me something to bite on and that helped (Carmela, Kantu).

Carmela’s story echoes a recurrent issue, while the fact that NMs are ‘learned’ or *estudiadas* is recognized, they still lacked the personal experience with birth which in the community’s view sealed the book-knowledge into a recognizable expertise. On a broader level this perception highlights a basic difference in the conception of how knowledge is acquired and legitimized. Traditional birth attendants, male and female, in Cusco and elsewhere in the Andes build authority based on practice and favorable results. Whereas NMs base their authority first on biomedical education and then practice. In an environment of high personnel rotation, where the NMs in rural areas are those with less experience and many times filling yearly positions⁷, there is no time for the community to experience and corroborate their practice in the same way possible with a locally based traditional attendant. The fact that in Kantu most NMs are childless serves then as further corroboration of their lack of experience.

On the whole data at the community level indicates that ‘*interculturalidad*’ is not recognized or demanded as such. However, the expectations and issues that community members in Uraymarca and Picos brought up regarding birth care; achieving a good birth, receiving proper bodily care, receiving respectful care and the importance of legitimate knowledge are all considered part of intercultural health. In this sense there are definite points of connection between the ideal practice of intercultural health and community expectations for health service birth. Emphasizing these connections to health service providers and the community can be a valuable tool to further interculturality in birth care and to improve health care provision in primary care.

⁷See Chapter 7

5.4 CONCLUSION

Data collected in both research sites indicates that emergence and acceptance of ‘*interculturalidad*’ is not directly connected to a renewed vigor of Andean elements in public life. However, it is linked directly to the existence of large numbers of indigenous groups in one given area. More specifically, it is related to areas where communities, who are largely indigenous Quechua in Cusco and rural Quechua descendants in Cajamarca, are perceived as resistant to standard health care practices. Although in some other Andean countries this resistance has coalesced around demands for culturally appropriate care, the same is not true for Andean Peru. Although at regional levels there are politically active groups identified with re-imagined Incan or Andean imagery and ideals, these have not made health care a central piece of their platform. As such, community members do not recognize the concept of *interculturalidad* nor approach the health service with a demand for cultural respect. Although they do have demands for respect to elements that could be considered culturally appropriate care, it is clear that in the Peruvian case the ideas of *interculturalidad* have been appropriated by the government officials, and as such are re-signified to maintain the existing structure, losing all subversive or transformational qualities in the process.

The conceptual division between theoretical (or ideal) and applied (or practical) notions of *interculturalidad* is found at all levels of policy making and direct-care. Furthermore, the notion of cultural encounter was a recurrent element of the theoretical understanding of *interculturalidad*.

Furthermore the understandings of ‘*interculturalidad*’ at policy levels reveals that although in discourse it is presented as an all encompassing aperture to dialog and change of perspective in biomedical birth care, in practice the only feature recorded is the vertical position. Additionally, for all the promotion of interculturality that regional policy makers espouse they do not offer any support or incentive to the health centers that choose to implement the policy.

At the primary care levels where direct implementation occurs there is a serious cognitive dissonance between the discourse of intercultural birthing, the understanding of *interculturalidad* and finally the practice of birth. Intellectually NMs can speak of the change in the power

structure brought on by interculturality, the respect for others' cultures and the mutually beneficial partnership the perspective allows. As an applied concept they instrumentalize this notion into a logic of mutual accommodation, where each side cedes and also gains, through an active and productive dialog. However, in practice the dialog does not occur. Having been trained in interculturality, many NMs assume that training, prior experience and the normative document has told them almost all they need to know about the cultural preferences of the other side, and they take no time in explaining the reasoning for biomedical practices since they are the norm. Additionally the interaction is only respectful if the patient is compliant, and bears no resemblance at all with the ideal forms of intercultural partnership espoused in MoH discourse.

Furthermore, changes in the biomedical protocol to include non-standard elements are considered a temporary allowance which would change with younger generations and progressive 'modernization' or urbanization of the rural areas. As such '*interculturalidad*' in birth care becomes only a retooled biomedical protocol, with special allowances for vetted innocuous practices, and which does nothing to change the power inequity inherent in biomedical care. Moreover it serves as an instrument to normalize institutional birthing, and to return to the path of MoH standard biomedical birthing.

It is interesting to note that the issue of who possesses 'legitimate' knowledge emerges as one of the core sources of contention in the relationship between public health providers and community members. Though the adoption of a framework of *interculturalidad* considers that non-western medical knowledge as equal to biomedicine and the creation of a negotiated birth practice presupposes an equal dialog, it is clear that from an applied perspective policy makers and direct-care providers at all levels of care dismiss traditional medical practice. The MoH has officially alienated the TBAs who represent non-western birth care knowledge, and MoH staff views cultural preferences as 'customs' (not knowledge) to be overcome with 'medical-knowledge'. However, community members also reject the claims of the health providers to 'useful or legitimate' knowledge because of lack of embodied or practical experience of birth. The implementation of the intercultural birthing policy in Peru has recreated a long-standing confrontation about whose knowledge matters. In the case of birthing, however, it would seem that the power of a bureaucracy that has means

to cajole and coerce is gaining ground by subsuming re-imagined traditional elements into medical practice without granting legitimacy to its practitioners.

The following chapter will describe how interculturality is enacted in the pregnancy and birth process, analyzing the reconstruction of interculturality into a civilizing endeavor, inducting women into institutional birth.

6.0 CONSTRUCTING INTERCULTURALITY CIVILIZING BIRTH

This chapter will describe the use of interculturality on the implementation level. I propose that the way in which interculturality is being enacted on a face to face level reinforces existing structures of power within the health service. In the primary level of care from the perception of risk and contraceptive use, to prenatal care and into labor and delivery, the deployment of re-signified ideas of interculturality works towards the goal of modernizing birth care and normalizing a biomedical perspective of care. These results are based on participatory observation in the health services, including consultations and birthing processes, and on extended interviews and informal conversations with the nurse-midwives (NMs) and other health providers in the Kantu and Flores health centers.

6.1 RISK, CONTRACEPTION AND PREGNANCY

Although the scope of the intercultural birth care policy does not contemplate contraceptive care, the MoH itself has produced a guide on cultural adaptation of reproductive and sexual health counseling for indigenous communities ([Min. of Health Peru 2008a](#)). Thus in theory the whole approach to sexual and reproductive health should be conceived as intercultural. Although analyzing compliance or expectations with this document escapes the scope of the present research, understanding the context of contraception, specifically the notion of risk and the way pregnancy is received is important to understand the attitude of health personnel in the rest of the pregnancy and birth process. As such this section will briefly describe the identification and treatment of high risk women, the features of contraceptive care and the reception of pregnancy.

The Peruvian health care system organizes health care provision under a comprehensive health care model (*MAIS-Modelo de Atención Integral en Salud*) which takes the family as its unit, dividing it up in life stages to provide targeted care: children, teens, adults, and older adults. At clinics and hospitals of higher level complexity, health professionals of all types (doctors, nurses, specialists and nurse-midwives) are assigned to any life stage depending on specialty and experience. However, at the primary care facilities the program assignment is organized along professional lines: nurses and nurses aides are in charge of all programs related to children and teens (except teen women in unions), women in fertile age (15-49 approx.) are assigned to the care of nurse-midwives(NMs), and all the rest (adult men and older adults regardless of gender) under the care of physicians.

The life stages that are most important to policy makers are infants and mothers. As a group they are perceived to be the most at risk, but are also the most responsive to interventions in the short to medium term. Thus the programs that involve women in reproductive age and children up to age five receive more attention, more funding and more scrutiny. These programs include: family planning, pregnancy and birth, nutrition (including nutritional assistance), immunizations, well-child visits and targeted seasonal campaigns for acute intestinal illnesses (*enfermedades diarreicas agudas-EDAs*) during the hot season and acute respiratory infections (*infecciones respiratorias agudas-IRAs*) during wet season. Although each program has separate goals and results, there is an increasing level of collaboration between nurses and NMs to identify, attract and monitor patients.

The programs under the care of NMs(family planning and all pregnancy, labor and postpartum care) are undertaken in coordination with the national Sexual and Reproductive Health (SRH) strategy. The SRH strategy also coordinates prevention, diagnosis and treatment of sexually transmitted infections (STIs) which are screened for during family planning and prenatal care visits. Although for many women the first contact with the NMs at the health care service is through pregnancy, it has become increasingly common for adult women in unions to visit the health center for contraceptive care.

Increasing the number of women using modern methods of birth control has been a strong national policy since the 1980's and received a boost in the latter part of the 1990's when it was part of the Project 2000 program (See Section 3.7). Though much of the

underlying national rhetoric of contraceptive use is still imbued of ideas of population control as a means for development, both policy makers and direct-care providers were actively attempting to distance themselves from this type of discourse because it was symbolically linked to the abuses of the contraception programs of the Fujimori years during which forced sterilizations were widespread among indigenous women (Succar Rahme et al. 2002). As a result, the current contraceptive program does not promote tubal ligation or vasectomies as part of their contraceptive program, although they do offer them they are not publicized. Furthermore, policy makers have re-framed the matter of contraceptive access as a sexual and reproductive right, and under this framework it is a key element in the maternal death reduction strategy because, as the national coordinator of the SRH strategy put it *‘if you’re not pregnant you can’t die of maternal causes’* (Lucy, SRHS Lima).

Contraceptives at public health facilities in rural areas are free, however there is little variety to choose from. The most frequently used contraceptive methods in rural Peru generally, and in the research sites particularly, are the Depo-Provera injection and the contraceptive pills. Both methods require a medical visit every three months, to receive another injection or to replenish pill supplies. This strategy allows the NMs to keep a constant supervision and establish a relationship with the users, enabling screenings for other medical events, seasonal illnesses like flu, pneumonia and gastro-intestinal issues, or other frequent conditions like Malaria, Leishmaniasis and Tuberculosis. These visits also serve to screen for social issues like domestic violence, and also to offer special services, like Pap smears¹.

According to NMs at Kantu, women using birth control and correctly following indications were more likely to birth in the health center and be compliant. As the Kantu NMs explained it, women became familiar with the center and with the personnel, and were perceived to be more educated. Nonetheless, NMs in both research sites were generally wary of pressing the contraceptive issue due to the recent memory of abuses, and forceful and deceitful tactics used during the contraceptive program’s heyday in the 1990’s. As a result, NMs only insisted on use of contraception by those women who were considered at high risk

¹During the data collection period in Cajamarca there was a targeted campaign to increase Pap smears in the area, prompted by two recent cases of death due to uterine cancer. However, most women offered the procedure declined it or demurred and postponed the decision.

for death and thus were problematic from a public health perspective. Specifically:

1. Women perceived as older (by health service definition past 40);
2. Women with more than two or three children;
3. Single mothers;
4. Women with medical or mental health problems;
5. Women with previous pregnancy related emergencies; and
6. Women who had recently birthed.

This categorization is not officially sanctioned in policy documents, it is transmitted in the form of verbal directives within health centers and micro networks. The six categories I identified the research sites cover a broad swath of the female population and are the result of aggregated experience of obstetrical emergencies at the local level combined with moral judgments over who should and should not reproduce. For example, women over forty were perceived as high risk because of the dangers of several consecutive pregnancies at short intervals. In the Andes and in many rural areas a woman over the age of 40 have already had three or more pregnancies, and there was a generalized perception among health workers at the research sites that at that age Andean women's bodies were tired and spent from years of hard work and would not produce healthy babies. Thus pregnancy was discouraged and use of birth control methods aggressively pursued. A similar argument was made for the inclusion of women with more than two or three children in the high risk group though the medical reasons were not as compelling, in this group the push for contraception was linked to the perception that two or three was a sufficient number of offspring. On the other hand the inclusion of single mother's in the high risk group was mostly on social and moral grounds rather than medical, they were perceived as more likely to be promiscuous because according to NMs " *They are searching for a father to their child* "). Furthermore, they are perceived as more at risk because they lack a robust support system, perhaps they live alone, with elderly parents or have been shunned because of their single parent status, in these cases NMs argue that there is no one to call the health center or to take the women there should an unexpected event or emergency occur.

In the research sites, this medium to high risk group of women would be identified through community health agents or at the health center through other personnel. They would be visited, subjected to admonishing and, sometimes well meaning but quite menacing, lectures to convince or cajole them into acquiescing to using a modern method of birth control. Once a patient was registered as a contraceptive user, very close monitoring and multiple layers of follow ups were pursued. Patients would be reminded of upcoming visits when encountered on the street, at their children's appointments, at the schools directly or through notes taken by their children or when attending other medical visits, they would be sought out during market days and on special community visits. A missed contraceptive appointment would generate these same contact strategies with an added level of urgency, it wasn't unheard of for NMs to take contraceptives to the community women directly when possible and convenient.

Though intense, the methods of the current contraceptive program have been scaled-down from previous administrations. During the late 1990's the MoH had established a quota system which penalized health personnel for not achieving the desired numbers of contraceptive users, tubal ligations and vasectomies which led to rampant human rights abuses ([Succar Rahme et al. 2002](#)). Nonetheless, the pervasiveness of the current family planning program demonstrates that though couched in the discourse of reproductive rights an underlying attempt to limit rural fertility persists.

On a community visit in Flores, Sarah and I dropped in to see Maria. Sarah had heard she had accepted back her alcoholic husband into her home and was genuinely worried for her safety and that of her small child. Furthermore she was convinced, through local gossip, that the woman wanted to get pregnant again to somehow coerce the partner into staying with her. Additional dramatic details of how the previous child's pregnancy had been difficult due to her age and tendency to pre-eclampsia made her quest for birth control use all the more poignant. Once the initial niceties were over Sarah confirmed that the partner was really back and not at home, and launched into her worried big sister tone and lecture:

*Maria, I'm not one who is going to tell you how to live your life or what to do, if you want that *hombrecito* then that is your business and all I can do is wish you well right? But I **am** going to tell you that this has me worried because you stopped getting your shots, do you remember? You told me there's no man and no need, but now there's a man, right? and it is my job to educate you so you know your options right? Remember how you were this side of death when Carlitos was born, remember how we almost had to send you to*

Cajamarca? these problems could come back, you never know and then what will you do, what will your child do if you can't save well (salvas con bien)?, may god spare us (dios no lo quiera)/makes sign of cross/you know that you can even do this alone and nobody has to know, you can take care of yourself and your child and be safe, now you think about it and come visit me nobody needs to know anything ok? (Sarah, NM Flores)

During the whole of the short but urgent lecture, Maria said very little, she sometimes repeated ‘*mm I know*’ or ‘*yes, doña Sarita*’ and as we left she meekly assured Sara she would be up to center in a short while. Overall Sarah considered it a success and a good example of the education she and other health care providers bestow on community women.

This episode illustrates the way in which communication of medical risk is also imbued with the language of paternalism. In both Cajamarca and Cusco, health care providers interviewed, from the higher policy levels to the primary care levels, perceived community women in a diminished capacity for decision making, and as such in need to be taken to the correct option. This view was frequently articulated in the repeated mention of the need to educate women. Although clearly the role of a medical professional in any capacity does include the transmission of knowledge, the use of the term education observed in research areas was permeated by a sense of moral superiority based on biomedical knowledge which only admitted agreement. Thus, as in the case of Sara’s lecture to Maria, education efforts are basically one sided pitches which attempt to guilt or frighten² women into agreeing and accepting the biomedical point of view. This paternalistic attitude is a common feature of medical encounters (Nápoles-Springer et al. 2005; Zadoroznyj 2001), however in the research areas it becomes enhanced by the racial, social and economic inequalities which provide context to the medical encounter.

Furthermore, Sara’s lecture to Maria highlights the use of a discourse of risk and responsibility, which places the onus for adverse results on the women themselves. Thus in Maria’s case, she is reminded of her responsibility to her child and also of the apparent, from the NMs point of view, lack of barriers to seek contraception by doing it covertly. This invitation to covertly assume the only responsibility for contraception was a recurrent theme when pitching modern methods to patients, and was made easier by the widespread use of

²In this case, the mention of referral to Cajamarca is used as a threat since being taken to the regional hospital is one of the biggest fears of community women in both sites

the Depo injections. Paradoxically this proposal was based on the perception of the woman as diminished in her capacity to choose freely, because of her subservience to her husband, but at the same time required an act of rebellion which was viewed as smart by the NMs. The other side of this reasoning is that those women who could not choose or did not want to use modern contraceptive methods were dismissed as uneducated or downtrodden by their own inaction. As such, unintended pregnancies are frequently treated by health care workers as a personal and moral failure on the part of the woman. An exchange observed in Kantu illustrated this very clearly. Claudia receives Justina into the room, looks over the papers on her file, and asks her why she had come. Justina thinks she is pregnant and is worried because she is 45 and has six children:

Claudia [forcefully]: So, you could be pregnant again? Very bad, very bad, so now what's going to happen?

Justina [looking worried]: ay! perhaps I will die! what can we do señorita? You can't stop men.

Claudia: Well now you are in a dangerous situation no? You will have to come here for birth and maybe you will have to go to Cusco, they may even need to cut you [referring to C-section].

Justina: [looks shocked] You know señorita how our life is like and how men are like...

*Claudia: No, that is not an excuse because you know that **intelligent** women find a way to take care of themselves without their husband's knowing, **intelligent** women **find** a way, you know this... What can we do now then? We'll just have to see? no? (Kantu, Observations).*

In this particular case while Justina seeks empathy and reassurance, Claudia blames her for her inaction, for her lack of intelligence in managing or deceiving male desires and in doing this she also makes Justina responsible for all future negative outcomes and complications of her condition.

Although Claudia's negative reaction to this possible pregnancy may have been increased by the fact that Justina was part of a high risk group, I never witnessed a joyous or congratulatory announcement of pregnancy in Kantu. Pregnancy announcements were accompanied with an aura of disappointment, and in the case of method failure, open censure. Whereas in Flores, even in the case of method failure, it was something to be greeted with, at least, a passing congratulatory remark.

From a research perspective this apparent dislike coming from NMs whose careers are

based on caring for women's reproduction seemed out of place. However, over the course of my observations and conversations with the Kantu NMs I understood that there was an inherent mistrust in the motives of women seeking care. For example, those seeking to receive a Depo shot after a missed dose were perceived as wanting a *malogro* or abortion, although the NMs know the shot, a synthetic form of progesterone, will not cause an abortion, the belief that the 'hot' quality of the medicine or the supposed hormone overload will produce a miscarriage, is widespread in Peru. Additionally women who already had children and were poor and became pregnant were seen as doing it to be able to continue as JUNTOS beneficiaries. In addition to this mistrust the NMs in Kantu viewed the community's desire for children as utilitarian and profoundly different from their own perspective: *'they want kids to work in the fields, to take care of the sheep and the cows. Since it doesn't cost them? Right? the SIS pays for pregnancy and birth and then the child has insurance, and if they're in JUNTOS they can receive money for that child! If it was more like in the city, where children are expensive then they wouldn't have that many!'* (Gloria, Kantu)

Thus in essence NMs, in Kantu generally seem to disapprove of reproduction among their indigenous patients, saving their praises for those women who use birth control and only have two or three children and whom they see as more 'evolved', more urban and in essence more like them. The overall atmosphere of reproductive care in Kantu was an 'Us versus Them' affair where NMs perceived patients as constantly trying to trick and deceive them. Although, this attitude was not uniform among all the NMs³ it was reinforced in their daily patient gripe sessions. During these informal talks they collectively painted a picture of calculating or uncaring patients and strengthened their collective perception of moral and, cultural superiority.

Although I observed this only in Kantu, the themes of women getting pregnant only to participate in JUNTOS and the disagreements over early unions and the value of children were also present in informal conversations with health personnel in Flores. However, they were not as pervasive or damning, perhaps because at least two health workers came from nearby communities and that the NM was an older woman who came from a similar belief

³One of the NMs, Yuli, the only one with recent Quechua ancestry was generally wary and uneasy with these assertions, although she did participate in the patient critiques

system.

On the whole, however the three elements presented in this section: the perception of women as in diminished capacity to understand risk and act rationally in accordance to it, the perception of pregnancy as a moral failure, and the inherent mistrust of the patient's motives; characterize the relationship between women and NMs throughout both research areas. In turn they echo the mistrust that community men and women feel towards the health service. In this climate the incorporation of the discourse of mutual respect through *interculturalidad* falls on barren ground.

The following sections will detail the way in which ideas of interculturality are constructed and presented during the pregnancy and labor process. In these sections I will argue that intercultural discourse is being used as way to prompt 'urbanization' or civilization of birth care through small repeated impositions of power which seek to break down resistance and normalize institutional biomedical birth among indigenous women.

6.2 PRENATAL CARE: THE BEGINNING OF *INTERCULTURALIDAD*?

This section will analyze how the prenatal encounters between the NMs and pregnant women set the tone of interaction for the rest of the birth care process. On paper, the implementation of the intercultural adaptation policy should begin with the prenatal controls, thus they are viewed by proponents of the policy as the key to the construction of interculturality. Prenatal controls in implementation sites incorporate additional elements which are not present in regular (non-intercultural) MoH controls. These new elements include the preparation of a birth plan and an open ended discussion of birth preferences which should prompt intercultural dialog. However, observation data from the research sites indicates that intercultural prenatal controls do not promote dialog. Moreover, they serve to reinforce unequal power positions, and strive to cajole women into a submissive rather than cooperative relationship.

6.2.1 The First Control: Initiating the Relationship

Prenatal controls are the chance for providers and patients to establish a relationship. The first visit is perhaps the most important since it is the longest time a woman will have with the health care provider prior to labor and delivery. In Peru, women coming in for this visit within the first trimester are eligible to be refocused or *reenfocada*, which constitutes the maximum quality of prenatal control process within the MoH system. A refocused prenatal care package includes:

1. At least one prenatal visit per trimester;
2. Reception of folic acid and iron supplements;
3. A Dyptheria-Tetanus Vaccine;
4. A Pap smear;
5. Detection and treatment of Bacterial Vaginosis;
6. Full blood and and urine lab work (including Syphilis and HIV);
7. At least one fetal sonogram,;
8. Dental check up and cleaning;
9. Preparation of the birth plan; and
10. Counseling on: danger signs in pregnancy, breastfeeding and infant care, contraceptive methods, physical activity, rights and responsibilities in health, and personal and dental hygiene.

The MoH goal is to increase the number of women who complete this prenatal package. Both research sites were theoretically able to provide the complete package, although Kantu had better in-house lab facilities (Flores needed to send some lab work off-site), both had dental offices and one physician trained as a sonographer. However, in Kantu the dentist had recently resigned his post, making it impossible for them to comply with that part of care; and in Flores, both the dentist and the sonographer were SERUMS personnel who were unlikely to remain longer than their allotted 12 month service, thus endangering the continuation of the full prenatal package at the site. Despite the drawbacks the ability to complete the package and designate a larger number of women as ‘refocused’ gave more prestige to the centers.

In both the biomedical and intercultural birth protocols the first visit should serve to acquaint women with the personnel, their services, and to inform her of rights and responsibilities through the joint preparation of the personal birth plan (see Figure 10).

A typical first prenatal control begins after the confirmation of pregnancy through lab tests prescribed by one of the NMs, and it should ideally involve a complete physical check and workup of the past obstetric history of the woman, filling in the control card and birth plan form, an explanation of danger signs of pregnancy, the reception of the iron supplement and explanation of its proper use, indications for participation in the National Food Program (Pronaa) for pregnant and nursing women administered by the health center, and indication of tests and procedures that need to be completed before the following appointment.

The main difference in the areas that implemented an intercultural birth care protocol is that the first visit and the discussion of the birth plan in particular are slated as the beginning of the intercultural dialog. Thus questions like ‘Where do you want to give birth?’, ‘What position do you want to give birth in?’, and ‘Who will accompany you when you give birth?’ are designed to introduce the topic of birth preference which should lead to establishing the ‘equal and respectful dialog’ (See sections 2.4 and 4.3) which is at the heart of intercultural health policy.

However, observations in both research sites, on different days, times, and with different NMs reveal that prenatal controls are far from being dialogical. One reason for this is the sheer amount of paperwork that had to be completed by the health personnel in a short amount of time. For each patient the NM must fill in at least five forms or record books (SIS-insurance forms, JUNTOS forms, prescriptions, medical histories, lab orders, SRH strategy records and an obstetrical service log book). Thus from the patient’s entrance, almost to the moment of the physical examination, the NMs were filling in paperwork and there was little eye contact. When eye contact did occur it was when the patient did not respond to the NM’s questions.

Nonetheless, the lack of engagement with the patient was also a consequence of the inherent power imbalance in the medical interview and a consequence of the disapproval of pregnancy and mistrust of the patient. Typically, talk was unidirectional, from the NM to the woman, and consisted of questions toned imperatively (both in Quechua and Spanish).

Ministerio de Salud
 Promoción y desarrollo personal
 RED NACIONAL DE ATENCIÓN
 DIRECCIÓN NACIONAL DE SALUD

ESPERANDO MI PARTO

**ATENCIÓN INTEGRAL
ADULTO MUJER**

NOMBRE DE LA GESTANTE: _____
 EDAD: _____ COMUNIDAD: _____ Dirección de Referencia: _____
 GRUPO SANGÜINEO: _____ FECHA PROBABLE DE PARTO: _____
 ESTABLECIMIENTO: _____ RED: _____ MICRO RED: _____
 TELÉFONO DEL ESTABLECIMIENTO DE SALUD: _____ TELÉFONO ALTERNATIVO: _____

FECHA		1ª ENTREVISTA (I TRIMESTRE)	2ª ENTREVISTA (II TRIMESTRE)	3ª ENTREVISTA (III TRIMESTRE)
1	EDAD GESTACIONAL			
2	¿DÓNDE SE ATENDERÁ SU PARTO? HOSPITAL C.S. P.B. DOMICILIO OTRO			
3	¿QUÉN ATENDERÁ SU PARTO?			
4	¿EN QUÉ POSICIÓN PREFERIRÁ DAR A LUZ? ECONOM. SUCULIAS ASIMETRADA OTRO			
5	¿CÓMO SE VA A TRANSPORTAR EN EL MOMENTO DEL PARTO O EN CASO DE EMERGENCIA? CAMIÓN ACÉNSULA CAMILLA OTRO			
6	¿QUÉ TIEMPO TARDA EN LLEGAR AL ESTABLECIMIENTO DE SALUD?			
7	¿QUÉN AVISARÁ AL PERSONAL DE SALUD EN EL MOMENTO DEL PARTO U EMERGENCIA?			
8	¿QUÉN CUIDARÁ DE SUS HIJOS, SU CASA Y ANIMALES DURANTE SU AUSENCIA?			
9	¿ACEPTARÍA IR A LA CASA DE ESPERA U OTRA CERCA AL ESTABLECIMIENTO DE SALUD?			
10	¿SABE CUÁNDO DEBE IR A LA CASA DE ESPERA? (SI (FECHA) NO)			
11	FIRMA DE LA GESTANTE			
12	FIRMA DE LA PAREJA ACOMPAÑANTE O FAMILIAR			
13	FIRMA DEL TRABAJADOR QUE REALIZA LA VISTA			

(¿QUÉ PERSONAS LA ACOMPAÑARÁN O AYUDARÁN EN SU TRASLADO AL ESTABLECIMIENTO PARA EL PARTO O EN CASO DE EMERGENCIA?)

NOMBRE	PARENTESCO	¿DENTURA SANGÜINEA? FUEBRI MEDICAMENTO? SI / NO	DNI	FIRMA

¿QUÉ NECESITO PARA MI PARTO?

NOTA: Este plan deberá aplicarse en el 1er. Control pre natal y monitorearse mensualmente en las visitas domiciliarias, para tener el Plan de Parto final en el tercer trimestre.

Figure 10: Birth Plan- *Esperando Mi Parto* (Waiting for My Birth)

Source: MINSA and UNFPA (2005) Norma Técnica Para la Atención del Parto Vertical con Adecuación Intercultural

The sense of urgency and impatience was palpable, in Kantu for example, women who came late or near closing time were sent away and told to return the next day. Furthermore, in both sites all medical consultations on Friday were especially rushed and finished earlier so personnel could take their leave time as early as possible, many of them traveled to Cusco-City for the weekend if they were not on-call.

In this environment, one of the key pieces of the intercultural birth policy, the birth plan, was dealt with quickly and dispatched. In several cases I observed in Kantu, the phrasing and tone of the questions left no doubt as to the correct answer. For example: *‘so where do you want to give birth to your baby? here right? true? if not where? [smiles and laughter](en donde lo quieres dar a luz a tu wawa? aqui no? cierto? sino en donde pues no?)’*(Gloria, Kantu). In these cases, and others where the answer was a non-committal variation of *‘where ever it is best’*, NMs rapidly checked the ‘birth-in-health-facility’ column of the plan and moved on. During my observations the only time when longer discussions occurred in this part of the first visit, was when the answer provided to the birthing preferences questions were strongly biased towards home birth. Thus, for NMs the main objective of the birth plan was to identify ‘resistant’ families:

So you see if they answer they want to birth at home or with the partera then we can talk to her and convince her that the best is to come to the center with us, we tell them ‘it’s just like in your house! you want your partera to come? then bring her here! you want your mother, your husband there then let them come! and we talk about the dangers and all that. If she still persists then we still have two more applications of the plan during family visits..but we have to get her to agree to come because we cannot leave a birth plan with ‘home birth’ on it, then it’s like we didn’t do our job!’(Susana, Kantu)

As Susana’s statement indicates the NMs in both sites evaluate the success of the first control and the especially of the birth plan if all women agree, explicitly or implicitly, to health service birth. If the woman and her family are seen as favoring home birth, the NM in charge would attempt to coax her into declaring her preference for home birth. This process which the NMs in both areas called ‘education and sensitization’ (*educación y sensibilización*) followed a recurrent script which began with ‘Why would you want to do that?’ and would then go point by point on the woman’s objections and tried to elicit acceptance of health service birth.

Table 4: Typical Reasons for Home Birth Preference and NM Responses (Summary of 50 Observations)

Recurrent Reasons for Home Birth Preference	Typical Responses to Home Birth Reasons
Cold: <i>The cold makes us ill and in my house it is warmer</i>	<i>Have you seen our birthing room, it has a wooden bed and wooden floors and thick blanket to keep you warm (Kantu). Your family can bring hot beverages, and we can also make you some, and you can bring your blankets (Flores)</i>
Children: <i>Who is going to care for my children?</i>	<i>Can your mother or sister come, or a neighbor, an older sibling come if not bring them (Both)</i>
Animals: <i>Who will feed and care for my animals?</i>	<i>Find a family member or a neighbor or if not your community or your authorities have to help you (Both)</i>
After hours labor: <i>I'll only stay in my house if it's a night labor</i>	<i>No you can't. Even if its a night labor you can get to the phone and call the center, there is always someone here and in an emergency they can call the ambulance. Or if you can't get to phone send someone to call us or ask for help from the communal authorities (Kantu). Call the center or send someone if there's an emergency, If you can't, then come in the morning or call us so we can go get you in the car (Flores)</i>
Transport issues: <i>What if we can't get a car? It's too far too walk with pain!</i>	<i>You can always send someone to call us personally or by phone we'll go as far as we can to the community in the car (Both)</i>
Bad weather: <i>And if the weather is bad (generally refers to rain or icy conditions) and we cannot leave the house, even walking is a problem!</i>	<i>Call us and we'll see if we can make it. Also if you know that it's close to the birth and the bad weather season is near you should come and stay in the Mama Wasi or the maternal waiting house (Both)</i>
Agricultural issues: <i>It's going to be harvesting or sowing season and we'll be working in the fields far from the village</i>	<i>You should not be working in the fields so near to birth, you have to come to the Mama Wasi. Your husband has to care more about you and his child than his harvest, he can find other people to help him (Both)</i>
Lay birth care: <i>My husband (or mother, father, father in law, etc.) knows about birth and so with them I think it is better.</i>	<i>They may know about normal birth but if it gets complicated? It is dangerous and you can die! They know?! what do they know? have they studied?! (Kantu)</i>

Table 4 summarizes the most frequent reasons mentioned by women to prefer home birth and the typical responses NMs gave during the preparation of a concerted birth plan. On the whole the most important issues raised were the problem of cold air, the care of children and animals and the possible complications of inconvenient times or weather. Of these, the reference to cold is directly related to cultural preferences for care due to the Andean conception of birth as a hot event and the need to keep the body warm to facilitate it. Generally at the mention of Cold or cold air the NM would present the health center service as akin to a home environment. NMs would, then also typically ask about the desired position of birth and would then talk of the possibility of birthing on a stool or kneeling down, they would also mention the possibility of bringing husbands and mothers and other family members, and of using hot beverages to speed the birth, thus portraying the process as home-like as possible. This brief description was the closest any NM came to establishing some kind of intercultural dialogue with the patient.

In some cases this was enough for the woman to accept institutional birth, and the dialog ended there. However, if they did not, increasingly threatening rhetoric ensued. Interestingly, in Kantu there were more women who openly opposed or were reluctant to accept institutional birth however they boasted nearly 90% of births as institutional. In Flores, I witnessed very few contentious encounters, most women seemed to accept institutional birth in the first prenatal visit, but only 60-70% of births occurred in-service. Despite the low rates of institutional birth, and perhaps due to the lower number of total births, the attitude during prenatal controls in Flores was much more relaxed, the tone less authoritative or accusatory and the consultation was longer.

In Kantu the atmosphere and tone of the interaction with women who expressed preference for home birth was at best hurried and sometimes menacing. If the line of reasoning detailed in Table 4 failed, other more dire warnings were used, among them the exclusion of the JUNTOS program which requires institutional birth to receive the subsidy and also the possibility of death and jail time. Gloria, the only tenured NM in Kantu, for example told one patient who refused to agree to health service birth during the first control: *‘It’s not you I’m concerned about, if you choose that and you die then it’s really not my problem. You are an adult after all! But the child is my concern because you know now that the Peruvian*

State grants rights to the unborn child so if that child dies because you didn't come here then you could go to jail and you don't want that right?' (Gloria, Kantu). In this particular case the woman would not back down, and finally Gloria told her that they would talk about it at later time, that she would visit her house and talk to her husband and family. However, frequently women in consultations would not persist and would agree to going to the center for birth, even though perhaps they were not planning on doing so.

As Susana's earlier quote indicates, obtaining a commitment to institutional birth in Kantu is viewed as a successful result and proof that the NM is doing her job. As such, the younger NMs, who are on fixed term contracts, probably pushed harder for women to comply since they feared negative evaluations of their work. In Flores there was only one NM, she was also the health center head and thus not subject to internal evaluation. Furthermore since she was the only NM in the center, she could only do follow up visits with 'resistant' women in the vicinity of the center or in those where she could reasonably reach using the ambulance this may have hindered increase of institutional births in her area. However, although she also engaged in a script of increasingly dire warnings, her manner was more understanding and on the whole would consider attending births in the family houses if she could reach them and the condition of the woman and child was not dangerous. Her accommodating manner came across in the prenatal controls and several women told her they would only accept health service birth if she was at the center, but not with the female or the male doctor (both SERUMS) who covered her functions when she was away. Thus, they were marked as institutional birth on the Birth plan document, but were probably not going to birth in the center if Sarah was not present.

The refocused prenatal care protocol assumes three applications of the birth plan, one in each trimester, the second and third applications may occur during regular consultations, however in the case of 'resistant' women the NMs would preferably do a home visit. During these visits, the NM will attempt to convince the woman and/or her immediate family of the importance of health service birth. Gloria, the chief Kantu NM, assessed that if women refused to come to the birth center they could be convinced if authoritative figures in her immediate family could be made allies. In that sense visits centered on talking with the husband, the parents of the woman or the mother in law and '*enamorarlos*' (sweet talk

them) as Gloria called it.

In all cases of application of the birth plan, the document was signed both by the woman and the NM and any of the woman's adult companions. The NMs likened the signature of the birth plan to a contract, telling patients that it symbolized their written commitment and implying that a breach of what was stipulated may result in punitive consequences. Although this detail may seem of small importance, in rural areas in Peru signed documents are taken very seriously. As a rule, people will not sign their name on any paper especially if he or she could not read or understand what the paper said. In the case of the birth plan, even if the woman agreed with all the NMs suggestions (health facility births and stays in the Mama Wasi) sometimes there was still a struggle for them to sign the paper. In cases of home birth preference like the one above, for example the paper remained unsigned until the woman and family changed their minds. In Kantu, acceptance was further ensured by involving both the municipal and communal authorities who imposed fines or made obtaining the birth certificate difficult to those who birthed at home.

Apart from the questions regarding place and position of birth, the birth plan also had one section which was featured prominently in the following controls: the identification of danger signs. A series of drawings and pictures (see Figure 10) demonstrated women who have headaches, vomit, get dizzy, have foul smelling odors and were printed on the birth plan card. NMs would finish the first visit going through each with the woman pointing to the drawing and mentioning the danger sign in Quechua and Spanish, this part of the visit was supposed to educate women about the danger signs of common pregnancy related emergencies, however, the process was perfunctory at best, and were generally rushed. After the supposed education about danger signs the rest of the first appointment continued with signing women up for the national food aid program (PRONAA), providing iron supplements, and finally a physical examination. First pregnancy visits or controls as they are called in Peru, were very long, up to 30 minutes or more and NMs disliked them in part because of the length and the amount of paperwork involved.

At the end of the first visit in both Kantu and Flores, the woman and health care provider have established a relationship which will set the tone for the rest of care. If compliant and submissive, they are mostly deemed a thoughtful or good patient. If not, they will be labeled

difficult and contentious. Both types of patients have been informed of their responsibilities and of the negative consequences of varying from the path of in-service birth. However, for the most part they have not been informed of their rights and there has been no intercultural dialog.

6.2.2 Regular Visit: Continuing Supervision, Continuing Evaluation

The regular visits that follow the first prenatal control are mainly geared towards three things from the health care perspective: evaluating progress and health of child and mother, reiterating education on danger signs and replenishing the nutritional supplements. From an intercultural health policy perspective they should provide a space to continue the dialog established in the first visit and continue to develop the joint vision for a culturally appropriate birth. In practice, regular visits served to further constrain and cajole community women into the role of submissive patient. This was achieved through pressure strategies which included punitive consequences for failure to comply correctly with appointments, pointed discussions of the evils of home birth and by evaluating women on their knowledge and preparation for birth.

Although in both areas the follow up controls are used to apply further pressure on women to accept or continue towards an institutional birth, the strategies to achieve this differed. In Flores, the main strategy was for Sara to remind women of the dangers of home birth, especially with those who faltered when asked about preparations for transportation to the health service or those who lived too far away and did not want to go to the maternal waiting house in advance. She used her experience in the area to bring up cases of women who had died or nearly died in childbirth fairly recently. Juana for example lived in a community distant a three hour walk from the health center, although there was a road into the community, it only reached the central green area and her house was an additional 10 minutes uphill walk from there. The road was not paved, none in the Flores area were⁴;

⁴The closest paved road to the Flores health center could be reached after a one and half hour drive in the direction of the provincial capital. Secondary roads are seldom maintained, but the main road that connects to the paved provincial road is kept clear by the district which pays for a roller to compact gravel once a year. However, this treatment doesn't last long. During my stay at the beginning of the rainy season the main road was washed out twice.

this meant that in rainy season this secondary road was mostly unusable and the ambulance driver would not attempt to surmount it. Sara thought it would be dangerous for Juana to try to walk to the center with labor pains and wanted her to come to the maternal waiting house, located adjacent to the health center. Juana was pregnant with her third child, both previous births had been at home however she was considering institutional birth because of her family's participation in the JUNTOS program. She knew she was required by the program to birth in the center but was doubtful about coming to the maternal waiting house:

Juana: but señora Sarita if my husband calls why can't the ambulance come to get me? or let it go as far as it can and then I can walk the other part to meet it. Sara: Juanita and if the ambulance can't even get close, and if you can't walk, what happens if it's raining and you will catch cold and then what will happen to you? what will happen to your child? [pause] Did you know don Marcelo Acha, no? I will tell you. His wife was the daughter of Don Matias the governor from Agua Verde! When her time came, they sent the brother to call us. It was during that November that had the really heavy rain and the ambulance could not reach so close. We took a long long time to get there and then there was a complication with the placenta and it wouldn't come out. It was before my time here, but I was here helping out my colleague and we went together. We referred her to San Marcos and then she had lost too much blood, and she died at the center, god rest her soul. And you now that could have been avoided! She could have come to the maternal house but in the end [makes hand gesture] there was an unexpected problem. Dios no lo quiera [makes sign of cross] that it will not happen again but we have to take precautions! And doña Emilia from just up the road where the store is, she waited too long to come to the center and in the middle of the night the baby was born on the road! The problem is sometimes you only call us when it is too late or there you have been with pains for three days or come when it is already too advanced!

Juana: [looks worried but not really convinced]

Sara: Look, here in the waiting house is an improved stove and we bring you wood and give you some food, you can come with your children if that is the problem, and you know that if you birth with me you can be like in your house, ashuturada⁵ and covered. Hum? what do you think?

This particular strategy worked fairly well for Sara, who in this case was able to secure a firm promise to call the ambulance as soon as the pains started or come to the maternal house before the pains if the weather got too wet for the ambulance to pass. She tailored the stories to the woman and specific living area if she could and hoped that patients were sufficiently scared by the real references to come to the center or call the ambulance.

In Kantu, strategies tended to be more forceful. Although during controls there was also talk of the dangers of home birth, the main strategy I observed, the punishment for late or

⁵local dialect word meaning squatting

missed appointments, was not necessarily aimed at ensuring health service birth specifically. Rather, it was oriented at molding women into a regulated compliance of all health service policies including institutional birth. Regardless of the NM in charge, a late appointment, for example coming in the late afternoon or on a different day than was specified, was cause to be admonished and threatened with possible suspension of the food program aid. A repeated late appointment was cause for the NM to place a 'hold' on the woman's package of products. Although the NMs did not manage the delivery of food products from the National Food Assistance Program directly, it was managed by health service personnel. Each prepackaged portion consisted of vegetable oil, lentils and other grains, several cans of tuna or other fish and a dried flour-like nutritional mixture which had oatmeal and other grains. This program was designed to accommodate pregnant and breastfeeding women and children under age five who were in poor or extreme poor conditions. Given the rural nature of the research areas almost all families in then the towns and surrounding communities were potential beneficiaries. Pregnant women were signed up to the program by default. However, they had to demonstrate that they had complied with the required consultations to receive their portion. Each time a woman came for regular prenatal control their control cards were signed by the attending NM and they would also be given a small hand-written note signed and stamped by the NM verifying their eligibility to receive the food program package. Packages were handed out once a month according to a community role published in the health center. As a rule if the family had not claimed their corresponding monthly package they would not be eligible to receive it retrospectively. So if you came in late or somehow disobeyed the orders of the NMs you would effectively lose the food package. This was a recognized coordinated strategy at the Kantu health center to discipline families into complying with the required obstetrical and also child development consultations.

From the perspective of the Kantu NMs, women who came near the end of the day or a day or two late for their appointments were not taking their health care seriously and didn't really care about the supplements:

"there are roads, and public transport and they know how to plan [...]and I see them just dawdling (andando) in the shops or talking on their phones so if they come late or a different day it's because they don't want to, they don't care about the supplement. I tell you if you go their homes it's there, they don't eat it! They give it to their animals. You say you're

not going to give them their package and they come right back to tell you, they don't need it, so if they don't care, I don't either!" (Gloria, Kantu)

Although this may be true for some cases, the harsh response underscores the mistrust and general perception of dishonesty on the part of the patient. Any failing was seen as a sign of disrespect. This view indicates a basic misunderstanding of the many activities which rural women must manage on a day to day basis: the support role in agricultural activities, the care of animals, food preparation and other activities which ensure family survival. It also fails to take into account the rhythms of rural agricultural life which may require more labor at different times of the year. Additionally NMs do not seem to understand that one visit to town to attend a health center appointment may take a whole day between travel, wait time and consultation.

Although attitudes towards late appointments in Flores were laxer with Sarah (the NM), in her absence there was less patience with tardiness. Gracia or Leon (who came from a subsidiary health post when Gracia was off duty) the physicians who covered the obstetrical appointments on Sara's days off did chastise patients for coming in late and also warned them that they would send them home with no consultation if it was repeated. However, the food program was not an issue any of them could use as an incentive since Sarah, as Health Center Head, had designated that the reception of food aid program was a right that should not be withheld; thus even in the event of a missed pick up, packages could be retrieved for one month after the original date. This created some discomfort among staff, nurses especially, who had experiences of much stricter management of patients' food aid in other centers.

A further strategy to mold women into patients was the pointed and, sometimes, hostile evaluation of knowledge of danger signs. The danger signs pictures are printed on the birth plan, during the first control they were reviewed and explained briefly and there was an expectation that the woman should remember them for following controls. In Kantu the recognition of signs was almost presented as a test '*we'll see how much you were paying attention*', as a rule the NM would point to the picture and say 'what is this' in each one, the woman was supposed to answer too much vomiting, strong headaches, etc and the NM would follow each with '*And what do you do when this happens? You come to the center!*

right?’ There was little eye contact and sometimes palpable exasperation when the woman did not answer correctly.

Although the tone and general attitude of health care providers in Kantu and Flores differed in the application of the evaluation, it was clearly a stressful moment in the prenatal consultation. One that resulted, in emphasizing the separation between those with ‘the knowledge’ (health personnel) and those without. Furthermore in Kantu there was a general perception among NMs that it was necessary to be forceful because women in the community willfully neglected the health of the fetus: *They **do** know the danger signs, but they are very careless. Since here the child doesn’t really matter, even if she has noticed any signs these ladies don’t really take note if their child is dead inside her or not. When they have so many kids, one dies, one doesn’t, they don’t really care*’ (Susana, Kantu). NMs considered it was an effect of a cultural view of children as unwanted and a result of male dominated women who could not or did not use birth control. In their eyes, the woman failed by not using birth control and also by neglecting danger signs.

The whole interaction reiterated the message that you come to the center for each of those maladies. Sometimes the attending NM would also interject to not use herbal medicine ‘*I know in your community you sometimes take yantén for vomiting, or mate de hierba do NOT do it! then when you come to the health center you don’t tell us what you took and that can make you very ill! understand?*’ (Claudia, Kantu). Although herbal care in birth is recognized in the policy text the attitude to herbal medicine during pregnancy is very hostile. In Kantu all herbal drinks are forbidden during pregnancy and during labor NMs will only allow hot chocolate. Given that some herbal medicines are recognized in the policy texts, discussion of common maladies and herbal possibilities could serve as a way to engage in dialog with community members. The blanket rejection of all herbal remedies makes sense from a biomedical perspective, because of the dangers of self-medication health providers cannot endorse herbs they do not know; furthermore, names of herbs change between regions, and most personnel have no time, interest or resources to research which particular herbs are used in their area. However, health providers fail to take into account that most women will take herbs anyway and that not talking about herbal remedies are in fact not limiting their use, rather providers miss an opportunity to engage in intercultural dialog.

Thus at the end of each regular control there has also been no dialog, intercultural or otherwise, between the patient and the provider. Furthermore women and their families are further shown that any transgression of health service rules, especially in Kantu, will receive a punishment. As such they are continuously being pressured, tested and molded into compliance.

6.2.3 Nearing Term: Increasing Pressure

Towards the end of the pregnancy period, in the third trimester, controls take on an added urgency and pressure to conform to health center rules. NMs in both research sites will remind women of their commitment to health service birth, of the possibility of suspension from the JUNTOS program for not birthing in the center, of the dangers of home birth and of the possibilities of death or prosecution. These arguments are a reiteration of those previously espoused during regular controls. However, in these controls two additional issues loom contentiously: the practice of *acomodo* or *suysusq'a* and the use of the maternal waiting house or Mama Wasi.

The *acomodo* (*suysusq'a* in Quechua⁶) consists of massaging the woman's abdomen or shaking her on a blanket to correct the position of the fetus. It is generally administered by a traditional midwife or a knowledgeable older woman or man, who are sometimes referred to as *curiosa(o)* to indicate their understanding of some health related issues. These procedures are part of traditional Andean birth practice and are commonly administered throughout the pregnancy, but more frequently in the third trimester to ensure the child is positioned head down for birth. In both Kantu and Flores women interviewed regularly sought the *acomodos*, to help the child 'grow right' ('*criarse bonito*' in spanish and '*allin diricho*' in quechua). They also required them when they felt their child was turning into their side or into their back. Furthermore almost all interviewees sought a last *acomodo* before going to the health center for birth, as it was well known that if the child was not 'correctly in its place' they would be referred to the provincial hospitals for a C-section, commonly know as

⁶Suysusq'a literally translates as the substance you obtain when passing something through a sieve, because the short firm shakes of the blanket used during the *acomodo* process are similar to the movement used to sieve flour.

‘el corte’. This was a much feared outcome.

From the perspective of the health service personnel these practices are dangerous, especially in the third trimester when the child is fairly large; the umbilical cord may be wrapped around its neck or it may be too short and could pull on the placenta separating it from the wall of the uterus. Both occurrences can result in major medical emergencies during labor and birth. As such NM in both areas were adamant in warning women of the dangers of the procedures. At Flores they opted for restricting the prohibition of *acomodos* to the last month, but did not object too strongly to those occurring before: *‘you must not do any acomodados in this next month, you can tangle the child in his vince (umbilical cord) remember this! right now your child is straight and he probably won’t move from there so NO acomodados ok?!’*.

In Kantu NMs practiced zero tolerance to *Suysusqa*, chastising those who admitted to the practice during controls. For example Susana told one lady *‘if something goes wrong with your child I will not accept the responsibility if there is a tangle in his neck or there are problems with the madri (placenta in quechua) that will be on you! Because I know you have done Suysusqa even after I told you not to, do you understand?!’*. Furthermore, Kantu midwives had a spoken agreement to not inform women if their child was transverse during the second and third trimesters, unless asked directly, so as not to encourage the practice.

However, the most contentious issue of the third trimester controls is by far the proposal to use the Maternal Waiting House. Both health service sites administered a maternal waiting house which was part of the coordinated maternal death reduction package promoted by the Sexual and Reproductive Health Strategy ([Min. of Health Peru 2006d](#)). The objective of the maternal homes is to lodge women near the health service to reduce the geographic barrier of access to care (See Section 4.2) and to allow for rapid response in case of emergency. It is conceived as a public service and is frequently administered or supported by the local community. Although the strategy has been heavily promoted in Latin America and other parts of the world it’s effectiveness in aiding death reduction or institutional births has not been conclusively proven ([Van Lonkhuizen et al. 2012](#)). In Peru for example maternal homes are not necessarily welcomed since they require that women leave their homes, families and animals ([Summer 2008](#)). In both Kantu and Flores interviewees echoed this sentiment, trying

to avoid going there at all costs, some jokingly called the maternal home ‘the health center jail’.

In Kantu the Mama Wasi (quechua for ‘house of mothers’) was located in the old health center on the other side of the small town. The concrete health center consulting rooms had been converted into small bedrooms, some with bunk beds. There were at least six rooms used to lodge women. During my time in the area three rooms were in use. Other rooms were occupied by health personnel and by medical students from Cusco’s Universidad Nacional San Antonio Abad (UNSAAC) who were on a one to three month practice visit. The old health center, also housed the warehouse where the monthly food aid was handed out. Women living in the Mama Wasi shared one wood burning stove, two outdoor bathrooms and an open indoor grass patio. The municipality paid Frances, a nurse technician, to live with and supervise the mothers. She was in close contact with the women all day, organizing knitting and sewing, and also accompanied the NMs or doctors on their daily check up rounds on the lodgers. Women living in the Mama Wasi were rarely accompanied by other family members, were seldom left alone, unless they were in their rooms, and all their movements were registered as part of Frances’ job.

Although all women who went to the health service in their last trimester were offered lodging at the Mama Wasi, it was only required of those who lived far away from the center and could not provide details of their transportation arrangements, those that had indications of possible dangerous labors (multiparous women or those with previous history of complicated births) and those who certainly had to be referred to the regional hospital for a C-section (placenta previa, multiple births, high blood pressure, etc). For this ‘required’ sub group of women the Mama Wasi was very often an imposition, requiring extensive negotiating, convincing, sometimes involving coercive strategies or the police. For example, Olga, a 40 year old mother of four came to the center for a third trimester control, two months shy of her due date. She came from Chinchipugio, a community distant 3-4 hours by car and 6 hours on foot. Although her appointment was set for the following Tuesday she came on a Sunday because there was more available transportation to and from the community due to the weekly market in Kantu. The fact that she came in on a different day was not particularly welcome by the attending NM and set a stressful tone for the rest of

the visit. Yuli and Gloria are both present but Gloria led the visit. On reviewing her control card and medical record she notices a previous perinatal death :

“Gloria: [...]listen to me señora Olga. That child that died where was he born? Was it here or in your house?”

Olga: in my house

Gloria: listen well Olga, this is a reference center and we don't want to have any problems, you're not going to birth in your house right?

Olga: but that time I was coming here and on the way coming in I gave birth!

Gloria: No, that explanation is not valid, because you have to come to the mama wasi one month before your date! You are an experienced woman and you have to be responsible and do what's best. If you want to have problems you will have problems!! Look there's an ordinance here from the municipal authority that says that all women must come to the mama wasi starting the 9th month, not only from Chichipuggio, also from T'ika and Wayta(the two dependent health posts) they have to come here to birth too so that women and children won't die. They have doctors and nurses but they can't attend birth, the law forbids it, so all women have to come here and then we have to do this for prevention... see it is dangerous even with the doctor and nurses, but here we have the equipment right? even if the child is before their time we can save them, understand?

Olga:mmm! mmm![seems to be agreeing] but all my children have been born well and in their full time

Gloria: Oh! this lady [in Spanish to Yuli and me] we have had a lot of problems with her the last time! a lot of problems! [switches to Quechua again] No hija this time you are going to come to the mama wasi because your baby can come early, your matriz(uterus) is like a balloon that's been blown up too many times you understand? so we don't know how strong it is and your baby could come early! Since you're going to be in the mama wasi we can monitor you with a sonogram each week

Yuli: (in spanish) I don't think she wants to come to the mama wasi.

*Gloria: (in spanish) She better come, because if not I am going to make a problem for her. I'll talk to the authorities if I have to! (turns to the woman in spanish) You **are** going to come, right? Arí? (yes?)*

Olga: Yes (Arí.)

Although in this case the forceful talk and negotiation occur in the consulting room other occurred in the Mama Wasi, for example when women were told they should remain in town that very day. During observations in Kantu two women were told they must remain that day, although both made a few meager attempts to negotiate with the nurse midwives at the center with little success but were both able to negotiate a different intake day with Frances. Alcida for example told NM Claudia she came to her control but was not prepared to stay because she was in the middle of picking produce, if she stopped picking it somebody could steal it, this had happened to a neighbor. Her husband was working in Cusco and was

not due back until the following week, She and her children were harvesting the produce. Claudia, told her she should not be working, that she should have planned ahead, ‘*that’s what the birth plan is for! and here you said you would come to the Mama Wasi, is this not your name? you did sign this here right?*’ and asked her to follow her to the mama wasi. On the way Alcida tried to make phone calls on her cell phone and also tried to float the idea of coming back a different day. Claudia was not particularly receptive but left the possibility open, telling her that she could perhaps talk it over with the person in charge. Once there she presented Frances and gave her a copy of Alcida’s medical records and left. Alcida was then able to negotiate with Frances, who served as an intermediary with the NMs and was able to let her go home after obtaining a signed a written commitment to come to the Mama Wasi in two days once her produce harvest was completed.

In Flores the *casa materna*, was immediately adjacent to the health center it was an adobe and wood structure, similar to a regular community house, it had three single bed rooms a shared kitchen equipped with a gas oven and a wood burning improved stove and a shared bathroom. During my time in the community two rooms were occupied for a short period. The Maternal House depended exclusively on the health center budget, women there received their respective food rations from the assistance program but all fuel and wood was provided by the health center’s contingency fund or sometimes out of the pocket of health workers. There was no person directly involved in supervising the lodgers and no help from municipal funding. As a rule lodger would be visited once a day in the morning but for the most part came and went at will.

Sara, the Flores NM, also focused her energy on getting a specific subset of women to come early to the center, mostly focusing on women who lived very far away from the center and had known current health problems or had experienced previous problematic deliveries but who still were probably going to experience a normal birth. Women with known complications that were likely to need a c-section were generally encouraged to go to the provincial capital San Marcos, to seek consultation and if possible remain there for birth. The average time to reach the San Marcos Health Center was three hours, and at the time of research⁷ they also referred most c-sections to the Cajamarca Regional Hospital,

⁷San Marcos was in the midst of finishing construction on a modern maternal and neonatal unit. Once

distant another hour and a half. A woman in labor hemorrhaging from a placenta previa for example, would be in serious danger of death in this situation. Furthermore the roads frequently become impassable in the rainy season further hindering Flores' health center referral possibilities. Additionally women who did not have any type of complication but who were told to come to the *Casa Materna*, because of the distance or accessibility to their communities, were permitted to lodge with relatives or friends in the surrounding area, provided they received daily visits from the NM and their conditions' evolved favorably.

Overall, evidence from observations and interviews in the research sites indicates that the long arc of the prenatal control process serves in both sites to mold or induce women into a compliant patient role. Although similar strategies are employed in both sites to attain this goal, for example: fear talk, pressure on the families, mention of possible sanctions, etcetera. These carry extra weight and force in Kantu. There, strong arm techniques are more prevalent, interaction with non compliant women more contentious and general attitude towards patients bordering on hostile. Based on research experience I believe that language differences, general distrust of the population and less experience in the area may account for the differences in attitudes between research sites. I will explore these issues in detail further on, however it is important to note that the general differences in the interactions in the prenatal controls persist into labor and delivery processes.

At this juncture in the implementation of the intercultural birth care policy in the research sites the only reference to respect of cultural preferences or adaptation of services is made during the first control. However, it is presented as a set service and does not serve any dialogical purpose. Furthermore, during the rest of prenatal care interactions important cultural elements of traditional birth care like the *acomodo* are derided, as are lay healers and herbal remedies. Additionally the maternal house, a supposed culturally appropriate or home like service, is crudely enforced, and other important aspects of women's daily lives (household and family economy responsibilities) and values (role of children, need or use of food aid) are questioned or diminished.

The following sections will explore three scenarios of the labor and birthing process (normal birth, difficult birth and home birth) and their relationship to the implementation operational they would be able to employ obstetrical specialists and surgeons to conduct c-sections on site.

of intercultural birth care and the furthering of interculturality in health in Peru.

6.3 NORMAL BIRTH: YOUR CULTURE, OUR WAY

The care of normal birth is the center piece of the intercultural birth policy. Although there is a place for intercultural approaches to birth care in difficult births, the adaptation of health services and training with Andean birth elements is specifically designed only for normal birth. As such in both sites normal birth follows at least two basic elements of Andean traditional birth, the vertical position and allowing family members to actively assist women in labor.

In Kantu additional effort was made to keep the labor and birthing room warm, the room itself was the only one in the center with a wooden floor and had the only space heater, also some effort had been made in making the room seem little less clinical by draping local textiles on the bed and room divider. However, these changes did little to promote an atmosphere of mutual collaboration in birth since they followed the same controlling tenor of the prenatal control processs.

For example, Dominga mother of five and about to give birth for the sixth time came to the center with her husband, mother, three older female children and her sister. Desiree, the sister told me in spanish that they were concerned for her and her child due to her being advanced in age, '*Her madri could be tired, because it's grown (ha criado) five children already. We came early because of this*'. In coming early, almost as soon as the pains became regular, Dominga and her family were correctly following instructions given by the NMs. This was the first child to be born in the health center, although with the previous child now about three years old there had been some problems with the placenta which had required medical attention. While Dominga was being checked by Claudia, the six companions sat on the floor, stood around the room or just outside the door. Dominga's mother busied herself arranging their bags and unpacking a thermos and a small metal pot which they had brought covered by several layers of textile throws. Once Claudia had finished her initial dilation check and had set up the IV-line, she moved the room divider and saw the family scene. Angrily in

half-Quechua-half-Spanish she started *‘Oh my god! Mamacita! What is all this! oh these people! Look at this you have to keep the door free, how is anybody going to come in or out! [noticing the food and drinks] What is all this? Do you think this is your house? You must keep this area clean! Also let me see what you have there, it better not be mejorana (marjoram) the only thing she can drink is hot chocolate!’* Dominga’s mother answered that it was in fact only hot chocolate. Claudia told her that anything the woman was to eat or drink should first be consulted with her or the other midwives and left.

In this case, and others observed in Kantu, the more home-like the atmosphere surrounding the process the more contentious and strained the interaction with the NMs. Thus when there were a lot of companions, people coming and going, beverages and food being administered and several voices counseling and supporting the woman, Kantu NMs became less permissive and more hostile. In Dominga’s case the family was very much treating the labor area as their home, which is in essence what Dominga had been told she could do during prenatal visits. However, Claudia griped openly to me and the other NMs of the ‘circus’ that the labor room had become and in due time sent everyone out of the room asking Dominga to choose either her husband or mother to stay with her.

However, health personnel observed no restrictions on the number of people they invited into the labor room, health providers that were not directly aiding the process came and went at will. Furthermore, because of the privileged status of the Kantu center as an intercultural internship center many visitors who wished to learn more about the vertical birth process were ushered in without consulting the woman or her family. The first time I inquired about which family member to approach to ask permission to observe the birth, I was cautioned by the NM on call that I’d better not ask since they might say no. I did ask, but did not witness interns, or others doing so. At times this outside presence was overwhelming, for example in the case of Yolanda, a younger woman who was birthing her first child, she was accompanied only by her husband and mother, but during her labor and delivery there were five outside observers including myself, two visiting nurse midwives from Tarapoto (a northern department which borders on the Amazon jungle) and two medical students on a three month community practice course.

The control of food and drinks was also a source of contention, the adapted protocol

allows the use of traditional herbs (listing their names and uses), however in Kantu the only allowed outside drink was hot chocolate, and the '*sopa de cabeza*' (sheep head stew) for after birth. However, other herbs were frequently used in the area to help promote uterine contractions and speed up the dilation process, among them oregano and marjoram. According the Kantu *partera* and other community women the drinks also serve to determine if it is real labor since it is assumed that they serve to calm false labor and speed up the real one.

However, in Kantu health personnel were wary of the effects and did not approve of their use. As such each woman that came in for birth care was asked pointedly if she had taken anything to hurry the birth, one interviewee reported that the attending NM had doubted her answer and asked her sister to drink a little of the concoction they had brought. During research observations only one woman accepted having taken oregano ostensibly 'to see if it was real labor'. Gloria rolled her eyes and curtly told her that then she couldn't get the health center medicine for hurrying births (oxytocin) and ominously added that she hoped nothing bad happened to her for not doing things right. In talking with community women I learned that taking hot chocolate or herbs was the norm, and as a rule women took them before going to the health center and did not disclose it.

The strict controls of food and drinks and number of family members who can be present serve to reinforce the structure of power and knowledge in the labor and birth process, despite overt claims to the contrary there is in fact very little room for dialog. The locus of power remains with those who own the location of birth, the NMs, and although they assert their respect for the community's cultural preferences of birth, in practice they attempt to conform it closely to their own perception of a medicalized encounter. In that sense although the rest of the birth care process is similar to that of home environments, using vertical position, aid of family member, offering of the placenta for disposal, etc, the changed elements are almost offered as a favor. As such they are often used as way to induce cooperation saying, for example '*if you don't collaborate (push harder), I will take you to the camilla (stretcher)*' or '*I will send your mother out of the room*'.

Treatment of the birthing woman at this time can sometimes be forceful, especially if she is perceived as uncooperative, for example if she screams a lot or doesn't want to push. In

these cases professionals engage in threats, telling women it will be their fault if their child dies or other similar statements designed to startled them into cooperation. The threats many times prompted family members present to act, applying fundal pressure, putting their hands over the woman's mouths or generally encouraging them. For example in the case of Natalia who was having her third child. She was kneeling in front of her mother with her arms around her neck, while the mother secured her at the high waist. She had been pushing for several minutes, Claudia and Yuli were both aiding the process although it was Claudia's patient. While Natalia pushed Yuli chanted *Cogmay! Cogmay! Mamacita*[push, push], the baby's head appeared to crown three times, only to be sucked up again when she stopped pushing. Claudia was losing her patience and was clearly exasperated. She threw up her arms and said '*Ay! With this lady! Well I'm going to leave since you won't cooperate. You have already done this two times, do you want your baby to suffer? It's only you who can do this. In the next contraction you **have** to push down **hard!***'. While waiting for the next contraction Natalia's mother, who seemed anxious, left the room and ushered in an older man, the birthing woman's father, who sat in the same position as his wife. Claudia welcomed the change '*Okay now señora Natalia let us see if you are better with your father! Now push, hija push! Papá you help her push down also! Come on!*' During the contraction he didn't let Natalia stop pushing, applying strong pressure on the upper uterus with his knees. The effort left him sweaty and flushed. The combined force made the baby's head emerge and the body was born in rapid succession. In other similar cases, the family would bind the woman's upper chest and head, cover their mouths, make them bite down on rags and even use wooden spoons to stimulate a strong gag reflex to help with the expulsion of the fetus.

NMs in both sites allowed, and sometimes praised, these practices as they sped up the birth of the child and also aided with the delivery of the placenta. They evaluated and allowed their use because they were considered medically innocuous. The same applied to giving the placenta to the family. However, all these techniques and desires for birth responded to a particular view of the inner workings of the body as understood from an Andean perspective. For example binding the body blocks the placenta and uterus from ascending into the chest cavity and blocking a woman's airways (the Andean conception of the female body assumes

a lot flexibility in the placement of organs), promoting a gag reflex is a way to make the stomach help keep the uterus and placenta in their places, and head binding keeps the head from opening due to force and thus, helps keep the body heat necessary for the expulsion of baby and placenta from escaping through the head. However, in the absence of a true dialog on the cultural reasons for birth care preferences the NMs at Kantu and Flores have no knowledge of the reasons behind birth preferences, and merely apply the interculturally adapted birth care protocol as they would a medical biomedical one.

Furthermore although the changes in the adapted protocol were followed, the timing of birth, specifically the ‘normal medical birth’ times still applied. A woman was supposed to progress at roughly one centimeter dilation per hour, and achieve full effacement and dilation no longer than 24 hours after the beginning of the active labor process. Several studies have questioned the validity of this set timetable ([Fox 1989](#); [Pizzini and Frankenberg 1992](#); [Simonds 2002](#); [Maher 2006](#); [McCourt 2010](#)) and biomedical practices in some areas of the world take it as an inexact guideline which can be tailored to specific cases. Nonetheless in Kantu if a woman did not follow this temporal line closely, the process could be labeled as stalled, and could end up being referred to the regional hospital. As a rule Kantu NMs did not disclose the results of their checks on the progress of labor, despite family inquiries, because they wanted to prevent them from giving them contraction inducing herbal beverages to avoid the much feared referral.

In Flores the number of institutional births was small and the adaptation of birthing area only contemplated a very basic wooden bed which was tucked into a corner of the large room. The room itself was quite cold, in contrast to the rest of the center it had concrete floors and tile covered walls. A small space heater was placed near the bed. Birth care in Flores was organized differently, in Kantu intake, IV placement and labor and delivery processes were all under the care of NM and only reception and care of the newborn under the care of the nursing staff. In Flores the same process was divided over three people, the nurse-technician or nurse’s-aide received the patient, and after an initial examination from the NM, settled her into the labor room; the nurse placed an IV line (and later prepared for the child’s arrival), and the NM or the physician tended to labor and delivery. Although there questions about herbal beverages during intake, neither Laura nor Mireya, the nurse’s aides

or *técnicas* pressed the issue further. Moreover, when asked what they could drink they sometimes suggested chamomile or lemongrass infusions so as to keep the woman warm. They generally conducted intake on their own and readily engaged locals in talk. However the colloquial atmosphere changed when the other medical professionals entered the room. Because of the *técnicas*' familiarity with both locals and medical professionals they were often called on by both family members and professionals to relay information. As a whole the fact that a family had come for institutional birth was seen as a success for the professionals and there was great effort in maintain a cordial productive environment. This was especially achieved when the labor and delivery was conducted and supervised by NM Sara, although she could be forceful and also use the threat of the stretcher or of being referred to the regional hospital to jolt a family and a birthing woman into collaboration, she also took great pains in being approachable and conciliatory in her manner. However, the supervisor role she had assumed as head of the center meant frequent absences, during which labor and delivery was tended by one of the Serums physicians. Birthing with Sara and birthing with Dr. Gracia or Dr. Leon were profoundly different experiences.

For example, in the case of Aracelli Sara worked actively with the family to achieve an institutional birth and avoid a dangerous referral to Cajamarca. Aracelli had gone to a peripheral health post in active labor, it was her first birth and she was accompanied by her mother and her husband. Although health posts are not supposed to attend births, the three peripheral posts that form part of the Flores micronetwork mostly still birth in their own premises. Knowing that they will seldom convince women to refer themselves to the Flores center, they register these births as imminent. However in this case the dilation had stalled, the *tecnico* feared it could be problematic, had convinced the family to move to Flores, and had been able to secure transportation. Sarah received them and recommended Aracelli walk around the room and the center to restart labor, although the contractions returned they were not regular or strong enough to speed dilation. Sara mentioned the possibility of referral and wanted to give Aracelli a shot of oxytocin to try to avoid it. Aracelli's mother did not want her to be referred, but also opposed oxytocin. She believed the injection to be too hot and thought it would be too strong for Aracelli's body. For around five minutes Sara and the mother spoke outside, Sara trying to convince her of the use of the injection,

while Aracelli and her husband walked in circles in the room. Sara and the mother brokered an agreement, Aracelli would take an herbal infusion under Sara's supervision, if after three hours it failed to strengthen labor or if the child's heartbeat on Doppler became irregular, Aracelli would be referred and the family would not oppose it. In this case Sara was in a difficult position, she was fairly certain that a normal birth could be possible but it needed a jolt, she did not want to refer the woman because part of the route would have to be made in the dark making the drive and a possible on route birth more dangerous. She told the mother they both had the same objective and was able to negotiate and achieve a positive outcome without resorting to strong armed tactics. Once the contractions restarted the birth was vertical and fairly quick, the husband supported Aracelli standing up and then on his knees as Sara knelt to receive the child.

In Sara's absence however Dr. Gracia was in charge of the administration of the center and of all birthing processes. She occupied the position of most responsibility because she was a physician but given she was fresh out of college she was the person with least experience and relied heavily on the nursing staff. Quality of patient care and respect for established rules suffered significantly. For example in the case of Emerita, who came with a 6 cm dilation she was received as always by Laura the *técnica* and shown into the birthing room where Gracia checked her with the help of the nurse. It was Sunday and another *técnico*, the boyfriend of the Flores nurse, had come to town from one of the peripheral posts. Since Gracia and the nurse were in the birthing room he joined them while waiting for the last two centimeters dilation. They sat to one side, listening to music on their cell phones, laughing and talking about their afternoon plans, and lamenting openly that the birth was taking so long. All the while Emerita and her husband were also in the room, concerned about the length of labor and visibly irritated at the others' attitude.

Gracia did little to engage with the women under her care, in Sara's absence she openly talked of her dislike of vertical birthing, and especially the fact that she could not see the expulsion clearly and needed to kneel on the cold floor to receive the child. Because of this she attempted to convince women to lie down but was respectful of their choice if they did not want to. On the other hand, however when Gracia and Sara were out on leave Dr. Leon refused to attempt birthing in *ashuturada*(squatting) position and made women lie

down even against their will. News of this came to Sara, and she was concerned that it reflected poorly on the center itself since they were not complying with the promises made. However Dr. Leon was not receptive to her suggestions and since he only had three months left on his Serums service, she let the issue slide and managed by coordinating her away times with Dr. Gracia's schedule. Sara's reticence in calling him to attention stemmed from the fact that he was a physician, and even though he was only months from having finished college, she viewed him as a hierarchical superior. She ascribed to the notion that as nurse-midwife you *'just don't argue with a doctor'*. Furthermore, given the staffing shortages, having a physician in the remote post where he was assigned was beneficial for the community at large.

Normal births in both Kantu and Flores are vertical and in the institution, as such they are considered a successful implementation of the intercultural birth policy by the MoH official standards. However analyzed from the ground the implementation does not respond to the MoH's stated ideals for intercultural birth care. Despite training in interculturality, the hierarchical structure of health care provision, and the institutional culture which views the patients as diminished in capacity and untrustworthy frustrates any possibility of dialog. As such from the prenatal controls and up to normal birth in the health center patients and their families are constantly reprimanded and constrained in their choices and actions to conform to expectations of health personnel. In this climate the elements that are purportedly designed to woo families into the health center by making it a home-like experience are treated almost as favors and bestowed reluctantly.

Furthermore, the data collected in Flores indicates the fragile and person dependent nature of the implementation. Something that is readily recognized by community members who strategize their health care seeking behavior accordingly. Furthermore the Flores case also denotes the division between nurse-midwives and physicians in acceptance of changing birth protocols and the negative effects of staffing restrictions on health care delivery in rural areas.

However, even if constrained, normal birth experiences in both research sites do have some space for choice. In difficult birth processes this space is completely lost.

6.4 DIFFICULT BIRTH: ‘A BODY NOT OF MY OWN’

The following section will describe what happens to the efforts of interculturality during difficult birth processes. A difficult birth in the context of this research is one that deviates from the normal birth process. This deviation can take many forms, some more complicated than others. During the data collection at Kantu and Flores, these complications ranged from delayed or stalled dilation, to possible placental retention and prolapsed cord. Some common problems like delayed dilation and breech or partially transverse fetus could be managed at the health center level if an experienced health professional was available. However given the lack of a surgery facility or a surgeon the possible clinical solutions in either site basically began and ended with increasing oxytocin level (for delayed dilation) and attempting external or internal versions (for a partially transverse fetus. Breech births were delivered in breech position if it was possible to ascertain, through sonogram, that shoulder and head circumference were not too large (macro-somic).

Cases that were deemed too dangerous to proceed in the health center were referred to the respective regional hospital. In Kantu to the Cusco city regional hospital, a 90 minute ambulance ride; and in Flores, the Cajamarca Regional hospital, a minimum four hour drive away. Referral protocols were strictly enforced and reception at the hospitals hostile if they deemed it unnecessary. In consequence a great deal of internal consultation among NMs and available physicians was conducted before engaging in the referral and if possible further diagnostic tests performed. Overall a sense of urgency permeated the health center given the possible consequences and time sensitive nature of some complications. In all, health professionals in both Flores and Kantu, tended to be quite cautious in their evaluation of possible complications and frequently referred patients to the Hospitals. In Flores mostly due to the long drive to the nearest surgery facility and in Kantu because of the strict maternal death reduction policy promoted by the regional health direction. Additionally punitive consequences for a neonatal, and especially maternal, death were severe and career damaging.

In both sites the sudden designation of a birth process as difficult, and non responsive to usual protocol, meant three things for the birthing mother and her family. First, the normally

sparse communication became much less, even as more health professionals came and went, families were not able to receive concrete answers as to the nature of the problem or the possible solutions. In Kantu NMs and other professionals purposefully talked in a Spanish full of medical jargon which prevented them from being understood, and in Flores the NM and physician met in an office away from the birthing room. In this charged atmosphere the extra exams meant more people and more hands pulling prodding and checking dilation without explanation. And finally decisions were made without participation or consultation with the woman or her family. In all the woman was treated merely like a biological entity with no opinion or choice, her body was no longer her own. A clear example of this was the particularly difficult case of Ramira in Kantu.

Ramira had been at the health center in labor for about four hours. She was admitted by Yuli and had not progressed beyond the four centimeters dilation she had arrived with. She was alone in the labor room, her husband had left for something to eat. During the second vaginal tact Yuli notices a palpable mass that she cannot identify. It worries her. She calls in Claudia who also performs a vaginal check on the woman. Both communicate their intentions to perform the check as a way of asking for permission, although the tone really doesn't really admit a negative answer. The patient assents but she appears to experience considerable pain during the exams, which are lengthy and repeated. Yuli and Claudia talk in Spanish among themselves, they cannot identify the mass, they fear it could be a prolapsed cord. They discuss the texture and feel of the mass comparing to previous experiences they seem, nonplussed. The mass could be the cord, or it could be scar tissue from a previous tear in the vaginal mucosa. Their tone is anxious as they discuss possible options. A prolapsed cord is a very serious occurrence, if allowed to birth vaginally the cord would be compressed, effectively cutting the oxygen to the fetus resulting in brain damage or death. If confirmed the only safe alternative is a referral to the regional hospital for a c-section.

Ramira, observes them with a worried look but doesn't receive any explanation. Both professionals leave the room and consult with the attending physician. He indicates that they need to confirm the nature of the mass using the sonogram. Yuli wants to refer Ramira immediately, but Dr. Carlos contends that they had already had problems with regional the previous day for a referral that a physician could have dealt with and doesn't want to get on

their wrong side again. He reminds Yuli that he is the head of the center in Dr. Teodoro's absence and as such he is the last word. Furthermore it seems he is eager to use the recently acquired sonogram and practice his recent training on it. Also, he thought it would be a good learning experience for the current medical interns he was supervising. Yuli, relents and returns to Ramira. She asks her to walk with her so the doctor can see her. Yuli makes no mention of the nature of the problem just that she'd like the doctor to take a look at her with the sonogram. Ramira is worried her husband won't be able to find her and Yuli says the process won't be long. Yuli makes Ramira lie down on a stretcher and someone wheels in the sonogram machine. The doctor uncovers Ramira's abdomen and calls in the three medical interns. At this point there are six people in the room in addition to the patient and the doctor performing the sonogram (two nurse-midwives, three interns and one anthropologist). The physician performs the abdominal scan, he is the only one in the center who has been trained to do it, but his training was not focused on pathologies. Ramira is worried because she is being uncovered, she tells Yuli pleadingly that the cold of the gel is not good. She repeats '*manan! chiri!, manan! chiri (no, the cold, no, the cold)*'. Only Yuli answers, telling her that it will be very short and not to worry. The interns, doctor and obstetric personnel comment on the images that appear on the screen, they think the findings are inconclusive because of the angle of the image and they decide to conduct a transvaginal ultrasound. All interactions occur in Spanish. Nobody talks to Ramira, she is in pain due to the prodding and clearly very scared.

Claudia asks Ramira in Quechua to open her legs but provides no other information, she looks afraid but complies. I see her wincing at the pain as the wand moves around trying to capture a better picture, she's crying and still has no information on why this is being done to her. Again the images of the ultrasound are not conclusive. As a last resort one by one, the doctor and both midwives, perform consecutive vaginal exams while discussing the placement of the mass, the texture and extension. Ramira screams and writhes in pain, she is only told to calm down but given no explanation. She continues crying quietly until they are done.

The decision to refer her to Cusco is made. At this time she is told by the doctor in half Quechua half Spanish, that she is going to the city hospital because her child cannot be

born in the center. She seems shocked and cries harder as Yuli accompanies her to the labor room to collect her things and to call her husband. Yuli finally tells her something about the problem, she is told that her child is fine but that the cord is being born before the baby. She is told this is a serious emergency and that in the hospital the doctors will probably have to cut her to take the child out (perform a c-section). This statement is followed by acute distress, she cries and shouts, Yuli is supportive she hugs and pats her on the back. Once calmer Yuli tells her that it is necessary to save her child, her husband and sister arrive at the center, they are briefed on the problem and the decision and all wait to be taken to the ambulance.

Although Ramira's case is not the norm it sheds light clearly on the way in which the woman-as-patient is non-existent as a person in the discussions regarding her own body during difficult birth processes. The violent and callous treatment that Ramira received violated her human rights, and should lead to disciplinary action. Sadly these cases are all too common, especially in indigenous or rural areas where the power imbalance is so great. Abuse during birth very rarely leads to any disciplinary action if the woman and child survive. However if maternal or neonatal death does occur the case is reviewed and the medical professional is often punished. This leads to a chronic dehumanization of the birthing woman during difficult birth processes, where health professionals focus on ensuring a live birth for mother and child, and not on the rights of the patient. In Flores and Kantu this led health personnel to focus on results and separated both the woman and her support system from the decision making process by withholding all information and requiring no consent. As one of the community women in Flores told me: '*once you're in **their** center they can do anything, you can do nothing*'. Although the intercultural birth policy does not regulate difficult births, the MoH does consider interculturality an integral part of the framework of all health care related to indigenous peoples. As such it is possible that traumatic cases could be avoided by effectively communicating with the patient in their own language or by explaining the process more clearly.

However, in as much as the treatment of difficult births alienated community members in Kantu and Flores, the alternative referral to the regional hospital was infinitely more feared. Nurse midwives in Kantu knew that the women they referred were going to be much worse

off in the hospital. describing the scene of an arriving referral Yuli commented that even though she knew she had to refer some women, she felt really bad doing it:

in the hospital they are really unfriendly (malos) with us and with the women we take, it doesn't matter what you have told the woman and her family to get them to go or even what you tell them at the point of intake, they just do what they want. In there nobody speaks Quechua, they don't ask anything it's pin, pan, pun, to the c-section! and they undress them all completely, no questions or please or anything, cut them and then it takes a loooooong time for them to get sewed up, and if anybody even seems to complain pum! a shout or a slap, and also just the anesthesia they sleep them and that's that!'. I wouldn't go there willingly if I was pregnant. I know what it's like!

For the families issues of mistreatment and loss of control, inability to communicate or understand non-Quechua speakers also mixed with preoccupations of the added expense in getting to and from Cusco city and also eating and staying there. Even though the SIS insurance will cover most of the hospital costs, Cusco is a very expensive city and rural families expecting normal births generally do not have enough cash on hand to handle the added expense. The aversion to referrals was the most important issue considered when strategizing for birth care.

Despite the myriad setbacks, Kantu had a clear advantage over Flores in relation to management of difficult birth processes. It was located in an area where more than one transportation choice existed in addition to the ambulance, it was quicker to get to the nearest surgery facility and the road to and from the city was paved all the way. Flores had serious transportation problems, in addition to an unpaved and dangerous road, nobody in the health service knew how to drive making them dependent on the one ambulance driver. Additionally there was a dearth of available transportation options if the ambulance was out of service. This added an extra layer of uncertainty and danger even to minor birth complications, which made referrals to the San Marcos health center more frequent. There, women could proceed to normal birth if all was well and if needed could be further referred to Cajamarca. In Juana's case after an overnight trial of labor augmented with oxytocin only achieved six centimeters dilation Sara decides she needs to be referred. For Juana, and her family especially, this is a surprise. Juana tells the nurse that her births are generally long and she doesn't see any problem, but the nurse and Sara (the NM) believe it's time for her to go. They are especially concerned because they know they have no ambulance, it was

in a minor accident and was out of commission. In private they tell me that it's very possible for them to manage Juana's birth with oxytocin and waiting, but given the transportation issue they have no recourse to evacuate if it became an emergency. Juana's father tried to get them to wait for the referral, he talks to Sara outside her office, far way from the labor room. But she is adamant and tells him firmly and curtly *'look papacito this is where I decide what to do and she's not progressing, we must go. There is no discussion.'* However, the father tells her about the previous long labors and she agrees to get Juana evaluated in San Marcos, and only take to Cajamarca after that if necessary. She does this to engage his help in securing transportation.

In absence of an ambulance the options are very limited. The one *combi*, a van that makes the trip to San Marcos has already left. Sara talks to the police for help but their cars are on assignment three hours away, time ticks on and Juana's family and Sara fan out to explore other options. Two neighbors in the area have cars, but one will only take the woman and her family if he is given four times the amount of gasoline it will take him to get to San Marcos and back, and the other refuses since he knows he'll be reimbursed with a coupon for gasoline and his car uses diesel. The mayor's car is also away, supervising work on an extension of the water system. Juana's father borrows money from a relative to pay one of the neighbors for gas, but he had already left. Finally, Sara arranges for the San Marcos ambulance to come to Flores to pick up Juana and one companion. However, while waiting for the child's heart rate lowers a little, Sara and the family are frantic and the ambulance is still an hour away. In the end, after almost two hours the family agrees to pay one of the available car owners enough gasoline to meet up with the San Marcos ambulance. Juana fully dilated on the way to San Marcos and they arrived just in time to birth her in the San Marcos health center.

In Flores, as this case illustrates, the decision to refer was not the most dangerous part of a difficult birth. Structural and contextual constraints on effectively achieving referrals make health personnel more timid in dealing with complications and also less forthcoming with the formal aspects of seeking consent, sometimes exaggerating the problems, or not seeking consent at all. Overall the circumstances and attitudes of health care professionals in difficult birth processes serve to reinforce the hierarchic of bureaucracy and power in

health care delivery. A structure where women and their families are situated at the bottom of the ladder and where there is very little connection to ideas of intercultural health or human rights.

6.5 HOME BIRTH: SHAMING, POWER AND MONEY

Some community members do not form part of the narrative of birthing in the health services because, either by design or by chance, they birth at home. Though this may help them avoid the possibilities of mistreatment, paternalistic down talk and referral they must still engage the health services for all future care of the child and for the birth certificate. As such in many cases they are the focus of reprisals from health providers to serve as examples and to discourage others from following the same path.

In both research sites community interviewees spoke of fines levied for not birthing in the health center. These fines took diverse forms, for example payment for services rendered after the birth was reported, or payment for gasoline for the ambulance if the woman was taken to the health center. In both Kantu and Flores the government sponsored comprehensive insurance (SIS) covered all prenatal care and birth as part of the strategy to eliminate the economic barriers of access to health care. However, home births fell into an outlier category in regard to coverage, for example emergency services to aid home births were covered, as were any home births that occurred in the presence of, or with the participation of a health provider. However, if a woman birthed at home with no complications and no health care provider present, any related cost would not be covered.

The treatment protocol for uncomplicated home births states that woman and child should be under observation for 24-48 hours because of the possibility of puerperal fever or neonatal sepsis due to poor hygiene. This requires that both mother and child be taken to the health care center, however, these transportation costs are not covered by the SIS. This means that in some cases where fines have been reported the demand for payment may stem from the lack of SIS coverage and not necessarily from a punitive endeavor. Furthermore fining for home birth or restricting access to the certificate of live birth to obtain payment

are violations of Peruvian law. Nevertheless many health providers see seeking payments as a tool for compliance.

In Flores this issue was a particularly sensitive one since seeking payment for home births was used heavily by the previous administration of the Flores Health Center. As reported by the NM, one of the *técnicas* and some community members, health providers who began implementation of intercultural births at the center were particularly harsh in punishing home births. Although technically the health service does not obtain reimbursement for transportation of already birthed women from home to the center, there is certain amount of fuel use that is discretionary. It is directly provided by the network and does not require detailed reporting. Furthermore there are covert ways in which home births can be ‘passed’ as in the presence of a provider to obtain credit for services rendered. However the previous administration had chosen to forgo any of these strategies as a way to send the message that home births were not admissible. Community members I interviewed reported being charged between 30-100 Nuevos Soles (approx. 11-36 US\$) for services rendered after a home birth. This sum is considerable for a rural family amounting to the sale of one farm animal (pig or sheep) or several chickens or guinea pigs. Paradoxically those who lived closer to the center and also had more possibilities of obtaining cash for produce in the Sunday market, were those that were charged less.

Sara, was working in a peripheral health post at the time, but recalls that the community backlash against health personnel was considerable. Moreover, community leaders lodged a complaint against the health personnel and achieved their relocation from the area:

I was in Lauricocha at the health post, I was the only professional there, and when my colleague here (in Flores) left for her days off I came to replace her. So I spent a lot of time in the combi and since the people from around here didn't know me as a health person they spoke in my presence. So I knew there was talk and people were unhappy. In the end it was a a regretful strategy that could not be enforced and rather created problems for us, because once they relocated the personnel from here (due to a complaint) I came here to the head of center and the people in the community were very predisposed against us, we had to try to gain back the trust(Sara, Flores).

At the time of my research Sara had been at the helm of the Flores center for almost a year, and in response to the downfall of the previous administration had a strict rule that any SIS charge should not be called a fine. Additionally, she went out of her way to attempt to

ensure that instances of home birth were covered by the SIS. For example, stressing to women the importance of calling the health service, or letting the health center know as soon as the contractions started, this way if possible she would bring them to the center or could ensure that the birth could be recorded as imminent and in the presence of a medical professional. However, home births that did not let the service know at all, were still sometimes charged for the transportation.

Although Sara did use the discretionary fuel allowance in some cases, allowed families to forgo the ambulance by bringing the women on their own, and sometimes allowed families without cash to pay in kind by cleaning or repairing the health center⁸, these strategies only benefited those in the vicinity of the health service. Furthermore Sara and health personnel were vague and ineffective in explaining the charges as an issue with the SIS coverage, and as result some community members still viewed the charges as a fine. Sara was adamant in separating the current administration from the former's transgressions, however other professionals in the center found her approach too lax and favored a much stricter response to home births. Thus nurses who were in charge of newborn care were strict in enforcing their requirement of a signed statement from a communal authority that asserted recognition of the child's parentage before signing the certificate of live birth. This was also viewed by the community as punishment for home birth.

While Flores tried overtly to distance themselves from the issue of fines for home birth, the Kantu health service had an overt strategy to penalize home births in different ways. The Kantu administrator boasted that it constituted a concerted strategy:

So when the people fear that they are going to be charged for home birth it's a strategy, no? Because we say if the women feel it's good to give birth in their homes then it's not good, we are in times where birth must be institutional. There's more communication, people are you know a little more educated. Because before they didn't want the birth to be in the institution only in their homes because they felt that nobody could see them. But now science has advanced all that knowledge in the population and in the health service we know that birth can only be in the health service. So strict controls, the affiliation to the SIS, are all strategies that we use so that women come to the health service, plus before with home births there were more maternal deaths and more perinatal deaths so that's why this has been out in place (Tony, Kantu).

⁸The rate considered for these in kind exchanges was the average amount paid for a day of unskilled labor, around 12-15 Nuevos Soles

Tony, the administrator, is purposefully vague on the specifics of those strategies, given the unlawful nature of the fines. However, interviews with community members, the municipal authorities and the Nurse Midwives indicates that in addition to charging between 100-150 NS(\$36 to \$54) for those services not covered by the SIS, the health service had lobbied the municipal authority and several communities to obtain public proclamations of the need for birth to be only in the health service. The Kantu municipality had issued a three page ordinance in support of the health service endeavors to improve maternal and perinatal care, stating their monetary support for the Mama Wasi and also that '*birth in the health service is indispensable to help reduce maternal and perinatal mortality*'. However, in the decree or mandate section of the document there is nothing to indicate that birthing in the health center has been declared compulsory in the municipality. Furthermore, the Mayor has no authority to decide on these issues, but women are willfully misinformed by health personnel. The decree was featured prominently in the NM consulting room and was dutifully mentioned and pointed to when anyone mentioned their desire for home birth. Sometimes they were even shown the section where the document mentions the '*indispensable need for an institutional birth*'. But many women are illiterate, not proficient enough to read the whole document, or do not understand that this is mentioned in the preliminary description not in the decree section. The document itself only exhorts the organizations and communities to support the efforts of the health center in reducing maternal mortality. There is no mention of obligation or of punitive consequences. This part was not communicated to the patients.

A more significant result of their effort to engage organizations in supporting health center birth was that some communities had voted to impose an internal fine on women who birthed at home. This was reported to me by the NM at Kantu, but I could not corroborate it with community members. However the center, like Flores, required women to bring in a signed declaration from their community leaders that the child they birth at home was in fact theirs. According to health personnel work or cash fines were then applied by communal authorities in four communities to provide that paper. NMs in Kantu were particularly proud of these strategies to make birth in the health center compulsory and took considerable effort to make an example of those who didn't comply.

Angelina, for example, had birthed at home ten days ago. Her family had waited a full 24 hours before letting the health center know of the birth because it was a remote house and the father was not at the home when the birth occurred. Since there was already a community visit planned for her area on that day she was checked in her house by Yuli and given a puerperal appointment. This circumstance was unusual since they made a special effort to make recently home birthed women go to the health center in the ambulance. But in Angelina's case there was no medical necessity since by the time the ambulance arrived at her community 48 hours had almost passed. At the puerperal appointments Gloria asked Angelina why she birthed at home and reminded her that it was compulsory to birth in the health center. Angelina responded that she was alone only with her mother and that nobody could come to the center or call. Gloria was not convinced:

'So you're trying to get me to believe that in this age when all of you have cell phones that nobody could let us know? [fake laughs] Ha! That's a joke! (que chiste!) Besides, you should have come to the mama wasi and you know that! Anyway you know mamacita, that it's compulsory to come to the center for birth. It's not me who says so, there you can see it's your own mayor who says so! And of course there are consequences if you don't come here right?.'

Angelina only assented and Gloria proceeded to ask her medical questions: 'who cared for your birth? who cut the cord? what did they cut it with?' Sometimes huffing at those that she could not obtain answers for like weight of the child at birth. Then she performed a physical examination. At the end of the visit:

Angelina [looked at the papers she had received and quietly asked]:Señorita what about the paper I need for the inscription'

Gloria: 'Hum! we'll that's the question right? remember I told you there were consequences?, well there it is! I need a signed paper from the president of your community stating that there are witnesses that you birthed this child and that he can personally vouch that this child is yours'

Angelina: But Señorita you know its mine, you've seen me pregnant. How can you say that this child is not mine?

Gloria: I don't know anything! How do I know if this child is the one you were pregnant with, did I see him come out of you? No, so there is no inscription without that paper.'

Once Angelina left I asked Gloria if she thought she could come back with the paper required for her to obtain the inscription:

'Yes, I think she will, because this is not one of the communities that has a fine or anything,

there are others where we were very successful in educating the leaders and they supported us 100 percent with the problems of maternal mortality and they require payment for birthing at home. But Piñicocha [Angelina's community] is not one of those so she'll go and they'll give her the paper. Other times women come to me and say they can't pay the fine to the community and time is short to put the inscription in without payment⁹ and I tell them 'well that's what happens when you birth at home, for the next time you'll come to the center!' But then there are some who have TVs, DVDs, in their houses and then come and don't care about any fine. They just do as they please! Especially in the areas where they have cattle they have money and they don't care what you say. To those from communities with no fines, or the ones that don't care, I sometimes try to delay giving them the certificate until the 30 days are over. But then I found out that here the municipality doesn't charge them the late fee, because they are from poor families and that, so they're just laughing in my face!'

Gloria's explanation of the strategies completes the picture of how birth in the health center is furthered in the Kantu area. In prenatal controls women are told that birthing in the center is compulsory, although technically it is not, some communities have assumed it to be so and charge fines to those that birth at home.

⁹Inscription in the civil registry after 30 days from birth is considered extemporaneous and carries a fine of 20-30 nuevos soles.

If the community doesn't charge a fine, patients will get the run around to obtain the certificate needed for regular inscription in the civil registry. Even if the municipality doesn't charge for the extemporaneous inscription, they will still have to pay for any services not covered by the SIS insurance (at least for one ambulance trip to the center), and waste time and money in pursuit of the certificate. Although these strategies certainly do nothing to further goodwill in the community they are not technically against the law. In all they are one more indication that health care providers view community members as only capable of responding to coercive measures. As such the fines, or the charges which are perceived as fines by community members, negate all the discourse of *interculturalidad* that Kantu NMs espouse. It also explains partially explains why community members in Kantu perceive institutional birth as inevitable but undesired.

The Peruvian cash transfer program JUNTOS was also used as a punitive measure, because one of the requirements of the program is birthing in a health facility. Although NMs in both Kantu and Flores repeatedly mention possible suspension of benefits to women during prenatal controls, health providers in both research sites were ambivalent about the program. For example, Marcela the head of the San Marcos network, believed that JUNTOS was perpetuating a dependent mentality where compliance was only achieved because of coercive measures and not through education. Furthermore, she believed that the program was directly responsible for increasing the number of pregnancies among beneficiaries as a strategy to extend benefits. These opinions were shared by the NMs at Kantu, who claimed that older women in their jurisdiction were getting pregnant to be able to qualify for the program. However, on its own the threat of suspension from the JUNTOS program could not serve to increase birthing in health facilities, especially because not all families participated in the program.

The punitive strategies towards home births in the research sites are possible due to the power and status that health professionals have in the communities they serve. Although not directly unlawful they serve to shame and cajole families into future compliance, and reflect the persistence of an institutional culture of coercion and deceit at the MoH. Specifically the persistence of the idea that end justifies the means and a wholesale disregard for the rights of the patients which directly contradicts any altruism embedded in the intercultural birth

care policy.

6.6 CONCLUSION

The construction of interculturality, understood as mutual accommodation through dialog, should occur in the pregnancy and birth care process detailed here. However this is not the case in the research sites. Despite the references to mutual understanding and respect, the process of pregnancy and birth is a months long induction into the role of submissive patient.

The relationship of women with health providers is built on a fractured sense of trust and a perception of moral and cultural superiority on the part of health personnel. This leads to discriminatory attitudes, abusive language and the inability to conceive the patient as a rights bearing individual. The issue of discrimination in health care provision is enhanced in contexts where idealized images of indianness are exalted but their current descendants are viewed as unevolved, and ignorant. Women who were viewed as urban, complaint, and similar to the NMs were respected, whereas those who were perceived as less modern or urban were dismissed as uneducated and incapable of making rational decisions.

These perceptions of rural women and men as childlike and deceitful are a pervasive problem in the health center structure. During my interview with the national level SRH official in Lima, I mentioned my concerns about some of the coercive strategies at the research sites. Her response was to actively dismiss all testimonies as *‘only stories of people who actively dislike health personnel and seek to undermine them.’* This persistent prejudice against indigenous communities cannot be simply overcome by training in *interculturalidad*. Having been stripped of all real reformatory potential, the discourse of *‘interculturalidad’* is hollow and becomes a tool for the continued imposition of external power in the lives of indigenous peoples.

The many missed or ignored opportunities to engage in intercultural dialog, or dialogue of any kind, are indication that there is in fact no desire to engage with community members as equals and with respect. Furthermore, there is willful ignorance and open disregard for the daily lives and experiences of community women. In addition to a concerted effort to

engage community members and organizations in policing each other.

Interculturality in birth care is limited to a scaled down and tightly controlled version of Andean birth. Despite some positive changes, like the ability to have company and to change position, it cannot be considered a home-like experience. As Brigitte Jordan asserted in the 1970's those who control the location and the birth technology control the process. Thus, in changing birth location through enticement or coercion, nurse midwives are ensuring control of the process. Furthermore, since health personnel view the issue of 'cultural need' as a transient phenomenon to be overcome with urbanization and modernization, the expectation is that normalizing the health center as the only location for birth will in turn lead to the normalization of standard biomedical birth.

7.0 BIRTH FROM DIFFERENT PERSPECTIVES: COMMUNITY MEMBERS AND NURSE MIDWIVES

The stories of intercultural birth in the research sites have described the birth process as a civilizing enterprise in which health providers wield power and community members are increasingly constricted in their decisions. However, taking one step back we find spaces of maneuvering and agency on the part of the community members to accommodate the process to their preferences. Additionally the power wielded by nurse midwives (NMs) at rural health centers was very restricted in the larger scheme of the MoH. They are also subjected to power inequality and other structural issues that constrain their possible choices within the birth care encounter.

7.1 MEN AND WOMEN: AGENCY IN HEALTH SERVICE BIRTH

Community interviews were designed to understand the experience and opinion of the intercultural birth processes. These were conducted at homes and public areas with both men and women, not necessarily couples, although some were. A feature of community interviews was the difference in male attitudes towards the process. In Kantu men were eager to talk of their partners' birth care and seemed to have been actively involved in the process. In Flores, those men who did not dismiss the issue as 'women's talk' and referred me to their wives, were generally brief and terse in their opinions. The exceptions in Flores were younger men, in their late teens and early twenties. I suspect that some of these differences stem from a site-specific tradition of direct male involvement in birth care in Kantu. In the research area, and in Cusco more generally, there is a long tradition of male birth attendants. Several

older women I talked to for example, referred to birthing with their husbands, fathers or father's-in-law. The same is not true for Cajamarca, where traditional midwifery is strongly female. On the other hand the generational difference in Flores could probably be due to younger men having been more exposed to differing ideas of masculinity or parenting through schooling or extended migration experience.

Although there were recurring themes in both research sites, the main difference encountered in the community perspective was the perception of choice. In Flores, although birthing in the health center was expected, community members considered the possibility of other options, especially if they did not participate in the Juntos program. However community members in Kantu continuously expressed dismay at the compulsory nature of institutional birth. For example the overt choice of home birth appeared only twice in interviews in Kantu, whereas the same option was considered several times among Flores interviewees.

In Kantu, interviewees who had birthed at home called it accidental and unintended. This was actively disbelieved by health personnel. Although it is possible that some of those cases were deliberate and presented as accidental due to the negative atmosphere surrounding home birth, for most of the poor families of the area the economic consequences of being suspended from the direct cash transfer program and the added expense of non-covered services, were probably too great to overtly choose home birth. Moreover, the fact that the two instances of deliberately planned home birth were by families who did not participate in the Juntos program and who hailed from nearby communities with no fines, seems to indicate that economic considerations may also preclude home birth in the area. In Flores the choice of home birth was also mostly a viable alternative only for those with greater economic means. However, the laxer attitude of the local Juntos program and health personnel in enforcing the suspensions imbued the interviewees with a sense of greater options.

Interviewees in both Kantu and Flores expressed similar concerns with some features of institutional birth; which led some to prefer home birth, community members also actively strategized to modify their experience within the perceived limits. The following sections describes these concerns and strategies.

7.1.1 Community Views of Intercultural Birth: Language, Abuse and Post Partum Care

Community perceptions of intercultural birth are directly linked to expectation, although, as I have mentioned before, community members in the research sites did not overtly demonstrate any expectation of culturally appropriate care. They did have definite ideas of what constituted a proper birth care. Some of these were directly related to differing conceptions of health and the body, for example the effect of cold and air in post partum care, and the use of herbal beverages to aid dilation and ‘close’ the body. Others were related to the common practices of home birth care, such as the expectation that focus be on the mother and not the child. However, many expectations of care were more generally related to quality of care: respectful treatment, being consulted or having problems explained and being given possible care options.

In the context of these expectations community members in both research sites welcomed some of the changes in the birth care protocol. The possibility to change positions and the company of a family member were both lauded as steps in the right direction which made birthing in the health center more appealing. Additionally a common sentiment among those happy with health service birth was that they felt safer because of the access to the *‘injection and the suero that stops the blood’*. This specifically refers to the IV-line with saline solution where oxytocin was injected after the birth of the child. This is important because it prevents placental retention and excessive post partum bleeding¹, which are the main causes of female deaths during home births. However, community members also doubted the long term maintenance of these changes, although they had been in effect for several years. The specific concern was the feeling that NMs changed every two or three months, that newer professionals were not as knowledgeable as the previous ones and that because of this the center would stop providing the same type of service or allowing the same liberties.

Despite praise for existing advances, concerns over mistreatment, verbal abuse, punishment for home births and improper care in the post partum period were much more frequent

¹Excessive post partum bleeding occurs frequently with multiparous women due to the inability of the uterine wall to contract efficiently after birth to constrict blood vessels attached to the placenta. It constitutes a life threatening medical emergency

than the praises. Approximately a third of all interviews and cases referred directly to verbal abuse during childbirth, and almost half related some form of abuse or discrimination during any part of the pregnancy, birth and post partum. References to feeling abused were commonplace among those who had birthed at home, those that resisted some part of medical protocol and those who did not want to go to the maternal waiting house.

For example, Armida's case, an accidental home birth, presents a picture of some of the concerns of verbal abuse and punishment:

I did all my controls in the posta and one week I was at the Mama Wasi. My house I left alone and I went to see my children and there suddenly I birthed in my house. The posta people don't believe me and to this day they don't want to give me the register, the señorita there millay (ugly) with the red hair she said 'you escaped and now your ojota (sandal made of tire rubber) you're going to buy and you're going to walk until it is spent looking for the certificate'. After the birth my son let them know and they took me to the posta anyway, I was 2 days there and the only thing they did was weigh and measure the baby, and to return I had to take the Taxi paying 20 soles. I don't know why it should be compulsory to go to the center for birth because it also mistreats our bodies to get to the community. I have walked from the road to my house and I only just arrived, all sweaty and the cold on my body. We need to be warm and be careful of the wind or the air it affects the body, they (in the center) do not take notice of that. (Armida, Kantu)

Similarly Alejandro's wife birthed premature twins at home, almost immediately following a check-up visit in Cusco where they were told all was well. He called the center and the NM who went with the ambulance accused him of not letting his wife go to the center: *'like dogs you are', she said. I got angry and I resisted 'because I wear ojota you call me that', I told her.* His wife and children were taken to the Kantu health center but they were punished by not releasing the live birth registries. He later obtained them after consulting with a lawyer.

However, even for women birthing in the health center uncooperative behavior is castigated verbally. Epifania, a first-time mother in a community near the Flores health center, recalled that she was feeling a lot of pain and was reluctant to push: *'it hurt and I screamed and the señorita said 'stop it!, you have to push, you didn't shout like this when you got pregnant did you?! Now you have to pay for that, like animals you are.'* I was crying, my mother who was there with me in my ear she said, *don't listen to her, you have to push! She put her hand on my mouth so I couldn't shout and that's how I pushed* (Epifania, Flores).

Instances of verbal abuse recounted by community members very often refer to words

used to humiliate or liken the population to animals, accusing them of caring more for their livestock than their offspring —when a woman doesn’t want to go to the Mama Wasi for example— and questioning their relationships and sexual practices. Overall the epithets were openly derisive of the people and their form of life. The use of derogatory language towards people of indigenous descent have been described by other researchers in Peru ? and attest to the deeply ingrained racism and discriminatory attitudes of elites and aspiring elites towards indigenous peoples.

Other problems perceived with birth care in both areas was the lack of proper postpartum care. Specifically in reference to the consequences of a humoral imbalance which occurs by moving the woman from the relatively warm birthing room to a different area of the building and by the cold and air encountered when she is discharged only a couple of days later. Both practices go against the cultural norms of avoiding cold and wind, and requiring women to repose for some time after birth. Later medical problems like weakness, unexplained pains and other issues, which are encountered by women in their lives are traced back to violating these principles. Common occurrences like having to walk one or two hours back home or being exposed to the bitter cold and rain too soon after the birth event are viewed as mistreatment by interviewees. Armida’s case in Kantu (above) and Micaela’s case in Flores illustrate this:

All the time in the posta I was cold, my mother gave me the head soup and everything but I felt my body shiver and shudder and it didn’t want stop. They lifted my skirt and put me on the stretcher (camilla) after the placenta came out because my part had torn (mi parte se habia rasgado) and there I felt the cold come into me, see how everything is stone and tile? I told the nurse I was cold, my body was shaking and she was angry with me for moving, Stop it! she said, you pushed before your time, you didn’t do as I told you and now you have to be here. Since then my body is not the same. I can’t lift heavy things (pesados) like I did before, my husband he quarrels (me reta) me that I cannot help like before, my body feels tired my legs are heavy. That señorita has damaged me (me ha dañado) (Micaela, Flores)

Micaela’s case is also similar to Sebastian’s story of how exposure to air during and after birth in the health center negatively affects the female body in Kantu (see 5.3.3). This indicates one of the major failings in the intercultural conception of birth as proposed by the MoH, which focuses only on the birth event and not on understanding and adapting to the whole process of pregnancy and birth as experienced in the Andes. Thus, in its current

iteration the intercultural birth policy, even if free of racism, pressure to conform and abuse, would still be insufficient because it does not provide proper post partum care and is seen as debilitating the female body.

The issue of language was a problem specifically related to Kantu, where Quechua is the language of everyday life. According to Cusco's regional health direction guidelines only Quechua speakers are allowed to be hired for those rural areas where Quechua use is more prevalent. However, the Kantu NMs had varying levels of fluency. Only one of them, Yuli, was a native speaker of Quechua origin; Claudia spoke fairly well using almost no Spanish, whereas Gloria and Susana only knew some phrases and words and used a lot of Spanish in their interactions with local women. Although NMs considered their management of the language was sufficient to communicate and provide intercultural care, interviewees in the community referenced instances of miscommunication or misunderstanding. For example, Anita thought they were asking about pain in her back when the nurse was asking about pain in the buttocks, which they came to notice when she touched the areas that did hurt while repeating '*nanay*' (pain), or Fidelia who always answered *ari*(yes) when they spoke to her in Spanish although she didn't understand what was said. Furthermore, since the Quechua knowledge of most NMs was not nuanced enough to include the required niceties for establishing interpersonal relationships² it was perceived as harsh, ugly and angry, '*like an order, like the lady who talks to her maid*'(Maria, assistant), further alienating the community members who viewed health personnel as always angry and bored.

The issues of miscommunication and abuse in Kantu were prevalent enough to be on the radar of the communal organizations. Asencio, the president of the Ronda Campesina, an organization with ample representation commonly tasked with enforcement of local rules, had recently called a meeting to discuss the problems of mistreatment with the health center head:

We told the doctor, your nurses they don't talk nicely to the women. The pregnant ladies they are mistreated psychologically. They receive insults 'sucia, tonta, sonsa (dirty, dumb, fool)'. Those that don't know just let them abuse them. The señoritas mistreat whenever they want (las señoritas maltratan a gusto). If they just talked nicely (bonito) and with affection and love for the other (cariño y amor al prójimo) saying 'look señora to come

²The use of diminutives, endearing terms and circumlocutions are important features of Quechua verbal communication

here you must wash' or 'look señora you should put you body this way please' like that. We come straight from the fields sometimes and we are dirty but that's not a reason for insulting. But the doctor he did not listen, he said it is not like that 'you people have no ears and you don't listen'. Now we have to call another meeting because women come to us saying they treat us bad, we go to the posta afraid, and that is not right!'(Ascencio, Kantu)

While this meeting did not achieve changes in attitude since Dr. Tony brushed off the implications as mere misunderstandings, it served to strengthen the resolve of the Ronda representatives. They were seeking to effect pressure on the medical personnel through the community representatives on the health center administration board. This was possible because the Kantu center was a CLAS, jointly administered by the community. However the real power of community representatives on the CLAS board was very small. Nonetheless the demands made on the communal organizations to intervene are one example of the strategies employed by men and women in the area to assert themselves and expand their choices. Other more personal strategies are described in the following section.

7.1.2 Strategizing

The possibilities for birth care choice in both sites, and in general in rural Peru, are relatively limited. Still women and families are not entirely without agency. Although men and women in the community still had free will to reject birthing in the health center in both sites, there were several official and unofficial mechanisms in place to discourage this option. However if a family openly chose to disregard, assume the punitive consequences and had no complications then there was nothing that medical personnel could do to force them. However this was not an option for the majority of interviewees. Thus families attempted strategies to mold available birth care options to their desires and needs. Most of these strategies were concurrent and came to light in case story interviews in both sites. Strategies can be loosely organized into several general types: strategies to establish interpersonal relationships and increase goodwill, strategies to spend less time in the Waiting Home, strategies to reduce time spent in the center during labor, strategies to make health service birth more home-like, strategies to manage humoral imbalance, and strategies to birth at home unpunished.

7.1.2.1 Relationships and Good Will One of the most common strategies, although it may not be directly recognized as deliberate, is attempting to establish interpersonal relationships with those nurse-midwives or other health personnel who were amenable to it. Making small gifts (eggs, grain, potatoes) on home visits, making jokes, and other small gestures. However, this is difficult for areas where there are problems of language, high personnel rotation and those where personnel do not remain engaged with the community outside of working hours. In Flores for example it was common to see the NM in the market, or in the plaza outside her rented room. She was part of the fabric of the community. Given the distance and transportation difficulties all Flores personnel lived in the community and remained there after working hours, giving the population opportunities to interact with them outside of the health center. Thus in Flores the relationship strategy was a possibility for those living in the vicinity of the health center. This sometimes resulted in Sara, the NM, allowing women to labor fully at home, not requiring a move to the waiting house or sometimes offering to be present at home births.

In Kantu health personnel were not as limited in their mobility and easily took days off here and there to make trips into the city of Cusco or surrounding provinces, spending little down time in the area. Furthermore most did not rent rooms from community members, living in a special wing of the new health center and in the old health center. They were always out as a group of doctors, nurses and nurse midwives, rarely interacting outside the group. This served to create distance from community members, who frowned on their ‘outsider’ customs, did not approve of the spaces where men and women lived together in close quarters, and suspected them of misbehaving and having drunken parties. Overall they were viewed as believing they were better or above the community people. This dismissive attitude towards the population left little room for them to be viewed as people or for the creation of relationships outside of the medical encounter and sometimes made it more strained. Community members were able to connect with the nurse technicians at the center, one of whom was from the Kantu community; however, this was helpful mostly for issues of child controls and general medical care but not for childbirth and labor.

A related strategy was to increase good will towards oneself by complying carefully with all prenatal care recommendations, following instructions and performing as the ‘good’

patient. Thus it could be possible to garner some of that good image to reduce or avoid punitive consequences. This is the strategy for Asunta, a recently returned Kantu resident who was pregnant for the second time: *‘When I am pregnant I go to all my controls and take all my pills and also try to do everything they tell me, then if something will happen I can sometimes say you know I do everything you ask, and perhaps they will believe me more. And I have never had a problem, if you are respectful they will be respectful’* (Asunta, Kantu). Asunta has several advantages over other Kantu women: she has experienced health care in urban areas and is more or less attuned to expectations of her as a patient; furthermore she speaks Spanish and can easily communicate with nurse midwives. She is viewed as modern and this profile makes her the ‘ideal patient’ from the NM perspective. Additionally, she is dedicated to other activities in addition to her agriculture, being entrepreneurial, she buys and manufactures head bands and other accessories and often goes to the center with trinkets for sale, establishing some connections with the NMs.

7.1.2.2 Mama Wasi Strategies In Kantu women were often strong-armed into remaining at the Mama Wasi. Women actively disliked having to leave animals, children and responsibilities. Furthermore it was counter-intuitive to a local expectation for women to continue on with their normal lives until contractions begin. From this perspective sitting, knitting and waiting for the process to begin was seen as a city luxury and unsuitable and damaging for strong Andean bodies: *‘in the city they can do this because their bodies are not as strong, here we carry heavy things and work in the fields from very small children if I don’t do anything it’s like my body becomes tired from not moving, here my head hurts, my joints hurt, but not in my house* (Ana, Kantu). Furthermore they are closely supervised and can seldom leave for long periods of time, and if they do they must tell Frances, the *técnica* in charge, of their whereabouts and provide cell phone numbers if possible so they could be reached at any time. Given all the restrictions some called the Mama Wasi the ‘health center’s jail (*la cárcel del centro de salud*).

However, some measure of negotiation was possible, though generally only with Frances who was from a neighboring province, spoke fluent Quechua and understood more fully the complications entailed in staying at the Mama Wasi. Some women were able to negotiate

with her and with the acquiescence of the NMs to take some days to organize their homes and return. Juana, for example, who was at the Mama Wasi because of her fetus was rather large and because she had received a previous c-section, lived only a short twenty minute walk away, in a neighboring community. She left each morning to feed her animals and see to her older children and returned after lunch to spend the afternoon and sleep at the waiting house. Antonia, who had a previous complicated birth, was from a remote community but had relatives in the town, she went daily to their house and went to the Mama only to sleep. However any allowances made by Frances came at the sole responsibility of the woman and her family. As a previous case has shown those who do not return to the waiting house or who birth at home during a visit, by design or accident, are said to have escaped and are liable to receive fines or some form of censure or punishment.

In Flores although the waiting house stay is not enforced as strictly, those women who are required to stay there will often be allowed to stay with relatives or neighbors who live within reach of the health center. However similar to Kantu, women are very much appreciated if they demonstrate bodily strength, being called '*macha*, which translates roughly as a manly woman, and is used to denote positive qualities. In this sense there is also the same impetus to keep the body working until the last moment, and even women in the waiting house will do chores, clean and cook.

7.1.2.3 Less Labor Time in the Center In both sites women generally take the majority of their prenatal advice from the traditional midwives or *curiosas* who live in the area. In both the vicinities of Kantu and Flores there was at least one known traditional birth attendant and some knowledgeable men and women in the surrounding communities. Although they have openly been barred from attending births they still diagnose and care for the most common prenatal problems. Both traditional midwives in the research sites were respected for their knowledge of pulse diagnosis, a technique which differentiates the diverse qualities of pulse to evaluate the degree of humoral balance in a pregnant woman's body. This is minimally invasive and can be used to prescribe different herbs to correctly balance the body. This is especially important nearing birth since possibilities of dangerous humoral imbalance increase with the opening of the body through birth. Additionally women will

visit midwives at least once or twice to ensure the child is growing in the correct direction, through massages with fat and alum (alumbre) or using the blanket shaking method *suy-susqa*. This is one strategy which is used generally to avoid being taken to the hospital because of a transverse or breech fetus and hopefully to make birth faster.

Furthermore, women in both areas will often wait a very long time in labor at their homes, permitting them to receive all home care possible, including herbal infusions and foods thought to speed the process³. Additionally, some will walk to the health service making dilation progress faster, others will keep on taking doses of herbal beverages—recommended by traditional birth attendants or *parteras*—covertly to hasten the birth. Arriving at the center with very little time to spare also allowed some women to avoid the Iv-line which some thought would make their bodies cool too much. Other familiar strategies to aid in the expulsion phase are to cover the mouth to prevent the woman shouting and breathing in thus bringing the fetus back up, to tie a heavy cotton or wool belt on the upper part of the abdomen, applying pressure on the fundus (upper abdomen) and to induce the nausea reflex with the back of a wooden spoon for more forceful contractions.

7.1.2.4 More Home-Like and Managing Humoral Imbalance For those already in the center making the process a more home-like experience involved bringing several family members, blankets, throws, food, drinks and sometimes mothers or grandmother who were *curiosas*. Alma in Kantu, remembered her birth in the health center as the occupation of the area:

I have come with my husband, my mother, my father, my father-in-law, who is a curioso and we brought blankets and food really well packed and I brought my pellejo (sheep hide) from home also so the child would be born there. The señorita did not seem very happy, but my father told her ‘you say we can come to the health center and bring our things, then that’s what we did’. And she didn’t say anything. She was there, but I pushed when my father-in-law told me to and he helped me more, the señorita was there just to pick up the wawa (baby). The only thing was that she said only one in there at the end with me, but it was my mother and my father in law. She let them both in. And she also put a plastic on top of the pellejo, but the rest was good.’

³Interestingly the same resistance strategy recorded by (Davis-Floyd 1992) in western women seeking to de-medicalize and regain control of their birth experiences

In this case having a lot of strong family support meant that for Alma her experience was very home-like. She was lucky that there were no complications and that the NM in charge was apparently quite permissive. Furthermore, it may be that her labor was very fast and that in light of that the addition of people and things was not so unwelcome.

A further issue of birth in the health center, the problem of humoral imbalance due to cold, is managed by covering the woman in blankets and ponchos and other warm clothes immediately after birth of the placenta, and also feeding her hot soups. Furthermore, if the woman is able to return to a close-by relative for some days before returning home that will be arranged. If a woman has to return to a distant community she is thoroughly wrapped for the trip. In Flores I witnessed as Emérita was prepared for her trip home. She had on woolen tights and socks and closed shoes, not the *ojotas* (rubber sandals) or plastic shoes with no socks women usually wore. She was also wearing her skirt and blouse and a poncho. And on top of that her mother and mother-in-law wrapped her body in blankets, securing them with large safety pins, covering her almost completely up to her eyes. They wrapped her head tightly with a *punta* (cloth shawl) and added a thick wool hat. She resembled a large roll and could hardly walk. They had contracted one of the local men who had a car to take them home since the ambulance was not available and very slowly took her to the back seat where she lay semi-flat next to her mother who carried the child. The mother-in-law, who stayed back and would walk home, told me they needed to cover all the areas of her body that had opened during birth: her head, her hips, her vagina, and ‘seal’ her to prevent any cold and air from coming in.

7.1.2.5 Home Birthing Unpunished Some community members mentioned a final strategy, calling the health service to alert them of a woman in labor when the process was so advanced that the woman could not be moved to the center or had already been delivered by the time the ambulance or NM arrived. This sometimes allowed those who openly disliked birthing in the health center or those who preferred birthing alone to avoid punitive consequences since they had formally complied with ‘letting the health center know’.

For example in the case of Catalina, a mother of five in Flores, who disliked birthing in the presence of others:

'I told señora Sarita yes I would send my son to call her so I could come to the health center for birth, she said it was dangerous because I had four living and two malogros [failed pregnancies, miscarriages] and it was too much for my body. But I am very cowardly with people around, if there's people puf! my pains go away and nothing happens.. so I birth alone, and when it is time to push I hold onto the bed post really hard and ashuturada (squatting) on a pellejo (sheepskin) I push and push and then they [the family] come in when I call them to pick the baby up from the floor. So when I started with the pains, with this little one, I stayed at home and when my husband saw me that I was almost ready to be left alone in the room, he sent my eldest on foot to call doña Sarita. And a good person she is, she came and didn't make me go to the center, but checked me and the baby, others who give birth at home even forcefully they are taken to the center' (Catalina, Flores)

As Catalina points out, the problem with this strategy is that although it may allow birth at home it may also enhance the chances of being taken to the health service in the delicate post-birth status. It is considered protocol in most areas due to the possibility of infection in mother and child. This is the case at Kantu, where protocol is enforced strictly as it is also part of a punitive mechanism. However in some cases, specifically if the child is born in the presence of and with the assistance of the health provider at home, the move to the health center may be avoided. In Flores some of the interviewees were able to achieve this with the acquiescence of the NM.

It is important to note that when asked what would be an ideal birth, the majority of interviewees in both sites responded 'that the nurses come to my house and care for me there'. This position was seen as unacceptable both from a public health and maternal death reduction perspective. All medical personnel I consulted made the same reasonable arguments: emergencies were sudden occurrences and it was impossible to have all the required medicines and technology to deal with them in a rural home birth. However, the desire for nurse-midwives to come to the women's house, indicates the importance of location of birth, as an intersection of place, control and power in the birthing preferences of community members in both research sites.

The different strategies were ways in which community members sought to regain control of birthing and combat abuse. Through regaining some control over birthing they assert their citizenship rights to tradition and culture, in a hostile modernizing health care environment.

The following section will explore the other side of this equation, the health personnel. Specifically the nurse-midwives, who despite asserting power over the location of birth in the

health center, are also subject to pressures and abuses from the MoH structure.

7.2 ON THE OTHER SIDE: NURSE MIDWIVES AND THE CHALLENGES OF INTERCULTURAL BIRTH

Nurse midwives' attitudes towards implementation of the intercultural birth policy in both research sites were heavily influenced by their own views of culture and interculturality, which I have detailed earlier in this text (see Chapter 5). However, they are also influenced by the structural constraints of their professional lives, their professional aspirations and their personal histories. In this section I describe how rural NMs are also submitted to pressures and discrimination from the male, physician-centered, and urban health care system. NMs who are subjected to, and also create an unequal structure, in-turn replicate discrimination and inequality. In this sense, the creation of a true *interculturalidad* in health in Peru will also require a profound health system reform.

7.2.1 Personal Histories and Culture Shock

The personal history of a health professional is generally considered irrelevant in the application and practice of medicine. Medicine is commonly perceived through training medical professionals become objective vessels of medicine. Some studies have shown that induction into medicine re-signifies the existing experiences of the person or persons involved by imbuing them with the vocabulary, technology and knowledge that separates them from 'civilian' others by creating a culture of medicine (Good and Good 1993). However, in as much as the practice of medicine implies the connection of human beings it cannot be objective. Thus, for example, in the case of the intercultural birth policy text, there are implicit subjective assumptions about the value of culture, the role of government, the extent of rights, the value of life, proper and improper activities of birth, the barriers of access to care, and others which were mostly medically informed moral judgments. Furthermore the implementation process of this policy hinges on the evaluation of a subjectively identified 'cultural need'. One of the

objectives of the present research was to explore the subjective effects of personal histories on the implementation of the intercultural birth policy.

In both research sites, all professional medical personnel, doctors, nurses and nurse midwives were originally from outside the area. However, most were from the large cities in the same department or from neighboring departments. On the other hand non-professional personnel (the *técnicas(os)*) were from closer by areas, and sometimes from the same communities where the health services are situated. This is a common feature of the Peruvian health system, which affects the way in which health personnel approach the community, for example asking *técnicas* to act as go-betweens and negotiators, and also how the community approaches the medical establishment, for example seeking out the more familiar personnel outside their work hours to consult on medical matters and course of action.

Most of the NMs in both sites identified more with urban and non-indigenous communities and had suffered some measure of culture shock when being sent to work in remote rural areas. Gloria, Susana, and Claudia all arrived in the Quispicanchis area, though not directly in Kantu, as part of their SERUMS program. Gloria came from Lima, Susana from a city in the neighboring department of Apurimac and Claudia from nearby Cusco city; none spoke Quechua fluently on their arrival to the health center were sent to fill in remote rural posts where they had to learn the language and live in what they considered to be extreme circumstances, with no electricity and in a strange environment.

Yuli and Sara were both more prepared for their early posts. Yuli came from a Quechua family and spoke the language fluently which helped her in adapting to her SERUMS position. Similarly Sara, although originally from the low-lying area of the neighboring La Libertad, had lived in an area with a lot of Cajamarca migrants whose beliefs and customs were not that dissimilar from those of her own family. These early trajectories were influential in the way in which NMs approached the medical encounter. Those who had the ability, through language or familiarity, to connect with patients on a personal level acted and were perceived by the population as more approachable and more flexible. This affected the way in which patients related to them in contrast with the other NMs. However, from a policy implementation perspective Yuli was not in any position to change or defy expectations in the Kantu health center. In the case of Flores, Sara's charisma in contrast with previous

ad current colleagues helped her in maintaining maternal deaths low, but did not increase the number of births in health service significantly. Furthermore the differences with other medical professionals cemented in the community the personal nature of the intercultural birth policy, considering that only Sara could treat them well and as such if possible avoiding the health center when she was not there.

In addition, to the culture shock that a change in living conditions and language brought, none of the NM received any practical training on vertical birthing or interculturality. The younger midwives had heard of vertical birthing and the intercultural birth strategy; however, it was not part of their professional training. As such their first encounter with a different birthing position was a shock. Susana had worked in a clinic before her SERUMS and had been part only of horizontal births. Once in the rural areas she describes her bewilderment:

I had only trained horizontal, I had worked in a clinic, but where I did my SERUMS once I got there they told all here is vertical. I had heard something but didn't really know what it was. When I was able, I observed the colleague doing it on the sly, but I didn't tell her that I had no experience. The first time I was left on the shift alone I was begging the lord that no one came. When a woman finally came once I convinced her to lie down and did horizontal, but my colleague noticed and told me off! She said no don't do this here it is vertical so I had to learn'

Sara, Yuli and Claudia had similar stories of being faced with the prospect of not attending births or doing them horizontally. Furthermore, in Sara's previous work experience in other parts of the regions she had accepted that most women birthed at home with a traditional midwife. In the micronetwork where she was employed prior to arriving in the province of San Marcos it was normal that only 30- 40% of births occurred in the health facility. However, when she was transferred to the Flores micronetwork, she began at a peripheral health post where very few birth occurred, so her learning experience of vertical-birthing came only when she was called from the Flores health center as back-up for NMs who were on leave.

Gloria, the only tenured NM in Kantu was part of the training done by UNICEF and Future Generations as part of the plan to replicate the initial pilot programs. Thus she considered herself as one of the founders of the intercultural birth strategy. Her encounter with the concept came before the policy was implemented, since the strategy was enthusiastically replicated in the Cusco South network. Prior to the beginning of intercultural

birthing the Kantu health center had very low percentages of institutional birth percentages (around 30%) and a sizable contingent of traditional birth attendants working as part of the extended community health agent network. After implementation, and with the support of international non-profits, Kantu and increased its coverage of birth, had built a new health center and had implemented the maternal waiting house. Gloria considered it one of her most important personal achievements.

NMs in both sites expressed that vertical birth is more taxing on them than the horizontal one: *'it's not as comfortable as the normal way, you have to be on your knees a lot, you have no line of vision to see the head emerging, it's just awkward, but you have to do it if not the women won't come'*(Yuli, Kantu) Thus the attitudes towards implementation of the vertical birth policy are based on a cost benefit analysis, although more uncomfortable it must be done because women are not coming. Younger NMs perceive their abandonment of horizontal birth techniques and all related knowledge as a concession to the community, a sacrifice that is not gratefully recognized.

Taken together the culture shock, lack of support or training in vertical birth and the overall feeling of ignored sacrifice can create a negative atmosphere which is replicated in patient encounters.

In addition, to these already complicated issues, there were other more personal problems which made working in rural health services particularly difficult for young women. The most salient of these was that none felt it was possible to achieve a work-life balance while still employed at a rural center. Those that had the aspiration to become mothers, and who were, or desired to be in a committed relationship were discouraged by the experiences of those few rural peers that had achieved some measure of professional stability. For example, Sara in Flores and Gloria in Kantu, both older NMs, each had one child, but the child lived with their relatives in a different city distant more than two or three hours, they were both divorced or separated, and currently single. Both women tried to maximize the time they could spend with their offspring by accumulating days -off and leaving the health center for longer periods of time, leaving their younger colleagues to cover for them. At Kantu, Yuli commented that Gloria's life was really not one she wanted for herself, even though Gloria had job security *'it is not worth the effort, professionally you cannot be here like*

fully, no? And then you also can't be with your family. But I really don't know how we can do otherwise. Anyway, she added sighing wistfully 'maybe I'll be able to get a job in town and find a relationship there'(Yuli,Kantu).

Furthermore, the type of job stability that Gloria had was becoming very rare in the MoH, most positions were short-to-medium term contracts. In this sense, there was no added incentive for younger women to remain at a rural health center, and most of those I interviewed saw themselves living and working somewhere else in the future. All were hoping they could find a way to use their experience at the MoH as a spring-board for some type of urban employment. However, they were very guarded about saying this out-loud and in the company of the other NMs because each thought they might be labeled as unprofessional and uncommitted to their profession.

The idea that the health care professional should espouse an ethos of commitment, and a desire to serve others, even through sacrifice was also mentioned by Constantina, the head of the Cusco South network (see Subsection 5.3.1), and is prevalent in policy makers' discourse on the health profession. As a result of the fear of being labeled as non-committed by their peers and bosses NMs do not speak of these issues; and the system itself is unwilling and unable to provide a solution. The lack of avenues to achieve personal goals, in addition to the low-wages, lack of stability, and other problems of the system which I detail below, result in a high level of attrition of young educated women from rural health services and from the health care system in general.

7.2.2 Structural Inequalities in the Health System

In addition to the slights and constraints described in the previous section. NMs were also severely constrained by the reduced wages and unstable contracts, their relatively powerless role in the health structure and the possible reduction of professional prospects.

Most of the medical professionals in both research areas were there on short term contracts. There was an ample range of possible contractual levels, some with more benefits than others. The highest possible rank was to be a tenured personnel, but that was a feat achieved by few, since it required more than 6 years of uninterrupted service to the health

system in a specific hiring category which was initially less attractive than other shorter term contracts. Those who achieved tenured positions received bounties and benefits, took longer leaves and could not be required to work outside their hours. A further perk was that they could ask to be reassigned together with the funding for their post to a different health service. In Flores two assigned personnel had relocated to Cajamarca for health and education reasons, but since they were still officially slated to return to their posts (although nobody expected them to) Flores could not consider their spots as vacant and could not hire anybody else.

Nonetheless, these types of contract were very scarce, most NMs and other health personnel were on short term (3 months to one year) contracts which were generally renewed. They had no benefits and no bonuses and only one of these hiring contracts allowed the person to accrue service time to the health system, half of which could be recognized for tenure purposes. Different types of contracts meant different remuneration levels for people doing the same work since funding came from different sources. This also meant that funding crises affected some personnel more than others, for example during my time in Kantu a third of the professional personnel all hired through the Comprehensive Health Insurance *Seguro Integral de Salud* (SIS) had not been paid for three months, this included two of the NMs⁴.

On the whole NMs under contract had little job security, they were constantly expecting the possibility that their contracts would not be renewed, it was a common topic of conversation and on their days off several visited the Regional Health offices to see what other positions were available. This context created discomfort among the NM team and also discouraged engagement with the community since there was little incentive to settle in one area.

Furthermore, the structure and organizational culture of the health care system provides more professional development opportunities for those in urban rather than rural areas. This also fuels an internal rural-urban divide within the MoH systems, where the urban

⁴This was caused by an improper use of SIS funds from the regional direction, who had hired personnel through using these funds as part of an emergency measure that had then been informally extended. The time limit on this emergency measure had been reached, drying up funds for personnel commitments. As of my leaving Kantu payment had resumed but only a third of the owed amount for previous months had been disbursed.

professionals see themselves as more important or knowledgeable than the rural professionals and frequently mistreat and abuse them. For example in Kantu, the NM feared patient transfers almost as much as the community, because it was difficult to accomplish and exposed them to mistreatment from the Regional Hospital professionals. During one referral for ‘failure to progress’ Yuli was on the phone to the Regional Hospital and the back-up hospital, repeatedly because they denied her the referral. She didn’t know what to do, or where to go. Finally after an hour of calling she was allowed to refer the patient to the backup hospital. However now she feared she would be mistreated by the attending doctor for bringing in a patient who had been in labor for too much time:

‘the other time I took a gordita [literally translates to ‘little fat woman’ it is her endearing term for patients] too late, I got thoroughly shouted at by the attending doctor, Ay! qué no me dijo? (what didn’t he say!) that we were unprofessional, should have referred her earlier, should not work with patients, where did I study, I thought he was going to insult my mother, I swear⁵! I didn’t say anything, calladita nomás, and let him vent, it’s easier that way with doctors.’ (Yuli, Kantu)

The problems brought on by lack of hospital beds in the city delayed referrals, much to the chagrin of primary care personnel who were then held responsible for the consequences of that delay. Furthermore in the case of the NMs, they are additionally treated in a patronizing manner by the mostly male medical doctors, whom they need to accommodate and tolerate. NMs were frequently abused by physicians in the hospital, their medical proficiency was questioned and their diagnoses were openly doubted. This made arranging patient referrals very complicated and added to the overall tension that an emergency situation already supposed for the staff.

On paper the need for a referral has to be established by the attending personnel, generally a nurse-midwife and if applicable by an on-call doctor in the health center; after this step, staff are supposed to communicate their impending arrival to the hospital or public clinic and provide details of the emergency so that the receiving physician is aware of the issues. In practice, both in Kantu and Flores, once the need for referral had been ascertained NMs began to fret about who the on-call doctor at the hospital emergency room was, who had a better relationship with him or her, who should actually make the call, what to say so they

⁵In Spanish ‘mentarme la madre’ or insulting one’s mother, is considered one of the most grievous forms of insult.

wouldn't be denied the referral authorization, and a myriad other things that were ancillary to the emergency itself. In more than one occasion I witnessed NMs in Kantu begging one of the male physicians at the center, and even one of the male interns, to arrange for obstetric referrals directly doctor-to-doctor since they felt they would not be treated seriously because they were only nurse midwives and also women.

However, if a maternal death occurred the blame fell squarely on the nurse-midwives in charge of that patient, even if the time spent attempting to achieve a referral and being dismissed by the emergency attending physician was a contributing factor in the demise. Moreover, the consequences for a maternal death for the NM were severe, at the very least an internal inquiry and most often a dismissal from their position. Gloria referred to it as a persecution

We know from maternal death analysis that education, transport, economics, cultural barriers, all that influences maternal death, and although we have reduced the gaps there are still deaths... but there has also been a persecution of the colleagues from the administration. So if a mother died the midwife loses her job. Patients die, doctors don't get canned and children die and they are not fired. So why the midwives!?' (Gloria, Kantu).

The legacy of these administrative procedures was that NMs were on the one hand relatively conservative in making referrals, tempting the wrath of the attending doctors by sending women with manageable complications to diminish the risk of dealing with a potential fatality. This additionally led them to pressure and cajole families for referrals even when they could attempt to solve the crisis themselves, sometimes recurring to the police to make families comply.

Working at a rural health center, being female and a NM were all problematic for the professional advancement of the women I interviewed. However, the fact that they were working in a micronetwork that specialized in intercultural birthing was also very detrimental to their career prospects. Many physicians at the regional level were opposed to the implementation of intercultural birthing, and viewed those that practiced vertical birth as working counter to the advancement of the medical profession, for example, Susana recalled a hospital doctor telling her that: *I was betraying the medical profession, that my medical knowledge was atrophying , that I went to the university for nothing (por gusto estudiaste), and that I was nothing more than a glorified traditional midwife (partera)*(Susana, Kantu).

As a result, time spent in rural areas with intercultural health implementation was not a positive experience for those NMs who aspired to urban clinic jobs. Although the intercultural birthing experience could be useful if there was an opening to work in health related issues with international aid groups or non-profits. This was the aspiration of Gloria, the only tenured NM in Kantu, who was trying to get funding for a joint project with a local affiliate of an international non-profit. This was not a viable option for the other NMs, for them the fact that they had worked in a rural center that specialized in intercultural birthing was detrimental to their ambitions of obtaining urban posts. At Kantu, for example, Susana was actively pursuing specialization studies in fertility which she hope would help her to reconnect with what she called ‘the scientific medicine community’ and obtain a post at a fertility clinic in the city.

In sum, NMs suffered discrimination due to the gendered hierarchy of the health care system, their adequacy as professionals and their commitment to the job were constantly questioned, and they lacked decent wages and job security. Furthermore the rejection of *interculturalidad* from urban based medical professionals negatively affected the possible long-term career goals and made them loose job prospects. This in turn affected the way in which they related to patients, to the idea of *interculturalidad* in health, and to the local population and their culture.

It is important to note that many of these problems are not exclusive to NMs working at rural health centers, those in urban positions also suffer discrimination and mistreatment in their workplace, and also in turn discriminate and mistreat their patients. This is, in-fact, an endemic problem in the Peruvian health system, an unequal system produces and reproduces inequality. Regrettably there are few incentives for reform.

7.3 CONCLUSION

Viewed from a community perspective the intercultural birth policy seems to have made some advances by providing community members resources for negotiation of birth care preferences. However, there are serious concerns among community members about the

continuity of the positive changes in birth care, and about the persistence of abuse and mistreatment of women and their families. These concerns are based on past community experiences and are justified given the rapid turnover of personnel, and the previous policy changes like the one experienced by the TBAs. The abuses were on the one hand result of the structural pressures on NMs but also due to the persistence of a discriminatory attitude towards indigenous populations among mestizo-identified health personnel.

From the perspective of the NM, there were very few professional or personal incentives to implement the intercultural birthing policy, and less to establish relationships which would allow them to connect to the community on better terms. Rural NMs, and also other rural health personnel including physicians, were on the lower rung of the urban-physician-centered, male, hierarchical structure of the health system. Rural health personnel, and NMs in particular can be easily blamed for maternal deaths, and are also discriminated against professionally for their link to the intercultural birth policy.

In this context the community has developed strategies to mold the existing and variable options of birth care to their ideals and preferences. Whereas the NMs are faced with further restriction in their career development options the longer they remained linked to the rural areas. This status quo is extremely detrimental to the success of the policy of intercultural birthing and to its continued implementation.

Regrettably as other studies [Reyes \(2007\)](#); [Planas and Valdivia \(2007\)](#); [Reyes and Valdivia \(2010\)](#), have shown the cycle of discrimination and abuse is not restricted to health services in rural areas, or to rural health professionals, rather it is endemic to the Peruvian health system at large. It will require a great deal of soul-searching and a profound reform to change the system, and at the present time this seems unlikely.

8.0 DISCUSSION: CULTURE, POLICY AND SAFE MOTHERHOOD

In this dissertation I have presented an analysis of the implementation of the Peruvian Intercultural Birth Care Policy in two sites. This chapter presents the results of that analysis in relation to the original study goals and theoretical background. This study had two major goals: to understand the impact of the use of interculturality as government discourse in maternal health care for the nurse midwives and in the provision of health care services; and to uncover and describe the role of medically trained nurse-midwives in the process.

The driving questions of the research concerned three levels of analysis of this policy. On one level I was interested in observing intercultural birth in action and understanding its concrete effects on birth care in rural areas: was it accepted by the community?, did it improve birth care outcomes?, and was it a viable model for the region? All questions specifically related to the implementation, its long term viability and its contribution to the goal of Safe Motherhood in Peru.

Further, I sought to understand the policy itself, the context it was created in and the context in which it was applied. Given that it signified a radical change for public health services to incorporate previously censored traditional medical practices into biomedical birth care: why was it accepted and promoted by health services?, what were the effects and opinions of health care workers and community members regarding these changes? and what were the consequences to policy implementation?.

Finally, the notion of *interculturalidad* carried a transformative potential for indigenous populations in Peru, a promise of equal and respected citizenship, that could change the way in which they related to the nation. However, does this implementation of *interculturalidad* under a government sponsored program realize this potential? Furthermore, what can the example of intercultural birth care policy in Peru indicate regarding the role of culture in

health care, and in public policy more generally?

The following sections explore the results of the study at these three levels in dialogue with broader discussions.

8.1 CULTURE AND INTERCULTURALIDAD IN PERUVIAN BIRTH CARE

Analysis of the Peruvian intercultural birth care policy that I have presented in this dissertation questions the transformative potential of *interculturalidad* in policy, and in this case specifically health policy. This case evidences an instrumental deployment of the concept. In discourse it retains explicit equality-laden and change-evocative language, however this potential is lost in concrete implementation of *interculturalidad* through day-to-day encounters. This establishes a profound dissonance between discourse and practice.

8.1.1 Instrumentalizing Culture

The use of interculturality as part of the Peruvian birth policy corresponds to what other researchers have termed ‘cosmetic interculturality’, a continuation or reassertion of regimes of power furthered by re-purposing the concept and emptying it of real transformational charge ([Tubino 2005](#); [Walsh 2009](#); [Viaña Uzieda et al. 2010](#)). The implementation of *interculturalidad* in birth care, more specifically the incorporation of Andean perceptions and elements of home care into biomedical settings, is part of a continuing modernizing enterprise which, rooted in the early 20th century ideas of modernity, remains at its core hostile to non-western medical beliefs. Not only does *interculturalidad* in Peruvian birth policy fail to establish a dialog between existing birth care traditions, it also serves to assert that the knowledge that really counts is biomedical, and contributes to the reification of the concept of culture in medicine.

Viewed from a historical perspective the process of interculturalizing birth policy in Peru follows a similar pattern to the previous work with TBAs, which was also proposed as a way

to provide better, more effective care for indigenous minorities and poor women, but which proved to be little more than a stop-gap measure. The work with *parteras(os)*(TBAs), which has been thoroughly described in the anthropological and public health literature (see Sections 2.1 and 3.3), was also touted as an attempt to build bridges between traditional and biomedical systems of birth by training TBAs to become liaisons between two separate-but-equal systems of care (Jordan 1978).

However, from a governance perspective, traditional medical systems of care were never recognized as stemming from ‘knowledge’ but were considered belief or custom, not as part of a comprehensive but different view of health and body. As a result TBA training consisted mostly on imparting a medical perspective on birth-care, basic information on the physiology of conception, pregnancy, fetal development and medical birthing practice, an approach which some asserted was focused on converting TBAs into lay-medical agents by dismissing and replacing their prior knowledge (Carlough and McCall 2005). In Peruvian public health, despite a robust and extensive collaboration between the MoH and the TBAs, traditional birth practices were still considered a barrier to proper medical care, not as an alternative system, and TBAs were only supported in areas that medically trained personnel were not able to reach. Maternal health policies progressively restricted the scope of collaboration of TBAs with the MoH while the public health facilities expanded to occupy areas where *parteras* previously worked. Over the arc of the official relationship of the TBAs with the MoH in Peru government policies and programs have revealed a disregard for non-biomedical birthing practice.

Interculturalidad, seen as part of the same process, further alienated *parteras* from their embodied traditional knowledge by dissecting it, evaluating each part for compatibility with the existing medical protocol and engulfing that which could be controlled and/or did not conflict with current biomedical practice. Thus, under the guise of acceptance and respect, the process of interculturalizing birth care debases and fragments Andean birthing knowledge and asserts the dominance of western medical knowledge.

Furthermore, the process through which *interculturalidad* in birth care was created, by selecting certain elements of Andean TBA practice and separating them from the cultural context in which they were created, has contributed to the reification of the concept of culture

in health care policy. This means that a whole alternative form of conceiving the person, and the body in relation to health, illness and death, have been reduced to a few listed characteristics through which medical professionals purport to provide culturally competent care. Furthermore, the equivalence established between *interculturalidad* and Andean culture more generally has served to reassert that ‘having culture’ is only a purvey of indigenous or marginal others and that biomedicine has no culture. In this sense, the focus on a bounded and homogenized idea of ‘cultural need’ that can be easily overcome with *interculturalidad* detracts focus from structural issues affecting economic and social equality in Peru.

Anthropological critiques of public health systems’ lack of attention to cultural difference and needs and the international policy bodies’ adoption of *interculturalidad* have contributed to the adoption of homogenized notions of culture in health care training and policy in the developing world (Page 2005; Gregg and Saha 2006), and though within anthropology there is a long-standing discussion of the problems of reification and an emphasis on the importance of context, cultural process, critical notions of culture have yet to materialize in the realm of health care or in the result-driven practices of international development organizations.

This problem merits a more extensive discussion which escapes the focus of the present research, though the failings of the policy of intercultural birthing in Peru are indubitably partly an issue of the essentialization of Andean culture in Peruvian health care, they are also an effect of the persistence of racial/ethnic discrimination; the gendered-hierarchical inequality of the Peruvian health system structure; and the absence of popular momentum and demand for cultural respect in health in Peru.

8.1.2 Racial and Ethnic Discrimination

The discriminatory attitudes towards people of indigenous descent, in relation to nation building efforts and gendered perceptions of ethnicity in Peru have been described thoroughly by Weismantel (2001), De la Cadena 2009, García (2005), Ewig (2010) and others. These authors propose that the bodies of indigenous women are the center of contention in the nation building enterprise, they are viewed as more indian, more natural, untamed and rural, and as such a danger to a modernizing project which equates modernity with urbanity, and

both with an ideal of social, if not biological ‘whiteness’. Thus, for example, Peruvian policy makers in regional health directions and other policy making spheres focused intercultural policy changes in birth care only on those areas that were rural, remote, and/or monolingual Quechua, where that ‘indigenous other’, the people with culture, could be easily defined by their language, their daily clothes, or their agricultural way of life.

On the ground implementation of the intercultural birth policy was an instrument for continued discrimination of those identified as indigenous. Nurse midwives in the research areas reserved positive adjectives—good patient, knowing or *entendida* and smart—for women who in their view embodied modernity, spoke Spanish, did not wear traditional garb, limited their fertility, and birthed in the health center, and whom they felt similar to themselves. Women and men who did not embody this ideal were thoroughly dismissed, treated as less than citizens, their practices were considered backwards and animalistic, and their opinions shady and untrustworthy. This negative attitude towards those whose culture they said to respect was a constant, from the upper echelons of policy in Lima, where the national coordinator of the strategy rejected my concerns over mistreatment as ‘misconceptions told by a discontented few’, right down the institutional hierarchy to the nurse midwives who likened their patients to animals and threatened them with jail. In this attitude there is a conflagration of race and class that permeates much of the political and social discourse in Peruvian daily life where the poor and indigenous are seen as burdens for the development of the nation.

In this context, their knowledge cannot be seen as equal as that of biomedicine and as a result practitioners of medicine, even nurse-midwives in policy implementation sites, view biomedical birth protocols as the only proper and normal way to birth. In consequence, catering to special cultural needs of less developed others is perceived as a burden on nurse-midwives and medical personnel. It is viewed as a dangerous undertaking because it supposes physical closeness, especially of the face to the genitals, which was deemed specially impure and unbecoming position for a medical practitioner. As Pedro, one of the Kantu physicians remarked *‘I don’t know why the ministry puts the girls (‘las chicas’ referring to NMs) in danger like this, it’s a bio-hazard, even with gloves and a mask, the blood and the amniotic fluid everything gets on your hands and can get on your face! I really feel for them!’*, prompt-

ing knowing nods and similar concerns from the two nurse midwives present. Without the protection of the distance afforded by biomedical birthing as practiced in the urban health centers with the woman lying down, covered in sterile cloths and using tools (forceps, scissors) and techniques (episiotomy) which ensured their distance and separation, they were seemingly forced not only to cater to a less evolved body but were also in danger of being contaminated by it.

8.1.3 Inequality in the Health System

On the other hand nurse midwives, and in general rural health personnel, were also subject of discrimination within the Peruvian health system structure, where gender, chosen profession within the field of health, and place/area of work defined one's place in the hierarchy. Thus male-urban-physicians occupy most of the positions of power and are viewed as most important and youngish-female-rural-midwife were among the least important. This configures a profoundly unequal system where NMs are routinely made to feel less than physicians in general, especially males, for example medical diagnoses of female NMs are doubted unless they are supported by a physician and doctors routinely patronize NMs by referring to them as the girls, little daughters (*hijitas*), or little mothers (*mamitas*). Furthermore, as rural health professionals, NMs and others in the rural health centers were viewed as less skilled by their colleagues that practiced and lived in urban areas, they were restricted by virtue of their work in a remote area to actively work towards career advancement, for example opportunities to continue education were severely limited, and possibilities to provide highly lucrative private medical services nigh on impossible. Many rural health workers worked on short-term contracts that afforded no job stability, their wages were low and the sources of compensation were not secure. Almost all who had families lived away from them and used much of their limited resources on traveling to visit partners and children, others were unable to find ways to balance rural health work and a desirable home-life. In the research areas planning their exit to a better life was a favorite subject of discussion among health workers. The lack of motivation of older colleagues dented the enthusiasm of younger professionals and on the whole made for an unpleasant work environment, where health personnel repli-

cated the discrimination they felt, an unequal health system which created unequal health providers.

In addition to these problems, rural NMs who worked in health care services that had implemented intercultural birthing were seen as ‘traitors to their craft’ and ‘nothing more than *parteras*’ by the higher-ups in the regional(urban) medical establishment, further restricting their particular career options and limiting their job prospects. Many medical professionals in the urban hospitals and clinics viewed vertical-birth and the intercultural policies as a capitulation to backward thinking, and somewhat as a betrayal of modernity, in consequence NMs in Kantu were leery of having that experience on their resumes. Furthermore, they also spoke of feeling left out of the techno-medical advancements by virtue of their remote location, for example Yuli recalled talking to colleagues from her graduating class and feeling ashamed of not being able to join in their discussion of the benefits of new equipment. In this sense, it was not only that the urban medical establishment discriminated against them, it was also the case that they too felt that time spent providing and perfecting vertical birthing techniques was a barrier to professional advancement in better paying and more prestigious urban environments. Thus efforts to implement intercultural birthing were seen not as a worthwhile and needed service by nurse-midwives, but rather as an unrecognized favor and somewhat of a sacrifice on their part. One which they endured under the expectation that urbanization, knowledge, modernity or generational change would render unnecessary in the short to medium term.

8.1.4 Interculturality from the Top-Down

A further issue which limited the scope of implementation of the intercultural birthing policy was an absence of a broad base or momentum in support of the political framework of *interculturalidad* or more generally a public demand for culturally appropriate health care in the Andes. Moreover, despite the growth in the number of political groups which appeal to voters’ ethnic identities and the potential for a culturally tailored approach to health due to decentralization, regional and national discourse related to ethnicity and policy is centered on economic issues. Specifically, in relation to important issues of territory, benefits and

ownership of valuable raw materials like gold, copper, oil and gas. There area very few, if any mentions of cultural preferences or requirements in education or health. In this context, it is not surprising that no community members in the research areas, or indeed lay people in the city of Cusco who asked about my research, had heard about the concept of *interculturalidad* or knew about the changes to birthing practice. Though talk about the recognition of indigenous cultural rights seemed familiar, community members tended to assume these were mostly restricted to their rights to the land and to the defense of their environment and livelihood, issues that had been at the root of recent protests and were very much in the air. Rights for culturally competent birth or education were not mentioned spontaneously at all.

Nonetheless, community members did have critiques of the health services, and voiced their desires for care and respect for their rights as citizens. These opinions and requests touched on issues had been considered solved by the MoH through the intercultural birthing policy or the mainstreaming of the frameworks of interculturality, human rights and gender equity in Peruvian health policy more generally ([Min. of Health Peru 2006b](#)); the community demands were overall concerned with obtaining equal and respectful treatment which entailed: the ability to engage and understand the medical professionals, asking they speak the commonly used language or make an effort to communicate more effectively; the rejection of coercive tactics, fines, threats and verbal abuse; the respect for differing views of bodily needs for birth; and the request of being informed or included in decisions regarding the process of care. These demands echo the findings of Niño de Guzmán ([2007](#)) in Cajamarca before the implementation of the birth policy pilot there, and are also part of the discourse of both patient rights and intercultural policy, but were not part of daily care practice.

In sum, the incorporation of interculturality into birth care in Peru did not respond to popular demands, did not promote or succeed in changing longstanding attitudes relating to perception of biomedical superiority and racial discrimination despite the change in discourse. Furthermore the core actors in the implementation process view it either reductively as only a change in position or negatively as an added burden on their already taxed professional lives.

It is important to note that several of the issues discussed, discrimination of community

members, forceful measures of patient compliance, and paternalistic attitudes toward patients and female colleagues do not occur only in rural and indigenous areas. Discrimination in patient care disproportionately affects the urban poor. As a result, pregnancy and birth care in urban health centers can be a violent and alienating experience, women who suffer the indignities of birthing in small urban centers or large hospitals are subjected to stricter regimes of bodily control (Reyes 2007), longer wait times for prenatal visits, shorter visit times and no space for dialog or adaptation of birth care, no company in the birthing room, routine episiotomies, extra expenses on transport, food, clothing, and diapers, and almost no possibilities of changing birth position at will.

This is the form of birth care which some NMs and other health personnel call ‘proper’, it is indeed very far removed from the ideal of intercultural birthing. Why then did the central MoH officials and medical personnel at regional health directions in Peru accept, promote, and implement *interculturalidad* in some areas of the country?

8.2 INTERCULTURALIDAD AND REPRODUCTIVE GOVERNANCE

The question of why *interculturalidad* was promoted and implemented in Peruvian health care can be answered at different levels. The first and more basic answer is that incorporation of Andean elements into birthing is a way to entreat women, who were reluctant to go to the public health facilities for birth, by offering them home-like birthing environment and a safeguard against the inherent risks of birth. Interviews with health providers and officials indicate that there was some expectation that within a medium to long-term horizon birthing in a health facility would become a new custom, and that with captive demand they could phase out cultural adaptations and return to a more urban model of biomedical birth care. This has in fact been the case for several of the original pilot sites, for example the San Marcos health center in Cajamarca, which was one of the original UNICEF pilot sites and which at the time of research (almost 7 years after the end of UNICEF involvement) had stopped offering home-like birthing and had also ceased to consider it necessary because, in the words of the NM, there was no cultural need, women were educated and urban and wanted regular

care(see Chapter 5). This has also been the case for the Quiquijana micronetwork in the province of Quispincanchi, which was another early adopter of the intercultural framework in birth. In that case, which was confirmed by the regional official in charge of the SRH strategy, the long-serving NM who had pioneered the program had obtained a new job elsewhere, current personnel including the head of the center were ambivalent towards the program and the replacement NM (a young recent female graduate) had no training in vertical birthing or commitment to learning and continuing the practice (see Subsection 5.2).

Further analysis of this case indicates that another answer is that reduction of maternal mortality, framed as ‘Safe Motherhood for all’, has become a global moral imperative. In consequence for the Peruvian government interculturality in birth has become a means to achieve the desired and demonstrative reduction in numbers of maternal deaths. The national coordinator of the SRH strategy, for example, referred to the numbers being the most important factor in her view (see 5.3.1). Though certainly avoiding preventable deaths from maternal causes is in itself an important goal the undercurrent of these declarations, and the extreme focus on numbers, not people, is that the result is more important than the means used to achieve it. In this case several of the strategies employed are to achieve the death reduction goal are at odds with human rights and/or Peruvian health care law. Thus the case of the implementation of intercultural birthing in Peru can also be viewed as an example of what Morgan and Roberts term Reproductive Governance, understood as ‘*the mechanisms through which different configurations of actors use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce monitor and control reproductive behaviors and practices*’ (Morgan and Roberts 2012:p.43). Viewed as form of reproductive governance the discourse of interculturality, the implementation of *interculturalidad* in birth care and the coercive measures employed to ensure patient compliance are instruments for governing bodies and limiting decisions to ensure a predefined ‘greater good’, which in this case is the reduction of maternaks deaths.

As chapter three has demonstrated maternal mortality loomed progressively larger in global policy throughout the latter part of the twentieth century. International commitments became at once more public and progress, or lack there of, was increasingly monitored. Results were respectively lauded or derided in reports that trickled down from supranational

development related organizations to their regional and national affiliates, became the subject of many academic papers and even made it to the national and international headlines all under the umbrella of producing a common global moral good (Fassin 2012). The incorporation of the rights discourse in the late 1990's which expanded the realm of human rights to reproductive and sexual rights, to cultural and economic rights and further to specific rights for indigenous peoples and contributed to the establishment these common sense ideas of global good. However, as Fassin (2012) indicates the realm of global health is also about competing truths and ethics, thus the globalization inherent in the global health policy is also an expression of power to *'act on people and things as well as on subjectivities and ideologies'* (Fassin 2012:p.107). Thus I contend that in the case of the Peruvian intercultural birth care policy, the demonstration of success in achieving an appearance of global good, by viably reducing the number of maternal deaths has become more important than the means used in its pursuit. As such the dissonance between discourse and practice, and the conception of birth in the health center as the only possible moral regime are constitutive elements of the intercultural policy since its inception and lead national policy makers and NGO representatives to turn a blind eye to the particular forms of coercive measures of governance which are employed.

In chapter six I have described the particular forms in which reproductive governance is enacted through contraceptive, pregnancy and birth care by nurse midwives in health care services at the research sites. Indigenous women are subjected to continuous and pervasive micro rituals of power which attempt to subjugate their choices, repress their will and mold them into the accepted moral regime of model-patient-and-citizen. This is achieved through direct coercion, forceful or abusive language, moral judgment, fines, withholding food aid and the deployment of a panoptic-like control over female reproduction at the local level, aggressively pursuing contraception for those health personnel thought should not reproduce, and those whose birthing practices public health personnel sought to control. Though the tools and expected results of reproductive governance were not created or defined by the health service personnel that applied them, these nurse-midwives and doctors truly considered that their actions were justified by the end result. This is not be the first time that health care providers have put the results of a policy above the lives and rights of their patients in Peru,

the family planning campaign that coerced indigenous women into tubal ligations (surgical contraception) was also part of the same trend within public health provision in indigenous communities in Peru (Coe 2004; CLADEM 1998; Morgan and Roberts 2012). Furthermore, instances of discrimination, racism and violation of rights on the part of health care workers are more the norm than the exception (Planas and Valdivia 2007; Pacheco 2012; Reyes and Valdivia 2010; Valdivia 2010).

As I have described earlier in this discussion the mostly younger female nurse midwives working in rural health centers who were charged with providing intercultural birth care were almost the last rung in the gendered hierarchy ladder of the MoH. They were derided by urban professionals, mistreated or pitied by doctors and pressured through contract limitations, unfair hiring and compensation practices, overwork, lack of job stability, the reduction of their career advancement prospects and the possibility of being on the receiving end of an official maternal death inquiry. The subjugated position of this key group, the profound mark of racist views towards indigenous populations, and the normalizing force of the perception of working towards a moral good, precluded nurse-midwives from perceiving the dissonance between discourse and practice, and promoted conformity among personnel. An example is the case of Yuli, the only direct Quechua descendant among the NMs in Kantu, she evidently struggled with some of the attitudes of colleagues and felt somewhat uncomfortable with some of the forms of coercion and mistreatment, sometimes attempting to assuage them with sweet encouraging words in Quechua, but who did not really consider challenging them. Furthermore, nurse midwives truly believed that their attitudes in the day-to-day care of indigenous patients corresponded to a successful implementation of interculturality in health. The lack of dialog, coercive strategies and discomfort from the community were regarded as merely enthusiastic or overzealous care.

In consequence I propose that this iteration of the application of *interculturalidad* in health in Peru is an example of an the-end-justifies-the-means approach. It does not challenge existing structures of power. Rather, in its journey from global policy, to national and regional policy, to local realities this framework is a tool of reproductive governance which advances a longstanding homogenizing enterprise. In essence, it continues to marginalize non-western beliefs and practices, to deny full citizenship rights to indigenous people and to progressively

constrain their practice and options for birth and health care more generally.

8.3 MATERNAL MORTALITY AND INTERCULTURAL BIRTH POLICY

Viewed from an anthropological perspective policy processes are not passive and objective, policy is at once created by a specific social and cultural context and at the same time affects reality in unsuspected ways (Shore and Wright 1997; Singer and Castro 2004). The attempt to enact a global health policy which has seemingly positive effects in one area, can bring negative consequences in another (Singer and Castro 2004). Taking the intercultural birthing policy in this context the present section discusses its effects on maternal mortality in the region; on the people involved as proponents, facilitators or subjects of policy; and finally on the overall goal of promoting Safe Motherhood in Peru.

8.3.1 Effects on Maternal Mortality

As I have shown in chapter three there is a clear reduction in overall maternal mortality in Peru, in the specific regions where the research sites are located, and also in the jurisdiction of both research sites, at least during the time of the data collection and up to the end of year 2011¹. However, it is very difficult to ascertain if these reductions are indicative of a long term trend or respond to a normal fluctuation. Moreover, it is also very difficult to ascertain the concrete effect that implementation of intercultural birthing may have had on these reductions.

Though in the research sites health personnel were fairly confident in the utility of the intercultural strategy to increase the number of women birthing in their health centers and in avoiding maternal deaths, there were other several health and non-health related factors which also contribute to the general reduction in maternal deaths; for example, the expansion of the use of contraceptives and the consequent reduction in the number of pregnant and birthing women, and the increasing urbanization of the rural areas, through urban expansion

¹According to epidemiological data published in December 2012 the Flores micronetwork suffered two maternal deaths and Cajamarca as a whole a total of 33, prompting a red alert in the region

or through internal migration, which leads to a normalization of birth in the health facilities as part of an aspirational whitening process that accompanies the creation of an urban persona.

In addition, over the past five years Peru has been immersed in an economic boom which accelerated urbanization, and also allowed some groups of people that were previously dependent on public health care to attain private or social security care, which in some cases could help women and families have more options of care and perhaps more capacity for negotiation of birthing preferences. In the research areas, women whose husbands worked for mining companies or in the road construction projects were able to get second opinions on public health NMs diagnoses, some with enough resources had prenatal care visits at both the health center and the social security clinic in the city so they could access the extra ultrasounds and ultimately have options in case the pregnancy or birth were complicated by an emergency. However, a negative side of the boom years for the public health sector, especially in Cajamarca, was the reduction in available medical and nursing school graduates to fill existing professional positions, furthermore several who had trained in the public system and had achieved a high level of specialization through public health funding were leaving the public system in droves for highly lucrative, if intense, jobs at mining and natural gas companies in the region. This left health centers in the Cajamarca region understaffed and reduced the resolution capacity of networks and micronetworks which resulted in increased risk of death in the rural areas of the region.

A final related external factor influencing maternity and birthing in health facilities was the expansion of the JUNTOS Peruvian cash transfer program, which was funded in part by the new revenue generated by the extraction industries. The effect of this program on birth and birthing varies, some health care providers see it as the final economic incentive that many needed to birth in a health facility rather than at home, but others viewed it as inducing unsafe pregnancies. Those critical of the program asserted that the requirements to form part of JUNTOS (proof of economic need, having a child under the age of 18, and being pregnant or nursing) prompted families to have a higher number of children, older women to become pregnant when their offspring were aging out of the program, and younger women who might have delayed childbearing to speed it to become eligible. As a

result they argued that JUNTOS had created a dependent populous and promoted risky reproductive behaviors. Though proof of these dire consequences were mainly anecdotal, it is possible that this may be an effect of JUNTOS, however it seems somewhat unlikely since the waiting list for being included in the program was so large and the wait time so long that it seems somewhat unlikely. Furthermore, JUNTOS provided only a three year allowance to participating families so long term participation may not have been possible. The reception of JUNTOS money was contingent on families following a list of requirements, which included complying with birthing in public health facilities, going to prenatal and well-child care visits at the health center in a timely fashion, sending all children to school and preschool if possible, and not allowing more than three absences a month from school. The way in which the JUNTOS program itself is a form of governance focused on re-making rural and indigenous peoples into a certain type of model subject-compliant-citizens warrants further research and analysis, however, from the perspective of this research the birthing requirements did have bearing on the increase in health facility births.

Most policy level interviewees at the research areas did not seem convinced that favorable results, like the increase in birthing at health facilities and reduction of maternal deaths, could be attributed to the intercultural birthing policy. Rather preferring to explain them as a consequence of the success in training health personnel in cultural awareness which brought them closer to the communities they served. A second explanation for the good-end results was that the education campaigns, in rural communities were having the desired effect, making men and women more responsible, more attuned to the proper ways to care for pregnancy and birth. This distinct lack of fanfare regarding the possible role of the intercultural birthing policy in the reduction of maternal deaths, was especially poignant in light of the broad promotion and praise that the policy had received nationally and internationally. The responses from policy makers and health personnel during my research have led me to conclude that this dismissive attitude towards the intercultural birthing policy, the lack of monitoring and support for implementation, and the patent lack of interest in systematizing and evaluating results at diverse implementation sites are all indicative of the uncomfortable nature of *interculturalidad* and what it represents, at least on paper, the recognition of marginalized others and their medical knowledge as equals.

8.3.2 Effects on Community Members

For the intended subjects of policy, rural indigenous women and their families, there were two key changes impulsed by the intercultural birthing policy that were notable and important: the possibility to choose a position for birth, including the preferred squatting or vertical positions, and the possibility of being accompanied by family members to provide guidance and support. This was noted, especially, among women who had had experiences with birthing in the health center before and after the implementation of birth as companions, or as pregnant women themselves. As I have described in Chapter three biomedical birth in the rural Andes in areas where there is no intercultural birthing, and in urban and peri-urban low income areas, can be a violent and forceful endeavor where a woman is alone with health providers, is routinely forced to lay down, sometimes being strapped to the gurney, and can be subjected to interventions that are no longer considered necessary like routine shaving and episiotomy.

However, while recognizing the positive changes, women and men in the community resented the restriction of choice that has come with the implementation. According to community members as things stood in years past a woman would go to prenatal care with the *partera* and at the health center, some wanted to birth in the health center and did so, other preferred to birth at home and also did so with the help of a family member or a certified TBA. Certified TBAs were those who were part of a system of reference and counter-reference with the health center. As such a birthing notice from her was considered official notice of birth. TBAs were also concerned with the risk of maternal or fetal death and the repercussions, and took time to evaluate and decide if a woman could be accepted as a would-be patient, for example Maria in Flores only accepted *mujeres probadas*, that is women who had birthed vaginally with success before, and Barbara in Kantu did not accept to birth or treat women from outside her extended family members. However, the implementation of the intercultural birthing policy at the health centers was accompanied by a ban on TBA-led birthing, at least officially. This meant that the most frequent answer to my probing questions on reasons to go to the health center for birth was *es obligado* (its compulsory).

However, the ban on TBA care has not ended the role of the *parteras* in the research communities, rather it has been driven farther underground. TBAs still provide massages and herbal medicines as they have always done, but are perhaps less open about it. Furthermore, those I interviewed still helped some women birth in their homes, though they were much more selective in accepting cases.

Overall, however the available options for birth care have been reduced by the implementation of the intercultural birthing policy. In Kantu those who did not have enough money to pay for private care, or who were unable to use social security clinics only had two choices, go to the health facility for birth, or birth at home, perhaps with no specialized person, and face the consequences. In Flores there was an additional third choice, which was a hybrid option, to birth at home with a NM. However, this was only available to those who had good relations with health personnel and lived close to the health center. Furthermore, it was not an officially accepted or sanctioned practice.

When presented with only the option of birthing in the health facility or facing fines and possible backlash most community members opted for going to the health centers, though they also employed a series of strategies (see 7.1.2) which allowed them to regain some agency in the birthing process (one of the most common was waiting out the prodromal phases of labor at home, taking herbs, traditional soups and then almost at the end of the process to be taken to the health center) and which sometimes succeeded in allowing women and their families achieve a home-like experience while still complying with health center and JUNTOS regulations.

Nonetheless, for many birthing in the health center was generally not the first option (although some families did plan to birth in a health facility these were not many). It was clear that men and women in the research sites were acutely aware of the dangers of home birth, and when asked what their ideal birth option would be several mentioned the risks involved and proposed a model of home-birthing with both a family member or *partera* and a health provider. In this sense one could argue that there was an implicit demand for real intercultural birth care although the word itself was not recognized.

The model proposed by community interviewees indicated that there was no overt rejection of bio-medicine or of the public health system more generally, rather there was a

recognition that skills and knowledge of health personnel were useful to avoid the risks of the birthing process. Policy makers surmised that given that the intercultural birth policy combined the positive aspects of biomedical and traditional home birthing it would be welcomed and readily adopted by the community, but it wasn't.

Though improper implementation, persistence of discriminatory behaviors, the mistreatment of the TBAs and the presentation of the intercultural birth as an obligation all contributed to the lukewarm perception of intercultural birthing in the health center. There were also other concerns which were not addressed by the intercultural policy. The first was that there were no considerations of the problems of cold air in the postpartum stage, thus there was a concern that birthing in the health center was debilitating community women by exposing them to cold and producing humoral imbalance. Women who birthed at the center were discharged one or two days after birth, many had to face wind and cold and walk large distances to reach their homes, putting their bodies at risk for *sobrepardo*, a debilitating and progressive syndrome that is caused by cold air entering through the still open orifices of the female body. Thus one of the effects of the policy could be understood as the progressive weakening of females bodies in the community.

The second issue raised by community members was related to the obligation, for some women, to remain in the maternal waiting house in anticipation of birth. In Kantu, interviewees called it the 'health center's little jail', and I witnessed several women taken there against their will. Though the maternal waiting house was not directly a birth care issue, it was part of the broader intercultural reproductive health strategy, and it tainted the perception of health providers, interviewees in Kantu especially could not view NMs in a positive light because they were almost equated with jailers. The waiting house strategy and how it was employed by medical personnel and viewed by women and their families warrants a broader discussion in a further document, however it is important to point out that the obligation to go to waiting house, the obligation to birth in the health center, and the coercive strategies employed by health personnel to ensure compliance were all compounded to create an uncomfortable fear-laden atmosphere in relation to birthing in the community.

In this context the preference for home birthing is not an issue of stubborn cultural beliefs, just custom, or cultural need like policy makers and health providers assert repeatedly,

rather it is a strategy to regain or maintain control of the process in relation to decision making, consent (which is lost once in the health center), and to form of birth (position, clothing, people present, and temperature). Being in one's home the NM cannot hold all the power, this serves as way to prevent mistreatment and to be an active participant in the process, as a Kantu interviewee summed up '*in their center they can do anything, you can do nothing*'. Home birthing options are in essence a bid from community members to be able to exercise their rights as humans, citizens and clients of public health services. In this sense a central node of conflict is that health policy makers, health providers and other government structures and aid organizations do not, cannot or will not recognize them as full rights bearing citizens. The conflicts over birthing are yet another expression of the profound inequality inherent in the structure of governance which are endemic in Peru and other parts of the world.

8.3.3 Effects on Nurse-Midwives

The effects of the policy on the nurse midwives who were in charge of implementing intercultural birthing were also largely negative, especially if that particular person was intent on following a clinical career path which was the case of the majority of the NMs I interviewed. As I have mentioned before in this discussion in the health system structure rural health personnel were generally viewed as less sophisticated than their urban counterparts. NMs were in turn viewed as less knowledgeable in general than physicians, and sometimes nurses, because of their specialized expertise in female reproductive issues, which though important are generally seen as less interesting or challenging than other medical issues (like infectious diseases for example).

In this context being part of the implementation of a policy which, in the view of some urban doctors, was a regression to the dark ages of health care and a betrayal to the profession, effectively hindered the possibilities of the young NMs to work in urban clinics. Furthermore, living and working in remote areas would segregate them from other professional development opportunities available to colleagues who resided in urban or peri-urban areas who took specialization seminars, advanced technology courses and could pursue mas-

ters degrees. This meant that the NMs I interviewed lagged behind their peers in clinical expertise which also negatively impacted their future job prospects.

As a result, the belief among health personnel at the research sites was that if you weren't able to leave a rural for a better area in three years or less you were condemned to remain in a rural post for the remainder of your health related career. The NMs I interviewed in the research areas were at different points in their careers and had varied aspirations and perspectives and being part of the intercultural birthing policy was only seen positive for those who aspired to careers in rural areas or as part of international development projects or programs. Others were actively searching for a way to limit the repercussions of working in a rural and intercultural birth area on their resumes. In Kantu, for example, two of the younger NMs were in the process of completing online specialization courses and were actively looking for posts which would take them closer to Cusco City or to a larger urban area away from Kantu.

In addition to the problems of reduced job prospects as a result of the participation in the intercultural birthing policy, young NMs faced added issues in their personal lives. Specifically the perception that there was no possibility of achieving some measure of work-life balance, settling down and having children were deemed incompatible with working in a rural health care. This is not a direct consequence of the intercultural birthing itself. It is an endemic problem for women in health care, education and other service professions in Peru, and many other places, and is also a consequence of the persistent inequality in development, and abysmal differences in living conditions and opportunities between urban and rural areas. Health providers in rural posts live separated from partners and children who remain in cities and towns, this creates uneasiness, added stress, lack of focus and taxes their limited income. It also makes work in a remote health post feel like a burden and a sacrifice which in turn affects the way in which personnel relate to the indigenous communities they are paid to serve.

Further, the focus of policy makers at the national and regional levels on reducing or maintaining reductions in maternal deaths were also a constant source of stress for the NMs in the research areas. The perspective of being dismissed from the post as a result of a death or of being subjected to a maternal death review was an added element which negatively

affected their relationship with the patients.

Though on paper the MoH promotes equality, dialog and cultural understanding in practice the ministry does not evaluate any of these aspects, nor does it follow up on implementations of intercultural birthing or provide any monetary support, training or incentive to those health providers who promote equality or establish dialogical relationships with culturally diverse populations. It measures efficiency and efficacy as numbers (numbers of birth in the health center, number of maternal deaths, number of perinatal deaths and number of near misses) and only commends or punishes based on these data. The dissonance between discourse and practice is a pervasive problem of health care provision in Peru, it is an unequal system, that generates inequality, while espousing ideals that it has no interest, or intention to fulfill.

8.3.4 Effects on the Goal of Safe Motherhood in Peru

On the whole I contend that the intercultural birth policy, in its current iteration and as implemented in the research sites, is not furthering the cause of Safe Motherhood for all in Peru.

In the first place since the intercultural framework is subsumed under the already existing structure of the MOH, and has been emptied of all transformational power it fails in its very essence of making birth in the health services more equal, more respectful and more culturally appropriate. This reflects poorly on the MoH itself and makes promotion and replication of the intercultural policy ineffective. Furthermore in enforcing coercive measures to promote birthing in the health service the Peruvian MoH is violating the all inclusive safe motherhood ideal they claim to represent.

Furthermore since it has been a marginalized practice within the public health system it is highly person dependent. This means that if a specific person or group of people are moved away from the health service, the intercultural birthing changes could easily cease to exist. This on the one hand could lead to a loss in quality of care and a potential reduction in the population who used the service.

Additionally by rejecting traditional births attendants the health care services are losing

an important source of knowledge, information and a key ally in the care of pregnancy and birth processes in the community. If older *parteras* who were familiar with health care services die out, they could be replaced by non-trained traditional midwives with less interest in collaborating with the health services or by equally unknowing private biomedical practitioners.

Overall, I conclude that although there are indications that the effects of the lukewarm implementation of interculturality in birth care serve as proxy for the uneasy relationship between governing structures of power the marginalized segments of the nation. It is thus a further attempt to bait and switch or cajole those ‘others’ into the realm of government control and power.

8.4 CONCLUSIONS

In this research I sought to understand the reception and effects of the framework of *interculturalidad* in reproductive health policy in Peru. In the analysis I describe how global and Peruvian contexts coalesce to promote the issue of culture and *interculturalidad* into a prominent role in health care policy. This was viewed by some as a watershed event which would transform the power structure of health care and would in turn make society at large more equitable in the process.

However, as the present analysis of the Peruvian Intercultural birth policy has demonstrated the intercultural framework cannot be fully implemented or successful in subverting the power structures of health care and promoting an equal and culturally respectful dialog if it is not supported by a wholesale change in the perception of the indigenous ‘other’ at a larger institutional and societal level.

Furthermore, it cannot be implemented from an institutional structure that replicates inequality, that continues to hold the results as more important than the means to achieve them, and that rewards cognitive dissonance between discourse and practice.

Thus applied conceptions of *interculturalidad* which are readily espoused at the policy levels in Peru are in fact a cooptation of the concept which is put to the service and main-

tenance of an already existing form of governance, which restricts citizenship rights to the poor and indigenous.

The intercultural birth policy is a tool to promote a civilizing agenda which seeks to control who reproduces and how. It conflates issues of citizenship and gender inequality to recreate a system where indigenous women, and the women who tend to them are excluded from decisions about their own bodies, the former, and their own professional lives, the latter. What is more, it is a stepping stone in a broader process of normalizing a different kind of homogenized modernity modeled on an urban western ideal of behavior, but devoid of agency and decision making potential.

Culture in this context is merely a red herring in terms of seeking the means to equity in safe motherhood. The control of birthing and reproduction is at once a way to modernize and maintain inequality. To be truly equitable a reproductive policy needs to be based on flexibility and choice, as it stands this policy restricts both.

In this context the question becomes is there a place for interculturality in health care and in public policy more generally?

Despite the challenges and lukewarm reception from direct care personnel, *interculturalidad* as a conceptual framework for policy has become mainstream in Peru and boasts a robust following in Global Health organizations. As such it will persist as a model and basis for policy in the years to come. As such I believe it can still be a useful perspective to consider and think with in regards to policy. Additionally its acceptance, on paper at least, by the biomedical representatives of policy in the MoH is still useful as an entrance to the discussion of culture which has previously been suppressed in relation to biomedical practice. However it also seems clear that any implementation of *interculturalidad* in health in Peru, or elsewhere, should be a way to channel the concrete expectations and concerns of the intended subjects of policy instead of pre-defining their needs unilaterally as has often been the case.

Furthermore in Peru with the creation of the Vice -Ministry of Interculturality there is a certain responsibility, to remain engaged in the discussion of the meaning of the Intercultural framework, and how it could or should be incorporated, and beneficial to the creation of truly subversive policy endeavors.

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